

**TITLE 10. DEPARTMENT OF HUMAN SERVICES**

**CHAPTER 77. REHABILITATIVE SERVICES FOR CHILDREN**

CHAPTER AUTHORITY: *N.J.S.A. 30:4D-1* et seq. and *30:4J-8* et seq.

CHAPTER SOURCE AND EFFECTIVE DATE:

R.2008 d.251, effective July 25, 2008.

See: *40 N.J.R. 1040(a)*, *40 N.J.R. 4807(a)*.

CHAPTER EXPIRATION DATE:

Chapter 77, Rehabilitative Services for Children, expires on July 25, 2013.

## **CHAPTER 77. REHABILITATIVE SERVICES FOR CHILDREN**

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## SUBCHAPTER 1. GENERAL PROVISIONS

### § 10:77-1.1 Purpose and scope

(a) This chapter is concerned with the provision of, and reimbursement for, medically necessary Medicaid-covered and NJ FamilyCare fee-for-service covered rehabilitative services, specifically, environmental lead inspection/hazard assessment services and mental health rehabilitation services for children, youth and young adults, in accordance with the New Jersey Medicaid and NJ FamilyCare fee-for-service program rules, including those mental health rehabilitation services provided under the auspices of the Department of Children and Families' (DCF) Division of Child Behavioral Health Services (DCBHS).

(b) Medically necessary services shall meet all applicable State and Federal Medicaid and NJ FamilyCare laws, and all applicable rules as specified in the appropriate provider services manual of the New Jersey Medicaid/NJ FamilyCare program.

(c) The chapter is divided into seven subchapters and an appendix, as follows:

1. N.J.A.C. 10:77-1 contains general provisions to rehabilitative services, including introductory general provisions and general definitions;

2. N.J.A.C. 10:77-2 contains definitions, provisions for provider participation, basis for reimbursement, policies and procedures, and recordkeeping requirements pertaining to the specific Medicaid-covered and NJ FamilyCare-Plan A-covered rehabilitative service: environmental lead inspection service;

3. N.J.A.C. 10:77-3 contains definitions, provisions for provider participation, basis for reimbursement, policies and procedures, and recordkeeping requirements pertaining to the specific mental health rehabilitation services provided in psychiatric community residences for youth, group homes or residential childcare facilities, available to children, youth or young adults who are Medicaid/NJ FamilyCare beneficiaries or children, youth or young adults who are ineligible for Medicaid/NJ FamilyCare but are receiving mental health rehabilitation services under DCF/DCBHS.

4. N.J.A.C. 10:77-4 contains the definitions, provisions for provider participation, basis for reimbursement, policies and procedures, and recordkeeping requirements pertaining to the specific Medicaid/NJ FamilyCare-covered mental health rehabilitation service of behavioral assistance services available to children, youth or young adults who are Medicaid/NJ FamilyCare beneficiaries or children, youth or young adults who are ineligible for Medicaid/NJ FamilyCare but are receiving mental health rehabilitation services under DCF/DCBHS.

5. N.J.A.C. 10:77-5 contains the definitions, provisions for provider participation, basis for reimbursement, policies and procedures, and recordkeeping requirements pertaining to the specific Medicaid/NJ FamilyCare-covered mental health rehabilitation service of intensive in-community services; available to children, youth or young adults who are Medicaid/NJ FamilyCare beneficiaries or children, youth or young adults who are ineligible for Medicaid/NJ FamilyCare but are receiving mental health rehabilitation services under DCF/DCBHS.

6. *N.J.A.C. 10:77-6* contains the definitions, provisions for provider participation, basis for reimbursement, policies and procedures, and recordkeeping requirements pertaining to the specific Medicaid-covered and NJ FamilyCare-Plan A covered mobile response and stabilization management services for children; available to children, youth or young adults who are Medicaid/NJ FamilyCare beneficiaries or children, youth or young adults who are ineligible for Medicaid/NJ FamilyCare but are receiving mental health rehabilitation services under DCF/DCBHS.

7. *N.J.A.C. 10:77-7* pertains to the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System (HCPCS). The HCPCS contain procedure codes and maximum fee allowances corresponding to the Medicaid/NJ FamilyCare and PFC reimbursable services of this chapter; and

8. The chapter Appendix pertains to the Fiscal Agent Billing Supplement. The Fiscal Agent Billing Supplement contains billing instructions and samples of forms (claim forms, prior authorization forms, and consent forms) used in the billing process.

#### § 10:77-1.2 General definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Care management organization" (CMO) means an independent, community-based organization that combines advocacy, service planning and delivery, and care coordination into a single, integrated, cross-system process, in order to assess, design, implement and manage child-centered and family-focused individual service plans (ISPs) for children, youth and young adults whose needs require intensive care management techniques that cross multiple service systems. See *N.J.A.C. 10:73*.

"Centers for Medicare & Medicaid Services" (CMS) means the agency of the Federal Department of Health and Human Services, which is responsible for the administration of the Medicaid program and the State Children's Health Insurance Program (SCHIP) in the United States.

"Child, youth or young adult" means a Medicaid beneficiary under 21 years of age or a NJ FamilyCare-Plan B or C beneficiary under 19 years of age, or an individual receiving services under the Division of Child Behavioral Health Services who is not eligible for Medicaid/NJ FamilyCare who is under 21 years of age.

"Contracted system administrator" (CSA) means an administrative organization contracted by, and serving as an agent of, the Department of Children and Families to provide utilization management, care coordination, quality management and information management for the Division of Child Behavioral Health Services in its administration of the locally managed system of care that provides mental and behavioral health services and supports to eligible children, youth and young adults.

"County Case Assessment Resource Team" (CART) means a team which is part of a county-based interagency system of individual case planning and service system development. This multi-disciplinary team reviews cases of children with emotional or

behavioral disturbances, who are placed residentially, or at risk of psychiatric hospitalization, to determine if a community-based placement is more appropriate. The CART also promotes partnerships with parents, advocates across all child-serving systems and coordinate services.

"Department" means the Department of Human Services (DHS).

"Department of Children and Families" (DCF) means the Department of New Jersey government, created by P.L. 2006, c. 47, that has the goal of ensuring safety, permanency, and well-being for all children and that has direct responsibility for child welfare and other child and family services. DCF includes the Division of Youth and Family Services, the Division of Child Behavioral Health Services, the Division of Prevention and Community Partnerships, the New Jersey Child Welfare Training Academy and the Office of Education.

"Division" means the Division of Medical Assistance and Health Services (DMAHS) within the New Jersey Department of Human Services.

"Division of Child Behavioral Health Services" (DCBHS) means the Division established within the Department of Children and Families, which provides a comprehensive approach to the provision of mental health/behavioral health services to eligible children, youth and young adults.

"Family support organization" (FSO) means an independent community-based organization providing services through a contract with the Department of Children and Families. The FSOs are comprised of family members who are involved or have been involved in the system of children's mental health services and who provide direct peer support and advocacy to children and families receiving services under DCBHS.

"Healthcare Common Procedure Coding System" (HCPCS) means a nationwide coding system, established and maintained by CMS in accordance with the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191.

"Joint Committee on Accreditation of Healthcare Organizations (JCAHO)" means the organization that evaluates and accredits health care organizations and programs in the United States. Information about JCAHO can be obtained from: Joint Committee on Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181; telephone (630) 792-5000; and on the web at [www.jcaho.org](http://www.jcaho.org).

"NJ FamilyCare" means the health insurance coverage program administered by DMAHS under the provisions of Title XIX and Title XXI of the Social Security Act, in accordance with N.J.A.C. 10:49, 10:78, and any other applicable rules of the Division.

"Rehabilitative service" is an optional service that a state may define to include (pursuant to 42 C.F.R. 440.130) medical or remedial services recommended by a physician or other licensed practitioner within the scope of practice under State law, for maximum reduction of physical or mental disability and restoration of an individual to his or her best possible functional level.

"Young adult" means, for purpose of eligibility for DCF/DCBHS services, an individual, at least 18 years of age and under 21 years of age, who had been receiving mental/behavioral health services under DCF/DCBHS prior to becoming 18 years of age,

or who is currently receiving services in the child-serving system and who demonstrates a clinical need for the continuation of such services.

"Youth case management" means services provided in accordance with N.J.A.C. 10:37H and 10:73 to facilitate a level of case management that assists children, youth or young adults in accessing and receiving the appropriate level of care, interventions and supports to maintain the optimal functioning level in the community.

## SUBCHAPTER 2. ENVIRONMENTAL LEAD INTERVENTION SERVICES

### § 10:77-2.1 Scope of services

This subchapter describes the New Jersey Medicaid and NJ FamilyCare-Plan A program's provisions specifically pertaining to environmental lead inspection/hazard assessment services.

### § 10:77-2.2 Environmental lead inspection service definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Certified lead inspector/risk assessor" means one who is hired by the local health department and certified by the State Department of Health and Senior Services in accordance with *N.J.A.C. 8:62* to perform and conduct hazard assessments in order to find lead hazards.

"Elevated blood lead level" (EBLL) means an excess of lead in the bloodstream as defined in *N.J.A.C. 8:51A*.

"Environmental lead inspection service or hazard assessment" means an epidemiologic investigation by a certified lead inspector/risk assessor in order to identify lead hazards in the primary residence of a child who is a Medicaid beneficiary and who is determined to have an EBLL.

"Environmental intervention" means the application of detection techniques and the performance of tests in order to assess the origins and extent of lead hazards in the child's primary residence.

"High risk" means a child whose history is positive for one or more of the following criteria in assessing his or her risk of high-dose exposure to lead:

1. Lives in a house built before 1978 with leaded paint that is peeling, chipped or otherwise in a deteriorated condition;
2. Lives in a house built before 1978 with lead contaminated dust created during removal or disturbance of leaded paint in the process of home renovations or repairs;
3. Lives with a child being followed or treated for EBLL; and/or
4. Lives with an adult whose occupation or hobby involves contact with or exposure to lead or materials containing lead.

"Lead hazard" means any condition that allows access or exposure to lead, in any form, to the extent that adverse human health effects are possible. (*N.J.A.C. 8:51-1.3*)

"Local health department" (LHD) means the board of health of any region or municipality or the boards, bodies or officers in such region or municipality lawfully exercising any of the powers of a local board of health under the laws governing such



region or municipality, and includes any consolidated local board of health or county local board of health created and established pursuant to *N.J.S.A. 26:1A-1*.

"Screening" means the taking of a blood sample from an asymptomatic child, and its analysis by a medical laboratory, to determine if the child has EBLL.

#### § 10:77-2.3 Provider participation requirements

(a) Requirements for a provider to participate in environmental lead inspection services shall be as follows:

1. An applicant shall be a local health department (LHD);

2. Each LHD shall enroll and be approved by the New Jersey Medicaid/NJ FamilyCare programs specifically for reimbursement for this service, including LHD's previously approved as Medicaid/NJ FamilyCare independent clinic providers;

3. An LHD not previously approved as a Medicaid/NJ FamilyCare independent clinic provider but wishing to enroll as a Medicaid/NJ FamilyCare-participating provider for environmental lead intervention services shall complete and submit a provider application packet pursuant to *N.J.A.C. 10:49-3.2*;

i. The completed application packet shall be submitted to:

Unisys  
Provider Enrollment  
PO Box 4804  
Trenton, New Jersey 08650

ii. The applicant shall receive written notification of approval or disapproval of its provider status. If approved, the applicant shall be assigned a Medicaid/NJ FamilyCare Provider Number and shall receive a packet which contains a Medicaid/NJ FamilyCare Provider Manual (*N.J.A.C. 10:77*) and the Fiscal Agent Billing Supplement (FABS);

4. An LHD previously approved as a Medicaid/NJ FamilyCare independent clinic provider or an LHD previously issued a provider number but requiring reactivation of its provider number, wishing to perform environmental lead inspection services needs only to submit a request on LHD letterhead to:

Division of Medical Assistance and Health Services  
Office of Provider Enrollment  
Mail Code #9  
PO Box 712  
Trenton, New Jersey 08625-0712

5. Upon approval as a Medicaid/NJ FamilyCare provider, the LHD shall conform to applicable State and Federal laws, rules and regulations including, but not limited to, *N.J.A.C. 10:49* and this chapter.

#### § 10:77-2.4 Environmental lead intervention services

(a) All Medicaid/NJ FamilyCare-Plan A beneficiaries up to 72 months of age and older children who are considered as "high risk" for lead poisoning, shall be screened for such through venous or capillary blood tests.

1. Pursuant to *N.J.A.C. 8:44-2.11*, clinical laboratories are required to report to the New Jersey Department of Health and Senior Services (DHSS) the results of all lead screenings;

2. The DHSS, in turn, through the "Environmental Investigation and Abatement Report Form" (LP-1), will notify the appropriate LHD of the need to conduct an environmental lead inspection/hazard assessment of the child's primary residence;

3. The LHD shall have a certified lead inspector/risk assessor conduct an environmental lead inspection/hazard assessment of the Medicaid/NJ FamilyCare-Plan A beneficiary's primary residence in order to locate existing lead hazards.

(b) To be reimbursable as a rehabilitative service, the LHD's environmental lead inspection/hazard assessment shall meet the following requirements:

1. The rehabilitative service--environmental lead inspection/hazard assessment service shall be provided by the LHDs and performed by a Department of Health and Senior Services-certified lead inspectors/risk assessors;

2. The on-site environmental lead inspection/hazard assessment shall be of the child's primary residence for the source(s) of lead contamination; and

3. The inspection/assessment shall include tests performed by the certified lead inspector/risk assessor designed to locate lead hazards.

i. Laboratory testing and analysis of substances such as water and paint shall not be included as reimbursable environmental lead inspection services.

(c) When the initial inspection of the child's primary residence results in a recommendation for abatement, as defined at *N.J.A.C. 8:51-1.3*, a reinspection to determine if the lead hazard has been eliminated may be reimbursed.

1. Should the reinspection result in finding a still-existing lead hazard in the child's primary residence, then a second reinspection may be reimbursed.

2. A maximum of two reinspections of the child's primary residence may be reimbursable.

#### § 10:77-2.5 Basis for reimbursement

(a) The reimbursement for rehabilitative service--environmental lead inspection service shall be based on the provider's usual and customary charge or the maximum fee allowance as contained in *N.J.A.C. 10:77-7.2(a)*, whichever is less.

(b) The service shall meet the following conditions:

1. The service shall be performed by a certified lead inspector/risk assessor;
2. The service shall be provided in the primary residences of Medicaid/NJ FamilyCare-Plan A beneficiaries who are children identified as having EBLLs; and
3. The child(ren) shall have been referred by the New Jersey State Department of Health and Senior Services (DHSS).

(c) Only claims for Medicaid/NJ FamilyCare-Plan A-eligible individuals referred through the Department of Health and Senior Services to the LHDs can be considered for reimbursement by the Medicaid/NJ FamilyCare program.

