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New Jersey Department of Human Services
Division of Mental Health and Addiction Services
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# Mental Health Fee-for-Service Program Provider Manual Version 2.0 July 2017

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# 1. Introduction

Beginning January 1, 2017, the New Jersey Department of Human Services (DHS), Division of Mental Health and Addiction Services (DMHAS) instituted a new approach to funding certain community-based mental health services, known as the Mental Health Fee-for-Service Program ("MH FFS Program"). The MH FFS Program pays provider agencies under contract with the DMHAS to deliver community-based mental health services on a fee-for-service basis.

The MH FFS Program is funded primarily from State appropriations.[1] In order to conserve that limited resource, the MH FFS Program is the payer of last resort. As such, payment through the MH FFS Program is prohibited when other sources of payment are available, such as Medicaid, Medicare, charity care, or private insurance.

All contracted provider agencies with eligible FFS program elements will transition from their current cost-related contracts with installment payments (also known as cost-reimbursement contracts) to a non-cost related contract with fee-for-service payment on July 1, 2017. Community Support Services (CSS) programs have been offered the choice of transitioning to FFS on either July 1, 2017, or remaining cost-based until January 1, 2018, when they will transition to FFS.

The purpose of this manual is to provide guidance to those provider agencies that are participating in the MH FFS Program. More specifically, this manual includes information on provider eligibility, program eligibility, billing procedures, documentation requirements and other related topics. The goal is to provide uniform direction and guidance to provider agency staff when participating in the MH FFS Program.

This manual is supplemented by the NJ Mental Health Application for Payment Processing Provider (NJMHAPP) User's Guide, which contains detailed information about how to use NJMHAPP and detailed requirements for provider billing.

This manual primarily addresses procedures and practices specific to the Mental Health FFS Program. As such, it is not a comprehensive guide to all requirements related to operating a mental health program. Each provider agency is responsible for assuring that it operates in conformance with all applicable federal and State statutes and regulations, as well as contractual requirements and applicable DHS and DMHAS policies. Information on current DHS regulations is available of the DHS website at http://www.nj.gov/humanservices/providers/rulefees/regs/.

The DMHAS has made every effort to ensure that the information in this manual reflects current legal requirements. In the event of conflicting requirements, however, governing Federal and State legal authority takes precedence over guidance in this manual.

The DMHAS periodically will review and revise this manual as needed. All information provided in this manual is subject to change at any time the DMHAS deems it necessary to do so.

Questions or requests for manual revisions should be directed to the Division's FFS Transition help desk at: MH-FFSTeam@dhs.state.nj.us

[1] A small proportion of funding is from the federal Mental Health Block Grant.

# 2. Provider Eligibility to Participate in the MH FFS Program

## A. Contract with DMHAS

At this time, participation in the MH FFS Program is limited to providers that were under contract with DMHAS for state funding as of December 31, 2016, with the exception of Community Support Service (CSS). The MH FFS Program does not create an opportunity for providers to expand state-funded services beyond those approved and authorized within the scope of their current contract.

## B. Enrollment as NJ FamilyCare Provider[2]

All providers in the MH FFS Program are required to be an approved NJ FamilyCare provider and have an assigned NJ FamilyCare provider billing number. Further, a provider must maintain its status as an approved Medicaid/NJ Family Care provider as a condition of continuing participation in the MH FFS Program. A NJ Family Care provider enrollment application can be requested at https://www.njmmis.com/onlineEnrollment.aspx. Any questions regarding the provider's status as an approved NJ Family Care provider should be directed to Molina Medicaid Solutions Provider Services at 1-800-776-6334.

Providers under contract with the DMHAS to provide only services not covered by Medicaid, i.e., those providing only supported employment or supported education services, will be required to enroll as a Medicaid non-billable provider. DMHAS staff will assist with this process.

## C. Qualified Entity to Perform NJ Family Care Presumptive Eligibility Determinations

Although not required, providers are strongly encouraged to become qualified entities to perform NJ FamilyCare presumptive eligibility determinations. This will expedite NJ FamilyCare coverage for eligible consumers and maximize federal financial participation. Providers interested in becoming qualified entities should send an email to the DMHAS State Presumptive Eligibility Coordinator at: Pe-Trainingrequests@dhs.state.nj.us. The availability of presumptive eligibility training is subject to available funding. . Once training is successfully completed, the provider should request the Site Certification Form by sending an email to the State Presumptive Eligibility Unit at MAHS.PE.Response@dhs.state.nj.us.

# 3. Services covered by the MH FFS Program

## A. MH FFS Program Services

Table 1 lists the mental health programs eligible for funding through the MH FFS Program. In this context, "mental health program" refers to a category of services, e.g., outpatient programs, community residences. Some of those categories include subtypes of services, for example, outpatient programs include diagnostic evaluations, medication monitoring, individual therapy, etc.[3]

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[2] NJ FamilyCare is New Jersey's Medicaid system.

[3] More detailed information on the services encompassed within a mental health program category is provided in the rate table located at Appendix D.

That table provides a brief description of the services, as well as a citation to any DMHAS regulations, policies or guidelines specifically applicable to the service. In addition to the listed specific regulations, providers should be mindful that the Community Mental Health Act regulations at N.J.A.C. 10:37 generally apply to all community-based mental health services, as do the Management and Governing Body Standards set forth at N.J.A.C. 10:37D. Community-based mental health programs licensed under N.J.A.C. 10:190, Licensure Standards for Mental Health Programs, also must follow the standards therein. The Annex A for the program, which is part of the provider agency's contract with the DMHAS, should also be consulted for program requirements, particularly with respect to ICMS, Supported Employment, Supported Education, in-reach services and pre-admission services.

Table 1 also identifies those services covered by Medicaid/NJ FamilyCare. This is very important information with respect to whether funding is available through the MH FFS Program for the following reason. If the service is covered by Medicaid/NJ FamilyCare and the consumer is Medicaid/NJ FamilyCare eligible, then funding is not available through the MH FFS Program because it is the payer of last resort. Accordingly, providers should submit claims for Medicaid-covered services provided to Medicaid-eligible consumers to Molina, the Medicaid/NJ FamilyCare fiscal agent.[4]

As denoted in Table 1, the following MH FFS Program services are not covered by NJ FamilyCare and, accordingly, should be accessed through the MH FFS Program regardless of whether or not the consumer is Medicaid-eligible:

- ICMS In-Reach
- ICMS Pre-Admission
- PACT In-Reach
- PACT Pre-Admission
- Supported Employment
- Supported Employment In-Reach
- Supported Employment Pre-Admission
- Supported Education
- Supported Education In-Reach
- Supported Education Pre-Admission
- Supervised Housing Room and Board
- Supervised Housing Bed Holds and Overnight Absences
- Supervised Housing Pre-Admission
- Community Support Services In-Reach
- Community Support Services Pre-Admission

[4] When providing a Medicaid covered services to a Medicaid eligible consumer, providers also must adhere to the applicable Division of Medical Assistance and Health Service regulations.

Table 1: MH FFS Program Services

| Program/Service | Brief Description | Applicable Regulations (if any) or other guidelines | Covered by Medicaid/NJ FamilyCare |
|---|---|---|---|
| Outpatient | Mental health services provided in a community setting. Specific services include psychiatric evaluation, medication monitoring, individual therapy, group therapy and family therapy. | N.J.A.C. 10:37H | Yes |
| Partial Care (PC) | Individualized, outcome oriented, structured, non-residential program offered in a non-hospital setting. The program includes active treatment and psychiatric rehabilitation. | N.J.A.C. 10:37F | Yes |
| PC Transportation | Transportation to and from the service location | N.J.A.C. 10:66-2.17 | Yes |
| Partial Hospital (PH) | Individualized, outcome-oriented psychiatric service which provides a comprehensive, structured, non-residential, interdisciplinary treatment and psychiatric rehabilitation to assist individuals who have serious mental illness in maximizing independence and community living skills. | N.J.A.C. 10:52A | Yes |
| PH Transportation | Transportation to and from the service location. | | |
| Acute Partial Hospital (APH) | Intensive and time limited acute psychiatric service for individuals who are experiencing, or at risk for, rapid decompensation. This mental health services is intended to minimize the need for hospitalization. | N.J.A.C. 10:52A | Yes |
| APH Transportation | Transportation to and from the service location. | | |
| Integrated Case Management Services (ICMS) | Individualized, collaborative and flexible outreach service designed to engage, support and integrate individuals with serious mental illness into the community of their choice and | N.J.A.C. 10:73-2.1 to -2.13[5]<br><br>ICMS Annex A | Yes |
| | | | |

[5] DMHAS does not have regulations governing ICMS, but expects providers to comply with the requirements set forth in the Medicaid regulations governing mental health case management services for adults at N.J.A.C.10:73-2.1 to -2.13, except to the extent that those regulations require consumers to be eligible for Medicaid. Further, where there is a conflict regarding the billing and reimbursement requirements and procedures between this manual and the Medicaid regulations, this manual shall govern with respect to services funded under the MH FFS Program.

| Program/Service | Brief Description | Applicable Regulations (if any) or other guidelines | Covered by Medicaid/NJ FamilyCare |
|---|---|---|---|
| Integrated Case Management Services (ICMS) | Individualized, collaborative and flexible outreach service designed to engage, support and integrate individuals with serious mental illness into the community of their choice and facilitate their use of available resources and supports in order to maximize independence. Provided primarily in the consumer's natural environment. ICMS services include, but are not limited to assessment, service planning, service linkage, ongoing monitoring, ongoing clinical support and advocacy. | N.J.A.C. 10:73-2.1 to -2.13[6]<br><br>ICMS Annex A | Yes |
| ICMS In Reach Services | ICMS services provided to consumers in certain in-patient or correctional facility. Consumers must be enrolled in the ICMS program at the time of admission to the inpatient unit or correctional facility in order for the provider to seek reimbursement | In-Reach Guidelines[7]<br><br>ICMS Annex A | No |
| ICMS Pre-Admission Services | ICMS services provided to consumers in certain inpatient facilities who were not previously enrolled in the ICMS program at the time of admission. | Pre-Admission [8]Guidelines<br><br>ICMS Annex A | No |
| Programs of Assertive Community Treatment (PACT) | Comprehensive, integrated rehabilitation, treatment and support services for individuals with serious and persistent mental illness, who have repeated psychiatric hospitalizations and who are at serious risk of psychiatric hospitalization. Provided in the consumer's home or other natural setting by a multi-disciplinary treatment team. PACT is the most intensive program element in the continuum of ambulatory community mental health care. | N.J.A.C. 10:37J<br>N.J.A.C. 10:76-2.4[9]<br>N.J.A.C. 10:79B-2.4(g) | Yes |

[6] DMHAS does not have regulations governing ICMS, but expects providers to comply with the requirements set forth in the Medicaid regulations governing mental health case management services for adults at N.J.A.C.10:73-2.1 to -2.13, except to the extent that those regulations require consumers to be eligible for Medicaid. Further, where there is a conflict regarding the billing and reimbursement requirements and procedures between this manual and the Medicaid regulations, this manual shall govern with respect to services funded under the MH FFS Program.

[7] Reprinted in Appendix A of this manual.

[8] Reprinted in Appendix G of this manual.

