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TITLE 10. HUMAN SERVICES
CHAPTER 76. PROGRAMS OF ASSERTIVE COMMUNITY TREATMENT (PACT) SERVICES

N.J.A.C. 10:76 (2016)

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SUBCHAPTER 1. GENERAL PROVISIONS

N.J.A.C. 10:76-1.1 (2016)

§ 10:76-1.1 Purpose, scope, and eligibility

(a) The purpose of this chapter is to set forth the rules governing the provision of Programs of Assertive Community Treatment (PACT) services to New Jersey Medicaid and certain NJ FamilyCare-Plan A beneficiaries and NJ FamilyCare Alternative Benefit Plan beneficiaries.

1. Beneficiaries enrolled under the Medically Needy program (N.J.A.C. 10:70) are not eligible to receive PACT services.

2. NJ FamilyCare-Plans B, C, and D beneficiaries are not eligible for PACT services.

(b) PACT services provide community based, intensive, comprehensive, integrated mental health rehabilitation services by a professional, multi-disciplinary team to adults who are the most seriously challenged by the presence of a serious and persistent mental illness, as evidenced by repeated previous psychiatric hospitalizations and/or a serious risk for psychiatric hospitalization and who have not benefited from traditional mental health services.

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N.J.A.C. 10:76-1.2 (2016)

§ 10:76-1.2 Definitions

The following words and terms, as used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Adult" means an individual age 18 and older.

"Centers for Medicare and Medicaid Services (CMS)" means the agency of the Federal Department of Health and Human Services that is responsible for the administration of the Medicaid program and the State Children's Health Insurance Program (SCHIP) in the United States. In New Jersey, the SCHIP is known as NJ FamilyCare.

"Department (DHS)" means the New Jersey Department of Human Services.

"Division of Mental Health and Addiction Services (DMHAS)" means the organizational component of the New Jersey Department of Human Services that is responsible for the administration of the State's mental health and addiction programs.

"Division of Medical Assistance and Health Services (DMAHS)" means the organizational component of the New Jersey Department of Human Services that is responsible for the administration of the State's medical assistance programs.

"Prior authorization" means approval by DMHAS before services are rendered.

"Programs of Assertive Community Treatment (PACT)" means mental health rehabilitative services which are delivered in a self-contained treatment program, provided by a service delivery team and managed by a qualified program director, that merge clinical and rehabilitative expertise to provide mental health treatment, rehabilitation, and support services which are individualized and tailored to the unique needs and choices of the individual receiving the services.

"Provider" means an organization that has a contract with, and is licensed by, the DHS to provide PACT services.

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N.J.A.C. 10:76-1.3 (2016)

§ 10:76-1.3 Provider participation criteria

(a) To participate in the Medicaid/NJ FamilyCare program, all providers shall be under contract with the Division of Mental Health and Addiction Services (DMHAS) as a provider of PACT services and shall meet the requirements set forth by the DMHAS related to PACT services in accordance with N.J.A.C. 10:37J.

(b) In order to participate in the Medicaid/NJ FamilyCare program, all applicants shall complete and submit the "Medicaid Provider Application" (FD-20) and the "Medicaid Provider Agreement" (FD-62), as well as a copy of their license provided by DHS, in accordance with N.J.A.C. 10:190, to:

Division of Medical Assistance and Health Services
Office of Provider Enrollment, Mail Code #9
PO Box 712
Trenton, New Jersey 08625-0712

(c) The applicant will receive written notification of approval or disapproval of Medicaid/NJ FamilyCare provider status from DMAHS. If approved, the applicant will be assigned a Medicaid/NJ FamilyCare Provider Number, and will receive a copy of this chapter as part of the provider manual.

(d) Prior to billing for PACT services, those who have previously enrolled, and are currently approved, as Medicaid/NJ FamilyCare providers in other categories of service, shall be required to enroll as a PACT provider by completing and submitted a new provider application and shall receive an additional, unique, provider identification number for submitting claims for the provision of PACT services.

