

## Department of Health

### Division of Mental Health and Addiction Services

#### Q & A: Frequently Asked Questions Regarding the DMHAS Mental Health Fee-For-Service (FFS) Program

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## General Mental Health FFS Questions

### 1. Q: What is the Mental Health FFS Program?

*A: The Mental Health FFS Program is the Division of Mental Health and Addiction Services' State-funded program that contracts with provider agencies to deliver community-based mental health services on a fee-for-service basis. It is the payer of last resort and, as such, payment through the program is prohibited if there is another available source of payment for the service; for example - Medicaid, Medicare, Charity Care or private insurance. For additional information, please see page 10 "Questions Regarding Third Party Liability, Charity Care & Medicare."*

### 2. Q: Which mental health agencies are eligible to participate in the DMHAS Mental Health FFS Program?

*A: At this time, participation in the MH FFS Program is limited to provider agencies under contract with DMHAS to provide Outpatient, Partial Care, Partial Hospital, Acute Partial Hospital, Integrated Case Management (ICMS), Programs of Assertive Community Treatment (PACT), Residential, Supported Employment (SE), and Supported Education (SEd). In addition, all providers participating in the Mental Health FFS Program must be an approved NJ Family Care provider.*

### 3. Q: Does my agency need to be enrolled as a NJ Family Care Provider to participate in FFS?

*A: Yes. As noted above, all providers transitioning to the MH FFS Program are required to be an approved NJ Family Care (Medicaid) provider and have an assigned NJ Family Care provider number. In addition, 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. For mental health agencies that do not provide Medicaid covered services, DMHAS will work with Medicaid and the provider to get a number assigned in order to receive payment.*

### 4. Q: How do we go about becoming an approved NJ Family Care provider?

*A: A NJ Family Care enrollment application can be obtained by contacting Molina, the fiscal agent for the Division of Medical Assistance and Health Services, which is the single state Medicaid agency in New Jersey. The application may be requested on Molina's website at <https://www.njmmis.com/onlineEnrollment.aspx> or by telephone at 1-800-776-6334.*

### 5. Q: Which mental health programs are eligible to transition to FFS?

*A: All DMHAS contracted mental health agencies that provide the following programs were transitioned from cost-related contracts to fee-for-service contracts as of July 1, 2017: Outpatient, Partial Care, Partial Hospital, Acute Partial Hospital, Integrated Case Management (ICMS), Programs of Assertive Community Treatment (PACT), Residential, Supported Employment (SE) & Supported Education (SEd). CSS programs are expected to transition July 1, 2019.*

**6. Q: Which mental health programs will remain in cost reimbursement contracts?**

*A: At this time, the following services are not scheduled to move to Fee-For-Service (FFS) and will remain in cost reimbursement contracts: Training and Technical Assistance Services; Specialized Services; Intensive Outpatient Support Services (IOTSS); Involuntary Outpatient Commitment (IOC); Early Intervention Support Services (EISS); Psychiatric Emergency Screening Services/Affiliated Emergency Services; Systems Advocacy/Legal Services; PATH (Homeless Outreach); Intensive Family Support Services (IFSS); Self Help Recovery Centers; Justice Involved Services; Peer Respite Housing; Technical Assistance Services; Cultural Competency Contracts; Information Technology Services; Warm lines and Hotlines; and other specialized services. With respect to CSS, please see question number 5 above.*

**7. Q: Can a mental health provider that is not contracted with DMHAS participate in FFS?**

*A: No. Only DMHAS contracted providers are eligible to participate in FFS.*

**8. Q: Will training be made available to assist mental health providers in the transition to the Mental Health FFS Program?**

*A: Yes. Training is available for all mental health providers transitioning to FFS. DMHAS held FFS information sessions and User Acceptance Training sessions for the New Jersey Mental Health Application for Payment Processing (NJMHAPP), the secure web-based application that provider agencies use to submit information required to process payment for services funded by the Mental Health FFS Program. DMHAS anticipates “booster” trainings in the future and will provide scheduling information as it becomes available. DMHAS also holds scheduled weekly FFS webinars for direct provider support and feedback. The schedule of these feedback sessions is distributed to all Mental Health Fee-For-Service contracted providers.*

**9. Q: Where can I access DMHAS MH FFS Program Provider Manual and a New Jersey Mental Health Application for Payment Processing (NJMHAPP) User Guide?**