[9] It is the DMHAS practice to apply Division of Medical Assistance and Health Service rules prohibiting billing for more than one of specified types of mental health service. The cited regulations prohibit billing for PACT during the same month that a consumer receives ICMS or supervised housing services or while a consumer is receiving CSS services.

| Program/Service | Brief Description | Applicable Regulations (if any) or other guidelines | Covered by Medicaid/NJ FamilyCare |
|---|---|---|---|
| PACT In-Reach Services | PACT services provided to consumers in certain inpatient or correctional facilities. Consumers must be enrolled in the PACT program at the time of admission to the inpatient unit or correctional facility in order for the provider to seek reimbursement. | In-Reach Guidelines[7]<br><br>PACT Annex A | No |
| PACT Pre-Admission Services | PACT services provided to consumers in certain inpatient facilities who were not previously enrolled in the PACT program at the time of admission. | Pre-Admission Guidelines<br><br>PACT Annex A | No |

| Program/Service | Brief Description | Applicable Regulations (if any) or other guidelines | Covered by Medicaid/NJ FamilyCare |
| --- | --- | --- | --- |
| Supported employment (SE) | SE is for individuals with severe mental illness, with an interest in working, who require ongoing support services to succeed in competitive employment. Services include supports to access benefits counseling; identify vocational skills and interests; and develop and implement a job search plan to obtain competitive employment in an integrated community setting that is based on the individual's strengths, preferences, abilities, and needs. SE is provided in the community and as an "in-reach" service as outlined in the In-Reach Guidelines. | SE Annex A | No |
| Supported Employment In-Reach Services | SE services provided to consumers in certain inpatient facilities. Consumers must be enrolled in the SE program at the time of admission to the inpatient unit in order for the provider to seek reimbursement. | In-Reach Guidelines<br><br>SE Annex A | No |
| Supported Employment Pre-Admission Services | SE services provided to consumers in State Psychiatric Hospitals who were not previously enrolled in the SE program at the time of inpatient admission. | Pre-Admission Guidelines<br><br>SE Annex A | No |
| Supported Education (SEd) | SEd assists individuals with mental illness to participate in an education program so they may receive education and training needed to achieve their learning and recovery goals and become gainfully employed in a career of their choice. SEd provides direct services and support in educational coaching so that consumers may enter and succeed in educational opportunities. SEd also serves as a clearinghouse for information for consumers, families, colleges, and providers within a geographical area. The services also include enrollment and registration assistance, teaching study skills, illness management and recovery skills particularly related to school, and assistance and advocacy in obtaining reasonable accommodations from the educational institution. | SEd Annex A | No |
| | | | |

| Program/Service | Brief Description | Applicable Regulations (if any) or other guidelines | Covered by Medicaid/NJ FamilyCare |
|---|---|---|---|
| Supported Education In-Reach Services | SEd services provided to consumers in certain inpatient facilities. Consumers must be enrolled in the SEd program at the time of admission to the inpatient unit in order for the provider to seek reimbursement. | In-Reach Guidelines<br><br>SEd Annex A | No |
| Supported Education Pre-Admission Services | SEd services provided to consumers in State Psychiatric Hospitals who were not previously enrolled in the SEd program at the time of inpatient admission. | Pre-Admission Guidelines<br><br>SEd Annex A | No |
| Community Residences for Adults with Mental Illness ("Supervised Housing") | Rehabilitation and support services provided in a community-based residential setting to adults with mental illness who require assistance to live independently in the community. | N.J.A.C. 10:37A | Yes |
| Supervised Housing Room and Board | Shelter and food provided to consumers receiving supervised housing services | N.J.A.C. 10:37A | No |
| Supervised Housing Bed Holds | Reimbursement for maintaining a consumer's placement periods of brief hospitalization and temporary absences as required by N.J.A.C. 10:37A-11.4(c). | Bed Hold and Overnight Absence Reimbursement Guidelines[10] | No |
| Supervised Housing Overnight Absence | Reimbursement for room and board when the consumer is present in the supervised housing setting for at least part of the day, but does not sleep in the supervised housing setting. | Bed Hold and Overnight Absence Reimbursement Guidelines | No |
| Supervised Housing Pre-Admission Services | Services provided to consumers in certain inpatient facilities who were not previously enrolled in the Supervised Housing program prior to admission to the inpatient unit. | Pre-Admission Guidelines | No |
| Community Support Services (CSS) | Mental health rehabilitation services that assist individuals with severe mental health needs to attain the skills necessary to achieve and maintain their valued life roles in employment, education, housing, and social environments. | N.J.A.C. 10:37B | Yes |
| | | | |

[10] Reprinted in Appendix B of this manual.

| Program/Service | Brief Description | Applicable Regulations (if any) or other guidelines | Covered by Medicaid/NJ FamilyCare |
|---|---|---|---|
| Community Support Services (CSS) In-Reach Services | CSS services provided to consumers in certain inpatient or correctional facilities. Consumers must be enrolled in the CSS program at the time of admission in order for the provider to seek reimbursement. | In-Reach Guidelines | No |
| Community Support Services (CSS) Pre-Admission Services | CSS services provided to consumers in State Psychiatric Hospitals who were not previously enrolled in the CSS program at the time of inpatient admission. | Pre-Admission Guidelines | No |

# 4. MH FFS PROGRAM: FISCAL REQUIREMENTS AND GUIDANCE

## A. Payer of Last Resort

The MH FFS Program is the payer of last resort. As such, prior to seeking payment through the MH FFS Program, provider agencies are required to determine whether there is any other source of payment, such as Medicaid, Medicare, charity care or health insurance and, if yes, seek payment from that source. Payment is not available through the MH FFS Program if there is another source of payment.

The most likely alternate source of payment in this context is Medicaid/NJ Family Care (see section 3, above, to identify mental health services covered by Medicaid/NJ Family Care). To maximize use of federal financial participation available under Medicaid, provider agencies must assist low-income consumers who are not current Medicaid beneficiaries to apply for Medicaid/NJ FamilyCare. To further that process, the New Jersey Mental Health Application for Payment Processing includes an income module that is used to identify low-income consumers that might meet the fiscal eligibility criteria for Medicaid/NJ FamilyCare. (That application is described in the next section). As previously noted, providers are encouraged to become qualified entities to perform Medicaid presumptive eligibility determinations to expedite the application process. Providers that are not qualified entities are expected to assist consumers in completing and submitting a NJ FamilyCare application. NJ FamilyCare on-line and downloadable applications are available at: http://www.njfamilycare.org/apply.aspx.

In order to insure that there has not been a change in Medicaid status, provider agencies are also expected to check the Medicaid status of consumers prior to submitting any claim for payment from the MH FFS Program through the eMEVS system.

In addition, providers must evaluate whether a consumer is eligible for charity care coverage if the consumer will receive hospital- based outpatient or partial hospitalization services. Providers

cannot request payment for those services through the MH FFS Program if the consumer is eligible to receive charity care.

With respect to insurance coverage, the DMHAS is using the third party liability edits used for New Jersey's Medicaid program as guidance. This information is included in the rate table included as Appendix D. If a consumer has insurance that covers the service, then payment is not available through the MH FFS Program.

## B. New Jersey Mental Health Application for Payment Processing

The New Jersey Mental Health Application for Payment Processing (NJMHAPP) is a secure web-based application developed by DHS to collect information from providers participating in the MH FFS Program that is needed for DHS to pay providers for covered services provided to qualifying consumers. Thus, payment under the MH FFS Program requires the provider to enter all required information into the NJMHAPP.

Information about the NJMHAPP, including an overview of its design and functionality and detailed instructions on its use, is provided in the NJMHAPP IT Help Manual and is found on the NJMHAPP home page.

## C. Rates for Services funded under the MH FFS Program

The rates for services funded through the MH FFS Program are listed in Appendix D, along with procedure codes, modifiers and business rules. The business rules describe limitations on the service, such as the number of units that can be provided during a period of time and any prohibitions against providing the service on the same day as another service.

Those rates are the result of a thorough and transparent process that included input from stakeholders. The rates were established to reflect the full costs of providing the service. The goals underlying the rate setting process are:

- Increased system capacity
- Create greater access for individuals seeking treatment to access the level of care needed at the time needed
- Standardization of reimbursement across providers
- Create greater budgeting and expenditure flexibility for providers

More detailed information on the rate setting process has been communicated to providers in presentations hosted by the DMHAS in 2016.[11] As noted in those presentations, the rate for State-funded services was set at 90% of the Medicaid rate when the service is covered by Medicaid, with the exception of PACT.

## D. 15 Minute Billing Unit Definition

As set forth in the rate table in Appendix D, the billing unit for Medication Monitoring, ICMS, Level B Supervised Apartments, CSS, Supported Employment, and Supported Education services is 15 minutes. A 15-minute unit of service is defined as 15 consecutive minutes of face-to-face services

[11] The slides from that presentation are available at: http://www.state.nj.us/humanservices/dmhas/information/stakeholder/Rate_Setting_Transition_Overview.pdf

with a consumer or on behalf of the consumer. Thus, a 15 minute unit can be billed only when 15 continuous minutes of services is provided. In setting the above-described requirement for the 15-minute billing unit, the DMHAS used the Division of Medical Assistance and Health Services (DMAHS) regulations for ICMS, Level B Supervised Apartment, and CSS as guidance. See N.J.A.C. 10:73-2.1 (ICMS), N.J.A.C. 10:77A-2.5(d) (Level B supervised apartment); and N.J.A.C 10:79 B-2.4 (CSS).

## E. Monthly Payment Limits for Services Funded through the MH FFS Program

In order to control expenditures of State funds, DMHAS has established a monthly limit for payment through the MH FFS Program by provider. The monthly limit is the limit for payment for all programs that the provider agency is authorized to deliver in the MH FFS Program with the exception of CSS, which has a separate monthly limit. The provider's monthly limit(s) are set forth in its contract with the DMHAS. NJMHAPP has functionality that will assist providers in tracking the status of available funds. These monthly limits will help to assure that funding through the MH FFS Program is available throughout the fiscal year.

## F. Requests to increase monthly limits

Provider agencies may submit a request for an increase in their monthly limit to the DMHAS if the Providers Agency's claims for the month exceed 90 % of its monthly limit. The request must include the justification for increasing the limit and how long the increase is needed. Requests for an increase shall be granted at the discretion of the DMHAS depending on the justification of the request and available resources.

## G. Roll over of unused amounts of the monthly limit for programs other than CSS

To ensure that available resources are used to meet the needs of consumers, the DMHAS expects that the total amount billed based on the provider agency's claims during a month will be at least 80% of its monthly limit. For example, if a provider agency's monthly limit is $100,000, then it is expected to submit claims totaling at least $80,000 during the month.

If the provider agency's claims for payment are under the monthly limit, the unused portion of the limit automatically will roll over to the following month during months one and two, regardless of whether or not the provider agency met the above-described 80% threshold. For example, if the monthly limit is set at $100,000 and the provider agency claims total $70,000 during month one, then $30,000 will be rolled over for month two.

However, after month two, the amount to be rolled over will be affected by whether or not the provider agency met the 80% threshold as follows. If the provider agency's claims for payment are under the monthly limit, the entire unused portion of the monthly limit will roll over to the following month only if the provider agency has met the 80% threshold. If the provider agency's billing for the month is less than 80% of the monthly limit, then only 50% of the unused portion of the monthly limit will be roll over to the following month. For example, if the monthly limit is set at $100,000 and the provider agency claims total $80,000 during the month, then the entire remaining $20,000 will be rolled over the following month. If the provider agency bills only $50,000 during the month, then only 50% of the remaining $50,000 will be rolled over the following month.

The monthly limit for the purpose of establishing the 80% threshold is not effected by the amount rolled over from the prior month. Thus, if the provider agency's monthly limit is set at $100,000 and the provider agency bills only $80,000 during the month one, then the monthly limit will remain at $100,000 and the provider agency bills only $80,000 during month one, the monthly limit will remain at $100,000 for month two for the purpose of establishing whether the provider agency has met the 80% threshold even though the provider agency will be able to bill up to $120,000 in month two. If the provider agency bills only $80,000 during month two, then the provider agency will have met the 80% threshold and all unused funds available in month two ($40,000) will be rolled over to month three.

