



*State of New Jersey  
Department of Human Services  
Partnership for  
Children:*

*NJ Children's System of Care Initiative*

*Partnership for Children*

Volume 3 No. 2

June 2003

**TO:** **Hospitals – For Action**  
Care Management Organizations – **For Information Only**  
Health Maintenance Organizations– **For Information Only**

**SUBJECT:** Inpatient Mental Health Services Provided in Out-of-State Hospitals to Beneficiaries Under the Age of 21

**EFFECTIVE:** **Immediately**

**PURPOSE:** The purpose of this Newsletter is to reiterate the current Medicaid/NJ FamilyCare requirements regarding the prior authorization procedures for inpatient mental health services provided in out-of-State hospitals to children/youth/young adults under the age of 21. These requirements are also applicable to all children/youth/young adults who are enrolled in the Partnership for Children and who are receiving Care Management Organization (CMO) Services.

**BACKGROUND:** Beneficiaries of the Partnership for Children (formerly known as the Children's System of Care Initiative) are children, youth or young adults under the age of 21 who are receiving services for emotional, mental or behavioral health issues. Medically necessary inpatient psychiatric services provided in hospitals are recognized as a reimbursable Medicaid/NJ FamilyCare/Partnership for Children service. Although the focus of the Partnership for Children is to maintain children, youth or young adults in their communities, there are times when out-of-State inpatient psychiatric services must be utilized. As stated in Children's System of Care Initiative Newsletter Vol. 2, No. 6, dated September 2002, all mental health services provided to children, youth and young adults receiving CMO services are required to be included in the child's/youth's/young adult's plan of care and authorized by the CMO.

Inpatient psychiatric services can be provided to New Jersey Medicaid/NJ FamilyCare children, youth and young adults in an acute care hospital (usually short term), a distinct unit of an acute care hospital (recognized as such by Medicare or the state licensing agency), or in a psychiatric hospital (recognized as such by the state licensing agency, Medicare, or the New Jersey Medicaid/NJ FamilyCare program). The hospital providing the service must be enrolled as a New Jersey Medicaid/NJ FamilyCare provider.

⇒ A hospital providing inpatient psychiatric services to a child, youth or young adult who is enrolled **only** in the Partnership for Children services **must be enrolled in the New Jersey Medicaid/NJ FamilyCare program as a PSYCHIATRIC HOSPITAL**; inpatient psychiatric services provided in an acute care hospital are not covered services.

⇒ A child, youth or young adult who is enrolled **only** in the Partnership for children will have an eligibility identification number beginning with **3560**.

All Partnership for Children beneficiaries, whether they are eligible under NJ Medicaid/NJ FamilyCare or only under the Partnership for Children, must receive services in accordance with the applicable Division of Medical Assistance and Health Services rules.

**ACTION:** Providers of inpatient hospital psychiatric services provided in out-of-State hospitals must continue to request and receive prior authorization in accordance with N.J.A.C. 10:52-1.10 and N.J.A.C. 10:54-7.9 before rendering elective psychiatric services to Medicaid/NJ FamilyCare or Partnership for Children beneficiaries. Care Management Organizations may submit the request and the material on behalf of the provider if they wish to do so. **However, approval for payment of services is only generated by the Division of Medical Assistance and Health Services at this time.**

**These requirements apply to out-of-State HOSPITALS only, they are not applicable to other residential facilities providing mental health services for children, including residential treatment centers and group homes.**

Providers must secure prior approval from the Division prior to admission of the child/youth/young adult into their out-of-State inpatient psychiatric hospital facility. Prior authorization requests must be submitted to:

Office of Utilization Management, Mental Health Services  
Division of Medical Assistance and Health Services  
Mail Code #18, PO Box 712  
Trenton, NJ 08625-0712

The request for prior authorization must include, at a minimum, the following information:

1. The Admission Certification of Need;
2. The diagnosis, as set forth in the latest edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-V);
3. A brief history, which MUST include:
  - A summary of all previous treatment and hospitalizations;
  - A complete list of all current medications; and
  - The child/youth/young adult's present clinical status;
4. A treatment proposal, including the anticipated length of the hospitalization; and
5. An attestation that suitable placement within New Jersey and/or a within a reasonable distance of the child, youth/young adult's home is not available.

