

[N.J.A.C. 10:52A](#)

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 52A. PSYCHIATRIC ADULT ACUTE PARTIAL HOSPITAL AND PARTIAL HOSPITAL SERVICES

Title 10, Chapter 52A -- Chapter Notes

Statutory Authority

CHAPTER AUTHORITY:

[N.J.S.A. 30:4D-1](#) et seq., and [30:4J-8](#) et seq.

History

CHAPTER SOURCE AND EFFECTIVE DATE:

Effective: July 29, 2021.

See: [53 N.J.R. 1491\(b\)](#).

CHAPTER HISTORICAL NOTE:

Chapter 52A, Psychiatric Adult Acute Partial Hospital and Partial Hospital Services, was adopted as new rules by R.2007 d.59, effective February 5, 2007. See: [38 N.J.R. 4359\(a\)](#), [39 N.J.R. 456\(a\)](#).

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 52A, Psychiatric Adult Acute Partial Hospital and Partial Hospital Services, was scheduled to expire on February 5, 2014. See: [43 N.J.R. 1203\(a\)](#).

Chapter 52A, Psychiatric Adult Acute Partial Hospital and Partial Hospital Services, was readopted as R.2014 d.114, effective June 17, 2014. See: [46 N.J.R. 420\(a\)](#), [46 N.J.R. 1694\(a\)](#).

In accordance with [N.J.S.A. 52:14B-5.1](#), Chapter 52A, Psychiatric Adult Acute Partial Hospital and Partial Hospital Services, was scheduled to expire on June 17, 2021. Pursuant to Executive Order Nos. 127 (2020) and 244 (2021) and P.L. 2021, c. 104, any chapter of the New Jersey Administrative Code that would otherwise have expired during the Public Health Emergency originally declared in Executive Order No. 103 (2020) is extended through January 1, 2022. Chapter 52A, Psychiatric Adult Acute Partial Hospital and Partial Hospital Services, was readopted, effective July 29, 2021. See: Source and Effective Date.

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Research References & Practice Aids

CHAPTER EXPIRATION DATE:

Chapter 52A, Psychiatric Adult Acute Partial Hospital and Partial Hospital Services, expires on July 29, 2028.

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§ 10:52A-1.1 Scope and purpose

(a) The rules in this chapter shall apply to all Division of Medical Assistance and Health Services (DMAHS) funded Psychiatric Acute Partial Hospital (APH), and Partial Hospital (PH) services for adults. To the extent that the provisions of this chapter conflict with the provisions of [N.J.A.C. 10:52](#), APH and PH services shall be regulated by this chapter.

(b) The concepts of wellness and recovery shall serve as the guiding principles in the delivery of both adult acute partial hospital and partial hospital services. As a result of their involvement with this program, beneficiaries should be able to better manage their illnesses and improve the quality of their lives. Each program shall identify and build upon each recovering beneficiary's strengths and areas of health in addressing the beneficiary's needs. The environment in which the program services are delivered shall encourage hope and emphasize individual dignity and respect. As recovery is most often a process, not an event, the provider shall address the needs of each beneficiary over time and across different levels of disability. Recovery principles shall be applied to the full range of engagement, intervention, treatment, rehabilitation and supportive services that a beneficiary may need.

1. The purpose of the APH services shall be to stabilize acute symptomatology in order to divert eligible beneficiaries from the need for inpatient psychiatric hospitalization. Treatment shall be provided at a level of intensity based upon clinical evaluation and formulation.
2. The purpose of PH services is to assist beneficiaries with severe mental illness to achieve community integration through valued living, learning, working and social roles. The role of PH is, therefore, to facilitate the beneficiary's integration into the community, not to become a permanent outcome, although it is recognized that some beneficiaries may need the support of PH for long periods of time. This balance between recovery and clinical services is accomplished through the provision of individualized, comprehensive, non-residential, structured programs which provide, but are not limited to, counseling, case management, psycho-education, pre-vocational services, community integration services and psychiatric services.

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§ 10:52A-1.2 Definitions

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

"Active treatment" means a process initiated at the point of intake for a psychiatric APH program and consists of the assessment, treatment, recovery and discharge planning phases of mental health services. Active treatment includes an integrated, comprehensive and complimentary schedule of treatment services for the purpose of maximizing a beneficiary's independence and community living skills to reduce unnecessary hospitalizations.

"Adult acute partial hospital" or "APH" means an intensive and time-limited acute psychiatric service for beneficiaries 18 years of age or older who are experiencing, or are at risk for, rapid decompensation. This mental health service is intended to minimize the need for hospitalization.

"Advanced practice nurse" means an individual certified as an advanced practice nurse by the New Jersey State Board of Nursing.

"Certified psychiatric rehabilitation practitioner" means an individual who has fulfilled all of the eligibility requirements of, and passed a comprehensive, standardized written examination as defined by, the Certification Commission for Psychiatric Rehabilitation.

"Clinician" means a mental health professional possessing a Master's or Doctoral degree from an accredited university in a field, such as psychiatry, psychology, social work, psychiatric nursing or rehabilitation counseling including, but not limited to, a licensed professional counselor. In addition to the degree, the individual shall have completed the applicable training including the appropriate residency (fellowship), internship or student placement required by the professional standards of the respective discipline as well as the applicable State license. A clinician may also serve in the capacity of a qualified addictions staff person.

"Community mental health associate" means a community mental health associate as defined by the Addiction Professional Certification Board, Inc., located at 1200 Tices Lane, East Brunswick, N.J. 08816.

"Direct care staff" means those personnel whose primary function is face-to-face and telephone interaction with the beneficiary providing the therapeutic contact necessary to achieve the beneficiary's treatment goals.

"Division" or "DMAHS" means the Division of Medical Assistance and Health Services within the New Jersey Department of Human Services.

"DMHS" means the Division of Mental Health Services within the New Jersey Department of Human Services.

"DSM-IV-TR" means the Diagnostic and Statistical Manual of Mental Disorders, incorporated herein by reference, as amended and supplemented, published by American Psychiatric Publishing, Inc., 1000 Wilson Boulevard, Suite 1825, Arlington, Virginia, 22209.

§ 10:52A-1.2 Definitions

"Educational services" means a formal educational course of study leading to a degree, certificate or graduation from an accredited institution or program and may include basic educational courses, special educational courses, G.E.D., and precollege preparation.

"Family therapy" means an outpatient therapy approach which involves assessment and treatment with all immediate family members present and which places emphasis on the family as a system rather than focusing on one person who might be deemed the identified patient.

"Group outpatient hospital psychiatric services" means an outpatient therapy for mental health disorders which involves a group of usually four to 12 beneficiaries who have similar problems and treatment needs. The group meets regularly with a therapist who uses the interaction of the group members to relieve distressful symptoms and modify beneficiaries' behavior.

"Individual outpatient hospital psychiatric services" means an outpatient therapy for mental health disorders that is tailored for a beneficiary and is administered one-on-one, in sessions which last between 30 minutes and one hour and which are provided on a regular basis for a course of treatment over a defined period of time.

