CHAPTER 67

MANUAL FOR PSYCHOLOGICAL SERVICES

Authority

N.J.S.A. 30:4D–6B(10), 30:4D–7, 7a, b and c.

Source and Effective Date

R.1991 d.142, effective February 19, 1991.
See: 22 N.J.R. 3615(a), 23 N.J.R. 859(b).

Executive Order No. 66(1978) Expiration Date

Chapter 67, Manual for Psychological Services, expires on February 19, 1996.

Chapter Historical Note

Chapter 67, Manual for Psychological Services, was filed as R.1973 d.368, on December 28, 1973, to become effective January 1, 1974. See: 5 N.J.R. 415(a), 6 N.J.R. 68(a). Pursuant to Executive Order No. 66, Chapter 67 was readopted by R.1991 d.142. See: Source and Effective Date.

See subchapter and section annotations for specific rulemaking activity.

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SUBCHAPTER 1. PSYCHOLOGIST'S SERVICES MANUAL

Authority

N.J.S.A. 30:4D–6b(10)7 and 7b.

Source and Effective Date

R.1985 d.114, effective February 19, 1985.
See: 16 N.J.R. 3163(a), 17 N.J.R. 706(c).

Historical Note

All provisions of this subchapter were effective January 1, 1974 as R.1973 d.368. See: 5 N.J.R. 415(a), 6 N.J.R. 68(a). Amendments became effective April 1, 1980 as R.1980 d.137. See: 11 N.J.R. 445(c), 12 N.J.R. 277(b). Further amendments were filed and became effective October 8, 1981 (operative January 1, 1982) as R.1981 d.374. See: 12 N.J.R. 662(a), 13 N.J.R. 706(d). This subchapter was readopted pursuant to Executive Order 66(1978) effective February 19, 1985, with amendments effective March 18, 1985, as R.1985 d.114. See: 16 N.J.R. 3163(a), 17 N.J.R. 706(c). See chapter and section levels for further amendments.

10:67–1.1 Definitions

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

"Psychologist" means a practicing professional psychologist who is licensed by the New Jersey State Board of Psychological Examiners. Psychologists practicing in states other than New Jersey are not eligible for reimbursement under the New Jersey Health Services Program.

"Psychological services" means those services rendered within the scope of the profession of psychology as defined by the laws of the State of New Jersey. Psychological services include such services no matter where or in what environment rendered (that is, office, home, clinic, hospital, mental institution and so forth).

"Psychological specialist" means an individual, fully licensed by the New Jersey State Board of Psychological Examiners, who limits his practice to his specialty and who:

1. Is a Diplomate of the American Board of Professional Psychology (Diplomate Qualified) or;

2. Has been notified of admissibility to the examination by the American Board of Professional Psychology (Diplomate Eligible).

Amended by R.1985 d.52, effective February 19, 1985 (operative March 1, 1985).
See: 16 N.J.R. 2333(a), 17 N.J.R. 452(a).
Deleted old (c) and substituted new.
Administrative Correction to definition of "Psychological specialist".
See: 21 N.J.R. 1430(b).

10:67–1.2 Consultative services

(a) "Consultation" means advice or counsel of a qualified specialist as requested by the attending physician. This requires a personal examination of the patient with a written notation of the history, physical description, diagnosis and recommendations of the consultant.

(b) When the consultant assumes the continuing care of the patient, any subsequent services rendered by him will no longer be considered as consultation.

(c) Except where medical necessity dictates, or where hospital policy (therapeutic abortion) or State law, (commitment to a mental institution) dictates otherwise, multiple and simultaneous consultations in the same specialty for the same disease, illness or condition, whether in or out of a hospital are not reimbursable. Reimbursement for consultations will be limited to one per specialty per hospital admission.

(d) Consultation services can be paid only when they meet the three criteria of eligible consultation services under the Medicaid program to be paid, a consultation must:

1. Be a professional service furnished to a patient by a psychologist at the request of the attending physician;
2. Include a history and examination of the patient;
3. Include a written report.

(e) When consultation services are performed in the psychologist's office or the patient's home, the name and Individual Medicaid Practitioner number of the referring physician must be included on the claim form. The name must be listed in item 19 of that form.

(f) When reporting consultation services, be sure to specify whether they were limited or comprehensive.

