State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

NEWSLETTER

Volume 24 No. 10 **October 2015**

THIS NEWSLETTER ANNOUNCES REVISED BILLING PROCEDURES
PLEASE DISREGARD THE AUGUST 2014 AND FEBRUARY 2015 VERSIONS OF THIS NEWSLETTER

TO: All providers **– For Action**
Health Maintenance Organizations **– For Information Only**

SUBJECT: **Additional Information Regarding NJ FamilyCare (NJFC) Coverage and Reimbursement for Psychiatric Emergency Rehabilitation Services**

EFFECTIVE: Claims with service dates on or after May 6, 2014

PURPOSE: To provide NJ FamilyCare (NJFC) fee-for-service (FFS) providers of Psychiatric Emergency Rehabilitation Services follow-up information regarding NJFC coverage and reimbursement for these services. **This Newsletter is intended to announce changes and replace the billing procedures previously announced in Newsletter Volume 24, No. 10 (see Attachments A - C).**

INTRODUCTION: The New Jersey Division of Medical Assistance and Health Services received approval from the Centers for Medicare and Medicaid Services (CMS) to provide Psychiatric Emergency Rehabilitation Services (PERS) to Medicaid's NJFC FFS beneficiaries. These services are also included in the Alternative Benefit Plan (ABP) described in the NJFC Newsletter, Volume 24, No. 03, dated April 2014. This follow-up Newsletter is intended to clarify policies and procedures related to the provision of PERS.

BACKGROUND: PERS services are provided to a NJFC beneficiary (i.e. the "consumer") who is experiencing a behavioral health crisis. PERS services are designed to interrupt and/or ameliorate a crisis experience, including an assessment, immediate crisis resolution, de-escalation, and referral and linkage to appropriate services to avoid, where possible, more restrictive levels of treatment. The goals of PERS are symptom reduction, stabilization, and restoration to a previous level of functioning.

PERS is a face-to-face intervention that may occur in a variety of locations including, but not limited to the emergency department of a hospital, a clinic setting or other

community-type settings, such as the home, the workplace, at school or a location where the individual socializes.

PERS services include the following:

- An assessment of risk and mental status, as well as the need for further evaluation or other mental health services.
- Short-term PERS that includes crisis resolution and de-briefing with the consumer in crisis.
- Follow-up with the consumer, caretaker and/or family member(s); and
- Consultation with qualified healthcare professionals to assist with the specific crisis situation.

In response to a crisis, certified assessors perform any necessary assessments; crisis stabilization and de-escalation; develop alternative treatment plan(s); consult, train and provide technical assistance to other staff; consult with a psychiatrist; monitor consumers; and arrange for linkage, transfer, transport or admission as necessary for consumers at the conclusion of the PERS.

Each PERS program is supervised by a medical director who is a psychiatrist.

A licensed professional of the healing arts who is acting within the scope of his/her professional license and applicable state law must be available for consultation and to recommend treatment 24 hours a day, seven days a week to the PERS program.

Psychiatrists perform consumer assessments, evaluations and management as needed. They prescribe and monitor medication use; supervise and consult with PERS program staff. Services provided by psychiatrists and other licensed professionals shall be billed separate from those billed by assessors and specialists for the time spent in direct therapy by reporting direct therapy CPT procedure codes (i.e., all service billing shall be unbundled reporting the appropriate E & M procedure code).

PERS specialists provide PERS counseling on or off site, including the monitoring of clients; providing follow-up that may include further consumer assessments; referrals and linkage. PERS specialists who are licensed professional nurses may also provide medication monitoring and nursing assessment.

The medical necessity for these rehabilitative services must be recommended by a licensed practitioner of the healing arts who is acting within the scope of his/her professional license and applicable State law to promote the maximum reduction of symptoms, and/or restoration of an individual to his/her best age appropriate functional level.

