

2. Within 48 hours of the psychiatrist's review of the beneficiary or potential Medicaid beneficiary, the completed "Psychiatric Evaluation" form shall be sent to the Division of Mental Health Services, PO Box 727, Trenton, New Jersey 08625-0727, Attention: PASARR Coordinator.

i. A supply of the "Psychiatric Evaluation" form may be ordered from the PASARR Coordinator in the Division of Mental Health Services.

(c) Annual Resident Reviews (ARR) for individuals identified as having mental illness residing in Medicaid certified nursing facilities shall be performed by the individual's attending physician and forwarded to the Division of Mental Health Services for final determination of the need for specialized services.

1. The MACC will send a NF PASARR Reassessment List to the NF in the first week of every month. The reassessment date is based upon the month the individual was initially admitted to the NF. The attending physician completes the psychiatric evaluation form by the fifteenth of the following month on those individuals with mental illness.

2. The completed psychiatric evaluation form will be forwarded to the DMHS to be reviewed by DMHS psychiatrists to determine the need for specialized services.

3. The results of the DMHS determination will be returned to the nursing facility to be incorporated in the patient's chart.

Amended by R.2001 d.51, effective February 5, 2001.  
See: 32 N.J.R. 3929(a), 33 N.J.R. 555(a).

In (c)1, substituted "MACC" for "MDO" in the first sentence; and substituted references to beneficiary and beneficiaries for references to recipient and recipients throughout.

#### 10:54-7.8 Physician services to the hospital patients

(a) Physician services that are rendered to a patient registered in the hospital outpatient department that are reimbursed as part of hospital costs shall not be billed directly by the physician to the Medicaid program. Any arrangement, contractual, employment, grant or otherwise, for payment of the physician(s) providing a service(s) to such a registered clinic patient is between the hospital and the physician(s). Physician services provided in the hospital outpatient department to Medicaid beneficiaries that are not included in hospital costs may be billed by the physician directly to the New Jersey Medicaid program.

(b) For the hospital based physician providing services to an ambulatory non-registered (private) patient, the following applies:

1. This type of patient shall be considered to be the private ambulatory patient of a physician who has referred the patient to the hospital for the services provided, in part or whole, by a hospital based physician (for

example, radiologist, pathologist, electrocardiographer, and so forth);

2. Such specific services are considered hospital costs when provided by the physician who is customarily reimbursed directly by the hospital, contractually or otherwise, and are not reimbursable directly to the referring physician.

(c) Direct patient care physician services which are considered the professional component of hospital care, (that is, for some emergency room physicians, radiologists, pathologists, and electrocardiographers), may be reimbursed when the physician bills directly by the fiscal agent under the following circumstances:

1. The physician shall be under contract with the individual hospital for the performance of the specific services;

2. The services are not part of the hospital costs; and

3. The professional component of the services are not reimbursed to the physician in whole or in part by the hospital.

Amended by R.2001 d.51, effective February 5, 2001.  
See: 32 N.J.R. 3929(a), 33 N.J.R. 555(a).

In (a), substituted "beneficiaries" for "recipients".

#### 10:54-7.9 Psychiatric services; inpatient services

(a) The New Jersey Medicaid program recognizes as a covered service, a medically necessary inpatient service which is provided to a Medicaid beneficiary in an approved private psychiatric hospital or the psychiatric section of an approved general hospital with the following limitation. (See N.J.A.C. 10:49-2.3(b) for the Medically Needy program and the Hospital Services Chapter, N.J.A.C. 10:52-1.15, 2.9 and 4.2 for policies and procedures for hospital outpatient psychiatric services).

1. Reimbursement for either a psychiatric consultation, individual psychotherapy, family or group psychotherapy, or shock therapy shall be considered as inclusive for all psychiatric services performed on that day.

(b) When hospitalization is out-of-State, prior authorization is required for elective psychiatric hospitalizations but not for emergency hospitalizations.

1. When prior authorization is required, the request shall be submitted from the referring physician to the Office of Utilization Management, Mental Health Services, Division of Medical Assistance and Health Services, Mail Code #18, PO Box 712, Trenton, New Jersey 08625-9712, attached to the claim form.

2. The request shall include the following:

i. The diagnosis, as set forth in the Diagnostic and Statistical Manual of the American Psychiatric Association (Latest edition);

- ii. A brief history and present clinical status;
- iii. A treatment proposal;
- iv. A summary of previous treatment and hospitalizations;
- v. The anticipated length of hospitalization; and
- vi. Evidence that suitable placement within New Jersey and/or within a reasonable distance of the patient's home is not available.

3. A request for retroactive authorization will be considered only when the request has been delayed by circumstances beyond the control of the hospital.