The total amount that can be rolled over to the following month is capped at 100% of the provider agency's original monthly limit. No funds will automatically roll over at the end of the contract to the next contract period.

## H. Roll-overs of unused amounts of the monthly limit for CSS

All unused funds will be rolled over to the following month up to the amount of the provider agency's original monthly limit for CSS. The provider agency will not have access to unused funds available at the end of the contract period.

***Note regarding timing of availability of amounts**: The amount available to be rolled over will not be known until the 15th of the month because that is the final day that claims for the preceding month can be submitted. Consequently, the rolled-over funds will not be available until 3 business days after the 15th of the month.*

## I. CSS Prior Authorization Requirements and Related NJMHAPP Functionality

CSS providers are required to follow the prior authorization requirements in the companion Division of Medical Assistance and Health Services (Medicaid) CSS regulations at N.J.A.C. 10:79B-2.7 for services funded by the MH FFS Program. Applying those prior authorization requirements to State-funded services helps to ensure that limited resources are directed toward documented needs and also provides consistency of practice regardless of the funded source, i.e., NJ Family Care or the MH FFS Program.

As set forth at N.J.A.C. 10:79-2.7, prior authorization is not required for the first 60 days that a consumer receives CSS. During that period, the CSS provider should deliver and bill for services as set forth in the consumer's preliminary individualized rehabilitation plan (PIRP) as long as the units of services do not exceed the limitations set forth at N.J.A.C. 10:79B-2.4. Per those limits, the provider may bill for up to 28 units per day per consumer, with a limit of 8 units per day for services delivered by a psychiatrist and 12 units per day for services provided by an APN. Prior to the end of the 60 day period, the CSS provider must obtain prior authorization by submitting the consumer's individualized rehabilitation plan (IRP) to Rutgers University Behavioral Health Care, which is the Division's designated Interim Management Entity for CSS (IME-CSS). Prior authorizations are for a six-month period. The DMHAS is providing more detailed instructions and training to CSS providers on the procedures for obtaining prior authorization through the IME-CSS.

NJMHAPP 2.0 includes specific functionality to address the CSS prior authorization requirements. In order to encumber and bill for services for a newly admitted consumer during the initial 60-day period, the CSS provider must first enter the number of units per band from the consumer's PIRP (referred to in NJMHAPP at the 60 day IRP) in the CSS Admission/IRP module. Prior to the expiration of the initial 60-day period, the IME-CSS will enter the number of prior authorized units per band based on its review of the IRP submitted by the CSS provider. It is important for CSS providers to understand that they will not be able to encumber and bill through NJMHAPP without following these steps. The NJMHAPP User Guide, Version 2 includes further instructions on NJMHAPP's CSS-specific functionality.

Provider agencies should be aware that prior authorization is not a guarantee of payment, which is always subject to the availability of funds. For example, a provider agency will not be able to encumber and bill for a prior authorized service if it has exceeded its monthly limit.

***Special note regarding CSS providers remaining in cost-reimbursement contracts until January 1, 2018***: *As stated in Annex A for CSS cost-reimbursement contracts, the Division is requiring CSS providers remaining in cost-reimbursement contracts to enter information regarding services provided to non-Medicaid eligible consumers in NJMHAPP even though those providers will be paid as set forth in Annex B-1 of their cost-reimbursement contracts. The purpose of that requirement is to provide accurate information about the units of CSS delivered to consumers by the provider, which the Division will use to establish the provider's CSS monthly billing limit when the provider transitions to FFS in January 2018. In order to implement that requirement, the cost-reimbursement CSS providers will be required to enter the units per band from the PIRP in the NJMHAPP CSS Admission/IRP module and to submit IRPs to the IME-CSS, which will then enter the bands per unit from the IRP into NJMHAPP. There is no prior authorization requirement for CSS services provided under a cost-reimbursement contract and, as such, the IME-CSS will be entering the information from the IRP without a review of clinical necessity. This step is required only because of the NJMHAPP functionality requirements.*

## J. Encumbrances

The NJMHAPP includes an encumbrance module that will capture data on estimated monthly service needs. CSS providers should note that the encumbered number of units per band per consumer cannot exceed the number of units per band entered in the Admission/IRP module for the applicable time period, i.e., either the number of units per band entered by the provider based on the PIRP or the number of prior authorized units per band entered by the IME-CSS based on its review of the IRP. Additional details about the encumbrance module are provided in the NJMHAPP User's Guide.

## K. Claim Payments

A critical feature of the NJMHAPP is the encounter module, which captures the information on services actually provided to consumers and is used to generate claims. In order to ensure that there has not been a change in the consumer's Medicaid status, the NJMHAPP requires the provider agency to check a box indicating that it has checked eMEVS and confirmed that the consumer is not

Medicaid eligible by checking prior to submitting encounter information for a Medicaid-covered service. Further detail on that module is provided in the NJMHAPP User Guide.

Claims information processed through NJMHAPP will be reviewed by DMHAS fiscal staff. Following that review, a statement with the amount to be paid to each provider will be submitted to Molina, which will make the requested payment to the provider. Below is a sample financial payment from Molina Medicaid Solutions:

```
TO: XXXXXXXXXXXXXXXXXXXX            DEBIT  FINANCIAL TRANSACTION ADVICE            DATE: MM/DD/YYYY
    XXXXXXXXXXXXXXXXXXXX               NEW JERSEY MEDICAID PROGRAM          REMITTANCE NO: 9999999999
    XXXXXXXXXXXXXXXXXXXX          FISCAL AGENT - MOLINA MEDICAID SOLUTIONS    PROVIDER NO: 9999999
    XXXXXXXXXXXXXXXXXXXX                    P.O. BOX 4801
    XXXXXXXXXXXXXXXXXXXX                 TRENTON, NJ, 08650                        PAGE: 999999

                                                          PROCESSED     REMAINING     CONTROL
                                  DATE                     AMOUNT        BALANCE      NUMBER
Gross Payment                     MMDDYY            8,854.00          0       161279201

                        TOTALS    TRANSACTIONS      1       8,854.00          0
```

Payment will be based on the schedule followed by Molina. Providers will receive payment for services funded through the MH FFS Program as a single, lump sum amount from Molina for all approved claims during the billing cycle. NJMHAPP Claims detail will not be included in remittance advice generated by Molina. Rather, the DMHAS will send a notice to providers describing the basis for any denied or reduced claims for payment and Molina will have a payment line included in the remittance advice related to the DMHAS payment.

Encounter data must be entered into NJMHAPP after the service was delivered. Encounter data may be entered as frequently as daily. The deadline for submitting encounter data is the fifteenth ($15^{th}$) of the month after the month that the service was provided, i.e., if the service was provided in March 2018, the encounter data must be entered by April 15, 2018, or the claim will be denied. Providers should note that this is a stricter filing requirement than the Medicaid/NJ Family Care system, which allows claims to be submitted within one year of the service date. Agencies will be paid every two weeks based on the encounter/billing data entered into the NJMHAPP by the end date of the billing cycle (See Appendix F – Fee-for-Service Billing Schedule).

## L. Consumer Co-Payments

Provider agencies are required to collect co-payments from consumers eligible to participate in the MH FFS program pursuant to their current policies. Provider agencies shall report revenues generated through collection of consumer co-payments and/or consumer fees that are related to services reimbursed by DMHAS through the MH FFS Program. Such reports shall be made to the DMHAS fiscal unit on a monthly basis on a form that will be made available by the DMHAS. Provider agencies are required to submit the form even if there is no revenue activity for the month. Reported revenues will be deducted from future payment to the provider agency. Revenues generated through collection of consumer co-payments during the last month of the contract period will be recovered by the Division through an alternate mechanism.

## M. Claim Denials based on Failure to Apply for NJ FamilyCare

As described under Section 4.1, above, the MH FFS Program is the payer of last resort. In order to help assure that there is no other source of payment, providers are required to determine if a consumer is a current NJ FamilyCare/Medicaid beneficiary. For consumers who are not current NJ Family Care/Medicaid beneficiaries, NJMHAPP includes a module that screens for potential NJ FamilyCare/Medicaid eligibility based on the consumer's income as compared to the federal poverty guideline. When the screening indicates that the consumer may be eligible for NJ FamilyCare/Medicaid, providers are required to assist the consumer in applying for NJ Family Care/Medicaid, either through the presumptive eligibility process if the provider is a qualified entity or by assisting the consumer to complete a NJ FamilyCare application. Further, when there is a positive screen, the NJMHAPP will require the provider to indicate the status of the NJ FamilyCare application or provide a reason why an application has not been submitted. Payment through the MH FFS system may be denied for a Medicaid-covered service provided more than 60 days after a positive Medicaid screen unless there is documentation that the NJ Family Care application was submitted and denied, was submitted and is still pending, or was not submitted because the consumer does not meet the citizenship requirements. If a New Jersey Family Care application was not submitted because of consumer refusal, there must be documentation of the provider agency's good faith efforts to encourage the consumer's cooperation.

## N. Claim Adjustments and Payments Outside of NJMHAPP

NJMHAPP functionality will allow processing of timely claims for all services covered under the MH FFS Program. However, there will be certain circumstances when payments cannot be processed through NJMHAPP process.

Appendix E includes procedures for processing MH FFS payments outside of NJMHAPP.

NJMHAPP functionality will allow processing of timely claims for all services covered under the CSS Program except In-Reach and WRAP requests. Appendix E includes procedures for processing MH FFS payments outside of NJMHAPP through the FCAPS application.

Accordingly, the DMHAS has established a manual process for providers to request payment for services eligible for funding through the MH FFS Program that cannot be handled through NJMHAPP at this time. DMHAS hopes to update a subsequent version of NHMHAPP to accommodate these calculations and services.

## O. Medicaid Status Changes

When a consumer's Medicaid status changes, either becoming eligible or ineligible, the provider must take one of the following actions:

1. If the consumer becomes Medicaid eligible and is only receiving a Medicaid reimbursable service, the consumer must be discharged from NJMHAPP. The provider should then pursue Medicaid reimbursement.
2. If the consumer becomes Medicaid eligible but is receiving a non-Medicaid covered service; the consumer must be discharged and re-admitted in NJMHAPP. This discharge in NJMHAPP enables the client record to accurately reflect the consumer's Medicaid status and allows the provider to bill only for non-Medicaid reimbursable services.

3. If the consumer becomes ineligible for Medicaid, the consumer must be discharged and re-admitted to NJMHAPP so that the provider can access payment for eligible services through State funds.
4. If a consumer becomes Medicaid eligible but the provider has already received payment through NJMHAPP, the provider must reimburse the state and bill Medicaid for the time of service during Medicaid eligibility and receipt of state funds.

### P. Additional procedure for Medicaid status changes for CSS consumers

Providers must advise the IME-CSS of the change in status and also provide the IME-CSS with the number authorized units per band that remain unused at the time of the status change. That will allow the IME-CSS to apply the unused authorized units to the new payment source, i.e., the MH FFS Program through NJMHAPP for consumers that lose Medicaid eligibility and the NJ FamilyCare Program for those that become eligible for Medicaid.

# 5. Guidance for Hospital-Operated Providers Participating in the MH FFS Program

### A. Hospital-operated Providers and Charity Care Designation

Hospital-operated providers who have a charity care designation and operate an Outpatient Hospital and/or Partial Hospital service are expected to evaluate whether a consumer is eligible for charity care coverage if enrolled in either program. Hospital-operated providers cannot request payment for Outpatient Hospital and/or Partial Hospital services through the MH FFS Program if the consumer is eligible to receive charity care assistance. However, if a consumer does not meet the eligibility criteria for charity care, the provider can request reimbursement via the MH FFS Program. It is also important to note that hospital-operated providers operating other FFS eligible programs (e.g. ICMS, PACT, Residential, Community Support Services, Supported Employment and/or Supported Education) can request payment for these services through the MH FFS Program since charity care does not cover these services.