PERS services may be provided at an outpatient hospital, clinic or rehabilitation center either as a designated screening service (DSS) or an affiliated emergency service program (AES). DSS and AES both offer assessment and crisis intervention 24-hours

a day for mental health and psychiatric emergencies. For additional information regarding these programs, please see the New Jersey Administrative Code (N.J.A.C.) 10:31. Only a DSS program has the authority to ascertain whether a consumer being considered for civil commitment meets the standards for both mental illness and dangerousness as defined in P.L. 1987, c.116 (N.J.S.A. 30.4-27.1 et seq.) and that all stabilization options have been explored or exhausted.

PERS costs are reimbursed by the NJFC FFS program based on how and where a consumer accesses the PERS service and the provider type delivering the service. These distinctions are summarized below. **More detailed billing instructions, including those applicable to follow-up and outreach, may be found in Attachment B.**

	PERS Resources and Billing Requirements		
Setting	**Facility and Staffing Costs**	**Staffing Costs Only**	**Clinic Facility and Staffing Costs**
Emergency department entry/inpatient admission	**PERS hospital facility and staffing costs** are "rolled-up" into the inpatient billing and reported on the UB-04 claim form.	Medicaid maximum fee schedule billed for PERS **staffing costs** on the UB-04 claim form.	Medicaid maximum fee schedule billed for PERS **clinic facility and staffing costs** on the 1500 claim form.
Emergency department entry/no inpatient admission	Medicaid maximum fee schedule for **outpatient hospital services** billed for PERS **facility and staffing costs** on the UB-04 claim form.	Medicaid maximum fee schedule for **outpatient hospital services** billed for PERS **staffing costs** on the UB-04 claim form.	Medicaid maximum fee schedule billed for PERS **clinic facility and staffing costs** on the 1500 claim form.
Community-Based services provided in a non-hospital/non-clinic Inclusive of mobile outreach services	N/A	Medicaid maximum fee schedule for **outpatient hospital services** for PERS **staffing costs** billed by hospital staff enrolled in Medicaid as rehabilitation providers on the 1500 claim form.	Medicaid maximum fee schedule billed for PERS **clinic facility and staffing costs** on the 1500 claim form.
Non-Medicaid Client	**Remains under a DMAHS contract arrangement**	**Remains under a DMAHS contract arrangement**	**Remains under a DMAHS contract arrangement**

Important Definitions

An Episode of Care refers to the provision of mental health services by PERS program staff to a consumer that includes, at a minimum, a comprehensive face-to-face assessment of the consumer's mental health needs and a disposition that includes a transfer (to an in-patient unit) or a discharge plan to the community with aftercare recommendations.

Mobile Outreach is a face-to-face service delivered by PERS staff to a consumer outside of the building/campus/hospital that houses the PERS program. At a minimum, a comprehensive face-to-face assessment of the consumer's mental health needs and a disposition that includes a transfer (to an emergency department for further evaluation) or a discharge plan to the community with aftercare recommendations.

Follow-Up refers to a face-to-face contact between PERS staff and a consumer subsequent to the provision of a discharge plan provided within 14 days of an episode of PERS care. Follow-up is limited to 2 units per day and a maximum of 3 days of visits within the 14 days following a PERS episode of care.

ACTION: Please find attached documentation that provides information pertinent to the provisions of PERS. These attachments include the following:

- **ATTACHMENT A:** A table of Medicaid maximum fee allowances and related information;
- **ATTACHMENT B:** Detailed billing instructions for PERS episode of care dispositions
- **ATTACHMENT C:** Frequently Asked Questions (FAQs)