As amended, R.1981 d.249, effective July 9, 1981.
See: 13 N.J.R. 293(a), 13 N.J.R. 417(a).
(e): added: "and Individual Medicaid Practitioner number;" and the requirement that the name "must" (deleted "may") be listed in item "19" (was "13").

10:67–1.3 Concurrent care

(a) In the case of a consultation, the psychologist is entitled to payment for services rendered, subject to limitations under N.J.A.C. 10:67–1.2. However, once transfer is made, reimbursement for services can only be made to the current psychologist.

(b) Concurrent care will be covered only in an emergency or a significant illness or injury status for which the medical necessity for concurrent care can be clearly established.

10:67–1.4 Transfer defined

Transfer is the relinquishing of responsibility for the continuing care of the patient by one psychologist and the assumption of such responsibility by another psychologist.

10:67–1.5 Scope of reimbursable services

(a) Payment will be made for psychological services rendered, subject to the following limitations:

1. In the hospital or similar institution or setting, specific psychologist's services for which the psychologist is reimbursed directly by the institution under contractual or other arrangements may not be billed and reimbursed on a fee for service basis.
2. All psychological services provided to a patient registered in a hospital outpatient department are considered hospital costs whether or not the psychologist receives compensation from the hospital.
3. When psychological services are provided to persons in a skilled nursing home, payment will not be made for any services rendered by an owner, administrator, stockholder of the company or corporation, or any person who has a direct financial interest in the institution.
4. Psychological services rendered to any eligible recipient by an approved community mental health agency or by an approved independent outpatient health facility, or under the auspices of such agency or facility, shall not be billed by the psychologist.

10:67–1.6 General policy; recordkeeping

(a) Psychologists shall keep individual records as may be necessary to disclose fully the kind and extent of services provided and to make such information available as the Division or its agent may request.

(b) For the initial examination, the record shall show the following as minimum:

1. Date of service rendered;
2. Chief complaint(s);
3. Pertinent historical, social, emotional and additional data;
4. Reports of evaluation procedures undertaken or ordered;
5. Diagnosis;
6. Intended course of procedure and tentative prognosis.

(c) For subsequent progress notes made for each patient contact made by a psychologist, in other than a Partial Hospitalization or Personal Care Program, the following are required ingredients of a psychotherapy progress note:

1. Date and duration of service (hour, half-hour, etc.)

2. Signature of provider (if a member of a group).

3. Name of the modality used, individual, group, family therapy;

4. Notations of progress, impediments, or treatment complications;

5. Other, which may include dates or information not included in (c)1 through 4 above, and which may be important to the clinical picture and prognosis.

6. One or more of the following components must be recorded to delineate the visit and establish its uniqueness. Not all of the components need be included:

i. Symptoms and complaints;

ii. Affect;

iii. Behavior;

iv. Focus topics; and

v. Significant incidents or historical events.

Amended by R.1985 d.52, effective February 19, 1985 (operative March 1, 1985).
See: 16 N.J.R. 2333(a), 17 N.J.R. 452(a).
Deleted (c) and added more specific progress note requirements. Administrative correction to (c).
See: 21 N.J.R. 1430(b).

10:67–1.7 Policies related to inpatient care

(a) If the patient is admitted to a hospital or like institution and does not have private psychologist, a psychologist may, in accordance with regulations of the hospital's medical and governing boards, be assigned as the psychologist and be reimbursed as such, provided:

1. The patient is allowed free choice of psychologists;

2. The psychologists chosen accepts the professional responsibility for the patient within the scope of his practice.

(b) Patients will be admitted to a hospital only on the direction of a physician. Under the Health Services Program, the hospital record of admission will serve as the physician's certification of need. The physician's certification and recertification and utilization committee's approval and reapproval must be on file at the hospital and must be kept available for audit. Certification is not required for outpatient services.

(c) When an inpatient is to be discharged from the hospital and continuing care is required in another medical facility (that is, skilled nursing facility, intermediate care facility and so forth) or by a community health agency (for example, home health agency, visiting nurses association and so forth), a legible abstract or summary of those psychological services rendered must be prepared and signed by the psychologist and incorporated in the patient's overall discharge summary. This abstract shall include the patient's hospital course with recommendations for further psychological care, if any, and be made available to the facility, institution or agency to which the patient has been referred.

