Mental Health Fee-for-Service Program Provider Manual
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1. Introduction

Beginning January 1, 2017, the New Jersey Department of Human Services (DHS), Division of Mental Health and Addiction Services (DMHAS) is instituting 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.

At this time, participation in the MH FFS Program is limited to provider agencies under contract with the DMHAS as of December 31, 2016. Those provider agencies have been offered the choice of transitioning from their current cost-related contracts with installment payments (also known as cost-reimbursement contracts) to a non-cost related contract with fee-for-service payment on either January 1, 2017 (Phase I) or July 1, 2017 (Phase II).

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

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

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

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

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

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\(^1\) A small proportion of funding is from the federal Mental Health Block Grant.
Questions or requests for manual revisions should be directed to the Division’s FFS Transition help desk at: FFS.Transition@dhs.state.nj.us

2. Provider Eligibility to Participate in the MH FFS Program

A. Contract with DMHAS

As previously noted, only providers that hold contracts for state funding as of December 31, 2016 are eligible to participate in the MH FFS Program. The MH FFS Program does not create an opportunity for providers to expand state-funded services beyond those approved and authorized within the scope of their current contract.

B. Enrollment as NJ FamilyCare Provider

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

Providers under contract with the DMHAS to provide only services not covered by Medicaid, i.e., those providing only supported employment or supported education services, are exempt from the requirement to enroll as a NJ Family Care Provider.

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

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

3. Services covered by the MH FFS Program

A. MH FFS Program Services – Phase I

Table 1 lists the mental health programs eligible for funding through the MH FFS Program during Phase I, which begins January 1, 2017. In this context, “mental health program” refers to a

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2 NJ FamilyCare is New Jersey’s Medicaid system.
category of services, e.g., outpatient programs, community residences. Some of those categories include subtypes of services, for example, outpatient programs include diagnostic evaluations, medication monitoring, individual therapy, etc.\textsuperscript{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. 10:190, Licensure Standards for Mental Health Programs, also must follow the standards therein.

Table 1 also identifies those services covered by Medicaid/NJ FamilyCare. This is very important information with respect to whether funding is available through the MH FFS Program for the following reason. If the service is covered by Medicaid/NJ FamilyCare and the consumer is Medicaid/NJ FamilyCare eligible, then funding is not available through the MH FFS Program because it is the payer of last resort. Accordingly, providers should submit claims for Medicaid-covered services provided to Medicaid-eligible consumers to Molina, the Medicaid/NJ FamilyCare fiscal agent.\textsuperscript{5}

As denoted in Table 1, the following MH FFS Program Phase 1 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
- PACT In-Reach
- Supported Employment
- Supported Education
- Supervised housing room and board costs
- Supervised housing bed holds

\textsuperscript{3} Community Support Services will remain under cost-reimbursement contracts during Phase 1 of the MH FFS Program, but will transition to the MH FFS Program during Phase II. This manual will be updated as additional services transition to the MH FFS Program.

\textsuperscript{4} More detailed information on the services encompassed within a mental health program category is provided in the rate table located at Appendix D.

\textsuperscript{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>
<thead>
<tr>
<th>Program/Service</th>
<th>Brief Description</th>
<th>Applicable Regulations (if any) or other guidelines</th>
<th>Covered by Medicaid/NJ FamilyCare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>Mental health services provided in a community setting. Specific services include psychiatric evaluation, medication monitoring, individual therapy, group therapy and family therapy.</td>
<td>N.J.A.C. 10:37H</td>
<td>Yes</td>
</tr>
<tr>
<td>Partial Care (PC)</td>
<td>Individualized, outcome oriented, structured, non-residential program offered in a non-hospital setting. The program includes active treatment and psychiatric rehabilitation.</td>
<td>N.J.A.C. 10:37F</td>
<td>Yes</td>
</tr>
<tr>
<td>PC Transportation</td>
<td>Transportation to and from the service location</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Integrated Case Management Services (ICMS)</td>
<td>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.</td>
<td>N.J.A.C. 10:73-2.1 to -2.13&lt;sup&gt;6&lt;/sup&gt;</td>
<td>Yes</td>
</tr>
<tr>
<td>ICMS In Reach Services</td>
<td>ICMS services provided to consumers in certain in-patient or correctional facility</td>
<td>PACT/ICMS In-Reach Guidelines&lt;sup&gt;7&lt;/sup&gt;</td>
<td>No</td>
</tr>
</tbody>
</table>

