CHAPTER 73

CASE MANAGEMENT SERVICES MANUAL

Authority

N.J.S.A. 30:4D–6b(17); 30:4D–7, 7a, b and c; 30:4D–12; Section 1905(a)19 of the Social Security Act, codified as 42 R.S.C. 1396d; Section 1915g(1) and (2) of the Social Security Act, codified as 42 U.S.C. 1396n.

Source and Effective Date

R.1991 d.367, effective July 15, 1991.
See: 23 N.J.R. 1328(a), 23 N.J.R. 2137(a).

Executive Order No. 66(1978) Expiration Date

Chapter 73, Case Management Services Manual, expires on July 15, 1996.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. GENERAL PROVISIONS

10:73–1.1 Purpose and scope

(a) This chapter outlines information about targeted case management services provided by approved New Jersey Medicaid Program providers.

1. There are various types of case management providers who will provide different types of case management services to targeted groups of Medicaid recipients, as allowed under Federal statute.

i. The first case management provider type described in this chapter is the Case Management Program/Mental Health (CMP/MH) provider (see N.J.A.C. 10:73–2). Other case management provider types may be added to the chapter as programs are developed.

(b) N.J.A.C. 10:73–2 describes the Case Management Program/Mental Health, providing a description of the individuals for whom the services are targeted; the case management services covered; the requirements and responsibilities of the agencies that will provide the services, including agency staff; the procedures required to provide services and the reimbursement for the provision of those services.

(c) N.J.A.C. 10:73–3 provides a listing of HCPCS Procedure Codes (HCFA Common Procedure Coding System).

Amended by R.1994 d.585, effective November 21, 1994 (operative December 1, 1994).
See: 26 N.J.R. 3350(a), 26 N.J.R. 4614(a).

10:73–1.2 Definitions

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

"Advocacy" means the ongoing process of assisting the client in receiving all benefits to which he or she is entitled by working toward the removal of barriers to receiving needed services.

"Assessment" means the ongoing process of identifying and reviewing a client's strengths, deficits, and needs based upon input from the client and significant others including family members and health professionals. The assessment process continues throughout the entire length of service. The assessments are updated periodically based upon availability of client information.

"Case management" means any activity under which responsibility for locating, coordinating and monitoring necessary and appropriate services for an individual rests with a specific person or organization.

"Case Management Program/Mental Health (CMP/MH)" under the Division of Mental Health and Hospitals means a distinct program administered jointly with the Division of Medical Assistance and Health Services to provide case management services. The program offers targeted case management services to seriously mentally ill individuals, both adults and children, who do not accept or engage in community mental health programs and/or who have multiple service needs and require extensive service coordination.

"Case management services" means those services which will assist a Medicaid recipient in gaining access to needed medical, social, educational, and other services.

"Client monitoring" means the ongoing review of the client's status and needs.

"Clinical case management" means the provision of face-to-face individualized clinical support services for a client who needs consistent contact to ensure engagement to the case manager and to help the person maintain stability and remain linked to needed services.

"Division of Medical Assistance and Health Services" (DMA & HS) is an organizational component of the New Jersey State Department of Human Services.

"Division of Mental Health and Hospitals" (DMH & H) is an organizational component of the New Jersey State Department of Human Services.

"HCFA" means Health Care Financing Administration of the United States Department of Health and Human Services.

"HCPCS" (Health Care Financing Administration Common Procedure Coding System) means a nationwide three level coding system. Level 01 codes are adapted from codes published by the American Medical Association in CPT–4 and are utilized primarily by physicians and independent clinical laboratories. Level 02 codes are assigned by HCFA for physician and non-physician services which are not in the CPT–4. Level 03 codes are assigned by the State Medicaid Agency and are used for services not identified by the CPT–4 or HCFA assigned codes.

"Initial evaluation services" means the initial contact, evaluation, completion of a risk assessment and initiation of services.

"Liaison case management" means that part of the CMP/MH targeted to a seriously mentally ill individual, adult or child, who has been discharged from a State or county psychiatric hospital, psychiatric unit of a general acute care hospital or a specialty hospital, and who requires short-term assistance to ensure linkage to community mental health programs.