(e) Upon approval as a Medicaid/NJ FamilyCare provider of PACT services, the provider shall conform to the provisions of this chapter and the provisions of N.J.A.C. 10:49, the Administration Manual for DMAHS programs.

(f) If a PACT provider loses its license from DHS, and is unable to provide services, the provider shall notify the Provider Enrollment Unit, at the address in (b) above, within five business days of losing the license.

1. The PACT provider will be disenrolled as a Medicaid/NJ FamilyCare PACT provider until such time as the license is restored. Once the provider's PACT license is restored by the Department of Human Services, the provider will be reinstated as a Medicaid/NJ FamilyCare PACT provider as long as the requirements of N.J.A.C. 10:37J and this chapter are met and continue to be met.

2. A PACT provider shall be held liable for recoupment of any monies paid for services during the time that they did not possess a valid license.

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N.J.A.C. 10:76-1.4 (2016)

§ 10:76-1.4 Recordkeeping

(a) All agencies providing PACT services shall keep, and require individual PACT Teams to keep, such legible records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for such services.

(b) The PACT provider shall, at a minimum, maintain the following data in support of all payment claims:

1. The name of the beneficiary;

2. The name of the provider agency and the name and title of the staff person providing service;

3. The date(s) of service;

4. The length of time face-to-face contact was provided;

5. The name of individual(s) with whom face-to-face contact was maintained on behalf of the beneficiary;

i. If the person contacted refuses to give his or her name to the PACT team member, the team member shall document that refusal in the record of the contact. For example: "Spoke to the neighbor at (give time and date of contact) who spoke on the condition that the neighbor's name would not be revealed, and who said (include statement here)"; and

6. A summary of the services provided.

(c) All recordkeeping documents required by this section shall be made available, upon request, to the Department of Human Services (DHS), the DMAHS or DMHS, or their authorized agents.

(d) Providers shall maintain beneficiary records for a period of not less than five years.

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N.J.A.C. 10:76-2.1 (2016)

§ 10:76-2.1 PACT services

(a) All PACT services shall meet the requirements of N.J.A.C. 10:37J, Programs of Assertive Community Treatment.

(b) PACT services shall include mental health services and related supportive services, and shall be provided directly by one or more of the PACT team members. Such services shall include, but are not limited to, the following:

1. Emotional and/or behavioral treatment;

2. Individual and group interventions for substance abuse (see N.J.A.C. 10:37J-2.5(h));

3. Psychiatric treatment, including medication monitoring;

4. Psychotherapy or counseling as permitted by the provider's individual certification; and

5. Psychiatric rehabilitative services.

(c) The type and intensity of the PACT services provided shall be individualized based on the needs of the beneficiary, as determined by the PACT team.

1. The PACT team shall provide a minimum of two hours of face-to-face contact either with, or on behalf of, a beneficiary per month in order to claim reimbursement from the Medicaid/NJ FamilyCare-Plan A program.

(d) Examples of services provided by a PACT team shall include, but are not limited to:

1. Crisis assessment;

2. Symptom assessment, management, and supportive counseling;

3. Medication prescription, administration, monitoring, and documentation;

4. Support to assist the beneficiary to find and maintain employment in community-based job sites;

5. Provision of support to the beneficiary's family and other members of the consumer's social network to deal with the mental illness; and

6. Coordination of services with other community mental health and non-mental health providers.

(e) Substance abuse treatment services can be provided in either individual or group settings. Referrals for treatment at drug or alcohol detoxification and rehabilitation facilities shall be provided as needed.

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N.J.A.C. 10:76-2.2 (2016)

§ 10:76-2.2 Clinical supervision of PACT teams

(a) Each PACT team shall consist of a minimum of five separate clinical disciplines, including psychiatry, nursing, supportive counseling, substance abuse, and rehabilitation or occupation/vocational services, in accordance with N.J.A.C. 10:37J-2.8.