ATTACHMENT A

NJFC Billing Information

Service	Unit of Service	Provider Setting/Type	**Revenue Code**	**Procedure Code**	Medicaid Fee	Limitations
PERS, on site first 23.99 consecutive hours	Per episode of care	Hospital outpatient	OP 911	**S9480**	$820.80	Do not bill with a PERS off-site procedure code
		NJDHS-approved PERS clinic providers		**S9480**		
PERS, on site, beyond first 23.99 consecutive hours	1 hour unit of service	Hospital outpatient	OP 911	**S9484**	$27.23	Do not bill with a PERS off-site procedure code Only bill for each hour of PERS provided after first 23.99 hours have been billed under OP 911 and **S9480** OR **S9480**
		NJDHS-approved PERS clinic providers		**S9484**		
PERS, off-site mobile outreach	Per episode of care	Hospital outpatient	OP 900	**T2034**	$862.19	Do not bill with a PERS on-site procedure code or follow-up visit codes on same service date
		NJDHS-approved PERS clinic providers		**T2034**		
PERS, off-site follow-up outreach	1 hour unit of service	Hospital outpatient	OP 900	**90839**	$92.82	Limit of 2 units per day Only bill after another PERS service has been provided in the last 14 calendar days. Limit of 3 days of visits within 14 days post an episode of care.
		NJDHS-approved PERS clinic providers		**90839**		

ATTACHMENT B

Billing Instructions for PERS Episode of Care Dispositions

Type of Episode	Episode of Care Disposition	Revenue Code/HCPCS/CPT Procedure Code Combination To Be Billed (UB-04 Billing)	HCPCS Procedure Code/Modifier To Be Billed (1500 Billing)
On-Site	A consumer is discharged to the community within the first 23.99 hours.	OP 911/**S9480**	**S9480**
On-Site	A consumer is discharged to the community **after** 23.99 hours.	OP 911/**S9480** for the first 23.99 hrs of PERS AND OP 911/**S9484** per hr. after the first 23.99 hours of PERS	**S9480** – for the first 23.99 hrs. of PERS AND **S9484** – per hour of PERS after the first 23.99 hours of PERS
On-Site	A consumer is hospitalized in **a facility other than the one that administers the PERS**. The consumer is transferred to another facility within the first 23.99 hours.	OP 911/**S9480**	**S9480**
On-Site	A consumer is hospitalized in a **facility other than the one that administers the PERS**. The consumer is transferred to another facility after the first 23.99 hours.	OP 911/**S9480** for the first 23.99 hrs of PERS AND OP 911/**S9484** per hr. after the first 23.99 hours of PERS	**S9480** – for the first 23.99 hrs. of PERS AND **S9484** – per hour of PERS after the first 23.99 hours of PERS
On-Site	A consumer is hospitalized in the **same facility as the one that administers the PERS.** The consumer is transferred within the first 23.99 hours.	**PERS costs "rolled-up" into inpatient-stay costs**	**S9480**
On-Site	A consumer is hospitalized in the **same facility as the one that administers the PERS.** The consumer is transferred after first 23.99 hours.	**PERS costs "rolled-up" into inpatient-stay costs**	**S9480** – per episode of care **S9484** – per hour of PERS after first 23.99 hours of PERS
Off-Site/ Mobile Outreach	A consumer is transported back to a hospital emergency department for further evaluation.	**The PERS off-site visit is not covered.**	**S9480**
Off-Site/ Mobile Outreach	The evaluation of a consumer is completed at another facility	OP 900/**T2034**	**T2034**
Off-site/ Mobile Outreach	A consumer remains in the community	OP 900/**T2034**	**T2034**
Follow-Up	A consumer is transported back to an emergency department for further evaluation	**The PERS follow-up visit is not covered.**	**S9480**
Follow-Up	A consumer remains in the community	OP 900/**90839**	**90839**

ATTACHMENT C

FREQUENTLY ASKED QUESTIONS (FAQS)

These FAQs are intended to offer providers important guidance for ensuring that Psychiatric Emergency Rehabilitation Services are provided and billed appropriately to Medicaid's NJ FamilyCare Program.

1. **If a consumer is admitted to an inpatient unit through the emergency department of a hospital in which the PERS is provided by hospital staff of that same hospital, can the hospital bill for the PERS service?**

   No. The cost of the PERS must be "rolled-up" into the inpatient stay costs.

