

CHAPTER 77
REHABILITATIVE SERVICES

Authority

N.J.S.A. 30:4D-6, 7 and 12; Sections 1902(a) and 1905(a) of the Social Security Act, (42 U.S.C. §§ 1396a and 1396d, respectively); Sections 2101 and 2110 of the Social Security Act (42 U.S.C. §§ 1397aa and 1397jj, respectively; 42 CFR 440.130 and 42 CFR 447.325).

Source and Effective Date

R.2003 d.90, effective January 27, 2003.
See: 34 N.J.R. 3467(a), 35 N.J.R. 1287(a).

Chapter Expiration Date

Chapter 77, Rehabilitative Services, expires on January 27, 2008.

Chapter Historical Note

Chapter 77, Rehabilitative Services, was adopted as R.1998 d.143, effective March 16, 1998. See: 29 N.J.R. 543(a), 30 N.J.R. 1081(a).

Subchapter 3, Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS), was recodified as N.J.A.C. Subchapter 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).

Chapter 77, Rehabilitative Services, was adopted as R.2003 d.90, effective January 27, 2003. See: Source and Effective Date. See, also, section annotations

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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 mental health rehabilitation services available only to:
 - i. Children covered under Medicaid/NJ FamilyCare-Plan A;
 - ii. Children covered under NJ FamilyCare-Plan B, C or D who are also enrolled in the Children's System of Care Initiative (CSOCI); and
 - iii. Children who are ineligible for Medicaid or NJ FamilyCare and who are enrolled in the CSOCI only;

4. N.J.A.C. 10:77-4 pertains to the Centers for Medicare & Medicaid Services' Healthcare Common Procedure Coding System (HCPCS). The HCPCS contain procedure codes and maximum fee allowances corresponding to the Medicaid/NJ FamilyCare and CSOCI-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".

Amended by R.2003 d.90, effective March 3, 2003.

See: 34 N.J.R. 3467(a), 35 N.J.R. 1287(a).

In (a) and (b), substituted "FamilyCare" for "KidCare" throughout; in (c), rewrote 3 and 4.

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, or a NJ FamilyCare beneficiary under 19 years of age, or a child enrolled in the Children's System of Care Initiative who is not a Medicaid/NJ FamilyCare beneficiary, but who is under 21 years of age.

"Children's System of Care Initiative (CSOCI)" means the Department of Human Services' initiative developed to provide a comprehensive approach to the treatment of mental illness in children, adolescents and young adults.

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

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

"Rehabilitative service" is an optional service 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.

Amended by R.2003 d.90, effective March 3, 2003.

See: 34 N.J.R. 3467(a), 35 N.J.R. 1287(a).

Amended "Child"; added "Children's System of Care Initiative (CSOCI)" and "NJ FamilyCare".

SUBCHAPTER 2. ENVIRONMENTAL LEAD INSPECTION SERVICES

10:77-2.1 Scope of services

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

Amended by R.2003 d.90, effective March 3, 2003.

See: 34 N.J.R. 3467(a), 35 N.J.R. 1287(a).

Inserted "and NJ FamilyCare-Plan A" following "New Jersey Medicaid".

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.

"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.

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 Temporary absences from the facility

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

(b) The dates and purpose of the temporary absence shall be recorded in the beneficiary's record maintained by the facility.

(c) A provider may seek reimbursement for a beneficiary's temporary absence from the facility due to a hospital or therapeutic leave for periods of up to 14 continuous days per episode. If the beneficiary is present in the facility for any part of the day, beginning and ending at midnight, the HCPCS procedure codes for a day of service shall be used for that day. (See N.J.A.C. 10:77-4.2(b)).

New Rule, R.2003 d.183, effective May 5, 2003.
See: 34 N.J.R. 4306(a), 35 N.J.R. 1904(a).

Former N.J.A.C. 10:77-3.7, Conflict with personal care services, recodified to N.J.A.C. 10:77-3.8.

10:77-3.8 Conflict with personal care services

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

Recodified from N.J.A.C. 10:77-3.7 by R.2003 d.183, effective May 5, 2003.

See: 34 N.J.R. 4306(a), 35 N.J.R. 1904(a).

Former N.J.A.C. 10:77-3.8, Recordkeeping, recodified to N.J.A.C. 10:77-3.9.

10:77-3.9 Recordkeeping

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

services, and the place, date, and the amount of time the services were provided.

(b) All recordkeeping documents required by (a) above shall be made available, upon request, to the Division or its agents.

Recodified from N.J.A.C. 10:77-3.8 by R.2003 d.183, effective May 5, 2003.

See: 34 N.J.R. 4306(a), 35 N.J.R. 1904(a).

SUBCHAPTER 4. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:77-4.1 Introduction

(a) The New Jersey Medicaid, NJ KidCare and NJ FamilyCare programs utilize the Centers for Medicare & Medicaid Services (CMS) Healthcare 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 CMS 1500 claim form, a CPT/HCPCS procedure code as listed in CPT or in this subchapter;

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

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

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

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

Amended by R.2003 d.90, effective March 3, 2003.

See: 34 N.J.R. 3467(a), 35 N.J.R. 1287(a).

In (a), substituted "Centers for Medicare & Medicaid Services (CMS) Healthcare" for "Health Care Financing Administration's (HCFA)"; in (d)3, substituted "CMS" for "HCFA".

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
	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	Contract pricing

Ind	HCPCS Code	Procedure Code Definition	Maximum Fee Allowance
		of Youth and Family Services, under N.J.A.C. 10:128.	
	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
	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

<u>Ind</u>	<u>Code</u>	<u>Procedure Code Definition</u>	<u>Maximum Fee Allowance</u>
	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
	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:

Unisys Corporation
 PO Box 4801
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