*A: The Mental Health FFS Program Provider Manual and NJMHAPP User Guide are both available through a link on the NJMHAPP login page [NJMHAPP login page](#). The Provider Manual includes information on the MH FFS Program, including: provider eligibility; services covered under the MH FFS Program; the MH FFS Program as the payer of last resort; rates for services under the MH FFS Program; monthly billing limits; billing procedures; documentation requirements; and the use of monthly limits. The NJMHAPP User Guide provides an overview of NJMHAPP and instructions on its use.*

**10. Q: Is there a limit on reimbursement through the MH FFS Program?**

*A: Yes, the monthly limit is calculated and set forth in the provider agency’s FFS contract with the DMHAS. More information about the monthly limit, including modification of the limit, is available in the provider’s contract and in the MH FFS Program Provider Manual, Section 4E. As a State-funded program, the amount of available funds for the MH FFS Program is fixed by the annual Appropriations Act. The monthly limits will help to assure that funding through the MH FFS Program is available throughout the year. Accordingly, the monthly limit is subject to revision consistent with the MH FFS Addendum to the Standard Language Document.*

## DMHAS Contract Specific Mental Health FFS Questions

**1. Q: Will providers still have a contract with DMHAS when we transition to the Mental Health FFS Program?**

*A: Yes. DMHAS will maintain FFS contracts with all providers participating in the Mental Health FFS Program.*

**2. Q: How will the transition to FFS change the reporting requirements for my current DMHAS contract?**

*A: Providers transitioning all DMHAS contracted programs to FFS will no longer need to submit contract budgets and reports of expenditure (ROE's). Providers that have DMHAS contracted programs in FFS and in cost related contracts will need to reflect the FFS program on the budget/ROE documents if the programs share any direct or indirect costs with the cost-related programs. Sufficient detail will be required on the budget/ROE to assure the appropriateness of indirect and shared cost allocations.*

**3. Q: Does my agency still need to complete Annex As, QCMRs & USTFs for programs that move to FFS?**

*A: Yes. All provider agencies with programs moving to FFS still need to complete and submit to DMHAS Annex As (in the new, revised format), QCMRs and USTFs for all eligible FFS programs. However, providers that transitioned all DMHAS contracted programs to FFS no longer need to submit contract budgets and reports of expenditure (ROE's).*

**4. Q: Does my agency still need to complete Annex A program-specific commitments and summary pages for programs that move to FFS?**

*A: No. Provider agencies with programs moving to FFS will no longer need to submit the old Annex A forms that include the total clients served and units of service. There are new, revised Annex A's for all DMHAS FFS contracted programs which are in a narrative format. Provider agencies are required to submit the revised, narrative FFS Annex A's. The FFS Annex A's are part of the provider agency's MH FFS contract.*

**5. Q: Does my agency need to prepare and submit a package to DMHAS for our Mental Health FFS contract?**

*A: Yes. All provider agencies with a MH FFS contract will need to prepare and submit to DMHAS a complete contract application package. Approximately three months before the date of contract renewal, DMHAS will send provider agencies a Contract Memorandum with instructions for preparing a Mental Health FFS contract. An award reflecting the provider agency's FFS Monthly Limits will be included with the Contract Memorandum. The memo will include a list of the required documents for FFS contracts and a timeframe summary with an overview of the contract renewal process, detailing the various actions that should occur.*

**6. Q: Can agencies still submit requests for Wrap around support (Wrap) funds?**

*A: Yes, the new process for FFS Wrap requests is detailed in Appendix I of the Provider Program Manual. FFS programs can apply for Wrap funding for consumer-specific requests in the following categories (more*

*specifically defined in Appendix I): Furniture; Utilities; Security deposit; Staffing; Medical services; Medications; Equipment; Security and monitoring; Environmental health and safety; and Other. Requests must satisfy all of the criteria in Appendix I and must be detailed in the FFS Excel Wrap Request Worksheet found on the NJMHAPP landing page and submitted via NJMHAPP ticket. If DMHAS approves the request, the provider will be notified via the original ticket and instructed to bill FCAPS for offline payment. Programs not yet in FFS contract will continue using the existing cost-based process for one times and accrual requests, submitting requests via Regional Community Services and/or Olmstead staff.*

## Questions Regarding the New Jersey Mental Health Application for Payment Processing (NJMHAPP)

### 1. Q: What is NJMHAPP?

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

### 2. Q: What if client information was entered incorrectly?

*A: A client data correction can be requested via NJMHAPP ticket. A 'Correction of Client Data' form containing the correct information must be attached in order for FFS staff to make the correction. Please see section 6.17, "Ticket Management" in the NJMHAPP IT User Manual for more information.*

### 3. Q: I understand we can enter the billing data daily, but how often do we get paid? Can we bill weekly or do we have to bill monthly on the 15<sup>th</sup> of each month?