DMHAS has assigned hospital-operated providers with either an Outpatient Hospital or Partial Hospital program status in the New Jersey Application for Payment Processing (NJMHAPP), if the provider utilizes the UB-04 Hospital Medicaid billing number for each specific program. Charity care status is assigned in NJMHAPP only if the hospital-operated provider has been designated as charity care provider.

### B. Hospital-operated Providers and NJMHAPP Billing Codes

Hospital-operated providers with Outpatient Hospital and/or Partial Hospital programs typically bill Medicaid using the three-digit hospital billing codes (REV codes). The NJMHAPP billing system essentially replicates the three digit Medicaid billing codes, modifiers and business rules. The complete rate table with all FFS program billing information is available in Appendix D of this manual.

It should be noted that the 90791 code (Psychiatric Diagnostic Evaluation) and the 90792 code (Psychiatric Diagnostic Evaluation with Medical Services) are used interchangeably in NJMHAPP for both hospital-operated providers and non-hospital operated providers billing for these services. In addition, the rate for the 919 code (Medication Monitoring) has been increased in order to match the recent increase in the Evaluation and Management Service code for a 15-minute unit under code 99213.

# 6. FFS Program Contract Requirements

## A. Program and Budget Reports of Expenditures

1. Providers that have all of their programs converting to FFS will not need to complete the budget matrix for budgets, modifications, or expenditure reports because a cost related contracting relationship no longer exists between these providers and DMHAS.

2. Providers that have a both FFS programs and programs included in a DMHAS cost related contract must continue to complete the budget matrix for budgets, modifications, and expenditure reports. Programs compensated under a cost related contract will be reported under current requirements, which include full detail in columns to the right of the DMHAS subtotal. Programs compensated through non-cost related, fixed price FFS may need to be reported to the left of the DMHAS subtotal depending on whether the programs compensated through cost-related contract include any indirect or shared costs, including shared staff, space, general and administrative expenses, etc. with the FFS Programs. This is required to evaluate the distribution base(s) used to allocate such costs and to assure that those programs compensated through cost related compensation absorb an appropriate portion of such costs and to maintain an appropriate audit trail. Providers may elect to show full detail of the cost of FFS Programs exactly as is done for the cost-related programs or summarize the information in such a manner that totals are provided for each budget category and line item detail is provided for only those line items where costs are shared between the FFS and cost related programs.

# 7. Required Documentation Supporting Claims for Payment

Every claim must be supported by a progress note entered into the consumer's clinical record prior to the submission of the claim. To support a claim, the progress note must contain, at a minimum, the following information:

- A description of the service rendered
- The date and time that services were rendered
- The duration of services provided
- Name, credentials and signature of the individual who rendered the service (not required for bed holds);
- The setting in which services were rendered except for bed holds, in which case the record should document the location of the consumer justifying the bed hold.

The above represents the minimum required documentation supporting claims for services under the MH FFS Program. This does not negate any additional recordkeeping requirements set forth in

applicable regulations or policies. With respect to services that are covered by Medicaid, DMHAS suggests that it would be good practice to follow the record keeping requirements in the applicable Division of Medical Assistance and Health Service regulations even when the consumer is not a Medicaid beneficiary.

To document room and board claims, providers must develop processes to assure that a consumer was in a residential setting for the date of the claim, and that the consumer was not in an excluded setting, including but not limited to inpatient services or PACT. A separate daily progress note is acceptable to document room and board billing, as is a weekly or monthly census report that includes admissions, discharges or any other changes in status.

# 8. Fraud, Waste and Abuse

Providers are expected to take steps to prevent fraud, waste, and abuse by knowing the regulations and laws governing the services offered, and implementing a compliance program. The compliance program should include the following elements:

- Internal monitoring, oversight, and auditing;
- Implementing written standards and procedures;
- Designating an individual responsible for monitoring compliance: and
- Training staff on the standards and procedures.

Examples of fraud, waste and abuse include, but are not limited to:

- Billing for services that have not been performed or have been performed by another person
- Submitting false or misleading information about services performed
- Misrepresenting the services performed (e.g., up-coding to increase reimbursement)
- Retaining and failing to refund and report overpayments (e.g., if a claim was overpaid, the provider is required to report and refund the overpayment)
- Providing or ordering medically unnecessary services based on financial gain
- Providing services in a method that conflicts with regulatory requirements (e.g., exceeding the maximum number of patients allowed per group session)
- Misrepresenting credentials, such as degree and licensure

# 9. Claim Dispute Review

If a provider disputes the denial or reduction of a claim, the provider may request a review within 60 days of notice of the denial or reduction. The request should include the following information:

- NJMHAPP-generated consumer ID number
- Provider name, address, and contact person
- Description of the reason why the provider believes that the denial or reduction of the claim was inappropriate.

- To expedite review, attach a  copy of the notice from DMHAS showing the denial or payment reduction
- Any additional documentation supporting the provider's position that the claim was inappropriately denied or reduced.

The request should be submitted via electronic mail to: is Mh-Ffsclaimdisputes@dhs.state.nj.us.

# Appendix A—In-Reach Guidelines

I. PURPOSE: To set forth the conditions for PACT, ICMS, CSS, SE and SEd providers that are under a fee-for-service contract with the Division of Mental Health and Addiction Services (DMHAS) to receive payment for in-reach services. In-reach services are provided to or on behalf of a consumer in an in-patient setting or, for PACT, ICMS and CSS providers, a correctional facility, who was receiving services from the provider agency at the time of hospitalization or incarceration.

II. GENERAL PRINCIPLES:

A. The general goal of in-reach services is to facilitate continuity of services and a successful return to the community upon the consumers discharge from the in-patient setting or release from the correctional facility.
B. In-reach services for hospitalized consumers are available for consumers who were receiving PACT, ICMS, CSS, SE or SEd services at the time of admission to the hospital. In-reach services for incarcerated consumers are limited to consumers who were receiving PACT, ICMS or CSS services at the time of incarceration.
C. Although PACT, ICMS, and CSS are Medicaid-covered services, New Jersey Medicaid rules generally prohibit payment to such providers for services provided to consumers during periods of hospitalization or incarceration. SE and SEd are not Medicaid-covered services. Consequently, funding for in-reach services is being made available through the State-funded MH FFS Program for Medicaid eligible consumers in addition to non-Medicaid eligible consumers as set forth under Sections III through VII, below.
D. In-reach services are intended for relatively short-term absences from the provider agency due to hospitalization or incarceration. For long periods of hospitalization or incarceration, transition back to the community may be facilitated through a provider agency's provision of pre-admission services.
E. Descriptions of the types of activities that fall within the scope of in-reach services are set forth in the provider agency's Annex A for the applicable program type.
F. Reimbursement under Sections III and VII of these guidelines is expressly dependent upon the availability to the Department of funds appropriated by the State Legislature from State and/or Federal revenue or such other funding sources as may be applicable.

III. GUIDELINES FOR FFS STATE RATE REIMBURSEMENT FOR IN-REACH SERVICES BY PACT PROVIDERS

A. Medicaid Billing when a consumer is hospitalized or incarcerated for part of a month
   1. In general, Medicaid cannot be billed when PACT in-reach services are provided to a consumer residing in an Institution for Mental Disease (IMD) or correctional facility. See N.J.A.C. 10:76-2.6(c)2. In those cases, reimbursement will be from State funds only and according to the guidelines set forth at Section III.b, below.
   2. HOWEVER, Medicaid should be billed in accordance with the Division of Medical Assistance and Health Services rules at N.J.A.C. 10:76-2.6, when the following conditions are met:

a. The consumer is eligible for Medicaid and
b. The consumer is a resident of the IMD or correctional facility for only part of the month and the two-hour minimum of face-to-face services delivered to or on behalf of the consumer is met during the remainder of the month.

B. MH FFS Program Reimbursement for In-reach by PACT Providers

1. This section applies when Medicaid cannot be billed for PACT services during a month because the criteria set forth in Section III.A.2, above, are not met.
2. The unit of service for PACT is one month and reimbursement for in-reach services will be at the full monthly State rate provided that the following criteria are met:
    a. PACT staff has had a minimum of two hours of face-to-face contact with, or on behalf of, the consumer during that month except that:
        i. The two-hour minimum requirement set forth above does not apply during the month PACT services are initiated. Thus, if a PACT provider initiates services while the consumer is in an in-patient setting or correctional facility, the PACT provider will receive full reimbursement for that month regardless of whether the two-hour minimum is met.
        ii. No reimbursement is permitted during the month that PACT services are terminated. Consequently, if the PACT provider is terminating services while the consumer is in an in-patient setting or correctional facility, then no payment will be made for in-reach services provided during the month that services are terminated.
    b. The consumer has been in the inpatient setting or incarcerated for less than six continuous months.
        i. See section iii.B.3, below, for guidelines when a consumer has been an inpatient setting for six or more continuous months.
        ii. Consumers who have been incarcerated for six continuous months should be discharged from PACT services. If the PACT provider chooses to continue services beyond six months, there will be no State-funded reimbursement for those services.
3. The following guidelines apply to consumers who have been in the inpatient setting for six continuous months or more:
    a. If the consumer had been in the inpatient setting for six continuous months and the in-patient treatment team has not projected a discharge date, PACT may terminate services pursuant to N.J.A.C. 10:37J-2.7(c). If the PACT provider chooses to continue services under those circumstances, there will be no State-funded reimbursement for the PACT services provided.
4. The following guidelines apply when a consumer is in the inpatient setting or incarcerated for part of a month:
    a. For purposes of determining whether the two-hour minimum of face-to-face contact as set forth at III.b.i has been met, the cumulative amount of face-to-face time for the month will count toward the minimum requirement regardless of whether the contact occurred when the consumer was an inpatient or in the community. For example, if one hour of face-to-face contact occurs when the consumer is an inpatient and one hour of face-to-face contact occurs when the consumer is in the community,

then the two-hour minimum has been met and state dollars will be used to reimburse for the service. As set forth in Section III.A.2, above, if a Medicaid eligible beneficiary is in an IMD or correctional facility for only a portion of the calendar month, and the minimum monthly service requirement is met during the remainder of the month, the provider shall bill Medicaid for PACT service for that month.

## IV. GUIDELINES FOR FFS STATE RATE REIMBURSEMENT FOR IN-REACH SERVICES BY ICMS PROVIDERS

A. The ICMS provider will be reimbursed for in-reach services at the full State rate for each 15 minutes of in-reach services that involves either direct face-to-face contact with the consumer or face-to-face contact on behalf of the consumer subject to the limits set forth in Section IV.B., below.

B. Limit on state-funded reimbursement for ICMS in-reach services:

1. Monthly limit: Two (2) hours (equivalent to eight (8) units) of in-reach services per month. ICMS providers will not be reimbursed for in-reach services that exceed the monthly limit.
2. Limit per hospitalization or incarceration episode: Eight (8) hours (equivalent to thirty-two (32) units) per hospital or incarceration episode. ICMS providers will not be reimbursed for in-reach services delivered after the episode limit is reached.

## V. GUIDELINES FOR FFS STATE REIMBURSEMENT FOR IN-REACH SERVICES BY CSS PROVIDERS

A. The CSS provider will be reimbursed for in-reach services based upon the staff credential at the full State rate for each 15-minute unit of in-reach services that involves either direct face-to-face contact with the consumer or face-to-face contact on behalf of the consumer subject to the limits set forth in Section V.B, below.

