



New Jersey Medicaid Supplemental Clinical Criteria

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Introduction & Instructions for Use

Introduction

The following State or Contract Specific Clinical Criteria defined by state regulations or contractual requirements are used to make medical necessity determinations, mandated for members of behavioral health plans managed by Optum and U.S. Behavioral Health Plan, California (doing business as Optum Health Behavioral Solutions of California (“Optum-CA”)).

Other Clinical Criteria may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required, or when state or contractual requirements are absent for certain covered services.

Instructions for Use

When deciding coverage, the member’s specific benefits must be referenced. All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member’s benefits prior to using these Clinical Criteria. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this Clinical Criteria and the member’s specific benefit, the member’s specific benefit supersedes these Clinical Criteria.

These Clinical Criteria are provided for informational purposes and do not constitute medical advice.

Developmental Services for Autism Spectrum Disorder

Developmental interventions for Autism Spectrum Disorder (ASD) are a social-emotional approach to promote engagement, thinking, and communication that includes:

- Relationship-based interactions with a parent or therapist/educator that consider the child’s individual sensorimotor profile, motivation, and focus of attention;
- Child-directed learning experiences where the child’s intrinsic motivations are a basis for interaction and affective social engagement is the reinforcement;

- Goals that are based on the child’s social-emotional strengths and needs;
- A heavy focus on social-emotional development and parent coaching;
- Interventions informed by the child’s stages of development and overall development;
- Play/Passion-Based interventions.

Types of Developmental Interventions

- Developmental, Individual-difference, Relationship-Based Intervention (DIR) is a Developmental, Individual-difference, and Relationship-based framework for understanding the social-emotional developmental process that begins at birth and continues through the lifespan. The “D” is the social-emotional developmental road map that is used to identify where a person is at developmentally and the next steps of development. Individual-differences are all the unique ways that each person perceives and interacts with the world including, but not limited to, health challenges, sensory processing, motor processing, auditory processing, visual perceptual and visual spatial challenges, and other biological and environmental factors unique to each individual. Finally, the “R” is the impact of social relationships on human development and how relationships are essentially needed to promote development. Floortime (aka DIRFloortime) is the most common and direct application of the DIR framework into practice.
 - Communication of Need
 - Functional Emotional Development (typically measured using the FEAS and/or clinical observation). Severity of functional emotional developmental needs as compared to typical expectations for age.
 - Identification of specific gaps or constrictions and increased needs under stress.
 - Key Dimensions
 - Availability of Natural Supports
 - Successful implementation of a DIR home program is dependent on the availability of parents or other secured attached relationships (natural supports such as nuclear and extended family that are actively involved in the child’s life) to implement the home program. The goal is to have the natural supports implement 14 to 20 hours of Floortime with the child at home. This goal can be impacted by factors including, but not limited to:
 - Individual differences of parents and natural supports including, but not limited to, emotional, physical, cognitive, sensory, or medical complications
 - Vocational demands
 - Demands of other children, especially with their own developmental challenges
 - Psychosocial stress within home affecting natural supports
 - Stability and permanency of home environment
 - It is important to note that a Floortime-based intervention can still be very effective even if there are real limitations that reduce the ability of the family (natural supports) to implement as many hours of Floortime at home. This should not make the family ineligible for Floortime. Rather, the professionals just need to develop a more comprehensive plan to support the family and to find other ways to get the intensity of services the child requires.
 - Complexity of Individual Differences
 - Children may also be receiving specific focused treatment for these issues depending on severity. The focus of the Floortime (covered under the DIR benefit) is on how these differences impact the functional emotional developmental trajectory. This is all about understanding the whole child or whole person.
 - Course of Intervention: There are a few important considerations about the course of intervention that can impact intensity of services including:
 - Initial intervention: Initial intervention often benefits from short-term high frequency of professional treatment services and may reduce the duration of professional services if the parent-mediated aspects are effectively launched.
 - Extended services without progress or very limited progress: A program with lower frequency of professional services may result in increased duration, so it is important to consider increasing frequency when duration without significant progress is evident.
 - Early intervention: A very young child first diagnosed with autism, or another developmental disorder may not have as many known complications in the other dimensions of this tool and may not be as delayed in months or years as an older child, yet all of the science and research supports that intensive early intervention is very effective in positively impacting the long-term course of the disorder and need for future treatment.
 - Minimal Floortime Program: this is the minimal program needed to guide parents/caregivers in implementing a parent-mediated intervention program, with a total of 14 to 20 hours of parent/caregiver led Floortime intervention at week.

