

New Jersey Department of Human Services
Division of Mental Health and Addiction Services

**Mental Health Fee-for-Service
Program Provider Manual
Version 5.1.0 January 2024**

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1. Introduction

Beginning January 1, 2017, the 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.

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 DOH, DHS and DMHAS policies. Information on current DHS regulations is available on the DHS website at <http://www.nj.gov/humanservices/providers/rulefees/regs/>.²

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 MH FFS Unit at: MH.FFSTeam@dhs.nj.gov.

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

² As of the publication date of Version 4.9.1 of this Provider Manual, the regulations applicable to the programs and services included in the MH FFS program will remain within Title 10, Human Services. However, the licensing regulations that appeared at N.J.A.C. 10:190, et seq., have been recodified, as amended, in Title 8 by the Department of Health, Certificate of Need and Licensing.

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.

Provider agency contracts for State-funded services are site specific, consistent with the provider's program license for applicable services. Providers are not authorized to bill, and DMHAS is under no obligation to pay, for services rendered at sites not authorized by the provider's current contract. Accordingly, providers must obtain DMHAS approval of all program site changes by making advance written request to the MH-FFS Unit via an NJMHAPP ticket. Upon approval and formal modification of the contract, DMHAS will update the provider's list of authorized sites in NJMHAPP; the former site will be deactivated and the new site will be added.

B. Enrollment as NJ FamilyCare Provider³

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 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/providerEnrollment.aspx>. Any questions regarding the provider's status as an approved NJ Family Care provider should be directed to Gainwell Technologies 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. 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.nj.gov.

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,

³ NJ FamilyCare is New Jersey's Medicaid system.

community residences. Some of those categories include subtypes of services, for example, outpatient programs include diagnostic evaluations, medication monitoring, individual therapy, etc.⁴

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. 8:121, 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 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 NJ FamilyCare and the consumer is 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 Gainwell Technologies, the NJ FamilyCare fiscal agent.⁵

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
- ICMS Ancillary & Transportation Services
- PACT In-Reach
- PACT Pre-Admission
- Supported Employment
- Supported Employment In-Reach
- Supported Employment Pre-Admission
- Supported Employment Non-Face to Face
- Supported Education
- Supported Education In-Reach
- Supported Education Pre-Admission
- Supported Education Non-Face to Face
- 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 More detailed information on the services encompassed within a mental health program category is provided in the rate table located at Appendix D.

⁵ 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. 10:37E	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 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 ICMS Annex A	Yes
ICMS In Reach Services	ICMS services provided to consumers in certain inpatient or correctional facilities. 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 from NJMHAPP.	In-Reach Guidelines ⁶ 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 Guidelines ⁷ ICMS Annex A	No

⁶ Reprinted in Appendix A of this manual.

⁷ Reprinted in Appendix G of this manual.

Program/Service	Brief Description	Applicable Regulations (if any) or other guidelines	Covered by Medicaid/NJ FamilyCare
ICMS Ancillary Services	Non-rehabilitative support services, provided with or on behalf of a specific consumer, that are established and documented as necessary to support the consumer's recovery plan.	ICMS Ancillary & Transportation Services Guidelines	No
ICMS Transportation Services	Direct consumer transportation that is provided when the consumer has no other mode of transportation available to address or resolve a critical need identified in the consumer's recovery plan.	ICMS Ancillary & Transportation Services Guidelines	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 N.J.A.C. 10:76-2.4 ⁸ N.J.A.C. 10:79B-2.4(g)	Yes
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 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 PACT Annex A	No
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 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 SE Annex A	No

⁸ 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
Supported Employment Non-Face to Face Services	Non-face to face SE services provided to consumers. NF activities include telephone communications, research & job or educational search tasks on behalf of the consumer.	As per formal DMHAS communication dated 1/24/2018	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
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 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 SEd Annex A	No
Supported Education Non-Face to Face Services	Non-face to face SEd services provided to consumers. NF activities include telephone communications, research & job or educational search tasks on behalf of the consumer.	As per formal DMHAS communication dated 1/24/2018	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 ⁹	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

⁹ Reprinted in Appendix B of this manual.

Program/Service	Brief Description	Applicable Regulations (if any) or other guidelines	Covered by Medicaid/NJ FamilyCare
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
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 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 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 NJ FamilyCare. (That application is described in the next section.) As previously noted, providers are encouraged to become qualified entities to perform NJ FamilyCare 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 required 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 are required to answer the NJMHAPP radio prompt and verify that they evaluated and determined whether the consumer is eligible for charity care. Providers must maintain supporting documentation. 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 to collect information from providers participating in the MH FFS Program that is needed for DMHAS 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 User Manual and is found on the NJMHAPP home page at <https://dmhas.dhs.state.nj.us/NJMHAPP/>.

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 2016.¹⁰ 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, ICMS in-reach and preadmission, SEd in-reach and preadmission and CSS in-reach is 15 minutes. A 15-minute unit of service is defined as 15 consecutive minutes of face-to-face services 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 and contract period.

¹⁰ The slides from that presentation are available at:

http://www.state.nj.us/humanservices/dmhas/information/stakeholder/Rate_Setting_Transition_Overview.pdf

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. Please see Appendix H of this manual for instructions on submitting a request to increase your agency's monthly limit.

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.

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 rolled 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 affected 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 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 expiration of each State Fiscal Year, no matter the contract period.

Please note that rollover funds are not immediately available because DMHAS requires sufficient time to review and finalize all pending Electronic Claims Adjustment System (ECAS) claims. The billing buffer day is the 15th of the month after the month the service was provided; the ECAS deadline is the 5th of the month **after** the billing buffer day. Therefore, rollover funds will become available no earlier than the 6th of the month and no later than the 10th of the **month following the ECAS deadline**. For example, unused funds from September will become available no earlier than November 6th and no later than November 10th because the billing buffer day is October 15th and the ECAS deadline is November 5th. DMHAS reserves the right to make very limited extensions of time under very limited circumstances.

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 remaining at the expiration of each State Fiscal Year, regardless of the contract period.

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 funding source, i.e., NJ Family Care or the MH FFS Program.

As set forth at N.J.A.C. 10:79B-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 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 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 in cost-reimbursement contracts: 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 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.

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 Medicaid status of consumers receiving a NJ FamilyCare-covered service, 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. 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 Gainwell Technologies, which will make the requested payment to the provider.

Payment will be based on the schedule followed by Gainwell Technologies. Providers will receive payment for services funded through the MH FFS Program as a single, lump sum amount from Gainwell Technologies for all approved claims during the billing cycle. NJMHAPP claims detail will not be included in remittance advice generated by Gainwell Technologies. Rather, the DMHAS will send a notice to providers describing the basis for any denied or reduced claims for payment and Gainwell Technologies 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 (15th) 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 NJ FamilyCare 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. Revenues shall be submitted monthly to the DMHAS fiscal unit by going to the NJMHAPP revenue template screen and selecting from the drop-down menu the appropriate fiscal year, month and qualifying program(s) for which the agency is required to submit revenue information. Reported revenues are due on the 15th of the month subsequent to service delivery and 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 DMHAS through an alternate mechanism, if necessary.

M. Wrap Funding Requests

Wraparound Support (Wrap) provides discretionary funding for certain necessary services and consumer expenses that are not reimbursable under the provider agency's Fee-for-Service (FFS) contract with the DMHAS and that are not available through other benefit programs.

Additional information on Wrap, including eligibility requirements and the process for submitting requests, is provided in the FFS Wrap Guidelines and Procedures included as Appendix I of this Manual.

N. Claim Denials based on Failure to Apply for NJ FamilyCare

As described under Section 4.A, 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 beneficiary. For consumers who are not current NJ Family Care beneficiaries, NJMHAPP includes a module that screens for potential NJ FamilyCare 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, providers are required to assist the consumer in applying for NJ Family Care, 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.

O. Electronic Claims Adjustment System (ECAS)

There will be instances/circumstances when payments for certain mental health services cannot be processed in the ordinary course. 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.

The NJMHAPP Electronic Claims Adjustment System (ECAS) gives users the ability to request payment(s) and void claims beyond the billing buffer day (15th of the following month) under the type of limited circumstances identified above, subject to DMHAS approval. ECAS claims for CSS denials from other payers must be submitted within 180 days of the monthly closeout. All other ECAS claims must be submitted no later than the 5th of the month subsequent to the billing buffer day. Monthly closeout is the fifteenth (15th) of the month following the month of service provision.

Please note, due to the accounting process to close out the fiscal year, the period of ECAS submission is truncated for the final month (June) of the fiscal year, regardless of the contract period. Accordingly, claims for the month of June must be submitted no later than July 20th of any given fiscal year. Please be further advised that claims submitted in ECAS for a Medicaid covered service must include, via attachment, an Electronic Medicaid Eligibility Verification System (eMEVS) report regarding the consumer for whom the agency is seeking reimbursement. As part of the NJMHAPP 4.2.0 enhancements, the ECAS module will not allow ECAS claims for a Medicaid covered service to be submitted without an eMEVS report attached.

Please also note that CSS claims submitted in ECAS must include, via attachment, the unit summary page of the approved Individualized Rehabilitation Plan (IRP) corresponding to the dates of the CSS claim submissions. Details regarding ECAS can be found in the IT User Manual 4.0 which is accessible via hyperlink on the NJMHAPP login page.

P. Medicaid Status Changes

When a consumer's Medicaid status changes, either becoming eligible or ineligible, the provider must immediately 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 by voiding all erroneous claims in NJMHAPP and bill Medicaid for the time of service during Medicaid eligibility and receipt of state funds.

Q. 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 of 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 must evaluate and document 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 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.

6. FFS Program Contract Requirements

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, including start/end time
- 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.
- For residential Bed Hold claims and Overnight Absence - Room & Board claims, the record shall document the date and time the consumer departed from the residential site and the date and time the consumer returned to the residential site.

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; and
- Any additional documentation supporting the provider's position that the claim was inappropriately denied or reduced.

The request should be submitted via NJMHAPP ticket using the form found at Appendix N.

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 hospital, inpatient substance use disorder treatment setting or, for PACT, ICMS and CSS providers, a correctional facility, who was receiving services from the provider agency at the time of inpatient facility admission 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 consumer's 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 inpatient setting. 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 admission to an inpatient setting 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 admission to an inpatient setting or incarceration. For long periods of admission to an inpatient setting 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 through 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 STATE FFS RATE REIMBURSEMENT FOR IN-REACH SERVICES BY PACT PROVIDERS

A. State FFS Reimbursement Requirements for In-reach Services by PACT Providers

- 1. The unit of service for PACT in-reach is one month and the rate is the same as the State-rate for PACT services.

2. Reimbursement for in-reach services through the State-funded FFS Program under procedure code and modifier H0040-IR is available for a month when all of the following criteria are met:
 - a. The consumer is hospitalized or incarcerated and was receiving PACT services from the provider at the time of admission to the inpatient facility or incarceration, as set forth at Section II.B., above;
 - b. All or any portion of the two-hour minimum is provided in the inpatient setting. For example, if one hour of face-to-face contact occurs when the consumer is in an inpatient setting and one hour of face-to-face contact occurs when the consumer is in the community, then the two-hour minimum is satisfied;
 - c. It is not the consumer's first month of PACT services and the consumer has not been discharged from PACT during the month (it is not the consumer's last month of PACT services); and
 - d. The consumer has been in the inpatient setting or incarcerated for less than six continuous months.
 3. Consumers who have been incarcerated for six continuous months should be discharged from PACT services. If the PACT provider chooses to continue in-reach services beyond six months, there will be no State-funded reimbursement for those services.
 4. Consumers who have been in the inpatient setting for six continuous months or more 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.
- B. Reimbursement for "regular" PACT services for consumers in an inpatient setting or incarcerated for part of the month.
1. Medicaid-enrolled consumers
 - a. PACT providers are expected to be familiar with and understand the DMAHS rules for billing Medicaid for PACT services and should not rely solely on the summary provided in this subsection III.B. Specific questions regarding Medicaid billing should be directed to Gainwell Technologies, which serves as DMAHS' fiscal agent.
 - b. Providers shall bill Medicaid for "regular" PACT services (as opposed to the State MH FFS Program for in-reach) when a consumer is in an inpatient setting or incarcerated for part of a month to the extent permitted under the applicable Division of Medical Assistance and Health Services (DMAHS) regulations at N.J.A.C. 10:76-2.6.
 - c. In general, providers cannot bill Medicaid for PACT services when a consumer is residing in an Institution for Mental Disease (IMD) or correctional facility. See N.J.A.C. 10:76-

2.6(c)2. However, Medicaid billing is permitted for the month if one of the following conditions is met:

- i. 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, see N.J.A.C. 10:76-2.6(c)2.i; (Note however, Medicaid cannot be billed if the consumer is discharged from PACT services during the same month, see N.J.A.C. 10:76-2.6(b) (stating that no reimbursement is provided during the month services are terminated); OR
- ii. It is the first (initial) month of PACT services for the consumer and the consumer was admitted to the IMD or incarcerated later that same month. See N.J.A.C. 10:76-2.6(b) (stating that full reimbursement is provided during the month services are initiated regardless of the quantity of services provided).