B. Limit on state-funded reimbursement for CSS in-reach services:

1. Monthly limit: Two (2) hours (equivalent to eight (8) units) of in-reach services per month. CSS providers will not be reimbursed for in-reach services that exceed the monthly limit.
2. Limit per hospitalization or incarceration episode: Eight (8) hours (equivalent to thirty-two (32) units) per hospital or incarceration episode. CSS providers will not be reimbursed for in-reach services delivered after the episode limit is reached.

## VI. GUIDELINES FOR FFS STATE RATE REIMBURSEMENT FOR IN-REACH SERVICES BY SE PROVIDERS

A. The SE provider will be reimbursed for in-reach services at the full State rate for each 15 minute unit of in-reach services that involves either direct face-to-face contact with the consumer or face-to-face contact on behalf of the consumersubject to the limitations set forth in Section VI.B., below.

B. Limitations on State-funded reimbursement for SE in-reach services.

1. Reimbursement for SE in-reach services is not available for services provided to consumers during periods of incarceration.

2. Monthly limit: Two (2) hours (equivalent to eight (8) units) of in-reach services per month. SE providers will not be reimbursed for in-reach services delivered after the episode limit is reached.
3. Limit per hospitalization episode: Eight (8) hours (equivalent to thirty two (32) units) per inpatient hospital episode. SE providers will not be reimbursed for in-reach services delivered after the episode limit is reached.

## VII. GUIDELINES FOR FFS STATE REIMBURSEMENT FOR IN-REACH SERVICES BY SEd PROVIDERS

A. The SEd provider will be reimbursed for in-reach services at the full State rate for each 15-minute unit of service that involves either direct face-to-face contact with the consumer or face-to-face contact on behalf of the consumer subject to the limitations set forth in Section VII.B., below.

B. Limitations on State-funded reimbursement for SEd in-reach services

1. Reimbursement for SEd in-reach services is not available for services provided to consumers during periods of incarceration.
2. Monthly limit: Two (2) hours (equivalent to eight (8) units) of in-reach services per month. SEd providers will not be reimbursed for in-reach services delivered after the episode limit is reached.
3. Limit per hospitalization episode: Eight (8) hours (equivalent to thirty two (32) units) per inpatient hospital episode. SEd providers will not be reimbursed for in-reach services delivered after the episode limit is reached.

# Appendix B – Bed Hold and Overnight Absence Reimbursement Guidelines

Bed Holds and Overnight Absences in Supervised Housing Programs

I. PURPOSE: To set forth the standards for supervised housing providers licensed under N.J.A.C. 10:37A that have transitioned to Fee-for Service (FFS) to receive payment for bed holds on behalf of consumers during brief hospitalizations and temporary absences. These guidelines also include standards for receiving room and board payment when a consumer does not sleep in the supervised housing setting but is present during part of the day.

II. GENERAL PRINCIPLES:
  a. Supervised housing providers are required to maintain the consumer's placement during periods of brief hospitalizations and temporary absences for a period of at least 30 days from the date of admission to the hospital or the beginning of the temporary absence. See N.J.A.C. 10:37A-11.4(c). This is known as the required 30-day bed hold.
  b. Supervised housing providers are authorized to bill Medicaid for supervised housing services provided to a Medicaid-eligible consumer only on days where the conditions set forth at N.J.A.C. 10:77A-2.5(c)1 are met. Those criteria include, but are not limited to, the consumer's physical presence in the supervised housing facility for at least part of the 24-hour period beginning and ending at midnight. N.J.A.C. 10:77A-2.5(c)1iii.
  c. Consequently, the Division is setting forth criteria for payment from State funds for bed holds applicable to both Medicaid-eligible and non-Medicaid eligible consumers.
  d. The "bed hold" reimbursement guidelines apply when a consumer is absent from the facility for a minimum of an entire day, which is defined as a 24 hour period starting and ending at midnight.
    i. Reimbursement will be available for a bed hold of up to 30 days as set forth in Section III below. Reimbursements for bed holds beyond the 30th day will not be available except as provided under Section IV, below.
  e. An "overnight absence" occurs when a consumer is present in the supervised housing setting for at least part of the day, but does not sleep in the supervised housing setting and returns to the supervised housing setting the next day. Guidelines for overnight absences are set forth in Section V, below.
    i. For example, the overnight absence guidelines apply when a consumer is present in the supervised housing setting until 5pm on Monday and then leaves for an overnight visit with a family member and returns to the supervised housing setting at 1pm on Tuesday.
    ii. In contrast, if a consumer is absent from the supervised housing setting for a continuous period of 24 hours beginning and ending at midnight, then reimbursement will be according the "bed hold" guidelines set forth in Section III.
  f. Reimbursement under these guidelines is expressly dependent upon the availability to the Department of funds appropriated by the State Legislature from State and/or Federal revenue or such other funding sources as may be applicable.

III. Guidelines for reimbursement for initial 30-days of a bed hold required as set forth under II(d), above.
  a. All supervised housing programs except Level B apartment services

i. Reimbursement will be at the full per-diem State rate for the applicable level of service.
ii. There will not be any reimbursement for room and board during the bed hold period.
iii. The start of the bed hold reimbursement period will begin at 12:00AM midnight on the day after the day of departure from the residential site. For example, if the consumer leaves the residential site on Monday at 2:00PM, the bed hold reimbursement period will begin at 12:00AM midnight on Tuesday and continue through each 24-hour period until the day of return to the residential site.
    1. The provider agency may submit a claim through NJMHAPP for room and board on the day of departure. For non-Medicaid eligible consumers, the provider agency may submit a claim for the residential level of service on the day of departure. For Medicaid eligible consumers, the provider agency may submit a Medicaid claim for the residential level of service on the day of departure to the extent permitted under N.J.A.C. 10:77A-2.5(c)1.
iv. The end of the bed hold reimbursement period is 11:59 pm on the day prior to the date of the consumer's return to the residential site. For example, if the consumer returned to the residential site on Friday at 3:00PM, the last day eligible for bed-hold reimbursement is Thursday. The provider agency may submit a claim through NJMHAPP for room and board on the return day (in this example, Friday). For non-Medicaid eligible consumers, the provider agency may submit a claim for the residential level of service on the return date. For Medicaid eligible consumers, the provider agency may submit a Medicaid claim for the level of service on the day of return to the extent permitted under N.J.A.C. 10:77A-2.5(c)1.

b. Level B apartment services
    i. Reimbursement during the 30-day bed hold period will be at a per diem rate established by DMHAS. That per diem rate is determined by first estimating the statewide average of the number of 15 minute units of service provided per day to consumers in the level B apartments. That statewide average number of 15 minutes units of service per day is then multiplied by the rate per 15 minute of level B apartment services to calculate the per diem rate for the 30-day bed-hold.
    ii. There will not be any reimbursement for room and board during the bed hold period.
    iii. The start of the bed hold reimbursement period for consumers in Level B supervised apartments is the same as for other supervised housing services. It will begin at 12:00AM midnight on the day after the day of departure from the residential site. For example, if the consumer leaves the residential site on Monday at 2:00PM, the bed hold reimbursement period will begin at 12:00AM midnight on Tuesday and continue through each 24-hour period until the day of return to the residential site.
        1. The provider agency may submit a claim through NJMHAPP for room and board on the day of departure.
        2. On the day of the consumer's departure, the PA is authorized to bill only for the units of service actually provided; for non-Medicaid eligible consumers that claim should be submitted through NJMHAPP and for Medicaid-eligible consumers the claim should be submitted to Molina.
    iv. The end of the bed hold reimbursement period for consumers in Level B supervised apartments is the same as for other supervised housing services. It is 11:59 pm on the day prior to the date of the consumer's return to the residential site. For

example, if the consumer returned to the residential site on Friday at 3:00PM, the last day eligible for bed-hold reimbursement is Thursday. The provider agency may submit a claim through NJMHAPP for room and board on the return day (in this example, Friday). The provider agency may submit a claim for the number of units actually provided on the return day; for non-Medicaid eligible consumers that claim is submitted through NJMHAPP; for Medicaid-eligible consumers that claim is submitted to Molina.

IV. Guidelines for reimbursement for bed holds beyond 30 days
   a. A request for reimbursement will be considered by the Division for bed holds beyond the initial required 30 day bed hold period when it is demonstrated that all of the following criteria are met:
      i. The consumer's continued absence is due to ongoing receipt of inpatient hospitalization, residential addictions treatment or residential rehabilitative care;
      ii. The treatment team can project a discharge date in the reasonably foreseeable future;
      iii. Clinical information indicates imminent reoccupation of the bed; and
      iv. Loss of the placement would delay the consumer's discharge back into the community.
   b. When the above criteria are met, the Division will approve reimbursement for the bed hold for up to an additional 30 days. The provider agency may request one additional extension of reimbursement for an additional 30 days if the criteria in IV(a) continue to exist.
   c. Reimbursement will not be available for bed holds longer than 90 days.
   d. Procedures for requesting reimbursement for bed holds longer than 30 days
      i. The provider agency must request reimbursement for bed holds longer than 30 days by submitting a Bed Hold Reimbursement Extension Request Form. That form is included in Appendix C.
      ii. The Bed Hold Reimbursement Extension Request Form must be submitted according to the directions included on the form.
      iii. The Bed Hold Extension Reimbursement Extension Form must be submitted within the following time frames:
         1. Initial 30-day extension request must be submitted at least 10 days before the end of the required 30-day bed hold period.
         2. The second 30-day extension request must be submitted at least 10 days before the end of the first 30-day extension period.

V. Room and Board payments for overnight absences
   a. The provider agency may submit a claim for room and board payment for an overnight absence through the NJMHAPP subject to the limitations set forth in section b, below.
   b. Limitations on room and board payments for overnight absences
      i. Rationale: The Division of Mental Health and Addiction Services recognizes that consumers receiving supervised housing services occasionally may spend the night elsewhere, for example with a family member. Nonetheless, the general expectation is that consumers receiving supervised housing services will sleep at the supervised home or apartment. As such, reimbursement for room and board of overnight stays outside of the supervised housing setting are subject to the following limitation.
      ii. Limitation: Room and board payments for overnight absences are limited to three overnight absences per consumer per month.

## Appendix C – 30 Day Residential Bed Hold Extension Request Form

### 30 DAY RESIDENTIAL BED HOLD EXTENSION REQUEST

*For all bed hold requests beyond the standard 30 day residential bed hold period (see N.J.A.C 10:37A-11.4(c)below) , this form should be completed and sent to the DMHAS –Mental Health FFS Unit (see e-mail below) for review by the 20th day of the previous month for which the extension is being requested. The MH-FFS Unit will then forward the completed document to the appropriate DMHAS Program Analyst and Olmstead Coordinator (when applicable) for review.*

COUNTY: _____ AGENCY: _____ DATE: Click here to enter a date.

NAME: _____ DATE OF BIRTH: _____

DATE OF INITIAL INPATIENT HOSPITALIZATION, RESIDENTIAL ADDICTIONS TREATMENT OR RESIDENTIAL REHABILITATIVE CARE: Click here to enter a date.

NAME OF FACILITY WHERE THE CONSUMER INITIALLY RECEIVED, OR IS RECEIVING, INPATIENT HOSPITALIZATION, RESIDENTIAL ADDICTIONS TREATMENT OR RESIDENTIAL REHABILITATIVE CARE: _____

DATE OF TRANSFER TO EXTENDED TREATMENT UNIT (IF APPLICABLE): Click here to enter a date.

