

N.J.A.C. 10:73

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > **TITLE 10. HUMAN SERVICES** >
CHAPTER 73. CASE MANAGEMENT SERVICES

Title 10, Chapter 73 -- 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: August 3, 2021.

See: [53 N.J.R. 1492\(a\)](#).

CHAPTER HISTORICAL NOTE:

Chapter 73, Case Management Services Manual, was adopted as R.1991 d.367, effective July 15, 1991. See: 23 N.J.R. 1328(a), 23 N.J.R. 2137(a).

Pursuant to Executive Order No. 66(1978), Chapter 73, Case Management Services Manual, was readopted as R.1996 d.363, effective July 12, 1996. See: [28 N.J.R. 1977\(a\)](#), [28 N.J.R. 3788\(a\)](#).

Pursuant to Executive Order No. 66(1978), Chapter 73, Case Management Services Manual, was readopted as R.2001 d.198, effective May 17, 2001. See: [33 N.J.R. 978\(a\)](#), [33 N.J.R. 2193\(a\)](#).

Subchapter 3, Care Management Organization Services--Children's System of Care Initiative, was adopted as new rules and former Subchapter 3, HCFA Common Procedure Coding System (HCPCS), was recodified as N.J.A.C. 10:73-4 by R.2001 d.475, effective December 17, 2001. See: [33 N.J.R. 349\(a\)](#), [33 N.J.R. 1167\(a\)](#), [33 N.J.R. 4357\(a\)](#).

Subchapter 4, Youth Case Management (YCM) Services, was adopted as new rules and former Subchapter 4, Healthcare Common Procedure Coding System, was recodified as N.J.A.C. 10:73-5 by R.2005 d.78, effective February 22, 2005. See: [36 N.J.R. 1271\(b\)](#), [37 N.J.R. 651\(a\)](#).

Chapter 73, Case Management Services, was readopted as R.2006 d.421, effective November 8, 2006. As a part of R.2006 d.421, Subchapter 3, Care Management Organization Services--Children's System of Care Initiative, was renamed Care Management Organization Services, effective May 21, 2007. See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Title 10, Chapter 73 -- Chapter Notes

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 73, Case Management Services, was scheduled to expire on November 8, 2013. See: [43 N.J.R. 1203\(a\)](#).

Chapter 73, Case Management Services, was readopted, effective September 24, 2013. See: [45 N.J.R. 2334\(b\)](#).

In accordance with [N.J.S.A. 52:14B-5.1](#), Chapter 73, Case Management Services, was scheduled to expire on September 24, 2020. 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 73, Case Management Services, was readopted with technical changes, effective August 3, 2021. See: Source and Effective Date. See, also, section annotations.

Annotations

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Research References & Practice Aids

CHAPTER EXPIRATION DATE:

Chapter 73, Case Management Services, expires on August 3, 2028.

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N.J.A.C. 10:73-1.1

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CHAPTER 73. CASE MANAGEMENT SERVICES > **SUBCHAPTER 1. GENERAL**
PROVISIONS

§ 10:73-1.1 Chapter purpose and organization

(a) This chapter outlines information about targeted case management services provided by approved New Jersey Medicaid/NJ FamilyCare program providers.

(b) N.J.A.C. 10:73-2 describes the Case Management Program/Mental Health for Adults, providing a description of the individuals for whom the services are targeted; the case management services covered; the requirements and responsibilities of the agencies that will provide the services, including agency staff; and the procedures required to provide services and the reimbursement for the provision of those services.

(c) N.J.A.C. 10:73-3 describes the Care Management Organization services component provided under the Department of Children and Families' Children's System of Care (CSOC). The subchapter describes the target population to be served; services provided; and the requirements and responsibilities of the provider, including, but not limited to, the organizational structure, staffing, procedures, reporting requirements, monitoring, evaluation, and reimbursement requirements.

(d) N.J.A.C. 10:73-4 describes Youth Case Management services provided by the Division of Medical Assistance and Health Services under the auspices of the Department of Children and Families' Children's System of Care (CSOC), and provides a description of what is included in the services; the requirements and responsibilities of the providers rendering the services; beneficiary eligibility; and the reimbursement for the provision of those services.

(e) N.J.A.C. 10:73-5 provides a listing of the Centers for Medicare & Medicaid Services Healthcare Common Procedure Coding System (HCPCS) Procedure Codes.

History

HISTORY:

Amended by R.1994 d.585, effective November 21, 1994 (operative December 1, 1994).

See: 26 N.J.R. 3350(a), 26 N.J.R. 4614(a).

Amended by R.1996 d.363, effective August 5, 1996.

See: [28 N.J.R. 1977\(a\)](#), [28 N.J.R. 3788\(a\)](#).

Amended by R.2001 d.198, effective June 18, 2001.

See: [33 N.J.R. 978\(a\)](#), [33 N.J.R. 2193\(a\)](#).

In (a), inserted "/NJ FamilyCare" preceding "program providers" in the introductory paragraph, and substituted "/NJ FamilyCare beneficiaries" for "recipients" preceding "as allowed" in 1.

Amended by R.2001 d.475, effective December 17, 2001.

§ 10:73-1.1 Chapter purpose and organization

See: [33 N.J.R. 349\(a\)](#), [33 N.J.R. 1167\(a\)](#), [33 N.J.R. 4357\(a\)](#).

In (a), deleted 1; inserted new (c); recodified former (c) as (d) and amended N.J.A.C. reference.

Amended by R.2005 d.78, effective February 22, 2005.

See: [36 N.J.R. 1271\(b\)](#), [37 N.J.R. 651\(a\)](#).

Rewrote the section.

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Rewrote (d) and (e).

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

Annotations

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CHAPTER 73. CASE MANAGEMENT SERVICES > **SUBCHAPTER 1. GENERAL**
PROVISIONS

§ 10:73-1.2 Definitions

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

"Advocacy" means the ongoing process of assisting the beneficiary in receiving, and maintaining receipt of, all services and benefits to which he or she is entitled by working toward the removal of barriers to receiving needed services and benefits.

"Assessment" means the ongoing process of identifying and reviewing a beneficiary's strengths, deficits, and needs based upon input from the beneficiary and significant others including, but not limited to, family members and health professionals. The assessment process continues throughout the entire length of service. The assessments are updated periodically based upon availability of beneficiary information and the requirements of this chapter.

"Beneficiary monitoring" means the ongoing review by the provider of the beneficiary's status and needs.

"Case management services" means those services which will assist a beneficiary of Medicaid/NJ FamilyCare or a child, youth, or young adult receiving services from the Children's System of Care (CSOC) in gaining access to needed medical, social, educational, and other services.

"Centers for Medicare & Medicaid Services (CMS)" means the agency of the Federal Department of Health and Human Services which is responsible for the administration of the Medicaid program and the State Children's Health Insurance Program (SCHIP) in the United States.

"Child Protection and Permanency (CP&P)" means the agency that is the organizational component within the New Jersey Department of Children and Families that administers the Title IV-E program of the Social Security Act, Federal Payments for Foster Care and Adoption Assistance, [42 U.S.C. §§ 670-679.b.](#)

"Children's System of Care (CSOC)" means the organizational component within the Department of Children and Families that provides a comprehensive approach to the provision of mental health and behavioral health services to eligible children, youth, and young adults.

"Contract systems administrator (CSA)" means an administrative organization contracted by, and serving as an agent of, the State of New Jersey to provide utilization management, care coordination, quality management and information management for the Department of Children and Families' Children's System of Care (CSOC) in its management of the Statewide system of care that provides mental and behavioral health services and supports to eligible children, youth, and young adults.

"Contract systems administrator care coordination (CSACC)" means management and coordination of the assessment process by the CSA for children, youth and young adults with mental or behavioral healthcare needs.

"Department of Children and Families (DCF)" means the department of New Jersey government, created by P.L. 2006, c. 47, that has the goal of ensuring safety, permanency, and well-being for all children and has direct responsibility for child welfare and other child and family services, supported by

§ 10:73-1.2 Definitions

strong inter-agency partnerships among other State departments also responsible for family services. The new department includes Child Protection and Permanency, the Children's System of Care (CSOC), the Division of Prevention and Community Partnerships, and the New Jersey Child Welfare Training Academy.

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

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

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

"Healthcare Common Procedure Coding System (HCPCS)" means a nationwide coding system, established and maintained by CMS in accordance with the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191. Level 1 codes are adapted from codes published by the American Medical Association in the Common Procedural Terminology (CPT) and are utilized primarily by physicians and independent clinical laboratories. Level 2 codes are assigned by CMS for physician and non-physician services which are not in the CPT.

"Juvenile Justice Commission (JJC)" means the agency in, but not of, the Department of Law and Public Safety which is mandated by statute to develop and operate both non-secure residential programs and secure facilities for adolescent juvenile offenders sentenced to the Commission by the New Jersey Superior Court, Family Part, and to provide parole supervision to juvenile inmates released by the New Jersey Parole Board. (See N.J.S.A. 52:17B-17O)

"Service planning" means the process of organizing the outcomes of the assessment in collaboration with the beneficiary, significant others, potential service providers, and others as designated, to formulate a written service plan that addresses the beneficiary's needs, planned services to address these needs, and plans to motivate the beneficiary to utilize services. The service planning process continues throughout the beneficiary's entire length of stay with the case management entity.

"Service provider monitoring" means the process of routine follow up with the beneficiary's service providers to assess provision and coordination of all aspects of the services specified in the beneficiary's service plan.

"Services linkage" means the referral to and enrollment with other appropriate service providers for the purposes of addressing the needs identified in the beneficiary's assessment, including facilitating linkages to community resources or services included in the beneficiary's treatment goals.

"Young adult" means, for purpose of eligibility for CSOC services, an individual at least 18 years of age and under 21 years of age who:

1. Prior to becoming 18 years of age, received services from the child-serving system in New Jersey, including, but not limited to:
 - i. CSOC;
 - ii. CP&P;
 - iii. The Juvenile Justice Commission; or
 - iv. Any other child-serving State agency; and
2. Demonstrates a clinical need for the continuation of services provided by the CSOC, as part of the transition into adult services.

History

HISTORY:

§ 10:73-1.2 Definitions

Amended by R.1994 d.585, effective November 21, 1994 (operative December 1, 1994).

See: [26 N.J.R. 3350\(a\)](#), [26 N.J.R. 4614\(a\)](#).

Amended by R.1996 d.363, effective August 5, 1996.

See: [28 N.J.R. 1977\(a\)](#), [28 N.J.R. 3788\(a\)](#).

Amended by R.2001 d.198, effective June 18, 2001.

See: [33 N.J.R. 978\(a\)](#), [33 N.J.R. 2193\(a\)](#).

In "Case management services", substituted "/NJ FamilyCare beneficiary" for "recipient"; in "Clinical case management", substituted "beneficiary" for "client"; rewrote "HCPCS".

Amended by R.2001 d.475, effective December 17, 2001.

See: [33 N.J.R. 349\(a\)](#), [33 N.J.R. 1167\(a\)](#), [33 N.J.R. 4357\(a\)](#).

Rewrote the section.

Amended by R.2005 d.78, effective February 22, 2005.

See: [36 N.J.R. 1271\(b\)](#), [37 N.J.R. 651\(a\)](#).

Rewrote the section.

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

In definition "Advocacy", inserted ", and maintaining receipt of," and "services and" and the second occurrence of "and benefits"; in definition "Assessment", inserted "and the requirements of this chapter"; substituted definition "Centers for Medicare & Medicaid Services (CMS)" for "Centers for Medicare and Medicaid Services (CMS)"; in definition "Centers for Medicare & Medicaid Services", deleted comma following "Services", and deleted the last sentence; added definitions "Contract systems administrator (CSA)", "Contract systems administrator care coordination (CSACC)", "Department of Children and Families (DCF)", "Service provider monitoring" and "Young adult"; rewrote definitions "Division of Child Behavioral Health Services (DCBHS)" and "Services linkage"; in definition "Division of Mental Health Services (DMHS)", inserted ", primarily for adults"; in definition "Division of Youth and Family Services (DYFS)", substituted "Children and Families" for "Human Services", inserted "Federal Payments for Foster Care and Adoption Assistance," and substituted "§§ 670-679.b" for "§§ 670-679.b"; substituted definition "Healthcare Common Procedure Coding System (HCPCS)" for "HCPCS" and rewrote the definition; and in definition "Service planning", deleted "program" preceding "length" and inserted "with the case management entity".

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

Annotations

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CHAPTER 73. CASE MANAGEMENT SERVICES > **SUBCHAPTER 2. ADULT CASE**
MANAGEMENT PROGRAM/MENTAL HEALTH (CMP/MH)

§ 10:73-2.1 Definitions

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

"Adult" means any individual over age 21, or an individual over age 18 who did not receive services from the Department of Children and Families' child-serving systems, including, but not limited to, the Children's System of Care, prior to their 18th birthday.

"Clinical case management" means the provision of face-to-face individualized clinical support services to adult Medicaid/NJ FamilyCare beneficiaries, in accordance with [N.J.A.C. 10:73-2.11](#), for a beneficiary who needs consistent contact to ensure that the beneficiary remains:

1. Engaged with the case manager;
2. Stable in his or her individual situation; and
3. Linked to needed services.

"Ongoing support services" means the provision of face-to-face individualized clinical support services for a beneficiary who needs such contact, as determined in accordance with [N.J.A.C. 10:73-2.4\(a\)](#)5.

"Risk category" means the three levels of clinical case management involvement, based upon assessed risk of hospitalization, functional level and willingness and/or ability to access needed services. The three risk categories are: high-risk, or intensive case management; at-risk, or supportive case management; and low-risk, or maintenance level case management.

"Service provider monitoring" means the process of routine follow-up by a case manager or by the Division of Mental Health and Addiction Services with the beneficiary's service providers to assess whether services have been provided as planned and whether such services meet the beneficiary's needs, in accordance with [N.J.A.C. 10:73-2.4\(a\)](#)4.

"Targeted case management" under Case Management Program/Mental Health (CMP/MH) means the provision of services targeted to adults with serious mental illness who are at high risk of hospitalization or deterioration in their functioning and who require an assertive community outreach service to meet their needs. Targeted case management services include, but are not limited to: assessment, service planning, services linkage, ongoing monitoring, ongoing clinical support and advocacy.

"Unit of service," for the purposes of this subchapter, means a continuous face-to-face contact with an enrolled beneficiary, or on behalf of an enrolled beneficiary, which lasts 15 minutes, not including travel time.

History

HISTORY:

§ 10:73-2.1 Definitions

New Rule, R.2001 d.475, effective December 17, 2001.

See: [33 N.J.R. 349\(a\)](#), [33 N.J.R. 1167\(a\)](#), [33 N.J.R. 4357\(a\)](#).

Former [N.J.A.C. 10:73-2.1](#), Case management program/mental health CMP/MH; general, recodified to [N.J.A.C. 10:73-2.2](#).

