

i. Hemoglobin/Hematocrit three times: six to eight months; two to three or four to six years; and 10 to 12 years.

ii. Urinalysis a minimum of twice: 18 to 24 months and 13 to 15 years.

iii. Tuberculin test (Mantoux): nine to 12 months; and annually thereafter.

iv. Lead screening using blood lead level determinations between six and 12 months, at two years of age, and annually up to six years of age. At all other visits, screening shall consist of verbal risk assessment and blood lead level test, as indicated; and

v. Other appropriate screening procedures, if medically necessary (for example: blood cholesterol, test for ova and parasites, STD).

8. Health education and anticipatory guidance; and

9. An offer of social service assistance; and, if requested, referral to a county welfare agency.

(k) The record and documentation of a Home Visit or House Call shall become part of the office progress notes and shall include, as appropriate, the following information:

1. The purpose of visit;
2. Pertinent history obtained;
3. Pertinent physical findings, including pertinent negative physical findings based on (k)1 and 2;
4. The procedures, if any performed, with results;
5. Lab, X-ray, ECG, etc., ordered with results; and
6. Diagnosis(es) plus treatment plan status relative to present or pre-existing illness(es) plus pertinent recommendations and actions.

10:58A-1.5 Basis of reimbursement

(a) A claim is a request for payment for a Medicaid-reimbursable or NJ KidCare-reimbursable service provided to a Medicaid eligible or NJ KidCare-eligible individual. The claim may be submitted via hard copy or by means of an approved method of automated data exchange.

(b) An approved New Jersey Medicaid or NJ KidCare CNP/CNS provider (see N.J.A.C. 10:58A-1.3, Provisions for participation) shall be reimbursed on a fee-for-service basis in accordance with N.J.A.C. 10:58A-4. Reimbursement shall be limited to payment for medically necessary covered services provided within the appropriate scope of practice in accordance with the individual category of certification for advanced practice. The applicable categories of advanced practice are defined by the New Jersey State Board of Nursing in N.J.A.C. 13:37-7.11 as further amended.

(c) CNP/CNS services may be reimbursed (see N.J.A.C. 10:49-7 and 10:49-8) under either of two billing mechanisms provided by Medicaid or NJ KidCare for reimburse-

ment of his or her services. The two mechanisms are: a direct billing entity as stated in this chapter, or an employee reimbursed by another Medicaid or NJ KidCare provider who bills Medicaid or NJ KidCare on behalf of the CNP/CNS's services, that is physician employer, group, clinic or hospital.

1. When a CNP/CNS is employed by a practitioner/physician group, the Medicaid or NJ KidCare program does not routinely reimburse both a CNP/CNS visit and, on the same day, a visit to an MD or DO within the same billing entity.

i. If specific circumstances should require the two same-day visits, however, the provider entity shall document the medical necessity for the second visit (see concurrent care in (a)2 below).

ii. If a patient receives care from more than one member of a group practice, a partnership or corporation in the same specialty, the total maximum fee allowance shall be the same as that for a single practitioner.

2. Concurrent care will be reimbursed under the following circumstances:

i. If concurrent care is provided, it shall be clearly documented that significant medical necessity exists for more than one clinician's services, as defined at N.J.A.C. 10:58A-1.2; and

ii. At such time as the patient's condition permits, the primary practitioner/physician shall either resume sole responsibility or transfer the patient to the practitioner/physician supplying additional (concurrent) care.

3. A nurse practitioner and her or his collaborating physician shall not bill for concurrent care except when the concurrent care is necessary for admitting a patient for inpatient hospital care, treating a medical emergency, or arranging for prescriptions for controlled drugs. Such concurrent care is normally limited to a single visit.

4. A CNP/CNS-initiated consultation to another health care professional, excluding another CNP/CNS, will be allowed under the following conditions:

i. Where a medical condition requires evaluation from more than one perspective, discipline or specialty;

ii. Where significant medical necessity exists; and

iii. Where, subsequent to the consultation, the primary practitioner will either resume sole responsibility or transfer the patient to the consultant.

5. When Division review of the documentation of a consultation fails to demonstrate medical necessity, reimbursement will be denied to the physician rendering the consultation.

6. A collaborating physician shall not bill for a consultation for the patient of the CNP/CNS. When it becomes necessary to admit a patient for inpatient hospital care, or to prescribe controlled drugs, the collaborating physician may bill for concurrent care. Such concurrent care is limited to a single visit for each episode.

(d) A CNP/CNS shall not be reimbursed as an independent provider by the New Jersey Medicaid program when the program is required to reimburse an approved provider through another mechanism for these same services, for example, a hospital or home health agency-salaried CNP/CNS whose salary is included in the Medicaid rate.

1. If a CNS/CNP is employed by a physician, a physician group, another practitioner or practitioner group, a hospital, an independent clinic or other similar health care entity who is a Medicaid provider, the CNP/CNS is referred to Physician Services (N.J.A.C. 10:54) or Hospital Services (N.J.A.C. 10:52), or Independent Clinic Services (N.J.A.C. 10:66) for regulations and billing instructions.

i. Practitioners rendering services in clinics cannot bill fee-for-service. The clinic must bill for all services rendered in the clinic setting.