1. The provider shall request the beneficiary's Medicaid/NJ FamilyCare-Plan A Eligibility Identification Card and verify Medicaid/NJ FamilyCare-Plan A eligibility for the date of service before submitting a claim to the Medicaid/NJ FamilyCare program. For additional information regarding verification of beneficiary eligibility, refer to *N.J.A.C. 10:49-2.11*.

(d) A claim for environmental lead inspection shall be submitted on a CMS 1500 claim form to Unisys, the Medicaid/NJ FamilyCare fiscal agent at the following address:

Unisys  
PO Box 4808  
Trenton, New Jersey 08650-4808

1. Claims shall include a procedure code(s) (HCPCS) reflecting the service(s) provided and the corresponding fee for the service(s). See *N.J.A.C. 10:77-7.2(a)*.

2. Upon receipt of the CMS 1500 claim form, the Medicaid/NJ FamilyCare fiscal agent will process the claim and reimburse the LHD the Federal share (50 percent for Medicaid and 65 percent for certain NJ FamilyCare-Plan A beneficiaries) of the amount approved by Medicaid/NJ FamilyCare (*N.J.A.C. 10:77-4*), the remaining cost of this mandated service, as specified in *N.J.A.C. 8:51*, being the responsibility of the LHD.

#### § 10:77-2.6 Recordkeeping

(a) All LHDs shall keep such legible records as are necessary to fully disclose the kind and extent of services provided, as well as the necessity for such services and the place, date, and time the services were provided.

(b) The minimum recordkeeping requirements for LHDs performing environmental lead inspections shall be a completed copy of the "Environmental Investigation and Report Form" (LP-1).

1. A copy of the completed form (LP-1) for each Medicaid/NJ FamilyCare-Plan A beneficiary shall be sent quarterly to the following address:

Office of Preventive Health/EPSTD  
Division of Medical Assistance and Health Services

PO Box 712, Mail Code #15  
Trenton, NJ 08625-0712

(c) All required recordkeeping documents shall be made available, upon request, to the New Jersey Medicaid/NJ FamilyCare program or its agents.

## SUBCHAPTER 3. RESIDENTIAL MENTAL HEALTH REHABILITATION SERVICES

### § 10:77-3.1 Scope of services

This subchapter sets forth the New Jersey Medicaid/NJ FamilyCare programs provisions pertaining to mental health rehabilitation services for children provided under the auspices of the Division of Child Behavioral Health Services within the Department of Children and Families. These services are provided in psychiatric community residences for youth, children's group homes or residential childcare facilities.

### § 10:77-3.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Children's group homes" means facilities licensed by the Department of Children and Families and that meet the requirements of *N.J.A.C. 10:127*, and provide mental health rehabilitation services.

"Contract pricing" means each facility shall have an individual rate based on the rate in the contract negotiated by either the Division of Mental Health Services or the Division of Youth and Family Services.

"Discharged" means that the child, adolescent or young adult receiving mental health rehabilitation services has been permanently discharged home or to another treatment facility. "Discharged" does not mean temporary absences from a facility due to therapeutic or hospital leave.

"Hospital leave" means temporary absence from the facility providing mental health rehabilitation services for the treatment of an acute medical or mental health condition.

"Mental health rehabilitation services" means psychiatric and psychological services, including emotional and/or behavioral treatment, drug and alcohol dependency treatment, psychiatric treatment, psychotherapy and related nursing services.

"Psychiatric community residences for youth" means facilities licensed by the Department of Human Services in accordance with *N.J.A.C. 10:37B* that provide mental health rehabilitation services.

"Regional area" means one of four possible geographic provider groupings. Providers are assigned to a regional area depending on the county in which the facility is located.

1. Northern: Bergen, Hudson, Morris, Passaic, Sussex and Warren
2. Metropolitan: Essex, Middlesex and Union
3. Central: Hunterdon, Mercer, Monmouth, Ocean and Somerset
4. Southern: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester and Salem

"Residential child care facilities" means facilities licensed by the Department of Children and Families in accordance with *N.J.A.C. 10:128* that provide mental health rehabilitation services.

"Temporary absence" means an absence from the facility of more than 24 hours, starting and ending at midnight.

"Therapeutic leave" means the temporary absence, for therapeutic reasons, of a resident from a facility providing mental health rehabilitation services. Reasons for such absences may include, but are not limited to, visits with parents or caregivers, attendance at a residential camp, or residence in a temporary shelter.

### § 10:77-3.3 Provider participation requirements

(a) Requirements for participation as a mental health rehabilitation provider shall be as follows:

1. An applicant shall be licensed by the Department of Human Services in accordance with *N.J.A.C. 10:37B*, or by the Department of Children and Families in accordance with *N.J.A.C. 10:127* or *10:128* and shall provide mental health rehabilitation services.

2. A psychiatric community residence for youth or any other provider that is not enrolled as a provider of mental health personal care services by the Department of Human Services in accordance with *N.J.A.C. 10:37B*, or by the Department of Children and Families in accordance with *N.J.A.C. 10:127* or *10:128*, shall enroll as a mental health rehabilitation provider.

3. All applicants shall complete and submit a provider application, including a copy of their license, to:

Division of Medical Assistance and Health Services  
Office of Provider Enrollment, Mail Code #9  
PO Box 712  
Trenton, New Jersey 08625-0712

i. The applicant shall receive written notification of approval or disapproval of its provider status. If approved, the applicant shall be assigned a Provider Number, and shall receive a copy of this chapter.

ii. Upon approval as a Medicaid/NJ FamilyCare provider, the provider shall conform to all the provisions of *N.J.A.C. 10:49*, this chapter and any applicable rules of the Department of Children and Families.

4. A provider is required to enroll each site at which services are provided and obtain a separate provider number for each site.

### § 10:77-3.4 Eligibility for services

(a) The Division shall consider claims for children, youth or young adults who are eligible for Medicaid/NJ FamilyCare, and children who are ineligible for Medicaid/NJ FamilyCare, but who are receiving mental/behavioral health services from DCF/DCBHS. Children eligible as "medically needy" in accordance with *N.J.A.C. 10:71* shall not be eligible for mental health rehabilitation services.

(b) Children are eligible for services under this subchapter if the services have been determined clinically necessary using the criteria established by the Department of Human Services or Children and Families, or have been prior authorized by the Division of Medical Assistance and Health Services, or any contracted agent of the Department of Human Services or Children and Families used to authorize the clinical need for these services.

### § 10:77-3.5 Mental health rehabilitation services for youth

(a) Mental health rehabilitation services for youth shall include the psychiatric and psychological services, including emotional and/or behavioral treatment, drug and alcohol dependency treatment, psychiatric treatment, psychotherapy, and related nursing services, provided by the mental health rehabilitation provider.

1. All services shall meet the requirements specific to provider type as defined in *N.J.A.C. 10:37B*, Psychiatric Community Residences for Youth, *N.J.A.C. 10:127*, Residential Child Care Facilities, and *N.J.A.C. 10:128*, Children's Group Homes.

2. All providers shall also meet the requirements of *N.J.A.C. 10:49*, this chapter and any applicable rules of the Department of Children and Families.

3. All mental health rehabilitation services provided by psychiatric community residences for youth, group homes or residential child care facilities shall meet the referral requirements of their respective division.

4. All mental health rehabilitation services shall be provided directly by facility staff or under the direction or coordination of facility staff.

### § 10:77-3.6 Basis of reimbursement

(a) The reimbursement for mental health rehabilitation services for a psychiatric community residence for youth, a residential child care facility or group home shall be based on reasonable, negotiated, contracted costs as defined in the Department of Human Services' Contract Reimbursement Manual and the Contract Policy and Information Manual. Providers have access to these manuals as indicated at *N.J.A.C. 10:3-3.3(e)12*.

1. These rates shall not be adjusted in the provider's current contract year except for Department-approved adjustments that would otherwise have been provided for under the terms of the existing contracts if Medicaid/NJ FamilyCare reimbursement for these services had not occurred, such as scheduled cost-of-living adjustments.

2. The total amount reimbursed by the Division, including room and board, shall be based on the approved negotiated contracted rates each provider receives under contract

with the Division of Mental Health Services or the Division of Youth and Family Services, with any approved Departmental adjustment.

3. All facilities, under their contract, will receive at least a minimum per diem reimbursement rate of \$ 155.00, provided that they meet all other contractual and rule requirements.

4. This negotiated rate for DMAHS reimbursement purposes shall be divided into two rates, one for the Title XIX Federally reimbursable therapeutic services, and one for the non-reimbursable Title XIX services. Non-reimbursable services shall include, but shall not be limited to, such costs as personal needs allowances, other non-rehabilitative services, and the cost of room and board.

i. Reimbursement for clothing that is required as a part of a treatment regimen and included in the plan of care shall be included in the reasonable costs.

ii. Reimbursement for transportation for medically necessary purposes shall be included in the Title XIX reimbursable per diem rates. Transportation costs related to meetings and conferences will be included in the Title XIX reimbursable per diem rates when the primary purpose of such meetings and conferences is the dissemination of information for the advancement of patient care or efficient operation of the facility.

iii. The non-Title XIX reimbursable transportation shall be included in the non-reimbursable HCPCS. The cost of non-patient related travel, such as commuting, shall be included in the non-Title XIX reimbursable costs.

5. To establish the rates for these two HCPCS, the Division shall use the following Federally approved methodology, that results in a percentage to determine the amount that is non-Title XIX Federally reimbursable. The figure that results from this methodology shall be developed for each class of provider and then applied to each provider within the class.

i. The amount of reimbursement for room and board will be determined from an analysis of the per diem rates as follows: The costs of all the providers in each provider group in the selected regional area shall be analyzed to determine the percentage of each provider's total costs that are used to cover room and board and the percentage of the total cost that is used to cover the therapeutic services. The median percentage factor may vary depending on the provider group a provider belongs to.

ii. The median percentage for contracted room and board expenditures in relation to total operating expenditures shall be applied to each provider's rates to separately determine the reimbursement rates for the therapeutic HCPCS and room and board HCPCS procedure codes.

iii. Each year, on a rotating basis, a different regional area of the State shall be used to determine the median percentage for each provider group for room and board services and for therapeutic services.

iv. If a regional area contains too few provider groupings to use the median-based methodology, reimbursement for room and board will be computed for each individual facility, based on the actual costs for the facility.



Example: When applied in the selected region of the State, the methodology determines that the non-Title XIX reimbursable costs (room and board) are 20 percent for Provider Type A. Based on this determination, for provider A, whose current negotiated per diem is \$ 200.00, the rate for the Title XIX reimbursable HCPCS (therapeutic services) shall be \$ 160.00 (\$ 200.00 less (200 x .20)). The reimbursement for the non-Title XIX services shall be \$ 40.00.

For provider B, who is the same provider type as provider A, but whose current negotiated per diem is \$ 160.00, the rate for the Title XIX reimbursable HCPCS shall be \$ 128.00 (\$ 160.00 less (160 x .20)). The reimbursement for the non-Title XIX services shall be \$ 32.00.

(b) Providers shall be reimbursed on a per diem basis.

1. Providers may seek reimbursement for services provided on the date that the child, youth or young adult is admitted to the facility, but shall not seek reimbursement for services provided on the child's, youth's or young adult's date of discharge.

i. On the dates that the child, youth or young adult is listed as being under the care of the facility, but is not physically present in the facility for the 24-hour period starting and ending at midnight, due to therapeutic or hospital leave, the applicable HCPCS procedure codes shall be used. See *N.J.A.C. 10:77-7.2(b)*. Therapeutic or hospital leave shall be authorized by appropriate medical staff and shall be included in the plan of care.

#### § 10:77-3.7 Temporary absences from the facility

(a) Temporary absence for the purpose of therapeutic or hospital leave shall be approved by the child, youth or young adult's treatment team and included in the plan of care developed by the facility in accordance with *N.J.A.C. 10:37B*, Psychiatric Community Residences for Youth, *N.J.A.C. 10:127*, Children's Group Homes, or *N.J.A.C. 10:128*, Residential Child Care Facilities, this chapter and any applicable rules of the Department of Children and Families.

(b) The dates and purpose of the temporary absence shall be recorded in the child, youth or young adult's record maintained by the facility.

(c) A provider may seek reimbursement for a child, youth or young adult's temporary absence from the facility due to a hospital or therapeutic leave for periods of up to 14 continuous days per episode. If the child, youth or young adult is present in the facility for any part of the day, beginning and ending at midnight, the HCPCS procedure codes for a day of service shall be used for that day. (See *N.J.A.C. 10:77-7.2(b)*).

#### § 10:77-3.8 Conflict with personal care services

A provider shall not claim reimbursement for mental health personal care services and mental health rehabilitation services for the same child, youth or young adult for the same day of service.

### § 10:77-3.9 Recordkeeping

(a) All community psychiatric residences for youth, residential child care facilities, and group homes shall keep such legible records as are necessary to fully disclose the kind and extent of services, as well as the medical necessity for such services, and the place, date, and the amount of time the services were provided.

(b) All recordkeeping documents required by (a) above shall be made available, upon request, to the Department of Human Services or Children and Families or authorized agents of either Department.

### § 10:77-3.10 Collaboration with mobile response agencies

(a) As part of an individual crisis stabilization plan (see *N.J.A.C. 10:77-6*) a mobile response agency may contact a non-JCAHO accredited psychiatric community residence for youth, group home or residential childcare facility to place a child, youth or young adult receiving mobile response and/or stabilization management services for a period of up to seven days.

(b) The psychiatric community residence for youth, group home or residential childcare facility providing the crisis bed for the child may request reimbursement of a per diem fee, for up to seven days, to cover additional costs incurred by the facility during this period as included in a plan of care prepared by the mobile response agency and authorized by the Contracted Systems Administrator (CSA). This per diem fee shall be reimbursed in addition to their usual reimbursement using the HCPCS procedure code, H0018 TJ. (See *N.J.A.C. 10:77-7.2(b)*).

(c) Effective for date of service on or after January 1, 2004 the Contracted Systems Administrator (CSA) will issue an authorization number for the facility providing the crisis bed to use when requesting reimbursement. The provider must enter this authorization number on the CMS-1500 claim form to ensure proper reimbursement is received.

## SUBCHAPTER 4. BEHAVIORAL ASSISTANCE SERVICES

### § 10:77-4.1 Purpose and scope

(a) This subchapter sets forth the manner in which behavioral assistance services shall be provided to eligible Medicaid/NJ FamilyCare and Division of Child Behavioral Health Services beneficiaries under age 21.

(b) Behavioral assistance services shall be provided and administered in a manner consistent with Department of Human Services (DHS) and Department of Children and Families (DCF) rules and contract requirements. If a conflict arises between the contract requirements and any existing provider rules, the terms set forth in the DHS/DCF contract shall prevail.