Amended by R.2005 d.78, effective February 22, 2005.

See: [36 N.J.R. 1271\(b\)](#), [37 N.J.R. 651\(a\)](#).

Rewrote the section.

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Deleted definitions "Initial evaluation services" and "Liaison case management"; in definition "Risk category", deleted ", as determined in accordance with [N.J.A.C. 10:73-2.10](#)" at the end; in definition "Targeted case management", substituted "Program/Mental" for "Program/ Mental" and "means" for "is" following "(CMP/MH)" and deleted the former second sentence.

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

Annotations

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MANAGEMENT PROGRAM/MENTAL HEALTH (CMP/MH)

§ 10:73-2.2 Adult Case Management Program/Mental Health (CMP/MH); general

(a) The CMP/MH is under the auspices of the Division of Mental Health and Addiction Services (DMHAS) and is administered jointly with the Division of Medical Assistance and Health Services, in accordance with [N.J.A.C. 10:37](#), the DMHAS Community Mental Health Services rules, [N.J.A.C. 10:49](#), and this chapter. The CMP/MH is a program that provides case management services to seriously mentally ill adult Medicaid/NJ FamilyCare beneficiaries who do not accept, or engage in, community mental health programs and/or who have multiple service needs and require extensive coordination.

(b) Case management services shall not be available to beneficiaries of the Medically Needy Program, except pregnant women, or to beneficiaries served in the Department's Home and Community Based Services Waiver Program, Community Resources for People with Disabilities Waiver Program, DDD Waiver, Traumatic Brain Injury Waiver or the Home Care Expansion Program.

1. For information on how to identify a Medicaid/NJ FamilyCare beneficiary, refer to N.J.A.C. 10:49-2, Administration.

History

HISTORY:

Administrative Change.

See: 26 N.J.R. 797(b).

Amended by R.1994 d.585, effective November 21, 1994 (operative December 1, 1994).

See: 26 N.J.R. 3350(a), 26 N.J.R. 4614(a).

Amended by R.1996 d.363, effective August 5, 1996.

See: [28 N.J.R. 1977\(a\)](#), [28 N.J.R. 3788\(a\)](#).

Amended by R.2001 d.198, effective June 18, 2001.

See: [33 N.J.R. 978\(a\)](#), [33 N.J.R. 2193\(a\)](#).

In (a), substituted "/NJ FamilyCare beneficiaries" for "recipients" in the introductory paragraph; in (b), substituted "beneficiaries" for "recipients" throughout the introductory paragraph and substituted "/NJ FamilyCare beneficiary" for "recipient" in 1.

Recodified from [N.J.A.C. 10:73-2.1](#) by R.2001 d.475, effective December 17, 2001.

See: [33 N.J.R. 349\(a\)](#), [33 N.J.R. 1167\(a\)](#), [33 N.J.R. 4357\(a\)](#).

§ 10:73-2.2 Adult Case Management Program/Mental Health (CMP/MH); general

Former [N.J.A.C. 10:73-2.2](#), Individuals targeted to receive CMP/MH services, recodified to [N.J.A.C. 10:73-2.3](#).

Amended by R.2005 d.78, effective February 22, 2005.

See: [36 N.J.R. 1271\(b\)](#), [37 N.J.R. 651\(a\)](#).

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Rewrote (a) and the introductory paragraph of (b).

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

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MANAGEMENT PROGRAM/MENTAL HEALTH (CMP/MH)

§ 10:73-2.3 Individuals targeted to receive adult CMP/MH services

(a) Clinical case management services under CMP/MH are targeted to adults with serious mental illness who are at high risk of hospitalization or deterioration in their functioning and who require an assertive community outreach service to meet their needs. This targeted group is composed of individuals who meet at least two of the following criteria:

1. Have repeated admissions to inpatient services. Priority will be given to persons with two or more admissions to inpatient psychiatric services within a 12-month period, or two or more uses of emergency/screening services within a 30-day time period;
2. Participate in mental health services, but are not receiving additional services which meet the individual's multiple needs, and who require extensive service coordination (for example, individuals who are dually diagnosed as mentally ill and chemical abusing);
3. Have a recent history of being a danger to self or others within a time period of three months;
4. Have a history of resistance or non-compliance in use of medication, resulting in a pattern of decompensation and rehospitalization;
5. Are in another service system and in need of assessment and possible treatment prior to linkage to case management (for example, residential, drug and alcohol programs, or shelters for the homeless);
6. Reside with family, in boarding homes, or other residential settings and are not receiving needed mental health services;
7. Recently were discharged from a State or county psychiatric hospital or a general acute-care hospital psychiatric inpatient unit and are in need of linkage services to ensure continuity of care with other mental health services; and/or
8. Have a recent history of a hospitalization as a result of mental illness and dangerousness to self or others.

History

HISTORY:

Recodified from [N.J.A.C. 10:73-2.2](#) by R.2001 d.475, effective December 17, 2001.

See: [33 N.J.R. 349\(a\)](#), [33 N.J.R. 1167\(a\)](#), [33 N.J.R. 4357\(a\)](#).

Former [N.J.A.C. 10:73-2.3](#), Case management services provided under CMP/MH, recodified to [N.J.A.C. 10:73-2.4](#).

Amended by R.2005 d.78, effective February 22, 2005.

§ 10:73-2.3 Individuals targeted to receive adult CMP/MH services

See: [36 N.J.R. 1271\(b\)](#), [37 N.J.R. 651\(a\)](#).

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

In the introductory paragraph of (a), inserted "criteria"; in (a)5, deleted "and/or" from the end; in (a)6, substituted a semi-colon for the period at the end; added (a)7 and (a)8; and deleted (b).

Annotations

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MANAGEMENT PROGRAM/MENTAL HEALTH (CMP/MH)

§ 10:73-2.4 Case management services provided under adult CMP/MH

(a) CMP/MH services for adults shall include, but shall not be limited to, assessment, service planning, services linkage, ongoing monitoring, ongoing clinical support, and advocacy. These services are described below:

1. Assessment means the ongoing process of identifying, reviewing and updating a beneficiary's strengths, deficits, and needs, based upon input from the beneficiary and significant others, including family members and community and hospital professionals. The assessment process continues throughout the beneficiary's entire length of stay in the program. (See [N.J.A.C. 10:73-2.10](#) for information about the beneficiary's risk status.)
2. Service planning means the process of organizing the outcomes of the assessment in collaboration with the beneficiary, significant others, potential service providers, and others as designated, to formulate a written service plan that addresses the beneficiary's needs, planned services to address these needs, and plans to motivate the beneficiary to utilize services and remain in the community. The service planning process continues throughout the beneficiary's entire program length of stay.
3. Services linkage means the ongoing referral to, and enrollment in, a mental health and/or non-mental health program. Mental health program linkage means that the beneficiary has completed the mental health program's intake process, that the beneficiary has been accepted for service, and that the beneficiary has effectively participated in the program.
4. Ongoing monitoring consists of both beneficiary monitoring and service provider monitoring by the case manager:
 - i. Beneficiary monitoring means the ongoing review of the beneficiary's status and needs, the frequency of which is contingent upon the beneficiary's risk status and reported changes from the beneficiary, significant others and/or service providers. An update of the service plan may result from the monitoring process to address changing needs.
 - ii. Service provider monitoring means the process of routine follow-up with the beneficiary's service providers to assess provision of services as planned in accordance with the beneficiary's needs, in accordance with the beneficiary's individualized service plan. Provider monitoring may result in the adjustment of the individualized service plan including provider changes. Service provider monitoring includes the following:
 - (1) Monitoring the plans, including the medication management plan for beneficiaries in need of such plans; and
 - (2) Coordination of services from multiple providers including calling and coordinating treatment team meetings of a beneficiary's service providers until the beneficiary exits from the CM program.
5. Ongoing support services means the provision of face-to-face individualized clinical support services for beneficiaries who need consistent contact to ensure engagement with the case manager and to

§ 10:73-2.4 Case management services provided under adult CMP/MH

help the beneficiary maintain stability and remain linked to needed services. Ongoing support services include support within the beneficiary's natural support system, including family, friends, and employers and typically occurs where the beneficiary resides or frequents. The frequency of support services is contingent upon the beneficiary's risk status and individual needs.

6. Advocacy means the process of assisting the beneficiary in receiving all benefits to which he or she is entitled by working toward the removal of barriers to receiving needed services. Beneficiary advocacy by the case manager continues throughout the beneficiary's entire program length of stay.

History

HISTORY:

Amended by R.2001 d.198, effective June 18, 2001.

See: [33 N.J.R. 978\(a\)](#), [33 N.J.R. 2193\(a\)](#).

Substituted references to beneficiaries for references to clients throughout.

Recodified from [N.J.A.C. 10:73-2.3](#) and amended by R.2001 d.475, effective December 17, 2001.

See: [33 N.J.R. 349\(a\)](#), [33 N.J.R. 1167\(a\)](#), [33 N.J.R. 4357\(a\)](#).

In (a)1, amended the N.J.A.C. reference. Former [N.J.A.C. 10:73-2.4](#), Requirements for providers participating in CMP/MH, recodified to [N.J.A.C. 10:73-2.5](#).

Amended by R.2005 d.78, effective February 22, 2005.

See: [36 N.J.R. 1271\(b\)](#), [37 N.J.R. 651\(a\)](#).

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Substituted "means" for "is" throughout; in (a)1, inserted "beneficiary's" preceding "entire length", inserted "in the program" and inserted "the" preceding "beneficiary's risk status"; rewrote (a)4ii; in (a)4ii(1), inserted "and" at the end; and rewrote (a)5 and (a)6.

Annotations

Notes

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Research References & Practice Aids

CROSS REFERENCES:

Clinical case management services under CMP/MH, see [N.J.A.C. 10:73-2.10](#).

§ 10:73-2.4 Case management services provided under adult CMP/MH

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N.J.A.C. 10:73-2.5

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MANAGEMENT PROGRAM/MENTAL HEALTH (CMP/MH)

§ 10:73-2.5 Provider enrollment requirements for providers participating in adult CMP/MH

- (a) This section lists the specific provisions relevant to a provider who wishes to apply and be approved as a provider of CMP/MH services. [N.J.A.C. 10:73-2.6](#) provides information about service responsibilities of the CMP/MH provider and [N.J.A.C. 10:73-2.7](#) describes the responsibilities of staff members of a CMP/MH provider agency.
- (b) Any agency providing CMP/MH services shall first be certified by the Division of Mental Health and Addiction Services (DMHAS), shall be under contract as an approved clinical case management provider and shall be individually approved as a Medicaid/NJ FamilyCare provider by the New Jersey Medicaid/NJ FamilyCare program.
- (c) Case management providers under CMP/MH shall comply with Medicaid/NJ FamilyCare program rules regarding provider participation (see [N.J.A.C. 10:49-3.1](#)). Provider entities shall be mental health provider organizations that contract with the New Jersey Division of Mental Health and Addiction Services in accordance with the Community Mental Health Services Act rules, [N.J.A.C. 10:37](#), to provide clinical case management services.
- (d) Upon notification from DMHAS of the completion of the certification of, and contract with, a CMP/MH provider, the New Jersey Medicaid/NJ FamilyCare program will forward the appropriate provider enrollment forms to the provider. (See [N.J.A.C. 10:49-3.1](#), Eligible providers)
- (e) The CMP/MH provider will receive written notification of approval or disapproval from the Division of Medical Assistance and Health Services.
1. If approved, the CMP/MH provider will be assigned a provider number by the Medicaid/NJ FamilyCare fiscal agent; and
 2. The New Jersey Medicaid/NJ FamilyCare program will furnish a provider manual (which includes this chapter, other relevant chapters including [N.J.A.C. 10:49](#) and additional non-regulatory material).

History

HISTORY:

Administrative Change.

See: 26 N.J.R. 797(b).

Amended by R.1996 d.363, effective August 5, 1996.

See: [28 N.J.R. 1977\(a\)](#), [28 N.J.R. 3788\(a\)](#).

Amended by R.2001 d.198, effective June 18, 2001.

§ 10:73-2.5 Provider enrollment requirements for providers participating in adult CMP/MH

See: [33 N.J.R. 978\(a\)](#), [33 N.J.R. 2193\(a\)](#).

Rewrote (b).

Recodified from [N.J.A.C. 10:73-2.4](#) and amended by R.2001 d.475, effective December 17, 2001.

See: [33 N.J.R. 349\(a\)](#), [33 N.J.R. 1167\(a\)](#), [4357\(a\)](#).

In (a), amended the N.J.A.C. references. Former [N.J.A.C. 10:73-2.5](#), Service responsibilities of the CMP/MH provider, recodified to [N.J.A.C. 10:73-2.6](#).

Amended by R.2005 d.78, effective February 22, 2005.

See: [36 N.J.R. 1271\(b\)](#), [37 N.J.R. 651\(a\)](#).

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Section was "Requirements for providers participating in adult CMP/MH". Rewrote and recodified former (b) as (b) through (e).

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

Annotations

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N.J.A.C. 10:73-2.6

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MANAGEMENT PROGRAM/MENTAL HEALTH (CMP/MH)

§ 10:73-2.6 Service responsibilities of the adult CMP/MH provider

(a) The CMP/MH provider rendering services to adults shall:

1. Provide ongoing support to enrolled CMP/MH beneficiaries, in their own environment, who are at risk of hospitalization or deterioration in function, to enable them to function in the community and to enable them to access other mental health services whenever possible;
2. Provide or arrange for a clinical offsite service capability to enrolled CMP/MH beneficiaries seven days a week;
3. Provide community-based engagement activities, coordination, and integration for enrolled CMP/MH beneficiaries;
4. Provide ongoing, individualized clinical support and monitoring to maintain stability until the beneficiary participates effectively in other needed services; and
5. Seek and accept referrals within provider capacity of beneficiaries from emergency/screening services, local inpatient units and other structured sites, such as homeless shelters or jails, and other referral sites as identified at the local level.

History

HISTORY:

Amended by R.2001 d.198, effective June 18, 2001.

See: [33 N.J.R. 978\(a\)](#), [33 N.J.R. 2193\(a\)](#).

Substituted references to beneficiaries for references to clients throughout.

Recodified from [N.J.A.C. 10:73-2.5](#) by R.2001 d.475, effective December 17, 2001.

See: [33 N.J.R. 349\(a\)](#), [33 N.J.R. 1167\(a\)](#), [33 N.J.R. 4357\(a\)](#)

Former [N.J.A.C. 10:73-2.6](#), Staff members of a CMH/MP provider; responsibilities, recodified to [N.J.A.C. 10:73-2.7](#).

Amended by R.2005 d.78, effective February 22, 2005.

See: [36 N.J.R. 1271\(b\)](#), [37 N.J.R. 651\(a\)](#).