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

<sup>7</sup> Reprinted in Appendix A of this manual.
<table>
<thead>
<tr>
<th>Program/Service</th>
<th>Brief Description</th>
<th>Applicable Regulations (if any) or other guidelines</th>
<th>Covered by Medicaid/NJ FamilyCare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programs of Assertive Community Treatment (PACT)</td>
<td>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.</td>
<td>N.J.A.C. 10:37J N.J.A.C. 10:76-2.4 N.J.A.C. 10:79B-2.4(g)</td>
<td>Yes</td>
</tr>
<tr>
<td>PACT In-Reach Services</td>
<td>PACT services provided to consumers in certain in-patient or correctional facility</td>
<td>PACT/ICMS In-Reach Guidelines</td>
<td>No</td>
</tr>
<tr>
<td>Supported employment (SE)</td>
<td>SE is for individuals with severe mental illness 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 has no eligibility requirements other than expressed interest. SE is provided in the community and as an “in-reach” service to patients in the State psychiatric hospitals.</td>
<td>Guidelines forthcoming</td>
<td>No</td>
</tr>
<tr>
<td>Supported Education (SEd)</td>
<td>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 the job or 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 an information clearinghouse for consumers, families, colleges, and providers within a geographical area. The services also include</td>
<td>Guidelines forthcoming</td>
<td>No</td>
</tr>
</tbody>
</table>

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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.
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 school.

<table>
<thead>
<tr>
<th>Program/Service</th>
<th>Brief Description</th>
<th>Applicable Regulations (if any) or other guidelines</th>
<th>Covered by Medicaid/NJ FamilyCare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Residences for Adults with Mental Illness (“Supervised Housing”)</td>
<td>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.</td>
<td>N.J.A.C. 10:37A</td>
<td>Yes</td>
</tr>
<tr>
<td>Supervised Housing Room and Board</td>
<td>Shelter and food provided to consumers receiving supervised housing services</td>
<td>N.J.A.C. 10:37A</td>
<td>No</td>
</tr>
<tr>
<td>Supervised Housing Bed Holds</td>
<td>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).</td>
<td>Bed Hold Reimbursement Guidelines⁹</td>
<td>No</td>
</tr>
</tbody>
</table>

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, charity care or health insurance and, if yes, seek payment from that source. Payment is not available through the MH FFS Program if there is another source of payment.

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

⁹ Reprinted in Appendix B of this manual.
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 addition, providers should evaluate whether a consumer is eligible for charity care coverage if the consumer will receive hospital-based outpatient or partial hospitalization services. Providers cannot request payment for those services through the MH FFS Program if the consumer is eligible to receive charity care.

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

B. New Jersey Mental Health Application for Payment Processing

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

Information about the NJMHAPP, including an overview of its design and functionality and detailed instructions on its use, is provided in the NJMHAPP Users Guide, which will be made available on the DMHAS website on or about December 5, 2016.

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 “from the ground up” 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.\(^\text{10}\) As noted in that presentation, the rate for State-funded

\(^{10}\) The slides from that presentation are available at: http://www.state.nj.us/humanservices/dmhas/information/stakeholder/Rate_Setting_Transition_Overview.pdf
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 above-referenced rate table, the billing unit for Medication Monitoring, ICMS, Level B Supervised Apartments, Supported Employment, and Supported Education services is 15 minutes. A 15-minute unit of service is defined as 15 consecutive minutes of face-to-face services 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 and Level B Supervised Apartment 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).

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 provider’s monthly limit is 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.

During Phase I, provider agencies that consistently meet the monthly limit during the first three months of their contract may request an increase in the monthly limit for the following months, which shall be granted at the discretion of the DMHAS depending on available resources.

To ensure that available resources are used to meet the needs of consumers, the Division 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.

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

However, after month two, the amount to be rolled over will be affected by whether or not the provider agency met the 80% threshold as follows. If the provider agency’s claims for payment are under the monthly limit, the entire unused portion of the monthly limit will roll over to the following month only if the provider agency has met the 80% threshold. If the provider agency’s billing for the month is less than 80% of the monthly limit, then only 50% of the unused portion of the monthly limit will be roll over to the following month. For example, if the monthly limit is set at $100,000 and the provider agency claims total $80,000 during the month, then only 50% of the remaining $20,000 will be rolled over the the following month.
The monthly limit for the purpose of establishing the 80% threshold is not effected by the amount rolled over from the prior month. Thus, if the provider agency’s monthly limit is set at $100,000 and the provider agency bills only $80,000 during the month one, then the monthly limit will remain at $100,000 and the provider agency bills only $80,000 during month one, the the monthly limit will remain at $100,000 for month two for the purpose of establishing whether the provider agency has met the 80% threshold even though the provider agency will be able to bill up to $120,000 in month two. If the provider agency bills only $80,000 during month two, then the provider agency will have met the 80% threshold and all unused funds available in month two ($40,000) will be rolled over to month three.

