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HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Independent Clinic Services

Readoption with Amendments: N.J.A.C. 10:66

Adopted Repeal: N.J.A.C. 10:66-2.19

Proposed: December 19, 2016, at 48 N.J.R. 2737(a).

Adopted: April 18, 2017, by Elizabeth Connolly, Acting Commissioner, Department of Human Services.

Filed: May 3, 2017, as R.2017 d.113, **with non-substantial changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 30:4D-1 et seq., and 30:4J-8 et seq.

Agency Control Number: 16-A-07.

Effective Dates: May 3, 2017, Readoption;

June 5, 2017, Amendments and Repeal.

Expiration Date: May 3, 2024.

Summary of Public Comments and Agency Responses:

Comments were received from: Ms. Kate Clark, External Relations Director, Family Planning Association of New Jersey; Ms. Kendria McWilliams, Maryville Addiction Treatment Centers of New Jersey; Mr. William J. Maslak, MSW, LSW, Associate VP of QA & IM/Privacy Officer; Care Plus NJ, Inc; Mr. Alan Oberman, CEO, John Brooks Recovery Center; and Debra L. Wentz, Ph.D, President and Chief Executive Officer, New Jersey Association of Mental Health and Addiction Agencies, Inc.

Care Plus NJ, Inc.

COMMENT: **General.** There are inconsistencies between these proposed rules and certain other Department of Human Services (DHS) standards regarding mental/behavioral health and substance abuse treatment that are codified at N.J.A.C. 10:37, the Community Mental Health Services Act, and N.J.A.C. 10:161B, Standards for Licensure of Outpatient Substance Use Disorder Treatment Facilities. Both of the aforementioned chapters contain regulations promulgated by the Division of Mental Health and Addiction Services (DMHAS). The inconsistencies between the proposed regulations and the DMHAS regulations are due, in part, to the proposed regulations not being specific with regard to service differences between substance use, outpatient, and intensive outpatient services, opioid, and non-opioid substance use services, and mental health and substance use services. The commenter recommends that the requirements of these proposed regulations be reconciled with N.J.A.C. 10:37 and 10:161B.

RESPONSE: The proposed changes to N.J.A.C. 10:66 introduce new substance use disorder services while maintaining Division of Medical Assistance and Health Services (DMAHS) requirements for independent clinics. It is the Department's belief that the proposed rules align those services with the requirements listed in N.J.A.C. 10:37 and 10:161B.

COMMENT: **General.** DMHAS Newsletters dated November 2016 and January 2017, contain specific standards not integrated into these proposed rules. The commenter

states that any new standards being included in the newsletters should be incorporated into these proposed regulations and open for public comment.

RESPONSE: The newsletters to which the commenter is referring were issued by DMHAS, not DMAHS, after these DMAHS proposed rules had been filed for publication with the Office of Administrative Law (OAL). The DMHAS newsletters will be reviewed and any content considered for inclusion in DMAHS rules will be published in a separate rulemaking to allow sufficient time for public review and comment.

COMMENT: **General.** Expanding eligibility to include substance use disorder treatment is a positive change; the commenter notes that such expanded eligibility does not equate to expanded service capacity for the providers. DMHAS rules codified at NJAC 10:161B-10.1, Provision of Substance Abuse counseling, set the maximum number of clients that a full-time equivalent (FTE) staff member may be assigned based on funding through the existing grant. The maximum caseload is strictly enforced by the DHS Office of Licensing, so unless there is an expansion of services capacity, any expanded eligibility will result in waiting lists.

RESPONSE: These proposed rules are not intended to revise or replace standards listed in N.J.A.C. 10:161B. Any concerns with a maximum caseload for counseling and supportive services should be addressed through changes to the standards listed in N.J.A.C. 10:161B.

COMMENT: **General.** Medicaid and NJ FamilyCare Fee-for-Service beneficiaries already are eligible under N.J.A.C. 10:66-2.3, Drug treatment center services. It is not

clear how the proposed changes in regulations are expanding eligibility because the major changes proposed are based on imposing a “prior authorization” system on the substance use disorder treatment providers as a fiscal control mechanism rather than a service expansion. Based on the change in funding methodology, which is changing from a grant system to a fee-for-service system, the providers have projected financial deficits which will likely result in a decrease in overall access to services by clients, not an increase.

RESPONSE: The substance use disorder (SUD) services provided under N.J.A.C. 10:66-2.3, prior to these proposed rules, were limited to Methadone Assisted Treatment (MAT) and certain counseling services. The coverage of SUD services under the Affordable Care Act (ACA) greatly expanded services available to Medicaid beneficiaries. As a result, DMHAS decided to utilize the American Society of Addiction Medicine (ASAM) criteria to ensure beneficiaries were receiving services that are clinically appropriate. Individuals requesting services are not denied access and prior authorization is not intended to control costs. Instead, ASAM criteria helps to ensure clients are directed to clinically appropriate services that address their individual situation and symptoms to ensure greater success.

COMMENT: **General.** There will be a negative economic impact on the providers for several reasons, including: acquiring computer equipment, training of staff, and securing IT support for the proposed prior authorization system; an anticipated reduction in services provided once prior authorization is in place; and that since “the changes and analysis do not fully differentiate the types of substances use treatment

program regulations as delineated in N.J.A.C. 10:161B. Due to their medical nature, opioid and detox programs have medical staffing requirements that outpatient programs does not." If programs are held to a higher level of requirements than delineated in N.J.A.C. 10:161B, higher costs are inevitable.