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MANAGEMENT PROGRAM/MENTAL HEALTH (CMP/MH)

§ 10:73-2.7 Service responsibilities of staff members of the adult CMP/MH provider

- (a) The case manager (CM) providing clinical case management services to adults shall:
1. Identify mentally ill beneficiaries in need of CMP/MH services regardless of residence (for example: homeless, shelter, family, boarding home);
 2. Provide clinical assessment of the beneficiary's strengths, needs, resources, motivation, level of functioning, mental status, and risk category;
 3. Provide functional assessment of the beneficiary's skills (daily living, self-care, social, vocational, and other skills);
 4. Provide intensive community based engagement services to maximize the beneficiary's access to services and ability to function adequately and integrate into the community;
 5. Provide or arrange for direct clinical intervention;
 6. Provide assessment of the need for crisis intervention, and assistance to providers of psychiatric emergency services in resolving crises;
 7. Provide assessment of the beneficiary's substance abuse symptoms;
 8. Provide assessment of available social services, health and mental health resources and the ability of these services to meet each beneficiary's needs;
 9. Develop beneficiary individualized service plans with the primary goal to motivate the beneficiary to access, appropriately use, and remain in community programs;
 10. Develop and monitor a plan for medication management for the beneficiary in need of such a plan, in consultation with the county mental health system's psychiatric services components;
 11. Provide ongoing service planning and periodic reviews and revisions of such plans;
 12. Provide access to appropriate services, and ensure the beneficiary receives needed transportation in order to attend services;
 13. Ensure that the beneficiary engages in the community mental health and non-mental health systems through provision of ongoing individualized clinical support and monitoring;
 14. Provide clinical consultation with other providers in a beneficiary's network;
 15. Coordinate and integrate services from multiple providers until the beneficiary exits from the CMP/MH, which shall include coordination of treatment team meetings of the service providers of a beneficiary in the community.
 16. Monitor service delivery to meet a beneficiary's changing needs;

§ 10:73-2.7 Service responsibilities of staff members of the adult CMP/MH provider

17. Identify resource gaps and problems of service delivery, and advocate for the resolution of these issues;
18. Provide direct service support to the beneficiary's natural support system, including family, friends, employers, self-help and other natural support groups; and
19. Develop discharge plans, in conjunction with other State or county psychiatric hospital or short-term care facility treatment team members, for beneficiaries assessed as able or willing to access or engage in necessary community mental health services after hospital discharge.

(b) Services rendered while the beneficiary is an inpatient in a State or county psychiatric hospital or psychiatric unit of a general acute care hospital shall not be billable activities.

History

HISTORY:

Amended by R.1994 d.585, effective November 21, 1994 (operative December 1, 1994).

See: 26 N.J.R. 3350(a), 26 N.J.R. 4614(a).

Amended by R.1996 d.363, effective August 5, 1996.

See: [28 N.J.R. 1977\(a\)](#), [28 N.J.R. 3788\(a\)](#).

Amended by R.2001 d.198, effective June 18, 2001.

See: [33 N.J.R. 978\(a\)](#), [33 N.J.R. 2193\(a\)](#).

Substituted references to beneficiaries for references to clients throughout.

Recodified from [N.J.A.C. 10:73-2.6](#) by R.2001 d.475, effective December 17, 2001.

See: [33 N.J.R. 349\(a\)](#), [33 N.J.R. 1167\(a\)](#), [33 N.J.R. 4357\(a\)](#).

Former [N.J.A.C. 10:73-2.7](#), Prior authorization for clinical case management services, recodified to [N.J.A.C. 10:73-2.8](#).

Amended by R.2005 d.78, effective February 22, 2005.

See: [36 N.J.R. 1271\(b\)](#), [37 N.J.R. 651\(a\)](#).

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Section was "Staff members of an adult CMP/MH provider; responsibilities". Rewrote the section.

Annotations

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MANAGEMENT PROGRAM/MENTAL HEALTH (CMP/MH)

§ 10:73-2.8 (Reserved)

History

Administrative Change.

See: 26 N.J.R. 797(b).

Amended by R.1996 d.363, effective August 5, 1996.

See: [28 N.J.R. 1977\(a\)](#), [28 N.J.R. 3788\(a\)](#).

Recodified from [N.J.A.C. 10:73-2.7](#) and amended by R.2001 d.475, effective December 17, 2001.

See: [33 N.J.R. 349\(a\)](#), [33 N.J.R. 1167\(a\)](#), [33 N.J.R. 4357\(a\)](#).

In (a), amended the N.J.A.C. references throughout. Former [N.J.A.C. 10:73-2.8](#), Basis of payment for CMP/MH services, recodified to [N.J.A.C. 10:73-2.9](#).

Amended by R.2005 d.78, effective February 22, 2005.

See: [36 N.J.R. 1271\(b\)](#), [37 N.J.R. 651\(a\)](#).

Repealed by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Section was "Prior authorization for clinical case management services for adults".

Annotations

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MANAGEMENT PROGRAM/MENTAL HEALTH (CMP/MH)

§ 10:73-2.9 Basis of payment for adult CMP/MH services

- (a) Reimbursement for services covered under the CMP/MH in accordance with this subchapter shall be determined by the Commissioner of the Department of Human Services. The provider of CMP/MH services shall be compensated on a fee-for-service basis. Reimbursement will be based upon HCPCS Codes as specified in N.J.A.C. 10:73-5. The provider shall submit a claim form and shall identify the services performed by the use of procedure codes based on the Centers for Medicare & Medicaid Services Healthcare Common Procedure Coding System (HCPCS).
- (b) A beneficiary who receives case management services shall be entitled to receive other approved mental health services that are rendered by authorized providers.
- (c) Each provider shall charge for all services to all beneficiaries, except as provided by legislation, except that no charge shall be made directly to the Medicaid/NJ Family Care beneficiary.
- (d) In no event shall the charge to the New Jersey Medicaid/NJ FamilyCare program exceed the charge by the provider for identical services to other groups or individuals in the community.
1. Payment for CMP/MH services shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose, including, but not limited to, the Home and Community Based Service Waiver programs. Payment for CMP/MH services shall not duplicate payment for case management services which are an integral part of another provider service.
- (e) See [N.J.A.C. 10:49-7.2](#) for requirements for timely submission of claims.

History

HISTORY:

Amended by R.1994 d.585, effective November 21, 1994 (operative December 1, 1994).

See: 26 N.J.R. 3350(a), 26 N.J.R. 4614(a).

Amended by R.1996 d.363, effective August 5, 1996.

See: [28 N.J.R. 1977\(a\)](#), [28 N.J.R. 3788\(a\)](#).

Amended by R.2001 d.198, effective June 18, 2001.

See: [33 N.J.R. 978\(a\)](#), [33 N.J.R. 2193\(a\)](#).

In (b), substituted "beneficiary" for "recipient" throughout; in (c), substituted "beneficiaries" for "clients" and "/NJ FamilyCare beneficiary" for "recipient"; in (d), inserted a reference to NJ FamilyCare.

Recodified from [N.J.A.C. 10:73-2.8](#) and amended by R.2001 d.475, effective December 17, 2001.

§ 10:73-2.9 Basis of payment for adult CMP/MH services

See: [33 N.J.R. 349\(a\)](#), [33 N.J.R. 1167\(a\)](#), [4357\(a\)](#).

In (a), amended the N.J.A.C. references in the introductory paragraph and in 3. Former N.J.A.C. 10:43-2.9, Procedures for providing initial risk assessment and evaluation for CMP/MH services, recodified to N.J.A.C. 10:43-2.10.

Amended by R.2005 d.78, effective February 22, 2005.

See: [36 N.J.R. 1271\(b\)](#), [37 N.J.R. 651\(a\)](#).

In (a), rewrote 1.

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Rewrote (a); in (b), deleted the first sentence and substituted "shall be" for "is"; rewrote (c); and in (e), updated the N.J.A.C. reference.

Annotations

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§ 10:73-2.10 (Reserved)

History

HISTORY:

Amended by R.1994 d.585, effective November 21, 1994 (operative December 1, 1994).

See: [26 N.J.R. 3350\(a\)](#), [26 N.J.R. 4614\(a\)](#).

Amended by R.1996 d.363, effective August 5, 1996.

See: [28 N.J.R. 1977\(a\)](#), [28 N.J.R. 3788\(a\)](#).

Amended by R.2001 d.198, effective June 18, 2001.

See: [33 N.J.R. 978\(a\)](#), [33 N.J.R. 2193\(a\)](#).

In (a), substituted "beneficiary" for "client" preceding "contact(s)" and "is found" in the introductory paragraph, and substituted "beneficiaries" for "clients" in 1, 2 and 3; in (b)1, substituted references to beneficiaries for references to clients; in (b)2, substituted a reference to beneficiaries for a reference to clients in the first sentence and a reference to beneficiaries for a reference to recipients in the second sentence; in (b)2i, substituted "beneficiary" for "recipient".

Recodified from [N.J.A.C. 10:73-2.9](#) by R.2001 d.475, effective December 17, 2001.

See: [33 N.J.R. 349\(a\)](#), [33 N.J.R. 1167\(a\)](#), [33 N.J.R. 4357\(a\)](#).

Former [N.J.A.C. 10:73-2.10](#), Clinical case management services under CMP/MH, recodified to [N.J.A.C. 10:73-2.11](#).

Amended by R.2005 d.78, effective February 22, 2005.

See: [36 N.J.R. 1271\(b\)](#), [37 N.J.R. 651\(a\)](#).

Repealed by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Section was "Procedures for providing initial risk assessment and evaluation for adult CMP/MH services".

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§ 10:73-2.11 Clinical case management services under adult CMP/MH

(a) Clinical case management services shall include, but shall not be limited to, assessment, individualized service planning, services linkage, ongoing clinical support and advocacy (see [N.J.A.C. 10:73-2.4\(a\)](#)).

(b) There are three levels (risk categories) of clinical case management involvement based upon assessed risk of hospitalization, functional level, and willingness and/or ability to access needed services as defined by DMHAS. The three risk categories are: high risk, or intensive case management; at risk, or supportive case management; and low risk, or maintenance level case management.

History

HISTORY:

Amended by R.1994 d.585, effective November 21, 1994 (operative December 1, 1994).

See: 26 N.J.R. 3350(a), 26 N.J.R. 4614(a).

Amended by R.1996 d.363, effective August 5, 1996.

See: [28 N.J.R. 1977\(a\)](#), [28 N.J.R. 3788\(a\)](#).

Amended by R.2001 d.198, effective June 18, 2001.

See: [33 N.J.R. 978\(a\)](#), [33 N.J.R. 2193\(a\)](#).

Substituted references to beneficiaries for references to recipients throughout; in (b)1i, inserted a reference to NJ FamilyCare.

Recodified from [N.J.A.C. 10:73-2.10](#) and amended by R.2001 d.475, effective December 17, 2001.

See: [33 N.J.R. 349\(a\)](#), [33 N.J.R. 1167\(a\)](#), [33 N.J.R. 4357\(a\)](#).

Amended N.J.A.C. references throughout. Former [N.J.A.C. 10:73-2.11](#), Liaison case management services under CMP/MH, recodified to [N.J.A.C. 10:73-3.12](#).

Amended by R.2005 d.78, effective February 22, 2005.

See: [36 N.J.R. 1271\(b\)](#), [37 N.J.R. 651\(a\)](#).

Rewrote the section.

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

§ 10:73-2.11 Clinical case management services under adult CMP/MH

Rewrote the section.

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

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§ 10:73-2.12 (Reserved)

History

HISTORY:

Amended by R.1994 d.585, effective November 21, 1994 (operative December 1, 1994).

See: [26 N.J.R. 3350\(a\)](#), [26 N.J.R. 4614\(a\)](#).

Amended by R.1996 d.363, effective August 5, 1996.

See: [28 N.J.R. 1977\(a\)](#), [28 N.J.R. 3788\(a\)](#).

Amended by R.2001 d.198, effective June 18, 2001.

See: [33 N.J.R. 978\(a\)](#), [33 N.J.R. 2193\(a\)](#).

In (a), inserted "shall" following "case management" and substituted "shall not be" for "are not" preceding "be limited to" in the introductory paragraph, and substituted "beneficiary" for "client" in 4; in (g), substituted references to beneficiaries for references to clients throughout.

Recodified from [N.J.A.C. 10:73-2.11](#) and amended by R.2001 d.475, effective December 17, 2001.

See: [33 N.J.R. 349\(a\)](#), [33 N.J.R. 1167\(a\)](#), [33 N.J.R. 4357\(a\)](#).

In (h), amended the N.J.A.C. reference. Former [N.J.A.C. 10:73-2.12](#), Recordkeeping for CMP/MH services, recodified to [N.J.A.C. 10:73-2.13](#).

Amended by R.2005 d.78, effective February 22, 2005.

See: [36 N.J.R. 1271\(b\)](#), [37 N.J.R. 651\(a\)](#).

Deleted (h).

Repealed by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Section was "Liaison case management services under adult CMP/MH".

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MANAGEMENT PROGRAM/MENTAL HEALTH (CMP/MH)

§ 10:73-2.13 Recordkeeping for adult CMP/MH services

- (a) Case management providers shall keep such individual records as are necessary to fully disclose the kind and extent of services provided and shall assure that such information is available to the DMAHS or DMHAS or their agents, upon request.
- (b) The CMP/MH provider shall maintain the following data in support of all payment claims as required by the rules:
1. The name of the beneficiary;
 2. The name of the provider agency and the name and the title of the individual providing service;
 3. The dates of service;
 4. The units of service;
 5. The length of time of all face-to-face contact (excluding travel to or from beneficiary contact);
 6. The name of individual(s) with whom face-to-face contact was maintained on behalf of beneficiary; and
 7. A summary of services provided.

History

HISTORY:

Amended by R.1994 d.585, effective November 21, 1994 (operative December 1, 1994).

See: 26 N.J.R. 3350(a), 26 N.J.R. 4614(a).

Amended by R.1996 d.363, effective August 5, 1996.

See: [28 N.J.R. 1977\(a\)](#), [28 N.J.R. 3788\(a\)](#).

Amended by R.2001 d.198, effective June 18, 2001.

See: [33 N.J.R. 978\(a\)](#), [33 N.J.R. 2193\(a\)](#).

Substituted "beneficiary" for "client" throughout.

Recodified from [N.J.A.C. 10:73-2.12](#) by R.2001 d.475, effective December 17, 2001.

See: [33 N.J.R. 349\(a\)](#), [33 N.J.R. 1167\(a\)](#), [33 N.J.R. 4357\(a\)](#).

Amended by R.2005 d.78, effective February 22, 2005.

§ 10:73-2.13 Recordkeeping for adult CMP/MH services

See: [36 N.J.R. 1271\(b\)](#), [37 N.J.R. 651\(a\)](#).

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Rewrote the section.