"Individualized Recovery Plan" means a beneficiary-directed, individualized treatment plan developed in collaboration with the beneficiary, which identifies clinical needs, current status and specific goals and objectives. The Individualized Recovery Plan identifies specific interventions and measurable outcomes and is revised on a regular basis to reflect the beneficiary's current status and achievement of goals.

"Interdisciplinary treatment team (IDT)" means a team of individuals consisting of at least a psychiatrist or an advanced practice nurse, a therapist, a rehabilitation counselor and other counselor(s), the beneficiary, direct APH or PH staff, an RN and others involved with meeting the beneficiary's treatment needs.

"Licensed associate counselor" means an individual licensed as an associate professional counselor by the Professional Counselor Examiners Committee of the New Jersey State Board of Marriage and Family Therapy Examiners.

"Licensed professional counselor" means an individual licensed as a professional counselor by the Professional Counselor Examiners Committee of the New Jersey State Board of Marriage and Family Therapy Examiners.

"Medication management" means medication services to evaluate, prescribe or administer and monitor a beneficiary's use of psychotropic medications, provided by, or under the supervision of, a licensed physician or APN.

"Medication monitoring" means medication services provided to monitor a beneficiary's use of psychotropic medications under the supervision of a licensed physician or APN.

"Mental health services worker" means an individual, working under the direct supervision of a licensed mental health professional, who possesses a bachelor's degree or associate's degree in psychosocial rehabilitation or mental health services, or possesses one of the following credentials: certified psychiatric rehabilitation practitioner or community mental health associate.

"Off-site interventions" means planned mental health programming provided by the APH staff or PH staff during hours of APH or PH, respectively, at a location other than that of the program site in order to assist the beneficiary to apply or practice critical community-learned skills.

"Partial hospital" or "PH" means an individualized, outcome-oriented psychiatric service which provides a comprehensive, structured, non-residential, interdisciplinary treatment and psychiatric rehabilitation program to assist beneficiaries who have a serious mental illness in increasing or maximizing independence and community living skills and enhancing the quality of their lives.

"Prevocational services" means prevocational services, as that term is defined at [N.J.A.C. 10:52-2.10A](#).

§ 10:52A-1.2 Definitions

"Prior authorization" means approval by the Division before a service is 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, which merges treatment, rehabilitation and support services, which are individualized and tailored to the unique needs and choices of the beneficiary receiving the services.

"Qualified addictions staff" means individuals credentialed to provide supervision, clinical or direct care pursuant to the Alcohol and Drug Counselor Licensing and Certification Act, [N.J.S.A. 45:2D-1](#) through 17.

"Rehabilitation counselor" means an individual licensed by the Professional Counselor Examiners Committee of the New Jersey State Board of Marriage and Family Therapy Examiners (licensed rehabilitation counselor (LRC)), certified as a certified rehabilitation counselor (CRC) by the Certification in Rehabilitation Counseling Board or possessing the education, training and experience sufficient to qualify for either credential.

"Registered nurse" or "RN" means a person who has graduated from an accredited nursing program and who possesses a valid nursing license in the State of New Jersey.

"Skill development" means learning the requisite knowledge, attitudes and specific actions that lead to the performance of a critical competency needed for valued community role functioning. Skill development can be accomplished through either individual or group instruction; however, the staff-to-consumer ratio in group instruction must not exceed 1:10.

"Social worker" means an individual licensed by the New Jersey Board of Social Work Examiners as a certified social worker (CSW), licensed social worker (LSW) or licensed clinical social worker (LCSW).

"Vocational services" mean those interventions, strategies and activities which assist the beneficiary in acquiring skills to enter a specific occupation or assist the beneficiary in directly entering the workforce as an employee.

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§ 10:52A-2.1 Authority to provide services

- (a) Each program site location, as described in [N.J.A.C. 10:52-1.3](#), at which APH or PH services are provided and which has been approved to be a Medicaid provider by the Division's Office of Reimbursement Services shall provide services and be reimbursed for those services pursuant to [N.J.A.C. 10:49](#) and 10:52 and this chapter.
- (b) Each program site location, as described in [N.J.A.C. 10:52-1.3](#), at which APH or PH services are provided, shall be approved to be a Medicaid provider by the Division's Office of Reimbursement Services and, additionally, shall either be licensed by the Commissioner of the Department of Human Services as a mental health program and have a purchase of services contract with the Division of Mental Health Services, or be licensed by the Commissioner of the Department of Health and Senior Services as a health care facility.

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§ 10:52A-2.2 Reporting change of address or ownership

A participating provider shall reapply to the DMAHS Office of Reimbursement Services prior to operating if there are any changes in ownership or site location. In the case of a site relocation, the provider shall reapply prior to operating at the new location. DMAHS shall not reimburse for services provided prior to the date of the approval of the application.

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§ 10:52A-3.1 Eligibility for APH services

- (a) In order to be eligible for APH services, an individual shall first be determined to be an eligible beneficiary in the Medicaid/NJ FamilyCare program in accordance with the Division's rules.
- (b) In order to be eligible for APH services, a beneficiary shall be at least 18 years of age or older, unless prior authorized by DMAHS.
- (c) In order to be eligible for APH services, a beneficiary shall:
1. At the time of referral or as a result of psychiatric evaluation provided or arranged for, have at least one of the following primary DSM-IV-TR diagnoses on Axis I:
 - i. Schizophrenia or Other Psychotic Disorders (298.9, 295.xx);
 - ii. Major Depressive Disorder (296.xx);
 - iii. Bipolar Disorders (296.xx, 296.89);
 - iv. Delusional Disorder (297);
 - v. Schizoaffective Disorder (295.7);
 - vi. Anxiety Disorders (300.xx); or
 - vii. A covered psychiatric disorder diagnosis consistent with codes, Axis I-V of the Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR as amended and supplemented, including some 301.XX Axis II codes if the personality disorder is considered in the severe range and the beneficiary is at high risk of psychiatric hospitalization;
 2. Have disordered thinking or mood, bizarre behavior or psychomotor agitation or retardation to a degree that interferes with activities of daily living or abilities to fulfill family, student or work roles to such an extent that a structured intensive treatment program is needed and cannot adequately be addressed at a less restrictive level of care; the beneficiary also has a need for prescribed psychotropic medications or has a need for assistance with medication adherence; and
 3. Have a Global Assessment of Functioning (GAF) Scale score of between 30 and 60, as found in the DSM-IV-TR page 32.
- (d) In order to be eligible for APH services, a beneficiary shall be referred by the local designated screening center or psychiatric emergency service as a diversion from hospitalization or by an inpatient psychiatric facility if the treating psychiatrist or APN clearly justifies acute clinical need. Additionally, for a beneficiary to receive APH services, the beneficiary must receive, from the referring treatment team, a certification containing the clinical evidence necessary to support the referral, documenting the required specific conditions contained in (c)1, 2, and 3 above.
- (e) In the case of a beneficiary who has previously been admitted to an APH program, in order to be eligible for APH services, the beneficiary shall be readmitted to an APH program only through a referral

§ 10:52A-3.1 Eligibility for APH services

from the local designated screening center or psychiatric emergency service as a diversion from hospitalization or by an inpatient psychiatric facility if the treating psychiatrist or APN clearly justifies acute clinical need. Additionally, for a beneficiary to receive APH services, the beneficiary must receive, from the referring treatment team, a certification containing the clinical evidence necessary to support the referral, documenting the required specific conditions contained in (c)1, 2, and 3 above.