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

F. Encumbrances

The NJMHAPP includes an encumbrance module that will capture data on estimated monthly service needs. Additional details about the encumbrance module is provided in the NJMHAPP User’s Guide.

G. 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. Further detail on that module is provided in the NJMHAPP User Guide.

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

| TO: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX | DEBIT: FINANCIAL TRANSACTION ADVICE | DATE: MM/DD/YYYY |
| XXXXXXXXXXXXXXXXXXXXXXXXXXXXX | NEW JERSEY MEDICAID PROGRAM | REMITTANCE NO: 99999999999 |
| XXXXXXXXXXXXXXXXXXXXXXXXXXXXX | FISCAL AGENT - MOLINA MEDICAID SOLUTIONS | PROVIDER ID: 9999999 |
| XXXXXXXXXXXXXXXXXXXXXXXXXXXXX | P.O. BOX 4061 | BILL: 9999999 |
| XXXXXXXXXXXXXXXXXXXXXXXXXXXXX | TISDAR, NJ, 08660 | |

Gross Payment | DATE | AMOUNT | BALANCE | CONTROL NUMBER |
---|---|---|---|---|
8,854.00 | 0 | 161279201 |

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

Encounter data must be entered into NJMHAPP after the service was delivered. Encounter data may be entered as frequently as daily. The deadline for submitting encounter data is the fifteenth (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 Medicaid/NJ Family Care system, which allows claims to be submitted within one year of the service date. Agencies will be paid every two weeks based on the encounter/billing data entered into the NJMHAPP by the end date of the billing cycle (See Appendix F – Fee-for-Service Billing Schedule).

H. Consumer Co-Payments
During Phase I, provider agencies are required to collect co-payments from consumers eligible to participate in the MH FFS program pursuant to their current policies. The Provider Agency shall report revenues generated through collection of consumer co-payments and/or consumer fees on a monthly basis on a form that will be made available by the DMHAS. That revenue will be deducted from future payment to the provider agency except that revenues generated through collection of consumer co-payments during the last month of the contract period will be recovered by the Division through an alternate mechanism.

I. Claim Denials based on Failure to Apply for NJ FamilyCare
The DMHAS is in the process of developing a Uniform Income Assessment and Consumer Co-Pay policy that it plans to implement during State Fiscal Year 2018. As described under Section 4.1, above, the MH FFS Program is the payer of last resort. In order to help assure that there is no other source of payment, providers are required to determine if a consumer is a current NJ FamilyCare/Medicaid beneficiary. For consumers who are not current NJ Family Care/Medicaid beneficiaries, NJMHAPP includes a module that screens for potential NJ FamilyCare/Medicaid eligibility based on the consumer’s income as compared to the federal poverty guideline. When the screening indicates that the consumer may be eligible for NJ FamilyCare/Medicaid, providers are required to assist the consumer in applying for NJ Family Care/Medicaid, either through the presumptive eligibility process if the provider is a qualified entity or by assisting the consumer to complete a NJ FamilyCare application. Further, when there is a positive screen, the NJMHAPP will require the provider to indicate the status of the NJ FamilyCare application or provide a reason why an application has not been submitted. The DMHAS will pay claims for a Medicaid-covered service following a positive Medicaid screen for 60 days to allow sufficient time for a NJ FamilyCare application to be submitted and processed. DMHAS will deny payment for claims for a Medicaid-covered service delivered more than 60 days after the positive Medicaid screen unless the provider agency has provided documentation that the NJ FamilyCare application is still being processed or that NJ FamilyCare coverage was denied.

J. Claim Adjustments and Payments Outside of NJMHAPP
During Phase I, NJMHAPP functionality will allow processing of timely claims for all services covered under the MH FFS Program except initial and extended bed holds for supervised housing programs. Furthermore, other circumstances might require a claims process outside of the NJMHAPP, for example, when a provider submits an untimely claim as the result of extraordinary circumstances. In addition, there will be situations when third party liability carriers deny payment for services that also have not been paid through NJMHAPP. Appendix E includes procedures for processing MH FFS payments outside of NJMHAPP.

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

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

1. If the consumer becomes 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.

5. FFS Program Contract Requirements

A. Program and Budget Reports of Expenditures

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.

Providers that have 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.

6. Required Documentation Supporting Claims for Payment

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

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

The above represents the minimum required documentation supporting claims for services under the MH FFS Program. This does not negate any additional recordkeeping requirements set forth in applicable regulations or policies. With respect to services that are covered by Medicaid, DMHAS suggests that it would be good practice to follow the record keeping requirements in the applicable Division of Medical Assistance and Health Service regulations even when the consumer is not a Medicaid beneficiary.