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

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N.J.A.C. 10:73-3.1

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CHAPTER 73. CASE MANAGEMENT SERVICES > **SUBCHAPTER 3. CARE**
MANAGEMENT ORGANIZATION SERVICES

§ 10:73-3.1 Purpose and scope

- (a) This subchapter sets forth the manner in which care management organization (CMO) services shall be provided to eligible Medicaid/NJ FamilyCare beneficiaries and children, youth and young adults receiving services under the Children's System of Care (CSOC), and shall apply to all CMO services provided under Title XIX and Title XXI of the Social Security Act, [42 U.S.C. §§ 1396](#) and [1397](#), or State-funded only programs.
- (b) Care management organization services are administered under the auspices of the Department of Human Services (DHS) and its Division of Medical Assistance and Health Services (DMAHS) and the Department of Children and Families' Children's System of Care.
- (c) All services shall be provided and administered in accordance with all DHS, DCF, CSOC, and DMAHS rules and contract obligations and all other applicable State and Federal laws, rules, and regulations including, but not limited to, [N.J.A.C. 10:3](#) and 10:49 and this chapter.
- (d) If a conflict arises between contract requirements and any existing provider rules, the terms set forth in the DHS or DCF contract shall prevail.

History

HISTORY:

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Rewrote (a); in (b), substituted "Division" for "Divisions", deleted "Mental Health Services (DMHS), Youth and Family Services (DYFS and" preceding "Medical", and inserted "and the Department of Children and Families' Division of Child Behavioral Health Services"; rewrote (c); and in (d), inserted "or DCF".

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

Annotations

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§ 10:73-3.1 Purpose and scope

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§ 10:73-3.2 Definitions

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

"Adult" means a beneficiary age 21 years or older.

"Care management organization (CMO)" means an independent, community-based organization that combines advocacy, service planning and delivery, and care coordination into a single, integrated, cross-system process that assesses, designs, implements and manages child-centered and family-focused individual service plans (ISPs) for children, youth and young adults transitioning into the adult system whose needs are complex, and who require intensive care management techniques that cross multiple service systems.

"Child" means an individual under 18 years of age.

"County Interagency Coordinating Council (CIACC)" means the county-based planning and advisory groups composed of individuals from governmental and private agencies that advise the county and the Department of Children and Families regarding children with serious emotional and behavioral health challenges.

"Department of Children and Families (DCF) Children's Implementation Team (DCF CI Team)" means a team consisting of staff from the Department of Children and Families, facilitated by the Children's System of Care, with representation from the Child Protection and Permanency and other DCF representatives, as needed. Other team members include staff from the Department of Human Services, with representation from the Division of Medical Assistance and Health Services and the Division of Mental Health and Addiction Services, as well as representatives from other child serving systems, including, but not limited to, the Juvenile Justice Commission and the Juvenile Justice system. The team assists the CMO in working with other systems partners.

"Family-friendly services" means services that are accessible, convenient, culturally competent, meet family defined objectives and goals, and are reasonably available to families in the communities in which they live.

"Family support organization (FSO)" means an independent community-based organization providing services through a contract with the Department of Children and Families. The FSOs are comprised of family members who are involved or have been involved in the system and who provide direct peer support and advocacy to children and families receiving CMO services, as well as provide advocacy and support for other children and families in the community who may need services under CSOC.

"Individual Service Plan (ISP)" means the plan developed by the child/family team that incorporates formal and informal services and supports into an integrated plan that, using the identified strengths of the youth and family, addresses the needs of the youth and family across life domains in order to support the youth and family in remaining in, or returning to, the community where they live, work and/or attend school.

§ 10:73-3.2 Definitions

"Individualized service planning" means a process that wraps services and supports around the child/family and provides access to the services they need, delivered in the communities where they live, work and attend school. ISPs are holistic in nature and address areas of everyday living beyond the treatment of emotional or behavioral health challenges.

History

HISTORY:

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Rewrote definitions "Care management organization (CMO)" and "Family support organization (FSO)"; deleted definitions "Children's System of Care Initiative (CSOCI)", "Contracted system administrator (CSA)", "County Case Assessment Resource Team (CART)" and "Young adult"; in definition "County Interagency Coordinating Council (CIACC)" inserted "of Children and Families" and substituted "health challenges" for "disturbances"; substituted definition "Department of Children and Families (DCF) Children's Implementation Team (DCF CI Team)" for definition "Department of Human Services Children's Initiative Team (DHS CI Team)" and rewrote the definition; added definition "Individual Service Plan (ISP)"; substituted definition "Individualized service planning" for "Individualized service planning (ISP)"; and in definition "Individualized service planning", substituted "emotional or behavioral health challenges" for "mental health symptoms".

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

Annotations

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§ 10:73-3.3 Provider enrollment and participation

(a) Prior to enrollment as a Medicaid/NJ FamilyCare provider, any agency applying to render Medicaid/NJ FamilyCare CMO services shall first be under contract with the New Jersey Department of Human Services as an approved CMO provider. Such contract shall be in full effect and shall not be currently suspended, terminated or in default.

(b) In order to participate as a provider of CMO services, all providers shall apply to, and be approved by, the New Jersey Medicaid/NJ FamilyCare fee-for-service program as a CMO provider, in accordance with N.J.A.C. 10:49-3 and this subchapter.

1. Applicants may obtain the Medicaid "Provider Application" (FD-20), the Medicaid "Provider Agreement" (FD-62), and the CMS 1513 form at www.njmmis.com, or from:

Gainwell Technologies

Provider Enrollment

PO Box 4804

Trenton, NJ 08650-4804

2. All applicants shall complete and submit the forms to:

Department of Children and Families

PO Box 717

Trenton, NJ 08625-0717

Attn: Director, Division of Child Behavioral Health Services

3. The Director, Children's System of Care, will review the contract status of the applicant and will forward the application, if approved, to the Medicaid/NJ FamilyCare program for further processing.

(c) CMO provider applicants will receive notification of approval or disapproval of provider status. If approved, an applicant will be enrolled as a Medicaid/NJ FamilyCare provider and will be assigned a Medicaid/NJ FamilyCare provider number for use in the claim reimbursement process.

(d) If a provider's contract with the Department of Children and Families is in default status or has been suspended or terminated for any reason, or if the provider is no longer approved by the Department of Children and Families, the provider shall immediately be disenrolled as a provider of CMO services until such time as the contract is renewed or reinstated and the Medicaid/NJ FamilyCare program has been notified by the Department of Children and Families that the provider should be reinstated as a provider of CMO services.

(e) If a provider receives notification that the provider's contract with the Department of Children and Families is in default status or has been suspended or terminated for any reason, or if a provider is no

§ 10:73-3.3 Provider enrollment and participation

longer approved by the Department of Children and Families, the provider shall notify the Division of Medical Assistance and Health Services at the address below within 10 business days:

Division of Medical Assistance and Health Services

Office of Provider Enrollment

PO Box 712

Trenton, NJ 08625-0712

(f) A provider shall be held liable for recoupment of any monies paid for services rendered during the time that the provider's contract with the Department of Children and Families is in default status or has been suspended or terminated or during the time that the provider did not meet any other requirements of this subchapter.

(g) All CMO providers shall, at all times, maintain compliance with all applicable State and Federal laws, rules and regulations, including, but not limited to, [N.J.A.C. 10:3](#) and 10:49 and this chapter.

History

HISTORY:

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Section was "Provider enrollment criteria". Rewrote the section.

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

Annotations

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Case Notes

Fact that a hospital patient who was a Colombian citizen in the U.S. on a tourist visa permitting him to remain in the U.S. for six months came to New Jersey for the purpose of receiving medical care negated residency, because the regulations defined a "resident" as "a person who is living in [N.J.] voluntarily and not for a temporary purpose," that is, with no intention of presently removing therefrom. Petitioner was not a "resident" of New Jersey as he was a temporary visitor to the U.S. As such, he was ineligible for any Medicaid benefits. J.G. v. DMAHS, OAL DKT. NO. HMA 5293-2016, 2016 N.J. AGEN LEXIS 1364, Final Administrative Determination (November 3, 2016).

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§ 10:73-3.4 CMO responsibilities and services; general overview

(a) Under contract to the Department of Children and Families and working as a systems partner with CSOC, each CMO provider shall:

1. Provide initial and continuing case management services to children and families referred to them by the Department of Children and Families or other designated agent of the Department of Children and Families.
 - i. Initial CMO services provided shall include, but shall not be limited to:
 - (1) Enrollment of the child, youth or young adult into CMO services; and
 - (2) Development of an interim plan to stabilize the child, youth or young adult and address the immediate concerns of the child, youth or young adult and his or her family/caregiver.
 - ii. Continuing CMO services provided shall include, but shall not be limited to:
 - (1) Comprehensive assessment services;
 - (2) Individual Service Plan (ISP) design and implementation;
 - (3) Advocacy and family support;
 - (4) Information management; and
 - (5) Quality assessment and improvement.
2. Perform the eligibility-related activities required under [N.J.A.C. 10:73-3.7](#);
3. Manage a DCF provided fund to develop community resources to support the child and family;
4. Manage a flexible fund to provide resources and services identified in the child's Individual Service Plan that are not available through other funding or community resources, in accordance with this chapter and the CMO provider's contract with the Department; and
5. Manage the resources provided under the CMO's responsibilities to a financial benchmark developed by DCF.

(b) Each provider shall ensure that no distinction is made with regard to the quality or availability of CMO case management services as defined at (a) above to children, youth, and young adults receiving CSOC services, regardless of the enrollee's eligibility type.

History

HISTORY:

Amended by R.2006 d.421, effective May 21, 2007.

§ 10:73-3.4 CMO responsibilities and services; general overview

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Rewrote the section.

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

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§ 10:73-3.5 Eligibility and referral for CMO services

(a) A child, youth, or young adult may be eligible for CMO services if:

1. He or she meets the requirements of this subchapter and is:
 - i. Enrolled in Medicaid/NJ FamilyCare as described at N.J.A.C. 10:49-2, and not enrolled in:
 - (1) The Medically Needy Program, except that pregnant women in that program may be eligible;
 - (2) The Home and Community Based Services Waiver Program;
 - (3) The DDD Waiver Program;
 - (4) The Traumatic Brain Injury Waiver Program;
 - (5) The Community Resources for People with Disabilities Waiver Program; or
 - (6) The Home Care Expansion Program; or
 - ii. Receiving services from the Children's System of Care and is not eligible for Medicaid/NJ FamilyCare; and
2. He or she has been determined by the Department of Children and Families, or its designated contract system administrator (CSA), to require CMO services due to any one or any combination of the following:
 - i. Serious emotional or behavioral health challenges resulting in significant functional impairment which adversely affects his or her capacity to function in the community;
 - ii. His or her CSOC assessment indicates a need for the intensive level of case management services provided by a CMO;
 - iii. He or she is involved with one or more agencies or systems, including, but not limited to:
 - (1) DMHAS;
 - (2) CP&P;
 - (3) Crisis/emergency service providers;
 - (4) Department of Human Services or Department of Children and Families provider agencies;
 - (5) JJC; or
 - (6) The court system;
 - iv. A risk of disruption of a current therapeutic placement exists;
 - v. A risk of a psychiatric rehospitalization exists; or
 - vi. A risk of placement outside the home or community exists, except for:

§ 10:73-3.5 Eligibility and referral for CMO services

(1) Foster care placement, unless one or more of the conditions in (a)2i through v above are also present.

(b) Referrals to CMOs for CMO services shall be made only by the Department of Children and Families' Children's System of Care Implementation Team or other agent designated by the Department, including, but not limited to, the CSA.

(c) A child, youth, or young adult shall not be referred for CMO services if:

1. His or her immediate crisis is not stabilized;
2. His or her sole diagnosis is:
 - i. Substance abuse; or
 - ii. Developmental disability;
3. His or her CSOC assessment, or an evaluation performed by an authorized agent of the Department of Children and Families, does not indicate a need for CMO services; or
4. The child, youth or young adult, or his or her parent or caregiver, refuses CMO services.

(d) All records supporting determinations of eligibility or ineligibility made in accordance with this subchapter shall be maintained by the CMO provider.

History

HISTORY:

Repeal and New Rule, R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Section was "Access to services".

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

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§ 10:73-3.6 Discharge from CMO services

(a) A child, youth, or young adult shall be discharged from CMO services if:

1. The child, youth, or young adult's CSOC assessment, ISP, and other relevant information indicate that the child, youth, or young adult no longer needs CMO services; or
2. The child, youth or young adult or his or her parent or caregiver refuse CMO services.

(b) The case manager shall provide information to the child, youth or young adult, or to his or her parent or caregiver, regarding accessing the appropriate level of services to meet the needs of the child, youth or young adult and shall give assistance in the transition to the level of case management services recommended in the ISP, if such services are needed, for any child, youth or young adult who is discharged from CMO services.

History

HISTORY:

Repeal and New Rule, R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Section was "Beneficiary eligibility criteria".

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

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§ 10:73-3.7 Processing eligibility applications

(a) All CMO providers shall:

1. Complete a presumptive eligibility (PE) application for each child, youth and young adult who is not otherwise covered under Medicaid/NJ FamilyCare at the time of the referral to the CMO, if the PE process has not already been initiated by another entity;
2. Submit all PE applications to DMAHS;
3. Assure that provider case management staff and other appropriate staff complete DMAHS PE training;
4. Assist the child, youth or young adult and/or his or her family in collecting the documentation required to complete and submit a Medicaid/NJ FamilyCare application within 30 days of enrollment, if this process has not already been initiated by another entity;
5. As family circumstances indicate, review eligibility factors for each beneficiary and assist the beneficiary and/or his or her family in applying for any and all benefits for which they may be eligible, including, but not limited to, Medicaid/NJ FamilyCare; and
6. Assist the beneficiary and/or his or her family in maintaining eligibility for Medicaid/NJ FamilyCare and other benefits.

(b) All records supporting determinations of eligibility or ineligibility made in accordance with this section shall be maintained by the CMO provider and available for audit.

History

HISTORY:

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Section was "Processing presumptive eligibility applications". Rewrote the section.

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

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§ 10:73-3.7 Processing eligibility applications

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§ 10:73-3.8 Enrollment of the beneficiary into CMO services and the initial ISP

- (a) The CMO shall initiate enrollment of the child, youth or young adult upon receipt of the referral from the Department of Children and Families or its designated agent and shall complete the electronic case record within seven calendar days of receipt of the referral.
- (b) The CMO shall begin the initial ISP by contacting the family and holding a face-to-face meeting with the child, youth or young adult, and the family or other caregiver within 72 hours of the referral from the CSA, the Department of Children and Families or the DCF-designated agent.
- (c) The CMO shall refer the child, youth, or young adult and his or her family or other caregiver(s) to the family support organization (FSO) within the CMO service area for family-to-family support services during this time period.
- (d) The initial ISP developed by the CMO shall include an interim plan to stabilize the child, youth or young adult and his or her family or other caregiver(s) and address immediate concerns, including, but not limited to:
1. Preliminary crisis management plans to address any crisis situations that may occur prior to the completion of the comprehensive ISP;
 2. Child and community safety;
 3. Clinical need; and
 4. Caregiver needs.
- (e) The initial ISP shall be completed within seven calendar days of referral from the Department of Children and Families or its designated agent and shall be registered with the CSA within 24 hours of completion.
- (f) The CMO shall coordinate and assure initiation of the immediate needed services identified in the initial ISP during the development and completion of the comprehensive ISP.