(b) The PACT Director shall provide administrative supervision and shall assure clinical oversight, as necessary, for the overall operation of the team, including, but not limited to, individual case reviews and quality assurance reviews of the clinical record.

(c) The PACT team psychiatrist, or other appropriately licensed clinical professional as permitted by DMHAS, shall provide supervision to the team regarding medication administration and monitoring for all beneficiaries served by the team.

(d) The clinical status of each beneficiary shall be reviewed by the team as a whole a minimum of 95 percent of the regular workdays in any given calendar month. Clinical supervision shall be provided as needed during these daily meetings by the Masters-level clinician or the team psychiatrist.

1. Notes for each meeting shall be maintained by each PACT team and shall include, at a minimum, a list of team members who attended the meeting and a list of cases that were discussed. This information need not be included in each beneficiary's individual record except as stated in (f) below.

2. A record of all team members present at the meeting shall also be documented on an attendance log. The participation of any team member from an off-site location via conference call shall be documented and that staff person shall sign the documentation within 30 days of the meeting.

3. If the daily meeting does not occur on any given day, the reason shall be clearly documented.

(e) The PACT team psychiatrist provides supervision to the PACT team a minimum of once per week through the daily review process and through individual case conferences for specific beneficiaries. The psychiatrist shall also complete a psychiatric evaluation for all new PACT beneficiaries and shall review and sign all initial, comprehensive and revised service plans.

1. During the first year of the beneficiary receiving services, clinical updates to the service plan shall be made every three months. Clinical updates shall be made every six months in subsequent years.

(f) Any significant changes to a beneficiary's service plan resulting from any of the methods of clinical supervision discussed above shall be documented in the beneficiary's individual progress notes.

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N.J.A.C. 10:76-2.3 (2016)

§ 10:76-2.3 Beneficiary eligibility

(a) Medicaid and NJ Family Care Plan A and NJ FamilyCare Alternative Benefit Plan beneficiaries age 18 and older shall be eligible to receive PACT services, except for beneficiaries enrolled under the Medically Needy program (N.J.A.C. 10:70).

1. NJ FamilyCare-Plan B, C, and D beneficiaries shall not be eligible for PACT services.

(b) Beneficiaries facing chronic and severe mental illness, who have not responded to traditional mental health treatment, using the criteria established by the Division of Mental Health and Addiction Services at N.J.A.C. 10:37J-2.3, shall be referred for PACT services by their mental health provider.

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N.J.A.C. 10:76-2.4 (2016)

§ 10:76-2.4 PACT beneficiaries receiving other mental health services

(a) Partial care/partial hospitalization (PC/PH) services shall not be available, except if clinically indicated and recommended by the PACT team, for up to the last 30 days before a beneficiary terminates from PACT services. The PACT agency shall obtain prior authorization for services before enrolling a beneficiary in a PC/PH program. See N.J.A.C. 10:76-2.5.

(b) A PACT provider shall not request reimbursement for PACT services delivered during the same month the beneficiary is also receiving integrated case management services (ICMS).

(c) A PACT provider shall not request reimbursement for PACT services when the beneficiary is also receiving mental health rehabilitation services provided in/by community residence programs during the same month of service. (See N.J.A.C. 10:77 and 10:77A).

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N.J.A.C. 10:76-2.5 (2016)

§ 10:76-2.5 Prior authorization

(a) No PACT services shall be provided to an eligible beneficiary without prior authorization. The eligible beneficiaries for PACT are described at N.J.A.C. 10:76-2.3(a).

(b) For the provision of PACT services, the provider shall obtain prior authorization as follows:

1. The provider shall complete the "DMHAS PACT Referral and Intake Outcome" form to request authorization to provide PACT services and shall submit the form to the DMHAS Regional Office in the county in which the provider is located.

2. The Regional DMHAS Program Analyst will evaluate the eligibility of the beneficiary for PACT services in accordance with N.J.A.C. 10:37J-2.3(b), and will advise the provider of results of the evaluation.