- Outpatient DIR services are most commonly delivered either in freestanding clinic/center or home (with telehealth as appropriate). The below intensity range is for DIRFloortime specific services. Other related services may also be needed and should be assessed as usual, such as OT, SLP, Psych, PT, etc. For the Floortime specific service, the intensity range is as follows:
 - Frequency
 - Least Intense: Up to five (5) hours of professional services a week
 - Most Intense: Up to 30 hours of professional services a week
 - The actual number of professional service hours a week can be dramatically less if the DIR home program is effectively supporting the child. Remember, a fundamental component of a DIR program is for the natural supports to be the primary deliverer of the Floortime intervention. So, children with higher needs can often require less frequent professional services than this tool's findings may indicate. This is why the dimension of "Natural Supports" is an important consideration for frequency of professional services.
 - Duration
 - Duration is directly related to functional emotional developmental progress and the interconnection of the success of the implementation of a DIR home program. Since a diagnosis of autism for most individuals has lifelong implications, the duration of treatment can be significant and rarely less than 12 months. However, the goal of a DIR program is to assist the family in being able to utilize Floortime strategies at home on an ongoing basis, so the need for professional services to support the implementation of Floortime generally decreases significantly over time.
 - Treatment Plan should include:
 - Functional Emotional Development (typically measured using the FEAS and/or clinical observation).
 - Availability of Natural Supports - indicate any factors that may impact the family and natural supports in implementing 14 to 20 hours of Floortime each week at home and how this impacts the need for professional services.
 - Complexity of Individual Differences - indicate the complexity of the child's individual differences that is impacting the development of the core Functional Emotional Development Capacities (FEDCs) and how this impacts the need for professional services.
 - Safety - indicate any factors that are increasing the safety risk for the child or others around the child and how this impacts the need for professional services.
 - Course of Intervention Modifier - indicate any circumstances that need to be considered in determining the overall intensity of the DIR program.
- Developmental or Developmental Relationship-Based Behavioral Interventions (DRBI) are used to describe a range of non-DIR approaches. The developmental interventions that can be provided under this benefit include, but are not limited to:
 - RDI – Relationship Development Intervention
 - Developmental Models in Autism Interventions
 - Infant Mental Health
- Naturalistic Developmental Behavioral Intervention (NDBI) are more targeted interventions that utilize a blended developmental and behavioral approach that can be utilized under this benefit. This includes, but is not limited to:
 - ESDM – Early Start Denver Model

Provider Qualifications

- DIR services may be provided by individuals with a DIR certification and a minimum of a high school diploma when supervised by a master's-level practitioner with an advanced certification in DIR.
- New providers who possess less than a bachelor's degree must be supervised.
 - Supervised providers must be certified to provide DIR by a certification/endorsement recognized by the Department of Human Services (DHS) and possess, at a minimum, a high school diploma, or equivalent.
 - Reimbursement for supervision of each provider at this level shall be for a minimum of 1-hour a week, but not to exceed 2-hours per week.
 - Supervision services will be billed using 96156EP26 in 15-minute units.
 - Supervision services are billed concurrently with the services being provided by the DIR provider utilizing 96158EP through 96171EP.
 - Supervision must be provided face-to-face

- Treatment, assessment and treatment planning must be completed by a licensed master’s level clinician whose scope of practice allows for assessment and treatment planning. These individuals are known as DIR Qualified Healthcare Providers (QHPs).
- Only QHPs shall review/revise the treatment plan while supervising the DIR provider.
- In order for a QHP to complete a treatment plan, the QHP must have specialized training and the required level of credentials in a developmental model:
 - DIR Credentialing Organizations
 - Interdisciplinary Council on Development and Learning (ICDL)
 - Profectum Foundation
 - The Play Project
 - Greenspan Floortime Approach
 - DRBI Credentialing Organizations
 - RDI – Relationship Development Intervention credentialed by the RDI® Professional Training Program
 - DMAI – Clinical, Developmental Models of Autism Intervention credentialed by the Montclair State University Certificate of the Center of Autism and Early Childhood Mental Health
 - Infant Mental Health Endorsements credentialed by the NJAIMH – Level II and IV Infant Mental Health Endorsed – Alliance for IMH
 - NDBI Credentialing Organization
 - Early Start Denver Model (ESDM)