### § 10:77-4.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context indicates otherwise:

"Behavioral assistance services" means concrete, outcome-oriented interventions that are components of a written, detailed plan of care prepared by a licensed behavioral healthcare practitioner, and authorized by the CSA or other DHS or DCF-designated agency, which includes an evaluation of the identified behavior(s), which includes recommendations for specific interventions with definable outcomes and strategies with the goal of restoring, rehabilitating or maintaining the child/youth or young adult's capacity to successfully function in the community and diminish the need for a more intensive level of care.

### § 10:77-4.3 Provider participation

(a) Providers of behavioral assistance services shall be providers that are licensed in New Jersey to provide medical/mental health services, a medical/mental health practice or other service provider that includes the appropriate licensed practitioners who can provide, or supervise the provision of, services. Examples of provider agencies include, but are not limited to, acute care or psychiatric hospitals, Joint Committee on Accreditation of Healthcare Organizations (JCAHO)-accredited residential treatment centers, licensed group homes or child care residential providers, psychiatric community residences for youth, home health agencies, mental health clinics or any other licensed clinic, Federally Qualified Health Centers, or other entities licensed by a New Jersey government agency to provide physical or mental/behavioral health services in New Jersey.

(b) Individual group practices or other individual service provider entities rendering behavioral assistance services shall employ at least one of the following licensed practitioners who can provide the service directly or supervise the provision of services:

1. Psychiatrist (*N.J.A.C. 13:35*);
2. Psychologist (*N.J.A.C. 13:42*);
3. Advance Practice Nurse (mental health) (*N.J.A.C. 13:37*);
4. Licensed Clinical Social Worker (*N.J.A.C. 13:44G*); or
5. A professional licensed in accordance with the Board of Marriage and Family Therapy Examiners (*N.J.A.C. 13:34*) including, but not limited to:
  - i. A Licensed Marriage and Family Therapist (*N.J.A.C. 13:34-4*);
  - ii. A Licensed Professional Counselor (*N.J.A.C. 13:34-11* or *12*);
  - iii. A Clinical Mental Health Counselor (*N.J.A.C. 13:34-14*); or
  - iv. A Rehabilitation Counselor (*N.J.A.C. 13:34-21* or *22*).

(c) Agencies providing behavioral assistance services shall have demonstrated experience, or shall employ sufficient staff with demonstrated experience of, providing services to children with serious emotional or behavioral health challenges and their families, including, but not limited to, appropriate qualifications and training to provide behavioral assistance in the context of other presenting problems. All agencies shall first be certified by DCBHS as meeting these criteria prior to being enrolled as a Medicaid/NJ FamilyCare provider.

(d) Provider entities shall employ appropriate staff necessary to provide administrative oversight, clinical supervision, management, plan development, evaluation and monitoring requirements.

(e) All providers of behavioral assistance services shall be enrolled in the New Jersey Medicaid/NJ FamilyCare fee-for-service program as a provider of behavioral assistance services. Providers enrolled in the NJ Medicaid/NJ FamilyCare fee-for-service program as any other provider type shall submit a separate application and shall first be approved as a provider of behavioral assistance services by DCBHS prior to receiving reimbursement for rendering these services.

(f) All applicants shall submit a completed Medicaid/NJ FamilyCare provider application to:

Department of Children and Families  
PO Box 717  
Trenton, NJ 08625-0717  
Attn: DCBHS Provider Enrollment Unit

(g) The applicant shall include a current and valid copy of their license(s) with the provider application.

(h) If a behavioral assistance provider loses their license, and is unable to provide services, the provider shall notify the Department of Children and Families, at the address in (f) above, within 10 business days of losing the license.

1. The provider will be disenrolled as a Medicaid/NJ FamilyCare provider until such time as the license is restored. Once the provider's license is restored, the provider will be reinstated as a Medicaid/NJ FamilyCare provider as long as any and all applicable licensure requirements and the requirements of this chapter are met and continue to be met.

(i) The applicant will receive written notification of approval or disapproval of provider status. If approved, the applicant will be assigned a provider number and will receive a copy of the Medicaid/NJ FamilyCare provider manual for Rehabilitative Services. The manual will include *N.J.A.C. 10:49* (the DMAHS Administration Manual), this chapter (Rehabilitative Services), relevant non-regulatory information and the fiscal agent billing supplement.

(j) Upon approval as a Medicaid/NJ FamilyCare provider, the provider shall conform to all the requirements of *N.J.A.C. 10:49*, this subchapter and any applicable rules of the Department of Children and Families.

#### § 10:77-4.4 Beneficiary eligibility

(a) Children/youth/young adults shall be eligible to receive behavioral assistance services if they are Medicaid/NJ FamilyCare beneficiaries or are ineligible for Medicaid/NJ FamilyCare but are receiving mental health rehabilitation services under DCF/DCBHS.

(b) Children/youth and young adults shall be eligible for behavioral assistance services if the services have been determined clinically necessary by the Division of Mental Health Services (DMHS), the Division of Youth and Family Services (DYFS), the Division of Medical Assistance and Health Services (DMAHS), the contract systems administrator (CSA), or any contracted and authorized agent of the Department of Human Services or Children and Families, which authorizes the clinical need for these services.

#### § 10:77-4.5 Beneficiary rights

(a) Any provider entity providing behavioral assistance shall demonstrate regard for the rights of the child, youth or young adult, their families and/or caregivers to exercise choice and to receive culturally appropriate, integrated, coordinated and carefully monitored services in the least restrictive setting appropriate to their individual needs.

(b) The provider entity shall deliver services in a manner that includes the beneficiary, primary caregiver, legal guardian and family support organization (FSO) representative in service planning and permits the maximum freedom of choice by the beneficiary in all areas of their lives, where possible, including, but not limited to:

1. Fully informing the child/youth or young adult and his or her parent/caregiver of all service options, and the benefits of these options; and

2. Allowing the child/youth or young adult and/or his or her parent/caregiver to make all possible decisions with regard to their lives, being appropriately advised of the expected benefits and possible consequences of those decisions.

(c) The agency shall inform each beneficiary, legal guardian, and primary caregiver, as applicable, of their rights and of the responsibilities of the agency in a language or format that is understood by the child/youth or young adult and his or her primary caregiver and legal guardian.

#### § 10:77-4.6 Program description

(a) Behavioral assistance shall be delivered in accordance with a plan of care approved by the Department of Human Services, Children and Families, or a designated agent of either Department, which has been prepared by the responsible case management function, including, but not limited to, the care management organization, the contracted system administrator, and mobile response agencies.

(b) Behavioral assistance is a dynamic process of intervention and ongoing evaluation resulting in effective modification of the identified behavior(s). Behavioral assistance shall be delivered in accordance with an individualized behavioral intervention plan that is based upon an evaluation of the identified behavior(s), which includes recommendations for specific interventions with definable outcomes and strategies and, developed in accordance with *N.J.A.C. 10:77-4.7* and any applicable rules of the Department of Children and Families.

(c) Behavioral assistance services shall include applying positive behavioral principles within community and culturally based norms to reduce undesirable behaviors and build appropriate behaviors that are rehabilitative and restorative in nature, resulting in durable and sustainable positive behavioral changes and improvement in functionality and quality of life. Behavioral assistance focuses on creating and sustaining environments that improve lifestyle changes by making problem behavior less effective and less relevant and the desired behavior more effective and relevant.

(d) Behavioral assistance services shall also include interaction and instruction, provided individually or in a group setting, with the child/youth or young adult's family and caregiver(s) to enable them to provide the necessary support to the child/youth or young adult to attain the goals of the service plan and sustain the positive behavioral changes and improvement in functionality and quality of life.

1. Behavioral assistance services provided in a group setting may be provided to the family member(s) and/or caregiver(s) of up to three children/youth or young adults in one session.

(e) Behavioral assistance services shall be clinically supervised, face-to-face behavioral healthcare interventions for children, youth, young adults and/or their families/caregivers in support of the child/youth or young adult that are designed to be rehabilitative and restorative in nature, with the goal of strengthening skills in a variety of life domains, including, but not limited to:

1. Physical and mental well being;
2. Interpersonal communications and relationships;
3. Social interactions;
4. Behavioral conduct;
5. Adaptive coping strategies and behaviors; and
6. Recreational/leisure activities.

(f) Behavioral assistance shall not include mentoring, tutoring, companionship, or other similar services which do not require clinical supervision, a plan of care, or behavioral assistance services in order to achieve the goals and objectives established in the child/youth or young adult's behavioral assistance service plan.

(g) Behavioral assistance services shall be provided either individually or in a group of up to three children/youth or young adults, as appropriate to the needs of the child.

(h) Behavioral assistance services shall be delivered in community-based, clinically appropriate settings that are convenient to the child or youth and his or her family. These services shall not be provided in an office setting, hospital or JCAHO-accredited residential treatment center.

1. For the purposes of this requirement, "providing services in an office setting" describes a concept whereby the provider is requiring the beneficiary to come to the provider for services rather than the provider rendering services to the child, youth or young adult in their natural environment. Examples are listed below:

i. The family, child, youth, or young adult is not comfortable meeting in their home and asks the provider to meet them at a local community center or church recreation hall. The community center or church agrees to provide a room for such a meeting. This is not considered an office setting, since the provider is meeting the family/beneficiary at the local community center or church recreation hall at the family's/beneficiary's request.

ii. Services provided to a child while the child is in a run away shelter and the staff of the run away shelter center offers the use of an empty office so that the child and the professional providing the behavioral assistance services can have a private conversation. As in the example above, this is not considered "providing services in an office setting," even though the staff and the child were physically in an "office" located in the building. The provider is rendering services to the child in the place where the child is currently residing, that is, the current home of the child.

iii. The provider has access to office space in a community setting, such as a YMCA or a church's community youth center, and children are scheduled to receive services and are required to come to that site to receive the intensive in-community services. This is considered "providing services in an office setting."

2. Services provided in any office of the provider shall not be reimbursed as behavioral health rehabilitation services. These services shall be reimbursed under the applicable Medicaid/NJ FamilyCare provider rules which describe reimbursement for services rendered in the provider's office.

3. Behavioral assistance services shall not be provided to a child, youth or young adult who is in a Joint Committee on Accreditation of Healthcare Organization (JCAHO)-accredited residential treatment center (see *N.J.A.C. 10:75*).

i. Behavioral assistance services shall only be rendered to a child, youth or young adult who resides in a JCAHO-accredited residential treatment center while the child is on an approved therapeutic leave from the facility. Behavioral assistance services shall not be provided on-site in a JCAHO-accredited residential treatment center.

4. Behavioral assistance services should not, and are not normally, provided to children, youth or young adults in other residential mental health rehabilitation facilities, including, but not limited to, group homes, psychiatric community residences for youth and residential child care centers (see *N.J.A.C. 10:77*) if the residential reimbursement includes these services. However, there may be exceptional circumstances in which these services are clinically required to help support the facility to admit the child into their program. These services are intended to be short-term and shall be clinically justified by the provider or the care management entity and prior authorized by the contracted systems administrator.

i. Behavioral assistance services can be rendered to a child, youth or young adult who resides in other types of residential mental health rehabilitation facilities while the child is on an approved therapeutic leave from the facility.

#### § 10:77-4.7 Individualized behavioral assistance service plan

(a) Each beneficiary receiving behavioral assistance services shall have a documented individual behavioral assistance service plan that is based on an evaluation of the identified behavior(s) which includes recommendations for specific interventions with definable outcomes and strategies and delivered in a culturally competent, family friendly manner and implemented with sufficient intensity and precision to produce behavioral gains that have a significant and durable positive impact on the child's quality of life.

(b) All evaluations of identified behaviors shall be completed by professionals who have, at a minimum, a bachelor's degree in social work, counseling, psychology or psychiatric nursing and at least one year of experience in analyzing behaviors and designing behavioral assistance plans. Individuals performing the evaluations shall function under the supervision of the clinical supervisor. All evaluations shall be approved by a licensed clinical professional prior to the implementation of the child/youth or young adult's behavioral assistance service plan. Licensed clinical professional staff are not precluded from performing these evaluations if they have the relevant experience and skills; however, if they need the assistance of a behavioral assistance specialist to assist in the review, the evaluator shall meet the standards described above.

(c) The evaluation analyzes the identified behavior(s) and includes recommendations for specific interventions with definable outcomes and strategies. The evaluation, whenever possible, shall focus on prevention and early identification of problem behaviors. The completed evaluation generates an individually tailored intervention plan that matches



the functions of the problem behaviors and incorporates generally accepted professional intervention models.

(d) For those children/youth and young adults receiving care management organization (CMO) services, the evaluation of the identified behavior(s) and subsequent behavioral assistance plan shall be included as part of the child's individualized service plan (ISP) prepared by the Child/Family Team. For all other children receiving behavioral assistance services, the plan of care shall be approved by the CSA or other agents designated by the Department of Human Services or Children and Families, prior to implementation. This plan of care shall include, at a minimum:

1. An evaluation of the identified behavior(s);
2. Defined and measurable goals and time frames as related to the goal;
3. Specific intervention techniques;
4. How the child/youth or young adult and his or her family/caregiver will access supportive services;
5. An implementation plan with provisions to train caregivers and other relevant parties who have regular contact with the child in environments where the behavior may be displayed in order to promote sustainability;
6. A process for ongoing monitoring and evaluation;
7. Quarterly progress reviews that include an onsite observation of the implementation of the plan; and
8. Ongoing monitoring/evaluation of the interventions that focus on determining the integrity with which the plan is delivered and the effectiveness of the plan in modifying the identified target behaviors through direct observation of the implementation of the plan.

(e) The evaluation of the identified behavior(s) shall be used in a proactive manner and shall focus on prevention and early intervention of problem behaviors to determine the variables that maintain, contribute to and/or reinforce problem behaviors.

(f) Each individual behavioral assistance service plan shall include specific interventions with definable outcomes, identified strategies, how those strategies will be implemented and by whom the strategies will be implemented, provisions to assure sustainability and normalization and a plan to monitor the defined interventions and evaluate the progress toward defined outcomes.

(g) Each individual behavioral assistance service plan shall incorporate the use of culturally sensitive assessments and interventions and shall be comprised of, at a minimum, interventions that consider the context within which the behavior occurs, address the functionality of the problem behavior and contains interventions that can be justified by outcomes that are acceptable to the child, the family and the child and family's environmental context.

(a) Behavioral assistance services shall be provided only in conjunction with other treatment, rehabilitative and social support services as part of a coordinated and authorized plan of care as described in *N.J.A.C. 10:77-4.7*.

(b) Effective for dates of service on or after January 1, 2004, behavioral assistance services shall be prior authorized by the CSA.

(c) Service utilization and continuing care criteria shall be determined by the CSA or other agent(s) designated by the Department to review the progress of the child/youth or young adult toward achieving the goals as defined in the individual behavioral assistance services plan.

#### § 10:77-4.9 Staffing requirements

(a) Behavioral assistance services shall be provided directly by, or under the supervision of, individuals who are licensed clinicians, who, at a minimum, are licensed in a behavioral health field including, but not limited to, social work, counseling, psychology or psychiatric nursing and are authorized, within the scope of their practice, to assume responsibility for the provision or supervision of these services.

