



MEDICAID ALERT

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

MA-2002-03

March 2002

TO: Hospitals, Physicians, Mental Health Clinics,
Federally Qualified Health Centers (FQHCs), Psychologists,
Certified Nurse Practitioners/Clinical Nurse Specialists,
Non-JCAHO Accredited Psychiatric Community Residences for Youth,
Non-JCAHO Accredited Residential Childcare Facilities,
Non-JCAHO Accredited Children's Group Homes,
Personal Care Assistance Services Providers (Mental Health), JCAHO-
Accredited Residential Treatment Centers, and
Care Management Organizations--**For Action**
Health Maintenance Organizations--**For Information Only**

SUBJECT: **Revised Forms: FD-07, Request for Prior Authorization for Mental Health and/or Mental Health Rehabilitation Services and FD-07A, Request for Prior Authorization Supplemental Information**

EFFECTIVE: Immediately

PURPOSE: To inform providers of the revised prior authorization forms for mental health services, which will be used by the Medicaid/NJ FamilyCare/Children's System of Care Initiative programs.

BACKGROUND: The Department of Human Services (DHS), as a result of the cooperative efforts of this Division (DMAHS), and the Divisions of Youth and Family Services (DYFS) and Mental Health Services (DMHS), developed the Children's System of Care Initiative (CSOCI). The CSOCI is an initiative that provides comprehensive and coordinated mental health services to children, adolescents and young adults up to the age of 21. Forms FD-07 (Request for Prior Authorization for Mental Health Services) and FD-07A (Request for Prior Authorization Supplemental Information), which are used to request prior authorization for mental health services, have been revised to reflect the addition of the CSOCI services.

ACTION: The Division has revised the forms FD-07 (Request for Prior Authorization for Mental Health Services) and FD-07A (Request for Prior Authorization Supplemental Information), to include mental health and mental health rehabilitation services that are being offered as part of the Children's System of Care Initiative (CSOCI).

All Medicaid/NJ FamilyCare-approved providers rendering mental health services, regardless of whether the service is provided to a child or an adult, are currently required to use forms FD-07 and FD-07A to request prior authorization for mental health services as described in their provider manuals and provider newsletters. This requirement is *not changing*; the forms have simply been revised to include the additional services.

The CSOCI-specific mental health services that have been added to the FD-07 form are:

- Residential Services;
- Behavioral Assistance Services;
- Crisis Management Services;
- Intensive In-Home Services; and
- Care Management Organization (CMO) Services.

Some of these services are still in the process of being implemented by the CSOCI and may not be available in all areas as of the date of this Alert. As the CSOCI is phased in statewide over the next few years, service expansion will continue and Newsletters will be distributed to notify providers as the additional services are implemented in their service area.

A provider is not to assume that they are authorized to provide a service just because it is listed on the form. Medicaid and/or CSOCI communications will provide specific instructions as to HOW and WHEN the new forms should be used for CSOCI services.

At this time, all CSOCI services are being authorized by the child's CMO and providers *should not* use these forms to request authorization to provide CSOCI services. If a CMO contacts an individual provider to provide services to a CSOCI enrolled child, the CMO will advise the provider whether to bill Unisys or the CMO for reimbursement for the service.

Do not contact Unisys or the DMAHS Provider Enrollment Office about providing any of the new services listed on the revised form until you receive information from DMAHS confirming that these services have been implemented in your service area.

IMPORTANT THINGS TO REMEMBER

- ♣ If you are an enrolled Medicaid/NJ FamilyCare program as a provider, and a CMO contacts you to provide a service that is Medicaid/NJ FamilyCare reimbursable, such as individual psychotherapy, you will send a HCFA 1500 claim form to Unisys according to the standard billing procedures in your provider manual.
- ♣ If the CMO contacts you to provide a service that is NOT Medicaid/NJ FamilyCare reimbursable, such as yoga instruction, then the CMO will ask you to enter into a contract with them and will reimburse you directly from their funds and you will not send a claim to Unisys.
- ♣ Any service that you provide to a child enrolled in a CMO must be included in the child's Individual Service Plan and approved by the CMO, no matter who reimburses you for the service.
- ♣ The Children's System of Care Initiative (CSOCI) is a program, NOT a provider type. There is no need to enroll as a "CSOCI Provider" because Medicaid/NJ FamilyCare providers are CSOCI providers.

ATTACHMENTS:

1. Copies of the revised versions of the FD-07 and FD-07A
2. Instructions for the proper completion of the forms
3. New Jersey MMIS Form Request

To request the revised forms, please make a photocopy of the New Jersey MMIS Form Request attached to this Newsletter, complete the necessary information, and mail to: Unisys, Attention: Forms Distribution, P.O. Box 4804, Trenton, NJ 08650-4804. All forms provided by Unisys may also be ordered on their website, www.njmmis.com or by calling Provider Services at 1-800-776-6334. You may continue to use the old forms until your current supply is depleted. Do not make copies of the form examples attached to this Alert, the forms are multi-part and pre-printed with the PA number.