Providing Developmental Therapy Services

- Once an individual is appropriately diagnosed with ASD, a QHP is required to assess the child for the need of Developmental therapy and of a proposed treatment plan. Qualified individuals must be a NJFC Medicaid provider or work for a NJFC Medicaid provider.
 - Providers must be licensed by New Jersey and/or certified by a nationally accredited credentialing body or by a recognized provider of continuing education. Licensed/credentialed disciplines include, but are not limited to:
 - Licensed Clinical Social Worker (LCSW);
 - Licensed Occupational Therapist;
 - Licensed Professional Counselor (LPC);
 - Licensed Marriage and Family Therapist (LMFT);
 - Licensed Associate Counselor (LAC);
 - Licensed Social Worker (LSW);
 - Licensed Clinical Professional Counselor (LCPC);
 - Certified Special Education Teacher
- Professionals with a master’s degree or Baccalaureate degree may provide services under the supervision of a licensed or certified independent practitioner.

Coverage Rationale

- The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit to provides comprehensive services and all medically necessary services needed to correct and ameliorate health conditions for New Jersey Family Care/Medicaid recipients under the age of 21. To meet the needs of this population, existing ASD services are expanded to offer a wider array of services designed to offer a combination of therapies, each targeting a different set of skills that will support a child’s development. In addition to existing therapies, NJFC/M will now cover Developmental Services.
- Developmental Services are available to support families with children diagnosed with ASD. These services are available to any NJ Family Care/Medicaid (NJFC/M) eligible child, under the age of 21, who has been diagnosed with ASD, as defined by ICD-10 diagnosis codes F84.0 through F84.9, by a qualified healthcare provider.

Clinical Best Practices

- Assessment and Treatment Planning
 - Floortime is a way to promote development; there are no exclusionary criteria for the use of Floortime nor age restrictions
 - Floortime can be used from birth and is for higher risk children
 - As an intervention for autism, the currently acceptable and approved assessment methods are generally workable unless they are purely based on behaviors, then it won’t capture success well
 - Examples of assessments include:
 - Functional Emotional Assessment Scale (FEAS)

- Childhood Autism Rating Scale (CARS),
- Autism Diagnostic Observation Schedule (ADOS),
- Bayley Scales of Infant and Toddler Development (Bayley's)
- DIR® Intensity of Services Decision Support Tool (DIR-ISDT)
- Therapy Program
 - Typically, the same amount of OT, Speech, PT, and behavioral health services as otherwise, would be utilized
 - Parent coaching: typically, once, or twice a week. Sometimes done with and sometimes without the child present
 - Parent coaching can be provided via telehealth
- Home Program
 - Dosing model for Parents: Generally, 6-8 session per day recommended.
 - 20+ continuous, undisturbed minutes per session, preferably in the home in a space free of interruptions.
 - As parents and professionals begin to understand Floortime as both a strategy and a philosophy, hundreds of micro moments and experiences lead to “Floortime all the time and everywhere.”

Developmental Services provided should be billed using the following CPT procedure codes:

- 96156EP - Health behavior assessment or reassessment
- 96156EP26 – Supervision/treatment plan modification
- 96158EP - Health behavior intervention, individual, face-to-face, initial 30 minutes
- 96159EP - Health behavior intervention, individual, face-to-face, each additional 15 minutes
- 96164EP - Health behavior intervention, group (2 or more patients), face-to-face, initial 30 minutes
- 96165EP - Health behavior intervention, group (2 or more patients), face-to-face, each additional 15 minutes
- 96167EP - Health behavior intervention, family (with the patient present), face-to-face, initial 30 minutes
- 96168EP - Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes
- 96170EP - Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes
- 96171EP - Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes
- Modifier EP - Service provided as part of Medicaid early periodic screening diagnosis and treatment (EPSDT) program.

Adult Mental Health Rehabilitation Services

Adult Mental Health Rehabilitative Services provides services in/by a licensed community residence. Services include, but are not limited to, the following:

- Assessment and evaluation
- Individual services coordination
- Training in daily skills
- Residential counseling
- Support services
- Crisis intervention counseling services
- Medication education and facilitation of proper administration techniques
- Health care monitoring and oversight services

The goal of AMHR is to support and encourage the development of life skills required to sustain successful living in the least restrictive environment within the community.