RESPONSE: The current prior authorization process is being used by DMHAS to obtain payment for State paid services. The staff already have been performing this function; the only difference now is that if a client is Medicaid-eligible, the number issued reflects that to identify claims for services rendered to that client as being eligible for Federal financial participation. Since providers have followed DMHAS rules prior to the promulgation of these corresponding DMAHS rules, the Department believes that there should be no change in cost to maintain compliance.

COMMENT: **General.** Since DHS is planning on a transition from a grant-based funding methodology to a fee-for-service funding methodology, providers are projecting major financial deficits resulting in the subsequent lay off of staff and any added cost resulting from the proposed changes for Medicaid will increase those deficits and projected lay off of staff.

RESPONSE: The Department recently raised rates for substance use disorder services in order to attract new providers and assist existing providers to transition to a fee-for-service funding methodology. The Department feels these increases will offset funding losses any programs may experience in the transition from the grant-based funding methodology.

COMMENT: **General.** There are inconsistencies between the proposed regulations and the applicable program regulations in DMHAS rules at N.J.A.C. 10:161B and 10:37. If providers must comply with what they perceive to be the higher standards outlined in these proposed regulations, the result will be increased costs for providers to be in compliance.

RESPONSE: The Department agrees that providers should comply with the most stringent regulatory requirement. Since providers have followed DMHAS rules prior to the promulgation of these corresponding DMAHS rules, the Department believes that there should be no change in cost to maintain compliance.

COMMENT: **General.** DHS is moving towards computerization and reporting through cloud-based portals. This technology requires investments in equipment, on-going equipment maintenance costs, staff training costs, software licensing cost, internet access, and other associated costs. Since providers are required to use the State internet portals, these costs are associated with the unfunded mandates. Again, the rates for reimbursement do not cover unfunded mandates, and the change from a grant-based system to a fee-for-service system will have a negative financial impact on providers.

RESPONSE: DMHAS began using a web-based IT solution, the NJ Mental Health Application for Payment Processing (NJMHAPP), in January 2017, for providers seeking State reimbursement for non-Medicaid reimbursable services provided to non-Medicaid eligible consumers. The implementation of that process does not impact

N.J.A.C. 10:66. There are no unfunded mandates associated with the adoption of these rules.

New Jersey Association of Mental Health and Addiction Agencies, Inc. (NJAMHAA)

COMMENT: **General.** The phrase “drug treatment center services” has been changed to “substance use disorder services” in many instances throughout N.J.A.C. 10:66, but not in all places. The commenter requests that the entire document be reviewed and have this change made in all instances, of note, in N.J.A.C. 10:66-2.2 and 2.3(d).

RESPONSE: It is noted that N.J.A.C. 10:66-2.2 does not contain a reference to “drug treatment center services” but is a rule about dental services. It is further noted that N.J.A.C. 10:66-2.3(d) is deleted as part of this rulemaking. Therefore, there are no changes that need to be made to N.J.A.C. 10:66-2.2 or 2.3(d). However, the comment prompted the Department to thoroughly review the text to ensure that all changes from the phrase “drug treatment center services” to “substance use disorder services” were made and identified the need for the change in terminology at N.J.A.C. 10:66-6.2(a) and 6.4(m)1 through 19. Since the change is not so substantive as to require additional public notice and comment in accordance with N.J.A.C. 1:30-6.3, the chapter shall be thoroughly reviewed and the necessary changes will be made upon adoption.

COMMENT: **General.** The commenter requests an explanation of how the independent clinic rules interface with licensure regulations, specifically, the Department of Human Services’ Office of Licensing, for outpatient SUD treatment facilities.

RESPONSE: The proposed changes to N.J.A.C. 10:66 set the requirements for providers that wish to seek Medicaid reimbursement. The standards used by DHS licensing set the requirements of any provider wishing to provide SUD services in New Jersey, regardless of payment source. The proposed changes to N.J.A.C. 10:66 were intended to establish Medicaid billing requirements for SUD services and to align with current rules for licensing and DMHAS.

Care Plus NJ, Inc.

COMMENT: **N.J.A.C. 10:66-1.1. "**The proposed changes are in delineation of the types of independent clinics identify mental health and substance use as a 'clinic type.'" Both types of "clinics" have been incorporated into the regulations, yet they are not new. The use of the term "clinic type" is critical since various provisions of the regulations use the term "clinic" without specificity to a particular type.

RESPONSE: There are instances in the rules that apply to all independent clinics, regardless of clinic type, and others that are specific to a particular clinic type. The Department considers the current text to be accurate and will not make any changes at this time.

Care Plus NJ, Inc. and NJAMHAA

COMMENT: **N.J.A.C. 10:66-1.2.** The proposed rules define "behavioral health" as combining both mental health and substance use treatment. This indicates the approach taken on how substance use disorder treatment was incorporated into the regulations. Where mental health was cited, substance abuse was inserted with some

variations. However, although both are behavioral health fields, there are clinical differences, as well as regulatory differences. This is also the only section that uses the term “behavioral health.” Since the term is not used anywhere else in the chapter, the commenter from NJAMHAA suggests removing the definition.

RESPONSE: The Department believes that defining “behavioral health” is necessary and denotes the Department’s efforts to combine mental health and substance use disorder under the industry accepted term of behavioral health and, therefore, will not make any changes.