History

HISTORY:

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

In (a), inserted ", youth or young adult" and substituted "of Children and Families or" for "for"; in (b) and (c), substituted "youth" for "adolescent"; in (c), substituted "family support organization (FSO)" for "FSO"; rewrote the

§ 10:73-3.8 Enrollment of the beneficiary into CMO services and the initial ISP

introductory paragraph of (d); and in (e), substituted "shall" for "should" following "ISP" and inserted "of Children and Families", and "shall be" preceding "registered".

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§ 10:73-3.9 Child/Family Team; members and responsibilities

(a) To complete the comprehensive ISP, the CMO shall develop a Child/Family Team, in conjunction with the family member or caregiver, which shall consist of, at a minimum, the following members:

1. A CMO care manager;
2. The child, youth or young adult and the parent or other caregiver;
3. Any interested person the family wishes to include as a member of the team, including, but not limited to, clergy members, family friends, and any other informal support resource;
4. A representative from the FSO, if desired by the family;
5. A clinical staff member who is directly involved in the treatment of the child, youth or young adult that the ISP is being developed for, if desired by the family;
6. Representation from outside agencies the child, youth or young adult is involved with, including, but not limited to, current providers of services, parole/probation officers, and/or educators that the child, youth or young adult and his or her family/caregiver agree to include on the team; and
7. The CP&P caseworker assigned to the child, if the child is receiving child protection or permanency services from CP&P.

(b) The CMO shall make diligent efforts to assure participation of all of the persons requested by the family to participate in the Child/Family Team. If the CMO is unable to secure participation of a family-requested member, despite their diligent efforts, the CMO shall document such efforts in the progress notes and in the record of the Child/Family Team meeting.

(c) The CMO Care Manager assigned to the child, youth or young adult and their family/caregiver shall:

1. Refer the child, youth or young adult or the family/caregiver for multi-system or any additional specialized assessments as indicated;
2. Serve as the facilitator of the Child/Family Team;
3. Actively engage the child and family as full partners in the Child/Family team, assuring their participation in the assessment, planning and service delivery process;
4. Ensure that all services and care management processes respect the child and family/caregiver's rights to define specific goals and choice of providers and resources;
5. Ensure that all services and resources are family friendly and culturally competent;
6. Ensure that all Child/Family team meetings are conveniently scheduled and located for the family/caregiver;
7. Ensure that the ISP is developed as a collaborative effort of all team members;

§ 10:73-3.9 Child/Family Team; members and responsibilities

8. Ensure that the ISP is approved by each team member, including the family/caregiver and the child, at the team meeting;
9. Ensure that the attendance of the team members and their approval of the ISP are documented in the case record;
10. Ensure that the written ISP is signed, at a minimum, by the CMO care manager, the parent/caregiver and the child, as age appropriate, and placed in the child's file within two weeks of the team meeting;
11. Forward the completed and approved ISP to the CSA, for registration, tracking and initiation of the claims payment authorization process; and
12. Forward the completed and approved ISP to each team member, including the family/caregiver, within one week of the team meeting.

History

HISTORY:

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Section was "ISP team; members and responsibilities". Substituted "youth" for "adolescent," throughout; in the introductory paragraph of (a), substituted "develop a Child/Family Team" for "be responsible for developing an ISP team"; in (a)5, substituted "youth" for "adolescent"; in (a)6, inserted ", youth or young adult"; added new (b); recodified former (b) as (c); in (c)2, substituted "Child/Family Team" for "ISP Team"; in (c)3, substituted "Child/Family" for "ISP"; and in (c)6, substituted "Child/Family team" for "ISP".

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

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§ 10:73-3.10 Comprehensive ISP; general

- (a) The ISP shall include a copy of the DHS or DCF confidentiality agreement form signed by all participants to adhere to all rules and procedures governing beneficiary confidentiality.
- (b) The ISP shall be comprehensive in nature, strength based, and developed in partnership with the child, youth, young adult and the family or other caregivers.
- (c) The ISP shall be based on the comprehensive assessments completed as indicated by the presenting problems, needs and strengths of the child, youth or young adult and his or her family/caregiver.
- (d) The ISP shall identify the services to be provided and shall ensure that the services are provided to the child, youth, or young adult in the least restrictive manner possible.
- (e) The ISP shall consist of outcome based, short term, interim, and long term goals to address each area of unmet need with measurable goals and time frames, specific individual roles and responsibilities, a crisis/emergency response plan and a schedule for ongoing review and assessment.
- (f) The ISP shall, at a minimum, address areas of unmet need in all areas of the following life domains, as indicated by the multi-system assessment process, including, but not limited to:
 - 1. Child safety;
 - 2. Child risk;
 - 3. Clinical needs;
 - 4. Non-clinical needs, if deemed therapeutic and approved by the Child/Family Team;
 - 5. Permanency planning; and
 - 6. Community safety issues.
- (g) Child safety, child risk, permanency planning, and community safety issues shall be coordinated with the CP&P worker, who has the primary responsibility for child safety under the Federal child protection mandates contained in Title IV-E of the Social Security Act. CP&P maintains the primary responsibility for the CP&P children.
- (h) The comprehensive ISP shall be developed for each beneficiary within 30 days of the referral to the CSA.
- (i) The completed ISP shall be submitted to the CSA for registration within 30 calendar days of the referral.

History

HISTORY:

Amended by R.2006 d.421, effective May 21, 2007.

§ 10:73-3.10 Comprehensive ISP; general

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

In (a), inserted "or DCF"; in (b), substituted "youth" for "adolescent"; in (c), deleted "that were" following "assessments", and inserted ", youth or young adult"; rewrote (d); in (e), deleted comma following "plan"; in (f)4, substituted "Child/Family" for "ISP"; in (h), inserted "for each beneficiary", and deleted "for each beneficiary" at the end; and in (i), substituted "for registration within 30 calendar days of the referral" for "within 30 calendar days of the referral for registration".

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

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§ 10:73-3.11 Comprehensive ISP; contents

(a) The comprehensive ISP shall contain the following components:

1. Documentation of the participation of providers and local community partners and the integration of available and appropriate services and resources;
2. Documentation of the responsibilities, objectives, and requirements of child welfare, mental health, juvenile justice, the courts, and other service systems, as applicable;
3. Documentation of the coordination of system partner mandates and responsibilities with the assessment plan;
4. Documentation of the involvement of FSOs, if desired by the family;
5. A plan for permanency, clinical care, and child and community safety (CP&P maintains the primary responsibility for permanency and child safety for the CP&P child);
6. A community based crisis management plan, which includes emergency response capability to respond in person to deliver in-home or off-site crisis support as warranted, and coordination of crisis response services, if intervention is needed beyond care manager response;
7. A plan to develop and purchase those items and/or services necessary to support the individual's needs as determined by the team and included in the ISP;
8. Documentation of the coordination of applicable services with the physical health insurer;
9. Measurable goals and the criteria to be met to obtain those goals;
10. A plan for transitioning the child, youth or young adult and the family/caregiver from CMO services to a community based, natural support network of services;
 - i. For children, youth or young adults who are transitioning from CMO services into youth case management (YCM) services, the initial 90 days of YCM services and other services specified in the ISP will be authorized as part of the transition plan. Additional authorizations shall be requested by the YCM agency, if needed. (See [N.J.A.C. 10:73-4.9.](#))
11. A plan to maintain enrollment for the child, youth or young adult receiving the CMO services on a "no eject/no reject" basis until the defined outcomes and discharge criteria specified in the ISP are met; and
12. The signatures of the CMO care manager, the parent/caregiver and the child, youth or young adult receiving the services.

History

HISTORY:

§ 10:73-3.11 Comprehensive ISP; contents

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

In (a)1, (a)3, (a)4 and (a)8, substituted "Documentation of the" for "The"; in (a)2, substituted "Documentation" for "The addressing"; in (a)5, substituted "A plan" for "Planning"; in the introductory paragraph of (a)10, substituted "youth" for "adolescent,"; added (a)10i; in (a)11 and (a)12, substituted "youth" for "adolescent"; and deleted (b).

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

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§ 10:73-3.12 Amendments to the ISP

- (a) The CMO shall review and update the ISP at least every three months, and more often if needed. The care manager shall work with the Child/Family Team to facilitate this process.
- (b) As part of the reviewed and amended ISPs, the Child/Family Team may need to change the composition of the team, based on the family requests, or to reflect changing circumstances and revised treatment goals.
- (c) Reviewed and amended ISPs shall reflect the review of existing services provided for effectiveness and shall include a determination of whether changes to the ISP are indicated based on the provision of current services and their effectiveness.
- (d) The CMO care manager shall have the following responsibilities to the rest of the team for the subsequent or amended ISPs:
1. Continue to engage the child, youth or young adult and his or her family as active participants in the assessment, planning and service delivery process;
 2. Continue to serve as the facilitator of the Child/Family Team;
 3. Continue to ensure that subsequent ISP meetings are convenient to the family; and
 4. Ensure that subsequent ISPs are developed as a collaborative effort of all Child/Family team members. The care manager shall:
 - i. Ensure that the written plan, and any subsequent amendments to the plan, are approved by each team member, including the family and the child, at the subsequent Child/Family Team meetings and placed in the child's file;
 - ii. Assure the subsequent reviewed and amended ISPs are signed, at a minimum, by the CMO care manager, the parent/caregiver, the child, as age appropriate, and submitted to the CSA within seven calendar days of the Child/Family Team meeting; and
 - iii. Forward the completed and approved revised ISP to each team member.

History

HISTORY:

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Substituted "Child/Family Team" for "ISP team" throughout; in the first sentence of (a), substituted "shall" for "is expected to", and "work" for "be responsible for working" in the second sentence; in (b), inserted "or"; in (c),

§ 10:73-3.12 Amendments to the ISP

substituted "Reviewed" for "Revised" and "services provided" for "provided services"; in the introductory paragraph of (d), substituted "subsequent" for "revised" and deleted ", as follows" at the end; in (d)1 through (d)3, substituted "Continue" for "Continuing"; in (d)1, inserted ", youth or young adult" and "his or her"; in (d)4, substituted "Ensure" for "Ensuring" and inserted "Child/Family"; and in (d)4ii, substituted "reviewed" for "revised".

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§ 10:73-3.13 Transition/discharge planning; general

Transition/discharge planning for children, youth and young adults receiving CMO services shall be considered within the context of the ongoing ISP process and shall guide the team process from the time of the referral.

History

HISTORY:

New Rule, R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Former [N.J.A.C. 10:73-3.13](#), Crisis Management, recodified to [N.J.A.C. 10:73-3.17](#)

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§ 10:73-3.14 Transition planning

- (a) The Child/Family team shall develop a transition plan if one or more of the following criteria are met:
1. The goals of the individual service plan (ISP) have been substantially achieved;
 2. The Child/Family Team determines that the child, youth or young adult no longer requires the intensive level of care management provided by the CMO;
 3. The Child/Family Team determines that the child, youth or young adult is ready to be transitioned to adult services; or
 4. The family requests transition. Family requests for transition shall be in written form and shall be made by the parent or legal guardian of the child, youth or young adult.

History

HISTORY:

New Rule, R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Former [N.J.A.C. 10:73-3.14](#), Community resource development, recodified to [N.J.A.C. 10:73-3.18](#).

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§ 10:73-3.15 Discharge planning

- (a) The Child/Family Team shall develop a discharge plan if one or more of the following criteria are met:
1. Active attempts to engage the family/guardian to participate in the CMO process, for a two-month period, have not been successful;
 2. The family has moved out of the geographic area with no intent to return;
 3. The child, youth, or young adult is missing and, after active searching by the CMO, the child, youth, or young adult continues to be missing and has had no contact with the CMO for more than two months. In actively searching for the child, youth, or young adult, the CMO shall request the assistance of the family support organization (FSO), the family and all other parties appropriate for the particular child, youth, or young adult, including, but not limited to, individuals and entities known to have contact with the child, youth, or young adult, such as the local or State police, Department of Human Services police, probation officers, and other law enforcement entities.
 - i. Active attempts to locate and engage the child, youth, or young adult and his or her family/guardian with the requested assistance of the FSO shall include, but not be limited to:
 - (1) Documented attempts to reach the family by telephone on a weekly basis;
 - (2) Monthly certified letters with copies to the referring agent and/or CP&P and/or the Family Court, as appropriate; and
 - (3) Scheduled and unscheduled visits to the child, youth or young adult's and/or family's or guardian's place of residence;
 - ii. The CMO shall document all efforts to locate the child, youth or young adult; and/or
 4. The family requests discharge. Family requests for discharge shall be in written form and shall be made by the parent or legal guardian of the child, youth or young adult.
- (b) The CMO shall discuss the recommended discharge of the child, youth, or young adult within the Child/Family Team process, including the referring agent and/or CP&P, and/or Family Court, as appropriate. Upon the recommendation of the Child/Family Team and the approval of the care management supervisor and the clinical/operations supervisor, a final registered letter shall be sent to the family with a copy to the referring agent, and/or CP&P, and/or the Family Court, as appropriate, if a case remains open. The copy of the final registered letter shall include a final date for case closure and information regarding the contract system administrator (CSA).

History

HISTORY:

New Rule, R.2006 d.421, effective May 21, 2007.

§ 10:73-3.15 Discharge planning

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Former [N.J.A.C. 10:73-3.15](#), Financial management, recodified to [N.J.A.C. 10:73-3.19](#).

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

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§ 10:73-3.16 CMO Pre-transition/pre-discharge responsibilities

(a) Upon determination that a transition/discharge from CMO services is appropriate, the CMO shall assure that:

1. A comprehensive transition/discharge ISP shall be developed by the Child/Family Team, and documented by the CMO. The transition/discharge ISP shall include:
 - i. The recommended date for transition/discharge;
 - ii. A recommendation for any needed additional care management services;
 - iii. For children, youth or young adults who will be transitioning into other case management services, 30 days notice and participation of a representative of the appropriate case management entity in the Child/Family Team meeting where the transition/discharge ISP is developed;
 - iv. Identification of responsible parties for all goals and objectives;
 - v. Confirmation of linkages to community organization, both formal and informal, and assurance that any services not currently in place for the child, youth or young adult are in place prior to the date of transition/discharge;
 - vi. Discussion at the Child/Family Team meeting of the availability of services provided by the FSO. The care manager shall ensure that the family is provided with the FSO information appropriate for the family's geographic location and shall document the receipt of the information in the child, youth or young adult's record; and
 - vii. If CP&P and/or Family Court/Probation will be involved after the transition/discharge, a CSA/CP&P/YCM/Family Court/Probation interface process shall be established, which shall include identification of designated individuals in each specific agency or entity.