Levels of AMHR are:

- Supervised Residence A+ - refers to licensed group homes or apartments. Community mental health rehabilitation services are available 24 hours per day, seven days a week. This includes awake overnight staff coverage.
- Supervised Residence A – refers to licensed group homes or apartments. Community mental health rehabilitation services are available 12 hours or more per day, but less than 24 hours per day, seven days a week.
- Supervised Residence B – refers to licensed group homes or apartments. Community mental health rehabilitation services are available for 4 or more hours per day, but less than 12 hours per day, seven days per week.

- Supervised Residence C – refers to licensed group homes or apartments. Community mental health rehabilitation services are available for one or more hours per week, but less than 4 hours per day.
- Family Care (Level D) – refers to a licensed program in a private home or apartment in which community mental health rehabilitation services are for 24 hours per day by a Family Care Home provider.

Admission Criteria

- The member is 18 years or older and has been diagnosed with a Serious Mental Illness that seriously impairs the member's capacity to live independently with appropriate supports as needed.
- The member is referred to AMHR by a licensed professional of the healing arts, including physicians.
- The member does not have an acute medical condition requiring inpatient hospitalization, does not need nursing home level of care, is able to evacuate the residence within 3 minutes, and is capable of managing incontinence and other medical care needs.
- Services are medically necessary.

Discharge Criteria

Any of the following conditions are met:

- The member creates a substantial, continuing, and immediate threat to the physical safety or other persons, or to the emotional or psychological health of other residents; provided, however, that the Provider Agency shall not discharge the member on this basis if the person has been civilly committed.
- The Provider Agency reasonably concludes that the member's clearly inappropriate behavior renders the program out of compliance with any agreement to which the Provider Agency is signatory as a lessee or with any applicable law or regulation.
- The member repeatedly violates a rule governing resident conduct, which is reasonable both in itself and its application, after the Provider Agency delivers to the member a written notice to cease violating such rule. No such rule shall be the basis for discharging a person unless it is reflected in a resident services agreement and/or other documents in compliance with these rules.
- The member has received maximum clinical benefit of the services offered by the Provider Agency, an appropriate alternative living arrangement (where the person has sufficient financial resources), other than a shelter, motel, or hospital, is available to the member prior to discharge, and the program reasonably determines that discharge would be in the member's best clinical interests.
- The member is absent from the residence for a continuous period of thirty (30) days without providing the Provider Agency with notice of intent to return after the expiration of the 30-day period; provided, however, that continued absence beyond 30 days shall be a condition for discharge if such absence is not in the member's clinical best interest.
- The member has refused necessary and appropriate services offered by the Provider Agency pursuant to a properly developed treatment plan; the refusal is contrary to the member's clinical best interest; the member has failed to offer any alternative plan which would be consistent with the member's clinical interest; and an alternative living arrangement other than a hospital is available.

Service Delivery

- A written comprehensive rehabilitation needs assessment for each consumer by the 14th day after admission.
- A nursing assessment is also completed within the first 14 calendar days. The assessment justifies the need for AMHR and recommends an appropriate level of service.
- The initial nursing assessment shall be used in conjunction with the comprehensive intake assessment to develop the comprehensive service plan.
- No later than 30 days after the consumer has been admitted, staff partner with the consumer to develop, implement, monitor, and update an individualized rehabilitation plan.
- Review of the individualized rehabilitation plan shall occur as follows:
 - A consumer may request a review and/or revision of the individualized rehabilitation plan at any time.
 - In addition to any request by the consumer, staff shall review and, as necessary, revise the individualized rehabilitation plan within 3 months of its development and every 3 months thereafter.
- A registered nurse or higher-level nursing professional shall provide face-to-face nursing visits every 90 days following the initial comprehensive nursing assessment while the consumer resides in a supervised residence and shall document such visits in the consumer's progress notes. In addition, where necessitated by the consumer's needs, a registered nurse or higher-level nursing professional shall visit the consumer to periodically evaluate the consumer's condition and the appropriateness of care provided by staff. These 90-day visits shall include an assessment and review of the consumer's

clinical condition, which shall assure that services are being provided consistent with the consumer's individualized rehabilitation plan.