NJAMHAA

COMMENT: **N.J.A.C. 10:66-1.3(c)5.** This provision states that an SUD treatment facility must be approved by DMHAS as a condition of participation as a Medicaid and NJ FamilyCare provider. Clarification is needed on the definition of “approved.” For example, if the meaning of “approved” means DMHAS licensure, that should be clearly stated.

RESPONSE: Prior to these services being eligible for Medicaid reimbursement, DMHAS had extensive interaction with community providers. The Department determined that DMHAS should review provider applicants and identify any known issues prior to final approval as a Medicaid and NJ FamilyCare provider. This process is not related to licensing.

Care Plus NJ, Inc. and NJAMHAA

COMMENT: **N.J.A.C. 10:66-1.4.** This provision is in regard to the use of LogistiCare transportation services. Since transportation vendors are subject to change during the time period these regulations will be in effect, the provision should reference “DMAHS contracted transportation broker” instead of the specific company.

RESPONSE: The Department agrees with the commenter and, since the change is not so substantive as to require additional public notice and comment in accordance with N.J.A.C. 1:30-6.3, the suggested change will be made upon adoption.

Care Plus NJ, Inc.

COMMENT: **N.J.A.C. 10:66-1.4(c).** The inclusion of both mental health services and substance use disorder services in this requirement for prior authorization after exceeding $6,000 of independent clinic services is a disadvantage to independent clinics that provide both types of services if the limit applies to the agency and not the specific type of clinic or service provided. For example: if a client is receiving mental health services from one agency and substance use services from a second, each agency would be allowed to provide services without prior authorization up to $6,000, for a total of $12,000 before having to request prior authorization. In contrast, an agency that provides mental health and substance use services will be subject to the $6,000 limit. The limit should be applied to the type of clinic.

RESPONSE: Subsequent to the publication of this proposed rulemaking, the Department was informed by the Centers for Medicare and Medicaid Services (CMS) that a hard fiscal threshold was inappropriate in consideration of the parity requirements of the Affordable Care Act. As a result of this communication, the Department made the

decision to deactivate the edit in the claims processing system that enforced that threshold. A separate rulemaking removing the threshold from the chapter will be proposed in conformance with the Administrative Procedure Act and filed with the Office of Administrative Law at a future date.

COMMENT: **N.J.A.C. 10:66-1.4(c).** The list of applicable services does not specify mental health partial care as requiring prior authorization. The list contains those types of service modalities common to mental health and substance use services. The list does not include intake assessment, psychiatric evaluation, or medication monitoring session. Does this mean that those specific services are excluded from the prior authorization requirement?

RESPONSE: Intake assessment, psychiatric evaluation, and medication monitoring do not require prior authorization.

COMMENT: **N.J.A.C. 10:66-1.4(f).** Proposed new subsection (f) covering substance use disorder services specifically excludes intake assessments as requiring prior authorizations. Does this mean that intakes are also excluded from prior authorization for mental health services? While this may seem simple, there are circumstances in which a client may have more than one intake within a 12-month period for the same agency, the same clinic or the same service. Are all intake assessments excluded from prior authorization?

RESPONSE: All behavioral health intake assessments may be provided without prior authorization.

COMMENT: **N.J.A.C. 10:66-1.4(f).** An intake assessment, psychiatric evaluation, suicide risk assessment, full mental status exam, substance use assessment, and psychosocial assessment are related, but not the same type of assessment. An intake assessment occurs at the start of treatment to determine the medical necessity and appropriateness of admission to the program. All others occur at various times through treatment. Will any or all of these types of assessments be exempt from prior authorization? Will there be limits placed on any or all of these? It is critical that providers be able to conduct the necessary type of assessment as needed without having to obtain or be denied authorization.

RESPONSE: N.J.A.C. 10:66-1.4(f) exempts the intake assessment from prior authorization requirements related to substance use services. Medicaid reimburses providers for a single intake assessment. The requirements for the intake assessment are described in the applicable rules. The other assessments listed are included in substance use services and are not individually reimbursable to programs and, therefore, not required to be prior authorized.

COMMENT: **N.J.A.C. 10:66-1.4(f).** The DMHAS newsletter for November 2016, advises providers to use an Evaluation and Management (E&M) Code to submit the psychiatric evaluation for reimbursement. To comply, providers must use two different billing codes for psychiatric evaluations depending on the individual client billing circumstance and not the type of service. Providers who use electronic medical records (EMRs) will need to have complex programming code incorporated into the EMR at

expense to the provider. The alternative is to have a manual system, which increases the administrative burden on staffing.

RESPONSE: The Department recognizes that there are times that SUD clients will require a psychiatric evaluation in addition to the intake assessment. The CPT code 90792 is used for the program's intake assessment, which includes a medical evaluation related to SUD treatment. Any subsequent psychiatric evaluation is not a part of the intake evaluation and should be billed as a stand-alone physician visit utilizing an E&M code. The psychiatric evaluation should be provided and billed on a separate date of service. This evaluation is not mandated by the Department and remains optional for an SUD provider.

COMMENT: **N.J.A.C. 10:66-1.4(f).** The proposed rule references "all other substance use disorder services" and lists the types of substance use services. Subsections (f)1 and 2 refer to "outpatient mental health" and "partial care services for mental health." This appears to be redundant since paragraphs (c)1 through 6 identify the same provisions for mental health. The regulations must be specific and clear as to what applies to mental health service, what applies to substance use service, and what applies to both. The absence of specificity leads to confusion and misinterpretation. Subsections (c) and (f) should either be combined or completely separated to be specific to each.