(b) The care management entity identified in the transition/discharge plan shall assure that the transition/discharge plan is implemented.

(c) For youth aging out of the children's system of care, transition planning shall include Child/Family Team participation by staff from adult services or other transition providers, as appropriate. (See also [N.J.A.C. 10:73-3.14.](#))

(d) The CMO care manager shall forward the transition/discharge ISP to the CSA for authorization within seven calendar days of the Child/Family Team meeting.

(e) After the completed transition/discharge ISP has been reviewed by the CSA, the CMO shall send letters to all Child/Family Team members confirming the transition/discharge date. A minimum of 30 days prior to the transition/discharge date, the CMO shall notify all appropriate service providers, providing continuation of services as part of the transition/discharge plan, with written notification of the transition/discharge date, changes in billing procedures, the effective date, and the responsible case management entity and contact person.

§ 10:73-3.16 CMO Pre-transition/pre-discharge responsibilities

(f) Following transition/discharge from the CMO, children/families may access CMO services again in accordance with the rules of this subchapter.

History

HISTORY:

New Rule, R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Former [N.J.A.C. 10:73-3.16](#), Information management, recodified to [N.J.A.C. 10:73-3.20](#).

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

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§ 10:73-3.17 Crisis management

- (a) The CMO shall identify, in each ISP and subsequent ISP, potential crisis(es) and shall include, in the ISP, a crisis management plan for each child, youth or young adult and his or her family or other caregiver(s). The crisis management plan shall assure that services are available to respond to a crisis on a 24 hour-a-day/seven-days-a-week basis.
- (b) The crisis management plan shall include specification of the coordination of the crisis management plan with the CSA crisis management services and the available local crisis intervention services.
- (c) The CMO shall maintain the capacity to respond face-to-face as needed to assess the need for additional crisis services that are not otherwise identified in the ISP, to provide support and to facilitate the provision of other crisis or emergency intervention services, as warranted.
- (d) Mobile response services may be provided by a mobile response agency (see N.J.A.C. 10:77-6) for up to 72 hours, spanning up to four days. Subsequent stabilization management services shall be included in the CMO's Individual Service Plan and shall be coordinated by the Child-Family Team, and shall not be provided by the mobile response agency.

History

HISTORY:

Recodified from [N.J.A.C. 10:73-3.13](#) and amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Rewrote (a) and (d); in (b), inserted "specification of the" and inserted "the" preceding "available"; and in (c), deleted "also" preceding "maintain" and substituted "not otherwise" for "otherwise not".

Former [N.J.A.C. 10:73-3.17](#), Quality assessment/evaluation, recodified to [N.J.A.C. 10:73-3.21](#).

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§ 10:73-3.18 Community resource development

- (a) Each CMO shall catalog all available services and community resources available to support the ISP design, and shall provide a list of these services and resources to the CSA for inclusion in the Statewide database that shall be maintained for children's services.
- (b) Each CMO shall assure that children, youth and young adults and their families have a choice of entities to provide the services identified in the ISP, and based on a thorough understanding of the cultural diversity of its service area, each CMO shall identify and develop accessible, culturally responsive services and supports, which shall include affiliations with informal or natural helping networks, such as neighborhood associations determined by the Child/Family Team to be appropriate, which support the ISP of one or more beneficiaries within the service area of the CMO.
- (c) Each CMO shall develop policies and procedures for identifying and recruiting appropriate informal community supports in the ISP and for providing supervision and oversight of their activities.
- (d) Each CMO shall develop and maintain working affiliation agreements or Memoranda of Understanding (MOUs) with all participants in the community service/resource network and shall identify in the MOUs specific goals, roles, and responsibilities for collaborative activity.
1. Each CMO shall develop working relationships reflected in Memoranda of Understanding with all key service providers, community organizations, and system partners.
- (e) The CMO shall include the local FSO as a partner in the resource development and coordination process.

History

HISTORY:

Recodified from [N.J.A.C. 10:73-3.14](#) and amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

In (a), (c), the introductory paragraph of (d) and (d)1; substituted "Each" for "The" preceding "CMO"; in (a), inserted "available" following "resources", and "services and" following "these"; rewrote (b); and in the introductory paragraph of (d), substituted "network and" for "network. These MOUs", and inserted "in the MOUs".

Former [N.J.A.C. 10:73-3.18](#), Staffing requirements, recodified to [N.J.A.C. 10:73-3.22](#).

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§ 10:73-3.19 Financial management

(a) Under the CSOC children's system of care, the care provided and the payment for care is individualized and child centered rather than program and service centered. The CMO has responsibilities, as a systems partner, to assist in the implementation of this principle as outlined in this subchapter and their individual DHS contract.

(b) Financial management and monitoring responsibilities of the CMOs shall include:

1. The design and implementation of Individual Service Plans (ISPs) that shall include a range of services and social supports, some of which will be eligible for reimbursement under Medicaid/NJ FamilyCare or other DHS/DCF contracts;
2. The administration of a flexible funding pool for purchasing services and social supports that contribute to the goals of an ISP, but are not reimbursable under Medicaid/NJ FamilyCare program or other DHS/DCF contracts;
3. The use of DCF funds to develop a local network of innovative community resources available to ISP through the flexible funding pool, and the community resource fund, organized specifically to contribute to ISP goals and outcomes;
4. The monitoring and tracking of the costs of the ISP in conjunction with DHS/DCF and CSA eligibility and other system partners, including, but not limited to, other State agencies;
5. The reporting of financial outcomes, correlating the clinical outcomes with the financial resources consumed to produce the clinical outcomes; and
6. The tracking and managing of funds consistent with DHS/DCF child monthly cost benchmarks.

History

HISTORY:

Recodified from [N.J.A.C. 10:73-3.15](#) and amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

In (a), substituted "DCBHS children's system of care" for "Children's System of Care Initiative"; in (b)1, (b)2, (b)4 and (b)6, substituted "DHS/DCF" for "DHS"; in (b)3, substituted "DCF" for "DHS"; and in (b)4, inserted ", including, but not limited to, other State agencies".

Former [N.J.A.C. 10:73-3.19](#), Staff Qualifications, recodified to [N.J.A.C. 10:73-3.23](#).

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

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§ 10:73-3.20 Information management

- (a) Each CMO shall establish and maintain an integrated electronic child and family file.
- (b) Each CMO shall use the software provided by the CSA to obtain, organize, analyze, and distribute the following information:
1. Records management, including creating and maintaining individual electronic case records;
 2. Real time enrollment, electronic assessment and ISP information;
 3. Tracking of client status, ISP outcomes, service/resource availability and utilization, and quality of care and cost indicators;
 4. Interfacing with the CSA's system, including the transfer of data for the purposes of updating individual electronic case records and facilitating the claims payment process for authorized service requests;
 5. Maintaining a registry of service providers practicing within the CMO's area of responsibility, and providing access to this registry as needed; and
 6. Reporting, as required by DHS/DCF in the CMO contract, which shall include the capability to report on services provided, payments made, and child and family outcomes by client and/or servicing provider.

History

HISTORY:

Recodified from [N.J.A.C. 10:73-3.16](#) and amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

In (a) and (b), substituted "Each CMO" for "The CMOs"; in (b)4, substituted "and" for the comma following "records"; and in (b)6, substituted "DHS/DCF" for "DHS" and "which shall" for "to".

Former [N.J.A.C. 10:73-3.20](#), Recordkeeping, recodified to [N.J.A.C. 10:73-3.24](#).

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§ 10:73-3.20 Information management

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§ 10:73-3.21 Quality assessment/evaluation

- (a) Each CMO shall develop an annual Quality Assessment and Performance Improvement (QAPI) Plan.
- (b) In addition to the CMO's annual QAPI Plan, each CMO shall be evaluated by DCF, or its designated agent, based on various performance measures, including the following:
1. Timeliness of service plan development;
 2. Progress towards the financial benchmarks specified in the CMO's contract;
 3. Cultural, ethnic, and linguistic competency;
 4. Individual service plan appropriateness;
 5. Restrictiveness of living environment;
 6. Hospital or CCIS readmission rate;
 7. Changes in the level of functioning of the child;
 8. Placement stability;
 9. Permanency including supporting the DYFS mandates and requirements in this regard;
 10. Length of stay in residential treatment centers;
 11. Reduction in the use of congregate care and increased use of community based treatment options;
 12. Involvement of the child and family; and
 13. Consumer satisfaction with the services provided.

History

HISTORY:

Recodified from [N.J.A.C. 10:73-3.17](#) and amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

In (a), substituted "Each CMO" for "CMOs"; rewrote the introductory paragraph of (b) and (b)2; added new (b)11; and recodified former (b)11 and (b)12 as (b)12 and (b)13.

Former [N.J.A.C. 10:73-3.21](#), Reimbursement methodology for CMO services, recodified to [N.J.A.C. 10:73-3.25](#).

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§ 10:73-3.22 Staffing requirements

(a) CMO staffing shall include:

1. An administrative staff, to include an executive director;
2. Adequate support staff to effectively perform clerical, financial, quality management, and MIS functions;
3. Direct care staff for clinical operations; and
4. Support for the community resource development function, consistent with DHS and DCF rules, and ISP planning and implementation.

(b) CMO care management staffing ratios shall be:

1. Supervisors to care managers, a 1:8 ratio; and
2. Care managers to families, a 1:10 ratio.

History

HISTORY:

Recodified from [N.J.A.C. 10:73-3.18](#) and amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

In (a)4, inserted "and DCF".

Former [N.J.A.C. 10:73-3.22](#), Fair hearings, repealed.

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§ 10:73-3.23 Staff qualifications

(a) The Executive Director shall have a Master's degree in a relevant discipline, such as social work, counseling, psychology, psychiatric nursing, criminal justice or special education, with a minimum of five years' post Master's related supervisory experience in child welfare, children's mental health, juvenile justice, special education, public administration or management or a related public sector human services or behavioral health field.

(b) Supervisors shall have a Master's degree in a relevant discipline, such as social work, counseling, psychology, psychiatric nursing, criminal justice or special education, with a minimum of two years post Master's related supervisory experience in child welfare, children's mental health, juvenile justice, special education or a related public sector human services or behavioral health field working with at risk children and families.

1. Supervisors shall have experience in clinical assessment and child/adolescent development, with community-based experience preferred.
2. Supervisors shall be clinically and culturally competent/responsive, with the training and experience necessary to manage complex cases in the community across child serving systems. Supervisors shall possess a valid driver's license.
3. Supervisors shall have experience with community relations and resource development. Bilingual ability (such as Spanish/English) is preferred in geographic areas with high concentrations of non-English speaking consumers.

(c) Care managers shall have a minimum of a Master's degree in a related field, such as social work, counseling, psychology, psychiatric nursing, criminal justice or special education, or a Bachelor's degree in a related field and a minimum of one year related experience.

1. Care managers with experience with community relations and resource development are preferred.
2. Bilingual ability (such as Spanish/English) is preferable in geographic areas with high concentrations of non-English speaking consumers.

History

HISTORY:

Recodified from [N.J.A.C. 10:73-3.19](#) by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

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§ 10:73-3.24 Recordkeeping

- (a) Each CMO provider shall maintain all records in accordance with [N.J.A.C. 10:3](#) and in compliance with all applicable State laws and rules including, but not limited to, [N.J.A.C. 10:49-9.8](#).
- (b) Each CMO provider shall keep such individual legible records as are necessary to fully disclose the nature and extent of the services provided.
- (c) Each CMO provider shall make all records, data, and information required by this chapter available to DHS, CSOC, DMAHS, DMHAS, CP&P, or other authorized agents, as requested.
- (d) Each CMO provider shall maintain the following data in support of all CMO fee-for-service claims:
1. The name of the client;
 2. The name, agency (if applicable), and title of the individual providing the service;
 3. The dates of service;
 4. The length of time that the service was provided;
 5. The length of time of the face-to-face contact (excluding travel to or from client contact); and
 6. The name of individual(s) with whom contact was maintained on behalf of the client.

History

HISTORY:

Recodified from [N.J.A.C. 10:73-3.20](#) and amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Rewrote (a) and (c); in (b), inserted "Each" and substituted "provider" for "providers"; in the introductory paragraph of (d), substituted "Each" for "The" and inserted "provider"; in (d)2, inserted ", agency (if applicable),"; and in (d)5, inserted "time of the".

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

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§ 10:73-3.25 Reimbursement methodology for CMO services

(a) Claims for CMO services shall be submitted on a monthly fee-for-service basis for the care management component of the CMO's services.

1. The CMO shall bill for the first month that a beneficiary begins receiving services from the CMO, regardless of the specific initial date of services.
2. The CMO shall not bill for the month that a beneficiary ceases receiving services from the CMO, regardless of the specific discharge date.

(b) Providers shall seek reimbursement by submitting a CMS-1500 claim form to the Medicaid fiscal agent, in accordance with [N.J.A.C. 10:49](#).

1. HCPCS code Z5008 shall be billed monthly for Care Coordination services provided by care management organizations, provided to beneficiaries eligible under the Children's System of Care. (See [N.J.A.C. 10:73-5.2](#))

History

HISTORY:

Recodified from [N.J.A.C. 10:73-3.21](#) and amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Deleted (a); recodified (b) and (c) as (a) and (b); rewrote (a)1 and (a)2; in the introductory paragraph of (b), substituted "CMS" for "HCFA" and inserted "to the Medicaid fiscal agent"; and in (b)1, substituted "eligible under the DCBHS" for "as part of", deleted "Initiative" following "of Care", and updated the N.J.A.C. reference.

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

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§ 10:73-3.25 Reimbursement methodology for CMO services

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N.J.A.C. 10:73-4.1

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§ 10:73-4.1 Purpose and scope

(a) This subchapter sets forth the requirements that all providers shall follow to receive reimbursement for the provision of youth case management (YCM) services to eligible Medicaid/NJ FamilyCare beneficiaries and children, youth, and young adults receiving services from the Children's System of Care (CSOC) and that shall apply to all YCM services provided under Title XIX and Title XXI of the Social Security Act or under State-funded only programs.

(b) Children, youth, and young adults receive youth case management services under the auspices of the Department of Human Services' Division of Medical Assistance and Health Services and the Department of Children and Families' Children's System of Care (CSOC). The services are rendered by providers licensed by the Department of Human Services and administered jointly by the Division of Mental Health and Addiction Services (DMHAS) in accordance with [N.J.A.C. 10:37H](#), CSOC, and the Division of Medical Assistance and Health Services (DMAHS) in accordance with these rules.