NAME OF FACILITY WHERE CONSUMER IS RECEIVING EXTENDED TREATMENT: _____

DOES THE TREATMENT TEAM HAVE A PROJECTED DISCHARGE DATE: YES ☐ NO ☐

PROJECTED DATE OF DISCHARGE: Click here to enter a date. (MUST BE WITHIN 45 DAYS FROM DATE OF REQUEST)

CLINICAL JUSTIFICATION FOR THE 30 DAY BED HOLD EXTENSION REQUEST (PLEASE PROVIDE DETAILED INFORMATION THAT THE RESIDENTIAL PROVIDER AND THE HOSPITAL, RESIDENTIAL ADDICTIONS OR RESIDENTIAL REHABILITATIVE CARE TREATMENT TEAM ARE IN AGREEMENT THE CONSUMER WILL BE ABLE TO RE-OCCUPY THE VACANT COMMUNITY BED WITHIN THE NEXT 30 TO 45 DAYS):

| |
|---|
| |

**Email completed form to: MH-FFSTeam@dhs.state.nj.us including "BH Extension Request" in subject line.**

**AGENCY REPRESENTATIVE SIGNATURE:** ________________________________

*DMHAS USE:*

**30 DAY BED HOLD EXTENSION/STATE RATE REIMBURSEMENT:**

☐ **Approved** ☐ **Denied** ☐ **Additional Information Needed**

DMHAS-FFS Representative: ______________________ DATE: ____/ /____

DMHAS-Program Analyst: ______________________ DATE: / /____

Olmstead Coordinator (If applicable): ______________________ DATE: ____/ /____

**N.J.A.C. 10:37A-11.4(c) The PA shall maintain the consumer's residential placement during brief hospitalizations and temporary absences for at least 30 days from the date of such consumer's admission to a hospital, or from the date of such consumer's leaving the residence.*

# Appendix D – NJMHAPP Code and Rate Table

| HOSPITAL-BASED SERVICES | | | | | | | |
|---|---|---|---|---|---|---|---|
| Service | Billing unit | Max. # of units per month | Revenue Code | Modifiers | DMHAS STATE ONLY RATE | Business Rules | TPL |
| HOSPITAL OUTPATIENT SERVICES | | | | | | | |
| Individual Therapy (30 min units, max units per day) | 30 Minutes | *10* | 914 | HW -Adult TJ-Child | *$61.39* | 2 units per day | X |
| Group Therapy (60 min unit, limit to 3 units per week) | 60 Minutes | *12* | 915 | HW -Adult TJ-Child | *$24.75* | 3 units per week, 1 unit per day | X |
| Medication Monitoring (15 min per unit, 2 units per day) | 15 Minutes | *4* | 919 | HW -Adult TJ-Child | *$73.44* | 2 units per day | X |
| Psychiatric Diagnostic Evaluation | One Evaluation | See Business Rules | 90791 | HW -Adult TJ-Child | *$142.15* | Can not bill 90792 on the same day. Limited to 2 evaluations per provider, per client in the calendar year. | X |
| psychiatric Diagnostic Evaluation with Medical Services | One Evaluation | See Business Rules | 90792 | HW -Adult TJ-Child | *$292.50* | Can not bill 90791 on the same day. Limited to 2 evaluations per provider, per client in the calendar year. | X |
| Acute and Partial Care Hospitalization | | | | | | | |
| Partial Hospitalization | 1 hour | *125* | 912 | | $16.13 | Minimum of 2 hrs, max of 5 hrs per day with a max of 25 hrs/wk | |
| Partial Hospitalization Transportation | one-way | *50* | 912 | HW | $6.30 | Must co-exist with a PH billing on the same date of service. Max of 2/day | |
| Psychiatric Diagnostic Evaluation | One Evaluation | See Business Rules | 90791 | HW -Adult | *$142.15* | Can not bill 90792 on the same day. Limited to 2 evaluations per provider, per client in the calendar year. | X |
| Psychiatric Diagnostic Evaluation with Medical Services | One Evaluation | See Business Rules | 90792 | HW -Adult | *$292.50* | Can not bill 90791 on the same day. Limited to 2 evaluations per provider, per client in the calendar year. | X |
| Acute Partial Hospitalization | 1 hour | *125* | 913 | | $58.50 | Minimum of 2 hrs, max of 5 hrs per day with a max of 25 hrs/wk | X |
| Acute Partial Hospital Transportation | one-way | 50 | 913 | HW | $6.30 | Must co-exist with a APH billing on the same date of service. Max of 2/day | X |

| Non Hospital-Based Services | | | | | | | |
|---|---|---|---|---|---|---|---|
| SERVICE | Billing unit | Max. # of units per month | Proc Code | *Modifiers | DMHAS STATE ONLY RATE Start 1/1/2017 | Business Rules | TPL |
| OUTPATIENT | | | | | | | |
| Psychiatric Diagnostic Evaluation | one evaluation | See Business Rules | 90791 | HW -Adult TJ-Child | *$142.15* | Can not bill 90792 on the same day. Limited to 2 evaluations per provider, per client in the calendar year. | X |
| Psychiatric Diagnostic Evaluation with Medical Services | one evaluation | See Business Rules | 90792 | HW -Adult TJ-Child | *$292.50* | Can not bill 90791 on the same day. Limited to 2 evaluations per provider, per client in the calendar year. | X |
| Individual Therapy | 20 - 30 minutes | 9 | 90832 | HW -Adult TJ-Child | *$61.39* | I unit per day | X |
| Individual Therapy with E/M | 20 - 30 minutes | 10 | 90833 | HW -Adult TJ-Child | *$63.30* | I unit per day. Can only be billed with codes 99212-99215 on the same date of service. | X |
| Individual Therapy | 45 - 50 minutes | 9 | 90834 | HW -Adult TJ-Child | *$81.23* | I unit per day | X |
| Individual Therapy with E/M | 45 - 50 minutes | 10 | 90836 | HW -Adult TJ-Child | *$81.23* | I unit per day. Can only be billed with codes 99212-99215 on the same date of service. | X |
| Special family therapy with patient present | 45 - 50 minutes | 4 | 90847 | HW -Adult TJ-Child | *$102.55* | I unit per day | X |
| Group Therapy | 90 minutes | 9 | 90853 | HW -Adult TJ-Child | *$24.75* | I unit per day | X |
| Family Conference | 25 minutes | 4 | 90887 | HW -Adult TJ-Child | *$20.62* | I unit per day | X |
| E/M Medication Monitoring -**Physician** | 10 minutes | 10 | 99212 | HW -Adult TJ-Child | $44.15 | 1 units per day | X |
| E/M Medication Monitoring -**Physician** | 15 minutes | 10 | 99213 | HW -Adult TJ-Child | $73.44 | 1 units per day | X |
| E/M Medication Monitoring -**Physician** | 25 minutes | 10 | 99214 | HW -Adult TJ-Child | $107.87 | 1 units per day | X |
| E/M Medication Monitoring -**Physician** | 40 minutes | 10 | 99215 | HW -Adult TJ-Child | $144.96 | 1 units per day | X |
| E/M Medication Monitoring -**APN** | 10 minutes | 10 | 99212 | SA + HW -Adult TJ-Child | $39.74 | 1 units per day | X |
| E/M Medication Monitoring -**APN** | 15 minutes | 10 | 99213 | SA + HW -Adult TJ-Child | $66.10 | 1 units per day | X |
| E/M Medication Monitoring -**APN** | 25 minutes | 10 | 99214 | SA + HW -Adult TJ-Child | $97.08 | 1 units per day | X |
| E/M Medication Monitoring -**APN** | 40 minutes | 10 | 99215 | SA + HW -Adult TJ-Child | $130.46 | 1 units per day | X |
| PACT | | | | | | | |
| Progressive Assertive Community Treatment (PACT) | Monthly rate | 1 | H0040 | HW | *$1,487.81* | Must provide ≥ 2 hours of service per month. No billing for consumers in IMD or correctional facility. No PC or PH unless approved; No ICMS, supervised housing or CSS during month billing for PACT. | |
| PACT In-Reach | Monthly rate | 1 | H0040 | IR | *$1,487.81* | Must provide ≥ 2 hours of service per month. See In Reach Guidelines for additional requirements and limitations. | |

| SERVICE | Billing unit | Max. # of units per month | Proc Code | *Modifiers | DMHAS STATE ONLY RATE Start 1/1/2017 | Business Rules | TPL |
|---|---|---|---|---|---|---|---|
| PACT Pre Admission | Flat rate | 1 | H0040 | PA | $1,598.08 | Must have contact with consumer while admitted to State hospital and consumer must be admitted to PACT at discharge from the State hospital. See Pre-admission Guidelines for additional requirements and limitations. | |
| | | | **PARTIAL CARE** | | | | |
| Partial Care (PC) | 1 hour | 125 | Z0170 | HW | *$16.13* | Minimum of 2 and max of 5 units per day , Maximum of 25 units per week. No PACT unless approved. | |
| Partial Care Transportation | one-way | 50 | Z0330 | HW | *$6.30* | Must have a PC billing on the same date of service. Maximum of 2 units per day | |
| Psychiatric Diagnostic Evaluation | One Evaluatio | See Business Rules | 90791 | HW -Adult | *$142.15* | Can not bill 90792 on the same day. Limited to 2 evaluations per provider, per client in the calendar year. | **X** |
| Psychiatric Diagnostic Evaluation with Medical Services | One Evaluation | See Business Rules | 90792 | HW -Adult | *$292.50* | Can not bill 90791 on the same day. Limited to 2 evaluations per provider, per client in the calendar year. | **X** |
| | | | | | | | |
| | | | **ICMS** | | | | |
| ICMS | 15 minutes | 24 | Z5006 | HW | *$34.31* | No billing for consumers during psychiatric hospitalization or in correctional facility. Unit is 15 consecutive minutes | |
| ICMS In-Reach | 15 minutes | 8 | Z5006 | QJ | *$34.31* | Maximum of 8 units (2 hours) of in-reach per month with a total episode maximum of 32 units (8 hours). Consumer must be receiving ICMS services at times of admission to inpatient setting or correctional facility. See In-Reach Guidelines for additional requirements and limitations. | |
| ICMS Pre Admissions | 15 minutes | 8 | Z5006 | PA | *$34.31* | Maximum of 8 units (2 hours) of pre admission services per month with a total episode maximum of 32 units (8 hours). Consumer must be admitted to ICMS services at time of discharge from a State or county hospital. See Pre Admission Guidelines for additional requirements and limitations. | |
| | | | | | | | |
| | | | **Supervised Residential Services** | | | | |
| Supervised Residential Group Homes Level A+ | per diem | # of days in the month. | Z7333 | HW | *$241.97* | Cannot bill with PACT, ICMS or CSS service. | |
| Supervised Residential Group Homes Level A+ **30 DAY BED HOLD** | per diem | max. of 30 consecutive days | Z7333 | QJ | *$241.97* | See Bed Hold Guidelines. During Phase I billing not available through NJMHAPP; follow procedures in Appendix E of the MHFFS Program Provider Manual. | |
| Supervised Residential Group Homes: Level A+ **30 DAY BED HOLD EXTENSION** | per diem | maximum of two (2) 30 day extensions | Z7333 | HWU8 | *$241.97* | See Bed Hold Guidelines. During Phase I billing not available through NJMHAPP; follow procedures in Appendix E of the MHFFS Program Provider Manual. | |