**NOTE:** *Any request for retroactive authorization will be considered by the Division only when the request has been delayed by documented circumstances beyond the control of the hospital.*

The Division of Medical Assistance and Health Services will inform the provider of the outcome of the request. **If the request is approved, the authorization letter will be returned to the provider. The authorization letter must be attached to the claim form to ensure reimbursement.**

**Prior authorization is not required for an emergency admission or transfer.** In the case of an emergency admission or transfer, the hospital must attach the attending physician's signed statement to the claim, attesting to the nature of the emergency; or, for transfer, attesting to the unavailability of the medically necessary service within a reasonable distance within the State of New Jersey.

**Prior authorization is required for continued stay after an emergency admission.**

Attached to this newsletter is a copy of the Admission Certification of Need that is required for all admissions and a checklist of required information to simplify the process of requesting prior authorization.

If you have any questions concerning this Newsletter, please contact the Office of Utilization Services, Mental Health Unit at (609) 588-2749.

**RETAIN THIS NEWSLETTER NUMERICALLY BEHIND THE NEWSLETTER TAB  
(BLUE TAB MARKED "5")**

**ADMISSION CERTIFICATION OF NEED  
FOR INPATIENT PSYCHIATRIC TREATMENT  
FOR UNDER AGE 21 MEDICAID/NJ FAMILYCARE/  
PARTNERSHIP FOR CHILDREN INDIVIDUAL**

**[MEDICAID REGULATIONS REQUIRE THAT CERTIFICATION BE MADE BY AN INDEPENDENT\* TEAM THAT INCLUDES A PHYSICIAN WHO HAS COMPETENCE IN DIAGNOSIS AND TREATMENT OF MENTAL ILLNESS, PREFERABLY IN CHILD PSYCHIATRY AND HAS KNOWLEDGE OF THE INDIVIDUAL'S SITUATION.]**

For admission of \_\_\_\_\_ Birth date \_\_\_\_\_  
Name of individual under age 21

To: \_\_\_\_\_  
Name of Psychiatric Hospital or Residential Treatment Center

I/we the undersigned, on the basis of clinical knowledge about the above named individual, have made the determination that:

- 1) Ambulatory care resources available in the community do not meet the treatment needs of the recipient.
- 2) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
- 3) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

Date \_\_\_\_\_ MD or DO

Date \_\_\_\_\_ MD, DO, RN, Ph.D., MSW, other \_\_\_\_\_

Date \_\_\_\_\_ MD, DO, RN, Ph.D., MSW, other \_\_\_\_\_

- NOTE:**
- 1) \*"Independent" means not to have employment or consultant relationship with the admitting facility. Thus, referring professionals or health agencies can best do certification.
  - 2) Team members have the option of certifying collectively or individually.
  - 3) Certification must be based on evaluation performed within 45 days of proposed date of admission.
  - 4) Certification should accompany child or youth to admitting facility and become part of the clinical record.

## CHECK LIST FOR PRIOR AUTHORIZATION REQUEST

### I. Identifying information of Referring Facility

Name of hospital/facility: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone #: \_\_\_\_\_  
Fax #: \_\_\_\_\_  
Contact Person: \_\_\_\_\_

Name of patient \_\_\_\_\_ Med.#: \_\_\_\_\_  
DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Phone # \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

### II. Identifying Information of Prospective Receiving Facility

Inpatient                       Outpatient                       Residential Facility

Name of hospital/facility: \_\_\_\_\_  
Address: (including phone #, fax #, contact person)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NJ Medicaid Provider # \_\_\_\_\_

### III. Check List

- Reason for referral
- Recent psychiatric evaluation
- Certificate of Need for patient under age 21
- Letter of pledge to assist reintegration of the patient into NJ State by referring agency/facility
- Check if any other agency is involved, etc.
  - Division of Developmental Disabilities
  - Division of Youth and Family Services
  - Division of Mental Health Services
  - Division of Addiction Services
  - Partnership for Children