Partial Care Services

PARTIAL CARE is an individualized, outcome-oriented mental health service, which provides a comprehensive, structured, non-residential, interdisciplinary treatment and psychiatric rehabilitation program in a community setting to assist members who have serious mental illness in increasing or maximizing independence and community living skills and enhancing the quality of their lives. Partial care services are offered to an individual age 18 or older with a primary psychiatric disorder that is accompanied by an impaired ability to perform living, learning, working or social roles. Partial care services support consumer stabilization and community integration and are alternatives to more intensive acute interventions. Partial care services provide active treatment and psychiatric rehabilitation for consumers who do not require inpatient hospitalization but require support and structured programming.

Partial Care Services assist members achieve community integration through valued living, learning, working, and social roles and to prevent hospitalization and relapse. The role of Partial Care is to facilitate the member's integration and maintenance in the community. A balance between recovery oriented and clinical services is provided to members in a comprehensive individualized manner. This involves non-residential, structured programming which provide, but are not limited to counseling, case management, psychoeducation, prevocational services, social and leisure services, and psychiatric services. Services are available on an hourly basis for up to five (5) hours a day at least five (5) times per week.

Admission Criteria

- The member is diagnosed with a severe and persistent mental illness such as
 - Schizophrenia or other Psychotic Disorders
 - Major Depressive Disorder
 - Bipolar Disorder
 - Delusional Disorder
 - Schizoaffective Disorder
 - Affective Disorders
- The member demonstrates impaired functioning that leads to a need to learn critical skills in order to achieve a valued community role and integration in at least one of the following areas on a continuing and intermittent basis for at least one year:
 - Personal self-care
 - Interpersonal relationships
 - Work
 - School
 - Ability to live in the community; or
 - Ability to acquire and/or maintain safe, affordable housing and is at risk of requiring a more restrictive living situation.
- The member is 18 years of age or older.
- There is clinical evidence to justify the necessity for partial care services. This necessity must be confirmed by the psychiatrist or advanced practice nurse and interdisciplinary treatment team and documented in the record.
- There is a need for psychiatric rehabilitation and active treatment of no less than two hours and no more than 25 hours weekly.
- The member meets one of the following:
 - The member has had one or more contacts with a screening center or emergency service mental health program
 - Two or more admissions to an inpatient behavioral health program including short term care facilities; or
 - One psychiatric hospitalization of three months or longer.
- Services are medically necessary

Exclusions

- A primary Substance Use Disorder diagnosis
- Imminent danger to self, others, or property
- A primary Developmental Disorder diagnosis
- Current participation in a PACT program

Service Delivery

- An initial service plan shall be completed during the intake process. This plan shall address the consumer's immediate needs and concerns, with special attention to urgent presenting problems, to meet immediate needs for food, clothing, shelter, and medication.
- The plan of care is designed to improve the member's condition to the point where continued participation in the program (beyond occasional maintenance visits) is no longer necessary.
- The plan of care is included in the member's records and consists of:
 - A written description of the treatment objectives including both the treatment regimen and the specific medical/remedial services, therapies, and activities that shall be used to meet the objectives;
 - A projected schedule for service delivery which includes the frequency and duration of each type of planned therapeutic session or encounter;
 - The type of personnel that will be furnishing the services; and
 - A projected schedule for completing reevaluations of the beneficiary's condition and updating the plan of care.
- The plan includes the member's self-stated overall goals related to chosen, valued roles and specific plans to achieve these roles, with target dates, including further in-depth and ongoing assessment in the identified areas.
- The plan includes a comment section under which the member states in his/her own words any concerns, agreements, or disagreements with either the development of or final service plan.
- Signatures are required on the plan of care from the member/responsible party; the clinician/provider and the physician/APN.
- The provider develops and maintains legibly written documentation to support each medical/remedial therapy service, activity, or session for which billing is made.
The individual services under partial care shall be documented on a daily basis. More substantive documentation, including progress notes and any other information important to the clinical picture, are required at least once a week.

Adult Acute Partial Hospital and Partial Hospital Services

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

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

Adult Partial Hospital Services are meant to stabilize acute symptomatology in order to divert eligible beneficiaries from the need for inpatient psychiatric hospitalization. Treatment shall be provided at a level of intensity based upon clinical evaluation and formulation.