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§ 10:52A-3.2 Eligibility for PH services

(a) In order to be eligible for PH services, an individual shall first be determined to be an eligible beneficiary in the Medicaid/NJ Family Care program in accordance with the Division's eligibility rules at [N.J.A.C. 10:49](#), 10:69, 10:71, 10:72, 10:78 and 10:79.

(b) In order to be eligible for PH services, an individual shall be at least 18 years of age or older, unless prior authorized by DMAHS.

(c) In order to be eligible for PH services, a beneficiary shall at the time of referral:

1. Have a primary diagnosis as set forth in [N.J.A.C. 10:52A-3.1\(c\)](#)1;
2. Have impaired functioning, which necessitates learning critical skills in order to achieve valued community roles and community integration in at least one of the following domains on a continuing, intermittent basis for at least one year or have recently decompensated to a significantly impaired status:
 - i. Maintenance of personal self-care;
 - ii. Development of interpersonal relationships;
 - iii. Ability to work;
 - iv. Ability to receive an education;
 - v. Ability to live in the community; or
 - vi. Ability to acquire or maintain safe, affordable housing when at risk of requiring a more restrictive living situation; and
3. Have a Global Assessment of Functioning (GAF) Scale scores of between 30 and 70, as set out in the DSM-IV-TR page 32.

(d) In order to be eligible for PH services, a beneficiary shall be referred by the APH or be significantly impaired such that a need for PH exists, and receive from the interdisciplinary treatment team certification containing the clinical evidence to justify the necessity for a beneficiary to receive PH services, documenting the beneficiary's specific conditions contained in (c)1, 2 and 3 above.

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§ 10:52A-3.3 Ineligibility for APH and PH services

(a) An applicant or beneficiary who presents with any of the following criteria shall be excluded from participation in APH and PH services:

1. Has a primary diagnosis of substance abuse or dependence;
2. Is an imminent danger to self or others;
3. Is in need of acute medical care;
4. Is in need of detoxification;
5. Has a primary diagnosis of "developmentally disabled" as defined in the term "developmental disability" at [N.J.A.C. 10:44A-1.3](#); or
6. Is currently participating in a PACT program, unless authorized in accordance with [N.J.A.C. 10:76](#).

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§ 10:52A-4.1 Program distinctions

APH programs deliver intense active treatment necessary to stabilize a beneficiary's acute symptomatology and more effectively address intractable symptoms. PH programs provide services which assist beneficiaries to integrate into valued community roles.

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§ 10:52A-4.2 Conditions which shall be met for APH and PH services

(a) All of the following conditions shall be met for the provision of APH and PH services to each beneficiary:

1. Assigned staff shall complete an intake evaluation for each beneficiary within the identified timeframe established in [N.J.A.C. 10:52A-4.7](#);
2. Assigned staff shall complete a comprehensive assessment for each beneficiary within the identified timeframe established in [N.J.A.C. 10:52A-4.9](#);
3. The provider shall develop and maintain an Individualized Recovery Plan for each beneficiary, and shall update that Individualized Recovery Plan within the identified timeframe established in [N.J.A.C. 10:52A-4.10](#);
4. Assigned staff shall record progress notes for each beneficiary within the identified timeframe established in [N.J.A.C. 10:52A-4.11](#);
5. Assigned staff shall develop and maintain an applicable discharge plan for each beneficiary within the identified time frame established in [N.J.A.C. 10:52A-4.12](#);
6. The provider shall monitor APH and PH services through a quality assurance, utilization review and outcome protocol;
7. Program hours of service:
 - i. APH and PH providers shall make services available to beneficiaries a minimum of five hours per day and a minimum of five days per week at the times most needed by the beneficiaries;
8. After conducting a treatment team evaluation, the treatment team shall certify that a beneficiary requires the services of APH or PH in strict accordance with the beneficiary eligibility requirements set forth in this chapter;
9. After the initial service plan required by [N.J.A.C. 10:52A-4.7](#) has been developed, the treatment team shall examine the beneficiary to determine whether the beneficiary needs APH service. If so, the treatment team shall prepare a certification to that effect at least every 30 days to document that clinical evidence exists for continued stay. With respect to PH services, the treatment team shall examine the beneficiary and, if appropriate, prepare such a certification, every 60 days to document whether clinical evidence exists for continued stay; and
10. APH programs shall maintain affiliation agreements with local psychiatric community designated screening centers and inpatient hospital programs.

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§ 10:52A-4.3 Reimbursable and non-reimbursable APH and PH services

(a) Reimbursable APH services are:

1. Psychiatric services in APH:
 - i. APH providers shall provide a face-to-face, individual encounter with a psychiatrist or an advanced practice nurse a minimum of every other week for at least 15 minutes in APH. More frequent encounters may be required as deemed clinically necessary during all program hours based upon the beneficiaries' symptomatology and acuity;
2. Treatment services and interventions which assist a beneficiary to resolve an immediate crisis and attain stabilization in order to remain in the community through the support of a less intensive service, which include the following:
 - i. Individual and group therapy to help identify and manage symptoms and interpersonal problems that contribute to a greater risk of decompensation and relapse. This may include clinical approaches, such as Motivational Interviewing, Dialectical Behavioral Therapy (DBT), Cognitive Behavioral Therapy (CBT) and Cognitive Remediation/Rehabilitation interventions. Staff-to-client ratio in therapy groups shall not exceed 1:10;
 - ii. Cognitive behavioral skill-building groups focused on affect regulation, stress management and problem solving to promote independence;
 - iii. Relapse prevention groups to provide psychoeducation and to teach implementation skills; and
 - iv. Promotion of the beneficiary's commitment to change problematic behaviors and to follow up with aftercare plans;
3. Medication-related services, as needed, which include the following:
 - i. Medication counseling and education, as provided in [N.J.A.C. 10:37-6.53](#) and [6.54](#);
 - ii. Information regarding, and documentation of, each beneficiary's current medication treatment or therapies;
 - iii. Procedures by which staff share clinical information regarding medication utilization;
 - iv. Educating beneficiaries, staff and other caregivers regarding adverse drug reactions, potential side effects and management procedures for responding to crisis situations; and/or
 - v. Medication education provided within the context of a collaborative and therapeutic relationship. Beneficiaries shall be provided with adequate information in an understandable format regarding a medication's relative effectiveness and safety in order to make an informed decision. Interventions such as medication self-management, behavioral tailoring, simplifying a beneficiary's medication regimen and motivational interviewing assist and support beneficiaries in adhering to their medication regimens. A provider shall specifically review with the beneficiary how medication