"Ongoing support services" means the provision of face-to-face individualized clinical support services for a client who needs such contact.

"Risk category" under CMP/MH means the three levels of clinical case management involvement, based upon assessed risk of hospitalization, functional level and willingness and/or ability to access needed services. The three risk categories are: high-risk, or intensive case management; at-risk, or supportive case management; and low-risk, or maintenance level case management.

"Services linkage" means the referral to and enrollment with other appropriate service providers to address the needs identified in the assessment.

"Service planning" means the process of organizing the outcomes of the assessment in collaboration with the client, significant others, potential service providers, and others as designated, to formulate a written service plan that addresses the client's needs, planned services to address these needs, and plans to motivate the client to utilize services. The service planning process continues throughout the client's entire program length of stay.

"Service provider monitoring" means the process of routine follow-up by case manager or by Division of Mental Health and Hospitals with the client's service providers to assess if services are provided as planned and if they meet the client's needs.

"Targeted case management" under Case Management Program/Mental Health (CMP/MH) is the provision of services targeted to adults and children with serious mental illness who are at high risk of hospitalization or deterioration in their functioning and who require an assertive community outreach service to meet their needs. Case management is for either long-term support (clinical case management) or linkage to other mental health services (liaison case management). Targeted case management services include, but are not limited to: assessment, service planning, services linkage, ongoing monitoring, ongoing clinical support and advocacy.

"Unit of service" under CMP/MH means a face-to-face contact with an enrolled client, or on behalf of an enrolled client, which lasts 15 minutes in duration. Travel time shall not be included as part of the face-to-face time. Contacts of less than 15 minutes can not be aggregated to produce one unit of service.

Amended by R.1994 d.585, effective November 21, 1994 (operative December 1, 1994).
See: 26 N.J.R. 3350(a), 26 N.J.R. 4614(a).

SUBCHAPTER 2. CASE MANAGEMENT PROGRAM/MENTAL HEALTH

10:73–2.1 Case Management Program/Mental Health (CMP/MH); general

(a) The CMP/MH is under the auspices of the Division of Mental Health and Hospitals and is administered jointly with the Division of Medical Assistance and Health Services. It is a program to provide case management services to seriously mentally ill Medicaid recipients, both children and adults, who do not accept nor engage in community mental health programs and/or who have multiple service needs and require extensive service coordination.

1. CMP/MH is for either long-term support (clinical case management) or short-term support (liaison case management).

(b) Case management services are not available to recipients of the Medically Needy Program, except pregnant women, nor recipients served in the DMAHS' Home and Community Based Services Waiver Program, Model Waivers, DDD Waiver, ABC Waiver, Traumatic Brain Injury Waiver, or the Home Care Expansion Program.

1. For information on how to identify a Medicaid recipient, refer to N.J.A.C. 10:49–2, Administration.

Administrative Change.
See: 26 N.J.R. 797(b).
Amended by R.1994 d.585, effective November 21, 1994 (operative December 1, 1994).
See: 26 N.J.R. 3350(a), 26 N.J.R. 4614(a).

10:73–2.2 Individuals targeted to receive CMP/MH services

(a) Clinical case management services under CMP/MH are targeted to children and adults with serious mental illness who are at high risk of hospitalization or deterioration in their functioning and who require an assertive community outreach service to meet their needs. This targeted group is composed of individuals who meet at least two of the following:

1. Have repeated admissions to inpatient services. Priority will be given to persons with two or more admissions to inpatient psychiatric services within a 12–month period, or two or more uses of emergency/screening services within a 30–day time period;

2. Participate in mental health services, but are not receiving additional services which meet the individual's multiple needs, and who require extensive service coordination (for example, individuals who are dually diagnosed as mentally ill and chemical abusing, or children involved with DYFS and school systems);

3. Have a recent history of being a danger to self or others within a time period of three months;

4. Have a history of resistance or non-compliance in use of medication, resulting in a pattern of decompensation and rehospitalization;

5. Are in another service system and in need of assessment and possible treatment prior to linkage to case management (for example, residential, drug and alcohol programs, or shelters for the homeless); and/or

6. Reside with family, in boarding homes, or other residential settings and are not receiving needed mental health services.