2. Consumers not enrolled in Medicaid

Providers shall bill using the State-only PACT services procedure code and modifier (H0040 HW) for non-Medicaid enrolled consumers when either of the conditions listed under Section III.B.1.c, above, are met.

C. Billing Hierarchy for “regular” PACT services and in-reach services

Reimbursement for “regular” PACT services has absolute priority over billing for in-reach services. Providers must bill “regular” PACT services whenever the two hours of “regular” face-to-face contact is satisfied and billable, and may not bill in-reach services (through the State-funded MH FFS Program under procedure code and modifier H0040-IR) regardless of whether the in-reach billing requirements have been satisfied. The “regular” PACT billing priority applies regardless of the consumer’s source of “regular” PACT funding (State MH FFS or Medicaid).

D. No Concurrent billing of “regular” PACT services and in-reach services

Reimbursement for in-reach services (through the State-funded MH FFS Program under procedure code and modifier H0040-IR) is never available in a month when the two-hour minimum of “regular” PACT face-to-face contact is satisfied and billable. The restriction against concurrent billing of in-reach and “regular” PACT services applies regardless of the consumer’s source of “regular” PACT funding (State MH FFS or Medicaid).

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:

Limit per inpatient admission or incarceration episode: Eight (8) hours (equivalent to thirty-two (32) units) per inpatient admission or incarceration episode. ICMS providers will not be reimbursed for in-reach services delivered after the 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:

Limit per inpatient admission 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 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 consumer subject 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 limit is reached.
3. Limit per inpatient admission: Eight (8) hours (equivalent to thirty-two (32) units) per inpatient episode. SE providers will not be reimbursed for in-reach services delivered after the 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. Limit per inpatient admission: Eight (8) hours (equivalent to thirty-two (32) units) per inpatient inpatient admission. SEd providers will not be reimbursed for in-reach services delivered after the 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.
 - 1. 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.
 - 1. For example, the overnight absence guidelines apply when a consumer is present in the supervised housing setting until 5 PM on Monday and then leaves for an overnight visit with a family member and returns to the supervised housing setting at 1 PM on Tuesday.
 - 2. 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. To insure billing accuracy, the record shall document the date and time the consumer departed from the residential site and the date and time the consumer returned to the residential site.
 - G. 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.
 - 1. Reimbursement will be at the full per-diem State rate for the applicable level of service.
 - 2. There will not be any reimbursement for room and board during the bed hold period.
 - 3. The start of the bed hold reimbursement period will begin at 12:00 AM 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 2:00 PM, the bed hold reimbursement period will begin at 12:00 AM midnight on Tuesday and continue through each 24-hour period until the day of return to the residential site.
 - a. 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.
 - 4. 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 3:00 PM, 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
 - 1. 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.
 - 2. There will not be any reimbursement for room and board during the bed hold period.

3. 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 12:00 AM 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 2:00 PM, the bed hold reimbursement period will begin at 12:00 AM midnight on Tuesday and continue through each 24-hour period until the day of return to the residential site.
 - a. The provider agency may submit a claim through NJMHAPP for room and board on the day of departure.
 - b. 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 Gainwell Technologies.
4. 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 3:00 PM, 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 Gainwell Technologies.

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:
 1. The consumer's continued absence is due to ongoing receipt of inpatient hospitalization, residential addictions treatment or residential rehabilitative care;
 2. The treatment team can project a discharge date in the reasonably foreseeable future;
 3. Clinical information indicates imminent reoccupation of the bed; and
 4. 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

1. 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.
2. The Bed Hold Reimbursement Extension Request Form must be submitted according to the directions included on the form.
3. The Bed Hold Extension Reimbursement Extension Form must be submitted within the following time frames:
 - a. Initial 30-day extension request must be submitted within three (3) days of, but no later than, the start of the anticipated extension period.
 - b. The second 30-day extension request must be submitted within three (3) days of, but no later than, the start of the anticipated 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
 1. 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.
 2. Limitation: Room and board payments for overnight absences are limited to three (3) 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 must be completed and submitted for review (via NJMHAPP ticket) within 3 days of ~ but no later than ~ the start of the anticipated extension period. The MH-FFS Unit will then forward the completed document to the appropriate DMHAS Program Analyst and Olmstead Coordinator (when applicable) for review. Requests shall be approved/denied in DMHAS's reasonable discretion, in consideration of the full and accurate disclosure of all of the facts and circumstances (including application for programmatic discharge), and consistent with App. B, Section IV of the NJMHAPP Provider Program Manual.

AGENCY: _____ COUNTY: _____ DATE: _____

NAME: _____ NJMHAPP ID: _____ DOB: _____

DATE OF INITIAL INPATIENT HOSPITALIZATION, RESIDENTIAL ADDICTIONS TREATMENT OR RESIDENTIAL REHABILITATIVE CARE: _____

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

START DATE OF INITIAL 30-DAY BED HOLD (the first 24-hr period, beginning at midnight, the consumer was out of the bed): _____

DATE OF TRANSFER TO EXTENDED TREATMENT UNIT (IF APPLICABLE): _____

➤ NAME OF FACILITY WHERE CONSUMER IS RECEIVING EXTENDED TREATMENT: _____

➤ DOES THE TREATMENT TEAM HAVE A PROJECTED DISCHARGE DATE W/IN 45 DAYS OF REQUEST: YES NO

➤ IF YES, DATE: _____

HAS THE PROVIDER SUBMITTED A REQUEST TO THE PROGRAM ANALYST TO DISCHARGE: YES NO

➤ DATE OF REQUEST TO DMHAS FOR DISCHARGE: _____ (MUST BE ATTACHED)

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 THAT, ACCORDING TO CLINICAL STABILIZATION, THE CONSUMER WILL BE ABLE TO RE-OCCUPY THE VACANT COMMUNITY BED WITHIN THE NEXT 30 TO 45 DAYS. Please describe and/or attach, as needed, all relevant documents (e.g. Court/Restraining Orders, police reports, applications for alternate placement, etc.):

AGENCY REPRESENTATIVE (name/title): _____ Email: _____

By signing above, Agency acknowledges and agrees that it shall accept the Consumer back into the Residential facility. Agency shall update this Request if additional information becomes available.

FOR DMHAS USE ONLY -- 30-DAY BED HOLD EXTENSION/STATE RATE REIMBURSEMENT (type name and title):	
BED HOLD Ext. Date Range: _____	1st <input type="radio"/> 2nd <input type="radio"/> APPROVED <input type="radio"/> DENIED <input type="radio"/>
DMHAS-FFS Representative: _____	DATE: _____
DMHAS-Program Analyst: _____	DATE: _____
Olmstead Coordinator (If applicable): _____	DATE: _____

**N.J.A.C. 10:37A-11.4(c) The Provider Agency 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.*

Rev 04/2022



Appendix D – NJMHAPP Code and Rate Table

HOSPITAL BASED SERVICES							
Service	Billing unit	Maximum # of units per month	Revenue Code	Modifiers	DMHAS STATE ONLY RATE	Business Rules	TPL
HOSPITAL OUTPATIENT SERVICES							
Individual Therapy	30 Minutes	10	914	HB - Adult HBTJ - Child	\$71.39	2 units per day.	X
Group Therapy	60 Minutes	12	915	HB - Adult HBTJ - Child	\$27.48	3 units per week, 1 unit per day.	X
Initial Evaluation	30 Minutes	4	918	HB - Adult HBTJ - Child	\$62.42	Maximum four (4) units per consumer per month.	X
Medication Monitoring	15 Minutes	4	919	HB - Adult HBTJ - Child	\$85.39	2 units per day.	X
ACUTE AND PARTIAL HOSPITALIZATION							
Partial Hospital	1 hour	125	912		\$17.91	Minimum of 2 hrs, max of 5 hrs per day with a max of 25 hrs/wk.	
Partial Hospital Telehealth Services	1 hour	125	H0035	GTUC-PH	\$17.91	Effective July 1, 2023 - Minimum of two (2) units of service and max of five (5) units per day; 25 units per week. For delivery of Partial Hospital Telehealth Services via ECAS Only. PH telehealth services must meet all the same requirements as face-to-face services and shall be billed using the H0035 Revenue Code and GTUC-PH Modifier. Provider agency must also document the specific medical need for PH telehealth services in the consumer's clinical record. Cannot be billed on the same day the consumer receives PH services on-site.	
Partial Hospital Transportation	one-way	50	912	HW	\$6.66	Must co-exist with a PH billing on the same date of service. Max of 2/day.	
Acute Partial Hospital	1 hour	125	913		\$64.95	Minimum of 2 hrs, max of 5 hrs per day with a max of 25 hrs/wk.	X
Acute Partial Hospital Telehealth Services	1 hour	125	H0035	GTUC-APH	\$64.95	Effective July 1, 2023 - Minimum of two (2) units of service and max of five (5) units per day; 25 units per week. For delivery of Acute Partial Hospital Telehealth Services via ECAS Only. APH telehealth services must meet all the same requirements as face-to-face services and shall be billed using the H0035 Revenue Code and GTUC-APH Modifier. Provider agency must also document the specific medical need for APH telehealth services in the consumer's clinical record. Cannot be billed on the same day the consumer receives APH services on-site.	
Acute Partial Hospital Transportation	one-way	50	913	HW	\$6.66	Must co-exist with a APH billing on the same date of service. Max of 2/day.	X
Initial Evaluation	30 Minutes	4	918	HB - Adult HBTJ - Child	\$62.42	Maximum four (4) units per consumer per month.	X
NON-HOSPITAL BASED SERVICES							
SERVICE	Billing unit	Maximum # of units per month	Procedure Code	Modifiers	DMHAS STATE ONLY RATE	Business Rules	TPL
OUTPATIENT							
Psychiatric Diagnostic Evaluation without Medical Services	One Evaluation	See Business Rules	90791	HW - Adult TJ - Child	\$171.99	Can not bill 90792 on the same day. Limited to two (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	\$437.76	Can not bill 90791 on the same day. Limited to two (2) evaluations per provider, per client in the calendar year.	X
Individual Therapy	20 - 30 minutes	9	90832	HW - Adult TJ - Child	\$71.39	1 unit per day.	X
Individual Therapy with E/M	20 - 30 minutes	10	90833	HW - Adult TJ - Child	\$73.61	1 unit per day. Must be billed concurrently with codes 99211-99215 on the same date of service.	X
Individual Therapy	45 - 50 minutes	9	90834	HW - Adult TJ - Child	\$94.46	1 unit per day.	X
Individual Therapy with E/M	45 - 50 minutes	10	90836	HW - Adult TJ - Child	\$94.46	1 unit per day. Must be billed concurrently with codes 99211-99215 on the same date of service.	X
Special family therapy with patient present	45 - 50 minutes	4	90847	HW - Adult TJ - Child	\$113.84	1 unit per day. May be billed concurrently with codes 99211-99215 on the same date of service.	X
Group Therapy	90 minutes	9	90853	HW - Adult TJ - Child	\$27.48	1 unit per day. May be billed concurrently with codes 99211-99215 on the same date of service.	X
Family Conference	25 minutes	4	90887	HW - Adult TJ - Child	\$23.17	1 unit per day. May be billed concurrently with codes 99211-99215 on the same date of service.	X
E/M Medication Monitoring - Physician	5 minutes	10	99211	HW - Adult TJ - Child	\$25.68	1 E/M Service Per Consumer/Per Day/Per Provider.	X
E/M Medication Monitoring - Physician	10 minutes	10	99212	HW - Adult TJ - Child	\$49.91	1 E/M Service Per Consumer/Per Day/Per Provider.	X
E/M Medication Monitoring - Physician	15 minutes	10	99213	HW - Adult TJ - Child	\$81.64	1 E/M Service Per Consumer/Per Day/Per Provider.	X
E/M Medication Monitoring - Physician	25 minutes	10	99214	HW - Adult TJ - Child	\$118.08	1 E/M Service Per Consumer/Per Day/Per Provider.	X
E/M Medication Monitoring - Physician	40 minutes	10	99215	HW - Adult TJ - Child	\$158.24	1 E/M Service Per Consumer/Per Day/Per Provider.	X