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

7. 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;
- 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
8. Claim Dispute Review

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

- NJMHAPP-generated consumer ID number
- Provider name, address, and contact person
- Description of the reason why the provider believes that the denial or reduction of the claim was inappropriate.
- To expedite review, attach a copy of the notice from DMHAS showing the denial or payment reduction
- Any additional documentation supporting the provider's position that the claim was inappropriately denied or reduced.

The request should be submitted via electronic mail to: MH-FFSclaimsdisputes@dhs.state.nj.us.
Appendix A—PACT/ICMS In-Reach Guidelines

PACT and ICMS Provided to Consumers in In-Patient Settings (“In Reach Services”)

I. PURPOSE: To set forth the conditions for PACT and ICMS Providers that have transitioned to Fee-for-Service (FFS) to receive payment for services provided to or on behalf of consumers in an in-patient setting or correctional facility (aka “in-reach” services).

II. GENERAL PRINCIPLES:

a. PACT and ICMS providers are expected to provide services to or on behalf of consumers during periods of in-patient care or incarceration to ensure continuity of services and a successful return to the community for consumers who received PACT or ICMS immediately prior to admission to the inpatient setting or correctional facility and consumers who are being referred to PACT or ICMS by the inpatient unit or correctional facility, upon release. See e.g., N.J.A.C. 10:37J-2.5 (PACT providers shall maintain clinical treatment relationship with consumer in a hospital or incarcerated); N.J.A.C. 10:73-2.6(a)5 (ICMS providers must seek and accept referrals, within available capacity, from inpatient units and correctional facilities); N.J.A.C. 10:73-2.7(a)19 (requiring ICMS case manager to develop discharge plans with in-patient treatment team members for consumers wishing to access community mental health services post-discharge). Services provided to or on behalf of consumers in in-patient settings or correctional facilities by PACT or ICMS providers are known as “in-reach” services.

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

c. Reimbursement for ICMS in-reach services: Medicaid billing for ICMS provided to a consumer who is an inpatient in a State or County psychiatric hospital or a psychiatric unit of a general acute care hospital is not permitted pursuant to N.J.A.C. 10:73-2.7(b). In addition, Medicaid cannot be billed for services provided to individuals confined to a correctional facility. Consequently, those services will be reimbursed with State funds.
according to the guidelines set forth at IV, below, regardless of whether or not the consumer is Medicaid-eligible.

d. Reimbursement under Sections III and IV of these guidelines is expressly dependent upon the availability to the Department of funds appropriated by the State Legislature from State and/or Federal revenue or such other funding sources as may be applicable.

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

a. This section applies when Medicaid cannot be billed for PACT services during a month because the criteria set forth in Section II.b.2, above, are not met.

b. The unit of service for PACT is one month and reimbursement for in-reach services will be at the full monthly State rate provided that the following criteria are met:

   i. PACT staff has had a minimum of two hours of face-to-face contact with, or on behalf of, the consumer during that month except that:
      1. The two-hour minimum requirement set forth above does not apply during the month PACT services are initiated. Thus, if a PACT provider initiates services while the consumer is in an in-patient setting or correctional facility, the PACT provider will receive full reimbursement for that month regardless of whether the two-hour minimum is met.
      2. No reimbursement is permitted during the month that PACT services are terminated. Consequently, if the PACT provider is terminating services while the consumer is in an in-patient setting or correctional facility, then no payment will be made for in-reach services provided during the month that services are terminated.

   ii. The consumer has been in the inpatient setting or incarcerated for less than six continuous months.
      1. See section c, below, for guidelines when a consumer has been an inpatient setting for six or more continuous months.
      2. Consumers who have been incarcerated for six continuous months should be discharged from PACT services. If the PACT provider chooses to continue services beyond six months, there will be no State-funded reimbursement for those services.

c. The following guidelines apply to consumers who have been in the inpatient setting for six continuous months or more:

   i. If the consumer had been in the inpatient setting for six continuous months and the in-patient treatment team has not projected a discharge date, PACT may terminate services pursuant to N.J.A.C. 10:37J-2.7(c). If the PACT provider chooses to continue services under those circumstances, there will be no State-funded reimbursement for the PACT services provided.
d. The following guidelines apply when a consumer is in the inpatient setting or incarcerated for part of a month:

For purposes of determining whether the two-hour minimum of face-to-face contact as set forth at III.b.i has been met, the cumulative amount of face-to-face time for the month will count toward the minimum requirement regardless of whether the contact occurred when the consumer was an inpatient or in the community. For example, if one hour of face-to-face contact occurs when the consumer is an inpatient and one hour of face-to-face contact occurs when the consumer is in the community, then the two-hour minimum has been met and state dollars will be used to reimburse for the service. As set forth in Section II.b.2, above, if a Medicaid eligible beneficiary is in an IMD or correctional facility for only a portion of the calendar month, and the minimum monthly service requirement is met during the remainder of the month, the provider shall bill Medicaid for PACT service for that month.

