State of New Jersey
Department of Human Services
Partnership for Children:
Children's System of Care Initiative

Volume 3 Number 6 **December 2003**

TO: JCAHO-Accredited Residential Treatment Centers,
Non JCAHO-Accredited Residential Child Care Facilities,
Non JCAHO-Accredited Psychiatric Community Residences,
Non JCAHO-Accredited Children's Group Homes and
Non JCAHO-Accredited Children's Treatment Homes – **For Action**
Care Management Organizations – **For Action/Information**
Health Maintenance Organizations – **For Information Only**

SUBJECT: Authorization for Mental Health Rehabilitation Services Provided in Out-of-Home Residential Settings

EFFECTIVE: **January 1, 2004**

PURPOSE: The purpose of this Newsletter is to notify providers of the authorization requirements for mental health rehabilitation services provided in out-of-home residential settings for Medicaid/NJ FamilyCare or the Partnership for Children (PFC) children, youth and young adults. This requirement applies to all in-State and out-of-State programs whether they are accredited or not accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), including Residential Treatment Centers, Psychiatric Community Residences for Youth, and Children's Group Homes and Treatment Homes. The Newsletter also informs all providers of the requirements concerning the registration, admissions and the Joint Care Review process. The Newsletter additionally informs in-State New Jersey providers only what they must do to meet the provider profile and bed-tracking requirements. Providers located outside New Jersey are not required to meet these standards.

BACKGROUND: Medically necessary treatment in out-of-home residential settings provided in JCAHO Accredited Residential Treatment Centers, Non-JCAHO Psychiatric Community Residences for Youth, and Children's Group Homes and Treatment Homes are recognized as a reimbursable Medicaid/NJ FamilyCare/Partnership for Children service for eligible children, youth and young adults.

Although the focus of the Partnership for Children is to maintain children, youth and young adults in their communities, out-of-home residential treatment services are sometimes utilized as an effective treatment component to facilitate optimal functioning with the goal of returning children, youth and young adults to their homes and communities as soon as the necessary treatment is completed. The Joint Care Review process will ensure appropriate utilization review for out-of-home treatment as an integral component of the continuum of mental/behavioral health rehabilitation services and subsequent reimbursement for services provided to eligible NJ FamilyCare/PFC enrolled children, youth and young adults. For in-State programs and facilities only, participation in the completion of provider profiles and bed tracking procedures will ensure that providers receive appropriate referrals, consistent with their treatment components, and that such providers have the ability to provide appropriate treatment.

The authorization and joint care review requirements are consistent with current contract requirements, previous correspondence sent by the Department of Human Services (DHS) and the Partnership for Children (PFC) and training on admission procedures, the prior authorization process and the joint care review process. In addition, for in-State providers only, provider profile and bed tracking procedures are consistent with the training provided by the DHS and PFC in conjunction with ValueOptions, the Contracted Systems Administrator (CSA).

ACTION: For claims with dates of service on or after January 1, 2004, authorization must be obtained for all Medicaid/NJ FamilyCare and PFC children, youth or young adults for all admissions and continued stays in all JCAHO and non JCAHO-Accredited residential mental health rehabilitation facilities including children's group homes, treatment homes, residential treatment centers and psychiatric community residences.

NOTE: During the first month of this new requirement, the PFC will be working closely with providers to ensure that there is no disruption in services, that all services are authorized and that providers continue to receive appropriate reimbursement. ***This transition period will last one month, and effective February 1, 2004, claims for services that were not appropriately authorized will be denied.***

For any provider who has not attended a previously scheduled PFC training regarding the admission/referral process, the Joint Care Review and bed tracking, or for those providers who would like a "refresher" course, a training session is being scheduled for January 6, 2004. Providers should contact Maria Sherry at ValueOptions at (609) 689-6231 to register for this training session or if they have any questions about the training. Providers must register for this training session no later than Friday, January 2, 2004.

GENERAL REFERRAL/ADMISSION & AUTHORIZATION REQUIREMENTS:

There are two primary pathways for entry into an out-of-home treatment setting- DYFS or the Care Management Organization (CMO). All children being considered for an out-of-home treatment setting will be involved with either DYFS or a CMO which will be responsible for the coordination of the referral and admissions process. This referral/admissions process should be completed within 30 days.

To initiate the referral/admissions process, DYFS or the CMO will contact the Contracted Systems Administrator (CSA) to secure a confirmation number for the requested level of service indicating the approved level of care only (e.g. Psychiatric Community Residence, Residential Treatment Center, Group Home, or Treatment Home). The referring agency will provide referral information packets to prospective providers including the confirmation number for the approved level of care on the child, youth or young adult. The providers shall review the referral information and notify the CSA of their final determination regarding admission within three days of the initial interview or ten days of receipt of the referral information packet. If the referral packet does not contain the confirmation number of the level of care authorized, the provider/facility should contact the agency coordinating the referral (DYFS or the CMO) prior to reviewing the referral packet.

If the provider AGREES to admit the individual, the provider, the agency coordinating the referral and the family must agree on the targeted admission date. The provider should contact the CSA to confirm acceptance and inform the CSA of the anticipated admission date. In addition, the provider must contact the CSA by telephone on the actual date of admission to secure an **authorization number** for reimbursement. ***ONLY the authorization number given to the provider by the CSA will authorize payment of a claim*.** Written confirmation of the authorization number will be sent to the provider within seven business days of this telephone call. The initial length of stay may be authorized for up to 120 days to provide the necessary authorizations to ensure compliance with treatment plan/ISP plan cycles.