OUTPATIENT (continued)							
E/M Medication Monitoring - APN	5 minutes	10	99211	SA + HW-Adult TJ - Child	\$25.68	1 E/M Service Per Consumer/Per Day/Per Provider.	X
E/M Medication Monitoring - APN	10 minutes	10	99212	SA + HW-Adult TJ - Child	\$46.21	1 E/M Service Per Consumer/Per Day/Per Provider.	X
E/M Medication Monitoring - APN	15 minutes	10	99213	SA + HW-Adult TJ - Child	\$76.87	1 E/M Service Per Consumer/Per Day/Per Provider.	X
E/M Medication Monitoring - APN	25 minutes	10	99214	SA + HW-Adult TJ - Child	\$112.90	1 E/M Service Per Consumer/Per Day/Per Provider.	X
E/M Medication Monitoring - APN	40 minutes	10	99215	SA + HW-Adult TJ - Child	\$151.71	1 E/M Service Per Consumer/Per Day/Per Provider.	X
PROGRESSIVE ASSERTIVE COMMUNITY TREATMENT (PACT)							
Progressive Assertive Community Treatment (PACT)	Monthly rate	One (1)	H0040	HW	\$1,651.59	Must provide ≥ 2 hours of service per month. The 2 hour minimum requirement does not apply during the month PACT services are initiated. No reimbursement is permitted during the month PACT services are terminated. 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. No PACT In-Reach billing in the same month.	
PACT IN-REACH	Monthly rate	One (1)	H0040	IR	\$1,651.59	See Appendix A — In-Reach Guidelines of the MHFFS Program Provider Manual for additional requirements and limitations.	
PACT PRE-ADMISSION	Flat rate	One (1)	H0040	PA	\$1,785.80	Must have contact with consumer while admitted to State hospital and consumer must be admitted to PACT at discharge from the State hospital. See Appendix G — Fee-for-Service Pre-Admission Service Guidelines of the MHFFS Program Provider Manual for additional requirements and limitations.	
PARTIAL CARE							
Partial Care (PC)	1 hour	125	Z0170	HW	\$17.91	Minimum of two (2) and max of five (5) units per day. Maximum of 25 units per week. No PACT unless approved.	
Partial Care Transportation	one-way	50	Z0330	HW	\$6.66	Must have a PC hourly service billing on the same date of service. Maximum of two (2) units per day.	
Psychiatric Diagnostic Evaluation without Medical Services	One Evaluation	See Business Rules	90791	PC HW	\$171.99	Can not bill 90792 on the same day. Limited to two (2) evaluations per provider, per client in the calendar year.	X
Psychiatric Diagnostic Evaluation with Medical Services	One Evaluation	See Business Rules	90792	PC HW	\$437.76	Can not bill 90791 on the same day. Limited to two (2) evaluations per provider, per client in the calendar year.	X
E/M Medication Monitoring - Physician	5 minutes	10	99211	PC HW	\$25.68	1 E/M Service Per Consumer/Per Day/Per Provider.	X
E/M Medication Monitoring - Physician	10 minutes	10	99212	PC HW	\$49.91	1 E/M Service Per Consumer/Per Day/Per Provider.	X
E/M Medication Monitoring - Physician	15 minutes	10	99213	PC HW	\$81.64	1 E/M Service Per Consumer/Per Day/Per Provider.	X
E/M Medication Monitoring - Physician	25 minutes	10	99214	PC HW	\$118.08	1 E/M Service Per Consumer/Per Day/Per Provider.	X
E/M Medication Monitoring - Physician	40 minutes	10	99215	PC HW	\$158.24	1 E/M Service Per Consumer/Per Day/Per Provider.	X
E/M Medication Monitoring - APN	5 minutes	10	99211	PC HW SA	\$25.68	1 E/M Service Per Consumer/Per Day/Per Provider.	X
E/M Medication Monitoring - APN	10 minutes	10	99212	PC HW SA	\$46.21	1 E/M Service Per Consumer/Per Day/Per Provider.	X
E/M Medication Monitoring - APN	15 minutes	10	99213	PC HW SA	\$76.87	1 E/M Service Per Consumer/Per Day/Per Provider.	X
E/M Medication Monitoring - APN	25 minutes	10	99214	PC HW SA	\$112.90	1 E/M Service Per Consumer/Per Day/Per Provider.	X
E/M Medication Monitoring - APN	40 minutes	10	99215	PC HW SA	\$151.71	1 E/M Service Per Consumer/Per Day/Per Provider.	X
Partial Care Telehealth Service	1 hour	125	H0035	GTUC	\$17.91	Effective July 1, 2023 - Minimum two (2) units of service and max of five (5) units per day; 25 units per week. For delivery of Partial Care Telehealth Services via ECAS Only. PC telehealth services must meet all the same requirements as face-to-face services and shall be billed using the H0035 Revenue Code and GTUC Modifier. Provider agency must also document the specific medical need for PC telehealth services in the consumer's clinical record. Cannot be billed on the same day the consumer receives PC services on-site.	
INTEGRATED CASE MANAGEMENT SERVICES (ICMS)							
Integrated Case Management Services (ICMS)	15 minutes	50	Z5006	HW	\$38.09	No billing for consumers during psychiatric hospitalization or in correctional facility. Unit is 15 consecutive minutes. Cannot bill with PACT, CSS or Supervised Residential Services.	
Integrated Case Management Services (ICMS) IN-REACH	15 minutes	See Business Rules	Z5006	QJ	\$38.09	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 Appendix A — In-Reach Guidelines of the MHFFS Program Provider Manual for additional requirements and limitations.	
Integrated Case Management Services (ICMS) PRE-ADMISSION	15 minutes	See Business Rules	Z5006	PA	\$38.09	Total episode maximum of 32 units (8 hours). Consumer must be admitted to ICMS services at time of discharge from a State hospital, County hospital or Diversion beds. See Appendix G — Fee-for-Service Pre-Admission Service Guidelines of the MHFFS Program Provider Manual for additional requirements and limitations.	

INTEGRATED CASE MANAGEMENT SERVICES (ICMS) (continued)						
Integrated Case Management Services (ICMS) in Excess of 50 units	15 minutes	150	Z5006	OL	\$38.09	No billing for consumers during psychiatric hospitalization or in correctional facility. Unit is 15 consecutive minutes. Cannot bill with PACT, CSS or Supervised Residential Services. DMHAS MH FFS Unit approval is required before billing is submitted.
Integrated Case Management Services Supportive Oversight & Monitoring	15 minutes	20	Z5006	AOM	\$38.09	Maximum, monthly, per consumer reimbursement is limited to 20 Units based on any combination of individual Ancillary, group Ancillary or individual Transportation, group Transportation units.
Integrated Case Management Services Accompanying/Waiting with Consumer at Appointments (Individual)	15 minutes	20	Z5006	AWAI	\$38.09	Maximum, monthly, per consumer reimbursement is limited to 20 Units based on any combination of individual Ancillary, group Ancillary or individual Transportation, group Transportation units.
Integrated Case Management Services Accompanying/Waiting with Consumer at Appointments (Group)	15 minutes	20	Z5006	AWAG	\$9.51	Maximum, monthly, per consumer reimbursement is limited to 20 Units based on any combination of individual Ancillary, group Ancillary or individual Transportation, group Transportation units. Group size limit is six (6) consumers.
Integrated Case Management Services Essential Errands with or on Behalf of Consumer (Individual)	15 minutes	20	Z5006	AEEI	\$38.09	Maximum, monthly, per consumer reimbursement is limited to 20 Units based on any combination of individual Ancillary, group Ancillary or individual Transportation, group Transportation units.
Integrated Case Management Services Essential Errands with or on Behalf of Consumer (Group)	15 minutes	20	Z5006	AEEG	\$9.51	Maximum, monthly, per consumer reimbursement is limited to 20 Units based on any combination of individual Ancillary, group Ancillary or individual Transportation, group Transportation units. Group size limit is six (6) consumers.
Integrated Case Management Services Participating with Consumer at Intake Appointment for Other Essential Services	15 minutes	20	Z5006	APCA	\$38.09	Maximum, monthly, per consumer reimbursement is limited to 20 Units based on any combination of individual Ancillary, group Ancillary or individual Transportation, group Transportation units.
Integrated Case Management Services Failed Contact Attempts	15 minutes	20	Z5006	AFCA	\$38.09	Maximum, monthly, per consumer reimbursement is limited to 20 Units based on any combination of individual Ancillary, group Ancillary or individual Transportation, group Transportation units.
Integrated Case Management Services Transportation (Individual)	15 minutes	20	Z5006	TRAI	\$38.09	Maximum, monthly, per consumer reimbursement is limited to 20 Units based on any combination of individual Ancillary, group Ancillary or individual Transportation, group Transportation units.
Integrated Case Management Services Transportation (Group)	15 minutes	20	Z5006	TRAG	\$9.51	Maximum, monthly, per consumer reimbursement is limited to 20 Units based on any combination of individual Ancillary, group Ancillary or individual Transportation, group Transportation units. Group size limit is six (6) consumers.
Integrated Case Management Services (ICMS) Ancillary/Transportation Services in Excess of 20 units.	15 minutes	60	Z5006	ATOL	\$38.09	No billing for consumers during psychiatric hospitalization or in correctional facility. Unit is 15 consecutive minutes. Cannot bill with PACT, CSS or Supervised Residential Services. DMHAS MH FFS Unit approval is required before billing is submitted.
SUPERVISED RESIDENTIAL SERVICES						
Supervised Residential Group Homes Level A+	per diem	# of days in the month	H0019	U1	\$270.45	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	H0019	U1BH	\$270.45	See Bed Hold Guidelines: follow procedures in Appendix B — Bed Hold and Overnight Absence Reimbursement Guidelines 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	H0019	U1BE	\$270.45	See Bed Hold Guidelines: follow procedures in Appendix B — Bed Hold and Overnight Absence Reimbursement Guidelines of the MHFFS Program Provider Manual.
Supervised Residential Apartments: Level A+	per diem	# of days in the month	H0019	U152	\$270.45	Cannot bill with PACT, ICMS or CSS service.
Supervised Residential Apartments: Level A+ 30 DAY BED HOLD	per diem	maximum of 30 consecutive days	H0019	U152BH	\$270.45	See Bed Hold Guidelines: follow procedures in Appendix B — Bed Hold and Overnight Absence Reimbursement Guidelines of the MHFFS Program Provider Manual.
Supervised Residential Apartments: Level A+ 30 DAY BED HOLD EXTENSION	per diem	maximum of two (2) 30 day extensions	H0019	U152BE	\$270.45	See Bed Hold Guidelines: follow procedures in Appendix B — Bed Hold and Overnight Absence Reimbursement Guidelines of the MHFFS Program Provider Manual.
Supervised Residential Group Homes: Level A	per diem	# of days in the month	H0019	U2	\$224.77	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	H0019	U2BH	\$224.77	See Bed Hold Guidelines: follow procedures in Appendix B — Bed Hold and Overnight Absence Reimbursement Guidelines 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	H0019	U2BE	\$224.77	See Bed Hold Guidelines: follow procedures in Appendix B — Bed Hold and Overnight Absence Reimbursement Guidelines of the MHFFS Program Provider Manual.
Supervised Residential Apartments: Level A	per diem	# of days in the month.	H0019	U252	\$224.77	Cannot bill with PACT, ICMS or CSS service.
Supervised Residential Apartments: Level A 30 DAY BED HOLD	per diem	maximum of 30 consecutive days	H0019	U252BH	\$224.77	See Bed Hold Guidelines: follow procedures in Appendix B — Bed Hold and Overnight Absence Reimbursement Guidelines of the MHFFS Program Provider Manual.
Supervised Residential Apartments: Level A 30 DAY BED HOLD EXTENSION	per diem	maximum of two (2) 30 day extensions	H0019	U252BE	\$224.77	See Bed Hold Guidelines: follow procedures in Appendix B — Bed Hold and Overnight Absence Reimbursement Guidelines of the MHFFS Program Provider Manual.