Amended by R.1985 d.114, effective February 19, 1985.
See: 16 N.J.R. 3163(a), 17 N.J.R. 706(c).
Deleted text in (b).

10:67–1.8 Prior authorization

(a) Prior authorization means approval by the Chief, Bureau of Mental Health Services, Division of Medical Assistance and Health Services, of a mental health service before the service is rendered.

1. Exception: For patients in long term care facilities, prior authorization of a mental health service is obtained from the Division's medical consultant at the Medicaid District Office (M.D.O.).

(b) Prior authorization is required for psychological services exceeding $300.00 in payments to the psychologist in any 12–month period, commencing with the patient's initial visit, when provided in other than an inpatient hospital setting. When approved by N.J. Medicaid, each authorization may be granted for a maximum period of one year. Additional authorizations may be requested.

1. Exception: After an initial evaluation, prior authorization is required under all circumstances for psychological services rendered to Medicaid eligible recipients in long-term care facilities and sheltered boarding homes.

(c) When prior authorization is required, the following procedures are to be observed:

1. For patients residing in a long term care facility (LTCF) the request is to be submitted on a "Request for Authorization of Psychiatric Services" form (FD–07) to the Medicaid District Office that services the LTCF. Items 1 through 17 on the FD–07 must be completed, except items 10, 11, 12 need not be filled in if a copy of the consultation report is attached.

2. For patients who do not reside in an LTCF, but live in a community setting, including a sheltered boarding home, the request for prior authorization is to be submitted (form FD–07) directly to the Chief, Division of Medical Assistance and Health Services, Quakerbridge Plaza, CN 712, Trenton, NJ 08625. Items 1 through 17 must be completed.

(d) The request must include the diagnosis, as set forth in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (latest edition), and must also include treatment plan and progress report in detail. No post facto authorization will be granted.

(e) If the request for prior authorization is approved, both the provider copy and the contractor copy will be returned to the provider. The provider must attach the contractor copy of the FD–07 to the claim form that is submitted to the Prudential Insurance Company; otherwise, the claim will not be processed for payment and will be returned to the provider.

(f) If the request for authorization is denied, the provider shall be notified of the reason, in writing, by the unit of the Division responsible for the decision.

As amended, R.1980 d.137, effective April 1, 1980.
See: 11 N.J.R. 445(c), 12 N.J.R. 277(b).
As amended, R.1981 d.374, effective October 8, 1981 (to become operative January 1, 1982).
See: 12 N.J.R. 662(a), 13 N.J.R. 706(d).
(b)1 added.
Amended by R.1985 d.114, effective February 19, 1985.
See: 16 N.J.R. 3163(a), 17 N.J.R. 706(c).
Section substantially amended.

10:67–1.9 Basis of payment

(a) Psychological services are reimbursed on a fee-for-service basis in accordance with the Procedure Code Manual, which is referenced at N.J.A.C. 10:54–4. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies; or other groups or individuals in the community. If a patient receives care from more than one member of a partnership or corporation in the same discipline, the maximum payment allowance would be the same as that of a single attending physician.

(b) Payment for a psychological consultation shall be considered as inclusive for all psychological services provided, performed or rendered on that day. No additional reimbursement will be allowed for therapy on the day that a consultation is provided.

Amended by R.1985 d.114, effective February 19, 1985.
See: 16 N.J.R. 3163(a), 17 N.J.R. 706(c).
Section substantially amended.
Amended by R.1991 d.142, effective March 18, 1991.
See: 22 N.J.R. 3615(a), 23 N.J.R. 859(b).
In (a): Revised N.J.A.C. reference.

10:67–1.10 Psychological generalists

Psychologists licensed by the State of New Jersey and approved as providers by the New Jersey Health Services Program shall be reimbursed for allowable psychological testing and psychotherapeutic services to the same extent as a licensed physician (M.D. or D.O.) generalist.

10:67–1.11 Psychological specialists

Psychologists licensed by the State of New Jersey and recognized by the New Jersey Health Services Program as "specialists" in accordance with N.J.A.C. 10:67–1.1 shall be reimbursed for allowable psychological testing and psychotherapeutic services to the same extent as a licensed physician (M.D. or D.O.) specialist as defined in N.J.A.C. 10:54–1.1.