*A: Agencies may bill in NJMHAPP as frequently as they like. However, agencies will be paid every two weeks based on the encounter/billing data entered into NJMHAPP by the end date of the billing cycle. Please see Appendix F of the Mental Health FFS Program Provider Manual for the complete billing schedule.*

### 4. Q: I understand our agency must enter claims into NJMHAPP for the previous month's service by the 15<sup>th</sup> of the following month in order to receive payment. What is the DMHAS policy if we fail to meet the billing deadline?

*A: Providers seeking payment through the Mental Health FFS Program must enter encounter data for a service by the 15<sup>th</sup> of the month after the service was provided. In order to meet the billing deadline, DMHAS suggests that providers enter encounter data on a daily or weekly basis. DMHAS recognizes certain extenuating circumstances that prevent the provider from submitting claims by the 15<sup>th</sup> of the following month. In the event of those circumstances, the agency can enter late claims (up to thirty (30) days after the billing deadline) into the Electronic Claims Adjustment Payment (ECAS) module now available in NJMHAPP Version 4.0. Please see "Questions Regarding Fiscal Procedures" in the section below for additional information on ECAS.*

### 5. Q: What if I make a mistake when billing?

*A: NJMHAPP includes Encounter Void functionality so that providers can correct billing errors. The NJMHAPP Encounter/Billing tab features an "Encounter Void" button that opens a calendar pop-up window. The provider agency can reverse charges by entering a negative number in each of the calendar days in which billing was mistakenly entered. For example, if five (5) units of Partial Care were entered but the consumer did not attend that day, the provider agency should enter -5 on that*

same calendar day to remove the erroneous charge. Please see section 6.10.10, “Encounter/Billing Void Calendar Screen functionality” in the NJMHAPP Provider User guide for more information.

**6. Q: How far back can I void erroneous encounters?**

*A: The void functionality now allows NJMHAPP users to void encounters for service dates going back for a period of up to twelve (12) months; counting the current month plus the previous eleven (11) months. For example, in the month of June 2018, encounters can be voided back to July 1, 2017.*

**7. Q: Once our agency enters the encounter data into NJMHAPP, do we have to upload an Electronic Data Interchange (EDI) file like we must enter for Medicaid billing?**

*A: No, once a provider enters the encounter data into NJMHAPP, the information will be automatically processed for payment. NJMHAPP does not have the capacity to accept EDI format at this time.*

**8. Q: Our agency operates a lot of level A+ residential sites and a PACT program where consumers can often stay for multiple years. How far in advance can my agency encumber funds in NJMHAPP for eligible consumers?**

*A: There is no time limit for encumbering funds in NJMHAPP, but the provider agency must monitor and manage its budget limits accordingly on a month to month basis. Please note, a provider agency cannot encounter (bill) for services to be provided in the future, only for services the agency has provided.*

**9. Q: Our agency has many consumers who have received services for years at a time, why do we have to enter an end date in NJMHAPP to receive reimbursement?**

*A: An end date must be captured so the NJMHAPP system can encumber funds for each month. Providers can change the end date at any time by reducing or extending it. The process offers more flexibility to providers to encumber funds based on need.*

**10. Q: Can a Provider bill NJMHAPP for consumers already receiving a sliding scale rate from our agency?**

*A: If the consumer meets all participation criteria for state reimbursement, the provider should bill through NJMHAPP and report revenue received in accordance with instructions from DMHAS per the MH FFS Revenue letter and template dated June 5, 2017. Please see Section 4, paragraph L: “MH FFS PROGRAM: FISCAL REQUIREMENTS AND GUIDANCE: Copays” of the Mental Health FFS Program Manual for additional information.*

**11. Q: Can a consumer be served at two different agencies and still receive state reimbursement through NJMHAPP?**

*A: Yes, as long as the consumer is not receiving the same service from both agencies and all rules regarding service conflicts and limitations are observed. The Mental Health FFS Program Provider Manual includes a summary of the business rules, including services that cannot be provided during the same time period, in Appendix D.*