§ 10:52A-4.3 Reimbursable and non-reimbursable APH and PH services

management issues will impact upon the beneficiary's personal recovery goals and shall be responsible for involving family members whenever possible;

4. Integrated treatment for co-occurring mental health and substance use disorders, which is a distinct clinical approach combining mental health and addiction into a unified, comprehensive and blended philosophy which provides prevention, intervention and treatment techniques which simultaneously address the beneficiary's needs;
5. Assessment and regular monitoring of co-occurring physical health needs to include procurement of medically necessary treatment(s) and services;
6. Beneficiary outreach to facilitate continued participation in the APH program;
7. Integrating the support of family and significant others into a beneficiary's treatment plan;
8. Other planning activities, which may include the development of an advance directive, meeting the requirements of P.L. 2005, c. 233, with specific instructions on what steps need to be taken in the event of a relapse and the development of a personal wellness and recovery action plan;
9. Environmental and safety procedures, which conform with [N.J.A.C. 10:37D-2.5](#) and [10:37F-2.7](#);
10. Referral procedures for crisis intervention in the event the beneficiary experiences exacerbation of medical or psychiatric symptoms; and
11. An illness management and recovery program, comprised of a broad set of strategies and activities, which help a beneficiary collaborate with practitioners to identify and pursue personally meaningful recovery goals founded upon a core set of interventions that include: psychoeducation, social skills training, cognitive-behavioral therapy, motivational interviewing and behavioral tailoring and relapse prevention techniques. This is accomplished by helping each beneficiary to develop coping strategies and skills which reduce the beneficiary's susceptibility to the illness, provide assistance and support to effectively manage symptoms to prevent relapse and rehospitalizations and reduce distress to the point where the beneficiary is able to enjoy an improved quality of life. The interventions are intended to be both didactic and practical in nature and can be provided in both group and individual settings. Such services shall be provided directly to beneficiaries and in support of family members or other significant individuals important to the beneficiaries. The services shall include, but are not limited to:
 - i. Coping skills, adaptive problem solving and social skills training, which teach a beneficiary strategies to self-manage symptoms and personal stress and strengthen life skills and abilities to attain his or her recovery goals;
 - ii. Psycho-education, which provides factual information, recovery practices, including evidence-based models concerning mental illness which instills hope and emphasizes the potential for recovery. Such services shall be geared toward the beneficiary developing a sense of mastery over his or her illness and life, and shall be effective in reducing relapse and rehospitalizations. The services may also provide support to the beneficiary's family and other members of the beneficiary's social network to help them manage the symptoms and illness of the beneficiary and reduce the level of family and social stress associated with the illness;
 - iii. Development of a comprehensive relapse prevention plan which offers skills training and individualized support focused on self-management of mental illness and other aspects of recovery, including early recognition, identification and management of symptoms and positive coping strategies and development of supports to reduce the severity and distress of disturbing symptoms. Special attention shall be placed on understanding, recognizing and monitoring of stressors which have triggered return of persistent symptoms in the past. In addition, adaptive problem-solving techniques shall be applied to avoid recurrences in the future;
 - iv. Dual disorder education which provides basic information to beneficiaries, family members or other significant individuals on the nature and impact of substance use and how it relates to the

§ 10:52A-4.3 Reimbursable and non-reimbursable APH and PH services

symptoms and experiences of mental illness and its treatment, as well as upon the attainment of the beneficiary's personal recovery goals;

v. Medication education to be provided within the context of a collaborative and therapeutic relationship. Each beneficiary shall be provided with adequate information in an understandable format regarding each medication's relative effectiveness and safety in order to make an informed decision. Interventions such as medication self-management, behavioral tailoring, simplifying a beneficiary's medication regimen and motivational interviewing assist and support a beneficiary in adhering to a medication regimen. Practitioners shall specifically review with the beneficiary how medication management issues will impact the beneficiary's personal recovery goals and shall be responsible for involving family members whenever possible; and

vi. Wellness activities consistent with the beneficiary's self-identified recovery goals. Wellness activities may address common physical health problems such as tobacco dependency, alcohol use, sedentary lifestyle, lack of physical exercise, overeating or poor nutrition. Other wellness services may address goals such as constructive use of leisure time and fulfilled spirituality and creativity pursuits.

(b) Reimbursable PH services are:

1. Psychiatric services in PH, which include assessment and ongoing treatment supervision.

i. A face-to-face, individual encounter with a psychiatrist or an advanced practice nurse shall be provided for each beneficiary at least once a month in PH. More frequent encounters may be required as deemed clinically necessary during all program hours based upon the beneficiary's symptomatology and acuity;

2. Counseling and case management services, which include evaluation, service planning and personal intervention;

3. Psychoeducational services for beneficiaries and families, which include mental health and medication education;

4. Prevocational services, as appropriate, directed toward maximizing vocational potential, including work readiness, prevocational experiences, prevocational training and counseling, prevocational assessment and planning. Prevocational services are an array of strategies and interventions that assist the beneficiary in acquiring general work behaviors, attitudes and skills in response to the interests and needs of beneficiaries who are considering, or intending to take on, roles which may be used in other life domains.

i. Prevocational intervention or strategies selected shall be based upon an assessment of the beneficiary's interest, needs, skills and supports and reflected in the beneficiary's Individualized Recovery Plan.

ii. Prevocational activities include, but are not limited to:

- (1)** Understanding and choosing work settings;
- (2)** Gathering and researching job information;
- (3)** Clarifying occupational values and interests;
- (4)** Defining work preferences;
- (5)** Identifying personal work criteria;
- (6)** Exploring barriers to working;
- (7)** Identifying and defining critical work skills;
- (8)** Researching personal work supports and resources;
- (9)** Identifying psychiatric illness management strategies related to working;

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(10) Simulated work activities, such as work units to address work hardening, concentration, attendance and other skills; and

(11) Learning methods to respond to criticism, negotiating for needs, dealing with interpersonal issues, and adherence to medication requirements.

iii. Therapeutic subcontract work may be provided within the context of partial hospitalization as prevocational therapy, if already provided by the provider's program as of October 1, 2006.

(1) Therapeutic subcontract work activity shall consist of the production, assembly or packing tasks for compensation obtained by the organization under a contract with a vendor for which individuals with disabilities performing the tasks are paid under a wage and hour certificate, which meets all Federal requirements, typically less than minimum wage.

(2) The beneficiary's Individualized Recovery Plan shall stipulate that the therapeutic subcontract work is a form of intervention intended to address the beneficiary as identified in the beneficiary's assessment.

(3) The therapeutic subcontract work shall be facilitated by a qualified mental health services worker.

(4) The therapeutic subcontract work activity shall be performed within the line of sight of the qualified mental health service worker.

