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

NEWSLETTER

Volume 6 No. 48 **September 1996**

TO: Providers of Personal Care Assistant Services

APPLICABLE: Home Health Agencies and Homemaker Agencies that provide Personal Care Assistant (PCA) Services

SUBJECT: Prior Authorization Procedure

EFFECTIVE: Claims with Service Dates on or after September 15, 1996

BACKGROUND: P.L. 1996, C. 42, the State Fiscal Year 1997 Appropriations Act, established a requirement for prior authorization of PCA service hours that exceed 25 hours per week. For additional background on program policy concerning this service, please refer to Medicaid Newsletters Volume 2 #62, dated November 1992 and Volume 5 #53, dated September 1995.

PURPOSE: The purpose of this Newsletter is to advise providers of the procedures required for prior authorization of PCA services in excess of 25 hours up to 40 hours per calendar work week. This Newsletter does not pertain to providers of PCA under contract with the Division of Mental Health Services.

ACTION: Effective for dates of service on or after September 15, 1996, Personal Care Assistant Services will be limited to 25 hours per calendar work week unless more extensive services are prior authorized. Prior Authorization for all hours over 25 up to 40 per calendar work week must be obtained from the Division of Medical Assistance and Health Services' Medicaid District Office (MDO) serving the beneficiary county of residence. The provider must obtain the authorization from the MDO before providing the additional service hours. The total hours of PCA services to be provided in the calendar work week must be reflected in the request, not only the additional hours over 25.

This action pertains when the provider is billing for these PCA services:

Z1600	Individual per hour/weekday
Z1611	Individual per half-hour/weekday

Z1614	Individual per hour/weekend/holiday
Z1615	Individual per half-hour/weekend/holiday
Z1605	Group (per person) per hour/weekday
Z1612	Group (per person) per half-hour/weekday
Z1616	Group (per person) per hour/weekend/holiday
Z1617	Group (per person) per half-hour/weekend/holiday

To facilitate the prior authorization process, attached for your information is a sample of the prior authorization form FD-365 (Rev. 9/91), (Exhibit I). Supplies of the form may be ordered by contacting Unisys, the Medicaid fiscal agent, at 1-800-776-6334 during normal business hours.

In addition, an excerpt from the Home Care Services fiscal agent billing supplement with field-by-field completion instructions for the FD-365 is attached (Exhibit II).

To accurately determine those cases that require more than 25 hours per calendar work week of service, a workgroup of Home Care Services/PCA providers and DMAHS representatives worked together to develop a process which is operationalized with the use of a clinically weighted evaluation scale. This tool must be used by the agency for all Medicaid beneficiaries assessed for PCA services and retained in the clinical file. Information on the evaluation scale and accompanying instructions are available through your professional association or by contacting the Bureau of Home and Community Services at (609) 588-2906.

Therefore, when requesting prior authorization from the MDO for more than 25 hours, and up to 40 hours per week, the request must include a completed FD-365 reflecting all hours of PCA services in the calendar work week and a copy of the patient evaluation scale with each submission. Please include the "weighted" score determined by your evaluation of need in the "Remarks" section of the prior authorization form (FD-365).

PCA services requiring prior authorization may be authorized by the MDO in intervals of up to 30 days minimum and are not to exceed 180 days maximum duration. The PCA provider will be notified in writing of the MDO's decision to approve, deny, or suspend a request upon receipt of a notification letter from Unisys. For your information, a copy of the notification letter (FD-362) is attached (Exhibit III).

Under certain circumstances it may be appropriate for two or more PCA agencies to be providing care to the same beneficiary within the same weekly period. In such instances, if the combined number of PCA hours within the calendar work week exceed 25 hours, both PCA agencies must submit a request for prior authorization to the appropriate MDO. The request from each agency

must indicate the number of hours to be provided and must include a notation in the "Remarks" section indicating participation of multiple PCA agencies within the same week.

The responsibility for assuring coordination of hours of service rests with the agencies involved. Failure to comply and coordinate such activity may result in denial of payment and recoupment of funds not prior authorized.

Questions regarding this Newsletter are to be directed to the Bureau of Home and Community Services, Division of Medical Assistance and Health Services, at (609) 588-2906.

For information concerning the prior authorization process, please call the Medicaid District Office serving the beneficiary's county of residence (Exhibit IV).