SUBCHAPTER 2. PSYCHOLOGIST'S BILLING PROCEDURES

10:67–2.1 General billing procedures

(a) A claim is a bill which indicates a request for payment for a Medicaid-reimbursable service provided to a Medicaid-eligible individual. The claim may be submitted hard copy or by means of an approved method of automated data exchange.

(b) This subchapter contains basic information necessary for the submission of a claim. Included is a sample claim form approved for use in submitting claims for covered items or services and appropriate instructions for the proper completion of the form.

Amended by R.1987 d.408, effective October 5, 1987.
See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).
(a) added; old text codified as (b).

10:67–2.2 Timeliness of claim submission and claim inquiry

For timeliness of claim submission and claim inquiry, see N.J.A.C. 10:49–1.12.

New Rule, R.1987 d.408, effective October 5, 1987.
See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).
Repealed rule was General policy.

10:67–2.3 Patient identification

Verify that the patient is a covered person on the first visit and each visit thereafter. This is done by viewing the patient's validation form which is issued monthly. Individuals under the jurisdiction of the Division of Youth and Family Services (DYFS) are issued quarterly validation cards. It is especially important to review a patient's validation form on each visit when extended plans of treatment have been authorized. Prior authorization is no guarantee that an individual is covered. Authorization becomes invalid upon termination of eligibility.

Amended by R.1986 d.236, effective June 16, 1986 (operative July 1, 1986).
See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a).
Deleted text "the first day of the month." and added "monthly. Individuals under ... quarterly validation cards."

10:67–2.4 Prior authorization

When submitting claims for payment, make certain all authorizations have been properly signed and are attached.

10:67–2.5 Combination Medicare/Medicaid claims

Services covered under Medicare rendered by noninstitutional providers to a Medicare/Medicaid eligible person shall be billed on The Health Insurance Claim Form (HCFA–1500) and the claims sent directly to the Medicare Intermediary, Prudential, Medicare B Division, P.O. Box 471, Data Base Systems Division, Millville, New Jersey 08332. The provider must record the Health Insurance claim number in item 6 and the New Jersey Health Services case and person number in item 8 on the form HCFA–1500.

NOTE: In cases where prior authorization is required for the Health Services Program, it must be obtained and submitted with the Medicare claim.

The Health Insurance Claim Form (HCFA–1500) may be obtained from Prudential.

As amended, R.1981 d.249, eff. July 9, 1981.
See: 13 N.J.R. 293(a), 13 N.J.R. 417(a).
Incorporated billing procedures using HCFA–1500 claim form, and deleted references to form SSA–1490.

10:67–2.6 Directory of Medicaid District Offices (MDO)

(a) The following is a list of local Medical offices (local Medicaid district offices or MDO), their county of location, their county(ies) of jurisdiction, their addresses and telephone numbers. It should be noted that the first two digits of the patient's Health Services Program case number indicates which MDO has jurisdiction.

1st Two Digits County Code	County	Street Address	Municipality	Zip Code	P.O. Box	Telephone
01,44	Atlantic	1601 Atlantic Avenue	Atlantic City	08404	1970	609–344–2861
05	Cape May	1601 Atlantic Avenue	Atlantic City	08404	1970	609–344–2861
02	Bergen	50 Main Street	Hackensack	07601		201–488–5667
03,45,46	Burlington	Chesley and Alloway Building Route 38 and Eayrestown Road	Mt. Holly	08060		609–261–0448
04,34	Camden	530 Cooper Street	Camden	08101	19	609–365–3926
06,41	Cumberland	7 E. Broad Street	Bridgeton	08302	440	609–451–6550
07	Essex	796 Broad Street	Newark	07101	1576	201–648–2470
08	Gloucester	42 Delaware Avenue	Woodbury	08096	1900	609–845–7185
17	Salem	42 Delaware Avenue	Woodbury	08096	1900	609–845–7185
09	Hudson	100 Newkirk Avenue	Jersey City	07306		201–792–6390
10,35,48	Hunterdon	6 Court Street	Flemington	08822		201–782–1130
18	Somerset	6 Court Street	Flemington	08822		201–782–1130
21	Warren	6 Court Street	Flemington	08822		201–782–1130
11,32,90	Mercer	324 E. State Street	Trenton	08625	2465	609–292–7315
12,47	Middlesex	75 Paterson Street	New Brunswick	08903	1274	201–246–0653
13,33,36	Monmouth	320 Broad Street	Red Bank	07701		201–842–6440
14,31	Morris	4 Court Street	Morristown	07960		201–267–1700
19	Sussex	4 Court Street	Morristown	07960		201–267–1700
15	Ocean	1851 Hooper Avenue	Toms River	08753		201–255–6226
16,42	Passaic	152 Market Street	Paterson	07509	2863	201–523–2800
20	Union	7 Bridge Street	Elizabeth	07201		201–355–8860

Amended by R.1985 d.114, effective February 19, 1985.
See: 16 N.J. 3163(a), 17 N.J.R. 706(c).
Deleted Note in (a).