**12. Q: Can we register and admit consumers for state reimbursement through NJMHAPP if they do not have a Social Security number?**

*A: Yes, the NJMHAPP system allows provider agencies to enter all nines (999-99-9999) in order to proceed in the application and admit the consumer for service if no Social Security is available.*

**13. Q: What if I attempt to register a new consumer in NJMHAPP and get a message that states that the Social Security number is already in use?**

*A: Open a ticket in NJMHAPP to inform the FFS team that this is occurring and with whom. The most common reason for this message is that the consumer was registered previously by another agency and was not formally discharged. If this is the case, NJMHAPP staff can contact the other agency and facilitate the discharge. However, if the consumer will be remaining with the other provider/program and the service that you are attempting to add does not violate existing business rules, you should add your program/service into the existing record. Please see section 6.4.1, "Consumer Search Screen Functionality" of the NJMHAPP IT User Manual for directions on how to locate an existing record and add additional services.*

**14. Q: What if our agency admits a consumer into NJMHAPP who does not have a Social Security number and we later obtain the consumer's actual Social Security number?**

*A: If the agency later obtains the consumer's actual Social Security number, the agency must submit a work "ticket" ("Client Data Correction") in the NJMHAPP system to change the Social Security number for that consumer. DMHAS staff will process the ticket accordingly.*

**15. Q: What if eligibility was entered incorrectly after a consumer was admitted into NJMHAPP?**

*A: With the release of NJMHAPP 3.5, providers have the ability to change the Program Eligibility answers even after the consumer has been admitted. Please see to section 6.7, "Program Eligibility Selection" of the Provider User Guide for additional information.*

**16. Q: What is the difference between Pre-Admission and In-Reach services?**

*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 community-based services. Pre-admission services are provided by specific community-based programs to consumers **newly-referred** from a state psychiatric hospital (ICMS/PACT/Residential/CSS/SE-SEd); or those referred from a County Hospital (ICMS only). Please see Appendix G, "Fee-For-Service Pre-Admission Service Guidelines," in the Mental Health FFS Program Provider Manual for additional information.*

*In-reach services are provided to facilitate continuity of care and a successful **return** to the community upon the consumer's discharge from the in-patient setting or release from the correctional facility. In-reach services are provided to a consumer **already on an existing caseload** whereby the respective community-based program engages the consumer while hospitalized (ICMS/PACT/CSS/SE-SEd; or hospitalized or incarcerated (ICMS/PACT/CSS only) in order to maintain engagement and facilitate a*

successful return to the community. Please see Appendix A, "In-Reach Guidelines," in the Mental Health FFS Program Provider Manual for additional information.

**17. Q: Must every consumer be registered with NJMHAPP, even if they have Medicaid?**

*A: Yes, but only if the consumer is receiving non-Medicaid reimbursable services including but not limited to Pre-Admission, In-reach, Bed Hold, and/or Room and Board.*

**18. Q: If we have a consumer who applied for Medicaid and we don't know whether they are approved, should we enter/encumber, etc.?**

*A: Yes, proceed in NJMHAPP. If the consumer's Medicaid eligibility is confirmed thereafter, a fiscal adjustment will be made, and the state funds returned. The provider can then bill Medicaid.*

**19. Q: If we encumber units for a consumer who doesn't use them by the end of the month, will the units be carried over?**

*A: For CSS, units will carry over to the next month. For program elements other than CSS, units will **not** carry over.*

**20. Q: Can a client be deleted from NJMHAPP?**

*A: No. It is the policy of DMHAS not to delete any consumer records. However, the provider agency may close a consumer's record by going into the Program Eligibility module and by changing all answers to "No." The consumer will then be identified as "IE - Not Eligible for Services," which effectively closes the record.*

**21. Q: When should I discharge a consumer in NJMHAPP?**

*A: Consumers should be discharged when they no longer receive any services from the provider agency. If, however, a consumer continues receiving one service while discontinuing another, the consumer can be discharged from that respective service and remain active in the other. It is important to formally discharge a consumer from specific program(s) in NJMHAPP, rather than to simply stop billing. This is so that if the consumer seeks services elsewhere, another provider can successfully admit and bill for the consumer in NJMHAPP.*

