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# Senior Services News

A Newsletter  
Published by the  
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Division of  
Aging and Community Services

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**TO:** Providers of Medicaid Adult Day Health Services

**SUBJECT:** Prior Authorization of Adult Day Health Services

**EFFECTIVE:** February 1, 2006

**PURPOSE:** To notify providers of Adult Day Health Services (ADHS) that all ADHS services must be prior authorized by Department of Health and Senior Services staff before services are provided.

**BACKGROUND:** The Department of Health and Senior Services and the Department of Human Services have determined that prior authorization of Adult Day Health Services is required for all eligible Medicaid beneficiaries, including waiver program participants.

**ACTION:** Effective February 1, 2006, ADHS Medicaid providers must submit a request for prior authorization, using the attached form, for eligible Medicaid beneficiaries of the following programs: community Medicaid; New Jersey Care . . . Special Medicaid Programs (including the medically needy segment); NJ Family Care--Plan A, fee-for-service; the Community Care Program for the Elderly and Disabled; the Caregiver Assistance Program; the Adult Family Care program; the Community Resources for People with Disabilities (formerly Model Waivers) program; the AIDS Community Care Alternatives Program and the Traumatic Brain Injury Program.

Prior authorization must be obtained for each new Medicaid beneficiary prior to initial provision of services to the beneficiary and, at a minimum, annually thereafter.

Prior authorization must be obtained for each Medicaid beneficiary enrolled in ADHS on February 1, 2006, prior to continuation of ADHS services to the beneficiary and, at a minimum, annually thereafter. Notification letters will automatically be sent to both the provider and the beneficiary currently enrolled as the PA becomes effective. This will be based on the existence of at least one paid or pended claim with a service date in the most recent calendar month preceding the date of effectiveness. The authorization period will be a minimum of one year. Authorization ending dates will be staggered based on the birth date of the beneficiary. This makes the earliest ending date one year beyond the start date. ADHS services rendered after will not be reimbursed until the prior authorization request is received and the request is approved.

All ADHS participants who change from one ADHS provider to another must have a new prior authorization request submitted to the Adult Day Health Services Unit before enrolling with the new provider. The new provider must submit the prior authorization request.

Providers must complete the ADHS prior authorization form, including diagnosis and length of time that the Medicaid beneficiary needs ADHS. The completed ADHS prior authorization form must be mailed to:

Department of Health and Senior Services  
Division of Aging and Community Services  
Adult Day Health Services Unit  
PO Box 807  
Trenton, NJ 08625-0807

Nurses from the Department of Health and Senior Services will assess the Medicaid beneficiary to determine clinical eligibility for ADHS. Upon completion of the clinical assessment and review of the prior authorization request, letters will be generated and mailed to the Medicaid beneficiary and ADHS provider with the prior authorization determination. The initial authorization letter for new beneficiaries and beneficiaries enrolled in ADHS on February 1, 2006 will include the ADHS prior authorization number and initial authorized dates of service. After the first year, all ADHS participants must have ADHS services prior authorized annually, at a minimum.

Questions about this newsletter and the ADHS prior authorization process may be directed to Sharon Briggs, Adult Day Health Services Unit, Department of Health and Senior Services, at (609) 633-8406.

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

# PRIOR AUTHORIZATION REQUEST ADULT DAY HEALTH SERVICES



STATE OF NEW JERSEY  
DEPARTMENT OF HEALTH AND SENIOR SERVICES  
DIVISION OF AGING AND COMMUNITY SERVICES  
OFFICE OF ADULT DAY HEALTH SERVICES

PA#1596 \_\_\_\_\_

1. Beneficiary's Last Name			First Name			M.I.			2. Beneficiary's Street Address			Telephone Number											
3. HSP (Medicaid) Case Number			4. Person No.			5. Date of Birth			6. Sex			City			State			Zip Code					
									M			F											
8. PROVIDER OF SERVICE INFORMATION												7. Remarks: Please include primary contact Name (other than beneficiary), Telephone Number, and Relationship to Beneficiary.											
												Telephone Number			Medicaid Provider Number (Enter only when not printed below)								
												Name and Address											
9. DIAGNOSIS AND FUNCTIONAL LIMITATIONS																							
10. PROPOSED PLAN OF CARE AT ADULT DAY HEALTH SERVICES PROGRAM																							
11. PROVIDER																							
NAME						TITLE						TELEPHONE NUMBER											
NUMBER OF DAYS PER WEEK BENEFICIARY IS TO ATTEND ADHS						REQUESTED DATES: FROM						TO											
12. AUTHORIZED DATE(S)												13. Reviewer ID			Review Date								
												From: _____						Thru _____					

14. PRIOR AUTHORIZED SERVICES DETAIL										GRAY SHADED AREA FOR DIVISION USE ONLY	
A.	B. PROCEDURE AND MODIFIER CODE REQUESTED	C. PROCEDURE AND MODIFIER CODE APPROVED	D. Units Requested	E. Units Approved	F.	G.	H. Description of Service	I. Total Fee Requested	J. FEE APPROVED	K.	L.