(c) All YCM services shall be provided and administered in accordance with all applicable State and Federal laws, rules and regulations, including, but not limited to, [N.J.A.C. 10:3](#), and 10:49 and this chapter.

(d) If a conflict exists between DHS/DCF contract requirements and the requirements of this subchapter, the terms set forth in the DHS/DCF contract shall prevail.

History

HISTORY:

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

In (a), inserted "that" and "and that shall apply to all YCM services provided under Title XIX and Title XXI of the Social Security Act or under State-funded only programs"; in (b), inserted "of Medical Assistance and Health Services and the Department of Children and Families' Division" and "rendered by providers licensed by the Department of Human Services and"; and added (c) and (d).

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

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§ 10:73-4.2 Definitions

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

"Collateral contact or activities" means non face-to-face contact or activities that the youth case manager engages in on behalf of the child, youth or young adult to advocate for, link to, coordinate and monitor the services included in the individualized service plan or otherwise support the provision of YCM services including, but not limited to, telephone contacts, development, review and update of service plans and 14-day plans, completion and follow-up of entitlements paperwork, completion of paperwork and data entry for prior authorization, and completion of service documentation and progress notes.

"Unit of service" means 15 continuous minutes of face-to-face contact with, or on behalf of, an enrolled beneficiary, or other collateral contacts or activities which support the provision of youth case management services, not including travel time.

"Youth Case Management" means services provided in accordance with [N.J.A.C. 10:37H](#) and these rules to facilitate a level of case management that assists children, youth or young adults in accessing and receiving the appropriate level of care, interventions and supports to maintain the optimal functioning level in the community.

History

HISTORY:

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Substituted definition "Collateral contact or activities" for "Collateral contact" and rewrote the definition; deleted definitions "Contracted Systems Administrator (CSA) Care Coordination", "Contracted Systems Administrator (CSA)" and "Young adult,"; in definition "Unit of service", inserted "or other collateral contacts or activities which support the provision of youth case management services,"; and in definition "Youth Case Management", deleted "moderate" following "facilitate a".

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§ 10:73-4.2 Definitions

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§ 10:73-4.3 Provider enrollment and participation

(a) Prior to enrollment as a Medicaid/NJ FamilyCare provider, any agency applying to render youth case management services shall first be under contract with the Children's System of Care, and licensed by DHS as an approved youth case management provider. Such contract and license shall be in full effect and shall not be currently suspended or terminated.

(b) In order to participate as a Medicaid/NJ FamilyCare/CSOC provider of youth case management services, a provider shall apply to, and be approved by, the New Jersey Medicaid/NJ FamilyCare fee-for-service program as a youth case management provider, in accordance with N.J.A.C. 10:49-3 and this subchapter. Providers who are enrolled as other provider types in the Medicaid/NJ FamilyCare program shall complete a separate application to enroll as a youth case management provider.

1. All applicants shall obtain the Medicaid "Provider Application" (FD-20), the Medicaid "Provider Agreement" (FD-62) and the CMS 1513 form at www.njmmis.com, or from:

Gainwell Technologies

Provider Enrollment

PO Box 4804

Trenton, NJ 08650-4804

2. All applicants shall complete and submit the forms to:

Department of Children and Families

PO Box 717

Trenton, NJ 08625-0717

Attn: Director, Division of Child Behavioral Health Services

3. The Director, Children's System of Care, will review the contract status of the applicant and will forward the application, if approved, to the Medicaid/NJ FamilyCare program for further processing.

(c) All YCM provider applicants will receive notification of approval or disapproval of provider status. If approved, the applicant will be enrolled as a Medicaid/NJ FamilyCare provider and will be assigned a Medicaid/NJ FamilyCare provider number for seeking reimbursement for the provision of youth case management services. All approved and enrolled providers will receive a copy of the provider manual and the fiscal agent billing supplement.

(d) If a provider's contract for youth case management services with the Department of Human Services or the Department of Children and Families is in default status or has been suspended or terminated for any reason, or if the provider is no longer approved, or licensed, by the Department of Human Services or the Department of Children and Families, as appropriate, the provider shall immediately be disenrolled as a provider of youth case management services until such time as the contract is renewed or reinstated and

§ 10:73-4.3 Provider enrollment and participation

the Medicaid/NJ FamilyCare program has been notified by the Department of Human Services or the Department of Children and Families, as appropriate, that the provider should be reinstated as a provider of services.

(e) If a provider receives notification that the provider's contract for youth case management services with the Department of Human Services or the Department of Children and Families is in default status or has been suspended or terminated for any reason, or if the provider is no longer approved, or licensed, by the Department of Human Services or the Department of Children and Families, as appropriate, the provider shall notify the Division of Medical Assistance and Health Services at the address below within 10 business days:

Division of Medical Assistance and Health Services

Office of Provider Enrollment

PO Box 712

Trenton, NJ 08625-0712

(f) A provider shall be held liable for recoupment of any monies paid for youth case management services rendered during the time that the provider's contract with the Department of Human Services or the Department of Children and Families, as appropriate, is in default status or has been suspended or terminated or when the provider did not meet other requirements of this subchapter.

(g) Providers of youth case management services shall, at all times, maintain compliance with all applicable State and Federal laws, rules and regulations, including, but not limited to, [N.J.A.C. 10:3](#), 10:37H and 10:49 and this chapter.

History

HISTORY:

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Section was "Provider participation". Rewrote (a); in the introductory paragraph of (b), substituted "N.J.A.C. 10:49-3 and" for "the provisions of"; added (b)1, recodified (c) as (b)2; added (b)3; recodified (d) as (c) and rewrote (c); added new (d) through (f); recodified former (e) as new (g) and rewrote (g); and deleted former (f) through (h).

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

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§ 10:73-4.4 Eligibility and referral for YCM services

(a) A child, youth, or young adult may be eligible for YCM services if:

1. He or she meets the requirements of this subchapter and is:

i. Enrolled in Medicaid/NJ FamilyCare, as described at N.J.A.C. 10:49-2, and not enrolled in:

- (1) The Medically Needy Program, except that pregnant women in that program may be eligible;
- (2) The Home and Community Based Services Waiver Program;
- (3) The DDD Waiver Program;
- (4) The Traumatic Brain Injury Waiver Program;
- (5) The Community Resources for People with Disabilities Waiver Program; or
- (6) The Home Care Expansion Program; or

ii. Receiving services from the Children's System of Care and is not eligible for Medicaid/NJ FamilyCare; and

2. He or she has been determined by the Department of Children and Families, or its designated contract systems administrator (CSA), to require YCM services due to any one or any combination of the following:

- i. He or she has emotional or behavioral health challenges which adversely affect his or her capacity to function in the community;
- ii. The child, youth or young adult and his or her family or caregiver requires face-to-face assistance in obtaining and coordinating treatment, rehabilitation, financial and/or social services, without which the child, youth or young adult could reasonably be expected to require more intensive services, including, but not limited to, intensive case management services provided by a care management organization (CMO), to maintain an optimal functional capacity; and
- iii. The child, youth, or young adult's CSOC assessment indicates a need for the level of case management services provided by a YCM.

(b) Referrals to YCMs for YCM services shall be made in accordance with this subchapter and only by the Department of Children and Families, or other agent designated by the Department of Children and Families, including, but not limited to, the CSA.

(c) A child, youth, or young adult shall not be referred for YCM services if:

- 1. The child, youth or young adult's sole diagnosis is:
 - i. Substance abuse; or

§ 10:73-4.4 Eligibility and referral for YCM services

ii. Developmental disability;

2. The child, youth, or young adult's CSOC assessment, or an evaluation performed by an authorized agent of the Department of Children and Families, does not indicate a need for YCM services;
3. The child, youth or young adult no longer requires YCM services to effectively function within the home and community; or
4. The child, youth or young adult or his or her parent or caregiver refuse YCM services.

(d) A child, youth, or young adult shall be discharged from YCM services if:

1. The child, youth, or young adult's CSOC assessment, ISP, and other relevant information indicate that the child, youth, or young adult no longer needs YCM services; or
2. The child, youth or young adult or his or her parent or caregiver refuse YCM services.

(e) The youth case manager shall provide information to the child, youth or young adult, or to his or her parent or caregiver, regarding accessing the appropriate level of services to meet the needs of the child, youth or young adult and shall provide assistance in the transition to the level of case management services recommended in the ISP, if such services are needed, for any child, youth or young adult who is discharged from YCM services.

History

HISTORY:

Repeal and New Rule, R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Section was "Beneficiary eligibility".

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

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§ 10:73-4.5 Youth Case Management (YCM) services; program description

(a) Youth Case Management (YCM) services are case management services provided to Medicaid/NJ FamilyCare beneficiaries of CSOC services who are under the age of 18 or those young adults between the ages of 18 and 21 who are transitioning from the child service system to the adult service system. YCM services ensure that individualized mental, emotional, and/or behavioral health services are obtained for the child, youth, or young adult by advocating for necessary mental/behavioral services and other necessary financial, educational, social, or other services to serve the needs of the child, youth, or young adult by restoring, enhancing, and maintaining an optimal level of functioning, ultimately reducing or eliminating the need for case management services.

1. YCM services that are included as part of a transition/discharge plan from inpatient psychiatric hospitalization, CMO services or other more intensive level of services, including, but not limited to, discharge from a residential mental health rehabilitation program or inpatient psychiatric hospitalization, are intended to support the maintenance of the child, youth or young adult's attained treatment goals to facilitate a successful transition from inpatient hospitalization or CMO services and prevent a relapse which would result in rehospitalization or the need for additional intensive services or return to previous out-of-home placement.

(b) YCM services shall include, but shall not be limited to:

1. Coordinating transition into YCM services in collaboration with the CSA, the family and the community providers, and facilitating transition out of YCM services to an alternate level of care and case management as appropriate, ensuring linkages are in place prior to the transition out of YCM services;
2. Assessment, which is the ongoing process of identifying, reviewing and updating a child, youth or young adult's strengths and needs, based upon input from the child, youth or young adult, the caregiver(s), significant others including family members, and behavioral health/mental health professionals. The assessment process continues throughout the entire time the child, youth or young adult receives YCM services;
3. Service planning, which is the process of organizing the outcomes of the assessment in collaboration with the child, youth or young adult, the caregivers, significant others, potential service providers, and others as designated, coordinating the receipt of the concurrent review information from provider(s) and formulating a written service plan that addresses the child, youth or young adult's needs, planned services to address these needs, and plans to remain in the community. The service planning process continues throughout the child, youth or young adult's length of stay in YCM services;
4. Services linkage, which is the ongoing referral to, and enrollment and participation in, mental health and/or non-mental health program(s). Mental health program linkage means that the child, youth or young adult has completed the mental health program's intake process, that the child, youth or young adult has been accepted for service, and that the child, youth or young adult has effectively participated in the program. Services linkage includes ensuring that individualized services are obtained for the

§ 10:73-4.5 Youth Case Management (YCM) services; program description

child, youth or young adult by facilitating linkages to community based resources and/or services included in the plan of care and preparing referral material for possible placement of the child, youth or young adult into an out-of-home treatment setting;

5. Ongoing monitoring, which consists of both beneficiary monitoring and service provider monitoring by the case manager, as follows:

i. Beneficiary monitoring, which is the ongoing review of the child, youth or young adult's status and needs, the frequency of which is contingent upon the child, youth or young adult's risk status and reported changes from the child/youth/young adult, significant others and/or service providers. An update of the service plan may result from the monitoring process to address changing needs. Beneficiary monitoring includes reviewing progress made toward the attainment of the defined treatment goals included in the individual YCM service plan, and ensuring that the child, youth or young adult and his or her family or caregiver is afforded the opportunity to participate in the beneficiary monitoring and review process; and

ii. Service provider monitoring, which is the process of routine follow-up with the child, youth or young adult's service providers to assess if services are provided as planned and if they meet the child, youth or young adult's needs. Provider monitoring may result in the adjustment of the service plan including provider changes. Service provider monitoring includes the following:

(1) Monitoring the plans, including the medication management plan for beneficiaries in need of such plans; and

(2) Coordination of services from multiple providers including calling and coordinating treatment team meetings of a child, youth or young adult's service providers until the child, youth or young adult leaves the YCM program;

6. Ongoing support services, which is the provision of face-to-face individualized support services for a child, youth or young adult and their natural support system, including their family. The frequency of support services is contingent upon the child, youth or young adult's individual needs; and

7. Advocacy, which is the process of assisting the child, youth or young adult in accessing, receiving and maintaining receipt of all benefits to which he or she is entitled. Beneficiary advocacy is an ongoing activity of the case manager, and includes advocating for services to meet the needs, desires and rights of the child, youth or young adult and his or her family or caregiver.

(c) YCM services include eligibility processing activities. All YCM providers shall:

1. Complete a presumptive eligibility (PE) application for each child, youth and young adult who is not otherwise covered under Medicaid/NJ FamilyCare at the time of the referral to the YCM, if the PE process has not already been initiated by another entity;

2. Submit all PE applications to DMAHS;

3. Assure that YCM case management and other appropriate staff complete DMAHS PE training;

4. Assist the child, youth or young adult and/or his or her family in collecting the documentation required to complete and submit a Medicaid/NJ FamilyCare application within 30 days of enrollment, if this process has not already been initiated by another entity;

5. As family circumstances indicate, review eligibility factors for each beneficiary and assist the beneficiary and/or his or her family in applying for any and all benefits for which they may be eligible, including, but not limited to, Medicaid/NJ FamilyCare; and

6. Assist the beneficiary and/or his or her family in maintaining eligibility for Medicaid/NJ FamilyCare and other benefits.

§ 10:73-4.5 Youth Case Management (YCM) services; program description

HISTORY:

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

In (a), deleted "moderate level" following "(YCM) services are"; in (b)4, inserted "and preparing referral material for possible placement of the child, youth or young adult into an out-of-home treatment setting"; in (b)5i, inserted "beneficiary monitoring and"; and added (c).

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

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§ 10:73-4.6 Referral and authorization process for Youth Case Management services

(a) The CSA shall conduct a basic preliminary screening of each child, youth, or young adult referred to the CSA by the Children's System of Care to determine the level of case management appropriate to meet the case management needs of the child, youth, or young adult. Upon determination that YCM services are needed, the CSA will refer the child, youth, or young adult and authorize YCM services for the first 90 days of service.

1. For children, youth or young adults who are court-ordered to receive a YCM assessment, the initial authorization of YCM services shall not exceed 30 days.

(b) If a child, youth or young adult is determined to need YCM services as described in this subchapter, within the first 14 days of the referral the YCM provider shall determine the specific case management needs of the child, youth or young adult and shall develop an individual service plan that includes the recommended scope and duration of mental health/behavioral health services needed as well as the scope and duration of the Youth Case Management Services. (See [N.J.A.C. 10:73-4.7.](#))

(c) For children, youth or young adults who are transitioning from a CMO, the initial authorization of YCM services shall be for 90 days and shall be authorized as part of the discharge/transition plan from the CMO. (See [N.J.A.C. 10:73-3.10.](#))

1. As part of the CMO discharge plan, the YCM agency shall participate in, at a minimum, one CMO-facilitated Child/Family Team meeting before the discharge from the CMO in order to allow YCM participation in the planning for the discharge and the transition from CMO to YCM services.