**22. Q: Is transportation a MH FFS covered service?**

*A: Yes, but only for non-Medicaid eligible consumers enrolled in Partial Care services under very limited circumstances. A provider agency may only bill for up to 2 units of transportation if the consumer receives Partial Care services on the same date.*

**23. Q: If the Third-Party Liability (TPL) radio button was clicked 'Yes' in error, can this be edited?**

*A: Yes, with NJMHAPP 4.0 enhancements, it is now possible to edit the answer to the TPL question.*

**24. Q: How do I add services for a discharged client?**

*A: You can re-register the consumer by going to start intake and clicking on the "Select" action link. This will bring you to the Consumer Registration screen with the demographic and address information prepopulated with the information existing in the system. You can then edit the program eligibility information to add services as needed. Please refer to section 6.3.2, "Preadmission Search Screen Layout," in the IT User Manual, located on the NJMHAPP landing page for further clarification. Please note, the TPL radio button is editable in NJMHAPP version 4.0.*

## Questions Regarding Fiscal Procedures

### **1. Q: Why should I be concerned about over-encumbering?**

*A: Encumbered units have a direct and real-time effect (increase/decrease) on the Net Encumbered dollars available. Over-encumbering funds reduces units and unused monthly limits that would otherwise be available. Providers, therefore, should reconcile and reduce over-encumbered client services and should discharge any inactive clients so those encumbrances are not counted against the provider's available monthly limit. Refer to the Provider User Guide 4.0, section 6.9, for additional instruction.*

### **2. Q: What if my agency is about to reach or has reached its monthly limit in NJMHAPP?**

*A: Provider agencies may submit to DMHAS a request for an increase in their monthly limit if the Provider Agency's claims for the existing month exceed 90 % of its monthly limit. The request must include the justification for increasing the limit and must specify how long the increase is needed. Please see Appendix H of the Mental Health FFS Provider Program Manual for additional information.*

### **3. Q: I understand that in NJMHAPP Version 4.0 there is a new module called the Electronic Claims Adjustment System (ECAS). Does ECAS replace the old off-line payment system called FCAPS (Fiscal Claims Adjustment Payment System)?**

*A: The Electronic Claims Adjustment System (ECAS), now available in NJMHAPP Version 4.0, provides users with the ability to request late payment(s) (up to thirty (30) days after the billing deadline) and void claims for services provided beyond the billing deadline (15<sup>th</sup> of the following month). Provider agencies must identify in the ECAS drop down box the reason for the delay in the submission of a claim. The reasons for delay include, but are not limited to: timely requirements not met, procedure code not available in NJMHAPP, claim previously denied by NJMHAPP, adjusted by state for TPL or denied by TPL provider, provider system error prevented us of NJMHAPP, state system error prevented entry in NJMHAPP, delay in consumer registration due to transfer, etc. DMHAS retains the right to determine in its sole and reasonable discretion if a late claim should be paid under the extenuating circumstances. Please see the IT User Manual 4.0 (Provider User Guide Document Project Name: NJ Mental Health Application for Payment Processing Version 4.0.) for additional details regarding the Electronic Claims Adjustment System.*

### **4. Q: Do Providers still need to use the old off-line payment system called FCAPS?**

*A: Yes, but only for Wrap funding requests. Please see Appendix I, "Procedures for Processing Approved Wrap Funding Payments Outside of NJMHAPP" of the Mental Health FFS Provider Program Manual for additional details regarding Wrap funding requests and procedures. Wrap funding requests cannot be processed through NJMHAPP or ECAS.*

## Questions Regarding Third Party Liability, Charity Care & Medicare

### **1. Q: What is Third Party Liability (TPL)?**

*A: For purposes of the Mental Health FFS Program, third party liability exists when there is a source of funding other than DMHAS funds, Medicaid or Charity Care; for example, Medicare, Tricare, or other health insurance.*

### **2. Q: Which programs in the MH FFS are subject to the TPL restriction?**

*A: The TPL restriction applies to all Outpatient services and to clinical services in Partial Care (specifically, all E&M codes, Psychiatric Diagnostic Evaluation, and Psychiatric Diagnostic Evaluation with Medical Services). However, the TPL restriction does not apply to the Partial Care hourly service, PACT, ICMS, Residential, CSS, Supported Education, Supported Employment, Pre-admission or Wrap.*