2. **If a consumer is admitted into an inpatient unit through the emergency department of a hospital in which the PERS is provided by staff from a different hospital or PERS provider, can the PERS provider bill for the PERS service?**

   Yes. The PERS provider can bill for the off-site PERS service.

3. **The NJFC Newsletter, Volume 24, No. 03 reported a NJFC maximum fee allowance of $653.40 for HCPCS procedure code and modifier H2011 26 (now S9484). Why was this fee allowance reduced to $27.23?**

   The State was compelled to change its decision regarding the Unit of Service to be reported for HCPCS procedure code and modifier H2011 26 **(now S9484)** from a "per diem" rate to an "hourly" rate.

4. **What revenue codes should be billed when reporting HCPCS procedure codes for PERS on hospital claims?**

   See Attachments A and B for appropriate Revenue Code/HCPCS/CPT procedure code combinations to bill on the UB-04 for PERS services.

5. **If the on-site episode of care exceeds 23.99 consecutive hours of service transcending several days, do we continue to report the episode of care in hours?**

   The Revenue/HCPCS procedure code combination OP 911/**S9480** OR HCPCS procedure code **S9480** must be reported when billing the first 23.99 consecutive hours of a PERS service. When a consumer requires a PERS service beyond the first 23.99 hours, the provider must report the Revenue/HCPCS procedure code combination OP 911/**S9484** OR HCPCS

procedure code **S9484** for any subsequent consecutive hour(s) of PERS provided to a consumer. Partial hours are not billable.

6. **If a consumer is admitted at 1:00 PM today; was stabilized and then committed, but a transfer to a State psychiatric facility cannot be completed until 48 hours after the first 23.99 hours, would the facility bill $820.80, plus $653.40 (now $27.23 per hour), plus $653.40 (now $27.23 per hour)?**

   Yes. The Revenue/HCPCS procedure code combination OP 911/**S9480** OR HCPCS procedure code **S9480** must be reported when billing the first 23.99 consecutive hours of an on-site PERS service. When a consumer requires a PERS service beyond the first 23.99 hours, the provider must report the Revenue/HCPCS procedure code combination OP 911/**S9484** OR HCPCS procedure code **S9484** for any subsequent consecutive hour(s) of PERS provided to a consumer. Partial hours are not billable.

7. **What is the definition of "outreach" as utilized by the Revenue/HCPCS procedure code combination OP 900/T2034 OR HCPCS procedure code T2034? Is this referencing a "mobile" outreach?**

   Yes, see definition for mobile outreach above.

8. **Is this mobile outreach provided by screeners or psychiatrists or both?**

   At a minimum, the mobile outreach is provided by a PERS certified assessor.

9. **Is there a timeframe for conducting mobile outreach services?**

   A minimum timeframe for conducting a PERS mobile outreach face-to-face evaluation has not been established. However, sufficient time must be allotted for the face-to-face evaluation to meet the requirements indicated below:

   - An assessment of risk and mental status, as well as the need for further evaluation or other mental health services.
   - Short-term PERS that includes crisis resolution and de—briefing with one of the consumers in crisis
   - Follow-up with the consumer, caretaker and/or family member(s): and
   - Consultation with qualified healthcare professionals to assist with the specific crisis situation.

10. **If a mobile outreach is conducted and the outcome of the assessment is to return the consumer to the emergency department of the same**

hospital where the PERS program is housed for continued evaluation, medication, etc., do we bill the T2034, S9480, and S9484 if necessary?

If an outreach is conducted and it is determined that the consumer must return to the emergency department of the same hospital as the PERS provider for further evaluation, the on-site per episode of care rate (OP 911/**S9480** OR **S9480**) shall apply and shall not bill the mobile outreach rate.