(b) Liaison case management services under CMP/MH are targeted to children and adults who:

1. Recently were discharged from a State or county hospital or a general acute-care hospital psychiatric inpatient unit and in need of linkage services to ensure continuity of care with other mental health services; or

2. Have a recent history of a hospitalization as a result of mental illness and dangerousness to self or others.

10:73–2.3 Case management services provided under CMP/MH

(a) CMP/MH services shall include, but are not limited to, assessment, service planning, services linkage, ongoing monitoring, ongoing clinical support, and advocacy. These services are described below:

1. Assessment is the ongoing process of identifying, reviewing and updating a client's strengths, deficits, and needs, based upon input from the client and significant others including family members and community and hospital professionals. The assessment process continues throughout the entire length of stay. (See N.J.A.C. 10:73–2.9 for information about client's risk status.)

2. Service planning is the process of organizing the outcomes of the assessment in collaboration with the client, significant others, potential service providers, and others as designated, to formulate a written service plan that addresses the client's needs, planned services to address these needs, and plans to motivate the client to utilize services and remain in the community. The service planning process continues throughout the client's entire program length of stay.

3. Services linkage is the ongoing referral to, and enrollment in, a mental health and/or non-mental health program. Mental health program linkage means that the client has completed the mental health program's intake process, that the client has been accepted for service, and that the client has effectively participated in the program.

4. Ongoing monitoring consists of both client monitoring and service provider monitoring by the case manager:

i. Client monitoring is the ongoing review of the client's status and needs, the frequency of which is contingent upon the client's risk status and reported changes from the client, significant others and/or service providers. An update of the service plan may result from the monitoring process to address changing needs.

ii. Service provider monitoring is the process of routine follow-up with the client's service providers to assess if services are provided as planned and if they meet the client's needs. Provider monitoring may result in the adjustment of the service plan including provider changes. Service provider monitoring includes the following:

(1) Monitoring the plans, including the medication management plan for clients in need of such plans;

(2) Coordination of services from multiple providers including calling and coordinating treatment team meetings of a client's service providers until the client exits from the CM program.

5. Ongoing support services is the provision of face-to-face individualized clinical support services for clients who need consistent contact to ensure engagement to the case manager and to help the person maintain stability and remain linked to needed services. It includes support within the client's natural support system including family, friends, and employers and typically occurs where the client resides or frequents. The frequency of support services is contingent upon the client's risk status and individual needs.

6. Advocacy is the process of assisting the client in receiving all benefits to which he or she is entitled by working toward the removal of barriers to receiving needed services. Client advocacy is an ongoing activity of the case manager.

10:73–2.4 Requirements for providers participating in CMP/MH

(a) This section lists the specific provisions relevant to a provider who wishes to apply and be approved as a provider of CMP/MH services. N.J.A.C. 10:73–2.5 provides information about service responsibilities of the CMP/MH provider and N.J.A.C. 10:73–2.6 describes the responsibilities of staff members of a CMP/MH provider agency.

(b) The following are the specific provisions for provider participation in CMP/MH.

1. Any agency that wishes to provide CMP/MH services must be certified by the Division of Mental Health and Hospitals and under contract as an approved clinical case management and/or liaison provider and must be individually approved as a Medicaid provider by the New Jersey Medicaid Program.

2. Case management providers under CMP/MH shall comply with general Medicaid program policies regarding provider participation (see N.J.A.C. 10:49–3.1). Provider entities must be mental health provider organizations who contract with the New Jersey Division of Mental Health and Hospitals in accordance with the "Rules and Regulations Governing Community Mental Health Services and State Aid Under the Community Mental Health Services Act" N.J.A.C. 10:37 to provide clinical case management and/or liaison services.

3. Upon notification from DMH & H of a certified, under contract CMP/MH provider, the New Jersey Medicaid program shall forward the appropriate provider enrollment forms to the provider. (See N.J.A.C. 10:49–3.1, Eligible Providers.)

