

CHAPTER 77
REHABILITATIVE SERVICES

Authority

N.J.S.A. 30:4D-1 et seq. and 30:4D-7.

Source and Effective Date

R.1998 d.143, effective March 16, 1998.
See: 29 N.J.R. 543(a), 30 N.J.R. 1081(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:15B-5.1c, Chapter 77, Rehabilitative Services, expires on September 12, 2003. See: 34 N.J.R. 3467(a).

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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, rendered by a provider other than an independent clinic, a hospital, a long term care facility, a home health agency, or a physician/practitioner office, in accordance with the New Jersey Medicaid and NJ FamilyCare fee-for-service program rules.

(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 four 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 Medicaid-covered and NJ FamilyCare-covered mental health rehabilitation services for children.

4. N.J.A.C. 10:77-4 pertains to the Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS). The HCPCS contain procedure codes and maximum fee allowances corresponding to the Medicaid/NJ FamilyCare-reimbursable services of this chapter; and

5. 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.

Amended by R.2001 d.144, effective May 7, 2001.
See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).

Rewrote section.

Amended by R.2002 d.401, effective December 16, 2002.
See: 34 N.J.R. 2709(a), 34 N.J.R. 4441(b).

Substituted "FamilyCare" for "KidCare" throughout; in (c)2, inserted "and NJ FamilyCare-Plan A-covered".

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.

"Child" means a Medicaid beneficiary under 21 years of age.

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

“Rehabilitative service” is an optional service which 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.

“Local health department” (LHD) means the board of health of any municipality or the boards, bodies or officers in such municipality lawfully exercising any of the powers of a local board of health under the laws governing such 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 applying detection techniques and performing tests to assess the origins and extent of lead sources in the child’s primary residence.

SUBCHAPTER 2. ENVIRONMENTAL LEAD INSPECTION SERVICES

10:77-2.1 Scope of services

This subchapter describes the New Jersey Medicaid program’s provisions specifically pertaining to the rehabilitative service: environmental lead inspection service.

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 conduct an epidemiologic investigation in order to find lead sources.

“Elevated blood lead level” means an excess of lead in the bloodstream as defined in N.J.A.C. 8:44 and 8:44A.

“Environmental lead inspection service” means an epidemiologic investigation by a certified lead inspector/risk assessor in order to identify lead sources in the primary residence of a child who is a Medicaid beneficiary and who is determined to have an elevated blood lead level.

“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 1960 with peeling or chipping paint;
2. Lives in a house built before 1960 with recent, ongoing, or planned renovation or remodeling;
3. Has a brother, sister, or housemate being followed or treated for lead poisoning (that is, blood lead >15 Sg/dL); and/or
4. Lives with an adult whose occupation or hobby involves exposure to lead.

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. Local health departments (LHD) shall enroll and be approved by the New Jersey Medicaid program specifically for reimbursement for this service, including LHDs previously approved as Medicaid independent clinic providers;
3. Local health departments wishing to enroll as a Medicaid-participating provider for environmental lead inspection 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:

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

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

- iii. Upon approval as a Medicaid provider, the LHD will also conform to all the provisions of N.J.A.C. 10:49.

10:77-2.4 Environmental lead inspection services

(a) All Medicaid/NJ FamilyCare-Plan A beneficiaries up to six years 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. When the initial test is a capillary blood test indicating an elevated blood lead level, the findings shall be confirmed by a venous sample.

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 certain lead screenings.

2. The DHSS, in turn, through the "Environmental Investigation and Abatement Report Form" (AP-6), will notify the appropriate LHD of the need to conduct an environmental lead inspection of the child's primary residence;

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

(b) To be reimbursable as a rehabilitative service, the LHD's epidemiologic investigation to locate the source contaminants shall meet the following requirements:

1. The rehabilitative service-environmental lead inspection service shall be provided by LHDs and performed by certified lead inspectors/risk assessors whose certification shall be designated as a certified lead inspector/ risk assessor;

2. The inspections shall be an on-site investigation of the child's primary residence for the source(s) of lead contamination; and

3. The inspection/investigation shall include simple tests designed to locate lead sources and easily performed by the "certified lead inspector/risk assessor" on site.

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 results in a recommendation for remedial action, 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, then a second reinspection may be reimbursed.

2. A maximum of two reinspections may be reimbursable.

Amended by R.2002 d.401, effective December 16, 2002.

See: 34 N.J.R. 2709(a), 34 N.J.R. 4441(b).

Inserted "NJ FamilyCare-Plan" throughout.

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. 10:77-4.2(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, meaning one who is hired and certified by the State Department of Health and Senior Services to conduct epidemiologic investigations in order to find lead sources;

2. The service shall be provided in the primary residences of Medicaid/NJ FamilyCare-Plan A beneficiaries who are children identified as having elevated blood lead levels; 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 DHSS to the LHDs can be considered for reimbursement by Medicaid/NJ FamilyCare.