RESPONSE: The Department acknowledges that some of the language at subsections (c) and (f) is repetitive; however, the repetition is to reinforce that the requirements apply to mental health services, whether provided in conjunction with substance use

disorder services or by themselves, and substance use disorder services whether provided in conjunction with mental health services or by themselves; all are subject to prior authorization. The Department feels that the text adequately expresses the prior authorization requirements for these services and, therefore, no changes will be made in response to the comment.

COMMENT: **N.J.A.C. 10:66-1.4(f)3.** It is unclear if the requirement to submit a prior authorization is based on a change in the ASAM level of service, a more generic level of service, or any level of service with regard to type of service and/or frequency of services. The commenter suggested that it be clarified that the requirement to submit a prior authorization should be based on a change in the ASAM level.

RESPONSE: The Department believes the language in N.J.A.C. 10:66-1.4(f)3 is sufficiently clear in indicating that requests for continued stay beyond the initial prior authorization period require a new prior authorization request. A new prior authorization will also be required when there is a departure from the ASAM level of care and the change in the client's clinical condition requires a change in the frequency and/or intensity of the services and the change in services exceeds the amount of the existing prior authorization.

COMMENT: **N.J.A.C. 10:66-1.4(f)3.** Various factors may impact on the level of services a client is receiving at a given time, including: client informed consent and right to choose, client readiness for treatment and disclosure of their drug use, and changes of the client's circumstances. Providers should base levels of service on need and

increase or reduce levels of services in response to changes in the client's condition. Clinical staff need flexibility to make decisions regarding the type and frequency of services being provided and the requirement to process a new prior authorization request in order to begin the new level of services is an unnecessary burden on the provider and the State; further, such a requirement may result in the delay of appropriate service level for the client. For example: can the Department provide clarification on prior authorization requirements in cases, such as when the client was authorized to receive individual therapy, but later consents to family therapy. In such situations, must a new prior authorization request be submitted and approved before providing family therapy services?

RESPONSE: The Department refers the commenter to N.J.A.C. 10:66-2.7(k)1i, which allows for the temporary deviation from the services written in the treatment plan, as long as the reason for the temporary deviation is clearly explained in the daily or weekly documentation, and, if the deviation does not resolve, that a written change be made to the treatment plan. This allows the provider the flexibility to provide a new level of services while waiting for the response to the prior authorization request. For this reason no change will be made upon adoption.

John Brooks Recovery Center and NJAMHAA

COMMENT: **N.J.A.C. 10:66-2.3(a).** The requirement for outpatient and intensive outpatient (IOP) substance use disorder services to be prescribed by a physician or advance practice nurse (APN) is a serious concern as it is a departure from decades of protocol, and it is impractical and costly. The requirement for a prescription can prove

to be an onerous requirement to a non-MAT clinic. This requirement would impose restrictions that could result in reduced access to services, as well as financial and administrative burdens on services providers, as many do not have physicians or APNs available to screen all potential referrals and provide prescriptions before treatment is initiated. In order to stay fiscally viable, many providers are only employing psychiatrists or APNs to provide direct treatment, not screening services; and programs that do not offer medication-assisted treatments often do not have physicians or APNs on staff at all. These new requirements would place clients at risk of losing these critical services and others not able to begin treatment. Additionally, the requirement for prescriptions contradicts contracts that some providers currently have with DMHAS. For example: Drug Court has recently moved to Medicaid billing and those clients are referred for treatment by court order, not prescribed by physicians or APNs. The policy is also a departure from current regulations for primary SUD treatment providers, specifically N.J.A.C. 10:161B-6.3 and 9.1, which do not require that potential clients be prescribed treatment.

RESPONSE: The Department notes that the requirement for a prescription for drug treatment services provided in independent clinics is not a newly proposed requirement. The existing requirement for a prescription is recodified as N.J.A.C. 10:66-2.3(a)1i and expanded to allow for the prescription to also be provided by an APN, as the result of new language. The Department also notes that the specific levels of substance use services are described at N.J.A.C. 10:66-2.3(c) through (i) and that those descriptions more clearly indicate which services require the prescription or recommendation of a physician or other licensed practitioner. The phrase “as described in (c) through (i)

below" will be added to N.J.A.C. 10:66-2.3(a)1i to clarify the requirement, since these subsections provide a brief description of each service and its requirements. Since the addition of this phrase is not so substantive as to require additional public notice and comment in accordance with N.J.A.C. 1:30-6.3, the suggested change will be made upon adoption.

NJAMHAA and Maryville Addiction Treatment Centers of New Jersey

COMMENT: **N.J.A.C. 10:66-2.3(a).** This is a significant departure from current regulations for primary addiction providers. Over the past several months, the provider community has requested direction from DMAHS on what physician documentation is required, and during what time intervals, to meet Medicaid and NJ FamilyCare requirements regarding the provision of SUD treatment. Recently, the provider community received informal communication that physician approval of treatment plans and level of care changes was all that was required to certify these services as medically necessary; the implication being that a prescription was not necessary to initiate evaluation for intake and the development of a treatment plan. We request that the proposed language be changed to be consistent with those communications, the language requiring a Physician/APN prescription be deleted. Secondly, we would like assurance that if indeed a Physician/APN prescription is now required, will they be found deficient during previous Medicaid audits? Maryville Addiction Treatment Centers of New Jersey noted that its organization participated in a practice Medicaid audit in December 2016, and that there was no mention of a requirement for Physician/APN prescription for treatment being required.