### **3. Q: Can DMHAS funds supplement or wrap around insurance payments up to the State rate for the respective service needed?**

*A: No. Insurance payments are considered payment in full.*

### **4. Q: Can DMHAS funds supplement or wrap around Charity Care up to the State rate for Mental Health services eligible for reimbursement through charity care at FFS eligible hospital-based programs?**

*A: No. Charity Care payments may not be supplemented by DMHAS payments. Consumers must be evaluated for participation in Charity Care and if they are found to be eligible, the mental health services they receive at the hospital should be included in the hospital's charity care claims data.*

### **5. Q: Are all consumers who have Third Party Liability (TPL) coverage ineligible for state reimbursement through NJMHAPP?**

*A: If a TPL plan covers a state funded service, then state funds cannot be accessed for reimbursement. If the TPL plan does not cover a state funded service, then NJMHAPP can be used for reimbursement through state funds. Reimbursement for program elements/services not covered by the TPL restriction (PACT, ICMS, Residential, FFS CSS, SE/SEd, Pre-admission, Wrap) may be sought consistent with and through the MH FFS Program.*

### **6. Q: If a consumer has insurance coverage for Mental Health and the provider is not in network, can DMHAS funds be accessed in lieu of insurance coverage?**

*A: No. Consumers must receive services from a provider participating in their insurer's network. Out of network providers can/should refer the consumer accordingly.*

**7. Q: Can a Partial Care provider bill NJMHAPP for state reimbursement when a Medicaid-enrolled consumer reaches the Medicaid prior-authorized maximum billable units within a 6-month time frame?**

*A: No. Medicaid is payment in full. The provider should seek another prior-authorization for that consumer from the local Medical Assistance Customer Centers (MACC) offices. If the consumer does not meet medical necessity criteria for Medicaid covered services, then the provider may not seek payment from the Mental Health FFS Program in NJMHAPP.*

**8. Q: If a consumer has Medicare as their primary insurance and has no secondary insurance, can our agency bill NJMHAPP for the amount Medicare does not cover?**

*A: No, payment received from Medicare and other insurances are considered payment in full.*

**9. Q: If a consumer with Medicare coverage is seen by a non-credentialed therapist, can we bill NJMHAPP for the service?**

*A: No, if the provider agency has not met the Medicare credentialing requirements for that Medicare covered consumer, then it cannot seek state reimbursement. Consumers should be assigned to appropriate TPL paneled clinicians. If a clinician is not available at the provider, a referral to an in-network provider should be facilitated.*

**10. Q: What is the NJMHAPP billing policy for instances when a provider agency is receiving state reimbursement for a non-Medicaid enrolled consumer and that consumer later obtains Medicaid coverage without informing the provider?**

*A: The provider agency is required to check the consumer's Medicaid status through eMEVS before entering encounter data for a Medicaid covered service. NJMHAPP will not allow the provider to enter encounter data for a Medicaid-covered service unless the provider checks a box indicating that it checked EMEVS. In the event Medicaid eligibility is retroactive, the provider agency must bill Medicaid for the services and reimburse the state for the dollars received through MH FFS Program during the consumer's Medicaid eligibility.*

**11. Q: What is the NJMHAPP billing policy for instances when a Medicaid enrolled consumer receiving services at the provider agency loses Medicaid coverage?**

*A: The provider agency may seek reimbursement consistent with and through the MH FFS Program on the date of service **after** Medicaid is terminated.*

**12. Q: Will our agency be able to receive a "client level" report from MOLINA, Medicaid fiscal agent, so we know exactly how much was paid for an individual consumer?**

*A: No, Molina will not provide client level claims data at this time. However, client level data (for MH FFS Program services) can be generated through reports in NJMHAPP.*

**13. Q: Our current MOLINA generated Medicaid payment report can be 500 pages of codes and numbers for one week of billing, how will we know what is state reimbursement through NJMHAPP and what is Medicaid reimbursement?**

*A: There will be a separate control number for state paid claims. The control number will differentiate state payments from Medicaid payments. DMHAS Fiscal will provide the agency with the control number for reference.*

**14. Q: Can our agency bill for children's services in our Outpatient program?**

*A: Yes, but only if the child is not receiving services through the Children's System of Care in the Department of Children and Families and is not covered by TPL.*