(b) Agencies providing behavioral assistance services shall designate an individual to function as the program supervisor. The program supervisor shall have, at a minimum, a Master's degree in an appropriate behavioral health field, two years post-graduate experience working directly with emotionally disturbed children and their families and one year of post-graduate administrative experience in an agency providing services to children.

(c) Agencies, group practices and other service providers providing behavioral assistance services shall assure that the individual rendering the service is provided with appropriate clinical supervision. The individual providing clinical supervision shall be employed by the provider entity and shall be a licensed mental health professional, who shall have, at a minimum, a Master's degree in an appropriate behavioral health field and one year of experience in child welfare, children's mental health, special education, or a related public sector human services or behavioral health field working with at risk children and families. The person providing the clinical supervision must be clinically and culturally competent/responsive with training and experience necessary to manage complex cases in the community across child serving systems.

(d) The agency, group practices or other service provider entity must ensure that the evaluation of identified behavior(s) which includes recommendations for specific interventions with definable outcomes and strategies is provided in accordance with the requirements of *N.J.A.C. 10:77-4.7*.

(e) All direct care staff shall, at a minimum, have a high school diploma or equivalent, be 21 years old and have a minimum of one year relevant experience in a comparable environment and shall be supervised by appropriate clinical staff in accordance with this subchapter.

(f) All employees shall have a valid driver's license if his or her job functions include the operation of a vehicle used in the transportation of the children/youth or young adults. Transportation is not a covered behavioral assistance service.

(g) All employees having direct contact with and/or rendering behavioral assistance services directly to the beneficiaries shall be required to successfully complete criminal background checks.

#### § 10:77-4.10 Staff responsibilities

(a) The provider shall be responsible for supervising the overall daily management of all facets of the program, including, but not limited to, assuring:

1. That all provider policies and procedures appropriately reflect the needs of the individuals being served, are implemented according to the service model as described in this subchapter, and are adhered to and revised when necessary;

2. That provider policies and procedures are in place regarding the safety and well being of the individual receiving services when the transportation and care of the individual outside of the individual's place of residence is necessary;

3. That all services are provided within the context of the service description and the individualized behavioral assistance service plan;

4. That all service delivery hours are designed to meet the flexible needs of the families served;

5. That the clinical supervisor maintains a system of clinical recordkeeping and a monitoring system that includes, at a minimum, the provision for periodic case reviews with all relevant staff, sign-off on progress notes, incident reports, and case plans and goals;

6. That monitoring of the completion and quality of progress notes for each case contact was done by all staff;

7. That the confidentiality of all records is maintained;

8. That the documentation of periodic performance reviews for all staff is in place;

9. That there is access to supervision of staff 24 hours a day, seven days per week by a licensed or credentialed mental health clinician;

10. That there is delivery of, and staff participation in, ongoing training programs, including staff development, that address the needs of the staff and of the children and families being served;

11. That the provider meets all MIS, Quality Assurance and outcome specifications for provider reimbursement, as provided by the DHS or the CSA; and

12. That criminal background checks are successfully completed on any employee who will have direct contact with children.

(b) Face to face clinical supervision shall be provided to the direct care staff for a minimum of one hour for every 40 hours worked. One hour of face-to-face clinical

supervision shall be provided a minimum of once a month for those direct care staff who work less than 40 hours a month.

(c) The clinical supervision shall ensure that an evaluation of the identified behavior(s) which includes recommendations for specific interventions with definable outcomes and strategies is completed and individual service plans are developed in accordance with *N.J.A.C. 10:77-4.7*.

(d) Direct care staff shall not deliver behavioral interventions beyond their skills, experience and applicable State licensure/certification in accordance with applicable statutes and rules.

#### § 10:77-4.11 Reimbursement

(a) Reimbursement for behavioral assistance services shall be fee-for-service.

(b) All reimbursements shall be restricted to approved Medicaid/NJ FamilyCare providers and shall be subject to Medicaid/NJ FamilyCare regulations.

1. Behavioral assistance services rendered in a location which does not meet Title XIX (*42 U.S.C. § 1396a*) requirements as a reimbursable service site shall be reimbursed if it is a part of the approved treatment plan of the child/youth or young adult using the HCPCS code S5125. See *N.J.A.C. 10:77-7.2(c)*.

(c) Providers use the appropriate Healthcare Common Procedure Codes (HCPCS) for the service provided. See *N.J.A.C. 10:77-7.2(c)*.

(d) A unit of service shall be defined as 15 consecutive minutes of face-to-face services provided to an individual. Non-consecutive shorter time periods may not be added together to total 15 minutes.

1. Time spent providing behavioral assistance services to a beneficiary while being transported shall be included in the units of service if a staff member other than the driver provided the therapeutic service while in the vehicle.

2. Non-therapeutic services, including, but not limited to, simple transportation, mentoring, respite care, educational tutoring, and non-therapeutic recreational activities shall not be reimbursed as behavioral assistance services by the Medicaid/NJ FamilyCare program.

3. Services shall be billed individually for each eligible member of a group receiving behavioral assistance services.

4. Reimbursement shall be provided for behavioral assistance services rendered to the child/youth or young adult's parent or caregiver as described in *N.J.A.C. 10:77-4.6(d)*.

(e) Reimbursement for behavioral assistance services shall be provided in conjunction with other mental health rehabilitation services provided that each service is a distinct service with its own purpose, goal and expected outcome and is delivered in accordance with an approved plan of care.

(f) The provision of clinical supervision to the direct care workers shall not be separately reimbursed.

(g) Behavioral assistance services that are under the scope of a Direct Care staff shall not be reimbursed at an increased rate if delivered by a clinical staff person.

(h) If the professional providing clinical supervision or other licensed behavioral healthcare practitioner accompanies the direct care worker to a service delivery site for the purpose of providing separate and distinct services to another beneficiary at the same location, those separate and distinct behavioral assistance services shall be eligible for reimbursement at the base rate for the service.

#### § 10:77-4.12 Required records for each beneficiary

(a) Each provider entity shall maintain all records in accordance with Departmental contract rules (see *N.J.A.C. 10:3*) and in compliance with appropriate Federal and State laws, regulations and rules, including, but not limited to, *N.J.A.C. 10:49-9.8*.

(b) Providers shall keep such individual and legible records as are necessary to fully disclose the nature and extent of the services provided in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. 104-191, August 1996.

(c) Providers shall maintain any information required by the Department of Human Services, Children and Families, the designee of either Department, the contracted system administrator or the care management organization for services rendered to a child receiving DCBHS services, including, but not limited to, the outcome measures listed in *N.J.A.C. 10:77-4.10*.

(d) Providers shall maintain the following data in support of all behavioral assistance services claims:

1. The name and address of the beneficiary;
2. The name and title of the individual providing the service;
3. The exact date(s), location(s) and time(s) of service;
4. The type of activity/service provided in accordance with the goals of the service plan; and
5. The length of face-to-face contact, excluding travel time to or from the location of the beneficiary contact.

(e) The provider shall maintain an individual service record for each child/youth or young adult which shall contain, at a minimum, the following information:

1. The dates of service and the number of care hours received;
2. The diagnosis provided with initial referral;
3. The reason for referral and involvement;
4. The individual behavioral assistance service plan;

5. Documentation of any and all crisis or emergency situations that occur during the provision of the services, including a summary of the corrective action taken and resolution of the situation; and

6. Weekly quantifiable progress notes toward defined goals as stipulated in the child/youth or young adult's BASP.

(f) All providers shall meet all Management Information Systems specifications as provided by the contracted system administrator (CSA) or other Department of Human Services or Children and Families-designated agent.

(g) Providers shall make the records described in (a) through (f) above available to the Department of Human Services, the Division of Medical Assistance and Health Services, the Division of Mental Health Services, the Department of Children and Families, the Division of Youth and Family Services, the Division of Child Behavioral Health Services, the contracted system administrator, or other authorized State agents, as requested.

#### § 10:77-4.13 System outcomes

(a) A provider entity providing behavioral assistance services shall deliver those services in accordance with the child/youth or young adult's plan of care and shall participate in studies related to consumer satisfaction developed by the Department of Human Services, Children and Families, or the contracted system administrator.

(b) This information shall be made available on a regular basis to the Department of Human Services, Children and Families, and/or the contracted system administrator.

(c) At a minimum, the provider entity shall maintain a record of the following information for each beneficiary for whom services are provided in a manner prescribed by the Department of Human Services, Children and Families, or the designated contract agent of either Department:

1. A complete service record as described in *N.J.A.C. 10:77-4.12(e)*;
2. A record of services required other than behavioral assistance services;
3. Frequency of staff changes for each beneficiary;
4. Level of beneficiary satisfaction for each service; and
5. Degree of improvement in the beneficiary's ability to function at home, in school, in the community and/or on the job, as applicable.

#### § 10:77-4.14 General provider recordkeeping requirements

(a) To qualify for Medicaid/NJ FamilyCare reimbursement, approved Medicaid/NJ FamilyCare enrolled behavioral assistance providers shall retain, in a secure location, and in compliance with all applicable laws and regulations, confidential information related to the individuals providing or supervising the provision of behavioral assistance services and

shall produce the information for the Department of Human Services, Children and Families or any authorized agents of either Department, in an orderly fashion on demand.

(b) For licensed clinical staff members of the agency, the following information shall be maintained:

1. Verified written documentation of the supervising licensed behavioral healthcare practitioner's credentials and any other adjunct staff involved with the direct administration and/or delivery of this service as appropriate, including, at a minimum:

i. His or her current and valid license number authorizing him or her to practice in New Jersey and the state where services are delivered; and

ii. Verified written documentation of his or her experience working with children; and

2. Updates or changes regarding all information required in (b)1 above. All such updates shall be forwarded to DHS and DCF by the provider within 10 days of receipt of the updated information. Updated information shall include, but not be limited to, additional continuing education units obtained, change of name and/or address, any action against licensure, and any criminal charges.

(c) For the direct care staff employed by the agency, the following information shall be maintained:

1. A copy of the direct care staff person's high school diploma or equivalent;

2. A copy of the direct care staff person's proof of age at the date of hiring;

3. Verified written documentation, including dates, of the direct care staff person's relevant experience in a comparable in community environment;

4. Verified written documentation of the direct care staff person's successful completion of any Behavioral Health Assistance Rehabilitation Services training required by the Department of Children and Families; and

5. Verified written documentation of the direct care worker's receipt of direct clinical supervision by a licensed behavioral healthcare practitioner in accordance with *N.J.A.C. 10:77-4.10(b)*, including the total number of hours of supervision received.

(d) In addition to the specific records required to be maintained for specific staff, the following information shall also be maintained for all individuals providing or supervising the provision of behavioral assistance services:

1. A copy of his or her current valid driver's license, if driving is required to fulfill the responsibilities of the job; and

2. Verified written documentation of successful completion of a criminal background check conducted by a recognized and reputable search organization for all staff having direct contact with children.

## SUBCHAPTER 5. INTENSIVE IN-COMMUNITY MENTAL HEALTH REHABILITATION SERVICES

### § 10:77-5.1 Purpose and scope

(a) This subchapter sets forth the manner in which intensive in-community mental health rehabilitation services (intensive in-community services) shall be provided, through community-based provider entities, to eligible Medicaid/NJ FamilyCare and Department of Children and Families' (DCF) Division of Child Behavioral Health Services beneficiaries under age 21.

(b) This subchapter describes intensive in-community services as one component of the continuum of mental health care services provided through the Division of Child Behavioral Health Services. Intensive in-community services are provided as part of an integrated service plan, addressing the unique needs of the child, youth or young adult and his or her family/caregiver with the goal of stabilizing and maintaining the child, youth or young adult in the community and averting the need for more intensive services, including, but not limited to, treatment in residential or other inpatient settings.

### § 10:77-5.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context indicates otherwise:

"Intensive in-community mental health rehabilitation services" means an array of mental health rehabilitation services delivered in community-based settings, not in provider offices or office settings, which address symptom reduction, and are restorative and preventative in nature. These services target problem solving and strengthening adaptive and coping skills that restore or maintain the child, youth or young adult's ability to function in the community. These services are provided as part of an approved plan of care and encompass a variety of mental health services, including, but not limited to, group, individual or family therapy, allied behavioral therapies and modalities, clinical consultation/evaluation, instruction in anger management, parenting skills, problem solving and stress reduction techniques, psycho-educational services and counseling.

### § 10:77-5.3 Provider participation requirements

(a) Providers of intensive in-community mental health rehabilitation services shall be providers that are licensed in New Jersey to provide medical/mental health services or a medical/mental health practice or other agency that includes the appropriate licensed practitioners who can provide, or supervise the provision of, services. Examples of appropriate provider agencies, include, but are not limited to:

1. Acute care or psychiatric hospitals;



2. Joint Committee on Accreditation of Healthcare Organization (JCAHO)-accredited residential treatment centers (see *N.J.A.C. 10:77-5.6(f)*);

3. Licensed group homes or childcare residential providers;

4. Psychiatric community residences for youth;

5. Home health agencies;

6. Mental health clinics or any other licensed clinics;

7. Federally qualified health centers; or

8. Other entities licensed by a State of New Jersey governmental agency to provide physical or mental health services in New Jersey.

(b) Provider entities rendering intensive in-community mental health rehabilitation services shall employ at least one of the following practitioners licensed in accordance with the following specified rules:

1. A psychiatrist (*N.J.A.C. 13:35*);

2. A psychologist (*N.J.A.C. 13:42*);

3. An advance practice nurse (mental health) (*N.J.A.C. 13:37-7*);

4. A licensed clinical social worker (*N.J.A.C. 13:44G*); or

5. A professional licensed in accordance with the Board of Marriage and Family Therapy Examiners (*N.J.A.C. 13:34*) including, but not limited to:

i. A licensed marriage and family therapist (*N.J.A.C. 13:34-4*);

ii. A licensed professional counselor (*N.J.A.C. 13:34-11* or *12*);

iii. A clinical mental health counselor (*N.J.A.C. 13:34-14*); or

iv. A rehabilitation counselor (*N.J.A.C. 13:34-21* or *22*).

(c) Providers of intensive in-community services shall have demonstrated experience, or shall employ individuals with demonstrated experience, in providing services to children with serious emotional or behavioral health challenges and their families, including, but not limited to, appropriate qualifications and training to provide services in the context of other presenting problems. All providers shall first be certified by the DCF Division of Child Behavioral Health Services as meeting these criteria prior to being enrolled as a Medicaid/NJ FamilyCare provider of intensive in-community services.

(d) Provider entities rendering intensive in-community mental health rehabilitation services shall employ appropriate and sufficient staff to comply with the administrative oversight, clinical supervision and service provision and monitoring requirements of this subchapter and of all appropriate licensing requirements.