RESPONSE: The Department notes that the requirement for a prescription for drug treatment services provided in independent clinics is not a new proposed requirement. The existing requirement for a prescription is recodified as N.J.A.C. 10:66-2.3(a)1i and expanded to allow for the prescription to also be provided by an APN, as the result of new language. The Department also notes that the specific levels of substance use services are described at N.J.A.C. 10:66-2.3(c) through (i) and that those descriptions more clearly indicate which services require the prescription of a physician or other licensed practitioner. The phrase "as described in (c) through (i) below" will be added to N.J.A.C. 10:66-2.3(a)1i upon adoption to clarify the requirement.

Concerning Medicaid audits: All audit results are determined in relation to the rules in effect at the time of the audit; therefore, these rules will not apply to any service date prior to their adoption.

Care Plus NJ, Inc. and NJAMHAA

COMMENT: **N.J.A.C. 10:66-2.3(b).** This proposed rule is inconsistent with the requirements of N.J.A.C. 8:43A-26.5 and 10:161B-10.1(g), which differentiate between outpatient and intensive outpatient programs and require that "… intensive outpatient services shall provide clients with at least weekly individual counseling sessions; outpatient programs shall provide at least monthly individual counseling sessions, based upon determination of the multidisciplinary team." This section should also specify whether the term "counseling" includes both individual and group counseling.

RESPONSE: N.J.A.C. 10:66-2.3(a) states that substance use disorder treatment services are to be provided in accordance with N.J.A.C. 10:161A and 161B. The

proposed amendment at N.J.A.C. 10:66-2.3(b) requires that a minimum of one counseling session per week be provided during the first three months of treatment; this is consistent with the existing requirements at N.J.A.C. 8:43A-26.5(b)3. Counseling, as defined in N.J.A.C. 10:161B, includes the provision of individual, group, and/or family therapy. The number of group versus individual therapy sessions should be determined by the multidisciplinary team based on the clinical need of the client.

COMMENT: **N.J.A.C. 10:66-2.3(c) and (d).** This proposed change requires medical visits by a physician or an APN as a service in ASAM Level of Care 1 and 2. N.J.A.C. 10:66-2.3(c) and (d) state, in part, "See N.J.A.C. 10:161B for program standards including documentation, staffing, and licensing requirements"; however, these proposed rules are inconsistent with the requirements of N.J.A.C. 10:161B-1.4, 1.5, 7.1, and 8.1. ASAM Level of Care 1 and 2 are outpatient and intensive outpatient programs. N.J.A.C. 10:161B-7.1 and 8.1 specifically state that medical services and nursing services are not required for outpatient and intensive outpatient programs. If the proposed rules require outpatient and intensive outpatient programs to provide physician and/or nursing services, this may increase the staffing cost for providers, resulting in severe recruitment difficulties and leading to reduced service capacity.

RESPONSE: N.J.A.C 10:66-2.3(c) and (d) list the required elements of outpatient and intensive outpatient programs, including physician or APN visits, and refers the provider to N.J.A.C. 10:161B for program standards. The Department agrees with the commenter that N.J.A.C. 10:161B-7.1 and 8.1 state that medical services and nursing services, respectively, are not required to be provided by outpatient or intensive

outpatient programs. However, N.J.A.C. 10161B-8.1 does require that these programs designate a staff person to obtain specified health information during the assessment process and arrange for referrals and/or treatment as indicated and that these services be included as part of the comprehensive treatment plan and documented in the client's chart. Therefore, in order to clarify the requirements of the program as described at N.J.A.C. 10:66-2.3(c) and (d), the following language will be added as N.J.A.C. 10:66-2.3(c)5 and (d)1:

"In accordance with N.J.A.C. 10:161B-8.1, the intake assessment shall include obtaining health related information from the client and recording the information in the client's record. If there is an indication for medical treatment or screening, the staff person shall coordinate referral for services. Resolution of health related problems shall be included as part of the comprehensive treatment plan and all referrals or treatment, and shall be documented in the client chart."

N.J.A.C. 10:161B-1.4 and 1.5 address the qualifications and responsibilities of the medical director and nursing director, respectively, of outpatient opioid treatment and detoxification facilities. N.J.A.C. 10:66-2.3(c) and (d) do not address that topic.

NJAMHAA

COMMENT: **N.J.A.C. 10:66-2.3(i).** Drug screening and lab work should be added to the list of services included in the bundled rate.

RESPONSE: Except for the initial screen at assessment, the number and frequency of drug testing is a patient-centered decision made by the provider. In addition, laboratory testing is not required to be conducted at the facility. Providers can choose to refer

these services to other providers. Therefore, the Department has decided not to include these services in the bundled rate.

Family Planning Association of New Jersey

COMMENT: **N.J.A.C. 10:66-2.5.** The commenter expressed appreciation for the Department's proposed amendment to replace the brand name "Norplant System (NPS)" with the generic term and recommends that the Department consider amending N.J.A.C. 10:66-2.5(b)5 to reflect the current effective lifespan of subdermal contraceptive implants. The current rule allows for two insertions and two removals during a five-year period; this was appropriate for Norplant as its effectiveness was five years. However, it is not sufficient for current contraceptive implants, which are considered effective for only three years. Under the proposed amendments this could result in a gap in coverage for the client's method of choice. The commenter is recommending that the existing language of "permitted during a five-year continuous period" be changed to read "permitted during the FDA-approved clinically appropriate time period for the device."