Attachments

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

Exhibit I

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

PRIOR AUTHORIZATION REQUEST

PA#_____

1. Recipient's Last Name | First Name | MI

2. Recipient's Street Address | Telephone Number ( )

3. MSP (MEDICAID) Case No.

4. Person No.

5. Date of Birth

6. Sex ☐ Male ☐ Female

City | State | ZIP Code

7. Remarks:

8. PROVIDER OF SERVICE INFORMATION

Telephone Number ( )

Medicaid Provider Number (Enter only when not printed below)

Name and Address

9. DIAGNOSIS

10. PROPOSED TREATMENT PLAN

11. REQUESTED DATE(S)
From:_____ Thru:_____

12. AUTHORIZED DATE(S)
From:_____ Thru:_____

13. Reviewer ID | Review Date

14. PRIOR AUTHORIZED SERVICES DETAIL (MAXIMUM OF 5 SERVICES)

GRAY SHADED AREA FOR DIVISION USE ONLY

A.	B. PROCEDURE & MODIFIER CODE REQUESTED	C.	D. Units Requested	E.	F.	G.	H. Description of Service	I. TOTAL FEE REQUESTED	J. FEE APPROVED	K.	L. Reason

FD - 365(9/91) FISCAL AGENT COPY Medicaid Part 1 of 2

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

PRIOR AUTHORIZATION REQUEST

PA#_____

1. Recipient's Last Name	First Name	MI	2. Recipient's Street Address	Telephone Number
				( )
3. MSP (MEDI/CAID) Case No.	4. Person No.	5. Date of Birth	6. Sex ☐ Male ☐ Female	City / State / ZIP Code

7. Remarks:

8. PROVIDER OF SERVICE INFORMATION

Telephone Number ( )

Medicaid Provider Number (Enter only when not printed below)

Name and Address

9. DIAGNOSIS

10. PROPOSED TREATMENT PLAN

11. REQUESTED DATE(S)
From:_____ Thru:_____

12. AUTHORIZED DATE(S)
From:_____ Thru:_____

13. Reviewer ID / Review Date

14. PRIOR AUTHORIZED SERVICES DETAIL (MAXIMUM OF 5 SERVICES) — GRAY SHADED AREA FOR DIVISION USE ONLY

A.	B.	C.	D. Units Requested	E.	F.	G.	M. Description of Service	I. TOTAL FEE REQUESTED	J. FEE APPROVED	K.	L.

FD - 365 (9/ 91) DIVISION COPY Medicaid Part 2 of 2

9/30/91

PRIOR AUTHORIZATION REQUEST

This section provides item-by-item instructions for the completion of the following prior authorization form:

Prior Authorization Request FD-365 (9/91)

The FD-365 is the form that is to be used when a provider is requesting approval for services requiring prior authorization. Instructions for completing the required billing form for reimbursement purposes are included in section 6 of the Provider Manual. It should be noted that this form is only utilized to attain prior authorization when there is no existing prior authorization form specific to the service being requested.

Prior Authorization Guidelines

- The prior authorization number, pre-printed on the upper right corner of the FD-365 (rev. 9/91) must be appropriately transferred to and designated on the submitted claim form by the provider. It should be noted that the required PA number is indicated on the notification notice distributed by Unisys to each provider in response to each submitted prior authorization request.

- Print the information legibly, completely, and correctly.

- Enter all dates in a month, day, and year sequence (MM/DD/YY). For example, September 10, 1990 is entered 09/10/90.

- Provide all required information for every prior authorization service detail line.

- Include a decimal point and "cents" positions for all dollar amounts. For example, enter 25.00, not 25. Do not use $ sign.

- Verify the accuracy of all information before submitting the appropriate form for prior authorization.

NOTE: Forms that are not legible will be returned to the provider.

Contact the recipient's respective Medicaid District Office for mailing instructions.

ITEM BY ITEM INSTRUCTIONS
PRIOR AUTHORIZATION REQUEST

1.	Recipient's Last Name/ First Name/M.I.:	Enter recipient's name as it appears on the Medicaid Eligibility Identification Card. Last name first, first name, middle initial (M.I.).
2.	Recipient's Street Address/Telephone Number:	Enter recipient's complete address and telephone number.
3.	HSP (Medicaid) Case Number:	Enter the first ten digits of the recipient's Medicaid Identification number EXACTLY as it appears on the Medicaid Eligibility Identification Card.
4.	Person Number:	Enter the last two digits of the Medicaid Identification number EXACTLY as it appears on the Medicaid Eligibility Identification Card.
5.	Date of Birth:	Enter the recipient's date of birth in month, day and year sequence (MM/DD/YY). For example, September 10, 1941 is entered as 09/10/41.
6.	Sex:	Check the appropriate block to identify recipient's sex.
7.	Remarks:	Enter remarks as applicable.
8.	Provider Of Service Information:	Enter the provider's name, address, telephone number and seven-digit Medicaid provider number.
9.	Diagnosis:	Supply a description of the diagnosis (narrative) as well as a valid diagnostic code (ICD-9-CM), when applicable.