| SERVICE | Billing unit | Max. # of units per month | Proc Code | *Modifiers | DMHAS STATE ONLY RATE Start 1/1/2017 | Business Rules | TPL |
|---|---|---|---|---|---|---|---|
| Supervised Residential Group Homes: Level A | per diem | # of days in the month. | Z7334 | HW | *$193.27* | Cannot bill with PACT, ICMS or CSS service. | |
| Supervised Residential Group Homes: Level A 30 **DAY BED HOLD** | per diem | maximum of 30 consecutive days | Z7334 | QJ | *$193.27* | See Bed Hold Guidelines. During Phase I billing not available through NJMHAPP; follow procedures in Appendix E of the MHFFS Program Provider Manual. | |
| Supervised Residential Group Homes: Level A 30 **DAY BED HOLD EXTENSION** | per diem | maximum of two (2) 30 day extensions | Z7334 | U8 | *$193.27* | See Bed Hold Guidelines. During Phase I billing not available through NJMHAPP; follow procedures in Appendix E of the MHFFS Program Provider Manual. | |
| Supervised Residential Apartments: Level A | per diem | # of days in the month. | Z7334 | 52 HW | *$193.27* | Cannot bill with PACT, ICMS or CSS service. | |
| Supervised Residential Apartments: Level A **30 DAY BED HOLD** | per diem | maximum of 30 consecutive days | Z7334 | 52 QJ | *$193.27* | See Bed Hold Guidelines. During Phase I billing not available through NJMHAPP; follow procedures in Appendix E | |
| Supervised Residential Apartments: Level A 3**0 DAY BED HOLD EXTENSION** | per diem | maximum of two (2) 30 day extensions | Z7334 | 52 U8 | *$193.27* | See Bed Hold Guidelines. During Phase I billing not available through NJMHAPP; follow procedures in Appendix E of the MHFFS Program Provider Manual. | |
| Supervised Residential Group Homes: Level B | per diem | # of days in the month | Z7335 | HW | *$150.50* | Cannot bill with PACT, ICMS or CSS service. | |
| Supervised Residential Group Homes: Level B - 30 **DAY BED HOLD** | per diem | maximum of 30 consecutive days | Z7335 | QJ | *$150.50* | During Phase I billing not available through NJMHAPP; follow procedures in Appendix E of the MHFFS Program Provider Manual. | |
| Supervised Residential Group Homes: Level B - 30 **DAY BED HOLD EXTENSION** | per diem | maximum of two (2) 30 day extensions | Z7335 | U8 | *$150.50* | See Bed Hold Guidelines. During Phase I billing not available through NJMHAPP; follow procedures in Appendix E of the MHFFS Program Provider Manual. | |
| Supervised Residential Apartments: Level B | 15 consecutive minutes | 1440 | Z7335 | 52 HW | *$12.00* | Cannot bill with PACT, ICMS or CSS service. | |
| Level B 30 **DAY BED HOLD** | per diem | 30 consecutive days | Z7335 | 52 U9 | *$22.36* | During Phase I billing not available through NJMHAPP; follow procedures in Appendix E | |
| Supervised Residential Apartments: Level B 30 **DAY BED HOLD EXTENSION** | per diem | maximum of two (2) 30 day extensions | Z7335 | 52 U7 | *$22.36* | See Bed Hold Guidelines. During Phase I billing not available through NJMHAPP; follow procedures in Appendix E of the MHFFS Program Provider Manual. | |
| Family Care Level D | per diem | # of days in the month | Z7337 | HW | *$15.80* | Cannot bill with PACT, ICMS or CSS service. | |
| Family Care Level D 30 **DAY BED HOLD** | per diem | maximum of 30 consecutive days | Z7337 | QJ | *$15.80* | See Bed Hold Guidelines. During Phase I billing not available through NJMHAPP; follow procedures in Appendix E of the MHFFS Program Provider Manual. | |
| Family Care Level D 30 **DAY BED HOLD EXTENSION** | per diem | maximum of two (2) 30 day extensions | Z7337 | U8 | *$15.80* | See Bed Hold Guidelines. During Phase I billing not available through NJMHAPP; follow procedures in Appendix E of the MHFFS Program Provider Manual. | |
| Supervised Residential Services - Room and Board | per diem | # of days in the month | Z7333 | U8 | *$27.47* | Cannot bill with PACT, ICMS or CSS service. | |
| Supervised Residential Services - Room and Board **OVERNIGHT** | per diem | maximum of 3 per month | Z7333 | U7 | *$27.47* | See Bed Hold and Overnight Absence Reimbursement Guidelines - Appendix B of | |
| RESIDENTIAL Pre- admission | Flat rate | 1 | Z7333 | PA | $1,598.08 | Must have contact with consumer while admitted to State hospital and consumer must be admitted to Residential services at discharge from the State hospital. See Pre Admission Guidelines for additional requirements and limitations. | |
| | | | | | | | |

| SERVICE | Billing unit | Max. # of units per month | Proc Code | *Modifiers | DMHAS STATE ONLY RATE Start 1/1/2017 | Business Rules | TPL |
|---|---|---|---|---|---|---|---|
| **Supported Employment/Supported Education** | | | | | | | |
| Supported Employment (15 min) | 15 Minutes | 80 | H2024 | HJ | *$19.19* | Cannot be enrolled in PACT to receive SE services. | |
| Supported Education(15 min) | 15 Minutes | 80 | H2024 | HW | *$19.19* | Cannot be enrolled in PACT to receive SED services. | |
| SE In-Reach | 15 minutes | 8 | H2024 | IR | *$19.19* | Maximum of 8 units (2 hours) of in-reach per month with a total episode maximum of 32 | |
| SED In-Reach | 15 minutes | 8 | H2024 | HW IR | *$19.19* | Maximum of 8 units (2 hours) of in-reach per month with a total episode maximum of 32 units (8 hours). Consumer must be receiving SE/SED services at times of admission to inpatient setting. See In-Reach Guidelines for additional requirements and limitations. | |
| SE Pre Admissions | 15 minutes | 8 | H2024 | PA | *$19.19* | Maximum of 8 units (2 hours) of services per month with a total episode maximum of 32 units (8 hours). Consumer must be discharged to SE/SED services from a State hospital. See Pre-Admission Guidelines for additional requirements and limitations. | |
| SED Pre Admissions | 15 minutes | 8 | H2024 | HW PA | *$19.19* | Maximum of 8 units (2 hours) of services per month with a total episode maximum of 32 units (8 hours). Consumer must be discharged to SE/SED services from a State hospital. See Pre-Admission Guidelines for additional requirements and limitations. | |

**Community Support Services**

| SERVICE | Billing unit | Max. # of units per month | Proc Code | *Modifiers | DMHAS STATE ONLY RATE Start 1/1/2017 | Business Rules | TPL |
|---|---|---|---|---|---|---|---|
| Band 1<br>Community Support Services Physician | 15 Minutes | 64 | H2000 | HE | $94.20 | Cannot be enrolled in ICMS, PACT or Community Residences | |
| Band 1<br>Community Support Services Physician **IN REACH** | 15 Minutes | * | H2000 | IR | $94.20 | Consumer must be receiving CSS at the time of admission to inpatient setting or correctional facility. Cannot be enrolled in ICMS, PACT or Community Residences. See In Reach Guidelines for additional requirements and limitations. | |
| Band 2<br>Community Support Services APN | 15 Minutes | 96 | H2000 | HESA | $48.53 | Cannot be enrolled in ICMS or PACT | |
| Band 2<br>Community Support Services APN<br>**IN REACH** | 15 Minutes | * | H2000 | HEIR | $48.53 | Consumer must be receiving CSS at the time of admission to inpatient setting or correctional facility. Cannot be enrolled in ICMS or PACT. See In Reach Guidelines for additional requirements and limitations. | |

| SERVICE | Billing unit | Max. # of units per month | Proc Code | *Modifiers | DMHAS STATE ONLY RATE Start 1/1/2017 | Business Rules | TPL |
|---|---|---|---|---|---|---|---|
| ***BAND 3 has a maximum number of units per month of 160 across all credentials*** | | | | | | | |
| BAND 3 Community Support Services Master's No Clinical Lic. | 15 Minutes | | H2015 | HE | $28.28 | Cannot be enrolled in ICMS, PACT, Community Residences | |
| BAND 3 Community Support Services Master's No Clinical Lic. **IN REACH** | 15 Minutes | * | H2015 | HEIR | $28.28 | Consumer must be receiving CSS at the time of admission to inpatient setting or correctional facility. Cannot be enrolled in ICMS, PACT or Community Residences. See In Reach Guidelines for additional requirements and limitations. | |
| BAND 3 Community Support Services RN | 15 Minutes | | H2015 | HETD | $28.28 | Cannot be enrolled in ICMS or PACT | |
| BAND 3 Community Support Services RN **IN REACH** | 15 Minutes | * | H2015 | TDIR | $28.28 | time of admission to inpatient setting or correctional facility. Cannot be enrolled in ICMS, PACT or Community | |
| Band 3 Community Support Services Psychologist | 15 Minutes | | H2015 | AHHE | $48.53 | Cannot be enrolled in ICMS, PACT or Community Residences. | |
| Band 3 Community Support Services Psychologist **IN REACH** | 15 Minutes | * | H2015 | AHIR | $48.53 | Consumer must be receiving CSS at the time of admission to inpatient setting or correctional facility. Cannot be enrolled in ICMS or PACT. See In Reach Guidelines for additional requirements and limitations. | |
| Band 3 Community Support Services Licensed Clinical | 15 Minutes | | H2015 | HEHO | $32.27 | Cannot be enrolled in ICMS, PACT or Community Residences. | |
| Band 3 Community Support Services Licensed Clinical **IN REACH** | 15 Minutes | * | H2015 | IR | $32.27 | Consumer must be receiving CSS at the time of admission to inpatient setting or correctional facility. Cannot be enrolled in ICMS, PACT or Community Residences . See In Reach Guidelines for additional requirements and limitations. | |
| ***BAND 4 has a maximum number of units per month of 260 across all credentials*** | | | | | | | |
| BAND 4 Community Support Services Bachelor Group | 15 Minutes | | H0039 | HNHQ | $6.24 | Cannot be enrolled in ICMS, PACT or Community Residences. | |
| BAND 4 Community Support Services Bachelor deg Individual | 15 Minutes | | H0039 | HN | $24.97 | Cannot be enrolled in ICMS, PACT or Community Residences. | |
| BAND 4 Community Support Services Bachelor deg Individual **IN REACH** | 15 Minutes | * | H0039 | IR | $24.97 | Consumer must be receiving CSS at the time of admission to inpatient setting or correctional facility. Cannot be enrolled in ICMS or PACT. See In Reach Guidelines for additional requirements and limitations. | |
| BAND 4 Community Support Services LPN Group | 15 Minutes | | H0039 | HQTE | $6.24 | Cannot be enrolled in ICMS or PACT | |
| BAND 4 Community Support Services LPN Individual | 15 Minutes | | H0039 | TE | $24.97 | Cannot be enrolled in ICMS or PACT | |