1. The provider shall request the beneficiary's Medicaid/NJ FamilyCare Eligibility Identification Card and verify eligibility for the date of service before submitting a claim.

2. The provider may verify Medicaid/NJ FamilyCare eligibility status of an individual by calling the "Recipient Verification Eligibility System" (REVS) at 1-(800) 676-6562, which will give a recorded message asking for the Medicaid/NJ FamilyCare beneficiary's correct name, the Medicaid/NJ FamilyCare Eligibility Identification (MEI) number, and/or the Social Security Number, as well as the Medicaid/NJ FamilyCare Provider Billing Number and the date of service.

(d) A claim for environmental lead inspection shall be submitted on a HCFA 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).

2. Upon receipt of the HCFA 1500 claim form the Medicaid 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 (N.J.A.C. 10:77-4), the remaining cost of this mandated service, as specified in N.J.A.C. 8:13, being the responsibility of the LHD.

Amended by R.2001 d.144, effective May 7, 2001.

See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).

In (a), amended N.J.A.C. reference; in (c)2, deleted "Eligibility" following "Verification" and inserted "Eligibility" preceding "Verification"; in (d)2, inserted references to NJ KidCare and amended N.J.A.C. reference.

Amended by R.2002 d.401, effective December 16, 2002.
See: 34 N.J.R. 2709(a), 34 N.J.R. 4441(b).

Inserted “/NJ FamilyCare–Plan A” and “/NJ FamilyCare” throughout; in (c), deleted references to “Medicaid”; in (d)2, inserted “for Medicaid and 65 percent for certain NJ FamilyCare–Plan A beneficiaries” and amended the N.J.A.C. reference preceding “the remaining cost”.

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” (AP-6).

1. A copy of the completed form (AP-6) for each Medicaid/NJ FamilyCare beneficiary shall be sent quarterly to the following address:

Chief Pediatric Consultant
Division of Medical Assistance and Health Services
PO Box 712
Trenton, New Jersey 08625-0712

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

Amended by R.2002 d.401, effective December 16, 2002.
See: 34 N.J.R. 2709(a), 34 N.J.R. 4441(b).
In (b)1 and (c), inserted “/NJ FamilyCare”.

SUBCHAPTER 3. MENTAL HEALTH REHABILITATION SERVICES FOR CHILDREN

Authority

N.J.S.A. 30:4D-7, §§ 1902(a)10 and 1905(a)(15) of the Social Security Act, 42 U.S.C. § 1396a(a)(10) and § 1396d(a) respectively, and 42 CFR 440.130.

Source and Effective Date

R.2001 d.144, effective May 7, 2001.
See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).

Subchapter Historical Note

Subchapter 3, Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS), was recodified as N.J.A.C. 10:77-4, and a new Subchapter 3, Mental Health Rehabilitation Services for Children, was adopted by R.2001 d.144, effective May 7, 2001. See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).

10:77-3.1 Scope of services

This subchapter sets forth the New Jersey Medicaid and NJ FamilyCare programs’ provisions pertaining to mental health rehabilitation services for children, as well as for children eligible for Children’s System of Care Initiative (CSOCI) services only.

Amended by R.2002 d.401, effective December 16, 2002.
See: 34 N.J.R. 2709(a), 34 N.J.R. 4441(b).
Rewrote the section.

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:

“Child,” as defined for the purposes of mental health services provided as part of the Children’s System of Care Initiative, means an individual under the age of 21.

“Children’s group homes” means facilities licensed by the Division of Youth and Family Services that meet the requirements of N.J.A.C. 10:127, and provide mental health rehabilitation services.

“Children’s System of Care Initiative (CSOCI)” means the initiative developed by the Department of Human Services to provide a comprehensive approach to the treatment of emotional and/or behavioral disturbances in children, adolescents and young adults up to the age of 21.

“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 Division of Mental Health 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 Division of Youth and Family Services in accordance with N.J.A.C. 10:128 that provide mental health rehabilitation services.

“Therapeutic leave” means that a resident of a facility providing mental health rehabilitation services is absent from the facility for therapeutic reasons. 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.

Amended by R.2002 d.401, effective December 16, 2002.
See: 34 N.J.R. 2709(a), 34 N.J.R. 4441(b).

Added “Children’s System of Care Initiative (CSOCI)”, “Discharged”, “Hospital leave”, “Regional area” and “Therapeutic leave”.

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 Division of Mental Health Services in accordance with N.J.A.C. 10:37B or by the Division of Youth and Family Services in accordance with N.J.A.C. 10:127 or 10:128 and shall be providing eligible mental health rehabilitation services.
2. A psychiatric community residence for youth or any other provider that is not currently enrolled as a provider of mental health personal care services by the Division of Mental Health Services in accordance with N.J.A.C. 10:37B, or by the Division of Youth and Family Services in accordance with N.J.A.C. 10:127 or 10:128, shall also 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 KidCare provider, the provider shall conform to all the provisions of N.J.A.C. 10:49.