11. **If a mobile outreach is conducted and the outcome of the assessment is to return the consumer to the emergency department of a different hospital other than where the PERS program is housed for continued evaluation, medication, etc., do we bill the T2034, S9480 and S9484 if necessary?**

    If an outreach is conducted and it is determined that the consumer must return to the emergency department of a different hospital other than where the PERS program is housed for further evaluation, the appropriate PERS mobile outreach rate (**T2034)** shall apply and no other PERS service should be billed.

12. **What is the definition of "follow-up" as utilized by CPT procedure code 90839?**

    See definition for "follow-up" above.

13. **Are services provided by a psychiatrist or other licensed professional part of the PERS billable service for a face-to-face evaluation?**

    No, the NJFC fee schedule for PERS does not include the cost for a psychiatrist providing a face-to-face evaluation. Services provided by psychiatrists and other licensed professionals shall be billed separate from those billed by assessors and specialists for the time spent in direct therapy by reporting direct therapy CPT procedure codes (i.e., all service billing shall be unbundled reporting the appropriate E & M procedure code).

14. **Can a hospital bill charity care for a PERS service?**

    PERS is ineligible for charity care coverage.

15. **Is there an expectation that a provider would bill for these services retroactively?**

    If appropriate, providers may submit claims with service dates on or after May 6, 2014 for PERS provided to **any** NJFC beneficiary. Claims for PERS

provided on or after January 1, 2014 and prior to May 6, 2014. may **only** be billed for ABP beneficiaries, as described in the NJFC Newsletter, Volume 24, No. 03.

16. **For PERS, does a provider require a unique NJFC provider ID if the screening service is hospital-based?**

    PERS does not require a unique NJFC provider ID. The hospital may choose to request a unique NJFC provider ID or utilize an existing Medicaid provider ID previously assigned to the hospital.

17. **Does billing need to be done using the 1500 claim form?**

    Please see the Background Section and Attachment B of this Newsletter.

18. **What criteria may be applied to determine when a PERS service is medically necessary?**

    All individuals who are identified as experiencing a seriously acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve the distress are eligible for PERS. Medical necessity for PERS services shall be recommended by a licensed practitioner of the healing arts who is acting within the scope of his/her professional license and applicable state law to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level.

19. **What are the documentation requirements for a PERS service?**

    N.J.A.C. 10:31 describes the screening process and procedures, inclusive of current documentation requirements.

20. **Is the term "psychiatric emergency rehabilitative services" used by Medicaid the equivalent of a designated screening? Does it apply to emergency services?**

    The term "psychiatric emergency rehabilitative service" is a federal term whose broader scope includes affiliated emergency services (AES) and designated screening services (DSS) previously established by the DMHAS.

21. **Can a non-hospital-based Designated Screening Service bill T2034 for PERS services provided to a patient in a hospital emergency department?**

Yes, the appropriate PERS off-site mobile outreach code shall apply (See Attachment B). If the PERS provider is housed in the hospital in which the PERS service is rendered, the on-site rate can be billed.

22. **Must a consumer be in an Extended Crisis Evaluation Bed (ECEB) to qualify for billing the PERS on-site codes or could the consumer be in a regular emergency department bed?**

No.

23. **Does the PERS evaluation have to be completed by a physician, or can it be completed by an unlicensed MA/MSW?**

PERS certified assessors and/or PERS specialists can complete PERS evaluations. The qualifications for PERS staff is referenced in the NJ FamilyCare Newsletter, Volume 24, No. 03, dated April 2014.

24. **Is the rate for the first 23.99 hours of on-site PERS in addition to the general emergency department rate for services or will the rate of $820.80 now be an all-inclusive rate for a hospital emergency department visit?**

The on-site rate for the first 23.99 hours of PERS is intended to complement a hospital's routine charges for an emergency department visit.