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

a. The ICMS provider will be reimbursed for in-reach services at the full State rate for each 15 minutes of service that involves either direct face-to-face contact with the consumer or face-to-face contact on behalf of the consumer, for all necessary treatment team meetings and/or discharge planning subject to the limits set forth in Section IV.b, below.

b. Limit on state-funded reimbursement for ICMS in-reach services:
   i. Monthly limit: Two (2) hours (equivalent to eight (8) units) of in-reach services per month. ICMS providers will not be reimbursed for in-reach services that exceed the monthly limit.
   ii. Limit per hospitalization or incarceration episode: Eight (8) hours (equivalent to thirty-two (32) units) per hospital or incarceration episode. ICMS providers will not be reimbursed for in-reach services delivered after the episode limit is reached.
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 prohibited from billing Medicaid for supervised housing services for a consumer who has not been physically present 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. 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. 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. 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. Guidelines for overnight absences are set forth in Section V, below.

i. For example, the overnight absence guidelines apply when a consumer is present in the supervised housing setting until 5pm on Monday and then leaves for an overnight visit with a family member and returns to the supervised housing setting at 1pm on Tuesday.

ii. In contrast, if a consumer is absent from the supervised housing setting for a continuous period of 24 hours beginning and ending at midnight, then reimbursement will be according the “bed hold” guidelines set forth in Section III.
f. Reimbursement under these guidelines is expressly dependent upon the availability to the Department of funds appropriated by the State Legislature from State and/or Federal revenue or such other funding sources as may be applicable.

III. Guidelines for reimbursement for initial 30-days of a bed hold required as set forth under II(a), above.

   a. All supervised housing programs except Level B apartment services
      i. Reimbursement will be at the full per-diem State rate for the applicable level of service.
      ii. There will not be any reimbursement for room and board during the bed hold period.

   b. Level B apartment services
      i. Reimbursement during the 30-day bed hold period will be at a per diem rate established by DMHAS. That per diem rate is determined by first estimating the statewide average of the number of 15 minute units of service provided per day to consumers in the level B apartments. That statewide average number of 15 minutes units of service per day is then multiplied by the rate per 15 minute of level B apartment services to calculate the per diem rate for the 30 day bed-hold.
      ii. There will not be any reimbursement for room and board during the bed hold period.

IV. Guidelines for reimbursement for bed holds beyond 30 days

   a. A request for reimbursement will be considered by the Division for bed holds beyond the initial required 30 day bed hold period when it is demonstrated that all of the following criteria are met:
      i. The consumer’s continued absence is due to ongoing receipt of inpatient psychiatric services;
      ii. The treatment team can project a discharge date in the reasonably foreseeable future;
      iii. Clinical information indicates imminent reoccupation of the bed; and
      iv. Loss of the placement would delay the consumer’s discharge back into the community.

   b. When the above criteria are met, the Division will approve reimbursement for the bed hold for up to an additional 30 days. The provider agency may request one additional extension of reimbursement for an additional 30 days if the criteria in IV(a) continue to exist.

   c. Reimbursement will not be available for bed holds longer than 90 days.
d. Procedures for requesting reimbursement for bed holds longer than 30 days

   i. The provider agency must request reimbursement for bed holds longer than 30 days by submitting a Bed Hold Reimbursement Extension Request Form. That form is included in Appendix C.

   ii. The Bed Hold Reimbursement Extension Request Form must be submitted according to the directions included on the form.

   iii. The Bed Hold Extension Reimbursement Extension Form must be submitted within the following time frames:

       1. Initial 30-day extension request must be submitted at least 10 days before the end of the required 30-day bed hold period.

       2. The second 30-day extension request must be submitted at least 10 days before the end of the first 30-day extension period.

V. Room and Board payments for overnight absences

   a. The provider agency may submit a claim for room and board payment for an overnight absence through the NJMHAPP subject to the limitations set forth in section b, below.

   b. Limitations on room and board payments for overnight absences

      i. Rationale: The Division of Mental Health and Addiction Services recognizes that consumers receiving supervised housing services occasionally may spend the night elsewhere, for example with a family member. Nonetheless, the general expectation is that consumers receiving supervised housing services will sleep at the supervised home or apartment. As such, reimbursement for room and board of overnight stays outside of the supervised housing setting are subject to the following limitation.

      ii. Limitation: Room and board payments for overnight absences are limited to three overnight absences per consumer per month.