## Questions Regarding Presumptive Eligibility (PE)

### **1. Q: What is Presumptive Eligibility?**

*A: Presumptive Eligibility (PE) is temporary health coverage for NJ residents who may be eligible for NJ Family Care (which include CHIP, Medicaid, and Medicaid expansion populations), but have not yet applied or their application is still being processed. An individual or family in need of medical services can be temporarily enrolled in Medicaid immediately if it appears they are eligible, and the PE application then can seamlessly result in full enrollment for NJ FamilyCare. Potential clients need to provide information such as their name, citizenship/immigration status, household size, monthly income, etc., and a PE determination can be made. During the PE period, services are covered through Fee-for-Service Medicaid; there is no managed care option available.*

### **2. Q: Who is qualified to submit a PE application and how long does it take?**

*A: Only a mental health agency that is a Medicaid provider and employs certified PE staff can apply for PE status. At least one certified PE staff member must be available to submit applications for individuals seeking services. Applications take approximately 15-20 minutes to complete and submit, depending upon the number of family members in the household. Medicaid will approve or deny the application within three (3) business days of the date of submission.*

### **3. Q: What does a provider have to do to become PE-certified?**

*A: The provider agency must be a Fee-for-Service Medicaid provider and send at least one (1) staff person to take the PE training and pass the certification test. Once the staff person is certified, the provider agency must have each site which will administer PE become certified as a PE site. If an agency has multiple sites, each site must have a trained, certified PE staff person available to take applications. Additionally, each site must have a PE Certified staff person designated as their PE Coordinator. The certified person and the PE Coordinator can be one and the same. PE Coordinators can “oversee” a maximum of two (2) sites and must be on-site to answer questions and act as the liaison to the State PE Unit if necessary. The PE Coordinator does not have to complete any additional training; the agency, however, must advise the State PE Unit who the PE Coordinator is for each of its sites. Providers must inform the State PE Unit if a Certified staff leaves the agency as their credentials must be revoked.*

### **4. Q: When and where is the next Presumptive Eligibility certification training going to take place?**

*A: The PE certification training is offered by DMHAS through the Civil Service Commission on a periodic basis. The DMHAS sends out communication regarding the date, time and location of each training session as it is scheduled.*

## Questions Regarding Bed Hold Reimbursements

**1. Q: What is the difference between an “Overnight Absence” and a “Bed Hold” in NJMHAPP?**

*A: 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. For example, an Overnight Absence is billed if a consumer stays overnight at their parent’s home. A “Bed Hold” occurs when a consumer is absent from the bed for a minimum of an entire day, which is defined as a 24-hour period starting and ending at midnight. Reimbursement will be available for a bed hold of up to 30 days. Please see Appendix B in the FFS Provider Manual for more detailed information.*

**2. Q: Can our agency bill NJMHAPP for residential “Bed Holds”?**

*A: Yes, Bed holds can be billed consistent with and through the MH FFS Program.*

**3. Q: How long does a consumer have to be absent from our facility in order to bill for a Bed Hold in NJMHAPP?**

*A: In order seek bed hold reimbursement consistent with and through the Mental Health FFS Program, the consumer must be absent from the facility for a minimum of an entire day, which is defined as a 24-hour period starting and ending at midnight. Please see Appendix B in the FFS Provider Manual for more detailed information.*

**4. Q: On the day of a consumer’s departure from our residential site, how do I bill for a bed hold in NJMHAPP?**

*A: The start of the bed hold reimbursement period would begin at 12:00 AM midnight on the morning after the day of departure from the residential site. For example, if a consumer leaves the residential site at 2:00 PM on a Monday, the bed hold reimbursement period would begin at 12:00 AM midnight on Tuesday and continue through each 24-hour period until the day of return to the residential site. Please see Appendix B in the FFS Provider Manual for more detailed information.*

**5. Q: Can our agency bill for room and board on the day of a consumer’s departure?**

*A: Yes, provider agencies can submit a claim consistent with and through the MH FFS Program for room and board on the day of departure. However, there will not be any reimbursement for room and board during the bed hold period. Please see Appendix B in the FFS Provider Manual for more detailed information.*

**6. Q: Can our agency bill for the residential level of service on the day of a consumer’s departure?**

*A: Yes. For non-Medicaid eligible consumers, provider agencies can submit a claim for the residential level of service on the day of departure. Please see Appendix B in the FFS Provider Manual for more detailed information. For Medicaid eligible consumers, provider agencies 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.*