(e) In order to participate as a Medicaid/NJ FamilyCare/Division of Child Behavioral Health Services provider of intensive in-community mental health rehabilitation services, a provider must apply to, and be approved by, the New Jersey Medicaid/NJ FamilyCare fee-for-service program as a provider of intensive in-community mental health rehabilitation services. Providers who are enrolled as other provider types in the Medicaid/NJ

FamilyCare program shall complete a separate application for this service. A provider with multiple locations shall submit a separate application for each county in which an office is located.

(f) All applicants shall complete and submit a provider application to:

Department of Children and Families  
PO Box 717  
Trenton, NJ 08625-0717  
Attn: DCBHS Provider Enrollment Unit

(g) The applicant shall include a current and valid copy of all staff and provider license(s) with the provider application.

(h) The applicant shall receive written notification of approval or disapproval of provider status. If approved, the applicant shall be enrolled as a Medicaid/NJ FamilyCare provider and shall be assigned a unique provider number for each approved application to use when requesting reimbursement for the provision of intensive in-community mental health rehabilitation services. Providers shall receive a copy of the provider manual and the fiscal agent billing supplement.

(i) Upon approval as a Medicaid/NJ FamilyCare provider, providers of intensive in-community services shall, at all times, maintain compliance with all applicable State and Federal laws, rules and regulations, including, but not limited to, all provisions of this subchapter, *N.J.A.C. 10:49*, and any applicable rules of the Department of Children and Families.

(j) If a provider receives notification that they are no longer approved by the DCF Division of Child Behavioral Health Services, the provider shall notify the Division of Medical Assistance and Health Services at the address below within 10 business days.

Division of Medical Assistance and Health Services  
Office of Provider Enrollment  
PO Box 712  
Trenton, NJ 08625-0712

(k) If the provider is no longer approved by the DCF Division of Child Behavioral Health Services, the provider shall be immediately disenrolled as a Medicaid/NJ FamilyCare provider of intensive in-community mental health rehabilitation services until such time as the Division has been notified by the Director of the Division of Child Behavioral Health Services that the provider should be reinstated as a Medicaid/NJ FamilyCare provider of intensive in-community mental health rehabilitation services.

(l) The provider shall forward updates or changes regarding provider information to the Department and the Medicaid Provider Enrollment Office at the addresses in (f) and (j) above, respectively, within 10 days of the provider's receipt of the updated information. Updated information shall include, but shall not be limited to: change of provider name and/or address; any change in the licensed staff employed by an agency; any action against licensure of the agency or of any individual staff member or any criminal charges against the agency or any individual staff member. The agency shall provide the

Department of Children and Families' Division of Child Behavioral Health Services and the Department of Human Services' Division of Medical Assistance and Health Services copies of the new license as part of this notification.

(m) An intensive in-community provider may be held liable for recoupment of any monies paid for services rendered during the time that the provider of services did not possess a valid license or did not meet any other qualifications as outlined in this subchapter.

#### § 10:77-5.4 Beneficiary eligibility

(a) Eligible children, youth or young adults shall be:

1. Enrolled in Medicaid/NJ FamilyCare; or
2. Children, youth or young adults who are ineligible for Medicaid/NJ FamilyCare but who are receiving services from DCF's Division of Child Behavioral Health Services.

(b) Children, youth and young adults are eligible for services under this subchapter if the services have been determined necessary for rehabilitative purposes by the contracted system administrator for the Division of Child Behavioral Health Services, or any contracted and authorized agent of the Department of Children and Families or Human Services, including the Division of Mental Health Services, the Division of Youth and Family Services, or the Division of Medical Assistance and Health Services.

#### § 10:77-5.5 Beneficiary rights

(a) Any provider entity providing intensive in-community mental health rehabilitation services shall demonstrate regard for the rights of the child, youth or young adult and their families/caregivers to exercise choice of provider. Service providers shall communicate with the child, youth or young adult in a language or format that is understood by all parties. Services shall be culturally sensitive, integrated, coordinated and provided in the least restrictive setting appropriate to the child's individual needs.

(b) The provider shall deliver services in a manner that includes the child, youth or young adult, primary caregiver, parent/legal guardian and Family Support Organization (FSO) representative in service planning and permits the maximum freedom of choice by the beneficiary in all areas of their lives, including, but not limited to:

1. Fully informing the child, youth or young adult and his or her parent/legal guardian or caregiver of all service options, and the benefits of those options; and
2. Allowing the child, youth or young adult and/or his or her parent/legal guardian or caregiver to participate in all decision-making processes about the services they receive, and to be appropriately advised of the expected benefits and possible consequences of those decisions.

(c) The agency shall inform each beneficiary, parent/legal guardian, and primary caregiver, as applicable, of their rights and of the responsibilities of the agency in a language or format that is understood by the individual to whom they are providing the information.

(d) The provider entity shall include the beneficiary, primary caregiver, parent/legal guardian and other relevant individuals in all phases of service planning, as appropriate.

#### § 10:77-5.6 General program description

(a) Intensive in-community mental health rehabilitation services are intensive community-based and family-centered mental health services delivered as a defined set of interventions, within the context of an approved plan of care and are restorative or preventative in nature. These services are geared toward improving or stabilizing the child, youth or young adult's level of functioning within the home and community in order to prevent, decrease or eliminate behaviors or conditions that may lead to or that may place the child, youth or young adult at increased clinical risk, or that may impact on the ability of the child, youth or young adult to function in their home, school or community. These services encompass a variety of mental health rehabilitative services including, but not limited to, group, individual or family therapy, allied behavioral therapies and modalities, clinical consultation, evaluation and counseling.

(b) Intensive in-community services shall be provided either individually or in a group of up to three children/youth or young adults, as appropriate to the needs of the child.

(c) Intensive in-community services shall also include interaction and instruction, provided individually or in a small group setting, to the child, youth or young adult's family and caregiver(s) to enable them to provide the necessary support to the child, youth or young adult to attain the goals of the service plan and sustain the positive behavioral changes and improvement in functionality and quality of life.

1. Intensive in-community services provided in a group setting may be provided to the family member(s) and/or caregiver(s) of up to three children/youth or young adults in one session.

(d) Intensive in-community mental health rehabilitation services may include, but are not limited to, the following interventions:

1. Clinical consultation/evaluation/assessment;
2. Counseling;
3. Group, individual or family therapy;
4. Anger management;
5. Parenting skill development;
6. Stress reduction;
7. Symptom reduction;

8. Problem solving skill development;

9. Adaptive and coping skills; and

10. Psycho-educational instruction related to mental health, including, but not limited to, improved decision-making skills to manage behavior and reduce risk behaviors.

(e) Intensive in-community mental health rehabilitation services shall be goal-oriented and focused, and are intended to support the needs of the child, youth or young adult and his or her family/caregiver to remain in the community. Intensive in-community services are intended to be time-limited interventions that support the child and family in the community while the child and family are connected with office-based practitioner services or as a short term adjunct to office-based practitioner services in order to support the child/family in their current living arrangement.

(f) Intensive in-community mental health rehabilitation services shall be delivered in community-based, clinically appropriate settings that are convenient to the child or youth and his or her family. Intensive in-community mental health rehabilitation services shall be available on a 24-hour basis, seven days per week. These outreach services shall not be provided in an office setting, hospital or Joint Committee on Accreditation of Healthcare Organizations (JCAHO)-accredited residential treatment center, nor should they supplant existing services.

1. For the purposes of this requirement, "providing services in an office setting" describes a concept, whereby the provider is requiring the beneficiary to come to the provider for services rather than the provider rendering services to the child, youth or young adult in their natural environment. Examples are listed below:

i. The family, child, youth, or young adult is not comfortable meeting in their home and asks the provider to meet them at a local community center or church recreation hall. The community center or church agrees to provide a room for such a meeting. This is not considered an office setting, since the provider is meeting the family/beneficiary at the church or recreation center at the family's/beneficiary's request.

ii. Services provided to a child while the child is in a run away shelter and the staff of the runaway shelter center offers the use of an empty office so that the child and the professional providing the behavioral assistance services can have a private conversation. As in the example above, this is not considered "providing services in an office setting," even though the staff and the child were physically in an "office" located in the building. The provider is rendering services to the child in the place where the child is currently residing, that is, the current home of the child.

iii. The provider has access to office space in a community setting, such as a YMCA or a church's community youth center, and children are scheduled to receive services and are required to come to that site to receive the intensive in-community services. This is considered "providing services in an office setting."

2. Services provided in any office of the provider shall not be reimbursed as behavioral health rehabilitation services. These services shall be reimbursed under the applicable Medicaid/NJ FamilyCare provider rules which describe reimbursement for services rendered in the provider's office.

3. Intensive in-community mental health rehabilitation services cannot be provided to a child, youth or young adult who is in a JCAHO-accredited residential treatment center (see *N.J.A.C. 10:75*).

i. Intensive in-community mental health rehabilitation services can be rendered to a child, youth or young adult who resides in a JCAHO-accredited residential treatment center only while the child is on an approved therapeutic leave from the facility; services cannot be provided on-site.

4. Intensive in-community mental health rehabilitation services cannot normally be provided to children, youth or young adults in other residential mental health rehabilitation facilities, including, but not limited to, group homes, psychiatric community residences for youth and residential child care centers (see *N.J.A.C. 10:77*) if the residential reimbursement includes these services. However, there may be exceptional circumstances in which these services are clinically required to help support the facility to admit the child into their program. These services are intended to be short-term and must be clinically justified by the provider or the care management entity and prior authorized by the contracted systems administrator.

i. Intensive in-community mental health rehabilitation services can be rendered to a child, youth or young adult who resides in other types of residential mental health rehabilitation facilities while the child is on an approved therapeutic leave from the facility.

(g) Intensive in-community mental health rehabilitation services shall be provided directly by mental health professionals that are licensed, or under the supervision of a licensed clinician.

#### § 10:77-5.7 Program description: levels of service

(a) The level of intensive in-community services provided shall be determined as part of the planning process of the individual service plan and shall be based on an assessment of need, a clinical evaluation and medical necessity. Such assessment shall determine the amount, duration and level and type of clinical intervention and professional support. There are three levels of intensive in-community services:

1. Supportive services (intensive in-community services that can be delivered by a bachelor's level direct care provider);

2. Professional services (intensive in-community services delivered by a master's level direct care provider); and

3. Clinical services (intensive in-community services delivered by a clinically licensed behavioral health care practitioner).

(b) Supportive services shall be delivered by individuals with a minimum of a bachelor's degree in a related field, including, but not limited to, social work, psychology, counseling or nursing and one year of relevant experience working with children and families with mental health needs. Supportive services shall be provided under the direct clinical supervision of a licensed behavioral health care practitioner, who within the scope of his or

her practice, is licensed to provide, or supervise the provision of, services. The direct service provider shall receive a minimum of one hour of direct clinical supervision for every 40 hours of work. For those direct service providers who work less than 40 hours a month, one hour of face-to-face clinical supervision shall be provided a minimum of once a month.

1. Supportive services provide time-limited face-to-face behavioral stabilization and support interventions as an adjunct to support clinical professional services or as a stand-alone service as part of a step-down/discharge plan of care, including, but not limited to, one or more of the following:

- i. Instruction in anger management skills;
- ii. Parenting skill development;
- iii. Instructions in stress reduction techniques;
- iv. Problem solving skill development;
- v. Psycho-educational services related to mental health including, but not limited to, improved decision-making skills to manage behavior and reduce risk behaviors; or
- vi. Referral to other necessary services and supports.

2. Supportive level services are concrete, outcome-oriented, time-limited and are components of an approved, written, detailed plan of care that has been prepared by a clinically licensed behavioral health care practitioner.

3. Supportive level services shall be delivered on site in the community at locations appropriate for the specific intervention which are convenient for the child, youth or young adult and/or his or her family.

4. Bachelor's level direct care providers may not provide interventions requiring skills, experience, credentials and licensure other than those allowed under the appropriate licensing regulations.

(c) Professional services shall be delivered by individuals with a minimum of a master's degree in related field including, but not limited to, social work, psychology, counseling or nursing and one year of relevant experience working with children and families with mental health needs. Professional services shall be provided under the direct clinical supervision of a licensed behavioral health care practitioner, who, within the scope of his or her practice, is licensed to provide, or supervise the provision of, services. The direct service provider shall receive a minimum of one hour of clinical supervision for every 40 hours of work. For those direct service providers who work less than 40 hours a month, one hour of face-to-face clinical supervision shall be provided a minimum of once a month.

1. Professional services are time-limited, clinically supervised, face-to-face interventions focused on behavior modification and symptom reduction, including, but not limited to, one or more of the following:

- i. Individual or family therapy;
- ii. Allied behavioral therapies and modalities, including, but not limited to, play therapy, art therapy, drama therapy, and/or music therapy;

- iii. Clinical consultation/evaluation;
- iv. Psycho-educational instruction related to mental health; and
- v. Counseling services.

2. Professional level services are concrete, outcome-oriented and are components of an approved, written, detailed plan of care that has been prepared by a clinically licensed behavioral health care practitioner.

3. Professional level direct care providers may not provide interventions requiring skills, experience, credentials and licensure other than those allowed under appropriate licensing regulations.

(d) Clinical services shall be delivered by a licensed clinical professional, including, but not limited to, a psychiatrist, a psychologist, an advanced practice nurse, a licensed clinical social worker or a mental health professional licensed in accordance with the Board of Marriage and Family Therapy Examiners (*N.J.A.C. 13:34*), who, within the scope of his or her practice, is authorized to provide or supervise the provision of mental health services. Clinical-level intensive in-community services may include, but are not limited to, all services described at (c) above, provided without additional clinical supervision. Clinical services shall be targeted to children and families requiring a more clinically intensive level of service provision, based upon clinical evaluation and determination of need. All services shall be provided by professionals with the appropriate licensure and/or specialty certification in accordance with all State rules and statutes.

(e) Services may be provided at any level by professionals whose credentials exceed the minimum requirements for that service level; however, increased reimbursement shall not be provided. More than one level of intensive in-community services may be provided to an individual child, youth or young adult and/or his or her family under the same approved plan of care if:

- 1. Each service is a distinct service with its own purpose, goal and expected outcome;
- 2. Each service is included in an approved, written, detailed plan of care developed by a licensed behavioral health care practitioner;
- 3. Each service is delivered under the direct clinical supervision of a clinically licensed behavioral health care professional as required; and
- 4. Each service is delivered at a separate time.

(f) Discrete interventions may be provided separately to the child/youth/young adult and the family caregiver at the same time, if they are clinically indicated and are included in the approved plan of care. For example, an approved family counseling session may be provided to the family/caregiver with the child/youth/young adult not present, while the child/youth/young adult is receiving a separate support intervention.

§ 10:77-5.8 Individual intensive in-community service plan



(a) Each child, youth or young adult receiving intensive in-community mental health rehabilitation services shall have an approved, documented individual plan of care addressing the services. The plan shall be individually tailored to address identified behavior(s) that impact on the child/youth/young adult's ability to function at home, school or in the community, and shall incorporate generally accepted professional interventions. The plan of care shall be authorized by the Department of Children and Families, the contracted system administrator or other authorized DCF designated agent(s).