SUPERVISED RESIDENTIAL SERVICES (continued)						
Supervised Residential Group Homes: Level B	per diem	# of days in the month	H0019	U3	\$167.94	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	H0019	U3BH	\$167.94	See Bed Hold Guidelines: follow procedures in Appendix B — Bed Hold and Overnight Absence Reimbursement Guidelines 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	H0019	U3BE	\$167.94	See Bed Hold Guidelines: follow procedures in Appendix B — Bed Hold and Overnight Absence Reimbursement Guidelines of the MHFFS Program Provider Manual.
Supervised Residential Apartments: Level B	15 consecutive minutes	1,440	H0019	U352	\$13.36	Cannot bill with PACT, ICMS or CSS service.
Supervised Residential Apartments: Level B 30 DAY BED HOLD	per diem	maximum of 30 consecutive days	H0019	U352BH	\$24.90	See Bed Hold Guidelines: follow procedures in Appendix B — Bed Hold and Overnight Absence Reimbursement Guidelines of the MHFFS Program Provider Manual.
Supervised Residential Apartments: Level B 30 DAY BED HOLD EXTENSION	per diem	maximum of two (2) 30 day extensions	H0019	U352BE	\$24.90	See Bed Hold Guidelines: follow procedures in Appendix B — Bed Hold and Overnight Absence Reimbursement Guidelines of the MHFFS Program Provider Manual.
Family Care: Level D	per diem	# of days in the month	H0019	U5	\$17.54	Cannot bill with PACT, ICMS or CSS service.
Family Care: Level D 30 DAY BED HOLD	per diem	maximum of 30 consecutive days	H0019	U5BH	\$17.54	See Bed Hold Guidelines: follow procedures in Appendix B — Bed Hold and Overnight Absence Reimbursement Guidelines of the MHFFS Program Provider Manual.
Family Care: Level D 30 DAY BED HOLD EXTENSION	per diem	maximum of two (2) 30 day extensions	H0019	U5BE	\$17.54	See Bed Hold Guidelines: follow procedures in Appendix B — Bed Hold and Overnight Absence Reimbursement Guidelines of the MHFFS Program Provider Manual.
Supervised Residential Services - Room and Board	per diem	# of days in the month	H0019	RB	\$29.04	Cannot bill with PACT, ICMS or CSS service.
Supervised Residential Services - Room and Board OVERNIGHT ABSENCE	per diem	maximum of three (3) per month	H0019	OA	\$29.04	See Bed Hold Guidelines: follow procedures in Appendix B — Bed Hold and Overnight Absence Reimbursement Guidelines of the MHFFS Program Provider Manual.
Supervised Residential Services - PRE-ADMISSION	Flat rate	One (1)	H0019	PA	\$1,785.80	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 Appendix G — Fee-for-Service Pre-Admission Service Guidelines of the MHFFS Program Provider Manual for additional requirements and limitations. The ONLY exception to the State Hospital referral requirement is for Olmstead-approved non-State-hospital referrals consistent with Appendix L — Preadmission for Olmstead-approved non-State-Hospital-referrals.
SUPPORTED EMPLOYMENT (SE) / SUPPORTED EDUCATION (SED)						
Supported Employment (SE)	15 Minutes	80	H2024	HJ	\$25.58	Cannot be enrolled in PACT to receive SE services.
Supported Employment - Non Face to Face (NF)	15 Minutes	See Business Rules	H2024	HJNF	\$25.58	NF activities include telephone communication as well as research and job, or educational search tasks on behalf of the consumer. NF billing activities, in combination with Face to Face (FF) activities, cannot exceed the individual client monthly limit of 80 units.
Supported Employment - Group	15 Minutes	80	H2024	HJG	\$6.39	Cannot be enrolled in PACT to receive SE services. Group size limit is six (6) consumers.
Supported Education (SED)	15 Minutes	80	H2024	HW	\$25.58	Cannot be enrolled in PACT to receive SED services.
Supported Education - Non Face to Face (NF)	15 Minutes	See Business Rules	H2024	HWNF	\$25.58	NF activities include telephone communication as well as research and educational search tasks on behalf of the consumer. NF billing activities, in combination with Face to Face (FF) activities, cannot exceed the individual client monthly limit of 80 units.
Supported Education - Group	15 Minutes	80	H2024	HWG	\$6.39	Cannot be enrolled in PACT to receive SE services. Group size limit is six (6) consumers.
Supported Employment - IN-REACH	15 minutes	See Business Rules	H2024	IR	\$25.58	Total episode maximum of 32 units (8 hours). Consumer must be receiving SE/SED services at times of admission to inpatient setting. See Appendix A — In-Reach Guidelines of the MHFFS Program Provider Manual for additional requirements and limitations.
Supported Education IN-REACH	15 minutes	See Business Rules	H2024	HW IR	\$25.58	Total episode maximum of 32 units (8 hours). Consumer must be receiving SE/SED services at times of admission to inpatient setting. See Appendix A — In-Reach Guidelines of the MHFFS Program Provider Manual for additional requirements and limitations.
Supported Employment PRE-ADMISSION	15 minutes	See Business Rules	H2024	PA	\$25.58	Total episode maximum of 32 units (8 hours). Consumer must be discharged to SE/SED services from a State hospital. See Appendix G — Fee-for-Service Pre-Admission Service Guidelines of the MHFFS Program Provider Manual for additional requirements and limitations.
Supported Education - PRE-ADMISSION	15 minutes	See Business Rules	H2024	HWPA	\$25.58	Total episode maximum of 32 units (8 hours). Consumer must be discharged to SE/SED services from a State hospital. See Appendix G — Fee-for-Service Pre-Admission Service Guidelines of the MHFFS Program Provider Manual for additional requirements and limitations.

COMMUNITY SUPPORT SERVICES (CSS)						
BAND 1 - Community Support Services Physician	15 Minutes	8 daily	H2000	HE	\$104.55	Cannot be enrolled in ICMS, PACT or Community Residences.
BAND 1 - Community Support Services Physician IN-REACH	15 Minutes	*	H2000	IR	\$104.55	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 Appendix A — In-Reach Guidelines of the MHFFS Program Provider Manual for additional requirements and limitations.
BAND 2 - Community Support Services APN	15 Minutes	12 daily	H2000	HESA	\$53.86	Cannot be enrolled in ICMS, PACT or Community Residences.
BAND 2 - Community Support Services APN IN-REACH	15 Minutes	*	H2000	HEIR	\$53.86	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 Appendix A — In-Reach Guidelines of the MHFFS Program Provider Manual for additional requirements and limitations.
BAND 3 - Community Support Services Master's Degree No Clinical License	15 Minutes		H2015	HE	\$31.39	Cannot be enrolled in ICMS, PACT or Community Residences.
BAND 3 - Community Support Services Master's Degree No Clinical License IN-REACH	15 Minutes	*	H2015	HEIR	\$31.39	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 Appendix A — In-Reach Guidelines of the MHFFS Program Provider Manual for additional requirements and limitations.
BAND 3 - Community Support Services RN	15 Minutes		H2015	HETD	\$31.39	Cannot be enrolled in ICMS, PACT or Community Residences.
BAND 3 - Community Support Services RN IN-REACH	15 Minutes	*	H2015	TDIR	\$31.39	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 Appendix A — In-Reach Guidelines of the MHFFS Program Provider Manual for additional requirements and limitations.
BAND 3 - Community Support Services Psychologist	15 Minutes		H2015	AHHE	\$53.86	Cannot be enrolled in ICMS, PACT or Community Residences.
BAND 3 - Community Support Services Psychologist IN-REACH	15 Minutes	*	H2015	AHIR	\$53.86	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 Appendix A — In-Reach Guidelines of the MHFFS Program Provider Manual for additional requirements and limitations.
Band 3 - Community Support Services Licensed Clinical	15 Minutes		H2015	HEHO	\$35.81	Cannot be enrolled in ICMS, PACT or Community Residences.
Band 3 - Community Support Services Licensed Clinical IN-REACH	15 Minutes	*	H2015	IR	\$35.81	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 Appendix A — In-Reach Guidelines of the MHFFS Program Provider Manual for additional requirements and limitations.
BAND 4 -Community Support Services Bachelor Degree Group	15 Minutes		H0039	HNHQ	\$6.92	Cannot be enrolled in ICMS, PACT or Community Residences.
BAND 4 - Community Support Services Bachelor Degree Individual	15 Minutes		H0039	HN	\$27.72	Cannot be enrolled in ICMS, PACT or Community Residences.
BAND 4 - Community Support Services Bachelor Degree Individual IN-REACH	15 Minutes	*	H0039	IR	\$27.72	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 Appendix A — In-Reach Guidelines of the MHFFS Program Provider Manual for additional requirements and limitations.
BAND 4 - Community Support Services LPN Group	15 Minutes		H0039	HQTE	\$6.92	Cannot be enrolled in ICMS, PACT or Community Residences.
BAND 4 - Community Support Services LPN Individual	15 Minutes		H0039	TE	\$27.72	Cannot be enrolled in ICMS, PACT or Community Residences.
BAND 4 - Community Support Services LPN Individual IN-REACH	15 Minutes	*	H0039	TEIR	\$27.72	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 Appendix A — In-Reach Guidelines of the MHFFS Program Provider Manual for additional requirements and limitations.
BAND 5 - Community Support Services Peer Group	15 Minutes		H0036	HQ52	\$4.15	Cannot be enrolled in ICMS, PACT or Community Residences.
BAND 5 - Community Support Services Peer Individual	15 Minutes		H0036	52	\$16.61	Cannot be enrolled in ICMS, PACT or Community Residences.
BAND 5 - Community Support Services Peer Individual IN-REACH	15 Minutes	*	H0036	52IR	\$16.61	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 Appendix A — In-Reach Guidelines of the MHFFS Program Provider Manual for additional requirements and limitations.