(5) The staff to consumer ratio shall not exceed a ratio of 1:12 qualified mental health services worker to consumer;

5. Community integration services, such as independent living skills training and goal-oriented cultural activities;

6. Engagement strategy services designed to connect with a beneficiary over time in order to develop a commitment on the beneficiary's part to enter into therapeutic relationships supportive of the beneficiary's recovery. This service may include, but is not limited to, activities, such as initial contacts with potential program participants, as well as continued efforts to engage individuals to participate in program services;

7. Activities designed to assist a beneficiary to identify, achieve and retain personally meaningful life goals over time which help the person resume normal functioning in valued life roles in self-chosen community environments. Examples of such goals include, but are not limited to, returning to work or school, returning to adult care-giving or parenting roles, resuming roles as a spouse or significant other, becoming a member of a religious community or becoming a neighbor;

8. An illness management and recovery program, comprised of a broad set of strategies and activities which help a beneficiary collaborate with practitioners to identify and pursue personally meaningful recovery goals founded upon a core set of interventions which include: psycho-education, social skills training, cognitive-behavioral therapy, motivational interviewing and behavioral tailoring, and relapse prevention techniques. This is accomplished by helping each beneficiary to develop coping strategies and skills which reduce the beneficiary's susceptibility to the illness, provide assistance and support to effectively manage symptoms to prevent relapse and rehospitalizations and reduce distress to the point where the beneficiary is able to enjoy an improved quality of life. They are intended to be both didactic and practical in nature and can be provided in both group and individual settings. Such services shall be provided directly to beneficiaries and in support of family members or other significant individuals important to the beneficiaries. The services shall include, but are not limited to:

i. Coping skills, adaptive problem solving and social skills training, which teach a beneficiary strategies to self-manage symptoms and personal stress and strengthen life skills and abilities to attain his or her recovery goals;

ii. Psycho-education which provides factual information, recovery practices, including evidence-based models concerning mental illness, which instills hope and emphasizes the potential for

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recovery. Such services shall be geared toward the beneficiary developing a sense of mastery over his or her illness and life, and shall be effective in reducing relapse and rehospitalizations. It may also provide support to the beneficiary's family and other members of the beneficiary's social network to help them manage the symptoms and illness of the beneficiary and reduce the level of family and social stress associated with the illness;

iii. Development of a comprehensive relapse prevention plan which offers skills training and individualized support focused on self-management of mental illness and other aspects of recovery, including early recognition, identification and management of symptoms and positive coping strategies and development of supports to reduce the severity and distress of disturbing symptoms. Special attention shall be placed on understanding, recognizing and monitoring of stressors which have triggered return of persistent symptoms in the past. In addition, adaptive problem-solving techniques shall be applied to avoid recurrences in the future;

iv. Dual disorder education, which provides basic information to beneficiaries, family members or other significant individuals on the nature and impact of substance use and how it relates to the symptoms and experiences of mental illness and its treatment, as well as upon the attainment of the beneficiary's personal recovery goals;

v. Medication education to be provided within the context of a collaborative and therapeutic relationship. Each beneficiary shall be provided with adequate information in an understandable format regarding each medication's relative effectiveness and safety in order to make an informed decision. Interventions such as medication self-management, behavioral tailoring, simplifying a beneficiary's medication regimen and motivational interviewing assist and support a beneficiary in adhering to a medication regimen. Practitioners shall specifically review with the beneficiary how medication management issues will impact a beneficiary's personal recovery goals and shall be responsible for involving family members whenever possible; and

vi. Wellness activities consistent with the beneficiary's self-identified recovery goals. Wellness activities may address common physical health problems such as tobacco dependency, alcohol use, sedentary lifestyle, lack of physical exercise, overeating or poor nutrition. Other wellness services may address goals such as constructive use of leisure time and fulfilled spirituality and creativity pursuits;

9. Skill development needed for beneficiary-chosen community environments, facilitating beneficiary-directed recovery and re-integration into community living, learning, working and social roles by developing critical competencies and skills. Skill development may be accomplished through either individual or group instruction; however, the direct staff-to-beneficiary ratio in group activities shall not exceed 1:12. Examples include, but are not limited to, developing:

i. Cognitive skills such as researching and recording information, decision making, identifying preferences and values, selecting clothing, interviewing, scheduling appointments, budgeting, personal nutrition planning, etc.;

ii. Physical skills such as showering, grooming, cooking, cleaning personal space, shopping, taking public transportation, parenting etc.; and

iii. Emotional skills such as negotiating, communicating, asking for help, avoiding risks to sobriety, greeting others, conversing, identifying psychiatric cues, planning for psychiatric emergencies, etc.;

10. Medication-related services, as needed, which include the following:

i. Medication counseling and education, as defined in [N.J.A.C. 10:37-6.53](#) and [6.54](#);

ii. Knowledge and documentation of each beneficiary's current medication treatment and therapies;

iii. Providing a mechanism for staff to share clinical information regarding medication utilization; and

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- iv. Education of beneficiaries, staff and other caregivers regarding adverse drug reactions, potential side effects and established procedures for responding to crisis situations;
11. Goal-oriented verbal counseling, which may include individual, group and family modalities to address the emotional, cognitive and behavioral symptoms of mental health illness or to engage, motivate, stabilize and address related effects on role functioning including beneficiaries with a co-occurring mental health and substance use disorder. Goal-oriented verbal counseling may also include motivational interviewing, connecting skills and cognitive behavioral therapy;
 12. Age-appropriate learning activities, which are directly tied to the learning of daily living or other community-integration competencies such as financial literacy, basic computer literacy and recognition of directions and safety warnings. Such basic computing, reading or writing skills are considered incidental and not student education;
 13. Community integration services, which include independent living skills training, interpersonal skills such as greeting, talking about impersonal topics, conversing, learning about available community cultural opportunities, practicing social interaction, and spiritual and cultural activities;
 14. Psychiatric services, which include assessment and ongoing treatment supervision;
 15. Other planning activities including the development of an advance directive, which meets the requirements of P.L. 2005, c. 233, with specific instructions on the steps to be taken in the event of a relapse and the development of a personal wellness and recovery action plan (WRAP); and
 16. Integrated treatment for co-occurring mental health and substance use disorders, which is a distinct clinical approach combining mental health and addiction into a unified, comprehensive and blended philosophy which provides prevention, intervention and treatment techniques which simultaneously address the beneficiary's needs.
- (c) Services which shall not be reimbursed shall include:
1. Vocational services, such as technical occupational skills training, college preparation, individualized job development and marketing to employers;
 2. Student education, including preparation of school-assigned class work or homework;
 3. Off-site services and activities, unless conducted in accordance with the provisions of this chapter;
 4. Transportation, which is not a component of active programming; and
 5. Breaks or mealtimes.
- (d) Reimbursement for APH and PH services shall be made pursuant to [N.J.A.C. 10:52-4.3](#).

History

HISTORY:

Amended by R.2012 d.050, effective March 5, 2012.

See: [43 N.J.R. 2112\(a\)](#), [44 N.J.R. 594\(a\)](#).

In (b)4iii(5) and (b)9, substituted "1:12" for "1:10".