RESPONSE: The Department agrees with the commenter and, as the change is a benefit to providers, the suggested change will be made upon adoption.

Care Plus NJ, Inc.

COMMENT: **N.J.A.C. 10:66-2.7(b).** The proposed rule states that only one type of mental health services can be provided per day, with the exception of one unit each of individual, group, or family psychotherapy services being allowed per day. Care Plus

NJ, Inc., requests that “unit” be defined and suggests that it be defined “based on a billable session and not the DMHAS contract Annex A definition.” NJAMHAA suggest that “billable session” be substituted for “unit” throughout the language for this provision.

RESPONSE: The length of units of service as they relate to specific mental health services can be found at N.J.A.C. 10:66-6.4(f). The length of units of service as they relate to specific substance use disorder services can be found at N.J.A.C. 10:66-6.4(m).

COMMENT: **N.J.A.C. 10:66-2.7(j).** The commenter requests that DHS define the term “first encounter” in regards to an intake evaluation. If the first encounter is defined as any type of contact or referral, such as a telephone call or a referral by someone other than the client orother than the first face-to-face contact with a client, that this could be problematic considering such factors as scheduling and client needs or preferences. The proposed rule should be restated to include the phrase “unless circumstances justify a longer period of time not to exceed …”

RESPONSE: The term “first encounter” begins with the first face-to-face contact with the client. The Department believes that the current wording is sufficient. Therefore, no change will be made upon adoption.

COMMENT: **N.J.A.C. 10:66-2.7(j).** The proposed 14-day timeframe also sets up competing priorities with N.J.A.C. 10:37, which prioritize those clients who are being referred from inpatient psychiatric units and psychiatric screening centers for

medications. This puts the agency in the position of treating someone differently based on the source of reimbursement and not the presenting clinical need.

RESPONSE: The Department respectfully disagrees that the 14-day timeframe creates competing priorities. N.J.A.C. 10:66-2.7(j) requires that "An intake evaluation shall be performed within 14 days of the first encounter or by the third clinic visit, whichever is later." The Department maintains that the requirement provides adequate time to complete the intake evaluation of each person, regardless of the source of the referral; therefore, no change will be made upon adoption.

NJAMHAA

COMMENT: **N.J.A.C. 10:66-2.7(j)5.** In several areas of the proposed regulations the language was amended from "physician" to "physician or APN," but N.J.A.C. 10:66-2.7(j)5 was not amended and it should be. Due to the limited supply and high cost of physicians, many agencies use APNs to help meet clients' needs. Limiting the responsibility of reviewing new cases to physicians would add a cost burden for the providers and could result in a delay of clients starting services.

RESPONSE: The Department agrees with the commenter and will add "or advanced practice nurse" to maintain consistency throughout the proposed rules.

Care Plus NJ, Inc.

COMMENT: **N.J.A.C. 10:66-2.7(k)1i.** The commenter supports this proposed rule, which allows for the temporary deviation from the services written in the treatment plan, as long as the reason for the deviation is clearly explained in the daily or weekly

documentation and, if the deviation does not resolve, that a written change be made to the treatment plan. The commenter requests clarification of the term “temporary.”

RESPONSE: In this context the term “temporary” means on a very short-term basis, and can occur for a variety of reasons, such as staff absence, a special occasion, or the uncooperative nature of the client on a particular day. This type of deviation from treatment is meant to provide the flexibility to manage a client while still ensuring that they experience some therapeutic effect from attending the program, even if that day they are refusing to attend their own scheduled activity but are willing to participate in another activity. If the team is unable to direct the client back to their original treatment plan in a reasonable amount of time then the client’s treatment plan should be adjusted.

COMMENT: **N.J.A.C. 10:66-2.7(m).** Some flexibility in the 90-day requirement related to the review of the client’s plan of care is needed to allow for situations, such as weekends, holidays, and client treatment schedules that sometimes prevents the provider from completing such a review until the 91st day. The strict interpretation of the 90-day requirement results in staff having to count out exactly 90 days to identify the exact date that the plan review is required to take place, this adds to the administration burden, and while such a task may seem minor when applied to one case, it becomes exponentially burdensome when serving large numbers of clients. Additionally, the lack of flexibility conflicts with the recognition at N.J.A.C. 10:66-2.7(k)1i of mental illness treatment being a flexible process.

RESPONSE: The Department does not agree that maintaining a 90-day schedule adds any additional burden to the provider. Required timeframes for administrative purposes do not substantially conflict with mental illness treatment being a flexible process.

Summary of Agency-Initiated Changes

At N.J.A.C. 10:66-2.3(e) “a physician or an APN visit” is being deleted. N.J.A.C. 10:66-2.3(e)1 is added to require partial care programs to have in place written protocols ensuring access to psychiatric and medical services if needed. N.J.A.C. 10:66-2.3(e)2 is added to require that referral for necessary medical services shall be made if indicated after the initial assessment of the client. N.J.A.C. 10:66-2.3(e)1 and 2 are in accordance with the existing licensing standards at N.J.A.C. 10:161B and are added for clarity as it is already required in the other chapter.

Federal Standards Statement

Sections 1902(a)(10) and 1905(a) of the Social Security Act, 42 U.S.C. §§ 1396a(a)(10) and 1396d(a), respectively, allow a state Title XIX program to provide clinic services. Section 1905(a)(9) of the Social Security Act, 42 U.S.C. § 1396d(a)9, provides a definition of clinic services. The Federal statute and regulations allow a state broad latitude in defining clinic services, including the types of clinics the state enrolls into its program.