COMMUNITY SUPPORT SERVICES (CSS) (continued)						
BAND 5 - Community Support Services High School Group	15 Minutes		H0036	HQ	\$4.15	Cannot be enrolled in ICMS, PACT or Community Residences.
BAND 5 - Community Support Services High School Individual	15 Minutes		H0036		\$16.61	Cannot be enrolled in ICMS, PACT or Community Residences.
BAND 5 - Community Support Services High School Individual IN-REACH	15 Minutes	*	H0036	IR	\$16.61	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 Appendix A — In-Reach Guidelines of the MHFFS Program Provider Manual for additional requirements and limitations.
BAND 5 - Community Support Services 2 yr Associate Degree Group	15 Minutes		H0036	HMHQ	\$4.15	Cannot be enrolled in ICMS, PACT or Community Residences.
BAND 5 - Community Support Services 2 yr Associate Degree Individual	15 Minutes		H0036	HM	\$16.61	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	\$16.61	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 Appendix A — In-Reach Guidelines of the MHFFS Program Provider Manual for additional requirements and limitations.
Community Support Services PRE-ADMISSION	Flat rate	One (1) per admission	H0036	PA	\$1,785.80	Consumer must be receiving CSS at the time of admission to inpatient setting or correctional facility. Consumer 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 Appendix G — Fee-for-Service Pre-Admission Service Guidelines of the MHFFS Program Provider Manual for additional requirements and limitations.
NOTE: The total number of units for bands 1-5 can not exceed 28 units daily						
* 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 – NJMHAPP VS ECAS CHART

Program	NJMHAPP	ECAS
ACUTE PARTIAL HOSPITAL TELEHEALTH SERVICES		X
CSS IN REACH		X
CSS PREADMISSION	X	
ICMS ANCILLARY & TRANSPORTATION	X	
ICMS IN REACH	X	
ICMS PREADMISSION	X	
ICMS UNITS IN EXCESS OF 50		X
PACT IN REACH	X	
PACT PREADMISSION	X	
PARTIAL CARE TELEHEALTH SERVICES		X
PARTIAL HOSPITAL TELEHEALTH SERVICES		X
RESIDENTIAL BED HOLD	X	
RESIDENTIAL BED HOLD EXTENSIONS	X	
RESIDENTIAL OVERNIGHT ABSENCES	X	
RESIDENTIAL PREADMISSION	X	
SE IN REACH	X	
SED IN REACH	X	
SE PREADMISSION	X	
SED PREADMISSION	X	
SE NON-FACE TO FACE	X	
SED NON-FACE TO FACE	X	
WRAP REQUESTS	X	

Appendix F — Fee-For-Service Billing Schedule

FY 2023 BILLING CYCLES

<u>Billing Cycle Number</u>	<u>Billing Start Date</u>	<u>Billing End Date</u>
1	7/1/2022	7/16/2022
2	7/17/2022	7/30/2022
3	7/31/2022	8/13/2022
4	8/14/2022	8/27/2022
5	8/28/2022	9/10/2022
6	9/11/2022	9/24/2022
7	9/25/2022	10/8/2022
8	10/9/2022	10/22/2022
9	10/23/2022	11/5/2022
10	11/6/2022	11/19/2022
11	11/20/2022	12/3/2022
12	12/4/2022	12/17/2022
13	12/18/2022	12/31/2022
14	1/1/2023	1/14/2023
15	1/15/2023	1/28/2023
16	1/29/2023	2/11/2023
17	2/12/2023	2/25/2023
18	2/26/2023	3/11/2023
19	3/12/2023	3/25/2023
20	3/26/2023	4/8/2023
21	4/9/2023	4/22/2023
22	4/23/2023	5/6/2023
23	5/7/2023	5/20/2023
24	5/21/2023	6/3/2022
25	6/4/2022	6/17/2023
26	6/18/2023	6/30/2023

FY 2024 BILLING CYCLES

<u>Billing Cycle Number</u>	<u>Billing Start Date</u>	<u>Billing End Date</u>
1	7/1/2023	7/15/2023
2	7/16/2023	7/29/2023
3	7/30/2023	8/12/2023
4	8/13/2023	8/26/2023
5	8/27/2023	9/9/2023
6	9/10/2023	9/23/2023
7	9/24/2023	10/7/2023
8	10/8/2023	10/21/2023
9	10/22/2023	11/4/2023
10	11/5/2023	11/18/2023
11	11/19/2023	12/2/2023
12	12/3/2023	12/16/2023
13	12/17/2023	12/30/2023
14	12/31/2023	1/13/2024
15	1/14/2024	1/27/2024
16	1/28/2024	2/10/2024
17	2/11/2024	2/24/2024
18	2/25/2024	3/9/2024
19	3/10/2024	3/23/2024
20	3/24/2024	4/6/2024
21	4/7/2024	4/20/2024
22	4/21/2024	5/4/2024
23	5/5/2024	5/18/2024
24	5/19/2024	6/1/2024
25	6/2/2024	6/15/2024
26	6/16/2024	6/30/2024

Appendix G — Fee-For-Service Pre-Admission Service Guidelines

I. PURPOSE:

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 PRINCIPLES:

- 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 to facilitate discharge from the hospital and provide 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 A of this Manual.
- C. The reimbursement requirements for and scope of pre-admission services delivered by each type of program is set forth in detail in the applicable Annex A of the provider's fee-for-service contract.
- D. Payment for pre-admission services delivered by supervised housing, PACT, CSS, supported employment and supported education providers is limited to consumers receiving such services in a State psychiatric hospital. In addition, payment for pre-admission services is available to consumers outside of State psychiatric hospital *provided the consumer is being assigned to an A+ residential placement by the Olmstead Placement Entity because there is no available State psychiatric hospital assignment.*
- E. Payment for pre-admission services delivered by ICMS providers is limited to services provided to consumers in a state or county psychiatric hospital and DMHAS psychiatric diversion beds (as defined by DMHAS).
- 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 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 in this Appendix 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:

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.

Appendix H — Procedure to Request an Increase in Monthly Limits

I. Purpose:

As set forth in Section 4 of the Addendum to the Standard Language Document for Mental Health Fee-for-Service contracts, a provider agency may submit a request for an increase in the monthly limit set forth in Appendix B-2 of its contract if the provider agency's claims for the month exceed 90% of its monthly limit. The purpose of this document is to set forth the requirements for submitting a request to increase the monthly limit.

II. General Principles:

- A. The threshold requirement for requesting for an increase in the monthly limit is that the provider agency's NJMHAPP claims/encounters for the month exceeds 90% of its monthly limit. Requests will not be considered if that requirement is not met.
- B. If the threshold requirement set forth in II.a, above is met, then the provider agency must consider whether the trend is expected to continue based on seasonal factors and their historical program experience. Providers should demonstrate evidence of this analysis to the DMHAS.
- C. Requests for increases in the monthly limit that meet the threshold requirement set forth in II.a, above, and are submitted in accordance with the procedures set forth in Section III, below, will be granted at the discretion of the DMHAS depending on the justification for the request, DMHAS priorities and the availability of fiscal resources.

NOTE: A request to increase the monthly limit cannot extend into the next Fee-For-Service contract period. Consequently, the *maximum* time period that the monthly limit can be increased is the remaining number of months of the contract period, including the month in which the request is made. The monthly limit for ensuing contract periods is determined as part of the renewal process; however, consistent with Section 4(b) of the MH FFS SLD Addendum, DMHAS reserves the right to initiate modifications to the provider agency monthly limits during the contract period. In situations where unused monthly limits from one month are made available by the State in one or more ensuing months, such additional funds must be used before monthly limits may be further increased.

III. Procedures for requesting an increase in the monthly limit:

A. Required forms, signatures and supporting documentation

- 1. Completed "Increase in Limits Request Form" (available via hyperlink on the NJMHAPP login page).
- 2. Justification for the request, including the following supporting documentation as applicable:
 - a. General
 - i. Although increases in limits for client specific and non-client specific factors may be identified, providers should also present an analysis of historical turnover for all

services within the scope of the provider's current monthly limits. In other words, vacancies that the provider may reasonably expect based on historical turnover should be used to identify funds that may be available to offset the increase in need.

- ii. Narrative explanations should be provided for all factors for which increases are requested, including those impacting specific clients/services.
- iii. The duration over which the client-specific, or non-client specific factors are expected to impact provider billing.

b. Non Client-Specific Factors

- i. Changes in payer mix, broken down by service, e.g., reduced percentages of Medicaid, private pay and insured clients, noting overall dollar impact, by month.
 - Providers should highlight any changes in payer mix that may have been experienced relative to the prior contract period.
- ii. Increases in the raw number of clients, broken down by service. Dollar impact by month should be calculated.
 - Information regarding client-specific factors may be requested if applicable for cases in which the addition or subtraction of a single individual is impactful.

3. All requests for increases to contractual monthly limits must be signed by the Provider Agency's Chief Executive Officer.

The completed forms and supporting documentation must be submitted to DMHAS via NJMHAPP ticket by the 20th day of the month following the start of the requested increase. The Division will review the request and advise the provider via ticket response within fourteen (14) calendar days of submission of the request and all required information.

- Approvals of increases will be formalized through signature by DMHAS management on the Increase in Limits Request Form. Providers should not rely on any other verbal or written communication as evidence of approval.

Immediately upon signing the Increase in Limits Request Form, DMHAS will adjust the monthly limits in the New Jersey Mental Health Application for Payment Processing (NJMHAPP); this will enable providers to submit claims at the higher limits as of the next billing cycle.

Appendix I — FFS WRAP GUIDELINES AND PROCEDURES

I. PURPOSE

The Wraparound Support (Wrap) guidelines and procedures apply to all mental health providers operating under a Fee-For-Service (FFS) contract. The purpose of these Guidelines and Procedures is to set forth the standards and procedures for provider agencies to request this discretionary funding. Provider agencies must comply with all of the terms and conditions contained in these guidelines and procedures.

II. GENERAL PRINCIPLES

Wrap funds are discretionary funds available for application by provider agencies under a mental health FFS contract with DMHAS to provide CSS, ICMS, PACT, Residential, Outpatient, Partial Hospital, Partial Care, Supported Employment or Supported Education services to adult consumers with mental illness.

Wrap funds are limited to only those services and expenditures that: (a) address a specific, special need under exigent circumstances; (b) facilitate consumer discharge from a State or county psychiatric hospital, divert hospital admission, or maintain community tenure; and (c) are not duplicative of any service eligible for reimbursement under existing contract, program guidelines or the terms and conditions outlined in the DMHAS Mental Health Fee-For-Service Program Provider and IT Manuals.

GENERAL WRAP REQUIREMENTS

Provider agency must document that all available resources have been exhausted. More specifically, the provider agency must determine and document that there is no other source of payment for the requested service/expenditure, such as a governmental housing subsidy, Medicaid/NJ Family Care, Medicare, charity care, health insurance, discount medication programs, prescription coupons/cards, existing contract, **and** the Mental Health FFS Program.

Wrap services and expenditures are program specific; not all services/expenditures are available in all programs. For example, furniture expenditures are available in CSS, ICMS and PACT (as detailed below), but not in Residential, Outpatient, Partial Hospital, Partial Care, Supported Employment or Supported Education. A table of available services and expenditures, by program, is included as Attachment 1 to this Appendix. Documentation requirements pertinent to requests for payment for staffing relative to security and monitoring activities are delineated in Attachment 2. Eligible staffing and FFS rate calculations for allowable tasks as determined by DMHAS Fiscal are contained in Attachment 3.

Wrap funding will only be considered for consumers with net family assets below \$4,000.00. However, with prior DMHAS approval, households shall be given the opportunity to spend down assets in excess of \$4,000.00. "Net family assets," excluding IRA's, Keogh and other similar retirement accounts, is defined by and calculated consistent with the current N.J. Supportive Housing Connection Policies and Procedures at: https://www.nj.gov/dca/divisions/dhcr/offices/docs/shc/shc_policies_procedures.pdf.

Wrap funding for furniture, utilities and/or a security deposit (in accordance with sections IV.a, b and c, respectively) will only be considered for consumers who qualify for a government housing subsidy.

Provider agency must complete (and submit timely) the requisite fields in the Wrap module in the NJ Mental Health Application for Payment Processing (NJMHAPP). In addition to completing required fields, provider agency is obligated to submit supplemental verification and documentation to justify each service/expenditure when it applies for Wrap funding **and** when it applies for payment.

Provider agency shall include specific time parameters for services, including titration plans and detailed efforts designed to mitigate the need for future Wrap requests. Wrap services and expenditures are limited by rate, level of staff, and credential. DMHAS retains sole and exclusive authority to evaluate, approve and/or disapprove all applications for funds.

DMHAS approval of Wrap funding is expressly dependent upon the availability of funds appropriated by the State Legislature from State and/or Federal revenue or such other funding sources as may be applicable. DMHAS shall not be financially liable for the failure to make any payment to the provider agency, or to observe and adhere to the approval of Wrap funding, resulting from the unavailability of Wrap funds. In addition, future funding shall not be anticipated.

III. APPLICATION AND PROCESSING

The application deadline for services that will be provided before the expiring fiscal year is June 15 of the same fiscal year, regardless of the contract period. Applications for Wrap funding filed after June 15 shall not be considered in the expiring fiscal year and must be re-submitted after July 1 when the new fiscal year commences, subject to the availability of funds as more specifically described herein.