(e) When billing, a CNP/CNS shall use her or his Medicaid Provider Servicing Number (MPSN) to identify each service she or he has performed as separate and distinct from services of any other provider.

(f) CNP/CNS providers shall certify that they have personally rendered any services for which they have billed.

(g) Payment for CNP/CNS services covered under the New Jersey Medicaid program is based upon the customary charge prevailing in the community for the same service but shall not exceed the "Maximum Fee Allowance Schedule" specified in N.J.A.C. 10:58-4. In no event shall the charge to the New Jersey Medicaid program exceed the charge by the provider for identical services to other individuals, groups or governmental agencies.

1. A CNP/CNS billing independently receives direct payment from Medicaid for his or her services under the provisions of this chapter. Reimbursement is on a fee-for-service basis.

2. The submittal and processing of claims requires the entry of two numbers on the claim form: the Medicaid Provider Billing Number and the Medicaid Provider Servicing Number.

i. The Medicaid Provider Billing Number and Servicing Numbers are identical when the CNP/CNS is a solo practitioner who bills Medicaid directly for his or her services. The single number is entered on the claim form as the provider billing number and the identifier of the practitioner who rendered the service.

ii. If the CNP/CNS is a member of a CNP/CNS practitioner group, the number assigned to the practitioner group will be the Medicaid Provider Billing Number. The number assigned to the CNP/CNS practitioner will be the Medicaid Provider Servicing Number. (See Fiscal Agent Billing Supplement for instructions for filling out the claim form.)

iii. When an employer of the practitioner (such as a physician, independent clinic, or similar health care organization) bills on behalf of the services rendered by a CNP/CNS practitioner, the Medicaid Provider Billing Number is the number of the employer. The identifier of the CNP/CNS practitioner rendering the service will be the Medicaid Provider Servicing Number.

(h) Reimbursement is not made for, and clients may not be asked to pay for, broken appointments.

Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

See: 30 N.J.R. 1060(a).

In (a) through (c), inserted references to NJ KidCare throughout.

10:58A-1.6 Personal contribution to care requirements for NJ KidCare-Plan C

(a) General policies regarding the collection of personal contribution to care for or NJ KidCare-Plan C fee-for-service are set forth in N.J.A.C. 10:49-9.

(b) Personal contribution to care for or NJ KidCare-Plan C services is \$5.00 a visit for office visits, except when the service is provided for preventive care or for family planning services.

1. An office visit is defined as a face-to-face contact with a medical professional, which meets the documentation requirements at N.J.A.C. 10:58A-1.4.

2. Office visits include CNP/CNS services provided in the office, patient's home, or any other site, except a hospital, where the child may have been examined by the CNP/CNS. Generally, these procedure codes are in the 90000 HCPCS series of reimbursable codes at N.J.A.C. 10:58A-4.

3. CNP/CNS services which do not meet the requirements of an office visit as defined in this chapter, such as surgical services, immunizations, laboratory or x-ray services, do not require a personal contribution to care.

(c) CNPs/CNSs shall not charge a personal contribution to care for services provided to newborns, who are covered under fee-for-service for Plan C; for family planning services, for substance abuse treatment services, for prenatal care or for preventive services, including appropriate immunizations.

New Rule, R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

See: 30 N.J.R. 1060(a).

SUBCHAPTER 2. PROVISION OF SERVICES

10:58A-2.1 General provisions

(a) This subchapter describes the New Jersey Medicaid programs' policies and procedures for the provision of Medicaid-covered services by certified nurse practitioner/clinical nurse specialist providers. Services are separately identified and discussed only where unique characteristics or requirements exist. Unless indicated otherwise, reimbursement provisions are located in N.J.A.C. 10:58A-1.5, Basis for reimbursement.

(b) The New Jersey Medicaid program shall reimburse for CNP/CNS services provided only when the patient is an eligible Medicaid client at the time services are rendered. CNP/CNSs shall verify the patient's current eligibility status prior to providing services.

10:58A-2.2 Provisions concerning medical services

(a) For patient contacts where the patient presents with a chief complaint, the evaluation and management procedure codes at N.J.A.C. 10:58A-4.2(r)1 through 6 shall be applied.

(b) In the absence of patient complaints, the Preventive Medicine services codes and the Newborn Care code shall be applied for adults and for children. See N.J.A.C. 10:58A-4.2(r)7 and 8.

10:58A-2.3 Surgical procedures

Typically, office visits are not reimbursed in combination with surgical procedures. (When two services are rendered, for example, an office visit and a surgical procedure, the program will pay the higher fee, either the visit or the procedure.) The procedure codes within the CNP/CNS scope of practice which are excluded from the general policy are: 29105 through 29740 (see N.J.A.C. 10:58A-4.2(d), (e) and (f)), 31720, and 36415.