4. The CMP/MH provider shall receive written notification of approval or disapproval from the Division of Medical Assistance and Health Services.

i. If approved, the CMP/MH provider will be assigned a provider number by the Fiscal Agent.

ii. The New Jersey Medicaid Program will furnish a provider manual (which includes this chapter, other relevant chapters including N.J.A.C. 10:49 and additional non-regularity material) and an initial supply of pre-printed claim forms.

Administrative Change.
See: 26 N.J.R. 797(b).

10:73–2.5 Service responsibilities of the CMP/MH provider

(a) The CMP/MH provider shall:

1. Provide ongoing support to enrolled CMP/MH clients, in their own environment, who are at risk of hospitalization or deterioration in function, to enable them to function in the community and to enable them to access other mental health services whenever possible;

2. Provide or arrange for a clinical off-site service capability to enrolled CMP/MH clients seven days a week;

3. Provide community-based engagement activities, coordination, and integration for enrolled CMP/MH clients;

4. Provide ongoing, individualized clinical support and monitoring to maintain stability until the client participates effectively in other needed services; and

5. Seek and accept referrals within provider capacity of clients from emergency/screening services, local inpatient units and other structured sites, such as homeless shelters or jails, and other referral sites as identified at the local level.

10:73–2.6 Staff members of a CMP/MH provider; responsibilities

(a) The following apply to the case manager (CM):

1. Regarding his or her duties the CM providing clinical case management services shall:

i. Identify mentally ill clients in need of CMP/MH services regardless of residence (for example: homeless, shelter, family, boarding home);

ii. Provide clinical assessment of client's strengths, needs, resources, motivation, level of functioning, mental status, and risk category;

iii. Provide functional assessment of client's skills (daily living, self-care, social, vocational, etc.);

iv. Provide intensive community based engagement services to maximize the client's access to services and ability to function adequately and integrate into the community;

v. Provide or arrange for direct clinical intervention;

vi. Provide assessment of the need for crisis intervention, and assistance to providers of psychiatric emergency services in resolving crises;

vii. Provide assessment of substance abuse symptoms;

viii. Provide assessment of available social services, health and mental health resources and the ability of these services to meet each client's needs;

ix. Develop service plans with the primary goal to motivate client to access, appropriately use, and remain in community programs;

x. Develop and monitor a plan for medication management for the client in need of such a plan, in consultation with the county mental health system's psychiatric services components;

xi. Provide ongoing service planning and periodic reviews and revisions of such plans;

xii. Provide access to appropriate services, and ensure the client receives needed transportation in order to attend services;

xiii. Ensure that the client engages in the community mental health and non-mental health systems through provision of ongoing individualized clinical support and monitoring;

xiv. Provide clinical consultation with other providers in a client's network;

xv. Coordinate and integrate services from multiple providers until the client exists from the CMP/MH. This includes coordination of treatment team meetings of the service providers of a client in the community;

xvi. Monitor service delivery to meet a client's changing needs;

xvii. Identify resource gaps and problems of service delivery, and advocate for the resolution of these issues; and

xviii. Provide direct service support to the client's natural support system, including family, friends, employers, self-help and other natural support groups.

2. Regarding his or her duties, the CM providing liaison case management services shall:

i. Assess, as assigned, inpatients of State and county psychiatric hospitals and short term care facilities and determine patient assignment to either liaison case management or clinical case management services;

ii. Develop discharge plans, in conjunction with other State or county psychiatric hospital or short term care facility treatment team members, for clients assessed as able or willing to access or engage in necessary community mental health services within 60 days after hospital discharge;

(1) Services rendered while the client is an inpatient in a State or county psychiatric hospital or psychiatric unit of a general acute care hospital are not billable activities;

iii. Ensure that planned community mental health and non-mental health service linkages occur for clients assessed as willing or able to link within 60 days after hospital discharge; and

iv. Monitor the clients linkage to the primary mental health provider for 60 days post discharge.

Amended by R.1994 d.585, effective November 21, 1994 (operative December 1, 1994).
See: 26 N.J.R. 3350(a), 26 N.J.R. 4614(a).