Partial Hospital Services are meant to assist beneficiaries with severe mental illness to achieve community integration through valued living, learning, working and social roles. The role of PH is, therefore, to facilitate the beneficiary's integration into the community, not to become a permanent outcome, although it is recognized that some beneficiaries may need the support of PH for long periods of time. This balance between recovery and clinical services is accomplished through the provision of individualized, comprehensive, non-residential, structured programs which provide, but are not limited to, counseling, case management, psychoeducation, prevocational services, community integration services and psychiatric services.

Admission Criteria Acute Partial Hospital

- In order to be eligible for APH services, a beneficiary shall be at least 18 years of age or older
- At the time of referral or as a result of psychiatric evaluation provided or arranged for, have at least one of the following primary DSM-IV-TR diagnoses on Axis I:
 - Schizophrenia or Other Psychotic Disorders (298.9, 295.xx);
 - Major Depressive Disorder (296.xx);
 - Bipolar Disorders (296.xx, 296.89);

- Delusional Disorder (297);
- Schizoaffective Disorder (295.7);
- Anxiety Disorders (300.xx); or
- A covered psychiatric disorder diagnosis consistent with codes, Axis IV of the Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR as amended and supplemented, including some 301.XX Axis II codes if the personality disorder is considered in the severe range and the beneficiary is at high risk of psychiatric hospitalization;
- Have disordered thinking or mood, bizarre behavior or psychomotor agitation or retardation to a degree that interferes with activities of daily living or abilities to fulfill family, student, or work roles to such an extent that a structured intensive treatment program is needed and cannot adequately be addressed at a less restrictive level of care; the beneficiary also has a need for prescribed psychotropic medications or has a need for assistance with medication adherence; and
- Have a Global Assessment of Functioning (GAF) Scale score of between 30 and 60, as found in the DSM-IV-TR
- A beneficiary shall be referred by the local designated screening center or psychiatric emergency service as a diversion from hospitalization or by an inpatient psychiatric facility if the treating psychiatrist or APN clearly justifies acute clinical need. Additionally, for a beneficiary to receive APH services, the beneficiary must receive, from the referring treatment team, a certification containing the clinical evidence necessary to support the referral, documenting the required specific conditions.

Admission Criteria Partial Hospital

- In order to be eligible for PH services, an individual shall be at least 18 years of age or older.
- In order to be eligible for PH services, a beneficiary shall at the time of referral:
 - Have a primary diagnosis as set forth in N.J.A.C. 10:52A-3.1(c)1;
 - Have impaired functioning, which necessitates learning critical skills in order to achieve valued community roles and community integration in at least one of the following domains on a continuing, intermittent basis for at least one year or have recently decompensated to a significantly impaired status:
 - Maintenance of personal self-care;
 - Development of interpersonal relationships;
 - Ability to work;
 - Ability to receive an education;
 - Ability to live in the community; or
 - Ability to acquire or maintain safe, affordable housing when at risk of requiring a more restrictive living situation; and
 - Have a Global Assessment of Functioning (GAF) Scale scores of between 30 and 70, as set out in the DSM-IV-TR
- In order to be eligible for PH services, a beneficiary shall be referred by the APH or be significantly impaired such that a need for PH exists and receive from the interdisciplinary treatment team certification containing the clinical evidence to justify the necessity for a beneficiary to receive PH services, documenting the beneficiary's specific conditions.

Limitations and Exclusions

- An applicant or beneficiary who presents with any of the following criteria shall be excluded from participation in APH and PH services:
 - Has a primary diagnosis of substance abuse or dependence;
 - Is an imminent danger to self or others;
 - Is in need of acute medical care;
 - Is in need of detoxification;
 - Has a primary diagnosis of "developmentally disabled" as defined in the term "developmental disability" at N.J.A.C. 10:44A-1.3; or
 - Is currently participating in a PACT program, unless authorized in accordance with N.J.A.C. 10:76.