10.	Proposed Treatment Plan:	Enter a narrative description of the services and/or treatment plan to be rendered. Provide information necessary to support request.
11.	Requested Date(s):	Enter the requested from and thru dates of service in month, day, and year sequence (MM/DD/YY).
12.	Authorized Date(s):	Leave Blank.
13.	Reviewer ID/Review Date:	Leave Blank.
14.	Prior Authorized Services Detail:	Enter the authorized service(s) information in the following non-shaded subsections.
14. A.	Unlabeled:	Leave Blank.
14. B.	Procedure & Modifier Code Requested:	Enter the appropriate five-digit HCPCS procedure code and two-digit modifier (if applicable). A list of commonly used HCPCS codes can be found in the Medicaid Provider Manual.
14. C	Procedure & Modifier Code Approval:	Leave Blank.
14. D.	Units Requested:	Enter the number of days or other units of service (visits, days) as applicable.
14. E.	Units Approved:	Leave Blank.
14. F.	Unlabeled:	Leave Blank.
14. G.	Unlabeled:	Leave Blank.
14. H.	Description of Service:	Enter a description of service(s) to be rendered if applicable.

14.	I.	Total Fee Requested:	Enter the provider's usual and customary charge for each service or procedure. This amount must reflect the total charge for all days or units of service for the detail line. For example, five units of service at 5.00 per unit would be shown as 25.00. Do not use $ sign.
14.	J.	Fee Approved:	Leave Blank.
14.	K.	Unlabeled:	Leave Blank.
14.	L.	Status:	Leave Blank.

Exhibit III

State of New Jersey

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

SAUL M. KILSTEIN
DIRECTOR

QUAKERBRIDGE PLAZA
CN 712
TRENTON, NEW JERSEY 08625-0712

DATE: 02/28/91

PROVIDER INFORMATION	RECIPIENT INFORMATION
0728608	1111111111-01
JULIAN SOSNER, MD	JOSEPH ORANGE
339 WINDERMERE RD.	50 CAROLINA ICF
NEWARK, N.J. 07191	ATLANTIC CITY, N.J. 08401

Dear Provider:

Your prior authorization request for health care service(s) or item(s) has been approved.

Prior Authorization Number: *1199999998* Reviewer ID: *329*
Authorized From: *09/30/90* Thru: *09/30/91* Review Date: *09/30/91*

STATUS	PROC. CODE	DESCRIPTION
APPROVED	A0020	AMBULANCE SERVICE BLS PER MILE

FD-362 (3/91)

MEDICAID DISTRICT OFFICE DIRECTORY

Medicaid District Office	Director & Phone Number	Address
(01) Atlantic (05) Cape May (06) Cumberland Fax #1-609-441-3152	Barbara Smith, Director Tel. (609) 441-3620	1601 Atlantic Ave. 7th Floor Atlantic City, NJ 08401
(03) Burlington (11) Mercer Fax #1-609-265-0095	Eileen Calabro, Director Tel. (609) 261-0448	50 Rancocas Rd. Mt. Holly, NJ 08060
(04) Camden (08) Gloucester (17) Salem Fax #1-609-757-4626	Bill Underland, Director Tel. (609) 757-2870 Thomas Rafferty, Acting Regional Director Tel. (609) 757-2699	101 Haddon Ave. 5th Floor Camden, NJ 08103
(07) Essex Fax #1-201-642-6468	Kate Buckley-Straussl Director Tel. (201)648-2470 (201)648-3700 John Russell, Regional Director Tel. (201) 648-7186	153 Halsey Street 4th Floor Newark, NJ 07101
(09) Hudson Fax #1-201-217-7122	Ellen Keane, Director Tel. (201) 217-7100	438 Summit Avenue Jersey City, NJ 07306-3186
(12) Middlesex (10) Hunterdon (18) Somerset (20) Union Fax #1-908-603-5643	Colleen DeMarks, Director Tel. (908) 603-3151	25 S. Main St. Building B, Suites 5&6 Edison, NJ 08837
(13) Monmouth Fax #1-908-409-6446	Frances Garrett, Director Tel. (908) 308-1159	1003 Highway 9 North Howell, NJ 07731-3301
(14) Morris (19) Sussex (21) Warren Fax #1-201-631-6448	Marie Grubin, Director Tel. (201) 631-6440	10 Park Place 4th Floor Morristown, NJ 07960
(15) Ocean Fax #1-908-255-0743	Gail Dempsey, Director Tel. (908) 255-0731	1510 Hooper Ave. Suite 130 Toms River, NJ 08753
(16) Passaic (02) Bergen Fax #1-201-684-8182	Kathleen Lohrey, Director Tel. (201) 977-4077	66 Hamilton St. Paterson, NJ 07505