



State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

NEWSLETTER

Volume 27 No. 01

February 2017

TO: Independent Clinics, Mental Health - **For Action**
Health Maintenance Organizations – **For Information Only**

SUBJECT: **Prior Authorization of Partial Care Services**

EFFECTIVE: Prior authorization requests submitted on or after April 1, 2017

PURPOSE: To establish new requirements for requesting prior authorization of mental health partial care services for new admissions and those beneficiaries previously authorized to provide mental health partial care services.

BACKGROUND: The NJ FamilyCare program currently requires prior authorization of mental health partial care services provided as an independent clinic service. Providers have been submitting prior authorization requests for services that have not been properly documented in a treatment plan. All services provided by a partial care program must be listed in the Individual Recovery Plan (IRP) which must be properly dated and signed. Signatures, at a minimum, must include the licensed clinician completing the plan, the beneficiary and the Medical Director. The IRP is not valid until these signatures are obtained.

ACTION: Effective April 1, 2017, all initial prior authorization requests for newly admitted mental health partial care clients shall be submitted on a FD-07 Prior Authorization Request Form indicating that the request is for a new admission. Authorizations shall be limited to six weeks to allow completion of the comprehensive assessment. Upon completion of the comprehensive assessment, a prior authorization request, including a copy of a signed IRP, shall be sent to the Medical Assistance Customer Center (MACC) for prior authorization. The IRP shall document the proposed services to be provided during the requested ninety day prior authorization period.

For existing prior authorizations, providers must submit a prior authorization request at the end of the existing authorized period, attaching a newly completed IRP that covers the time period for the next prior authorization request. A periodic review of the beneficiary's plan of care shall take place at least every ninety days during the first year and every six months thereafter. The date of service of the initial (first) IRP, and not the date of admission, shall determine the beginning of the one year schedule for ninety-day reviews. Therefore, four ninety-day IRPs shall be completed prior to beginning the six-month review schedule.

The prior authorization request shall be denied if an IRP is received without the required signatures, or without proper documentation stating why the client did not sign. IRPs may not be completed and signed more than 7 days before the scheduled start date indicated on the IRP. If the IRP is properly signed, but the signatures are dated after

the IRP was scheduled to begin, the IRP start date will be modified to match the signature dates. For example, if an IRP is submitted with a start date of May 15th, but the required signatures on that plan were not obtained until May 20th, the prior authorization shall be modified to begin on May 20th. No billing will be allowed from May 15th through May 19th. IRPs will be expected to meet all requirements in N.J.A.C. 10:66-2.7.

N.J.A.C. 10:66-2.7 requires that a written, individualized plan of care shall be developed for each beneficiary who receives continued treatment. The plan of care, also known as the IRP, shall be designed to improve the beneficiary's condition to the point where continued participation in the program (beyond occasional maintenance visits) is no longer necessary. The IRP shall include:

1. A written description of the treatment objectives, including the treatment regimen and the specific medical/remedial services, therapies, and activities that shall be used to meet the objectives;
2. A projected schedule for service delivery which includes the frequency and duration of each type of planned therapeutic session or encounter;
3. The type of personnel that will be furnishing the services, and;
4. A projected schedule for completing re-evaluations of the beneficiary's condition and updating the plan of care.

The periodic review shall determine the beneficiary's progress toward the treatment objectives, the appropriateness of the services being furnished and the need for the beneficiary's continued participation in the program.

If you have any questions concerning this Newsletter, please contact the Office of Customer Service at 609 631-4641.

RETAIN THIS NEWSLETTER FOR FUTURE REFERENCE