*To review the 30-Day Residential Bed Hold Extension Request, please see Appendix C.*
Appendix C – 30 Day Residential Bed Hold Extension Request Form

30 DAY RESIDENTIAL BED HOLD EXTENSION REQUEST

For all bed hold requests beyond the standard 30 day residential bed hold period (see N.J.A.C 10:37A-11.4(c) below), this form should be completed and sent to the DMHAS –FFS Transition Team (see e-mail below) for review by the 20th day of the previous month for which the extension is being requested. When the request is being made for an individual served at one of the NJ State Hospitals, a copy of the document must be sent to the State Hospital Placement Entity and the Regional Olmstead Coordinator.

COUNTY: _____
AGENCY: _____
NAME: _____
DATE OF BIRTH: _____

NAME OF STATE/COUNTY HOSPITAL, STCF UNIT OR GENERAL ACUTE CARE HOSPITAL PSYCHIATRIC UNIT WHERE THE CONSUMER IS HOSPITALIZED: _____

DATE OF COMMUNITY PSYCHIATRIC HOSPITALIZATION: _____

DATE OF TRANSFER TO STATE/COUNTY PSYCHIATRIC HOSPITAL (IF APPLICABLE): Click here to enter a date.

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

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

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

Email completed form to: ffs.transition@dhs.state.nj.us including “BH Extension Request” in subject line.

AGENCY REPRESENTATIVE SIGNATURE: ________________________________
*N.J.A.C. 10:37A-11.4(c) The PA shall maintain the consumer’s residential placement during brief hospitalizations and temporary absences for at least 30 days from the date of such consumer’s admission to a hospital, or from the date of such consumer’s leaving the residence.
## Appendix D – Rate Table with TPL Coverage

### HOSPITAL-BASED SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Billing Unit</th>
<th>Maximum number of units per month</th>
<th>Revenue Code</th>
<th>Modifiers</th>
<th>DMHAS State Only Rate</th>
<th>Business Rules</th>
<th>TPL Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Therapy</td>
<td>30 minutes</td>
<td>10</td>
<td>914</td>
<td>HW-Adult</td>
<td>$61.39</td>
<td>2 units per day</td>
<td>X</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>60 minutes</td>
<td>12</td>
<td>915</td>
<td>HW-Adult</td>
<td>$24.75</td>
<td>3 units per week, 1 unit per day</td>
<td>X</td>
</tr>
<tr>
<td>Medication Monitoring</td>
<td>15 minutes</td>
<td>4</td>
<td>919</td>
<td>HW-Adult</td>
<td>$37.80</td>
<td>2 units per day</td>
<td>X</td>
</tr>
<tr>
<td>Psychiatric Diagnostic Evaluation</td>
<td>one evaluation</td>
<td>1</td>
<td>90791</td>
<td>HW-Adult</td>
<td>$142.15</td>
<td>1 eval per day per provider, cannot bill 90792 on the same day</td>
<td>X</td>
</tr>
<tr>
<td>Psychiatric Diagnostic Evaluation with Medical Services</td>
<td>one evaluation</td>
<td>1</td>
<td>90792</td>
<td>HW-Adult</td>
<td>$292.50</td>
<td>1 eval per day per provider, cannot bill 90791 in the same day</td>
<td>X</td>
</tr>
</tbody>
</table>