Section 1903(r)(1)(B)(iv) of the Social Security Act requires that states incorporate compatible methodologies of the National Correct Coding Initiative (NCCI) administered

by the Secretary of the United States Department of Health and Human Services (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) and such other methodologies of that Initiative (or such other national correct coding methodologies), as the Secretary identifies.

Section 1905(a)(2)(c) of the Social Security Act, 42 U.S.C. § 1396d(a)(2)(c), requires states to cover Federally Qualified Health Center (FQHC) services. FQHC services are defined at Section 1905(l)(2)(A) of the Social Security Act, 42 U.S.C. § 1396d(l)(2)(A).

Title XXI of the Social Security Act allowes states to establish a children's health insurance program for targeted low-income children. Section 2103 of the Social Security Act, 42 U.S.C. § 1397cc, provides broad coverage guidelines for the program. Section 2110 of the Act, 42 U.S.C. § 1397jj, allows clinic services for the children's health insurance program.

The Department has reviewed the Federal statutory and regulatory requirements and has determined that the readopted rules and adopted amendments and repeal do not exceed Federal standards. Therefore, a Federal standards analysis is not required.

Full text of the readopted rules can be found in the New Jersey Administrative Code at N.J.A.C. 10:66.

Full text of the adopted amendments follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

10:66-1.4 Prior authorization (PA)

(a) - (d) (No change from proposal.)

(e) Transportation services to and from a substance use disorder treatment facility will be authorized and provided by *[LogistiCare,]* the DMAHS transportation broker. Providers are responsible for arranging the transportation by contacting the *[LogistiCare reservation center by phone at 866-527-9945, or fax at 866-457-3316. Additional information and resources can be found on LogistiCare's website: http://facilityinfo.logisticare.com/njfacility/Home.aspx]* ***DMAHS transportation broker. A link to the transportation broker can be found on the DMAHS website: http://www.state.nj.us/humanservices/dmahs/home/index.html. If you do not have internet access call the Provider Services hotline at 1-800-776-6334.***

(f) (No change from proposal.)

10:66-2.3 Substance use disorder treatment services

(a) Substance use disorder treatment services provided in independent clinics include: substance use disorder outpatient rehabilitative services; substance use disorder intensive outpatient (IOP) services; substance use disorder partial care services; non-hospital based withdrawal management services; ambulatory outpatient withdrawal management services; short-term residential services; and opioid treatment and maintenance services, in accordance with N.J.A.C. 10:161A and 10:161B.

1. Medicaid and NJ FamilyCare fee-for-service beneficiaries shall be eligible for substance use disorder treatment *[center]* ***facility*** services only if those services:

i. Are prescribed by a physician or an advanced practice nurse (APN) ***as described in (c) through (i) below***;

ii. – iv. (No change.)

(b) (No change from proposal.)

(c) Substance use disorder outpatient rehabilitative services is a set of treatment activities designed to help the client achieve changes in his or her alcohol or other drug using behaviors. Outpatient rehabilitative services approximate ASAM Level of Care 1 and 2 and the services shall include: intake and assessment by appropriately licensed staff; *[a medical visit by a physician or an APN;]* and individual counseling, group counseling, and/or family counseling. See N.J.A.C. 10:161B for program standards including documentation, staffing, and licensing requirements. Services are provided in regularly scheduled sessions of fewer than nine contact hours per week in a licensed substance use disorder treatment facility.

1. – 4. (No change from proposal.)

5. In accordance with N.J.A.C. 10:161B-8.1, the intake assessment shall include obtaining health related information from the client and recording the information in the client's record. If there is an indication for medical treatment or screening, the staff person shall coordinate referral for services. Resolution of health related problems shall be included as part of the comprehensive treatment plan and all referrals or treatment, and shall be documented in the client chart.

(d) Substance use disorder IOP services are bundled rehabilitative services designed to help clients change alcohol or drug use and related behaviors while receiving treatment in a licensed substance use disorder facility. This service consists of nine to 12 hours of service per week that are delivered at a minimum of three hours per day, for a minimum of three days per week. This level of care approximates ASAM level 2.1. Services shall include: *[physician or APN visits;]* individual counseling; group substance use disorder counseling; other group counseling; and family counseling. Services are provided as listed in N.J.A.C. 10:161B-11. IOP services cannot be combined with individual outpatient rehabilitative services or partial care services.

1. In accordance with N.J.A.C. 10:161B-8.1, the intake assessment shall include obtaining health related information from the client and recording the information in the client's record. If there is an indication for medical treatment or screening, the staff person shall coordinate referral for services. Resolution of health related problems shall be included as part of the comprehensive treatment plan and all referrals or treatment, and shall be documented in the client chart.

(e) Substance Use Disorder–Partial Care Services is a bundled service program that provides a broad range of clinically intensive treatment services in a structured environment for a minimum of 20 hours per week, up to five days per week at a licensed substance use disorder treatment facility. Services shall be delivered for no less than four hours per day. This level of care approximates ASAM level 2.5. Services shall include: *[a physician or an APN visit;]* individual counseling; group substance use disorder counseling; group counseling; family counseling; and lab services. Services are provided as described in N.J.A.C. 10:161B. Services are billed in units of one hour

per day, with a maximum of five hours per day, not to exceed 25 units per week. Substance use disorder partial care services may be provided along with opioid treatment but cannot be provided concurrently with intensive outpatient services.