4. When the request for authorization is approved, both the request letter and the provider's claim form will be returned to the provider. When a claim is submitted for reimbursement, the provider must attach the request for approval and the approval to the UB-92 (HCFA-1450), the hospital claim form.

5. If request for prior authorization is denied, the physician and/or hospital shall be notified of the reason, in writing, by the Central Office, Mental Health Services Unit, Office of Utilization Management, Division of Medical Assistance and Health Services, PO Box 712, Trenton, New Jersey 08625-0712.

Amended by R.2001 d.51, effective February 5, 2001.  
See: 32 N.J.R. 3929(a), 33 N.J.R. 555(a).

In (a) introductory paragraph, substituted "beneficiary" for "recipient"; and in (b)1 and (b)5, substituted "Utilization Management" for "Health Services Administration".

#### **10:54-7.10 Psychiatric services (including prior authorization); hospital outpatient and other settings**

(a) The following policies and procedures were developed to help ensure the appropriate utilization of hospital outpatient psychiatric services. These include the role of the evaluation team in relation to the patient's treatment regimen, with emphasis placed on intake evaluation, development of a Plan of Care (PoC), performance of periodic review for evaluation purposes, and supportive documentation for services rendered. (See N.J.A.C. 10:52-2.3 Record-keeping and N.J.A.C. 10:66-2.5 for more specific policies and procedures for psychiatric (mental health services).

(b) Psychiatric services which are medically necessary rendered in an approved hospital outpatient department or in other settings, to a registered patient who is a Medicaid beneficiary, shall not require prior authorization, except in the following situations:

1. Prior authorization is required for partial hospitalization after the first 90 calendar days. Each authorization for this service may be granted for a maximum period of six months. Additional authorization may be requested. A new prior authorization request for partial hospitalization is required when a departure from the Plan of Care (PoC) is made because a change in the patient's clinical condition may necessitate an increase in the frequency and intensity of services, or a change which exceeds the type of services authorized.

2. Prior authorization is required for mental health services exceeding \$900.00 in reimbursement to the physician rendered to a Medicaid beneficiary in any 12-month service year, commencing with the patient's initial visit, when provided in other than an inpatient hospital setting. Reimbursement shall not be paid by the program for physician psychiatric services rendered to a registered hospital outpatient.

3. Prior authorization shall be required for mental health services exceeding \$400.00 in payments in any 12-month service year rendered to a Medicaid beneficiary residing in either a nursing facility or a residential health care facility.

(c) The request for authorization shall include the diagnosis, as set forth in the ICD-9 (latest revision), and also must include the treatment plan and progress report in detail. No post facto authorization will be granted.

1. For those Medicaid beneficiaries who do not reside in a nursing facility and live in a community setting, including a residential health care facility, or for those receiving mental health services in the outpatient department of a hospital, an independent clinic or a physician's office, the request for prior authorization shall be submitted directly to Office of Utilization Management, Mental Health Services Unit, Division of Medical Assistance and Health Services, PO Box 712, Mail Code #18, Trenton, New Jersey 08635-0712 on the "Authorization of Mental Health Services (FD-07)" form.

2. For a Medicaid beneficiary residing in a nursing facility, the request for prior authorization shall be submitted directly to the appropriate Medical Assistance Customer Center that serves that nursing facility on the "Authorization of Mental Health Services (FD-07)" form.

3. When approved by the New Jersey Medicaid program, each authorization may be granted for a maximum period of one year except as listed in (c)3i and ii below. Additional authorizations may be requested.

- i. Authorization for partial care and partial hospitalization shall be limited to a maximum period of six months.

- ii. Prior authorization shall be required for partial hospitalization after the first 90 calendar days. (See N.J.A.C. 10:52-2.9—Hospital Services Chapter, for further policies and procedures.)

4. The Division shall not reimburse the physician and/or hospital for both mental health services provided in the office and/or hospital or any other setting and medical day care center services provided to the same beneficiary on the same day. The Division shall also not reimburse the physician and/or hospital for both mental health services and partial hospitalization services provided to the same patient on the same day.

Amended by R.2001 d.51, effective February 5, 2001.

See: 32 N.J.R. 3929(a), 33 N.J.R. 555(a).

In (c)1, substituted "Utilization Management" for "Health Services Administration"; in (c)2, substituted "Medical Assistance Customer Center" for "Medicaid District Office"; and substituted references to beneficiary and beneficiaries for references to recipient and recipients throughout.

## SUBCHAPTER 8. PHARMACEUTICAL SERVICES

### 10:54-8.1 Pharmaceutical; conditions for participation as provider of pharmaceutical services

(a) All covered pharmaceutical services shall be provided under the New Jersey Medicaid program shall be provided to Medicaid beneficiaries within the scope of N.J.A.C. 10:49, Administration; N.J.A.C. 10:51, Pharmaceutical Services; and N.J.A.C. 10:54-8, Physician Services.