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

Amended by R.2002 d.401, effective December 16, 2002.
See: 34 N.J.R. 2709(a), 34 N.J.R. 4441(b).
Added new (a)4.

10:77-3.4 Eligibility for services

(a) The Division shall consider claims for Medicaid/NJ FamilyCare-Plan A-eligible individuals, and children enrolled in the home and community care-based 42 U.S.C. § 1915(c) waiver programs. Children eligible as “medically needy” in accordance with N.J.A.C. 10:71 shall not be eligible for mental health rehabilitation services for children or youth.

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

Amended by R.2002 d.401, effective December 16, 2002.
See: 34 N.J.R. 2709(a), 34 N.J.R. 4441(b).
Substituted “FamilyCare” for “KidCare”.

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.

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 licensing 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 for mental health rehabilitation services provided by psychiatric community residences for youth, group homes or residential child care facilities

(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, adolescent or young adult is admitted to the facility, but shall not seek reimbursement for services provided on the child's, adolescent's or young adult's date of discharge.

i. On the dates that the child 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. 10:77-4.2(b). Therapeutic or hospital leave shall be authorized by appropriate medical staff and shall be included in the plan of care.

Amended by R.2002 d.401, effective December 16, 2002.
See: 34 N.J.R. 2709(a), 34 N.J.R. 4441(b).
Rewrote the section.

10:77-3.7 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 for the same day of service.

10:77-3.8 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 Division or its agents.

SUBCHAPTER 4. HEALTH CARE FINANCING ADMINISTRATION (HCFA) COMMON PROCEDURE CODING SYSTEM (HCPCS)

Authority

N.J.S.A. 30:4D-7; §§ 1902(a)10 and 1905(a)(15) of the Social Security Act, 42 U.S.C. § 1396a(a)(10) and § 1396d(a) respectively, and 42 CFR 440.130.

Source and Effective Date

R.2001 d.144, effective May 7, 2001.
See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).

Subchapter Historical Note

Subchapter 4, Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS), was recodified from N.J.A.C. 10:77-3 by R.2001 d.144, effective May 7, 2001. See: Source and Effective Date.

10:77-4.1 Introduction

(a) The New Jersey Medicaid, NJ KidCare and NJ FamilyCare programs utilize the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology 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 HCFA assigned codes and modifiers contain alphabetic characters.

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

1. "HCPCS Code"—Lists the HCPCS procedure code numbers;

2. "DESCRIPTION"—Code narrative: Narratives for Level III codes are found at N.J.A.C. 10:77-4.2;

3. "MAXIMUM FEE ALLOWANCE"—Lists the New Jersey Medicaid/NJ KidCare/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.

(d) Listed below are both general and specific policies of the New Jersey Medicaid 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 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 HCFA 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; 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.

Amended by R.2001 d.144, effective May 7, 2001.

See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).

In (a), (b)3 and (c)3, inserted references to NJ KidCare and NJ FamilyCare; in (c)2, updated N.J.A.C. reference; and substituted "CPT" for "CPT-4" throughout.

10:77-4.2 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 Codes:

Ind	HCPCS Code	Procedure Code Definition	Maximum Fee Allowance
	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 Mental Health Services, under N.J.A.C. 10:37B	Contract Pricing

Ind	HCPCS Code	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 10:128.	Contract pricing
	Y9945	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

<u>Ind</u>	<u>HCPCS Code</u>	<u>Procedure Code Definition</u>	<u>Maximum Fee Allowance</u>
	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 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 Services provided in non-JCAHO accredited facilities under contract with DYFS	Contract Pricing
	Y9998	Hospital Leave for Rehabilitation Services provided in non-JCAHO accredited facilities under contract with DYFS	Contract Pricing

<u>Ind</u>	<u>HCPCS Code</u>	<u>Procedure Code Definition</u>	<u>Maximum Fee Allowance</u>
	Y9999	Hospital Leave for Room and Board Services provided in non-JCAHO accredited facilities under contract with DYFS	Contract Pricing

Amended by R.2001 d.144, effective May 7, 2001.
See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).

Added (b).
Amended by R.2002 d.401, effective December 16, 2002.
See: 34 N.J.R. 2709(a), 34 N.J.R. 4441(b).
Rewrote table in (b).

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. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages shall be distributed to providers and copies shall be filed with the Office of Administrative Law.

For a copy of the Fiscal Agent Billing Supplement, write to:

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PO Box 4801
Trenton, New Jersey 08650-4801
or contact:
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Quakerbridge Plaza, Bldg. 9
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