10:73–2.7 Prior authorization for clinical case management services

(a) Clinical case management services require prior authorization. (See N.J.A.C. 10:73–2.9(b) for exceptions concerning provision of services for a limited period of time while the prior authorization request is under review.)

1. Liaison case management services do not require prior authorization (see N.J.A.C. 10:73–2.11(c)).

(b) The CMP/MH provider shall request prior authorization from the Division of Mental Health and Hospitals, utilizing forms prescribed by that Division.

1. Prior authorization may be for up to 12 calendar months. It is the responsibility of the provider to request prior authorization before furnishing or rendering services. (See N.J.A.C. 10:49–6.1 regarding prior authorization.)

Administrative Change.
See: 26 N.J.R. 797(b).

10:73–2.8 Basis of payment for CMP/MH services

(a) Reimbursement for services covered under the CMP/MH shall be determined by the Commissioner of the Department of Human Services. The provider of CMP/MH services shall be compensated on a fee-for-service basis. Reimbursement is based upon HCPCS Codes as specified in N.J.A.C. 10:73–3.

1. The provider shall submit a claim form and identify the services performed by the use of procedure codes based on the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). Three HCPCS codes are assigned for the services provided under CMP/MH. If the services were provided to a child, the provider shall add a modifier (ZC) to the code to signify that the services were provided to a child. For CMP/MH purposes, a child is an individual under the age of 18.

2. The three CMP/MH services that shall be identified on a claim form and submitted for reimbursement are:

i. Initial Evaluation Services.

ii. Clinical Case Management; and

iii. Liaison Case Management.

3. For rules regarding the three case management services (initial evaluation, clinical case management, and liaison case management) see N.J.A.C. 10:73–2.9, 2.10 and 2.11.

(b) A provider may only render one type of case management service to the same recipient within the same time period. A recipient who receives case management services is entitled to receive other approved mental health services that are rendered by authorized providers.

(c) Each provider shall make a charge for services to all clients, except as provided by legislation, with the proviso that no charge will be made directly to the Medicaid recipient.

(d) In no event shall the charge to the New Jersey Medicaid Program exceed the charge by the provider for identical services to other groups or individuals in the community.

1. Payment for CMP/MH services shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose, including, but not limited to, the Home and Community Based Service Waiver programs. Payment for CMP/MH services shall not duplicate payment for case management services which are an integral part of another provider service.

(e) See N.J.A.C. 10:49 for requirements for timely submission of claims.

Amended by R.1994 d.585, effective November 21, 1994 (operative December 1, 1994).
See: 26 N.J.R. 3350(a), 26 N.J.R. 4614(a).

10:73–2.9 Procedures for providing initial risk assessment and evaluation for CMP/MH services

(a) Under clinical case management, the provider shall conduct an initial risk evaluation on a prospective CMP/MH client during the initial client contact(s) to determine the "risk category" using a form approved by the Division of Mental Health and Hospitals (DMH & H). If the prospective client is found to be eligible for CMP/MH services, he or she shall be assigned to a risk category described in (a)1–3, below. The provider shall immediately initiate a request for authorization to provide services beyond the initial evaluation services.

1. High risk (intensive case management involvement) shall be provided to clients who are in crisis and at immediate risk of decompensation, or who are experiencing situational crises which, without active intervention, would rapidly lead to decompensation and hospitalization.

2. At risk (supportive case management involvement) shall be provided to clients who exhibit signs of regression, who stop their medication, who are undergoing major transitions from an inpatient or residential treatment setting, or who are withdrawing or refusing needed aftercare services.

3. Low Risk (maintenance level case management involvement) shall be provided to clients who are stable but who have a pattern of psychiatric hospitalization, acute care recidivism, dropping out of mental health and non-mental health services, medication non-compliance, disruption of living, working program and social environments.

(b) The following apply to the initial evaluation services:

1. In order to facilitate the provision of services to the client while the initial risk evaluation is completed and the request for prior authorization is being evaluated, the initial evaluation services may be provided without prior authorization. Initial evaluation services shall only be provided to clients who appear to be in need of these services.