Service Delivery

- All of the following conditions shall be met for the provision of APH and PH services to each beneficiary:
 - Assigned staff shall complete an intake evaluation for each beneficiary within the identified timeframe established in N.J.A.C. 10:52A-4.7;
 - Assigned staff shall complete a comprehensive assessment for each beneficiary within the identified timeframe established in N.J.A.C. 10:52A-4.9;

- The provider shall develop and maintain an Individualized Recovery Plan for each beneficiary, and shall update that Individualized Recovery Plan within the identified timeframe established in N.J.A.C. 10:52A-4.10;
- Assigned staff shall record progress notes for each beneficiary within the identified timeframe established in N.J.A.C. 10:52A-4.11;
- Assigned staff shall develop and maintain an applicable discharge plan for each beneficiary within the identified time frame established in N.J.A.C. 10:52A-4.12;
- The provider shall monitor APH and PH services through a quality assurance, utilization review and outcome protocol;
- Program hours of service:
 - APH and PH providers shall make services available to beneficiaries a minimum of five hours per day and a minimum of five days per week at the times most needed by the beneficiaries;
- After conducting a treatment team evaluation, the treatment team shall certify that a beneficiary requires the services of APH or PH in strict accordance with the beneficiary eligibility requirements set forth in this chapter;
- After the initial service plan required by N.J.A.C. 10:52A-4.7 has been developed, the treatment team shall examine the beneficiary to determine whether the beneficiary needs APH service. If so, the treatment team shall prepare a certification to that effect at least every 30 days to document that clinical evidence exists for continued stay.
- With respect to PH services, the treatment team shall examine the beneficiary and, if appropriate, prepare such a certification, every 60 days to document whether clinical evidence exists for continued stay; and
 - APH programs shall maintain affiliation agreements with local psychiatric community designated screening centers and inpatient hospital programs.
- Psychiatric services in APH:
 - APH providers shall provide a face-to-face, individual encounter with a psychiatrist or an advanced practice nurse a minimum of every other week for at least 15 minutes in APH. More frequent encounters may be required as deemed clinically necessary during all program hours based upon the beneficiaries' symptomatology and acuity;
- Treatment services and interventions which assist a beneficiary to resolve an immediate crisis and attain stabilization in order to remain in the community through the support of a less intensive service, which include the following:
 - Individual and group therapy to help identify and manage symptoms and interpersonal problems that contribute to a greater risk of decompensation and relapse. This may include clinical approaches, such as Motivational Interviewing,
 - Dialectical Behavioral Therapy (DBT), Cognitive Behavioral Therapy (CBT) and Cognitive Remediation/Rehabilitation interventions. Staff-to-client ratio in therapy groups shall not exceed 1:10;
 - Cognitive behavioral skill-building groups focused on affect regulation, stress management and problem solving to promote independence;
 - Relapse prevention groups to provide psychoeducation and to teach implementation skills; and
 - Promotion of the beneficiary's commitment to change problematic behaviors and to follow up with aftercare plans;
- Medication-related services, as needed, which include the following:
 - Medication counseling and education, as provided in N.J.A.C. 10:37-6.53 and 6.54;
 - Information regarding, and documentation of, each beneficiary's current medication treatment or therapies;
 - Procedures by which staff share clinical information regarding medication utilization;
 - Educating beneficiaries, staff and other caregivers regarding adverse drug reactions, potential side effects and management procedures for responding to crisis situations; and/or
 - Medication education provided within the context of a collaborative and therapeutic relationship. Beneficiaries shall be provided with adequate information in an understandable format regarding a medication's relative effectiveness and safety in order to make an informed decision. Interventions such as medication self-management, behavioral tailoring, simplifying a beneficiary's medication regimen and motivational interviewing assist and support beneficiaries in adhering to their medication regimens. A provider shall specifically review with the beneficiary how medication management issues will impact upon the beneficiary's personal recovery goals and shall be responsible for involving family members whenever possible;
- Integrated treatment for co-occurring mental health and substance uses disorders, which is a distinct clinical approach combining mental health and addiction into a unified, comprehensive, and blended philosophy which provides prevention, intervention and treatment techniques which simultaneously address the beneficiary's needs;
- Assessment and regular monitoring of co-occurring physical health needs to include procurement of medically necessary treatment(s) and services;
- Beneficiary outreach to facilitate continued participation in the APH program;
- Integrating the support of family and significant others into a beneficiary's treatment plan;