Provider agency shall submit the request electronically via the Wrap Module in NJMHAPP. In some instances, depending upon the detail requirements for each category, provider agency must submit a MH FFS Wrap Request Worksheet, which shall be routed to the appropriate DMHAS unit for review and processing.

Within approximately five (5) to fifteen (15) business days of receipt of the application, DMHAS shall evaluate the application and respond to provider agency, via the Wrap module. DMHAS shall communicate the status of each request and any approved amount(s).

The “approval” grants the provider agency immediate authorization to render the approved service and/or incur the approved expense in accordance with the imposed limits. No funds may be expended until “approval” is granted. Provider agency shall stay within the specified limit of each procedure code.

Upon expending the approved funds, provider agency shall submit claims via the Wrap module, attaching all required documentation in support of the request for payment. DMHAS will verify that provider agency: (a) complied with the terms of the Wrap approval (that is, that provider agency complied with the approved rate, units, level of staff, and credential) and (b) provided proof of the delivery of services and/or incurred expenses for which reimbursement is sought. Provider agency shall provide any additional documentation DMHAS requires.

DMHAS shall evaluate provider agency's Payment Request, complete the Approval/Denial field, and indicate any reason for a denial of or variation in an amount to be paid.

Once payment requests are approved, DMHAS will notify the provider agency to submit all approved claims along with all required supporting documentation via the Wrap module. Provider agency may dispute a claim by following the dispute procedures contained in the DMHAS Mental Health Fee-For-Services Program Provider Manual.

IV. RULES & LIMITATIONS

Provider agency shall not remit Wrap funds directly to the consumer, regardless of form of remission. Cash, checks, debit cards and gift cards are strictly prohibited. Instead, provider agency shall appoint a staff member (at the appropriate level of qualification) to accompany the consumer to incur expenses/make any purchases or shall make payment directly payable to the appropriate third party payee (e.g. landlord, utility company, etc.).

The limitations specified below identify the maximum allowance. Provider agency shall render only those services that are required, without going over the maximum allowance. In addition, provider agency shall incur only those expenses that are necessary and reasonable under the circumstances, without going over the maximum allowance. It is in every provider's best interest to preserve Wrap funding and resources to ensure maximum benefit to the maximum number of consumers.

In addition to the general principles and application process requirements, the following business rules and limitations apply:

(a) Furniture:

Available only to recipients of a DMHAS or other governmental housing subsidy. The consumer must incur the expenditure within thirty (30) days of the date of execution of the lease agreement.

Documentation: Evidence of a governmental housing subsidy; Itemized list of, and a copy of paid receipts for, all expenditures.

Maximum allowance: \$3,000.00 for furnishings such as bed, dresser, kitchen table, chairs, sofa, lamps, cookware, clock, etc. Limited to one payment per consumer absent documentation of exceptional circumstances.

Also included within the \$3,000.00 limit: \$300.00 for groceries, cleaning supplies and paper goods; \$300.00 for entertainment equipment (TV, radio, etc.); \$400.00 for computer equipment; and \$150.00 for bicycle.

(b) Utilities: Available only to recipients of a DMHAS or other governmental housing subsidy. The consumer must incur the expenditure within thirty (30) days of the date of execution of the lease agreement.

Documentation: Evidence of a governmental housing subsidy; Utility invoice; Paid receipt.

Maximum allowance: \$300.00; Limited to one payment per consumer absent documentation of exceptional circumstances.

(c) Security Deposit:

Available only to recipients of a DMHAS or other governmental housing subsidy. In addition, the monthly rent must fall within the applicable county's fair market rent (FMR) value and the consumer must incur the expenditure within thirty (30) days of the date of execution of the lease agreement. Consumers are limited to one security deposit expenditure. In the event the consumer moves, provider agency shall apply the refunded portion of the initial security deposit to the new security deposit. The consumer shall be solely responsible for any short fall. In the event of eviction, damage or destruction of property, the consumer is solely responsible for additional security deposits. In the event some or all of the security deposit is refunded, and the consumer does not require it to secure a new lease, provider agency shall return the funds to DMHAS.

Documentation: Evidence of a governmental housing subsidy; Copy of the fully executed lease agreement and all statements of property damage (in connection with eviction or lease termination).

Maximum allowance: One and one-half month's rent based on applicable county's FMR; Limited to one award per consumer absent documentation of exceptional circumstances.

(d) Specialized Clinical Services:

A specialized service is one that is not available through a program in which the consumer is enrolled or qualifies to be enrolled. Specialized services may include: specialized clinical treatment when not available via existing service continuum (specifically; Dialectic Behavioral Therapy, Specialized Treatment for Sex Offenders, Specialized Behavioral Intervention Treatment, Eating Disorder Therapy, or other like services with clinical justification). The allowable rate and qualification shall be considered by DMHAS on a case by case basis in accordance with common industry guidelines for the clinical service requested.

Documentation: Provider agency shall document that the staff member will be/was at the appropriate level of qualification and that the services rendered will not be/were not duplicative of any service covered or eligible for reimbursement under existing program guidelines or the terms and conditions outlined in the DMHAS Mental Health Fee-For-Services Program Provider Manual. Clear time parameters for the clinical service will be specified including titration plans, as applicable. With respect to payment request, at a minimum, proof of expenditure must include the written agreement evidencing the hourly rate and/or rate for the contracted service along with verification of hours worked.

(e) Medical Services:

Services are limited to: medication administration for which there is clinical justification (specifically, injection monitoring, injections, blood pressure checks, oral medication administration, and/or medication monitoring); other medical services for which there is a

clinical justification; and/or services ordered by a physician. The allowable rate is up to RN, \$41.42 per hour, regardless of whether a higher credentialed staff delivers the service. If there is a clinical need for any other qualification level, DMHAS will consider requests for other staff and rates on a case by case basis.

Documentation: Provider agency shall document that the staff member will be/was at the appropriate level of qualification, that services are/were clinically justified and that the services rendered are/were not duplicative of any service covered or eligible for reimbursement under existing program guidelines or the terms and conditions outlined in the DMHAS Mental Health Fee-For-Services Program Provider Manual. With respect to payment request, at a minimum, proof of expenditure must include the written agreement evidencing the hourly rate and/or rate for the contracted service.

(f) Medications:

Expense is limited to prescribed medications not eligible for reimbursement from available resources, including but not limited to prescription coupons, prescription cards, and any other discount medication program.

Documentation: Provider agency shall provide copies of prescriptions and document that the services rendered are/were not duplicative of any service covered or eligible for reimbursement under: (a) any discount medication program; or (b) existing program guidelines or the terms and conditions outlined in the DMHAS Mental Health Fee-For-Services Program Provider Manual.

(g) Equipment:

Expenses are limited to adaptive and assistive devices, such as a chair lift, bariatric bed, or other medical devices ordered by a physician. The order should include a description of the clinical need for the equipment or device.

Documentation: Physician's order, three quotes for the equipment/device requested, itemized list of, and a copy of paid receipts for, all expenditures. Provider agency shall document that the expenses incurred were not eligible for reimbursement under existing program guidelines or the terms and conditions outlined in the DMHAS Mental Health Fee-For-Services Program Provider Manual.

(h) Security and Monitoring - Regular (pertains to ICMS, PACT Partial Care, Residential):

Services are only available to consumers who: demonstrate behaviors that place them at significant risk of hospitalization in the foreseeable future or require other site level security and monitoring to insure the safety of the consumer and the environment. The allowable rate is up to \$32.45 per hour.

Documentation: Provider agency shall document that the services are/were clinically justified, including but not limited to face to face coverage details and titration plans and are/were not duplicative of any service covered or eligible for reimbursement under existing program guidelines or the terms and conditions outlined in the DMHAS Mental

Health Fee-For-Services Program Provider Manual. Clear time parameters for the service will be specified including titration plans, as applicable. In addition, with respect to payment request, documentation including staff name(s), dates and hours worked for the respective timeframe is required.

(h) Security and Monitoring – CSS:

Services are only available to consumers who: demonstrate behaviors that place them at significant risk of hospitalization in the foreseeable future or require other site level security and monitoring to insure the safety of the consumer and the environment. The allowable rate is up to Bachelor’s level, \$38.79 per hour, regardless of whether a higher credentialed staff delivers the service. If there is a clinical need for any other qualification level, DMHAS will consider requests for other staff and rates on a case by case basis.

Documentation: Provider agency shall document that the services are/were clinically justified, including but not limited to face to face coverage details and titration plans and are/were not duplicative of any service covered or eligible for reimbursement under existing program guidelines or the terms and conditions outlined in the DMHAS Mental Health Fee-For-Services Program Provider Manual. Clear time parameters for the service will be specified including titration plans, as applicable. In addition, with respect to payment request, see Attachment 2 for documentation requirements.

(i) Environmental Health and Safety:

Temporary motel/hotel expenses are available only if a consumer: (a) is temporarily displaced from his/her residence because of an environmental health or safety hazard existing in the consumer’s residence; and (b) does not qualify for or does not have access to a homeless shelter or comparable community residence. The cost of repair to replacement of personal property is available only if a consumer: (a) incurs the loss as a result of a catastrophic event (including but not limited to fire, inclement weather and infestation); (b) the loss is not the direct result of the consumer’s intentional acts; and (c) the consumer has exhausted all emergency assistance benefits.

Documentation: Provider agency shall document that: access to a homeless shelter or comparable community resource is not available; the consumer exhausted all emergency assistance benefits; and that the expenses incurred are/were not duplicative of any service covered or eligible for reimbursement under existing program guidelines or the terms and conditions outlined in the DMHAS Mental Health Fee-For-Services Program Provider Manual. Provider Agency shall also provide an itemized list of, and copy of the receipts for, all expenditures.

- (j) Other: Interpreter services (all languages including sign) and court mandated services. The allowable rate and staff qualification shall be determined by DMHAS on a case by case basis in accordance with common industry guidelines for the service requested.

DMHAS will consider all other requests for services and expenses consistent with the general principles (specified in the above Section II), and subject to the applicable conditions, contained in these guidelines.

Documentation: Provider agency shall document that the staff member will be/was at the appropriate level of qualification, that services are/were clinically justified and that the services rendered are/were not duplicative of any service covered or eligible for reimbursement under existing program guidelines or the terms and conditions outlined in the DMHAS Mental Health Fee-For-Services Program Provider Manual. With respect to payment request, at a minimum, proof of expenditure must include the written agreement evidencing the hourly rate and/or rate for the contracted service.

ATTACHMENT 1

Element	CSS	ICMS	PACT	Residential	Outpatient	Partial Hospital	Partial Care	SE	SEd
Subsidy Startup - Furnishings	x	x	x						
Subsidy Startup - Deposits	x	x	x						
Specialized Clinical Services	x	x	x	x					
Medical Services	x	x		x					
Medical Services Medications	x	x	x	x	x	x	x		
Equipment	x	x	x	x					
Security / Monitoring Regular		x	x	x			x		
Security / Monitoring CSS	x								
Environment Health & Safety	x	x	x	x					
Other, Specify	x	x	x	x	x	x	x	x	x

ATTACHMENT 2

1. Documentation to support staffing activities in category (h) Security/Monitoring-Regular (ICMS, PACT, Partial Care, Residential):
 - A. Provider agency shall document that the staff member was at the appropriate level of qualification and that the services rendered were not duplicative of any service covered or eligible for reimbursement under existing program guidelines or the terms and conditions outlined in the DMHAS Mental Health Fee-For-Services Program Provider Manual.
 - B. Provider agency shall submit schedule detailing the hours worked, including dates, shifts and cumulative total, corresponding to the timeframe of the approved wrap request.