***1. In accordance with N.J.A.C. 10:161B-7.1, a partial care program shall have written protocols to ensure ready access to psychiatric and medical services if needed.**

2. In accordance with N.J.A.C. 10:161B-8.1, the intake assessment shall include obtaining health related information from the client and recording the information in the client's record. If there is an indication for medical treatment or screening, the staff person shall coordinate referral for services. Resolution of health related problems shall be included as part of the comprehensive treatment plan and all referrals or treatment, and shall be documented in the client chart.*

(f) – (i) (No change from proposal.)

10:66-2.5 Family planning services

(a) (No change.)

(b) Subdermal contraceptive implants are a Medicaid-covered and NJ FamilyCare fee-for-service-covered service when provided as follows:

1. – 4. (No change from proposal.)

5. Only two insertions and two removals of subdermal contraceptive implants per beneficiary are permitted during *[a five-year continuous period]* ***the FDA-approved clinically appropriate timeframe for the specific device***.

6. (No change from proposal.)

10:66-2.7 Mental health services

(a) – (i) (No change.)

(j) An intake evaluation shall be performed within 14 days of the first encounter or by the third clinic visit, whichever is later, for each beneficiary being considered for continued treatment. This evaluation shall consist of a written assessment that:

1. – 4. (No change.)

5. The evaluation for the intake process shall include a physician ***or an advanced practice nurse (APN)**** and an individual experienced in ***the**** diagnosis and treatment of mental illness. Both criteria may be satisfied by the same individual, if appropriately qualified.

(k) – (n) (No change from proposal.)

10:66-6.2 HCPCS procedure code numbers and maximum fee allowance schedule

(a) Evaluation and management and other procedures

* An asterisk preceding any procedure code may also be performed in a *[drug treatment center]* ***substance use disorder treatment facility****.

(b)-(r) (No change from proposal.)

10:66-6.4 HCPCS procedure codes--qualifiers

(a) – (l) (No change from proposal.)

(m) Substance use disorder treatment ***facility**** services:

1. Family therapy rendered in a *[drug treatment center]* ***substance use disorder treatment facility***: Z2000.

i. – iii. (No change.)

2. Family conference rendered in a *[drug treatment center]* ***substance use disorder treatment facility***: Z2001.

i. – ii. (No change.)

3. Prescription visit rendered in a *[drug treatment center]* ***substance use disorder treatment facility***: Z2002.

i. (No change.)

4. Psychotherapy rendered in a *[drug treatment center]* ***substance use disorder treatment facility***--full session: Z2003.

i. – ii. (No change.)

5. Group therapy rendered in a *[drug treatment center]* ***substance use disorder treatment facility***, per person: Z2004.

i. – ii. (No change.)

6. Psychological testing rendered in a *[drug treatment center]* ***substance use disorder treatment facility***, per hour; maximum of five hours: Z2005.

i. (No change.)

7. Methadone treatment rendered in a *[drug treatment center]* ***substance use disorder treatment facility***: Z2006.

i. (No change.)

8. Psychotherapy rendered in a *[drug treatment center--half]* ***substance use disorder treatment facility—half*** session: Z2007.

i. – ii. (No change.)

9. Urinalysis for *[drug treatment center]* ***substance use disorder treatment facility***: Z2010.

i. (No change.)

ii. To be used only by a *[drug treatment center]* ***substance use disorder treatment facility*** specifically approved by the Program to provide this service.

10. (No change.)

11. Family therapy rendered in a *[drug treatment center]* ***substance use disorder treatment facility*** for a WFNJ/SAI-eligible beneficiary: Z3348. Prior authorization is required.

i. – iii. (No change.)

12. Family conference rendered in a *[drug treatment center]* ***substance use disorder treatment facility*** for a WFNJ/SAI-eligible beneficiary: Z3349. Prior authorization is required.

i. - ii. (No change.)

13. Prescription visit rendered in a *[drug treatment center]* ***substance use disorder treatment facility*** for a WFNJ/SAI-eligible beneficiary: Z3353. Prior authorization is required.

i. (No change.)

14. Psychotherapy rendered in a *[drug treatment center]* ***substance use disorder treatment facility***--full session for a WFNJ/SAI-eligible beneficiary: Z3354. Prior authorization is required.

i. - ii. (No change.)

15. Group therapy rendered in a *[drug treatment center]* ***substance use disorder treatment facility***, per person for a WFNJ/SAI-eligible beneficiary: Z3355. Prior authorization is required.

i. – ii. (No change.)

16. Psychological testing rendered in a *[drug treatment center]* ***substance use disorder treatment facility***, per hour; for a WFNJ/SAI-eligible beneficiary: Z3356. Prior authorization is required.

i. (No change.)

17. Methadone treatment rendered in a *[drug treatment center]* ***substance use disorder treatment facility*** for a WFNJ/SAI-eligible beneficiary: Z3357. Prior authorization is required.

i. (No change.)

18. Psychotherapy rendered in a *[drug treatment center--half]* ***substance use disorder treatment facility--half*** session for a WFNJ/SAI-eligible beneficiary: Z3358. Prior authorization is required.

i. – ii. (No change.)

19. Urinalysis for drug addiction rendered in a *[drug treatment center]* ***substance use disorder treatment facility*** for a WFNJ/SAI-eligible beneficiary: Z3359. Prior authorization is required.

i. (No change.)

ii. To be used only by a *[drug treatment center]* ***substance use disorder treatment facility*** specifically approved by the WFNJ/SAI Program to provide this service.

(n) (No change from proposal.)