1. For those children, youth and young adults receiving care management organization (CMO) services, this plan shall be included as part of the child's CMO individual service plan (ISP) prepared by the Child/Family Team.

2. For all other Division of Child Behavioral Health Services-enrolled children, youth or young adults receiving intensive in-community mental health rehabilitation services, this plan of care shall be included in the comprehensive plan of care as coordinated and/or authorized by the CSA or other agent designated by the Department of Human Services, prior to implementation.

(b) Each individual plan of care shall include specific interventions with definable outcomes, identified strategies, specified time frames, the credentials of the person(s) rendering the services, and provisions to assure sustainability and normalization.

#### § 10:77-5.9 Staff requirements

(a) The individual(s) responsible for administrative oversight of the program shall have, at a minimum, a master's degree in social work or in a relevant discipline including, but not limited to, counseling, psychology or psychiatric nursing, and a minimum of three years of post-graduate experience in the delivery of mental health services to families and children. The administrative oversight duties and the clinical supervision described in (b) above may be provided by the same individual. At a minimum, administrative oversight responsibilities shall include:

1. The overall daily management of all facets of the program, including, but not limited to, the referral process, staffing, supervision of caseloads, case consultation and quality assurance;

2. Ensuring that all work hours are designed to meet the flexible needs of the families served and that access to services are provided 24 hours a day, seven days per week;

3. Ensuring clinical supervision of all appropriate service staff;

4. Ensuring that the individual(s) responsible for providing clinical supervision maintain a system of clinical recordkeeping and a monitoring system that includes, at a minimum, the provision for case reviews and a sign-off on progress notes;

5. Ensuring access to supervisory staff 24 hours a day, seven days per week; and

6. Ensuring that all information required or requested by the Department of Human Services or other authorized contract agent, including, but not limited to, Management

Information Systems, Quality Assurance and system outcome data are provided in the manner required or requested.

(b) Clinical supervision shall be provided by a licensed mental health professional, who, within the scope of his or her practice, is licensed to provide or supervise the provision of service. The individual providing clinical supervision shall have, at a minimum, a master's degree in social work or other relevant human service field and applicable training, certification or experience if working with a specialized population. The clinical supervisor shall also have, at a minimum, one year of relevant experience in the provision of mental health services to children and families and experience in child welfare, children's mental health, special education or a related human services or behavioral health field working with children and families. Experience shall include crisis de-escalation and therapeutic intervention in home and off site with children and families.

(c) The individual(s) providing clinical supervision to individuals rendering intensive in-community mental health rehabilitation services shall have experience in delivering the services as designed, and, at a minimum, have the ability to:

1. Assess the risk to child and family, child and family mental health, understand family functioning, including child and adolescent development;

2. Develop, in partnership with the child and family, a treatment plan that effectively addresses the family's needs in a culturally sensitive manner;

3. Recognize family strengths, needs, environmental and family stresses, and help families identify and utilize these strengths to assist and design and implement strategies to resolve family issues or crises; and

4. Promote timely resolution of the presenting problems/behaviors and the development of an aftercare plan that includes referrals to other appropriate provider entities.

(d) All staff shall meet all training and licensure requirements for their practice specialty or profession as set forth by New Jersey statutes and rules.

(e) All staff members coming into direct contact with the children, youth or young adults shall successfully complete a criminal background check.

(f) All employees shall have a valid driver's license if his or her job functions include the operation of a vehicle used in the transportation of the children, youth or young adults or their family or caregiver. Transportation is not considered a separately reimbursable intensive in-community service; however, if the provider is rendering other therapeutic interventions in the vehicle while operating the vehicle, the provider must have a valid driver's license.

#### § 10:77-5.10 Authorization for services

(a) Intensive in-community mental health rehabilitation services shall be provided only in conjunction with other mental health treatment, rehabilitative and social support services

as part of an individualized service plan authorized by the contracted system administrator or other authorized agent of the Department of Human Services or Children and Families.

(b) Effective for dates of service on or after January 1, 2004, intensive in-community mental health rehabilitation services included in the individual service plan of a Medicaid/NJ FamilyCare-Plan A child, youth or young adult or any other NJ FamilyCare-Plan child, youth or young adult who is receiving services under Division of Child Behavioral Health Services programs shall be subject to prior authorization by the CSA.

(c) Authorization for service utilization and continuing care shall be determined by the CSA and shall be based upon the individual needs of the child, youth or young adult receiving services.

(d) Requests for authorization for service utilization and continuing care shall include justification of the need for the level of service intervention, the frequency of the intervention, and the period of time the intervention is needed. Such justification shall be provided for the initial request as well as for each request for continued services beyond the initial authorization.

#### § 10:77-5.11 Reimbursement

(a) Reimbursement for intensive in-community mental health rehabilitation services shall be fee-for-service, based on the level of service required.

(b) All reimbursements shall be restricted to approved Medicaid/NJ FamilyCare providers and are subject to all Medicaid/NJ FamilyCare regulations.

(c) Providers shall seek reimbursement for each separate unit of service using the appropriate Healthcare Common Procedure Coding System (HCPCS) for the service provided. See *N.J.A.C. 10:77-7.2(e)*.

(d) A unit of service shall be defined as 15 minutes of face-to-face therapeutic services provided to an individual. Non-consecutive shorter time periods may not be added together to total 15 minutes.

1. Time spent providing intensive in-community services to a beneficiary while being transported shall be included in the units of service if a staff member other than the driver provided the therapeutic service while in the vehicle. Travel time to and from the location of beneficiary contact shall not be included in the units of service.

2. Non-therapeutic services, including, but not limited to, simple transportation, mentoring, respite care, educational tutoring, and non-therapeutic recreational activities shall not be reimbursed as intensive in-community services by the Medicaid/NJ FamilyCare program.

(e) Reimbursement shall be provided for intensive in-community services rendered to the child/youth or young adult's parent or caregiver as described in *N.J.A.C. 10:77-5.6(b)*.

(f) Services shall be billed individually for each eligible member of a group receiving intensive in-community services in accordance with the child's authorized plan of care.

(g) The provision of clinical supervision to the direct care workers shall not be separately reimbursed.

(h) Intensive in-community services that are within the scope of a direct care staff person shall not be reimbursed at an increased rate, if delivered by a clinical staff person.

(i) If the professional providing clinical supervision or other licensed behavioral health care practitioner accompanies the direct care worker to a service delivery site for the purpose of providing separate and distinct services to another beneficiary or to another family/caregiver as a support for the beneficiary at the same location, those separate and distinct intensive in-community services shall be eligible for reimbursement at the authorized level of service.

#### § 10:77-5.12 Recordkeeping; beneficiary information

(a) Each provider entity shall maintain all beneficiary records in compliance with appropriate State law and rules (see *N.J.A.C. 10:49-9.8*).

(b) Providers shall keep such individual and legible records as are necessary to fully disclose the nature and extent of the services provided in accordance with all applicable Federal and State requirements.

(c) Providers shall make the records described in (a) and (b) above available to the Department of Human Services, the Division of Medical Assistance and Health Services, the Division of Mental Health Services, the Department of Children and Families, the Division of Child Behavioral Health Services, the Division of Youth and Family Services, the contracted system administrator, or other authorized State agents, as requested.

(d) Providers shall maintain the following data in support of all intensive in-community mental health rehabilitation services claims:

1. The name and address of the beneficiary;
2. The name and credentials of the person(s) providing the service;
3. The exact date(s), location(s) and time(s) of service;
4. The type of the service(s) provided; and
5. The length of face-to-face contact, excluding travel time to or from the location of the beneficiary contact.

(e) The provider shall maintain an individual service record for each child, youth or young adult which shall contain, at a minimum, the following information:

1. The dates of service and number of care hours, per level of service, received;
2. The diagnosis provided with the initial referral;
3. The reason for initial referral and involvement;
4. The individual plan of care, including any amendments;

5. Documentation of any and all crisis or emergency situations that occur during the provision of the services, including a summary of corrective action taken and resolution of the situation; and

6. For each discrete contact with the child/family, progress notes which address the defined goals stipulated in the child/youth or young adult's plan of care must be completed.

(f) All providers shall meet all Management Information Systems specifications as provided by the CSA or other Department of Human Services or Children and Families-designated agent.

#### § 10:77-5.13 Outcomes

(a) A provider entity providing intensive in-community mental health rehabilitation services shall deliver those services in accordance with the child/youth or young adult's plan of care and shall participate in studies related to consumer satisfaction developed by the Department of Human Services, Children and Families or the contracted system administrator.

(b) This information shall be made available on a regular basis to the Department of Human Services, Children and Families and/or the contracted system administrator.

(c) At a minimum, the provider entity shall maintain a record of the following information for each beneficiary for whom services are provided in a manner prescribed by the Department of Human Services, Children and Families or the designated contract agent of either Department:

1. A complete service record as described in *N.J.A.C. 10:77-5.12(e)*;
2. A record of services other than intensive in-community mental health rehabilitation services required;
3. The frequency of staff changes for each beneficiary;
4. The level of beneficiary satisfaction for each service; and
5. The degree of improvement in the beneficiary's ability to function at home, in school, in the community and/or on the job, as applicable.

#### § 10:77-5.14 General provider recordkeeping requirements

(a) Approved Medicaid/NJ FamilyCare enrolled intensive in-community mental health rehabilitation providers shall retain, in a secure location, and in compliance with all applicable Federal and State laws and regulations, confidential information related to the individuals providing or supervising the provision of services and shall produce the information for the Department of Human Services, Children and Families, or any authorized agents of either Department, in an orderly fashion on demand.

(b) For licensed clinical staff members of the agency, the following information shall be maintained:

1. Verifiable written documentation of the supervising licensed behavioral health care practitioner's credentials and any other adjunct staff involved with the direct administration and/or delivery of this service as appropriate, including, at a minimum:

i. His or her current and valid license number authorizing him or her to practice in New Jersey and the state where services are delivered; and

ii. Verifiable written documentation of his or her experience working with the target population; and

2. Updates or changes regarding all information required in (b)1 above.

(c) For non-licensed direct care staff employed by the agency, the following information shall be maintained:

1. Proof of minimum education requirements;

2. Verifiable written documentation, including dates, of relevant experience with a comparable target population;

3. Verifiable written documentation of the direct care staff person's successful completion of any training required by the Department of Human Services or Children and Families; and

4. Verifiable written documentation of clinical supervision by a licensed behavioral health care practitioner, including the total number of hours of supervision received and the type of supervision provided, including, but not limited to, general, face-to-face, group, in-service or review of care records.

(d) In addition to the specific records required to be maintained for specific staff, the following information shall also be maintained for all individuals providing, or supervising the provision of, intensive in-community mental health rehabilitation services:

1. A copy of his or her current valid driver's license, if job duties include transportation of children, youth or young adults or their families/caregivers; and

2. Verifiable written documentation of successful completion of a criminal background check conducted by a recognized and reputable search organization for all staff having direct contact with children.

## SUBCHAPTER 6. MOBILE RESPONSE AND STABILIZATION MANAGEMENT SERVICES

### § 10:77-6.1 Purpose and scope

(a) This subchapter sets forth the manner in which mobile response and stabilization management services shall be provided to eligible children and youth up to 18 years of age and young adults 18 to 21 receiving services under the Department of Children and Families' Division of Child Behavioral Health Services, who are experiencing emotional or behavioral health challenges, placing them at risk of losing their current living arrangement.

(b) Mobile response services provide face-to-face response by a local response team 24 hours a day, 365 days a year, by trained professional team member(s) who is/are qualified to assess, stabilize the presenting crisis situation and respond to the child/youth or young adult's needs.

### § 10:77-6.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Authorization" means the authorization and the authorization number provided by the Contracted Systems Administrator or other agency authorized by the Department, in accordance with *N.J.A.C. 10:77-6.8*, allowing for reimbursement for services to be provided. This number is obtained before a provider requests reimbursement for a service.

"Collateral contact" means activities the provider engages in on behalf of the child, youth or young adult to advocate for, link to, coordinate and monitor the services included in the individualized crisis plan.

"Crisis bed" means an available bed in a psychiatric community residence for youth, group home or residential childcare facility (see *N.J.A.C. 10:77-3*) for the temporary placement (not to exceed seven days) of a child/youth or young adult who is in crisis.

"Individualized crisis plan (ICP)" means a crisis stabilization management plan that identifies target behaviors to be addressed, defines desired outcomes and develops and implements necessary mental/behavioral health services, for the initial mobile response period, and, if indicated, a period of up to eight weeks, to stabilize the presenting crisis situation. The ICP includes linking the child, youth or young adult with ongoing formal and informal mental/behavioral health services and other services in the community after the presenting situation has been stabilized.

"Mobile response services" means the time-limited, intensive, therapeutic and rehabilitative crisis intervention and stabilization management services provided for the initial 72 hours after the referral is received from the contract systems administrator.

"Prior authorization" means an authorization, and an authorization number, provided by the Division of Medical Assistance and Health Services, the Contracted Systems Administrator or other agency authorized by the Department, in accordance with *N.J.A.C. 10:77-6.8*, allowing for services to be rendered. This number is obtained before a provider renders a service to ensure appropriate reimbursement is received.

"Stabilization management services" means the development, monitoring, coordinating and implementing of an individualized crisis plan (ICP), for up to eight weeks subsequent to the initial 72 hours, to ensure the stabilization of the situation. The development and implementation of the ICP includes advocacy and networking to provide linkages and referrals to appropriate community-based services to aid the child, youth or young adult and his or her family in accessing other benefits or assistance programs for which they may be eligible.

#### § 10:77-6.3 Provider participation requirements

(a) In order to participate as a Medicaid/NJ FamilyCare/Division of Child Behavioral Health Services provider of children's mobile response and stabilization management services, a provider must apply to, and be approved by, the New Jersey Medicaid/NJ FamilyCare fee-for-service program as a mobile response agency, in accordance with the provisions of this subchapter. Providers who are enrolled as other provider types in the Medicaid/NJ FamilyCare program shall complete a separate application to enroll as a mobile response agency.

(b) Children's mobile response and stabilization management services providers shall be approved by the Division of Child Behavioral Health Services and under contract with the Department of Children and Families as a mobile response agency. Such contract shall be in full effect and not suspended or terminated.

(c) All applicants shall complete and submit a provider application to:

Department of Children and Families  
PO Box 717  
Trenton, NJ 08625-0717  
Attn: DCBHS Provider Enrollment Unit

(d) The applicant shall receive notification of approval or disapproval of provider status as determined by DCBHS. If approved, the applicant shall be enrolled as a Medicaid/NJ FamilyCare provider and shall be assigned a unique provider number for seeking reimbursement for the provision of mobile response and stabilization management services. All approved and enrolled providers shall receive a copy of the provider manual and the fiscal agent billing supplement.