2. Documentation to support staffing activities in category (h) Security/Monitoring-CSS: Provider agency shall document that the staff member was at the appropriate level of qualification and that the services rendered were not duplicative of any service covered or eligible for reimbursement under existing program guidelines or the terms and conditions outlined in the DMHAS Mental Health Fee-For-Services Program Provider Manual.
 - A. For full-time employee that is assigned to the wrap service:
 - i. Official payroll record indicating that this person is in fact an employee; this should include the employee's salary, position and credentials within the organization.
 - ii. Weekly timesheet (electronic or manual) signed by employee and supervisor indicating the hours worked in total by this employee as well as the hours on this particular wrap request.
 - iii. Fringe documentation at the budgeted rate.
 - B. For contracted employees:
 - i. Official agreement with the contract personnel agency specifying that the named employee is assigned to work at the community provider in the specified capacity for which the State would be paying the Wrap costs. The agreement should also specify the hourly rate paid by community provider to the contract personnel agency.
 - ii. Timesheet signed by employee and supervisor documenting the hours worked specific to the Wrap request.
 - a. If the contracted employee worked on two different projects, including the specified Wrap request, the timesheet should clearly indicate the number of hours worked on each.
 - iii. No Fringe

3. Documentation to support staffing in category (d) Specialized Clinical Services: At a minimum, proof of expenditure must include the written agreement evidencing the hourly rate and/or rate for the contracted service along with verification of hours worked and/or service provided. If the staff is an employee of the agency, refer to item 2A, above.

ATTACHMENT 3

Eligible Staffing and Rates

Wrap Category	Eligible staff	Rate per Hour
(d) Specialized Clinical Services	Specialized clinical	*
(d) Medical	LPN	up to \$35.40
(e) Medical	RN	up to \$41.42
(h) Security & Monitoring - Regular	ICMS, PACT, Partial Care, Residential	up to \$32.45
(h) Security & Monitoring - CSS	HS Diploma/GED/Peer	up to \$17.12
(h) Security & Monitoring - CSS	Associates Level	up to \$21.76
(h) Security & Monitoring - CSS	Bachelors Level	up to \$38.79
(j) Other	TBD	*

* Allowable rate and qualification to be determined on a case by case basis in accordance with common industry guidelines for the service requested.

Appendix J — ICMS IN EXCESS OF 50 UNITS POLICY

Integrated Case Management Services (ICMS) providers who anticipate a specific consumer will require service delivery in excess of the NJMHAPP monthly limit of 50 units should complete the ***“ICMS Clinical Justification Form for Units in Excess of the Monthly Limit”*** (see ICMS – Clinical Justification Form on page 58). This form is also available for downloading on the NJMHAPP login page. ICMS providers must complete this form in its entirety and submit it via NJMHAPP ticket to the DMHAS – Mental Health FFS Unit by the 15th day of the month after the services were delivered. The MH-FFS Unit will then forward the completed document to the appropriate DMHAS Program Analyst and DMHAS Statewide ICMS Coordinator for review and approval.

ICMS Clinical Justification Form for Units in Excess of the Monthly limit

*For ICMS providers who anticipate a specific consumer will require service delivery in excess of the monthly limit of 50 units per consumer as established in the New Jersey Application for Payment Processing (NJMHAPP), **this form must be completed and submitted by ticket to the DMHAS – Mental Health FFS Unit for review by the 15th day of the month after the services were delivered.** The MH-FFS Unit will then forward the completed document to the appropriate DMHAS Program Analyst and DMHAS Statewide ICMS Coordinator for review.*

COUNTY: _____ **AGENCY:** _____ **DATE:** [Click here to enter a date.](#)
CONSUMER NAME: _____ **DATE OF BIRTH:** [Click here to enter a date.](#)
NJMHAPP ID# _____ **DATE OF ADMISSION TO ICMS:** [Click here to enter a date.](#)

MONTH ICMS SERVICES WILL EXCEED THE MONTHLY LIMIT: _____
NUMBER OF UNITS THAT WILL EXCEED THE MONTHLY LIMIT: _____

DATE OF DISCHARGE FROM INPATIENT FACILITY IF D/C OCCURRED WITHIN LAST 60 DAYS: [Click here to enter a date.](#)

NAME OF FACILITY CONSUMER DISCHARGED FROM (IF APPLICABLE): _____

PLEASE PROVIDE THE CONSUMER’S CURRENT RISK LEVEL BASED UPON ASSESSED RISK OF HOSPITALIZATION: _____

CLINICAL JUSTIFICATION FOR ICMS UNITS FOR ENTIRE MONTH --

PLEASE INCLUDE AND/OR ATTACH **ACTUAL PROGRESS NOTE DOCUMENTATION** DETAILING: DATES OF CONTACT FOR MONTH, # OF UNITS PER CONTACT, SERVICES PROVIDED

DATE	# units	Detailed description of activity/time spent with consumer

~ Submit completed form via NJMHAPP ticket and select “ICMS Limit Request” in dropdown menu ~

AGENCY REPRESENTATIVE SIGNATURE: _____

DMHAS USE:

ICMS Units Exceeding Monthly Limit/STATE RATE REIMBURSEMENT:

Approved
 Denied
 Additional Information Needed

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

DMHAS-Program Analyst: _____ DATE: ____ / ____ / ____

DMHAS ICMS Coordinator: _____ DATE: ____ / ____ / ____

Revised 05-23-2019

Appendix K — ICMS Ancillary & Transportation Services Guidelines

- I. **PURPOSE:** These guidelines apply to all ICMS providers operating under a Fee-For-Service (FFS) contract with the Division of Mental Health and Addiction Services (DMHAS). The purpose is to set forth the standards and procedures for ICMS providers to request and receive payment for the delivery of specifically defined Ancillary and Transportation services.
- II. **GENERAL PRINCIPLES:**
 - A. Funding for Ancillary services is intended to ensure that consumers receive certain limited, but necessary, *non-rehabilitative support services* that do not qualify as allowable integrated case management services.
 - B. Funding for Transportation services is intended to ensure that consumers receive certain limited, direct transportation services that do not qualify as Medicaid eligible medical transportation services.
 - C. Funding for Ancillary and Transportation services is being made available through the State-funded MH-FFS Program for both Medicaid eligible and non-Medicaid eligible consumers who are receiving ICMS program services. These revised guidelines are effective July 1, 2023.
 - D. Reimbursement under this guideline is expressly dependent upon the availability of funds appropriated by the State Legislature from State and/or Federal revenue or such other funding sources as may be applicable. DMHAS shall not be financially liable for the failure to make any payment to the provider agency resulting from the unavailability of funds. In addition, future funding shall not be anticipated.
- III. **REIMBURSEMENT CRITERIA FOR ANCILLARY AND TRANSPORTATION SERVICES:**
 - E. Reimbursement for a specific Ancillary or Transportation service (as defined herein) through the State-funded MH-FFS Program is available only when the service is necessary to:
 1. maintain continuity of care;
 2. maintain community tenure; and/or
 3. avoid a reasonable expectation of decompensation and/or psychiatric hospitalization.
 - F. One individual unit of service for ICMS Ancillary services is 15 continuous minutes of qualifying face-to-face contact with or on behalf of the consumer. With respect to Failed Contact Attempts, the ICMS provider agency must have attempted to make a face-to-face contact with the consumer. During the COVID-19 N.J. State of Emergency, face-to-face waivers and telehealth guidelines apply to ancillary services, but not to transportation services.
 - G. One group unit of service for ICMS Ancillary services is 15 continuous minutes of qualifying face-to-face contact with at least two (2), but no more than six (6), consumers.
 - H. One individual unit of service for ICMS Transportation is 15 continuous minutes of direct consumer transport.

- I. One group unit of service for ICMS Transportation is 15 continuous minutes of direct consumer transport for at least two (2), but no more than six (6), consumers.
- J. ICMS provider agency is limited to a combined total of **twenty (20) units** of any combination of individual Ancillary, group Ancillary, individual Transportation and Group Transportation units **per month, per consumer**. ICMS provider agency may seek reimbursement for additional units of Ancillary and Transportation Services in accordance with Appendix O.
- K. ICMS provider agency may provide both Ancillary and Transportation services for the same consumer on the same service date. However, provider agency cannot provide Ancillary and Transportation units of service concurrently (at the same moment in time) for the same consumer.
- L. Ancillary and Transportation services are available to community consumers only.
- M. Ancillary and Transportation service units do **not** count toward the 50-unit monthly limit for ICMS services.
- N. Reimbursement for an Ancillary or Transportation service through the State-funded MH-FFS Program is available only when the service is not duplicative of any service eligible for reimbursement under Medicaid regulations (N.J.A.C. 10:73-1.2 et seq. (Adult Case Management) and N.J.A.C. 10:50-1.1 et seq. (N.J. Medicaid/FamilyCare Transportation Services Manual)), existing FFS program guidelines/contract annex A, or the terms and conditions outlined in the DMHAS Mental Health Fee-For-Service Program Provider and IT Manuals (including, but not limited to, the WRAP guideline at Appendix I).
- O. ICMS provider agency must determine and document in the consumer's record that there is no other source of payment for the Ancillary or Transportation service and that the service satisfies all of the criteria contained in these Guidelines. Provider agency shall provide any additional documentation DMHAS requires.
- P. DMHAS retains the authority to evaluate, approve and/or disapprove all requests for payment in accordance with these Guidelines. These Guidelines may be updated, as necessary.
- Q. ICMS provider agency may dispute a claim by following the dispute procedures contained in the DMHAS Mental Health Fee-For-Service Program Provider Manual.

VIII. ANCILLARY SERVICES

- A. Non-rehabilitative support services, provided with or on behalf of a specific consumer, that are established and documented as necessary to support the consumer's recovery plan and/or gain access to the integrated case management services identified in the consumer's recovery plan. Ancillary services are necessary for, but subordinate to, the consumer's overarching treatment and rehabilitative goals.

- B. ICMS services which are currently Medicaid billable under N.J.A.C. 10:73-1.1, et seq. (Adult Case Management Program/Mental Health (CMP/MH)) and/or the FFS contract do not qualify as Ancillary services.
- C. Ancillary services eligible for reimbursement (subject to the within Guidelines) are specified in table 1 below:
- D. Ancillary services can be provided in either an individual or group setting depending on the type of service provided (see Table 2 below).

Table 1.

Ancillary Services	Service Description
Supportive Oversight/Monitoring	Provided when the consumer requires supervision and/or monitoring (not authorized by WRAP) for the consumer’s own safety or the safety of others (e.g. Forensic/Legally Involved).
Accompanying/Waiting with Consumer at Appointments	Provided when the consumer must attend a required appointment and the consumer cannot reasonably be expected to keep the appointment without ICMS staff support (e.g. Court Hearing, Probation Appointment, Doctor’s Visit, etc.).
Essential Errands with or on Behalf of the Consumer	Provided when essential errands (e.g. trip to food pantry, trip to pharmacy), must be performed with or on behalf of the consumer. Errands must be consolidated whenever practicable.
Participating with Consumer at Intake/Appointment for Other Essential Services	Provided when the consumer requires non-rehabilitative assistance with an appointment for other essential services (e.g. Social Security, Board of Social Services, etc.).
Failed Contact Attempts	Provided when face-to-face contact is attempted but the consumer could not be located despite reasonable efforts and the contact was deemed necessary to maintain continuity of care and ensure the health and safety of the consumer.

- E. Ancillary services can be provided in either an individual or group setting depending on the type of service provided (see Table 2 below).

Table 2.

Allowable Ancillary Individual & Group Settings	Individual	Group Setting
Supportive Oversight/Monitoring	Yes	No
Accompanying/Waiting w/Consumer at Appointment	Yes	Yes
Essential Errands with or on Behalf of the Consumer	Yes	Yes
Participating with Consumer at Intake/Appointment for Other Essential Services	Yes	No
Failed Contact Attempts	Yes	No

IX. TRANSPORTATION SERVICES

- A. Direct consumer transportation must be established and documented as necessary for the consumer to address or resolve a critical need identified in the consumer's recovery plan.
- B. Direct consumer transportation can only be provided when the consumer has no other mode of transportation available to address or resolve a critical need identified in the consumer's recovery plan.
- C. Direct consumer transportation is limited geographically and may not be billed for transport outside of the common marketing area ***unless required by the particular circumstances. DMHAS will determine the circumstances on a case by case basis.***
- D. Direct consumer transportation is limited to vehicle transportation provided by licensed, insured ICMS staff (18 years of age and older) only.
- E. Direct consumer transportation for the same or similar services, and/or for multiple consumers, must be combined to avoid duplicate trips.
- F. Medical Transportation eligible for reimbursement under current Medicaid regulations (Modivcare) may not be billed as Transportation services.
- G. Transportation is not considered an ancillary service.
- H. Transportation can be provided in either an individual or group setting.