Allow approximately three (3) weeks for delivery. Please order no more than a three-month supply.

Questions?

If you have any questions regarding prior authorization procedures, please contact the Office of Utilization Management, Mental Health Services Unit, at (609) 588-2726.

If you have any questions regarding billing procedures, please contact Unisys Provider Services at: 1-800-776-6334.

RETAIN THIS MEDICAID ALERT CHRONOLOGICALLY BEHIND THE MEDICAID ALERTS TAB (GREEN TAB MARKED "4")

GENERAL INFORMATION RELATED TO REQUESTING PRIOR AUTHORIZATION FOR MENTAL HEALTH SERVICES

The two forms that Medicaid/NJ FamilyCare approved providers must use to request prior authorization for the provision of mental health services to eligible beneficiaries are the:

- Request For Prior Authorization For Mental Health Services and/or Mental Health Rehabilitation Services; form FD-07 (rev. 09/01); and
- Request for Prior Authorization Supplemental Information; form FD-07A (rev. 09/01)

The FD-07 is a two-ply form that must be used when a provider is requesting approval for Mental Health Services requiring prior authorization. This form has a pre-printed number in the upper right hand corner of the form.

The FD-07A is a two-ply form that provides supplemental information to the FD-07. Providers must enter the pre-printed number from the upper right hand corner of the FD-07 form on the designated line on the upper right hand corner of the FD-07A.

Providers submitting prior authorization requests for services offered under the Children's System of Care Initiative (CSOCI) must submit the FD-07 (rev. 09/01) and the FD-07A (rev. 09/01) because the new CSOCI services are not listed on the 1991 version of the form.

Providers requesting prior authorization for non-CSOCI services must use both the FD-07 and the FD-07A when requesting prior authorization for mental health services. However, these providers may continue to use the 1991 versions of the FD-07 and FD-07A until their current supply of forms is exhausted.

General Prior Authorization Guidelines

The provider must:

- Enter the prior authorization number, pre-printed on the upper right corner of the FD-07, on the FD-07A and the submitted claim form;
- Include the appropriate degree of clinical history and clinical status narrative to support the request for authorization;
- Enter all dates in a month, day, and year sequence (MM/DD/YY). For example, September 10, 1995 is entered 091095;
- Provide all required information for every prior authorization service detail line;

- Include the "cents" positions for all dollar amounts but do not use a decimal point and do not use a dollar sign. For example, enter 2500, **not** 25.00 or 25; and
- Verify the accuracy of all information before submitting the appropriate form for prior authorization.

NOTE: Please print or type all information on both forms. Forms that are not legible will be returned to the provider.

Prior authorization requests for Mental Health Services should be submitted as indicated below:

Prior Authorization requests for **Partial Care or Partial Hospitalization** should be submitted to the appropriate Medical Assistance Customer Center (MACC) based on the address of the facility providing the service. Do not use the address of the beneficiary. If the provider provides services at more than one location, use the address of the actual location where the services will be provided to determine which MACC to submit the request to.

Prior authorization requests for **Individual Therapies** should be submitted to:

Division of Medical Assistance and Health Services
Office of Utilization Management -- Mental Health Unit
Quakerbridge Plaza P.O. Box 712 Mail Code #18
Trenton, New Jersey 08625-0712



PA # _____

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

REQUEST FOR PRIOR AUTHORIZATION
SUPPLEMENTAL INFORMATION

Provider Information:

Name

Address

Provider Identification Number

Beneficiary Information:

Name

Eligibility Identification Number

Contact Person:

Name

Telephone Number

9a BRIEF CLINICAL HISTORY

10a PRESENT CLINICAL STATUS (to support request)

11a DIAGNOSIS AND CODE (must conform with ICD-9-CM) AND CURRENT MEDICATIONS

17 TREATMENT PLAN AND GOALS

18 ADDITIONAL CLINICAL INFORMATION (include all modifications of treatment/medication)

19. RESERVED FOR USE BY DMAHS CONSULTANT ONLY

DATA ELEMENT: Beneficiary's Last Name/First Name/M.I.

Definition:

Instruction: Enter beneficiary's name as it appears on the Medicaid/NJ FamilyCare/CSOCI Eligibility Identification Card. Last name, first name, middle initial (M.I.).

Field Characteristics:

Values:

Notes:

R

DATA ELEMENT: Beneficiary's Street Address/Telephone Number

Definition:

Instruction: Enter beneficiary's complete address and telephone number.