(e) Providers of children's mobile response and stabilization management services shall, at all times, maintain compliance with all applicable State and Federal laws, rules and regulations, including *N.J.A.C. 10:49*, this subchapter and any applicable Department of Children and Families rules.



(f) If a provider receives notification that the provider is no longer approved by DCBHS, or if the provider receives notice that its contract with the Department of Children and Families is in default status or has been suspended or terminated for any reason, the provider shall notify the Division of Medical Assistance and Health Services at the address below within 10 business days.

Division of Medical Assistance and Health Services  
Office of Provider Enrollment  
PO Box 712  
Trenton, NJ 08625-0712

(g) If the provider's contract with the Department of Children and Families is in default status or has been suspended or terminated for any reason, or if the provider is no longer approved by the Division of Child Behavioral Health Services, the provider shall be immediately disenrolled as a Medicaid/NJ FamilyCare mobile response and stabilization management services provider until such time as the Department of Children and Families contract is renewed or reinstated and the Division of Medical Assistance and Health Services has been notified by the Director of the Division of Child Behavioral Health Services that the provider should be reinstated as a Medicaid/NJ FamilyCare mobile response and stabilization management services provider.

#### § 10:77-6.4 Staff requirements

(a) Mobile response and stabilization management services shall be delivered directly by, or under the supervision of, a licensed behavioral clinician, who, at a minimum:

1. Is licensed in a behavioral health field, including, but not limited to: psychiatry, social work, counseling, psychology or psychiatric nursing;
2. Has three and one-half years applicable clinical and supervisory experience; and
3. Has the authority to directly provide, or supervise the provision of, these services within the scope of their practice, as defined by applicable New Jersey State statute and regulation.

(b) The direct care staff of the mobile response agency shall, at a minimum:

1. Possess a bachelor's degree in a behavioral health or related human services field, such as social work, counseling or psychology and have a minimum of one year related field work experience; or
2. Possess a master's degree in a behavioral health or related human services field.

#### § 10:77-6.5 Eligibility for services

(a) Children, youth and young adults are eligible for mobile response and stabilization management services under this subchapter if the services have been determined necessary by the Department of Human Services or Children and Families, any authorized

Division of either Department or any contracted agent of either Department authorized to assess the need for these services.

(b) Children, youth or young adults are eligible to receive mobile response and stabilization management services as described in this subchapter if they are:

1. Covered under Medicaid/NJ FamilyCare; or
2. Are ineligible for Medicaid or any NJ FamilyCare program and receiving services from the Division of Child Behavioral Health Services only.

#### § 10:77-6.6 Processing Medicaid/NJ FamilyCare eligibility applications

(a) All mobile response agencies shall designate a Medicaid presumptive eligibility (PE) coordinator and assure that this individual and all appropriate staff complete DMAHS PE training prior to completing any PE applications.

(b) Mobile response and stabilization management services include eligibility processing activities.

1. Mobile crisis response services shall include:

i. Completing a Medicaid/NJ FamilyCare Presumptive Eligibility (PE) application for each child, youth and young adult who are not Medicaid/NJ FamilyCare beneficiaries at the time of referral if this process has not already been initiated by another entity; and

ii. Submitting the completed PE application to DMAHS.

2. Stabilization management services shall include:

i. Assisting the child, youth or young adult and his or her family/caregiver in collecting the documentation required to complete and submit a Medicaid/NJ FamilyCare application within 30 days of referral for stabilization management services if this process has not already been initiated by another entity;

ii. Regularly reviewing eligibility factors for each child, youth or young adult and assisting the child, youth or young adult and/or his or her family in applying for any and all benefits for which they may be eligible, including, but not limited to, Medicaid and NJ FamilyCare; and

iii. Assisting the child, youth or young adult and/or his or her family in maintaining eligibility for Medicaid, NJ FamilyCare and other benefits, including, if applicable, assisting the beneficiary in obtaining any additional information needed for annual redeterminations of eligibility for services.

#### § 10:77-6.7 Mobile crisis response services; program description and agency responsibilities

(a) Mobile crisis response services shall be provided in the first 72 hours, spanning up to four days after the initial referral/dispatch, and shall include, but shall not be limited to:

1. Mobile outreach services;
2. Assessment and evaluation of the presenting crisis that shall include an assessment of child and community safety, caregiver capability, and clinical risk;
3. Clinical interventions to stabilize the presenting crisis;
4. Temporary placement (not to exceed seven days) in a community residence for youth, group home or residential childcare facility;
5. The development of an individualized crisis plan (ICP); and
6. Providing information to the family support organization (FSO), as appropriate.

(b) Mobile response services shall be targeted toward the stabilization of the presenting behaviors and situation, with the goal of preventing a disruption of current living arrangement, inappropriate psychiatric hospitalization or residential placement.

(c) Mobile response services shall be available 24 hours a day, seven days a week, and shall be rendered by a mobile response team wherever the need presents, including, but not limited to, the child's home, other living arrangement or other location in the community.

1. Mobile response services shall not be eligible for reimbursement if provided in an acute care hospital, a JCAHO accredited inpatient psychiatric hospital, or other JCAHO accredited residential facility, although an initial referral to a mobile response agency may be made prior to the child's discharge from the facility.

i. If the mobile response agency receives a referral for a child in an acute care hospital, a JCAHO accredited inpatient psychiatric hospital, or other JCAHO accredited residential facility, the 72-hour timetable shall begin upon referral. The first date of service on the claim shall be the date the child is discharged from the facility, with the last date indicating the end of the 72-hour period of service. Providers will receive reimbursement for one unit of service, which may cover less than 72 hours of service provided to the child outside the residential facility.

2. Initial face-to-face contact with the beneficiary and/or his or her family/caregiver by the mobile response team member(s) shall occur within 24 hours of the initial referral. However, for those situations determined to require an immediate response by the team, face-to-face contact shall be made within one hour unless a delay is requested by the family to meet the family's needs, for example, the family requests that the team member(s) be at the residence when the child returns from school that afternoon.

(d) The mobile response agency shall develop an individualized crisis plan (ICP) for the child/youth or young adult and his or her family/caregiver with the goal of stabilizing the presenting crisis situation. The mobile response agency shall develop the ICP after the initial contact with the child/youth or young adult and his or her family/caregiver and shall register the ICP with the contracted system administrator within 24 hours. At a minimum, the ICP shall include:

1. Appropriate therapeutic interventions to address the presenting problem and stabilize the situation; and

2. A transition plan, which shall include a plan to manage and coordinate the ICP subsequent to the initial 72 hours, including referrals for appropriate services, based on the individual situation, to be provided during the crisis stabilization period.

i. The transition plan for children, youth or young adults receiving CMO or YCM services shall reflect a discharge back to the CMO or YCM agency at the end of the mobile crisis response episode.

ii. The transition plan for children, youth or young adults who are not receiving CMO or YCM services and who do not require stabilization management services subsequent to the mobile response services shall include a discharge summary.

§ 10:77-6.8 Stabilization management services; program description and agency responsibilities

(a) Upon transition from mobile crisis response services, stabilization management services for children, youth or young adults who are receiving services from the Division of Child Behavioral Health Services but who are not receiving CMO or YCM services shall be provided by the mobile response agency in order to monitor and coordinate ongoing care and services.

(b) During the period of stabilization management services, the CSA and a designated representative from the mobile response agency shall review the individualized crisis plan (ICP), to ensure that the services included are effectively addressing the presenting issues. Amendments to the ICP shall be registered with the CSA within 24 hours.

1. For a child, youth or young adult who is temporarily placed in a crisis bed in a community residential mental health rehabilitation facility, the need for continued stay in the crisis bed shall be reviewed and documented by the mobile response agency during placement, which shall not exceed seven days, with appropriate amendments to the ICP as indicated.

2. For a child, youth or young adult receiving on-going stabilization management services, the ICP shall be reviewed by the mobile response agency a minimum of once per week. Stabilization management services shall be authorized by the CSA up to eight weeks. (See *N.J.A.C. 10:77-6.9*.)

(c) Services included in the ICP during the stabilization management period may include, but shall not be limited to:

1. Continued monitoring of the temporary placement of a child in a crisis bed located in a group home, a psychiatric community residence, or residential treatment center after the initial 72 hours;

2. Necessary mental/behavioral clinical interventions to stabilize the crisis, including, but not limited to: psychiatric services, medication management, psychological, community-based mental health rehabilitation services including, but not limited to, behavioral assistance services and intensive in-community services, or other formal or informal community-based mental health/behavioral health rehabilitation services; and

3. Continued advocacy and networking by the mobile response agency to provide linkages and referrals to appropriate community-based services and assisting the child, youth or young adult and his or her family/caregiver in accessing other benefits or assistance programs for which they may be eligible.

(d) The ICP shall include a transition plan that links the child to clinical behavioral and emotional services, formal and informal community supports and linkages with appropriate system partners subsequent to the period of stabilization management services. These services may include, but are not limited to, residential or other community-based mental/behavioral health rehabilitation services.

(e) For children, youth or young adults who are receiving care management organization (CMO) or youth case management (YCM) services, stabilization management services shall be provided by the CMO or YCM and shall not be reimbursable to the mobile response agency.

#### § 10:77-6.9 Authorization for services

(a) Initial response services shall be limited to 72 hours per episode, beginning at the start of the initial referral/dispatch and spanning up to four days, and shall be registered with the CSA. The CSA shall provide an authorization number upon registration of the initial plan, which shall be used by the mobile response agency when requesting reimbursement. Crisis response services may be provided immediately after receiving the referral from the CSA prior to receiving the authorization number.

(b) The stabilization management services provided by the mobile response agency, subsequent to the initial 72 hours, shall require authorization by the CSA. The CSA will authorize stabilization management services up to a maximum of eight weeks.

(c) For children, youth or young adults receiving care management organization (CMO) or youth case management (YCM) services, mobile crisis response services shall be authorized for the initial 72-hour period only. Stabilization management services for those receiving CMO or YCM services shall be included in the CMO's individualized service plan in accordance with *N.J.A.C. 10:73-3.12* or the individual YCM service plan in accordance with *N.J.A.C. 10:73-4.8*.

#### § 10:77-6.10 Reimbursement

(a) Reimbursement for mobile response services shall be fee-for-service. For the first 72 hours of service, a flat fee-for-service rate per episode shall be provided and shall cover all the services provided during this time period except for temporary placement in a community residence for youth, group home or residential childcare facility. Reimbursement for temporary placement shall be provided directly to the facility in which the child, youth or young adult is placed. Providers shall bill one unit of service per episode.

1. Mobile response services provided to children, youth or young adults who were discharged into the community from receiving mobile response services within three days of the last billable episode shall be provided by the mobile response agency without additional reimbursement.

2. Mobile response services provided to a child, youth or young adult who had been discharged from receiving stabilization management services shall initiate a new course of treatment, beginning with mobile response services, and shall be reimbursed accordingly.

(b) Stabilization management services provided after the first 72 hours, for a period not to exceed eight weeks, shall be fee-for-service and shall cover only the mobile response agency's monitoring and management of the child, youth or young adult's ICP. The unit of service shall be 15 minutes of continuous services provided directly to, or on behalf of, the child, youth or young adult, including collateral contacts and activities necessary to develop, implement, coordinate, monitor and support the ICP. The provider may bill for a maximum of 64 units (16 hours) over the eight-week period, as authorized by the CSA. The provider shall bill only for the amount of time actually provided for stabilization management on each date of service.

(c) For children, youth or young adults receiving care management organization (CMO) or youth case management (YCM) services, mobile crisis response services may be provided by a mobile response agency (see *N.J.A.C. 10:77-6.6*) for up to 72 hours, spanning up to four days. For children, youth or young adults receiving CMO or YCM services, stabilization management services shall be included in the individualized service plan developed and implemented by the CMO or YCM agency. Reimbursement for stabilization management services for children, youth and young adults who are receiving CMO or YCM services shall not be made to mobile response agencies.

(d) Individual Medicaid/NJ FamilyCare enrolled providers rendering services included in the authorized ICP shall receive reimbursement in accordance with the provider-specific rules relative to their provider type, including, but not limited to, meeting all provider qualification, prior authorization and service delivery requirements.

#### § 10:77-6.11 Required records for each beneficiary

(a) Each provider entity shall maintain all records in accordance with Department of Human Services contract rules (see *N.J.A.C. 10:3*) and in compliance with appropriate Federal and State laws, regulations and rules, including, but not limited to, *N.J.A.C. 10:49-9.8*, and any applicable rules of the Department of Children and Families.

(b) Providers shall maintain any and all information required by the Department of Human Services, Children and Families, or authorized designee of either Department, or the contracted system administrator for services rendered to a child receiving services from the Division of Child Behavioral Health Services.

(c) Providers shall maintain the following data in support of all mobile response services claims:

1. The name and address of the beneficiary;

2. The name and title of the individual providing the service;
3. The exact date(s), location(s) and time(s) of service; and
4. The length of face-to-face contact, excluding travel time to or from the location of the beneficiary contact.

(d) Providers shall maintain the following data in support of all stabilization management claims:

1. The name and address of the beneficiary;
2. The name and title of the individual providing the service;
3. The exact date(s), location(s) and time(s) of service;
4. The type of activity/service provided in accordance with, or in support of, the goals of the service plan; and
5. The length of face-to-face contact, excluding travel time to or from the location of the beneficiary contact.

(e) The provider shall maintain an individual service record for each child/youth or young adult, which shall contain, at a minimum, the following information:

1. The dates of service and the number of care hours received;
2. The child, youth or young adult's diagnosis;
3. The reason for referral and involvement;
4. The original, and all amendments to, the individualized service plan;
5. Documentation of any and all crisis or emergency situations that occur during the provision of stabilization management services (if applicable), including a summary of the corrective action taken and resolution of the situation; and
6. Weekly quantifiable progress notes toward defined goals as stipulated in the child/youth or young adult's service plan.

(f) All providers shall meet all Management Information Systems specifications as provided by the contracted system administrator (CSA) or other Department of Human Services or Children and Families-designated agent.

(g) Providers shall make the records described in (a) through (f) above available to the Department of Human Services, the Division of Medical Assistance and Health Services, the Division of Mental Health Services, the Department of Children and Families, the Division of Child Behavioral Health Services, the Division of Youth and Family Services, the contracted system administrator, or other authorized State agents, as requested.

#### § 10:77-6.12 General provider recordkeeping requirements

(a) Medicaid/NJ FamilyCare enrolled mobile response agencies shall retain, in a secure location, and in compliance with all applicable Federal and State laws, rules and regulations, confidential information related to the employees providing mobile response

services or stabilization management services as described in this subchapter and shall produce the information for the Department of Human Services, Children and Families or any State-authorized agents, in an orderly fashion on demand.