**7. Q: On the day of a consumer's return to our residential site, how do I bill for a bed hold in NJMHAPP?**

*A: 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. Please see Appendix B in the FFS Provider Manual for more detailed information.*

**8. Q: Can our agency bill for room and board on the day of a consumer's return?**

*A: Yes, provider agencies can submit a claim consistent with and through the MH FFS Program for room and board on the return day. Please see Appendix B in the FFS Provider Manual for more detailed information.*

**9. Q: Can our agency bill for the residential level of service on the day of a consumer's return?**

*A: Yes. For non-Medicaid eligible consumers, provider agencies can submit a claim for the residential level of service on the return date. Please see Appendix B in the FFS Provider Manual for more detailed information. For Medicaid eligible consumers, provider agencies can 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.*

**10. Q: How long can we select the "Bed Hold" service for a consumer in NJMHAPP?**

*A: Provider agencies can only select the "Bed Hold" service within the duration of the original Residential Service for the consumer. For example, a consumer is admitted into a Residential Service (A+ Supervised Apartment) from 7/1/17 through 12/31/17 in NJMHAPP. The consumer is either admitted into the hospital or incarcerated and is therefore out of the bed from 8/2/17 through 8/31/17. The provider agency is able to select the 30-day A+ Supervised Apartment Bed Hold for the period of time the consumer was out of the bed (8/2/17 through 8/31/17) but is not able to select dates prior to the service start date (7/1/17) or dates after the service end date (12/31/17). Additionally, the bed hold service cannot exceed 30 days. Please see Appendix B in the FFS Provider Manual for more detailed information.*

**11. Q: What is a Bed Hold Extension?**

*A: If the bed hold is expected to continue beyond 30 days, a Bed Hold Extension Request must be submitted to [mh.ffsteam@doh.nj.gov](mailto:mh.ffsteam@doh.nj.gov) for review by the Office of Community Services/Olmstead and the FFS Unit. Bed Hold extensions are considered only for extended hospitalizations/rehab stays and require signatures by DMHAS in order for the provider to bill in NJMHAPP for the bed hold extension service. Please see Appendix B in the FFS Provider Manual for detailed instruction.*

## Questions Regarding Ticket Management

### 1. Q: What is a ticket?

*A: A system within the NJMHAPP application that provides agencies with the ability to log system and data related issues through the application by utilizing graduated Priorities and various Categories to assure proper routing (IT, Program, and/or Fiscal departments) and timely resolution (High, Medium, and/or Low) by the MH FFS unit.*

### 2. Q: How do I submit a ticket?

*A: Using NJMHAPP, navigate to the Ticket window and click on "Create new ticket". Please refer to the IT Manual section 6.17, "Ticket Management," for more detailed information.*

### 3. Q: Why can't I call to discuss my question vs. submitting a ticket?

*A: The MH FFS unit uses the ticket management system within NJMHAPP to track, monitor and assign tickets to staff within the unit. The ticket system is also used to determine which issues or topics are common so that clarification can be provided via webinar discussion, and/or targeted training if needed.*

### 4. Q: After submitting a ticket, when will I hear back from MH FFS?

*A: The MH FFS unit strives to reply to all tickets in a timely manner, usually within 24-48 business hours. However, fiscal tickets are held open until the adjustment is made.*

### 5. Q: I have a consumer who is Medicaid eligible; however, NJMHAPP is showing that they are not. When submitting a ticket, what is needed in order to correct this?

*A: When submitting a ticket please provide the consumer's first and last name, NJMHAPP ID, and attach a PDF of the eMevs report. Please provide any details that are relevant to the consumer's Medicaid status (i.e. state hospital discharge date or jail release date, immigration status, etc.). All pertinent information will be reviewed, and corrections will be made accordingly.*

### 6. Q: A consumer's information was entered into NJMHAPP incorrectly. How do I correct this?

*A: Using the ticket management system, create a ticket as per the instructions in the IT Manual, choosing "Client data correction" from the category drop down menu. Complete all necessary fields and open the data correction file and save it to your computer. Make the necessary corrections on the form, save it as a PDF, and attach it to the ticket.*

### 7. Q: How do I check on the status of a ticket?

*A: Using NJMHAPP, navigate to the Ticket window. The default ticket screen will show all "open" tickets by category. Please see the IT Manual, section 6.17 Ticket Management, for more detailed information including how to search for closed tickets.*