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§ 10:52A-4.3 Reimbursable and non-reimbursable APH and PH services

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§ 10:52A-4.4 Length and hours of service

(a) Length and hours of service for APH shall be as follows:

1. Initial length of service requests for APH shall not exceed a maximum of seven business days, while awaiting prior authorization (PA) approval.
2. Prior authorization for APH is required every 90 days for up to a maximum of six months per beneficiary.
3. Beneficiaries receiving APH services shall receive no less than two hours of services per day and no more than five hours of services per day. Beneficiaries receiving APH services shall receive a maximum of 25 hours of services per week.

(b) Length of service for PH. PH service is limited to 24 months per beneficiary. However, in calculating this 24-month period, time spent in both PH and APH shall be included.

1. Beneficiaries receiving PH services shall receive no less than two hours of services per day and no more than five hours of services per day. Beneficiaries receiving PH services shall receive a maximum of 25 hours of services per week.

(c) Readmission. At the conclusion of the six-month maximum length of stay, any future readmission to an APH program is permitted only if the readmission meets the eligibility requirements in [N.J.A.C. 10:52A-3.1](#). The initial authorization for readmission shall not exceed a maximum of seven business days while awaiting prior authorization (PA) approval from DMAHS. Prior authorization for readmission to an APH shall be required every 90 days, up to a maximum of six months per beneficiary. In order to be eligible for readmission to PH services, a beneficiary shall be referred by the APH or a designated screening center or be significantly impaired such that a need for PH exists, and receive from the interdisciplinary treatment team certification containing the clinical evidence to justify the necessity for a beneficiary to receive PH services, documenting the beneficiary's specific conditions contained in [N.J.A.C. 10:52A-3.2\(c\)](#)1, 2 and 3. Readmission is limited to 24 months per beneficiary. However, in calculating this 24-month period, time spent in both PH and APH shall be included.

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§ 10:52A-4.5 Prior authorization for APH services

- (a) APH services provided to beneficiaries age 22 years or older require prior authorization for such services. Initial length of service requests for APH shall not exceed a maximum of seven business days, while awaiting prior authorization approval when the beneficiary is referred to adult acute partial hospital service by the local designated screening center or an inpatient psychiatric facility. Following the initial seven business days of service, prior authorization through a DMAHS concurrent utilization process review will be required for the remainder of the time the service is provided. Prior authorization in APH is required every 90 days for up to a maximum of six months.
- (b) When requesting prior authorization, Forms FD-07 and FD-07A, "Request for Authorization of Mental Health Services and/or Mental Health Rehabilitation Services" and "Request for Prior Authorization: Supplemental Information" shall be completed and forwarded to the Medical Assistance Customer Center (MACC) that serves the county in which the services are rendered. (The forms may be obtained through the website www.njmms.com or by contacting Unisys Provider Relations at 1-800-776-6334.) The "Brief Clinical History" and "Present Clinical Status" sections of the FD-07A "Request for Prior Authorization: Supplemental Information" form are particularly important and shall provide sufficient medical information to justify and support the proposed treatment request. A request for additional information may be made at the discretion of the Medicaid reviewer if the reviewer believes that insufficient medical information has been provided for the Division to make a determination. Failure to comply with such a request may result in a result in a reduction or denial of requested services.
- (c) Each request for prior authorization shall reflect the criteria listed in [N.J.A.C. 10:52A-3.1](#).
- (d) The notification of the disposition (approved, modified, denied, or suspended) of a prior authorization request will be made by the Division.

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§ 10:52A-4.6 Staffing

- (a) The APH and PH shall be staffed with personnel, who are licensed, when required, appropriately credentialed, culturally competent and trained to provide APH and PH services as set forth in this chapter. Staff may be engaged on a full time, part time or consulting basis, provided that services are adequate to meet the program needs of participating beneficiaries.
- (b) The APH program shall maintain a qualified direct and clinical care staff-to-beneficiary ratio of 1:6 for active programming.
- (c) The PH program shall maintain a qualified direct and clinical care staff-to-beneficiary ratio of 1:15 for active programming.
- (d) For APH and PH each program shall have:
1. A program director who shall:
 - i. Have primary responsibility for program operation, development and management;
 - ii. Possess a professional credential such as:
 - (1) Licensed clinical social worker;
 - (2) Licensed professional counselor;
 - (3) Licensed rehabilitation counselor;
 - (4) Licensed clinical alcohol and drug counselor;
 - (5) Licensed psychologist;
 - (6) Advanced Practice Nurse; or
 - (7) Master of Science in Nursing with the requisite number of years of experience or possess a master's degree in a human service field and five years experience in mental health services, with two years supervisory experience; or
 - iii. Be available for crisis consultation and management and for coordination with outside practitioners;
 2. A medical director who shall be licensed to practice in the State of New Jersey and be board certified in psychiatry. The medical director must be available to the APH program for sufficient time to oversee all clinical and medical responsibilities;
 3. A psychiatrist or advanced practice nurse who shall provide oversight of clinical activity including psychiatric evaluations, medication prescription and individual therapy and shall be available for consultation or emergencies during operation of the program. The Medical Director may also provide this function; and

§ 10:52A-4.6 Staffing

4. Staff, which shall also include the following, based upon the types of services and the intensity of services required by the beneficiaries:

- i. Professional registered nurse(s);
- ii. Clinician(s);
- iii. Primary case coordinator(s) or counselor(s);
- iv. Mental health service worker(s);
- v. Qualified addictions staff, as required; and/or
- vi. Primary staff providing pre-vocational services.

History

HISTORY:

Amended by R.2012 d.050, effective March 5, 2012.

See: [43 N.J.R. 2112\(a\)](#), [44 N.J.R. 594\(a\)](#).

In (c), substituted "1:15" for "1:12".

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§ 10:52A-4.7 Intake evaluation

(a) The intake staff in both APH and PH shall assess an applicant's eligibility for services and develop an initial service plan with the beneficiary. All intake procedures shall be guided by a beneficiary's preferences and goals with regard to treatment and community living.

1. The initial contact shall serve to orient and engage a new beneficiary in a culturally and linguistically appropriate manner and facilitate continuity of service.
2. Intake procedures shall be designed to facilitate the beneficiary's program participation at the earliest appropriate opportunity. A lack of completion of the formal intake process shall not preclude an otherwise eligible beneficiary from receiving services.

(b) In order to ensure that there is an adequate basis for a timely and accurate assessment, the provider agency shall develop and maintain written policies and procedures, which require that the following information be documented for all beneficiaries at intake interviews. These procedures shall include requirements for documenting the following:

1. Basic demographic information, including identification of an emergency contact;
2. Presenting problems and reason for referral, including the beneficiary's interests and preferences in achieving valued community living, learning, working or social roles;
3. A medical history, including a brief history of the illnesses, previous services received at an agency and elsewhere, a beneficiary's self-report of responses to previous treatment, a completed current mental status evaluation, medication information, current mental health and social service providers and any allergies;
4. A signed authorization for release of information, in accordance with all applicable legal requirements;
5. Basic family and social supports;
6. Legal information relevant to treatment;
7. Basic substance use information;
8. Basic employment and educational history; and
9. Risk factors (for example, under what circumstances the beneficiary may be a danger to self or others or present a risk of sexually predatory behaviors).