2. A claim for initial evaluation services, may be submitted following the initial assessment process performed on a prospective clinical case management client. Initial evaluation services may be billed once per recipient per provider. In the event a recipient changes providers, initial evaluation services can be reimbursed to the new provider.

i. Initial evaluation services may be billed by the same provider for the same recipient if there has been a lapse of more than 12 calendar months since the last case management service was provided.

3. During the initial evaluation services, the provider should submit form FD–365 (Prior Authorization Request) to DMH & H for future service units.

i. The request for prior authorization must be received by DMH & H not later than 45 days after providing the first initial evaluation service for which reimbursement is requested.

4. Reimbursement for initial evaluation services shall not exceed 28 units of service.

Amended by R.1994 d.585, effective November 21, 1994 (operative December 1, 1994).
See: 26 N.J.R. 3350(a), 26 N.J.R. 4614(a).

10:73–2.10 Clinical case management services under CMP/MH

(a) Clinical case management services include, but are not limited to: assessment, service planning, services linkage, ongoing clinical support and advocacy (see N.J.A.C. 10:73–2.3(a)). These services require prior authorization from the DMH & H and claims will not be processed without the appropriate prior authorization approval.

(b) There are three levels (risk category) of clinical case management involvement based upon assessed risk of hospitalization, functional level, and willingness and/or ability to access needed services as defined by DMH & H. The three risk categories are: high risk, or intensive case management; at risk, or supportive case management; and low risk, or maintenance level case management (see N.J.A.C. 10:73–2.9). The Risk Levels determine the number of units of service approved by DMH & H during a prior authorization period.

1. The following apply in recipient hospitalization or residency in Nursing Facility (NF) circumstances:

i. In the event a clinical case management recipient is hospitalized or admitted to a NF during a prior authorization period, the Medicaid program shall not be charged for CMP/MH services rendered during the hospitalization or residency in a NF.

(1) Upon discharge to the community, prior authorization is continued for a CMP/MH recipient if the recipient remains in the same risk level and has not exceeded the authorization period. No notice is required but the provider is expected to include this information in the recipient's chart.

(2) In the event a reassessment occurs following hospitalization, or residency in a NF, appropriate documentation must be placed in the case file and, if the risk level has changed, a request for prior authorization for the new level of case management services must be forwarded to DMH & H, no later than 10 days after discharge. Until then, the case manager must bill for continued services at the previously authorized risk level.

ii. In the event a CMP/MH recipient's hospitalization or residency in a NF extends beyond a prior authorization period, the provider shall request authorization from DMH & H to provide services post-discharge. Claims for initial evaluation services will not be processed if the recipient continues with the same provider. Claims for services post-discharge will not be honored without prior authorization.

2. For services rendered prior to December 1, 1994, each provider shall, within two months following the end of each prior authorization period, complete a reconciliation of services provided and payment received.

i. The reconciliation shall compare the units of service rendered during the authorization "period" and the initial evaluation month with the minimum required units of service during that period. If more units of service were provided than required, no adjustment will be made. If fewer units of service than the minimum were provided, the provider shall calculate the overpayment as follows:

(1) $50.00 shall be used as the hourly rate;

(2) The required units of service shall be determined by multiplying the number of months in the authorization period by the minimum average units of service per month as required under this section. If an initial evaluation month was billed for, seven units of service shall be added to the above calculation which was the required units of service only during the prior authorization period.

(3) The actual units of service provided during the authorization period (including initial evaluation month if applicable) shall be compared with the required units of service calculated above.

(4) The hourly rate shall be multiplied by the excess of required units of service over the actual units of service provided.

ii. In the event it is determined that the provider has received an overpayment, repayment shall be forwarded to the Medicaid Fiscal Agent within 30 days of reconciliation with appropriate documentation.

iii. DMH & H shall provide a sample form to reconcile and document services and payment. Whatever reconciliation form is used must be retained by the provider.

iv. Reconciliation and repayment, if applicable, must be completed within two months after the end of the prior authorization period.

Example: Mr. Jones is a client in a State psychiatric hospital whose treatment team is preparing a discharge plan. Mr. Jones is judged not to be able to effectively link with the community mental health system upon discharge and therefore the hospital treatment team incorporates a clinical case manager from an approved provider as part of the team (the XYZ Community Mental Health Center (CMHC)).