(d) For children, youth or young adults who require additional authorization for services, up to two additional 90-day periods may be authorized by the CSA if the YCM service plan indicates such YCM services are necessary, except that:

1. For those children, youth or young adults who are in an out-of-home treatment setting, the length of subsequent authorizations will coincide with the CSA authorization for additional out-of-home treatment, as indicated in the care review prepared by the out-of-home treatment provider. These authorization periods may range from 30 to 90 days.

History

HISTORY:

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

§ 10:73-4.6 Referral and authorization process for Youth Case Management services

Section was "Referral process to Youth Case Management". In (a), substituted "90" for "14"; added (a)1; in (b), inserted "shall" preceding "develop", deleted a comma following "service plan" and substituted "scope and duration of the Youth Case" for "plan to provide Youth Care"; and added (c) and (d).

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

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§ 10:73-4.7 Individual YCM service plan

(a) The individual YCM service plan shall be based on the results of the YCM agency's evaluation of the mental health/behavioral health needs as well as the case management needs of the child, youth or young adult. The YCM service plan shall be completed and registered with the CSA within 14 business days of the initial referral. Once approved and authorized by the CSA, the youth case management service provider will be authorized to provide continued YCM services. Authorizations for the individual services in the YCM service plan will be sent directly to individual provider.

(b) The child, youth or young adult's YCM service plan shall be developed in partnership with a team that shall be coordinated by the youth case manager. The YCM agency shall develop a team and shall include the following members:

1. The youth case manager assigned to the child, youth or young adult;
2. The child, youth, or young adult and the parent or caregiver; and
3. Any interested person the child, youth or young adult or their family wishes to include as a member of the team such as family, friends or clergy, and may include current providers of services as well as other entities providing formal or informal support to the child/youth/young adult and their family.

(c) Each individual YCM service plan shall include, at a minimum:

1. A summary of the strengths and existing resources of the child, youth or young adult and his or her family or caregiver;
2. Identification of the presenting problem and areas of unmet need;
3. Long and short term goals with defined and measurable objectives, including time frames for attaining the goals;
4. Recommended frequency, scope and duration of case management services, as well as the individual services needed by the child, youth or young adult;
5. Title and credentials of the individual responsible for the implementation of the specific formal and informal mental and behavioral health services provided; and
6. Discharge criteria.

(d) The individual YCM service plan shall be reviewed by the case manager a minimum of every 30 days and amended as necessary to provide the most effective level of services. Any amendments to the service plan shall be registered with, and authorized by, the CSA.

(e) The individual YCM service plan, and any subsequent amendments to the plan, shall be registered with the CSA within three business days.

History

HISTORY:

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

In (e), substituted "within three business days" for "by the end of the next business day".

Annotations

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N.J.A.C. 10:73-4.8

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

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CHAPTER 73. CASE MANAGEMENT SERVICES	>	SUBCHAPTER 4. YOUTH CASE	
MANAGEMENT (YCM) SERVICES			

§ 10:73-4.8 (Reserved)

History

HISTORY:

Repealed by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Section was "Authorization of services".

Annotations

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N.J.A.C. 10:73-4.9

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NJ - New Jersey Administrative Code > **TITLE 10. HUMAN SERVICES** >
CHAPTER 73. CASE MANAGEMENT SERVICES > **SUBCHAPTER 4. YOUTH CASE**
MANAGEMENT (YCM) SERVICES

§ 10:73-4.9 Recordkeeping

(a) YCM providers shall keep such individual records as are necessary to fully disclose the kind and extent of services provided.

(b) Each YCM provider shall maintain the following data in support of all claims:

1. The name and address of the child, youth or young adult;
2. The reason for the initial referral;
3. The name, credentials and title of the staff member(s) providing the service(s);
4. The exact date(s), time(s) and location(s) of the case management service(s) provided;
5. The total number of complete units of service provided per day;
6. The length of face-to-face contact with, or on behalf of, the child, youth or young adult (excluding travel to or from child, youth or young adult contact or collateral contact);
7. The name of individual(s) with whom face-to-face contact was maintained on behalf of the child, youth or young adult;
8. A summary of services provided in accordance with the goals of the service plan; and
9. The length of time spent in collateral activities which support the provision of YCM services.

(c) Each YCM provider shall maintain an individual service record for each child, youth or young adult which shall contain, at a minimum, the following information:

1. The date(s) of service and total number of units of service received;
2. The diagnosis provided with initial referral;
3. The reason for referral to YCM and involvement;
4. The individual service plan, including all amendments;
5. Documentation and reporting of any and all crisis or emergency situations that occur during the provision of the services, including a summary of the corrective action taken and resolution of the situation; and
6. Progress notes which include quantifiable measurements toward defined goals, as stipulated in the child, youth or young adult or young adult's service plan. Progress notes shall be completed for each contact with, or on behalf of, the child, youth or young adult. If not completed by a licensed professional, the progress notes shall be reviewed and signed off by the program supervisor.

(d) Each YCM provider shall meet all Management Information Systems specifications as defined by the Contract Systems Administrator (CSA) or other Department of Children and Families-designated agent.

§ 10:73-4.9 Recordkeeping

(e) Each YCM provider shall make the records described in (a) through (c) above available to the Department of Human Services, the Contract Systems Administrator, or other Department of Human Services or Department of Children and Families-authorized agents, as requested.

History

HISTORY:

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

In the introductory paragraph of (b), substituted "Each" for "The"; in (b)7, deleted "and" from the end; in (b)8, substituted "; and" for a period at the end; added (b)9; in the introductory paragraph of (c), substituted "Each YCM" for "The"; in (c)6, substituted "shall" for "should"; and rewrote (d) and (e).

Annotations

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N.J.A.C. 10:73-4.10

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CHAPTER 73. CASE MANAGEMENT SERVICES > **SUBCHAPTER 4. YOUTH CASE**
MANAGEMENT (YCM) SERVICES

§ 10:73-4.10 Basis of reimbursement

- (a) Reimbursement for YCM services shall be fee-for-service.
- (b) All reimbursement shall be restricted to approved Medicaid/NJ FamilyCare YCM providers and shall be subject to all applicable Medicaid/NJ FamilyCare rules, including [N.J.A.C. 10:49](#) and these rules.
- (c) A unit of service shall be defined as 15 minutes of face-to-face services or other collateral contact and activities that support the provision of youth case management services described at [N.J.A.C. 10:73-4.6\(b\)](#), provided directly to, or on behalf of, the child, youth or young adult receiving services. Non-consecutive shorter time periods shall not be added together to total 15 minutes. Transportation of a beneficiary shall not be included.
1. Examples of face-to-face services or other collateral contact and activities which can be included in calculating billable units of YCM services shall include, but are not limited to:
 - i. Preparing and reviewing a written service plan to address the needs of the child, youth, or young adult;
 - ii. Aiding in identifying and/or accessing local, State or Federal benefit programs for which the child, youth or young adult may be eligible, including telephone contact and/or working face-to-face with the child, youth, or young adult and his or her family to complete a PE application for Medicaid/NJ FamilyCare benefits; assisting the family in completing a Medicaid/NJ Family Care application; as well as assisting the family in applying for any other benefits for which they may be eligible;
 - iii. Communicating with current service providers to monitor the child, youth or young adult's progress towards attaining the goals of the service plan;
 - iv. Identifying and contacting potential service providers to meet the needs of the child, youth or young adult;
 - v. Preparing referral information for potential service providers;
 - vi. Completing paperwork and data entry for prior authorization; and
 - vii. Completing service documentation and progress notes.
- (d) When the child, youth or young adult is not the primary focus of the activity or the activity is not a reimbursable service, as specified in N.J.A.C. 10:73-5 and this subchapter, the activity shall not be included in calculating billable units of YCM services. Examples of non-billable activities shall include, but shall not be limited to:
1. Travel time to and from billable activities;
 2. Waiting time;

§ 10:73-4.10 Basis of reimbursement

3. Transportation of the child, youth or young adult, if no other YCM documented services are provided during the transportation;
 4. Supervision or supervisory time; and
 5. Administrative activities such as meetings or trainings.
- (e) Providers shall seek reimbursement for YCM services using the appropriate Healthcare Common Procedure Codes (HCPCS). (See N.J.A.C. 10:73-5.)
- (f) In no event shall the charge to the New Jersey Medicaid/NJ FamilyCare program exceed the charge by the provider for identical services to other groups or individuals in the community.
- (g) In the event a YCM child, youth, or young adult is hospitalized or admitted to a hospital for treatment of behavioral health/mental health needs or into a Joint Committee-accredited psychiatric treatment facility during a prior authorization period, the Medicaid/NJ FamilyCare program shall not be charged for YCM services rendered during the hospitalization or residency.
- (h) Providers of YCM services shall not bill for services provided while the child, youth or young adult is receiving CMO services, except that any services provided in the month in which the individual is discharged from the CMO may be billed.

History

HISTORY:

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Rewrote (c); added new (d); recodified former (d) through (g) as (e) through (h); and in (h), inserted "of YCM services", substituted "except that" for "which shall include", inserted "the" preceding "individual", and inserted "may be billed" at the end.

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

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N.J.A.C. 10:73-5.1

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CHAPTER 73. CASE MANAGEMENT SERVICES > **SUBCHAPTER 5. HEALTHCARE**
COMMON PROCEDURE CODING SYSTEM

§ 10:73-5.1 Introduction

(a) The New Jersey Medicaid/NJ FamilyCare program adopted the Centers for Medicare & Medicaid Services Healthcare Common Procedure Coding System (HCPCS) codes for 2006, established and maintained by CMS in accordance with the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, and incorporated herein by reference, as amended and supplemented, and published by PMIC, 4727 Wilshire Blvd., Suite 300, Los Angeles, CA 90010. Revisions to the Healthcare Common Procedure Coding System made by CMS (code additions, code deletions, and replacement codes) will be reflected in this chapter through publication of a notice of administrative change in the New Jersey Register. Revisions to existing reimbursement amounts specified by the Department and specification of new reimbursement amounts for new codes will be made by rulemaking in accordance with the Administrative Procedure Act, [N.J.S.A. 52:14B-1](#) et seq. The HCPCS codes as listed in this subchapter are relevant to Medicaid/NJ FamilyCare adult case management services, Medicaid/NJ FamilyCare/CSOC YCM services and care management organization services and must be used when filing a claim.

1. The responsibilities of the case management services provider when rendering adult case management services are listed in N.J.A.C. 10:73-2.
2. The responsibilities of the care management organization services provider when rendering services are listed in N.J.A.C. 10:73-3.
3. The responsibilities of the case management services provider when rendering youth case management services are listed in N.J.A.C. 10:73-4.
4. "P" is listed under Ind (indicator) which means that prior authorization is required.
5. "TJ" is listed under Mod (modifier) which means that service is rendered for children.

History

HISTORY:

Amended by R.1994 d.585, effective November 21, 1994 (operative December 1, 1994).

See: 26 N.J.R. 3350(a), 26 N.J.R. 4614(a).

Amended by R.1996 d.363, effective August 5, 1996.

See: [28 N.J.R. 1977\(a\)](#), [28 N.J.R. 3788\(a\)](#).

Amended by R.2001 d.198, effective June 18, 2001.

See: [33 N.J.R. 978\(a\)](#), [33 N.J.R. 2193\(a\)](#).

Amended by R.2001 d.475, effective December 17, 2001.

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See: [33 N.J.R. 349\(a\)](#), [33 N.J.R. 1167\(a\)](#), [33 N.J.R. 4357\(a\)](#).

In (a), rewrote the second sentence of the introductory paragraph, added 2 and recodified former 2 through 4 as 3 through 5.

Recodified from [N.J.A.C. 10:73-4.1](#) and amended by R.2005 d.78, effective February 22, 2005.

See: [36 N.J.R. 1271\(b\)](#), [37 N.J.R. 651\(a\)](#).

In (a), inserted "youth" following "Medicaid/NJ FamilyCare/Partnership for Children" in the introductory paragraph, added 3, recodified former 3 and 4 as 4 and 5 and deleted 5.

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Rewrote the introductory paragraph of (a); and in (a)5, substituted "'TJ'" for "'ZC'".

Notice of readoption with technical change, effective September 7, 2021.

See: [53 N.J.R. 1492\(a\)](#).

Annotations

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N.J.A.C. 10:73-5.2

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CHAPTER 73. CASE MANAGEMENT SERVICES > **SUBCHAPTER 5. HEALTHCARE**
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§ 10:73-5.2 HCPCS codes for case management services

<u>IND</u>	<u>Code</u>	<u>Mod</u>	<u>Description</u>	<u>Allowance</u>
P	T1017	TJ	Youth Case Management Services (unit of service=15 consecutive minutes)	\$ 20.30/unit
P	Z5008		Care Management Organization (CMO) Services for Children, Youth, and Young Adults receiving DCBHS Services; per month	\$ 960.00
	Z5006		Clinical Case Management Program/Mental Health (CMP/MH), Adults (unit of service=15 consecutive minutes)	\$ 30.19/unit

History

HISTORY:

Amended by R.1994 d.585, effective November 21, 1994 (operative December 1, 1994).

See: [26 N.J.R. 3350\(a\)](#), [26 N.J.R. 4614\(a\)](#).

Amended by R.1996 d.363, effective August 5, 1996.

See: [28 N.J.R. 1977\(a\)](#), [28 N.J.R. 3788\(a\)](#).

Amended by R.2001 d.475, effective December 17, 2001.

See: [33 N.J.R. 349\(a\)](#), [33 N.J.R. 1167\(a\)](#), [33 N.J.R. 4357\(a\)](#).

Inserted HCPCS Code Z5008.

Recodified from [N.J.A.C. 10:73-4.2](#) and amended by R.2005 d.78, effective February 22, 2005.

See: [36 N.J.R. 1271\(b\)](#), [37 N.J.R. 651\(a\)](#).

Rewrote the section.

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Rewrote the section.

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APPENDIX A

FISCAL AGENT BILLING SUPPLEMENT

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

Unisys Corporation
PO Box 4801
Trenton, New Jersey 08650-4801

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
PO Box 049
Trenton, New Jersey 08625-0049

History

HISTORY:

New Rule, R.1996 d.363, effective August 5, 1996.

See: [28 N.J.R. 1977\(a\)](#), [28 N.J.R. 3788\(a\)](#).

Amended by R.2006 d.421, effective May 21, 2007.

See: [38 N.J.R. 2585\(a\)](#), [39 N.J.R. 2096\(a\)](#).

Rewrote the introductory paragraph.

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APPENDIX A

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