



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

# NEWSLETTER

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**TO:** Independent Clinics, Mental Health and Substance Abuse- For Action

**SUBJECT:** Independent Clinic Services

**EFFECTIVE:** Immediately

**PURPOSE:** To clarify the provision and authorization of services provided by independent clinics.

**BACKGROUND:** The Division of Medical Assistance and Health Services (DMAHS) recently instituted several changes related to independent clinics including prior authorization of mental health partial care services, changes in billing and rates and the promulgation of new regulations in N.J.A.C. 10:66. These changes became effective June 5, 2017.

**ACTION: PARTIAL CARE MENTAL HEALTH:** Effective April 1, 2017, mental health independent clinics were required to submit a signed Individual Rehabilitation Plan (IRP) covering the dates of service requested on the prior authorization request. The IRP is required to be signed by the client, the staff person responsible for completion of the IRP, the direct care staff supervisor and the psychiatrist/APN. The signatures must be obtained within 7 business days of the start date for the IRP. If the psychiatrist/APN will not be available to sign the IRP within 7 business days of its start date due to a scheduled absence, the psychiatrist/APN may sign up to 14 business days before the scheduled start date of the IRP. The exception should include a brief notation as to the reason they are signing early. One example would be "attending medical conference 6/18/17-6/24/17." The staff person, supervisor and client must sign within 7 days of the scheduled start date of the IRP. If a client refuses to sign, the reason for refusal must be documented on the IRP when submitted. Every effort should be made to explain to the client why their signature is required.

For providers who have existing prior authorizations in place, at the end of the existing authorized period, they must submit a prior authorization request with a newly completed IRP that covers the time period for the next prior authorization request. 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 initial date of service of the 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 schedule.

If an IRP is received without the required signatures, or proper documentation stating why the client did not sign, the prior authorization will be denied. 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, prior authorization of services will be modified to match the dates the IRP covers as demonstrated by the dates the appropriate signatures were obtained. For example, if an IRP is submitted with a start date of May 15<sup>th</sup>, but the required signatures on that plan were not obtained until May 20<sup>th</sup>, the prior authorization shall be modified to begin on May 20<sup>th</sup>. No billing will be allowed from May 15<sup>th</sup> through May 19<sup>th</sup>. 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 both 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.

Due to the nature of mental illness and the provision of program services, there may be instances in which a temporary deviation from the services written in the treatment plan occurs. In this event, the client may participate in alternate programming that best meets his or her needs. The reason for the deviation **MUST** be clearly explained in the daily or weekly documentation but does not require a change to the IRP. Deviations that do not resolve shall require a written change in the treatment plan.

**MEDICATION MANAGEMENT MENTAL HEALTH AND SUBSTANCE ABUSE:**

Evaluation and Management codes may be utilized by providers to cover physician/APN services that are not included in any other service provided on the same date for which billing is made. They may be reimbursed when provided in addition to an intake assessment (90791 only), partial care (not for required psychiatric re-evaluations), individual psychotherapy (90832-90838), group psychotherapy (90847), family therapy (90853) or family conference (90887).

**Physician clinic rates**

99212HF or UC	\$49.06
99213HF or UC	\$81.60
99214HF or UC	\$119.85
99215HF or UC	\$161.06

APN medication monitoring services provided to existing clients in a clinic setting are reimbursed at 90% of the clinic rate. The program shall utilize the modifier combination of SA UC (independent clinic mental health) or HF SA (independent clinic substance abuse) when billing for E/M codes 99212-99215. Please note that 99211 will continue to be paid using the HF or UC modifier and is generally used for nursing services such as medication administration. **DO NOT** bill 99211 with the SA UC or HF SA modifier combination. E/M services provided by an APN for new clients (99201-99205) are billed using only the clinic modifier HF or UC and pay 100% of the clinic rate.

**APN Clinic rates**

99212 HF SA or SA UC	\$44.15
99213 HF SA or SA UC	\$73.44
99214 HF SA or SA UC	\$107.87
99215 HF SA or SA UC	\$144.95

**PSYCHOTHERAPY MENTAL HEALTH:** Recent changes to the regulations now state that, effective June 5, 2017, only one type of mental health service per beneficiary is reimbursable to an independent clinic per day with the following exceptions:

- Individual, group or family psychotherapy services may be provided on the same date of service, but are limited to one unit each (individual, group, family therapy or family conference). A maximum of three individual or group psychotherapy sessions may be provided per day but are limited to 5 units per week.
- Intake assessments (90791 & 90792) may be completed on the same date of service as an individual, group or family therapy. Intake assessments shall count toward the total of three units per day and five units per week.
- Evaluation and Management codes (E/M) may be provided concurrently with an intake assessment (90791 only) or psychotherapy services. E/M billing does not count toward the total of three units per day and five units per week.

System changes have been completed to allow billing for these combined services.

**INTAKE EVALUATIONS MENTAL HEALTH AND SUBSTANCE ABUSE:** For Independent Clinics, some programs allow the physician/APN component of an intake evaluation to be completed separately from the non-physician/APN portion. Providers have noted that the physician or APN may have over 14 days to complete their portion of the intake evaluation. Therefore, providers have two options:

- Bill the 90792 after the entire intake is completed, including the physician or APN assessment
- Bill 90791 after the non-physician/APN staff complete their portion of the intake. The clinic may then bill for the physician/APN assessment using an appropriate E/M code when their portion is completed.

Providers **MAY NOT** bill 90791 and 90792 for the same admission for the same client.

Providers **MAY NOT** bill for 90791 or 90792 on the same date they bill for partial care services.

**PRIOR AUTHORIZATION CLINIC SERVICES:** In order to meet mental health parity, the requirement to prior authorize behavioral health services that exceed \$6000 a year is being suspended while regulatory changes are pending.

**AMBULATORY DETOX SUBSTANCE ABUSE:** Regulations now provide for ambulatory outpatient withdrawal management services. Ambulatory outpatient withdrawal management (H0014) is provided by an independent clinic who offers a substance abuse treatment program approved by DMHAS to provide outpatient withdrawal management (WM), including opioid treatment programs providing short term (less than 30 days) opioid withdrawal management using methadone and/or other approved medications. Programs shall only provide withdrawal management services to clients who meet the ASAM Criteria Level 2-WM. Ambulatory withdrawal providers may not bill for evaluation and management services (physician services are included in the H0014 rate) or partial care services provided on the same date of service. Intake evaluations using 90791 or 90792 may be billed on the same date of service.

**COMMUNITY SUPPORT SERVICES (CSS):** Providers are no longer required to bill Medicare for CSS services. However, Third Party Liability (TPL) restrictions still apply. Therefore, if a client does have an insurance plan other than Medicare or Medicaid, you will need to bill that insurer first.

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

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