10:67–2.7 Eligibility questions

(a) Medicaid eligibility is determined by four different agencies (for example, county welfare boards, Bureau of Local Operations of the New Jersey Division of Public Welfare, New Jersey Division of Youth and Family Services, and the Federal Social Security Administration).

(b) Provider inquiries concerning patient eligibility and/or application for eligibility may be directed to the appropriate eligibility determination agency (if known by the provider) or the MDO serving the provider's area. The MDO will assist the provider by answering the questions and/or directing the provider to the appropriate eligibility determination agency.

10:67–2.8 Health Insurance Claim Form (HCFA–1500)

This form is used for the purpose of billing for covered services of physicians, podiatrists, optometrists, psychologists and chiropractors. Billing should be done on a monthly basis and submitted for payment as soon after the end of the month as is possible. (See N.J.A.C. 10:49–1.12.)

As amended, R.1981 d.249, effective July 9, 1981.
See: 13 N.J.R. 293(a), 13 N.J.R. 417(a).
Deleted catchline concerning Form MC–8, and substituted catchline and rule concerning Form HCFA–1500.

10:67–2.9 Mailing instructions

Mail the original copy (contractor's copy) together with authorization from FD–07 (when appropriate) to:

The Prudential Insurance Company of America
P.O. Box 1900
Millville, New Jersey 08332

NOTE: Forms and instructions were also adopted with the text of the above rules but are not reproduced herein. Information concerning the omitted data may be obtained from the Division of Medical Assistance and Health Services, Quakerbridge Plaza, CN 712, Trenton, New Jersey 08625.

As amended, R.1974 d.245, effective September 4, 1974.
See: 6 N.J.R. 399(b).

10:67–2.10 (Reserved)

R.1981 d.305, effective September 10, 1981 (to become operative October 1, 1981).

See: 13 N.J.R. 298(a), 13 N.J.R. 578(b).

Repealed by R.1986 d.52, effective March 3, 1986.

See: 17 N.J.R. 1519(b), 18 N.J.R. 478(a).

This section was "procedure codes" description of what is listed in the Procedure Code Manual.

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

Authority

N.J.S.A. 30:4D–6a(3)(4)b(5); 6b(1)(3)(5)(6)(7)(8)(10)(12)(15)(16); 7, 7a, 7b, 7c.

Source and Effective Date

R.1986 d.52, effective March 3, 1986.
See: 17 N.J.R. 1519(b), 18 N.J.R. 478(a).

EDITOR'S NOTE: The Division of Medical Assistance and Health Services utilizes the HCPCS (Health Care Financing Administration's Common Procedure Coding System) as the basis of reimbursement for providers of psychological services that participate in the New Jersey Medicaid Program. The HCPCS coding system utilizes procedure codes, narrative descriptions and corresponding fee schedules as the basis of reimbursement. The HCPCS coding system also indicates any limitations on a particular procedure code by the use of qualifiers and/or modifiers.

The HCPCS coding system is not published in the New Jersey Administrative Code but may be obtained from the Administrative Practice Officer, Division of Medical Assistance and Health Services, CN–712, Trenton, New Jersey 08625.

Amended by R.1988 d.156, effective April 4, 1988 (operative April 15, 1988).

See: 19 N.J.R. 2376(a), 20 N.J.R. 809(a).

A fee increase for family planning services

Public Notice: pursuant to the provision of N.J.S.A. 30:4D–2, 3, 5, 6 and 7 and the New Jersey Appropriations Act (P.L. 1988 c.47), increases for routine visits and Cytopathology effective August 1, 1988 and May 1, 1989; prolonged detention increased effective August 1, 1988; and obstetrical services increased effective October 1, 1988, January 1, 1989 and April 1, 1989.

See: 20 N.J.R. 2101(a).