25. **Is the reporting of a DSM-IV or DSM-V required when submitting claims for PERS?**

PERS providers are required to report the appropriate ICD-9 (DSM-IV) diagnosis code(s) on the 1500 professional and the UB-04 claim forms for service dates prior to October 1, 2015. On or after October 1, 2015, the appropriate ICD-10-CM diagnosis code(s) must be reported with implementation of the new ICD-10 code set. Claims reporting DSM-V diagnosis codes, instead of the appropriate ICD-10-CM diagnosis code, on claims with service dates on or after October 1, 2015 shall be denied payment by the State of New Jersey.

26. **Attachment A to the NJFC Newsletter Volume 24, No. 3, dated April 2014, includes a column for the NJFC Fee/Maximum Fee Allowed. Is this the rate expected to be paid for claims submitted on the 1500 professional claim form or the rate to be paid for claims submitted on the UB-04 claim form?**

The NJFC maximum fee allowance for PERS shall be reimbursed for claims submitted on the 1500 professional claim form. Hospitals report their charges for providing PERS on the UB-04 claim form.

27. **Is NJFC managed care providers required to pay for PERS regardless of a FFS provider's participation status with an HMO? Similar to emergency department visits for non-participating providers; will PERS be paid based on the NJFC fee schedule?**

    PERS services are not covered by the Medicaid medical managed care organizations (MCO) or commercial HMOs insurance plans. PERS fee allowances are paid fee-for-service regardless of a provider's participation status with an MCO and claims are submitted to Medicaid's fiscal agent.

28. **When a consumer is discharged to the community within the first 23.99 hours of a PERS, is this service billed on the UB-04 claim form with Revenue Code OP 911, along with the HCPCS procedure code S9480?**

    For an on-site PERS, providers must report the Revenue/HCPCS procedure code combination OP 911/**S9480** for the first 23.99 hours of PERS service **on a UB-04 form**.

29. **In the NJFC Newsletter Volume 24, No. 03, dated April 2014, the reported NJFC maximum fee allowance for S9480 was $820.80. Is this fee allowance to be billed using the 1500 claim form? If so, what fee schedule should be used for technical billing using the UB-04 claim form? (Fields 47/48)**

    The NJFC maximum fee allowance of $820.80 is only reported on the 1500 professional claim form. PERS providers must report their charges for a PERS on the UB-04 claim form in Field 47 and Field 48 with the appropriate code listed in Attachment A.

30. **The Unit of Service for certain PERS is based on an "episode of care" or "hour" of service. Per the HCPCS procedure code manual, hospital and professional billing is to be reported based on 15 minute increments, representing one unit of service as 15 minutes. If a consumer is to receive PERS for 8 hours, should we bill 32 units (i.e. 8 hrs X 4 units per hour)?**

    No. The Unit of Service for a PERS is per "episode of care" and the appropriate unit of service should be billed. The intent of this follow-up Newsletter is to change the allowed procedure codes to ensure the accurate reporting of unit(s) of service.

31. **What happens if the consumer does not present to the emergency department the same day the mobile outreach was provided? Must**

the consumer present in the emergency department within a certain number of hours?

When the mobile outreach and the on-site PERS are provided on the same date of service, only the on-site PERS rate shall be billed to the NJFC program. However, if the mobile outreach and the PERS on-site are provided on different dates of service, each may be billed separately to the NJFC program.

32. If a screener and a psychiatrist visit the same consumer on the same date of service in the same setting can the PERS provider bill the State for both services?

Services provided by psychiatrists and other licensed professionals who participate in the NJFC program shall be billed separate from those billed by assessors and specialists for the time spent in direct therapy by reporting direct therapy CPT procedure codes (i.e., all service billing shall be unbundled reporting the appropriate E & M procedure code).

33. There are instances when a consumer is in a hospital emergency department and is screened by a screener and the result is a transfer to a psychiatric screening center. Would both of these episodes of care be billed as one combined episode or billed as two episodes of care? Would the existing medical emergency department rate be replaced by the new PERS rate or would the new PERS rate be applied for the screening services on top of the medical charges?