X. REPLACEMENT OF ANCILLARY & TRANSPORTATION SERVICES BUNDLED RATE & OFFLINE PAYMENT PROCESSING WITH ANCILLARY AND TRANSPORTATION ENCOUNTER BILLING:

Bundled rate reimbursement and offline payment processing for ICMS Ancillary and Transportation services will terminate effective July 1, 2023. Beginning July 1, 2023, ICMS providers must enter into NJMHAPP the Ancillary and Transportation encounter data for each allowable service provided at the individual and/or group 15-minute unit rate. Reimbursement will be made in accordance with this Appendix K and Section 4 (Fiscal Requirements and Guidance) of the Mental Health Fee-for-Service Program Provider Manual.

Appendix L — Pre-admission for Olmstead-approved non-State-Hospital Referral Policy

Approval Process for Preadmission Services:

Olmstead approved non-State-Hospital Referrals to A+ Residential Only

Provider agencies obligated to provide preadmission services to consumers being assigned to an A+ residential placement by the Olmstead Placement Entity because there is no available State psychiatric hospital assignment must complete the “PRE-ADMISSION REQUEST FOR OLMSTEAD-APPROVED NON-STATE HOSPITAL REFERRAL” form (see Form on page 61). Providers must complete the form in its entirety and submit via NJMHAPP ticket. DMHAS MH FFS Unit will forward the completed form to the Olmstead/PE for review and approval. Upon receipt of Olmstead/PE approval, the MH FFS Unit will email the provider agency and authorize the agency to enter the pre-admission encumbrance in NJMHAPP (selecting the State Hospital pertinent to agency catchment in the only available drop down box). Upon discharge and admission to the A+ bed, provider agency may convert the request to “Pending” status. MH FFS Unit will then verify the consumer information and issue appropriate approvals in the payment processing module.

PRE-ADMISSION REQUEST FOR OLMSTEAD-APPROVED NON-STATE HOSPITAL REFERRAL



PRE-ADMISSION REQUEST FOR OLMSTEAD-APPROVED NON-STATE HOSPITAL REFERRAL

This form must be completed and submitted for review (via NJMHAPP ticket) after receiving instruction from Olmstead/ Placement Entity to accept a non-State Hospital referral to an A+ placement. The MH-FFS Unit will then forward the completed document to the appropriate DMHAS Olmstead Coordinator for review and signature. The signed form serves as authorization for Provider to submit a Pre-admission encumbrance in NJMHAPP. Only upon successful admission to Residential bed can the request be converted to "Pending" status for final approval by MH-FFS Unit.

AGENCY:

COUNTY: DATE:

CONSUMER: DATE OF BIRTH:

DATE OF COMMUNICATION FROM OLMSTEAD/PLACEMENT ENTITY TO ACCEPT A NON-STATE HOSPITAL REFERRAL:

NAME OF FACILITY WHERE THE REFERRED CONSUMER IS RECEIVING INPATIENT HOSPITALIZATION or OTHER LEVEL OF CARE (if OTHER, include pertinent detail):

NAME AND FULL ADDRESS OF RESIDENTIAL SITE WHERE CONSUMER WILL BE ADMITTED:

~ Submit completed form via NJMHAPP ticket and select "[Pre-admission Olmstead PE-approved]" in drop down menu ~

AGENCY REPRESENTATIVE SIGNATURE:

DMHAS USE: <u>PREADMISSION REQUEST FOR NON-STATE HOSPITAL REFERRAL:</u>		
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied	<input type="checkbox"/> Additional Information Needed
DMHAS-FFS Representative: <input type="text"/>	DATE: <input type="text"/>	
OLMSTEAD COORDINATOR: <input type="text"/>	DATE: <input type="text"/>	
DMHAS REGIONAL OFFICE (if indicated): <input type="text"/>	DATE: <input type="text"/>	

Revised 12/01/2020



Appendix M — Consumer Registration, Rental Subsidy Reporting and Revenue Reduction Requirements for Supervised Residential Providers

Purpose: To set forth the consumer registration requirements, rental subsidy reporting standards and revenue reduction policies applicable to Supervised Residential Providers licensed and under Fee-for-Service contract to provide residential services pursuant to N.J.A.C. 10:37A (Level A+ Group Home, Level A+ Apartment, Level A Group Home, Level A Apartment, Level B Group Home, Level B Apartment, Level D Family Care).

I. General Principles:

- A. The Division of Mental Health and Addiction Services (DMHAS) requires all consumers admitted into Mental Health Fee-for-Service (MH-FFS) contracted, residential sites, to be registered in the New Jersey Mental Health Application for Payment Processing (NJMHAPP), in order to monitor overall residential claims volume and to ensure proper billing. This includes both **Medicaid funded and non-Medicaid funded** consumers.
- B. The NJMHAPP encumbrance module automatically encumbers Room & Board claims for all consumers (Medicaid funded and non-Medicaid funded) admitted by the Supervised Residential Provider into supervised residential services. However, NJMHAPP does not automatically encounter (bill) Room & Board for all consumers.
- C. All consumers who receive a rental subsidy are subject to the same DMHAS policies, procedures, and business rules as detailed in Appendix D – NJMHAPP Code and Rate Table/Supervised Residential Services (pg. 33), Appendix B – Bed Hold and Overnight Absence Reimbursement Guidelines (pg. 26), Appendix C – 30 Day Residential Bed Hold Extension Request Form (pg. 30), Appendix G – Fee-for-Service Pre-Admission Service Guidelines (pg. 38) and Appendix I – FFS Wrap Guidelines and Procedures (pg. 42).
- D. Section L of the Mental Health Fee-for-Service Program Provider Manual states:

Consumer Co-Payments: 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 submitted monthly to the DMHAS fiscal unit by going to the NJMHAPP revenue template screen and selecting from the drop down menu the appropriate fiscal year, month and qualifying program(s) for which the agency is required to submit revenue information. Reported revenues will be deducted from future payment to the provider agency.
- E. Supervised Residential Providers must report consumer rental subsidies to DMHAS, consistent with Section L of the Provider Program Manual and this Appendix M, so DMHAS can deduct the rental subsidy revenue from Room & Board claims billed in NJMHAPP (see Section II(C) Rental Subsidy Reporting Requirements). It should be noted that the revenue template is now contained within its own module in NJMHAPP and has been revised to include a separate column for Supervised Residential Providers to report consumer rental subsidy income.

- F. Pursuant to the DMHAS Rental Subsidy Policy, no consumer admitted to a Supervised Residence licensed under N.J.A.C. 10:37A is eligible to receive a DMHAS rental subsidy. Accordingly, no DMHAS rental subsidies should appear in the monthly revenue template screen. However, all other rental subsidies including, but not limited to, Section 8 (Housing Choice) Vouchers, State Rental Assistance (SRAP), Public Housing, Section 811 (Supportive Housing for Persons with Disabilities), Section 202 (Supportive Housing for Elderly), county subsidies and other available options, are subject to DMHAS reporting requirements and revenue reductions, unless otherwise excepted in accordance with Section II(D), below (Third-Party Landlord Exception).
- G. This appendix does not supplant or provide guidance regarding the regulations or policies of any Federal, State and/or local rental subsidy programs. Provider is responsible for adhering to all applicable Federal and State statutes and regulations applicable to the consumer's specific rental subsidy program.

II. REGISTRATION, REPORTING REQUIREMENTS AND REVENUE REDUCTIONS FOR CONSUMERS WITH A RENTAL SUBSIDY:

- A. Registration Requirement. Effective immediately, Supervised Residential Providers are obligated to register all consumers admitted into MH-FFS contracted, residential sites, in the NJMHAPP billing system. This includes both **Medicaid funded and non-Medicaid funded** consumers.
- B. Room & Board Billing Requirements. Effective immediately, Supervised Residential Providers are required to submit claims for Room & Board, via the NJMHAPP billing system, for any consumers receiving services in MH-FFS contracted, residential sites, except as expressly provided in Section II(E), below (Third Party Landlord Exception). Room & Board billing must be consistent with all applicable DMHAS policies, procedures and business rules, including Appendix D – NJMHAPP Code and Rate Table/Supervised Residential Services (pg. 33), Appendix B – Bed Hold and Overnight Absence Reimbursement Guidelines (pg. 26) and Appendix C – 30 Day Residential Bed Hold Extension Request Form (pg. 30).
- C. Rental Subsidy Reporting Requirements. Consistent with established policy, if the consumer subsidy amount is equal to or exceeds the room & board amount for that month (whether for 30 days or for 31 days), the Supervised Residential Provider must report up to the maximum amount of room & board billed for that month in the NJMHAPP revenue template screen. If a residential consumer with a subsidy is out of the residence for part of the month, the Supervised Residential Provider must report in the NJMHAPP revenue template screen the amount equal to the number of days the consumer was present in the residential facility.
- D. Supplemental Security Income (SSI) & Social Security Disability Insurance (SSDI) Reporting Requirements. Supervised Residential Providers should only report the amount of SSI/SSDI income *collected and retained* as a fee for Residential services billed. Accordingly, Providers should not include the full SSI/SSDI amount collected; the amount reported should not exceed the total Room & Board amount billed when the bed is occupied.
- E. Third-Party Landlord Exception. Effective immediately, Supervised Residential Providers are barred from submitting in NJMHAPP a claim for reimbursement for Room & Board whenever the consumer's rent obligation is due and payable to a third-party landlord. It follows, therefore, that

the Supervised Residential Provider has no obligation to report in the monthly revenue template screen any amount of the consumer's rental subsidy (because the subsidy is paid to a third party). A third-party landlord means an individual or business entity that operates under a different taxpayer identification number than the Supervised Residential Provider.

Appendix N — Claim Dispute Review Request



CLAIM DISPUTE REVIEW FORM

If a provider disputes the denial or reduction of a claim, a request for review may be submitted within 60 days of notice of the denial or reduction. This form must be completed in its entirety and, along with any additional documentation supporting the Provider's position that the claim was inappropriately denied or reduced, submitted via NJMHAPP ticket, selecting "Claim Dispute Review Request" in the drop-down menu.

AGENCY: DATE:
ADDRESS: COUNTY:
CONSUMER NAME: NJMHAPP ID #:

SPECIFIC CLAIM DENIED OR REDUCED:
CLAIM DATE FROM: To:

DESCRIPTION OF THE REASON THE PROVIDER BELIEVES THAT THE DENIAL OR REDUCTION OF THE CLAIM WAS INAPPROPRIATE:

AGENCY CONTACT SIGNATURE: TITLE:
AGENCY CONTACT EMAIL:

Submit completed form via NJMHAPP ticket, selecting "Claim Dispute Review Request" in drop-down menu. To expedite review, a copy of the notice from DMHAS showing the denial or payment reduction should be included.

DMHAS USE:

CLAIM DISPUTE STATUS UPON REVIEW WITH EXECUTIVE STAFF:

Approved Denied Additional Information Needed

MH FFS Unit Regional Coordinator:

DMHAS Deputy Assistant Commissioner:

Rev 02.2022



Appendix O — REQUEST FOR ICMS ANCILLARY & TRANSPORTATION SERVICES IN EXCESS OF 20 UNITS

Integrated Case Management Services (ICMS) providers who anticipate a specific consumer will require Ancillary and/or Transportation service delivery in excess of the NJMHAPP monthly limit of 20 combined units must complete the ***“ICMS Ancillary/Transportation Justification Form for Units in Excess of the Monthly Limit”*** (see ICMS – Ancillary/Transportation Justification Form on page 67, also available for downloading on the NJMHAPP login page). ICMS providers must complete this form in its entirety and submit it via NJMHAPP ticket to the DMHAS – Mental Health FFS Unit by the 15th day of the month after the services were delivered. The MH-FFS Unit will then forward the completed form to the appropriate DMHAS Program Analyst and DMHAS Statewide ICMS Coordinator for review and approval/disapproval.