If a provider DOES NOT AGREE to admit the individual, the provider must notify the agency coordinating the referral (DYFS or the CMO) within the three day or ten day timeframe as referenced above AND must notify the CSA via fax at 609-689-6260 regarding non-admission. The fax must include details regarding the reason(s) for the decision not to admit the child, youth or young adult.

NOTE: Children's Crisis Intervention Services (CCIS) will continue to utilize existing admissions and referral procedures for admissions and referrals to Psychiatric Community Residences. The Psychiatric Community Residences must contact the CSA by telephone on the actual date of the admission of a child referred from CCIS to receive the authorization number for the admission and

continued stay as described in this newsletter. **Remember: ONLY the authorization number given to the provider by the CSA will authorize payment of a claim.**

NOTE: The Division of Medical Assistance and Health Services (DMAHS) shall provide authorizations for out-of-state facilities for children, youth and young adults whose admission is not being coordinated by CCIS, DYFS or a CMO. Providers should continue to follow current authorization procedures by contacting the DMAHS Office of Utilization Management at 609-588-2749.

AUTHORIZATION FOR AN EMERGENCY ADMISSION

Emergency placements coordinated through DYFS require the specific verbal approval of the DYFS Regional Assistant Director or designee. Emergency placements coordinated by a CMO require the specific verbal approval of the CMO Executive Director or designee.

Emergency Admissions may be authorized for up to Seven (7) Calendar Days.

For all emergency admissions which occur Monday through Friday between 8:00 a.m. and 10:00 p.m., the DYFS or the CMO must contact the CSA to obtain a specific confirmation number with the prefix "EMER". On the day of the emergency admission, the provider must contact the CSA to advise them of the admission and request an authorization number. The CSA will generate an authorization letter within seven business days effective from the date of admission. Claims submitted for services provided without proper authorization may be denied.

For all emergency admissions during weekdays from 10 p.m. to 8 a.m. and during weekends and during New Year's Day, Memorial Day, July 4th, Labor Day, Thanksgiving, the day after Thanksgiving and Christmas, DYFS or the CMO coordinating the placement will contact the CSA prior to 10 a.m. the following business day to register the emergency admission. The provider must call the CSA to verbally obtain an authorization number the next business day after the admission. Written confirmation of the number will be provided by the CSA within seven business days. Claims submitted for services provided without the proper **authorization number** will be denied. The provider must request additional authorization from the CSA for continuing stays beyond the initial seven days.

AUTHORIZATION FOR CONTINUED STAY/JOINT CARE REVIEW PROCESS

Providers will be given an initial authorization covering a period up to 120 days. As part of the prior authorization process for continued stay beyond the initially or previously authorized length of stay, providers must participate in the Joint Care Review Process. Providers must complete the requisite Joint Care Review/Treatment Plan form, and the Strengths and Needs Assessment using

the PFC Management Information System within fourteen days of the end of the authorization. The information submitted should be gathered in conjunction with the family and/or DYFS, the appropriate care management entity, clinical staff involved with the child, youth or young adult and any other appropriate participant. The CSA will issue a prior authorization for continued stay for up to 90 days within seven days of the submission of the documentation. If continued stay is clinically necessary, authorization will be provided for a time period not to exceed 90 days or in 30-day increments once a child is determined to be ready to transition to an alternate setting.

Prior to January 1, 2004, all providers must contact ValueOptions to ensure that authorizations are in place for children in their facilities and must complete any outstanding Joint Care Reviews.

GENERAL INFORMATION

No retroactive authorization will be provided. Authorization must be obtained prior to the provision of services EXCEPT for services provided under the auspices of an emergency placement as indicated above.

To ensure that the proper reimbursement is received, providers should confirm that the Medicaid/NJ FamilyCare number and the prior authorization numbers they are using are the accurate numbers for that claim.

To ensure appropriate reimbursement is received, when submitting all claims to Unisys, the provider must enter the **authorization number provided to them by the CSA upon admission** for the specific dates of service in the appropriate block (#23) on the CMS 1500 claim form to ensure proper reimbursement is received. **DO NOT enter the level of care confirmation number that was in the initial referral packet; this will cause the claim to be denied.**

Claims for services requiring an authorization number that do not have the correct number entered on the claim will be rejected for Error Code 423 (prior authorization required) or Error Code 774 (prior authorization code not on file). If you receive an Error Code 774, please contact the CSA to confirm that the correct prior authorization code was entered prior to resubmitting the claim.

IN-STATE PROGRAM/FACILITY INFORMATION FORM AND BED TRACKING PROCEDURES

In-State providers ONLY are required to complete a Provider Information Form, using the PFC Management Information System, AND are required to report bed availability to the CSA, also using the PFC Management Information System. The Provider Information Form is required to be completed once; however, if your provider information changes, please re-submit the form. The bed availability information should be completed each time bed availability changes, to keep the database current.

Participation in this process will ensure appropriate referrals are received by the provider community and that all available beds are utilized. Please contact Ken Dixon at ValueOptions at 609-689-6248 or *Kenneth.Dixon@valueoptions.com* to request the Provider Information Form or if you have any questions regarding the Provider Information Form or the Bed Tracking Form.

If you have any questions regarding the receipt of an authorization number for either a planned or an emergency admission, please contact ValueOptions at 1-877-652-7624.

For billing inquiries for prior authorized services, please contact Unisys Provider Services at 1-800-776-6334.

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