(b) For licensed clinical staff members of the agency, the following information shall be maintained:

1. Verifiable written documentation of the supervising licensed behavioral healthcare practitioner's credentials and any other adjunct staff involved with the direct administration and/or delivery of this service as appropriate, including, at a minimum:

i. His or her current and valid license number authorizing him or her to practice in New Jersey and the state where services are delivered; and

ii. Verifiable written documentation of his or her experience working with children; and

2. Updates or changes regarding all information required in (b)1 above, which shall be forwarded to DHS and DCF by the provider within 10 days of receipt of the updated information. Updated information shall include, but shall not be limited to, additional continuing education units obtained, change of provider name and/or address, any action against licensure of the provider, and any criminal charges.

(c) For the direct care staff employed by the agency, the following information shall be maintained:

1. A copy of the direct care staff person's educational credentials;

2. Verifiable written documentation, including dates, of the direct care staff person's relevant experience in a comparable in community environment; and

3. Verifiable written documentation of the direct care worker's receipt of direct clinical supervision by a licensed behavioral healthcare practitioner.

(d) In addition to the specific records required to be maintained for specific staff, the following information shall also be maintained for all individuals providing or supervising the provision of services:

1. A copy of his or her current valid driver's license, if the operation of a motor vehicle is required to fulfill the responsibilities of the job; and

2. Verifiable written documentation of successful completion of a criminal background check conducted by a recognized and reputable search organization for all staff having direct contact with children.



## SUBCHAPTER 7. CENTERS FOR MEDICARE & MEDICAID SERVICES' HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

*N.J.A.C. 10:77-7.1 (2008)*

### § 10:77-7.1 Introduction

(a) The New Jersey Medicaid NJ FamilyCare programs utilize the Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology (CPT) architecture, employing a five-position code and as many as two 2-position modifiers. CPT is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical procedures and services performed by physicians. Unlike the CPT numeric design, the CMS-assigned codes and modifiers contain alphabetic characters. The New Jersey Medicaid/NJ FamilyCare program adopted the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System codes for 2006, established and maintained by CMS in accordance with the Health Insurance Portability and Accountability Act of 1996, *42 USC §§1320d et seq.*, and incorporated herein by reference, as amended and supplemented, and published by PMIC, 4727 Wilshire Blvd., Suite 300, Los Angeles, CA 90010. Revisions to the Healthcare Common Procedure Coding System made by CMS (code additions, code deletions and replacement codes) will be reflected in this chapter through publication of a notice of administrative change in the New Jersey Register. Revisions to existing reimbursement amounts specified by the Department and specification of new reimbursement amounts for new codes will be made by rulemaking in accordance with the Administrative Procedure Act, *N.J.S.A. 52:14B-1 et seq.*

(b) HCPCS was developed as a three-level coding system:

1. LEVEL I CODES (narratives found in CPT): These codes are adapted from CPT for utilization primarily by physicians, podiatrists, optometrists, certified nurse-midwives, certified nurse practitioners/clinical nurse specialists, independent clinics and independent laboratories. Copyright restrictions make it impossible to print excerpts from CPT procedure narratives for Level I codes. Thus, in order to determine those narratives, it is necessary to refer to CPT, which is incorporated herein by reference.

2. LEVEL II CODES: The narratives for Level II codes are found in this subchapter. These codes are not found in the CPT and are assigned by HCFA for use by physicians and other practitioners.

3. LEVEL III CODES: The narratives for Level III codes are found in this subchapter. These codes are assigned by the Division of Medical Assistance and Health Services to be used for those services, which are unique to the New Jersey Medicaid or NJ FamilyCare programs.

(c) Regarding specific elements of HCPCS codes, which require the attention of providers, the lists of HCPCS code numbers for rehabilitative services are arranged in tabular form with specific information for a code given under columns with titles, such as

"IND," "HCPCS Code," "MOD," "DESCRIPTION" and "MAXIMUM FEE ALLOWANCE." The information given under each column is summarized below:

1. "IND "--(Indicator) Lists alphabetic symbols used to refer provider to information concerning the New Jersey Medicaid/NJ FamilyCare program's qualifications and requirements when a HCPCS procedure code is used.

i. A "P" indicates that prior authorization is required for that procedure code. A valid authorization number must be included on the claim form when seeking reimbursement for the provision of the service.

2. "HCPCS Code"--Lists the HCPCS procedure code numbers;

3. "DESCRIPTION"--Code narrative: Narratives for Level III codes are found at *N.J.A.C. 10:77-7.2*;

4. "MAXIMUM FEE ALLOWANCE"--Lists the New Jersey Medicaid/NJ FamilyCare programs maximum fee allowance schedule. If the symbol "B.R." (By Report) is listed instead of a dollar amount, it means that additional information will be required in order to properly evaluate the service. Attach a copy of the report to the claim form. If the symbol "N.A." (Not Applicable) is listed instead of a dollar amount, it means that service is not reimbursable.

5. "MOD" services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances are identified by the addition of a two-digit code following the HCPCS procedure number. The New Jersey Medicaid/NJ FamilyCare program's recognized modifier codes for behavioral assistance services are as follows:

HQ: Services provided in a group setting.

TJ: Program group, child and/or adolescent.

UN: Group services; two patients served.

UP: Group services; three patients served.

U1: Level of care 1 - residential care supervision

U2: Level of care 2 - residential care supervision

U3: Level of care 3 - residential care supervision

(d) Listed below are both general and specific policies of the New Jersey Medicaid/NJ FamilyCare program that pertain to HCPCS:

1. When filing a claim, the appropriate HCPCS Codes shall be used in conjunction with modifiers, when applicable;

2. The use of a procedure code shall be interpreted by the New Jersey Medicaid/NJ FamilyCare program as evidence that the provider personally furnished, as a minimum, the service for which it stands;

3. When billing, the provider shall enter onto a CMS 1500 claim form, a CPT/HCPCS procedure code as listed in CPT or in this subchapter;

4. Date(s) of service(s) shall be indicated on the claim form and in the provider's own record for each service billed;

5. The "MAXIMUM FEE ALLOWANCE" as noted with these procedure codes represents the maximum amount a provider can be reimbursed for the given procedure;

i. All references to time parameters shall mean the provider's personal time in reference to the service rendered unless it is otherwise indicated. These procedure codes are all-inclusive for all procedures provided during that time;

6. Written records in substantiation of the use of a given procedure code shall be available for review and/or inspection if requested by the Division or its fiscal agent; and

7. Certain listed procedures are commonly carried out as an integral part of a total service, and, as such, do not warrant a separate charge. When "Separate Procedure" is attached to a HCPCS/CPT description, indicating that a procedure may be carried out as a separate entity not immediately related to a specific service, separate charges for the procedure and reimbursement are applicable.

§ 10:77-7.2 HCPCS procedure code numbers and maximum fee allowance schedule

(a) Environmental Lead Inspection Codes:

HCPCS Code	Description	Maximum Fee Allowance
Y 9733	Initial Inspection for Lead	\$ 260.00
Y 9734	Reinspection for Lead	100.00

Qualifier: Limit of two reinspections per primary residence per family

(b) Mental Health Rehabilitation Services provided in psychiatric community residences for youth, group homes or residential childcare facilities:

IND	HCPCS Code	MOD	Procedure Code Definition	Maximum Fee Allowance
P	H0018	TJ	Mobile Response-Crisis Bed. For services rendered in psychiatric community residences for youth, group homes or residential childcare facilities to a child, youth or young adult receiving mobile response and stabilization management services (per diem, not to exceed seven days)	\$ 50.00 per diem
	Y9933		Mental health rehabilitation services provided in non-JCAHO accredited residential treatment centers licensed as community psychiatric residences for youth licensed by the Division of	Contract Pricing

IND	HCPCS Code	MOD	Procedure Code Definition	Maximum Fee Allowance
	Y9934		Mental health rehabilitation services provided in therapeutic foster care facilities, licensed by the Division of Youth and Family Services, that contract with the Division of Mental Health services under N.J.A.C. 10:128.	Contract pricing
	Y9935		Mental health rehabilitation services provided in group homes (serving six to 12 children) licensed by the Division of Youth and Family Services, under N.J.A.C. 10:128.	Contract pricing
	Y9936		Mental health rehabilitation services provided in supervised transitional living homes licensed by the Division of Youth and Family Services, under N.J.A.C. 10:128.	Contract pricing
	Y9937		Mental health rehabilitation services provided in teaching family homes licensed by the Division of Youth and Family Services, under N.J.A.C. 10:128.	Contract pricing
	Y9938		Mental health rehabilitation services provided in treatment homes licensed by the Division of Youth and Family Services, under N.J.A.C. 10:128.	Contract pricing
	Y9939		Mental health rehabilitation services provided in alternative care homes licensed by the Division of Youth and Family Services, under N.J.A.C. 10:128.	Contract pricing
	Y9943		Mental health rehabilitation services provided in non-JCAHO residential child care facilities licensed by the Division of Youth and Family Services, under N.J.A.C. 10:127.	Contract pricing
	Y9944		Room and board for mental health rehabilitation services provided in facilities under contract with the Division of Youth and Family Services, under N.J.A.C. 10:127 and	Contract pricing

IND	HCP Code	MOD	Procedure Code Definition	Maximum Fee Allowance
	Y9945		10:128. Room and board for mental health rehabilitation services provided in facilities under contract with the Division of Mental Health Services, under N.J.A.C. 10:37B.	Contract pricing
	Y9946		All other room and board for mental health rehabilitation services.	Contract pricing
	Y9947		Mental health rehabilitation services provided in JCAHO accredited RTCs licensed by the Division of Mental Health Services, under N.J.A.C. 10:37B.	Contract pricing
	Y9948		Mental health rehabilitation services provided in JCAHO accredited RTCs licensed by the Division of Youth and Family Services, under N.J.A.C. 10:127.	Contract pricing
	Y9992		Therapeutic Leave for Rehabilitation Services provided in non-JCAHO accredited facilities under contract with DMHS	Contract pricing
	Y9993		Therapeutic Leave for Room and Board Board Services provided in non-JCAHO accredited facilities under contract with DMHS	Contract pricing
	Y9994		Hospital Leave for Rehabilitation Services provided in non-JCAHO accredited facilities under contract with DMHS	Contract pricing
	Y9995		Hospital Leave for Room and Board Services provided in non-JCAHO accredited facilities under contract with DMHS	Contract pricing
	Y9996		Therapeutic Leave for Rehabilitation Services provided in non-JCAHO accredited facilities under contract with DYFS	Contract pricing
	Y9997		Therapeutic Leave for Room and Board Board Services provided in non-JCAHO accredited facilities under contract with DYFS	Contract pricing
	Y9998		Hospital Leave for Rehabilitation	Contract

IND	HCPCS Code	MOD	Procedure Code Definition	Maximum Fee Allowance pricing
	Y9999		Hospital Leave for Room and Board Services provided in non-JCAHO accredited facilities under contract with DYFS	Contract pricing

(c) Behavioral Assistance Services Codes:

IND	HCPCS Code	MOD	Procedure Code Definition	Maximum Fee Allowance
P	H2014	TJ	Individual behavioral assistance services. (15-minute unit of service)	\$ 9.75 (\$ 39.00 per hour)
P	H2014	TJ UN	Group behavioral assistance services. Services are limited to those provided directly to, or in support of, two children/youth or young adults. (15-minute unit of service)	\$ 5.62/unit per child
P	H2014	TJ UP	Group behavioral assistance services. Services are limited to those provided directly to or in support of three children/youth or young adults. (15-minute unit of service)	\$ 4.25/unit per child
P	S5125	TJ	Individual behavioral assistance services in non-Title XIX eligible locations. (15-minute unit of service)	\$ 9.75 (\$ 39.00 per hour)
P	S5125	TJ UN	Small group behavioral assistance services in non-Title XIX eligible locations. Services are limited to those provided directly or in support of two children/youth or young adults. (15-minute unit of service)	\$ 5.62/unit per child
P	S5125	TJ UP	Small group behavioral assistance services in non-Title XIX eligible	\$ 4.25/unit per child

IND	HCP Code	MOD	Procedure Code Definition	Maximum Fee Allowance
			locations. Services are limited to those provided directly or in support of three children/youth or young adults. (15-minute unit of service)	

(d) Mobile response and stabilization management services codes:

IND	HCP Code	MOD	Procedure Code Definition	Maximum Fee Allowance
P	S9485	TJ	Mobile Response--Initial (one unit of service per episode, not to exceed 72 hours, spanning up to four days)	\$ 1,307 per unit of service
P	H0032	TJ	Mobile Response--Care Coordination and Stabilization Plan (15 minute units of service, not to exceed a total of 64 units or 16 hours, up to eight weeks as authorized weekly)	\$ 8.32 per unit of service

(e) Intensive in-community mental health rehabilitation services:

IND	HCP Code	MOD	Procedure Code Definition	Maximum Fee Allowance
P	H0036	TJ U3	Supportive service level (intensive in-community services delivered by, at a minimum, a bachelor's level direct care provider) Individual, 15 minute units of service	\$ 18.25 per unit of service. (\$ 73.00 per hour)
P	H0036	TJ HQ	Supportive service level (intensive in-community services delivered by, at a minimum, a bachelor's level direct care provider) Group, 15 minute units of service	Contract Pricing
P	H0036	TJ U2	Professional service level (intensive in-community services delivered by, at a minimum, a master's level direct care provider) Individual, 15 minute units of service	\$ 21.25 per unit of service. (\$ 85.00 per hour)

IND	HPCPS Code	MOD	Procedure Code Definition	Maximum Fee Allowance
P	H0036	TJ HQ	Professional service level (intensive in-community services delivered by, at a minimum, a master's level direct care provider) Group, 15 minute units of service	Contract Pricing
P	H0036	TJ U1	Clinical level services (intensive in-community services delivered by a licensed behavioral health care practitioner) Individual, 15 minute units of service	\$ 28.25 per unit of service. (\$ 113.00 per hour)
P	H0036	U1 UN	Clinical level services (intensive in-community services delivered by a licensed behavioral healthcare practitioner) Group services provided directly to, or in support of, two children, youth or young adults, 15-minute units of service.	\$ 19.00/unit per child
P	H0036	U1 UP	Clinical level services (intensive in-community services delivered by a licensed behavioral healthcare practitioner) Group services provided directly to, or in support of, three children, youth or young adults, 15 minute units of service.	\$ 15.91/unit per child



## APPENDIX

### FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as a part of this chapter but is not reproduced in the New Jersey Administrative Code. The Fiscal Agent Billing Supplement can be downloaded free of charge from: [www.njmmis.com](http://www.njmmis.com). When revisions are made to the Fiscal Agent Billing Supplement, a revised version will be posted on the njmmis website and copies will be filed with the Office of Administrative Law.

If you do not have access to the Internet and require a copy of the Fiscal Agent Billing Supplement, write to:

Unisys Corporation  
PO Box 4801  
Trenton, New Jersey 08650-4801

or contact:

Office of Administrative Law  
Quakerbridge Plaza, Bldg. 9  
PO Box 049  
Trenton, New Jersey 08625-004