(b) All drugs shall be prescribed.

1. "Prescribed drugs" means simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance, that are:

i. Prescribed by a practitioner licensed or authorized by the State of New Jersey, or the state in which he or she practices, to prescribe drugs and medicine within the scope of his or her license and practice:

ii. Dispensed by licensed pharmacists in accordance with regulations promulgated by the New Jersey Board of Pharmacy, N.J.A.C. 13:39; and

iii. Dispensed by licensed pharmacists on the basis of a written prescription that is maintained in the pharmacist's records.

Amended by R.2001 d.51, effective February 5, 2001.

See: 32 N.J.R. 3929(a), 33 N.J.R. 555(a).

In (a), substituted "beneficiaries" for "recipients".

### 10:54-8.2 Pharmaceutical; program restrictions affecting payment for prescribed drugs

(a) The choice of prescribed drugs shall be at the discretion of the prescriber within the limits of applicable laws. However, the prescriber's discretion is limited for certain drugs. Reimbursement may be denied if the requirements of the following rules are not met:

1. Covered and non-covered pharmaceutical services as listed in the Pharmaceutical Services chapter, N.J.A.C. 10:51-1.11 and 1.13, respectively, incorporated herein by reference;

2. Pharmaceutical services requiring prior authorization (see N.J.A.C. 10:51-1.14, incorporated herein by reference);

3. Quantity of medication (see N.J.A.C. 10:51-1.15, incorporated herein by reference);

4. Dosage and directions (see N.J.A.C. 10:51-1.16, incorporated herein by reference);

5. Telephone-rendered original prescriptions (see N.J.A.C. 10:51-1.17, incorporated herein by reference);

6. Changes or additions to the original prescription (see N.J.A.C. 10:51-1.18, incorporated herein by reference);

7. Prescription refill (see N.J.A.C. 10:51-1.19, incorporated herein by reference);

8. Prescription Drug Price and Quality Stabilization Act (N.J.S.A. 24:6E-1 et seq.) (see N.J.A.C. 10:51-1.20, incorporated herein by reference);

i. Products listed in the current New Jersey Drug Utilization Review Council (DURC) Formulary, (hereafter referred to as "the Formulary"), and all subsequent revisions, distributed to all prescribers and pharmacists; and

ii. Non-proprietary or generic dispensing (see N.J.A.C. 10:51-1.9, incorporated herein by reference).

9. Federal regulations (42 CFR 447.301, 331-333) that set the aggregate upper limits on payment for certain multi-source drugs if Federal Financial Participation (FFP) is to be made available. The limit applies to all "maximum allowable cost" drugs (see N.J.A.C. 10:51-1.5, Basis of payment, incorporated herein by reference);

10. Drug Efficacy Study Implementation (DESI): "Less than effective drugs" subject to a Notice of Opportunity for Hearing (NOOH) by the Federal Food and Drug Administration (see N.J.A.C. 10:51-1.21 and listing of DESI drugs in Appendix A of N.J.A.C. 10:51, incorporated herein by reference);

11. Drug Manufacturers' Rebate Agreement with the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services (see N.J.A.C. 10:51-1.22, incorporated herein by reference);

12. Medical exception process (MEP) (see N.J.A.C. 10:54-8.3);

13. In addition, diabetic testing materials, including blood glucose reagent strips, urine monitoring strips, tapes, tablets, and lancets. Electronic blood glucose monitoring devices or other devices used in the monitoring of blood glucose levels are considered medical supplies and are covered services by Medicaid. These services may require prior authorization from the Medicaid District Office (MDO) (See Medical Supplier Services, N.J.A.C. 10:59);

14. For claims with service dates on or after July 1, 1998, all drugs prescribed for the treatment of impotency shall be limited to male beneficiaries over the age of 18 years and to four treatments per month;

15. For claims with service dates on or after August 1, 1998, prescribers shall write "Diagnosis of Impotency" on the face of any prescription for impotency drugs. Claims for such prescriptions without this written statement shall be subject to recoupment by the State of New Jersey; and

16. For claims with service dates on or after July 1, 1999, the pharmacist shall be reimbursed for the least expensive, therapeutically effective nutritional supplement or specialized infant formula, at the time of dispensing unless the prescriber indicates, in his or her own handwriting on each written prescription, or follow-up written prescription to a telephone rendered prescription, the phrase "Brand Medically Necessary."

Amended by R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).

See: 31 N.J.R. 245(a), 31 N.J.R. 1956(a).

In (a), inserted a new 12, and recodified former 12 as 13.

Amended by R.2001 d.51, effective February 5, 2001.

See: 32 N.J.R. 3929(a), 33 N.J.R. 555(a).