| SERVICE | Billing unit | Max. # of units per month | Proc Code | *Modifiers | DMHAS STATE ONLY RATE Start 1/1/2017 | Business Rules | TPL |
|---|---|---|---|---|---|---|---|
| BAND 4 Community Support Services LPN Individual **IN REACH** | 15 Minutes | * | H0039 | TEIR | $6.24 | Consumer must be receiving CSS at the time of admission to inpatient setting or correctional facility. Cannot be enrolled in ICMS, PACT or Community Residences. See In Reach Guidelines for additional requirements and limitations. | |
| ***BAND 5 has a maximum number of units per month of 260 across all credentials*** | | | | | | | |
| BAND 5 Community Support Services Peer Group | 15 Minutes | | H0036 | HQ52 | $3.74 | Cannot be enrolled in ICMS, PACT or Community Residences. | |
| BAND 5 Community Support Services Peer Individual | 15 Minutes | | H0036 | 52 | $14.96 | Cannot be enrolled in ICMS, PACT or Community Residences. | |
| BAND 5 Community Support Services Peer Individual **IN REACH** | 15 Minutes | * | H0036 | 52IR | $14.96 | Consumer must be receiving CSS at the time of admission to inpatient setting or correctional facility. Cannot be enrolled in ICMS, PACT or Community Residences. See In Reach Guidelines for additional requirements and limitations. | |
| BAND 5 Community Support Services HS Group | 15 Minutes | | H0036 | HQ | $3.74 | Cannot be enrolled in ICMS, PACT or Community Residences. | |
| BAND 5 Community Support Services HS Individual | 15 Minutes | | H0036 | | $14.96 | Cannot be enrolled in ICMS, PACT or Community Residences. | |
| BAND 5 Community Support Services HS Individual **IN REACH** | 15 Minutes | * | H0036 | IR | $14.96 | Consumer must be receiving CSS at the time of admission to inpatient setting or correctional facility. Cannot be enrolled in ICMS or PACT. See In Reach Guidelines for additional requirements and limitations. | |
| BAND 5 Community Support Services 2 yr Associate Degree Group | 15 Minutes | | H0036 | HMHQ | $3.74 | Cannot be enrolled in ICMS, PACT or Community Residences. | |
| BAND 5 Community Support Services 2 yr Associate Degree Individual | 15 Minutes | | H0036 | HM | $14.96 | Cannot be enrolled in ICMS, PACT or Community Residences. | |
| BAND 5 Community Support Services 2 yr Associate Degree Individual **IN REACH** | 15 Minutes | * | H0036 | HMIR | $14.96 | Consumer must be receiving CSS at the time of admission to inpatient setting or correctional facility. Cannot be enrolled in ICMS, PACT or Community Residences. See In Reach Guidelines for additional requirements and limitations. | |

| SERVICE | Billing unit | Max. # of units per month | Proc Code | *Modifiers | DMHAS STATE ONLY RATE Start 1/1/2017 | Business Rules | TPL |
|---|---|---|---|---|---|---|---|
| Community Support Services **Pre Admission** | Flat rate | **1 per admission** | H0036 | PA | $1,598.08 | Must have contact with consumer while admitted to State hospital and consumer must be admitted to CSS at discharge from the State hospital. Cannot bill for more than one episode of care in a six (6) month period per consumer, per provider. See Pre Admission Guidelines for additional requirements and limitations. | |
| *** All CSS In Reach is limited to 8 units per month across all bands and credentials with a maximum of 32 units per episode** | | | | | | | |

# Appendix E—Procedures for Processing MH FFS Payments Outside of NJMHAPP

Procedures for Processing MH FFS Payments Outside of NJMHAPP

There will be instances/circumstances when payments for certain mental health services cannot be processed through NJMHAPP. Those instances/circumstances include but are not limited to:

- Certain Payments related to final denials of third party liability coverage for services covered by the MH FFS system;
- Extraordinary circumstances leading to the filing of claims beyond the timely filing limits;
- Transfer of a client from one provider to another resulting in delay in registration and violation of timely filing limits:
- Provider system error;
- State system error.

The following procedures have been established for payment of claims that cannot be submitted through NJMHAPP:

- A secure web based application, the Mental Health Fee For Service – Fiscal Claim Adjustment and Payment System (MHFFS-FCAPS), has been developed to assist with the processing of claims that cannot be submitted through NJMHAPP at this time. Providers will use this system to enter information to allow evaluation and processing of non-NJMHAPP-payment requests. Instructions on use of the MHFFS-FCAPS have been distributed to FFS providers. The website location name for MHFFS-FCAPS is: **https://mhffs-fcaps.dhs.state.nj.us**
- In order to login to MHFFS-FCAPS, providers need to use the same login name and password used for NJMHAPP.
- An initial set of reason codes for requesting non-NJMHAPP payment including the above examples has been included as drop down values in the application. There is also a text field for reasons other than those provided for through the codes.
- In addition to utilizing the MHFFS-FCAPS, providers will be required to submit a completed State of New Jersey Payment Voucher approved by management to:

Department of Human Services
Division of Mental Health & Addiction Services
Office of Fiscal and Management Operations - MH FFS Payment Unit
Attn: John Fogliano
PO Box 700
Trenton, NJ 08625-0700

- State Payment Vouchers have been distributed to providers by the state office.

- The State Payment Voucher and the MHFFS-FCAPS claim form must be submitted to the Fiscal Office for payment. Payment will not be made if both forms are not submitted.

- Hard copy documentation will be required in support of certain non-NJMHAPP payment requests such as requests for payment of services that were denied by other payers. Additional requests for documentation may be made by State staff depending on the reason for the requested payment.

Please make sure the total requested payment on the State Payment Voucher agrees with the total entered into the MHFFS-FCAPS.

- Non-NJMHAPP payment requests for reasons other than denials from other payers are due no later than 30 days from the monthly closeout. Monthly closeout is the fifteenth ($15^{th}$) of the month following the month of service provision. Offline payment requests for denials from other payers must be submitted within 180 days of the monthly closeout.

State staff will review submissions to make payment determinations. Approved payments will be processed through the regular State accounting system (not through Molina) and reductions will be made to the provider's remaining unused monthly balance for the month of service provision by State staff.

Providers will receive notice of denials or reductions to non-NJMHAPP requests for payment by email, which will include the basis for the denial or adjustment. Denial codes will include but not be limited to:

- Service is covered by Medicaid and client is Medicaid eligible during dates of service;
- Duplicate payment – there has already been a payment for this service;
- Service conflict/limitation – the same rules that apply to claims processed through NJMHAPP will apply to offline payments;

  Providers seeking a review of a denial or reduction must submit a request for review within 60 days of the date of the email notice of denial or reduction and follow the requirements for such requests as set forth in the Mental Health Fee for Service Program Provider Manual, Section 9, Claim Dispute Review.

## NJMHAPP VS FCAPS CHART - JULY 1, 2017

| Program | NJMHAPP JULY 17 | FCAPS JULY 17 |
|---|---|---|
| CSS IN REACH | | X |
| CSS PREADMISSION | X | |
| ICMS IN REACH | X | |
| ICMS PREADMISSION | | X |
| PACT IN REACH | X | |
| PACT PRE ADMISSION | | X |
| RESIDENTIAL BED HOLD | X | |
| RESIDENTIAL BED HOLD EXTENSIONS | X | |
| RESIDENTIAL OVERNIGHT ABSENCES | X | |
| RESIDENTIAL PREADMISSION | | X |
| SE IN REACH | | X |
| SE PREADMISSION | | X |
| SED IN REACH | | X |
| SED PREADMISSION | | X |

## Appendix F- Fee-for-Service Billing Schedule

**FY 2018 BILLING CYCLES**

| Billing Cycle Number | Billing Start Date | Billing End Date |
|---|---|---|
| 1 | 7/2/2017 | 7/15/2017 |
| 2 | 7/16/2017 | 7/29/2017 |
| 3 | 7/30/2017 | 8/12/2017 |
| 4 | 8/13/2017 | 8/26/2017 |
| 5 | 8/27/2017 | 9/9/2017 |
| 6 | 9/10/2017 | 9/23/2017 |
| 7 | 9/24/2017 | 10/7/2017 |
| 8 | 10/8/2017 | 10/21/2017 |
| 9 | 10/22/2017 | 11/4/2017 |
| 10 | 11/5/2017 | 11/18/2017 |
| 11 | 11/19/2017 | 12/2/2017 |
| 12 | 12/3/2017 | 12/16/2017 |
| 13 | 12/17/2017 | 12/30/2017 |
| 14 | 12/31/2017 | 1/13/2018 |
| 15 | 1/14/2018 | 1/27/2018 |
| 16 | 1/28/2018 | 2/10/2018 |
| 17 | 2/11/2018 | 2/24/2018 |
| 18 | 2/25/2018 | 3/10/2018 |
| 19 | 3/11/2018 | 3/24/2018 |
| 20 | 3/25/2018 | 4/7/2018 |
| 21 | 4/8/2018 | 4/21/2018 |
| 22 | 4/22/2018 | 5/5/2018 |
| 23 | 5/6/2018 | 5/19/2018 |
| 24 | 5/20/2018 | 6/2/2018 |
| 25 | 6/3/2018 | 6/16/2018 |
| 26 | 6/17/2018 | 6/30/2018 |

# Appendix G - Fee-for-Service Pre-Admission Service Guidelines

I. PURPOSE:

A. To set forth the conditions for supervised housing, PACT, ICMS, CSS, supported employment and supported education providers that have transitioned to fee-for-service contracts to receive payment for pre-admission services.

II. GENERAL PRINPLES:

A. Pre-admission services are services provided by specified community-based programs to or on behalf of consumers during a psychiatric hospitalization prior to discharge from the hospital and admission to the community-based program. The goal of pre-admission services is the facilitate discharge from the hospital and a smooth transition into the community-based services.

B. Pre-admission services are not available for consumers who were admitted to the community-based program at the time of hospital admission and were not discharged from the community-based program during the course of the hospitalization. For example, if a consumer is admitted to a CSS program at the time of admission to the hospital and is not terminated from CSS during the course of the hospitalization, then the CSS program cannot provide pre-admission services to that consumer. In those situations, in-reach services may be available as set forth in the provider's applicable Annex A and Appendix B of this Manual.

C. The scope of pre-admission services delivered by each type of program is set forth in the applicable Annex A of the provider's fee-for-service contract.

D. Payment for pre-admission services delivered by supervised housing, PACT, supported employment and supported education providers is limited to consumers receiving such services in a State psychiatric hospital.

E. Payment for pre-admission services delivered by ICMS providers is limited to services provided to consumers in a state or county psychiatric hospital.

F. Providers will be reimbursed for pre-admission services only if the consumer is discharged from the hospital and is admitted to the program that provided the pre-admission services upon the consumer's return to the community.

G. Payment for pre-admission services is available through the MH FFS Program regardless of the consumer's Medicaid eligibility status because pre-admission services are not a Medicaid billable service.

H. Payment for pre-admission services is expressly dependent upon the availability to the Department of funds appropriated by the State Legislature from State and/or Federal revenue or such other funding sources as may be applicable.

III. General Requirements and Limitations for Reimbursement for Pre-Admission Services

A. The requirements in this Section are generally applicable to all pre-admission services and are in addition to the requirements and limitations set forth under Section II, above and the specific limitations set forth in Sections IV, below.

B. Reimbursement for pre-admission services provided by a community-based program is limited to one episode of pre-admission services per six-month period per consumer.

C. Pre-Admission reimbursement cannot be sought concurrently for the following services:

1. PACT cannot be billed with ICMS, SE, CSS or supervised housing
2. ICMS cannot be billed with PACT, CSS or supervised housing
3. CSS cannot be billed with PACT, ICMS or supervised housing
4. Supervised housing cannot be billed with PACT, ICMS or CSS
5. SE cannot be billed with PACT

IV. Pre-admission Service Reimbursement Rates and Limitations for Specific Programs

A. Pre-admission services provided by supervised housing, PACT and CSS programs: State reimbursement is based on a flat, one time rate as set forth in the rate table attached to Annex B-2 of the provider's contract, which also is included as Appendix D of this Manual.

B. Pre-Admission services provided by ICMS, SE and SEd programs

1. State rate reimbursement is at the full State rate for each 15-minute unit of pre-admission services provided.
2. Payment for pre-admission services provided by ICMS, SE and SEd programs are subject to the limits set forth below:

   Monthly limit: Two (2) hours (equivalent to eight (8) units) of pre-admission services per month. ICMS, SE and SEd providers will not be reimbursed for pre-admission services that exceed the monthly limit.

   Limit per hospitalization: Eight (8) hours (equivalent to thirty-two (32) units) per hospital episode. ICMS, SE and SEd providers will not be reimbursed for pre-admission services delivered after the episode limit is reached.