Together, the treatment team, Mr. Jones, and significant others prepare the discharge plan and treatment plan. The time spent by the clinical case manager (or liaison, had liaison staff been appropriate) while Mr. Jones is hospitalized is not billable to the Medicaid program.

On January 1, 19xx, discharge is planned for January 25. The clinical case manager initiates a request for prior authorization to the DMH & H to begin February 1. Mr. Jones is discharged on January 25. The XYZ CMHC continues to provide clinical case management services and receives the prior authorization from DMH & H on February 15, which is effective February 1, through July 31. Mr. Jones has been authorized at the high risk level.

The XYZ CMHC provides the following units of service and bills the following codes:

Period	Units	Code	Reimbursement *
1/25–1/31	5	Z5004 **	$350.00
2/01–2/28	8	Z5000	$350.00
3/01–3/31	7	Z5000	$350.00
4/01–4/30	6	Z5000	$350.00
5/01–5/31	6	Z5000	$350.00
6/01–6/30	5	Z5000	$350.00
7/01–7/31	8	Z5000	$350.00
TOTAL	45		$2,450.00

* This is the reimbursement based upon the HCPCS codes as of the promulgation of this Chapter and is subject to change from time to time.
** Z5004 is initial evaluation month and therefore no prior authorization is required.

By July 1, the XYZ CMHC initiates a new request for prior authorization to be effective August 1. After July 31, the XYZ CMHC will need to reconcile the payment received ($2450.00) with the reimbursement earned based upon the number of units of service provided as follows:

REQUIRED SERVICE

1.	Minimum units of service required during initial evaluation month (where applicable)	7
2.	Minimum units of service required during each month of prior authorization period based on approved risk level	7
3.	Number of months in authorization period	6
4.	Minimum units of service required for authorization period (# 2 × # 3)	42
5.	Total required units of service (# 1 + # 4)	49
6.	Actual units of service provided	<45>
7.	Excess of units required over <under> units provided	4

The XYZ CMHC provided four fewer units of service than required and therefore must calculate and make repayment as follows:

RATE/UNIT OF SERVICE

8.	Monthly reimbursement for authorized risk level	$350.00
9.	Divide by minimum required units of service	7
10.	Rate/Unit of Service	$50.00

CALCULATION OF OVERPAYMENT

Excess of units required over provided (# 7 above)	4
× Rate/Unit of service (# 10 above)	× $50.00
Overpayment	$200.00

The XYZ CMHC forwards the overpayment to the Fiscal Agent by the end of the second month following the authorized period.

Amended by R.1994 d.585, effective November 21, 1994 (operative December 1, 1994).
See: 26 N.J.R. 3350(a), 26 N.J.R. 4614(a).

10:73–2.11 Liaison case management services under CMP/MH

(a) Services provided under liaison case management include, but are not limited to:

1. Assessment and determination of need for services;

2. Development of discharge plans;

3. Assurance that mental health and non-mental health linkages occur; and

4. Monitoring of client linkage to mental health provider.

(b) Services listed in (a)1 to 4 above are reimbursed on a fee-for-service basis, not to exceed 16 units.

(c) Liaison case management services do not require prior authorization.

(d) Liaison case management services may be provided within 60 days of discharge from a hospital or inpatient psychiatric program.

(e) Liaison case management services may be billed for each discharge from a hospital, if services are provided.

(f) Liaison case management shall not be billed in conjunction with any other CMP/MH service.

(g) If the case manager determines during this period of time that the client will need clinical case management services and the liaison case manager is a certified provider of clinical case management, then the case manager is responsible for completing the risk assessment documentation and submitting a prior authorization request to DMH & H as soon as possible but no later than 30 days prior to the end of the liaison services. If the liaison case manager is not a certified clinical case manager, then the liaison case manager must refer the client to the clinical case manager identified to serve the client's geographic area as soon as possible, but no later than 40 days prior to the end of liaison services.