- Other planning activities, which may include the development of an advance directive, meeting the requirements of P.L. 2005, c. 233, with specific instructions on what steps need to be taken in the event of a relapse and the development of a personal wellness and recovery action plan;
- Environmental and safety procedures, which conform with N.J.A.C. 10:37D-2.5 and 10:37F-2.7;
- Referral procedures for crisis intervention in the event the beneficiary experiences exacerbation of medical or psychiatric symptoms; and
- An illness management and recovery program, comprised of a broad set of strategies and activities, which help a beneficiary collaborate with practitioners to identify and pursue personally meaningful recovery goals founded upon a core set of interventions that include psychoeducation, social skills training, cognitive-behavioral therapy, motivational interviewing and behavioral tailoring and relapse prevention techniques. This is accomplished by helping each beneficiary to develop coping strategies and skills which reduce the beneficiary's susceptibility to the illness, provide assistance and support to effectively manage symptoms to prevent relapse and rehospitalizations and reduce distress to the point where the beneficiary can enjoy an improved quality of life. The interventions are intended to be both didactic
- and practical in nature and can be provided in both group and individual settings. Such services shall be provided directly to beneficiaries and in support of family members or other significant individuals important to the beneficiaries. The services shall include, but are not limited to:
 - Coping skills, adaptive problem solving and social skills training, which teach a beneficiary strategies to self-manage symptoms and personal stress and strengthen life skills and abilities to attain his or her recovery goals;
 - Psychoeducation, which provides factual information, recovery practices, including evidence-based models concerning mental illness which instills hope and emphasizes the potential for recovery. Such services shall be geared toward the beneficiary developing a sense of mastery over his or her illness and life and shall be effective in reducing relapse and rehospitalizations. The services may also provide support to the beneficiary's family and other members of the beneficiary's social network to help them manage the symptoms and illness of the beneficiary and reduce the level of family and social stress associated with the illness;
 - Development of a comprehensive relapse prevention plan which offers skills training and individualized support focused on self-management of mental illness and other aspects of recovery, including early recognition, identification and management of symptoms and positive coping strategies and development of supports to reduce the severity and distress of disturbing symptoms. Special attention shall be placed on understanding, recognizing, and monitoring of stressors which have triggered return of persistent symptoms in the past. In addition, adaptive problem-solving techniques shall be applied to avoid recurrences in the future;
 - Dual disorder education which provides basic information to beneficiaries, family members or other significant individuals on the nature and impact of substance use and how it relates to the symptoms and experiences of mental illness and its treatment, as well as upon the attainment of the beneficiary's personal recovery goals;
 - Medication education to be provided within the context of a collaborative and therapeutic relationship. Each beneficiary shall be provided with adequate information in an understandable format regarding each medication's relative effectiveness and safety in order to make an informed decision. Interventions such as medication self-management, behavioral tailoring, simplifying a beneficiary's medication regimen and motivational interviewing assist and support a beneficiary in adhering to a medication regimen. Practitioners shall specifically review with the beneficiary how medication management issues will impact the beneficiary's personal recovery goals and shall be responsible for involving family members whenever possible; and
 - Wellness activities consistent with the beneficiary's self-identified recovery goals. Wellness activities may address common physical health problems such as tobacco dependency, alcohol use, sedentary lifestyle, lack of physical exercise, overeating or poor nutrition. Other wellness services may address goals such as constructive use of leisure time and fulfilled spirituality and creativity pursuits.

Length and Hours of Service

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

- Length of service for PH. PH service is limited to 24 months per beneficiary. However, in calculating this 24-month period, time spent in both PH and APH shall be included.
 - Beneficiaries receiving PH services shall receive no less than two hours of services per day and no more than five hours of services per day. Beneficiaries receiving PH services shall receive a maximum of 25 hours of services per week

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State of New Jersey, Newsletter, Volume 30 (March 2023). Provision of the Developmental, Individual Difference, Relationship-Based Model (DIR), Effective April 1, 2023.

Revision History

Date	Summary of Changes
June, 2014	Version 1
January, 2015	Version 2
January, 2016	Version 3
July, 2017	Version 4
October, 2018	Version 5
January, 2019	Version 6-Added Partial Care Services guideline.
January, 2020	Version 7- Updated Introduction & Instructions for Use; added Evidence-Based Practice Criteria section.
October, 2020	Version 8 – Annual Review
April, 2021	Version 9 – Annual Review - Added Developmental Services for ASD
September, 2022	Version 10 – Annual Review – Added Acute Partial and PHP.
May, 2023	Version 11 – Mid-term Review – DIR requirements update