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§ 10:52A-4.8 Initial service plan

- (a) Within 24 hours of admission, staff shall develop an initial service plan as part of the intake process. The plan shall address the beneficiary's urgent presenting problems in order to meet immediate needs for food, clothing, shelter, medication and safety.
- (b) The initial service plan shall be reviewed and approved by a psychiatrist within two business days after completion based upon the professional judgment of the psychiatrist that the treatment specified is clinically appropriate.
- (c) Based on the information obtained from the intake interview and assessment, staff shall record the beneficiary's strengths, weaknesses and needs as part of the initial service plan. The beneficiary's urgent presenting problems, including a medication review, shall be evaluated and addressed in the initial service plan.
- (d) Staff shall document the initial service plan in the beneficiary's record and staff shall revise it as needed until staff develop an Individualized Recovery Plan.

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§ 10:52A-4.9 Comprehensive written assessment

(a) The provider shall develop written procedures that require that every beneficiary receive a comprehensive written assessment, which includes, at a minimum, the assessment of the beneficiary's acute symptomatology, skill and resource strengths and barriers to attainment of the beneficiary's self-expressed goals related to community integration and living, learning, working and social role recovery.

(b) Within 14 business days of the admission of a beneficiary to the APH program, and within 30 days of admission of a beneficiary to the PH program, a comprehensive written assessment shall be completed for the purpose of developing an Individualized Recovery Plan. The comprehensive assessment shall include, at a minimum, the following:

1. Acute symptomatology that requires treatment interventions in order to return the beneficiary to a pre-morbid level of functioning;
2. The beneficiary's interest in, and strengths and goals related to, participation in the program;
3. The beneficiary's functioning including, but not limited to, the ability to make friends and communicate;
4. The beneficiary's emotional and psychological characteristics including, but not limited to, mental status, trauma and abuse history, if applicable, understanding of his or her own illness and coping mechanisms;
5. A review of medical history including, but not limited to, applicable allergic and adverse medication reactions and screening for current physical, emotional, sexual abuse or neglect. If abuse or neglect is identified, staff shall refer the matter to the appropriate authorities, as required by law;
6. The beneficiary's expressed interests, preferences, strengths and goal(s) related to community roles and quality of life;
7. Identification of the beneficiary's strengths and barriers to goal attainment;
8. A social (family) history;
9. A nutritional screening to identify potential health complications and a need for nutritional education;
10. An assessment of cultural preferences;
11. An assessment of spiritual preferences;
12. A legal assessment, if applicable, assessing the beneficiary's legal history and any current relevant legal issues relating to the beneficiary;
13. An assessment of educational and vocational issues or needs, if applicable;
14. Community resources needed to help the beneficiary achieve the identified goals and objectives. Staff members shall document alternative services identified and not provided by the psychiatric acute partial hospital program and shall refer the beneficiary to the appropriate service(s);

§ 10:52A-4.9 Comprehensive written assessment

15. An assessment of the beneficiary's emotional and psychological functioning including, but not limited to, mental status and understanding of his or her own illness, and coping mechanisms;
 16. An assessment of activities of daily living including, but not limited to, transportation, budgeting, self-medication and hygiene; and
 17. Living arrangements, including housing, entitlements and subsidies.
- (c) Assigned staff shall sign, date and maintain all assessment and evaluation documentation in the beneficiary's file.
- (d) Assigned staff from the interdisciplinary treatment team shall make reasonable efforts to involve the family and significant others in the assessment process to the extent possible.

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§ 10:52A-4.10 Individualized Recovery Plan

- (a) The interdisciplinary treatment team shall develop an Individualized Recovery Plan for each beneficiary participating in an APH and PH program. The Individualized Recovery Plan shall address urgent problems or barriers which staff have prioritized from the comprehensive assessment and, to the greatest extent possible, effectuate agreement and mutual understanding between the beneficiary and the program staff.
- (b) In each APH program, staff shall formulate the Individualized Recovery Plan and implement it at the completion of the comprehensive assessment, but no later than 14 business days after the beneficiary's admission to the program. In each PH program, staff shall formulate the Individualized Recovery Plan and implement it at the completion of the comprehensive assessment, but no later than six weeks after the beneficiary's admission to the program.
- (c) In each APH program, assigned staff from the interdisciplinary treatment team shall document in the Individualized Recovery Plan the beneficiary's progress toward treatment objectives and his or her response to interventions, and shall revise and update the Individualized Recovery Plan every 30 days. In each PH program, assigned staff from the interdisciplinary treatment team shall document in the Individualized Recovery Plan the beneficiary's progress toward treatment objectives and his or her response to interventions, and shall revise and update the Individualized Recovery Plan every 90 days for the first year and every 180 days thereafter.
- (d) The Individualized Recovery Plan shall:
1. Be written in language which can be easily understood by the beneficiary;
 2. Contain the signatures of the beneficiary, primary case coordinator or counselor and direct care staff supervisor. The beneficiary's signature on the Individualized Recovery Plan shall indicate that the beneficiary was involved in the formulation of the plan or that the beneficiary reviewed and approved of the plan. In the event that the beneficiary is not involved in the development of the plan or the beneficiary does not agree with any part of the plan, his or her lack of participation or disagreement shall be documented in the comments section of the Individualized Recovery Plan;
 3. Contain the direction of the course of treatment;
 4. Contain the psychiatrist's or advanced practice nurse's signature, which shall reflect agreement with the direction of the course of treatment;
 5. Contain the beneficiary's self-stated overall goals and objectives related to chosen, valued role(s) and specific plans to achieve these roles, with target dates for achievement, including further in-depth and ongoing assessment in the identified areas;
 6. List specific interventions, strategies and activities to implement the Individualized Recovery Plan, including clear reference to necessary off-site services to assist in the transfer of learning;
 7. Identify the staff responsible for implementing each intervention; and

§ 10:52A-4.10 Individualized Recovery Plan

- 8.** Contain a comment section under which the beneficiary states in his or her own words any concerns, agreements or disagreements with either the development or final Individualized Recovery Plan.
- (e)** The adult APH and PH program shall include the beneficiary and family (with consent) participation in service planning. To assure family participation in developing the Individualized Recovery Plan and revisions, the program staff shall seek input from family members at each service planning milestone, provided that the beneficiary has given written consent to release information related to the treatment of his or her mental illness.
- (f)** The beneficiary shall attend treatment team meetings to discuss progress and potential plan revisions. Staff shall document the beneficiary's involvement in the record.
- (g)** The treatment team shall document any progress after each Individualized Recovery Plan meeting.
- (h)** Following completion of the Individualized Recovery Plan, the treatment team shall develop an active treatment schedule which addresses the issues identified in the comprehensive assessment.