Field Characteristics:

Values:

Notes:

R

DATA ELEMENT: HSP (Medicaid/NJ FamilyCare or CSOCI) Case Number

Definition:

Instruction: Enter the first ten digits of the beneficiary's Medicaid/NJ FamilyCare or CSOCI Identification number EXACTLY as they appear on the Identification Card.

Field Characteristics:

Values:

Notes:

.

R

EFFECTIVE: September, 2001

FORM LOCATOR 4

DATA ELEMENT: Person Number

Definition:

Instruction: Enter the last two digits of the beneficiary's Medicaid/NJ FamilyCare or CSOCI Identification number EXACTLY as they appear on the Identification Card.

Field Characteristics:

Values:

Notes:

R

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 5

DATA ELEMENT: Date of Birth

Definition:

Instruction: Enter the beneficiary's date of birth in month, day and year sequence (MM/DD/YY). For example, September 10, 1981 is entered as 09/10/81.

Field Characteristics:

Values:

Notes:

R

FORM: FD-07

DATA ELEMENT: Sex

Definition:

Instruction: Check the appropriate block to indicate beneficiary's sex.

Field Characteristics:

Values:

Notes:

R

EFFECTIVE: September, 2001

FORM LOCATOR 7

DATA ELEMENT: Place of Service - Name and Address

Definition:

Instruction: Enter the name and address of the location where the service will be provided.

Field Characteristics:

Values:

Notes:

R

FORM: FD-07

DATA ELEMENT: Provider of Service Information

Definition:

Instruction: Enter the provider's name, address, telephone number and seven-digit Medicaid/NJ FamilyCare provider number. If the addresses in #7 and #8 are identical, enter "same" in #8.

Field Characteristics:

Values:

Notes:

R

DATA ELEMENT: Brief Clinical History

Definition:

Instruction: Enter a brief clinical history of beneficiary. Include the date and location of the beneficiary's last treatment or hospitalization.

Note: Providers using the FD-07 (rev. 09/01) enter this information at #9a on the FD-07A (rev. 09/01).

Field Characteristics:

Values:

Notes:

R

DATA ELEMENT: Present Clinical Status

Definition:

Instruction: Enter the current clinical status of the beneficiary.

Note: Providers using the FD-07 (rev. 09/01) enter this information at #10a on the FD-07A (rev. 09/01).

Field Characteristics:

Values:

Notes:

R

DATA ELEMENT: Diagnosis and Code and Current Medications

Definition:

Instruction: Enter a valid and appropriate ICD-9-CM diagnosis code and a brief narrative description of the diagnosis. List name, dose and frequency of currently medications.

Note: Providers using the FD-07 (rev. 09/01) enter this information at #11a on the FD-07A (rev. 09/01).

Field Characteristics:

Values:

Notes:

R

DATA ELEMENT: Treatment Request

Definition:

Instruction: Enter the number of visits that have been included in the treatment plan and check the box that indicates the length of each session. Enter the code number for each psychological test that is included in the treatment plan. If you check "other" please specify the service requested.

Field Characteristics:

Values:

Notes:

R

DATA ELEMENT: Requested Date(s)

Definition:

Instruction: Enter the requested from and through dates of service in month, day and year sequence (MM/DD/YY)

Field Characteristics:

Values:

Notes:

R

DATA ELEMENT: Authorized Date(s):

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

DATA ELEMENT: Reviewer ID/Review Date

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

DATA ELEMENT: Prior Authorized Services Detail

Definition:

Instruction: Enter the authorized service(s) information in the non-shaded subsections.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

EFFECTIVE: September, 2001

FORM LOCATOR 16A

DATA ELEMENT: Unlabeled

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

FORM: FD-07

DATA ELEMENT: Revenue Code or Procedure & Modifier Code Requested

Definition:

Instruction: Enter the Revenue Code or the appropriate five-digit HCPCS procedure code and two-digit modifier (if applicable). A list of appropriate HCPCS codes can be found in the Medicaid/NJ FamilyCare Provider Manual. Definitions of the Level I procedure codes are found in the American Medical Association Physicians' Current Procedure Terminology.

Field Characteristics:

Values:

Notes:

R

DATA ELEMENT: Revenue Code or Procedure & Modifier Code Approved:

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

DATA ELEMENT: Units Requested

Definition:

Instruction: Enter the number of days or other units of service (visits) as applicable.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

R

EFFECTIVE: September, 2001

FORM LOCATOR 16E

DATA ELEMENT: Units Approved

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 16F

DATA ELEMENT: Unlabeled

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 16G

DATA ELEMENT: Unlabeled

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 16H

DATA ELEMENT: Description of Service

Definition:

Instruction: Enter a brief description of service(s) to be rendered.