(h) The reconciliation process described at N.J.A.C. 10:73–2.10(b)2 with respect to clinical case management shall be required for liaison case management. The minimum average units of service to be provided are two units per month, post hospital discharge.

Amended by R.1994 d.585, effective November 21, 1994 (operative December 1, 1994).
See: 26 N.J.R. 3350(a), 26 N.J.R. 4614(a).

10:73–2.12 Recordkeeping for CMP/MH services

(a) Case management providers shall keep such individual records as are necessary to fully disclose the kind and extent of services provided to make sure such information is available as the DMA & HS or DMH & H, or its agents, may request.

1. The CMP/MH provider shall maintain the following data in support of all payment claims as required by the rules.

i. The name of the client;

ii. The name of the provider agency and staff person and the title of the individual providing service;

iii. The dates of service;

iv. The units of service;

v. The length of face-to-face contact (excluding travel to or from client contact);

vi. The name of individual(s) with whom face-to-face contact was maintained on behalf of client; and

vii. A summary of services provided.

Amended by R.1994 d.585, effective November 21, 1994 (operative December 1, 1994).
See: 26 N.J.R. 3350(a), 26 N.J.R. 4614(a).

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:73–3.1 Introduction

(a) The New Jersey Medicaid Program adopted the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). The HCPCS codes as listed in this subchapter are relevant to Medicaid case management services and must be used when filing a claim.

1. The responsibilities of the case management services provider when rendering services are listed in N.J.A.C. 10:73–2.

2. "P" is listed under Ind (indicator) which means that prior authorization is required.

3. "ZC" is listed under Mod (modifier) which means that service is rendered for children.

4. HCPCS codes Z5000 through Z5004 shall not be billed for services rendered after December 1, 1994.

Amended by R.1994 d.585, effective November 21, 1994 (operative December 1, 1994).
See: 26 N.J.R. 3350(a), 26 N.J.R. 4614(a).

10:73–3.2 HCPCS codes for case management services

Ind	HCPCS Code	Mod	Description	Maximum Fee Allowance
P	Z5000		High Risk Intensive Case Management Program/Mental Health (CMP/MH) Adults, Monthly	$350.00
P	Z5000	ZC	High Risk Intensive Case Management Program/Mental Health (CMP/MH) Children, Monthly	$350.00
P	Z5001		At Risk Supportive Case Management Program/Mental Health (CMP/MH) Adults, Monthly	$175.00
P	Z5001	ZC	At Risk Supportive Case Management Program/Mental Health (CMP/MH) Children, Monthly	$175.00
P	Z5002		Low Risk Maintenance Case Management Program/Mental Health (CMP/MH) Adults, Monthly	$100.00
P	Z5002	ZC	Low Risk Maintenance Case Management Program/Mental Health (CMP/MH) Children, Monthly	$100.00
	Z5003		Liaison Case Management Program/Mental Health (CMP/MH) Adults, Monthly	$100.00
	Z5003	ZC	Liaison Case Management Program/Mental Health (CMP/MH) Children, Monthly	$100.00
	Z5004		Initial Evaluation Month, Case Management Program/Mental Health (CMP/MH), Adults	$350.00
	Z5004	ZC	Initial Evaluation Month, Case Management Program/Mental Health (CMP/MH), Children	$350.00
	Z5005		Initial Evaluation Services, Case Management Program/Mental Health (CMP/MH) Adults	$ 12.50
	Z5005	ZC	Initial Evaluation Services, Case Management Program/Mental Health (CMP/MH), Children	$ 12.50
	Z5006		Clinical Case Management Program/Mental Health (CMP/MH), Adults	$ 12.50
	Z5006	ZC	Clinical Case Management Program/Mental Health (CMP/MH), Children	$ 12.50
	Z5007		Liaison Case Management Program/Mental Health (CMP/MH) Adults	$ 12.50

Ind	HCPCS Code	Mod	Description	Maximum Fee Allowance
	Z5007	ZC	Liaison Case Management Program/Mental Health (CMP/MH), Children	$ 12.50

Amended by R.1994 d.585, effective November 21, 1994 (operative December 1, 1994).
See: 26 N.J.R. 3350(a), 26 N.J.R. 4614(a).