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§ 10:52A-4.11 Documentation requirements for APH and PH

- (a) The APR and PH programs shall maintain a comprehensive signature log, signed by each beneficiary, which reflects the beneficiary's daily participation in the program.
- (b) Each APH program shall provide daily documentation for each beneficiary in the program. Each PH program shall provide weekly documentation for each beneficiary in the program. Documentation shall include, but not be limited to:
 - 1. A summary of the beneficiary's participation in therapies or activities and clinical progress;
 - 2. A description of any significant events which may have an effect on the beneficiary's achievement of his or her stated goals and objectives; and
 - 3. Treatment plan revisions, which shall be based on the beneficiary's response to treatment plan interventions.
- (c) Each progress note entry into the beneficiary's record shall be legible, signed, dated and shall include staff title and credentials.
- (d) A record of participation by the beneficiary shall be maintained by an assigned group facilitator.
- (e) Each provider shall make all records available for review by the Department.

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§ 10:52A-4.12 Discharge planning for APH and PH

- (a) A discharge plan shall be initiated by the interdisciplinary treatment team, with beneficiary participation, at the time of admission and shall be updated with the Individualized Recovery Plan.
- (b) The discharge plan shall consist of relevant, measurable goals and objectives to assist the beneficiary in accomplishing his or her discharge plan.
- (c) The discharge plan shall be implemented when the beneficiary's functioning or symptomatology has improved as evidenced by scores on the Global Assessment of Functioning Scale.
- (d) The discharge plan shall be implemented when the beneficiary meets the criteria for, has need for, or could benefit from, more or less intensive level of service or has achieved significant accomplishment of established goals and objectives.
- (e) A discharge summary shall be written within 10 days of the beneficiary's discharge, termination or transfer from the program and shall be maintained thereafter in the beneficiary's record. The summary shall include, but need not be limited to, the following:
 - 1. The beneficiary's presenting problem;
 - 2. The beneficiary's admission date and date of termination from the program;
 - 3. The course of treatment and the beneficiary's responses;
 - 4. The reason for termination; and
 - 5. The beneficiary's current medications.
- (f) The discharge planner shall send a copy of the discharge plan to all identified receiving providers.

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§ 10:52A-4.13 Quality assurance and outcome review

- (a) Each APH and PH program shall maintain an established Quality Assurance Plan for the program to improve performance and treatment outcomes.
- (b) Quality assurance indicators shall be based on beneficiary-identified issues and high risk factors.
- (c) The Quality Assurance Plan shall be reviewed and updated annually.
- (d) A copy of the Quality Assurance Plan shall be sent to the appropriate Medical Assistance Customer Center annually.

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[N.J.A.C. 10:52A-4.14](#)

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§ 10:52A-4.14 Off-site services

(a) Off-site interventions may be provided, as long as the beneficiary is accompanied or supervised by staff.

1. The off-site interventions shall be:

- i. Individualized for each beneficiary and non-stigmatizing;
- ii. Integrated as a subordinate component of the beneficiary's Individualized Recovery Plan, which clearly describes each specific off-site intervention and how the intervention relates to the overall achievement of the beneficiary's specific goals and objectives in the Individualized Recovery Plan, particularly in assisting beneficiaries to apply skills learned to community settings.
- iii. Properly documented in the beneficiary's record to include when the off-site activity commenced and terminated; and
- iv. Limited to a defined and measurable period of time.
- v. Services which are solely recreational or diversional in nature shall not be considered an APH or PH activity.

(b) Off-site services provided shall average less than 10 percent of each APH and PH program beneficiary's average active programming time in APH and PH during the previous month. If off-site activities are greater than 10 percent additional justification is required in the beneficiary's record and shall be subject to program audit by the Division. In no case may the time be more than 20 percent.

1. The beneficiary must sign in at the site of the APH or PH program prior to participating in any off-site activity and sign out of the program after completion of the off-site activity.
2. Transportation to and from an off-site activity shall not be counted as billable time for a beneficiary unless:
 - i. A qualified clinical staff member is in the vehicle functioning as a counselor;
 - ii. There are no more than four clients in the vehicle or, if there are more than four clients in the vehicle, a second staff person accompanies the clinical staff member and functions as the driver; and
 - iii. The clinical staff conducts activities for the beneficiary during the period of transportation which meet all of the requirements for reimbursable activities of the program.

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§ 10:52A-4.14 Off-site services

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§ 10:52A-4.15 Quality assurance reviews

- (a) DMAHS shall conduct quality assurance reviews of all hospital-based mental health programs annually or more frequently, as required by DMAHS if deficiencies in the program are identified by DMAHS staff.
- (b) DMAHS shall notify a program of any noncompliance findings revealed during the quality assurance review within 20 days of the review having been completed.
- (c) A program shall respond in writing to any notification of findings within 30 days of notice.
- (d) The program response shall include a corrective action plan to address and prevent all incidences of non-compliance.
- (e) The corrective action plan shall include, but may not be limited to:
 - 1. A timeline detailing remediation of noncompliance issues;
 - 2. A detailed description of those steps determined necessary by the provider to ensure compliance with the corrective plan; and
 - 3. Individuals and titles responsible for ensuring compliance with that plan.
- (f) DMAHS shall review the corrective action plan submitted by the program. If the corrective action plan does not adequately address the deficiencies identified in a quality assurance review, DMAHS shall return the plan to the program for revision. Any program deficiencies identified by DMAHS shall be rectified by the program within 30 days of receipt.
- (g) DMAHS has the authority to restrict and/or terminate program admissions of NJ FamilyCare/Medicaid or Work First New Jersey (WFNJ)/General Assistance (GA) beneficiaries because of provider noncompliance with Medicaid standards, such as, but not limited to, actions taken by DMHS, quality assurance reviews conducted by DMAHS and immediate health and safety concerns.
- (h) Programs may be subject to follow-up visits by DMAHS staff based on the outcome of quality assurance reviews conducted by DMAHS.

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§ 10:52A-4.15 Quality assurance reviews

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§ 10:52A-4.16 Termination of program

Each hospital that discontinues an APH or PH program shall do so in an orderly fashion. Each hospital shall comply with all applicable closure and pre-closure requirements contained in State and Federal statutes, laws, rules and regulations. Additionally, the hospital shall notify the DMAHS Office of Provider Relations in writing at least 60 days in advance of the actual closing. The hospital shall develop a plan which specifies and provides referral for mental health services that are needed to provide for the present and future mental health needs of each beneficiary.

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[N.J.A.C. 10:52A-5.1](#)

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§ 10:52A-5.1 Beneficiary rights

- (a) At the time of admission to an APH or PH program, program staff shall present and explain to each beneficiary all rights of the beneficiary under all applicable State and Federal statutes, laws, rules and regulations, as well as under all relevant hospital policies.
- (b) A signed, witnessed statement shall be recorded in the beneficiary's record to the effect that the beneficiary's rights have been explained to the beneficiary.
- (c) The psychiatric APH and PH program shall post, and advocate for, the beneficiary's exercise of rights.
- (d) Any actions by staff to promote or assist the beneficiary in exercising his or her rights shall be clearly documented in the beneficiary's record.

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