Field Characteristics:

Values:

Notes:

R

FORM: FD-07

DATA ELEMENT: Total Fee Requested

Definition:

Instruction: 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 2500. Do not use dollar signs or decimal points.

Field Characteristics:

Values:

Notes:

R

EFFECTIVE: September, 2001

FORM LOCATOR 16J

DATA ELEMENT: Total Fee Approved

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 16K

DATA ELEMENT: Unlabeled

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 16L

DATA ELEMENT: Status

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

FORM: FD-07

EFFECTIVE: September, 2001

FORM LOCATOR 9A

DATA ELEMENT: Brief Clinical History

Definition:

Instruction: Enter the brief clinical history of the beneficiary. Include date and location of last treatment/hospitalization.

Field Characteristics:

Values:

Notes:

R

FORM: FD-07A

EFFECTIVE: September, 2001

FORM LOCATOR 10A

DATA ELEMENT: Present Clinical Status

Definition:

Instruction: Enter the current clinical status of the beneficiary.

Field Characteristics:

Values:

Notes:

R

FORM: FD-07A

DATA ELEMENT: Diagnosis and Code and Current Medications

Definition:

Instruction: Enter a valid and appropriate ICD-9-CM diagnosis code and a brief narrative description of the diagnosis. List name, dose and frequency of current medications.

Field Characteristics:

Values:

Notes:

R

DATA ELEMENT: Treatment Plan and Goals

Definition:

Instruction: Briefly describe the treatment plan and the goals for the beneficiary that the requested services apply to.

Field Characteristics:

Values:

Notes:

R

DATA ELEMENT: Additional Clinical Information

Definition:

Instruction: Describe any modifications in the treatment and/or medications.

Field Characteristics:

Values:

Notes:

R

DATA ELEMENT: Reserved for use by DMAHS Consultant

Definition:

Instruction: Leave blank.

Field Characteristics:

Values:

Notes: All gray shaded areas on the form are for the use of the DMAHS consultant only. Please do not write in them.

NR

NEW JERSEY MMIS FORM REQUEST

Provider Name: _____ Provider # _____

Mailing Street Address: _____ IMPRINT FORMS
 (Do Not Use PO Box) (EXCEPT MC-6)
 Yes No

City/State/Zip: _____

INSTRUCTIONS: Type or print your name, provider number, and full address above. Below, indicate the type and quantity of forms desired. Maximum order = 3 Months, please indicate number of claim forms. UNISYS will imprint **claim forms** (except MC-6) with Provider name, address and Provider number unless declined by the provider.

<u>Quantity Needed</u>	<u>Form Number</u>	<u>Form Title</u>
_____	MC-6	Prescription Claim Form
_____	*MC-9	Request for Authorization and Payment--Optical Appliances
_____	*MC-10	Dental Prior Authorization/Claim Form
_____	MC-12	Transportation Claim Form
_____	MC-19	Report and Claim Form for EPSDT/HealthStart Screening and Related Procedure

PRIOR AUTHORIZATION FORMS

_____	MC-12(A)	Transportation Prior Authorization
_____	FD-06	Prior Authorization for Rehabilitative Services
_____	FD-07	Request for Authorization for Mental Health Services and/or Mental Health Rehabilitation Services
_____	FD-07A	Prior Authorization - Supplemental Information
_____	FD-287	Home Apnea Monitor Certification
_____	FD-352	Prior Authorization for Specialized Group Foster Home (ACCAP)
_____	FD-354	Medical Supplies and Equipment Prior Authorization
_____	FD-356	Request for Prior Authorization for Podiatric Services
_____	FD-357	Request for Prior Authorization for Prosthetic and Orthotic Services
_____	FD-358	Request for Prior Authorization for Vision Care
_____	FD-359	Request for Prior Authorization for Pharmaceutical Service
_____	FD-365	Prior Authorization Request

Attachment Forms

_____	FD-10	Definition and Criteria for Assessing Handicapping Malocclusion Permanent Dentition
_____	FD-36	Audiologic and Hearing Aid Examinations
_____	FD-179	Physician Certification (Abortion)
_____	FD-189	Hysterectomy Receipt of Information Form
_____	FD-244	Hearing Aid Follow-Up Report
_____	FD-257	Nursing Facility Hearing Aid Screening
_____	7473-M ED	Sterilization Consent Form

Miscellaneous Forms

_____	FD-197	Patient Certification Form
_____	FD-266	Medicaid Second Opinion Program Brochure
_____	FD-999	Adjustment Request Form-NJMMIS Medicaid
_____	FD-998	Medicaid Claim Inquiry/Response Form
_____	Reprint:	"Handicapping Malocclusion Assessment to Establish Treatment Priority"

* These forms are a combination Prior Authorization and claim form.

Return Completed form to: Unisys, P.O. Box 4804, Trenton, NJ 08650-4804