3. Upon receipt of this approval, the provider shall meet with the beneficiary, enroll the beneficiary into the PACT program, and return the signed and dated "DMHAS PACT Referral and Intake Outcome" form to the DMHAS Regional Office, confirming the enrollment of the beneficiary into the PACT program.

(c) For the provision of Partial Care/Partial Hospitalization (PC/PH) services to an eligible beneficiary enrolled in PACT, the provider shall obtain prior authorization as follows:

1. The PACT provider shall submit a written request to the Regional DMHAS Program Analyst requesting authorization to enroll a beneficiary receiving PACT services into a Partial Care/Partial Hospitalization program. The written request shall include:

i. A detailed justification for the necessity of the PC/PH services; and

ii. DMAHS prior authorization request forms (FD-07 and FD-07A) completed by the intended PC/PH provider requesting prior authorization of Partial Care or Partial Hospitalization services to a Medicaid/NJ FamilyCare beneficiary for a period not to exceed 30 days.

2. The Regional DMHS Program Analyst will evaluate the request, recommend services if appropriate, document the recommendation and forward their recommendations for approval of all requests for PC/PH services to: Division of Medical Assistance and Health Services, Office of Customer Service, Mental Health Services Unit, PO Box 712, Mail Code 25, Trenton, NJ 08625-0712.

3. The DMAHS Office of Customer Service will review the request and advise the Statewide PACT Coordinator of the approval or denial of the request.

i. PC/PH services shall not be approved for more than 30 days for an eligible beneficiary receiving PACT services.

ii. PC/PH services shall only be approved for the time period in which the eligible beneficiary is transitioning out of receiving PACT services.

iii. The providers will be notified by Molina Medicaid Systems that services have been authorized. Such authorization should be received before providing services.

(d) All claims filed for reimbursement with the Division's fiscal agent shall include the prior authorization number for any services rendered in order to ensure appropriate reimbursement is made. The prior authorization shall cover all dates that services were rendered to ensure proper reimbursement.

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N.J.A.C. 10:76-2.6 (2016)

§ 10:76-2.6 Reimbursement methodology

(a) Providers will be reimbursed on a fee-for-service basis for PACT services provided to an eligible beneficiary, as described at N.J.A.C. 10:76-2.3(a), based on the lower of the provider's usual and customary charge or the established DMAHS contracted reimbursement rate for the service.

1. Reimbursement amounts for PACT services shall be determined by the Commissioner of the Department of Human Services.

2. The DMAHS contracted reimbursement rate shall be based on an average of PACT provider costs for billable beneficiaries, that is, those beneficiaries who meet the minimum service standards in PACT programs that are under contract with, and licensed by, the Department of Human Services.

(b) A unit of service shall be defined as one calendar month of services, with full reimbursement being provided for the month services are initiated and no reimbursement being provided for the month services are terminated, regardless of the quantity of services provided in either of those months.

(c) For months of service other than the first and last months, a minimum of two hours of face-to-face contact with, or on behalf of, the beneficiary shall be provided.

1. If the minimum face-to-face contact is not achieved and documented during any calendar month, the provider shall not seek reimbursement for the provision of PACT services to an eligible beneficiary during that month.

2. In calculating the monthly minimum service requirement, the PACT service provider shall not count any face to face contact provided during any time during which the beneficiary was a resident of an institution for mental disease (IMD), including State, county or private psychiatric hospitals, or incarcerated in any correctional facility, however;

i. If a beneficiary is in one of the settings described above for only a portion of the calendar month, and the minimum monthly service requirement is met during the remainder of the month, the provider may bill for PACT service for that month.

3. General acute care hospitals shall not be considered IMDs for the purposes of the PACT, and therefore face-to-face contact provided to, or on behalf of, an eligible beneficiary, while the beneficiary is in a general acute care hospital, can be counted towards the monthly minimum service requirement.

(d) Providers shall seek reimbursement by submitting a CMS-1500 claim form, in accordance with DMAHS rules at N.J.A.C. 10:49.