### NON-HOSPITAL BASED SERVICES

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>Billing unit</th>
<th>Service Limitations min/max</th>
<th>Proc Code</th>
<th>*Modifiers</th>
<th>DMHAS STATE ONLY RATE Start 1/1/2017</th>
<th>Business Rules</th>
<th>TPL Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Diagnostic Evaluation</td>
<td>one evaluation</td>
<td>1</td>
<td>90791</td>
<td>HW-Adult</td>
<td>$142.15</td>
<td>1 eval per day per provider, cannot bill 90792 in the same day</td>
<td>X</td>
</tr>
<tr>
<td>Psychiatric Diagnostic Evaluation with Medical Services</td>
<td>one evaluation</td>
<td>1</td>
<td>90792</td>
<td>HW-Adult</td>
<td>$292.50</td>
<td>1 eval per day per provider, cannot bill 90791 in the same day</td>
<td>X</td>
</tr>
<tr>
<td>Individual Therapy</td>
<td>20 - 30 minutes</td>
<td>9</td>
<td>90832</td>
<td>HW-Adult</td>
<td>$81.30</td>
<td>1 unit per day</td>
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<tr>
<td>Individual Therapy</td>
<td>45 - 50 minutes</td>
<td>9</td>
<td>90834</td>
<td>HW-Adult</td>
<td>$81.23</td>
<td>1 unit per day</td>
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<tr>
<td>Special family therapy with patient present</td>
<td>45 - 50 minutes</td>
<td>4</td>
<td>90847</td>
<td>HW-Adult</td>
<td>$102.55</td>
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</tr>
<tr>
<td>Group Therapy</td>
<td>90 minutes</td>
<td>9</td>
<td>90853</td>
<td>HW-Adult</td>
<td>$24.75</td>
<td>1 unit per day</td>
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<tr>
<td>Family Conference</td>
<td>25 minutes</td>
<td>4</td>
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<td>HW-Adult</td>
<td>$20.62</td>
<td>1 unit per day</td>
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<tr>
<td>Medication Monitoring</td>
<td>15 minutes</td>
<td>10</td>
<td>99213</td>
<td>HW-Adult</td>
<td>$40.88</td>
<td>2 units per day</td>
<td>X</td>
</tr>
</tbody>
</table>

### PACT

| Progressive Assertive Community Treatment (PACT) | Monthly rate | 1 | H0040 | HW | $1,487.81 | Must provide ≥ 2 hours of service per month. No billing for consumers in IMD or correctional facility. No PC or PH unless approved. No ICMS, supervised housing or CSS during month billing for PACT. | X |
| PACT In-Reach | Monthly rate | 1 | H0040 | QJ | $1,487.81 | Must provide ≥ 2 hours of service per month. See PACT/ICMS In-Reach Guidelines for additional information. | X |

### Partial Care

| Partial Care (PC) | 1 hour | 125 | Z0170 | HW | $16.13 | Minimum of 2 and max of 5 units per day. Maximum of 25 units per week. No PACT unless approved. | X |
| Partial Care Transportation | one-way | 50 | Z0330 | HW | $6.30 | Must have a PC billing on the same date of service. Maximum of 2 units per day | X |
**ICMS**

<table>
<thead>
<tr>
<th>ICMS</th>
<th>15 minutes</th>
<th>24</th>
<th>Z5006</th>
<th>HW</th>
<th>$34.3f</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICMS In-Reach</td>
<td>15 minutes</td>
<td>8</td>
<td>Z5006</td>
<td>QJ</td>
<td>$34.3f</td>
</tr>
</tbody>
</table>

No billing for consumers during psychiatric hospitalization or in correctional facility. Unit is 15 consecutive minutes.

Maximum of 6 units (2 hours) of in-reach per month with a total episode maximum of 32 units (8 hours). See PACT/ICMS In Reach Guidelines for additional information.

---

**Supervised Residential Services**

<table>
<thead>
<tr>
<th>Supervised Residential Group Homes Level A+</th>
<th>per diem</th>
<th># of days in the month</th>
<th>Z7333</th>
<th>HW</th>
<th>$241.97</th>
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<tbody>
<tr>
<td>Supervised Residential Group Homes Level A+ 30 DAY BED HOLD</td>
<td>per diem</td>
<td>maximum of 30 consecutive days</td>
<td>Z7333</td>
<td>QJ</td>
<td>$241.97</td>
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<td>Supervised Residential Group Homes Level A 30 DAY BED HOLD EXTENSION</td>
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<td># of days in the month</td>
<td>Z7334</td>
<td>HW</td>
<td>$193.27</td>
</tr>
<tr>
<td>Supervised Residential Group Homes Level A 30 DAY BED HOLD</td>
<td>per diem</td>
<td>maximum of 30 consecutive days</td>
<td>Z7334</td>
<td>QJ</td>
<td>$193.27</td>
</tr>
<tr>
<td>Supervised Residential Group Homes Level A 30 DAY BED HOLD EXTENSION</td>
<td>per diem</td>
<td>maximum of 2 30 day extensions</td>
<td>Z7334</td>
<td>U8</td>
<td>$193.27</td>
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<tr>
<td>Supervised Residential Apartments Level A</td>
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<td># of days in the month</td>
<td>Z7334</td>
<td>52 HW</td>
<td>$193.27</td>
</tr>
<tr>
<td>Supervised Residential Apartments Level A 30 DAY BED HOLD</td>
<td>per diem</td>
<td>maximum of 30 consecutive days</td>
<td>Z7334</td>
<td>52 QJ</td>
<td>$193.27</td>
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<tr>
<td>Supervised Residential Apartments Level A 30 DAY BED HOLD EXTENSION</td>
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<td>maximum of 2 30 day extensions</td>
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<td>52 U8</td>
<td>$193.27</td>
</tr>
<tr>
<td>Supervised Residential Group Homes Level B</td>
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<td># of days in the month</td>
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<td>HW</td>
<td>$150.50</td>
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<tr>
<td>Supervised Residential Group Homes Level B 30 DAY BED HOLD</td>
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<td>maximum of 30 consecutive days</td>
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<td>QJ</td>
<td>$150.50</td>
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<tr>
<td>Supervised Residential Group Homes Level B 30 DAY BED HOLD EXTENSION</td>
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<td>maximum of 2 30 day extensions</td>
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<td>U8</td>
<td>$150.50</td>
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<tr>
<td>Supervised Residential Apartments Level B</td>
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<td>120</td>
<td>Z7335</td>
<td>52 HW</td>
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<td>Supervised Residential Apartments Level B 30 DAY BED HOLD</td>
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<td>maximum of 30 consecutive days</td>
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<td>52 QJ</td>
<td>$22.36</td>
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<td>Supervised Residential Apartments Level B 30 DAY BED HOLD EXTENSION</td>
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<td>52 HW</td>
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<tr>
<td>Family Care Level D</td>
<td>per diem</td>
<td># of days in the month</td>
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<td>HW</td>
<td>$15.80</td>
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<td>Family Care Level D 30 DAY BED HOLD</td>
<td>per diem</td>
<td>maximum of 30 consecutive days</td>
<td>Z7337</td>
<td>QJ</td>
<td>$15.80</td>
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<td>Family Care Level D 30 DAY BED HOLD EXTENSION</td>
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<td>maximum of 2 30 day extensions</td>
<td>Z7337</td>
<td>U8</td>
<td>$15.80</td>
</tr>
</tbody>
</table>