If an on-site PERS is conducted in a hospital emergency department and it is determined that the consumer must be transferred to a psychiatric screening center located at another location on the same hospital campus, the on-site provided in the emergency department and any PERS provided in the center shall be considered parts of one episode of care. The on-site PERS rate does not replace the existing medical emergency department rate. In this scenario, only the PERS provider of the DSS would bill for the onsite PERS services.

34. Are the follow-up rates per staff person each day if there are multiple screeners following up on their mobile outreaches?

The follow-up rates are limited to 2 units per day for a maximum of 3 days of visits within 14 calendar days of a PERS service and the rates are inclusive of all certified assessors or PERS specialists staff involved in the care.

35. Do I have to be in a NJFC MCO provider network to bill the State for a PERS?

No. PERS services are not covered by the MCO; therefore, PERS providers do not need to be in a MCO provider network to bill NJFC. Claims for PERS services are submitted to and reimbursed FFS by Medicaid's fiscal agent.

36. How do I bill a PERS service if a PERS service is provided in a medical unit within the same hospital that houses the PERS program?

The PERS provider shall bill the on-site rate for any PERS services provided within the same hospital facility address.

37. If a person is receiving a PERS service at an AES and it is determined that a DSS must be contacted for a PERS mobile outreach service, what are the billing procedures for the two PERS providers to bill NJFC?

For those cases in which the hospital setting does not offer either a certified screening or involuntary care, the AES would bill for related professional services and the DSS would bill the PERS mobile outreach rate.

38. DDD behavioral health services are carved into the NJFC MCO contract. Do we bill the FFS program or the MCO for individuals with DDD services who receive PERS service?

At this time, PERS services for DDD members are not included in the Medicaid MCO contract. For individuals with DDD receiving a PERS service, the PERS provider would bill the State fiscal agent for FFS reimbursement.

39. When a consumer is covered by other insurance, is a PERS provider required to submit their claims to the primary payer first?

Since NJFC is currently the only payer for PERS services, providers are not required to submit PERS claims to the other insurance first. If a consumer is ineligible for NJFC, the PERS may be reimbursed through their contractual relationship with DMHAS.

40. Are providers required to bill PERS services for uninsured individuals?

No.

41. Do these PERS billing procedures apply to NJFC members under the age of 18?

Yes.

42. When does the clock start for a PERS service?

The PERS clock starts when the PERS face-to-face evaluation commences.

43. What are the documentation requirements for a "follow-up?"

A brief progress note or a form that captures, at a minimum:

- the date of the follow-up contact;
- the time of the service (e.g. 3:00 P.M.) and the length (e.g. 30 minutes) of the face-to-face service;
- the mental status;
- the progression and disposition of the crisis event;
- an update on linkage/aftercare; and
- the signature of the staff member and their credential.

44. Will outpatient PERS services billed under the Revenue/HCPCS/CPT procedure code combination be included in the Cost Settlement Report generated by Molina Medicaid Solutions?

Outpatient PERS services billed under the Revenue/HCPCS/CPT procedure code combinations shall be excluded from the Cost Settlement Report generated by Molina Medicaid Solutions. These costs are excluded from the percent of charge calculation.

45. Please clarify the following: "The medical necessity for these rehabilitative services must be recommended by a licensed practitioner of the healing arts who is acting within the scope of his/her professional license and applicable State law to promote the maximum reduction of symptoms, and/or restoration of an individual to his/her best age appropriate functional level."

PERS services must be recommended by a licensed practitioner of the healing arts. A consultation with a licensed practitioner of the healing arts is sufficient to document medical necessity.

If you have any questions regarding PERS policies and/or procedures, please contact Roxanne Kennedy (DMAHS) at Roxanne.Kennedy@dhs.state.nj.us or John Verney (DMHAS) at John.Verney@dhs.state.nj.us . If you have any question concerning NJFC billing procedures, please contact Molina Medicaid Solutions Provider Relations at 800-776-6334.

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