In (a)13, substituted "Medical Assistance Customer Center (MACC)" for "Medicaid District Office (MDO)".

Amended by R.2001 d.124, effective April 16, 2001.

See: 32 N.J.R. 4392(a), 33 N.J.R. 1201(a).

In (a), substituted "Quantity" for "Quality" in 3, added 14 through 16, and amended N.J.A.C. references throughout.

### 10:54-8.3 Medical exception process (MEP)

(a) For pharmacy claims with service dates on or after September 1, 1999, which exceed PDUR standards recommended by the New Jersey DUR Board and approved by the Commissioners of DHS and DHSS, the Division of Medical Assistance and Health Services has established a Medical Exception Process (MEP).

(b) The medical exception process shall be administered by a contractor, referred to as the MEP contractor, under a contract with the Department of Human Services.

(c) The medical exception process shall apply to all pharmacy claims, regardless of claim media, unless there is a recommended exemption by the New Jersey DUR Board which has been approved by the Commissioners of DHS and DHSS, in accordance with the rules of those Departments.

(d) The medical exception process (MEP) is as follows:

1. The MEP contractor shall contact prescribers of conflicting drug therapies, or drug therapies which exceed established PDUR standards, to request written justification to determine medical necessity for continued drug utilization.

i. The MEP contractor shall send a Prescriber Notification Letter which includes, but may not be limited to, the beneficiary name, HSP identification number, dispense date, drug quantity, and drug description. The prescriber shall be requested to provide the reason for the medical exception, diagnosis, expected duration of therapy, and expiration date for medical exception.

ii. The prescriber shall provide information requested on the Prescriber Notification to the MEP contractor.

2. Following review and approval of a prescriber's written justification, if appropriate, the MEP contractor shall override existing PDUR edits through the issuance of a prior authorization number.

3. The MEP contractor shall notify the pharmacy and prescriber of the results of the review and include, at a minimum, the beneficiary's name, mailing address, HSP number, the reviewer, service description, service date, and prior authorization number, if approved, the length of the approval and the appeals process if the pharmacist does not agree with the results of the review.

4. Prescribers may request a fair hearing to appeal decisions rendered by the MEP contractor concerning denied claims (see N.J.A.C. 10:49-10, Notices, Appeals and Fair Hearings.)

5. Claims subject to the medical exception process which have not been justified by the prescriber within 30 calendar days shall not be authorized by the MEP contractor and shall not be covered by the Medicaid/NJ KidCare programs.

New Rule, R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).

See: 31 N.J.R. 245(a), 31 N.J.R. 1956(a).

Former N.J.A.C. 10:54-8.3, Pharmaceutical; Physician-administered drugs, recodified to N.J.A.C. 10:54-8.4.

### 10:54-8.4 Pharmaceutical; Physician-administered drugs

(a) The New Jersey Medicaid program shall reimburse physicians for certain approved drugs administered by inhalation, intradermally, subcutaneously, intramuscularly or intravenously in the office, home, or independent clinic setting according to the following reimbursement methodologies:

1. Physician-administered medications shall be reimbursed directly to the physician under certain situations. (See N.J.A.C. 10:54-9.8 for a listing of HCPCS procedure codes, "J" codes and applicable Level III procedure codes with a few exceptions such as, immunizations). For this methodology, the physician is required to bill the appropriate "J" code, Level III, HCPCS procedure code.

i. A "J" code may be billed in conjunction with an office, home, or independent clinic visit when the criteria for an office or home visit is met and the procedure code for the method of drug administration. The HCPCS 90799 may be billed for intradermal, subcutaneous, intramuscular, or intravenous drug administration. Other HCPCS procedure codes may be billed for the administration of allergy, chemotherapy or inhalation drugs.

ii. The New Jersey Medicaid program has assigned HCPCS procedure codes and Medicaid maximum fee allowances to certain, selected drugs for which reimbursement to the physician is based on the Average Wholesale Price (AWP) of a single dose of an injectable or inhalation drug, or the physician's acquisition cost, whichever is less.

iii. Unless otherwise indicated in Subchapter 8 or under the exception listed in (a)2 and 3 below, the Medicaid maximum fee allowance is determined based on the AWP per unit which equals one cubic centimeter (cc) or milliliter (ml) of drug volume for each unit. For drug vials with a volume equal to one cubic centim-

eter (cc) or milliliter (ml), the Medicaid maximum fee allowance shall be based on the cost per vial.

iv. When a physician office, home, or independent clinic visit is for the sole purpose of administering a drug, the reimbursement shall include the cost of the drug and administration. In these situations, there is no reimbursement for a physician office, home, or independent clinic visit. If, in addition to the physician administration of a drug, the criteria of an office, home, or independent clinic visit is met, the cost of the drug and administration may, if medically indicated, be reimbursed in addition to the visit.