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NJ Division of Mental Health and Addiction Services

See Bed Hold Guidelines. During Phase I billing not available through NJMHAPP; follow procedures in Appendix E of the MHFFS Program Provider Manual.

See Bed Hold Guidelines. During Phase I billing not available through NJMHAPP; follow procedures in Appendix E of the MHFFS Program Provider Manual.

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### Supported Employment and Education

<table>
<thead>
<tr>
<th>Service</th>
<th>Duration</th>
<th>Frequency</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supported Employment</td>
<td>15 minutes</td>
<td>80 H2024</td>
<td>$19.19</td>
</tr>
<tr>
<td>Supported Education</td>
<td>15 minutes</td>
<td>80 H2024</td>
<td>$19.19</td>
</tr>
</tbody>
</table>

*As set forth in Assistant Commissioner Mielke’s January 31, 2017, communication to providers, the implementation date of the increased medication monitoring rates is under discussion and this table will be revised once those rates are implemented.*
Appendix E—Procedures for Processing MH FFS Payments Outside of NJMHAPP

Procedures for Processing MH FFS Payments Outside of NJMHAPP

There will be instances/circumstances when payments for certain mental health services cannot be processed through the Phase one version of NJMHAPP beginning January 1, 2017. Those instances/circumstances include but are not limited to:

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

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

- A secure web based application, the Mental Health Fee For Service – Fiscal Claim Adjustment and Payment System (MHFFS-FCAPS), has been developed to assist with the processing of claims that cannot be submitted through NJMHAPP at this time. Providers will use this system to enter information to allow evaluation and processing of non-NJMHAPP-payment requests. Instructions on use of the MHFFS-FCAPS have been distributed to FFS providers. The website location name for MHFFS-FCAPS is: https://mhffs-fcaps.dhs.state.nj.us

- In order to login to MHFFS-FCAPS, providers need to use the same login name and password used for NJMHAPP.

- An initial set of reason codes for requesting non-NJMHAPP payment including the above examples has been included as drop down values in the application. There is also a text field for reasons other than those provided for through the codes.

- In addition to utilizing the MHFFS-FCAPS, providers will be required to submit a completed State of New Jersey Payment Voucher approved by management to:

  Department of Human Services
  Division of Mental Health & Addiction Services
  Office of Fiscal and Management Operations - MH FFS Payment Unit
  Attn: John Fogliano
  PO Box 700
  Trenton, NJ 08625-0700
- State Payment Vouchers have been distributed to providers by the state office.

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

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

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

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

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

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

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

Providers seeking a review of a denial or reduction must submit a request for review within 60 days of the date of the email notice of denial or reduction and follow the requirements for such requests as set forth in the Mental Health Fee for Service Program Provider Manual, Section 8, Claim Dispute Review.
## Appendix F - Fee-for-Service Billing Schedule

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