1. HCPCS code H0040 22 shall be billed monthly for PACT services. (See N.J.A.C. 10:76-3.2).

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SUBCHAPTER 3. PROCEDURE CODES FOR REIMBURSEMENT

N.J.A.C. 10:76-3.1 (2016)

§ 10:76-3.1 Introduction

(a) The New Jersey Medicaid/NJ FamilyCare programs utilize the Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology (CPT) architecture, employing a five-position code and as many as two 2-position modifiers. The CPT is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical procedures and services performed by physicians. Unlike the CPT numeric design, the CMS assigned codes and modifiers contain alphabetic characters. The New Jersey Medicaid/NJ FamilyCare program adopted the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System codes for 2006, established and maintained by CMS in accordance with the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, and incorporated herein by reference, as amended and supplemented, and published by PMIC, 4727 Wilshire Blvd, Suite 300, Los Angeles, CA 90010. Revisions to the Healthcare Common Procedure Coding System made by CMS (code additions, code deletions and replacement codes) will be reflected in this chapter through publication of a notice of administrative change in the New Jersey Register. Revisions to existing reimbursement amounts specified by the Department and specification of new reimbursement amounts for new codes will be made by rulemaking in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

(b) HCPCS was developed as a three-level coding system:

1. LEVEL I CODES (narratives found in CPT): These codes are adapted from the Current Procedural Terminology (CPT), incorporated herein by reference, and are utilized primarily by physicians, podiatrists, optometrists, certified nurse-midwives, certified nurse practitioners/clinical nurse specialists, independent clinics and independent laboratories. Copies of the CPT may be obtained from the American Medical Association, 515 North State Street, Chicago, IL 60610.

2. LEVEL II CODES: The narratives for Level II codes are found in this subchapter. These codes are not found in the CPT and are assigned by CMS for use by physicians and other practitioners.

3. LEVEL III CODES: The narratives for Level III codes are found in this subchapter. These codes are assigned by the Division of Medical Assistance and Health Services to be used for those services that are unique to the New Jersey Medicaid/NJ FamilyCare programs.

(c) The lists of HCPCS code numbers for rehabilitative services are arranged in tabular form with specific information for a code given under columns with the following titles:

1. "IND "--lists the indicators that define requirements to be met when using the HCPCS codes.

i. "P" indicates that prior authorization is required;

2. "HCPCS Code"--Lists the HCPCS procedure code numbers;

3. "DESCRIPTION"--Code narrative: Narratives for Level III codes are found at N.J.A.C. 10:76-3.2;

4. "MAXIMUM FEE ALLOWANCE" - Lists the New Jersey Medicaid/NJ FamilyCare programs maximum fee allowance schedule. The maximum fee allowance associated with a procedure code represents the maximum amount a provider will be reimbursed for the given procedure; and

5. "MOD" services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances are identified by the addition of a two-digit code following the HCPCS procedure number. The New Jersey Medicaid/NJ FamilyCare program's recognized modifier codes for PACT services are as follows:

22: Unusual Services: When the services provided are greater than that usually required for the listed procedure, it may be identified by adding modifier "22" to the usual procedure number. A report with additional documentation must accompany the claim form to justify the greater services, unusual services or complications.

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N.J.A.C. 10:76-3.2 (2016)

§ 10:76-3.2 Procedure codes and maximum fee allowance

IND	HCPCS Code	MOD	Description	Maximum Fee Allowance
P	H0040	22	Comprehensive PACT services, monthly (adults)	Contract Pricing

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APPENDIX

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as a part of this chapter but is not reproduced in the New Jersey Administrative Code. The Fiscal Agent Billing Supplement can be downloaded free of charge from: www.njmmis.com. When revisions are made to the Fiscal Agent Billing Supplement, a revised version will be posted on the njmmis website and copies will be filed with the Office of Administrative Law.

If you do not have access to the Internet and require a copy of the Fiscal Agent Billing Supplement, write to:

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PO Box 4801
Trenton, New Jersey 08650-4801

or contact:

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