

CHAPTER 58A

CERTIFIED NURSE PRACTITIONER/CLINICAL
NURSE SPECIALIST

Authority

N.J.S.A. 45:11-23 et seq.; N.J.A.C. 13:37; P.L. 1991, c. 377; N.J.S.A. 30:4D-6b(17), 7a, b and c; 30:4D-12; 1905(a)21 of the Social Security Act, 42 U.S.C. 1396d(a).

Source and Effective Date

R.1995 d.501, effective September 5, 1995.
See: 27 N.J.R. 2158(a), 27 N.J.R. 3343(a).

Executive Order No. 66(1978) Expiration Date

Chapter 58A, Certified Nurse Practitioner/Clinical Nurse Specialist, expires on September 5, 2000.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. GENERAL PROVISIONS

- 10:58A-1.1 Introduction: certified nurse practitioner and clinical nurse specialist
- 10:58A-1.2 Definitions
- 10:58A-1.3 Provider participation
- 10:58A-1.4 Recordkeeping
- 10:58A-1.5 Basis of reimbursement
- 10:58A-1.6 Personal contribution to care requirements for NJ Kid-Care-Plan C

SUBCHAPTER 2. PROVISION OF SERVICES

- 10:58A-2.1 General provisions
- 10:58A-2.2 Provisions concerning medical services
- 10:58A-2.3 Surgical procedures
- 10:58A-2.4 Pharmaceutical services
- 10:58A-2.5 Medical exception process (MEP)
- 10:58A-2.6 Clinical laboratory services
- 10:58A-2.7 Evaluation and management services
- 10:58A-2.8 Family planning services
- 10:58A-2.9 Mental health services
- 10:58A-2.10 PASARR, Pre-Admission Screening (PAS) and Annual Resident Review (ARR)
- 10:58A-2.11 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

SUBCHAPTER 3. HEALTHSTART

- 10:58A-3.1 HealthStart service
- 10:58A-3.2 Purpose
- 10:58A-3.3 Scope of services
- 10:58A-3.4 HealthStart provider participation criteria
- 10:58A-3.5 Termination of HealthStart Provider Certificate
- 10:58A-3.6 Records: documentation, confidentiality and informed consent for HealthStart maternity care providers
- 10:58A-3.7 Health support services
- 10:58A-3.8 Standards for HealthStart pediatric care certificate
- 10:58A-3.9 Professional requirements for HealthStart pediatric care providers
- 10:58A-3.10 Preventive care services by HealthStart pediatric care providers
- 10:58A-3.11 Referral services by HealthStart pediatric care providers
- 10:58A-3.12 Records: documentation, confidentiality and informed consent for HealthStart pediatric care providers
- 10:58A-3.13 HealthStart services

SUBCHAPTER 4. HCFA COMMON PROCEDURE
CODING SYSTEM (HCPCS)

- 10:58A-4.1 Introduction to the HCPCS procedure code system
- 10:58A-4.2 HCPCS procedure code numbers and maximum fee allowance schedule (Level I)
- 10:58A-4.3 HCPCS procedure codes and maximum fee allowance schedule for Level II codes and narratives
- 10:58A-4.4 HCPCS procedure codes and maximum fee allowance schedule for Level III codes and narratives
- 10:58A-4.5 HCPCS procedure codes—qualifiers

APPENDIX

SUBCHAPTER 1. GENERAL PROVISIONS

10:58A-1.1 Introduction: certified nurse practitioner and
clinical nurse specialist

(a) This chapter is concerned with the provision of health care services by certified nurse practitioners and clinical nurse specialists (CNP/CNS), in accordance with the New Jersey Medicaid Program policies and procedures and the standards set forth by the New Jersey Legislature (N.J.S.A. 45:11-23 et al. and P.L. 1991, c.377) and by the New Jersey Board of Nursing (N.J.A.C. 13:37-7).

(b) An approved New Jersey Medicaid CNP/CNS provider may be reimbursed for medically necessary covered services provided within the scope of her or his license, and her or his approved New Jersey Medicaid Program Provider Agreement.

(c) A CNP/CNS may enroll in the New Jersey Medicaid program and provide covered, medically necessary services as an independent practitioner, or may provide such services as part of another entity, such as a hospital or clinic, physician group practice, or a mixed practitioner practice.

10:58A-1.2 Definitions

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

“Ambulatory care facility” means a health care facility or a distinct part of a health care facility, licensed by the New Jersey State Department of Health, which provides preventive, diagnostic and treatment services to persons who come to the facility to receive services and depart from the facility on the same day.

“Certified nurse practitioner/clinical nurse specialist (CNP/CNS)” means a person currently licensed to practice as a registered professional nurse who is certified by the New Jersey State Board of Nursing in accordance with N.J.A.C. 13:37-7, and with N.J.S.A. 45:11-49a through d, or

similarly licensed and certified by a comparable agency of the state in which he or she practices.

“Certified nurse practitioner/clinical nurse specialist (CNP/CNS) services” means those services provided within the scope of practice of a licensed professional nurse (R.N.) and the certification as a CNP or CNS, defined by the laws and rules of the State of New Jersey, or if in practice in another state, by the laws and regulations of that state.

“Concurrent care” means care rendered to a patient by more than one practitioner/physician where the dictates of medical necessity require the services of one or more clinicians in addition to the attending clinician, so that appropriate and needed care may be provided to the patient.

“Consultation” means the professional evaluation of a patient from a perspective different from that of the treating practitioner, in order to bring enhanced clinical expertise for the benefit of the patient.

“Discipline” means a branch of instruction or learning, such as medicine, dentistry, advanced practice nursing, or chiropractic.

“Early and Periodic Screening, Diagnosis and Treatment (EPSDT)” means a preventive and comprehensive health program for Medicaid recipients through 20 years of age, including the assessment of an individual’s care needs through initial and periodic examinations (screenings), the provision of health education and guidance, and the assurance that any identified health problems are diagnosed and treated at the earliest possible time.

“Federally Qualified Health Center (FQHC)” means an entity that is receiving a grant under Section 329, 330, or 340 of the Public Health Service Act, section 1905(l) of the Social Security Act, 42 U.S.C. § 1396(l); or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under Section 329, 330, or 340 of the Public Health Service Act; or, based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant; or was treated by the Secretary, for purposes of Medicare Part B, as a Federally Funded Health Center as of January 1, 1990.

“HealthStart” means the program of health services provided to pregnant women, infants and small children, as defined at N.J.A.C. 10:49-1.4, Administration, and at N.J.A.C. 10:58A-3.

“HealthStart Maternity Care Services” means a comprehensive package of maternity care services which includes two components, “Medical Maternity Care” and “Health Support Services.” (See N.J.A.C. 10:58A-3 for information about HealthStart Services and provider requirements for participation.)

“HealthStart Maternity (Comprehensive) Care Services Provider” means a practitioner who provides HealthStart Maternity Care services either directly, or indirectly through linkage with other practitioners, in independent clinics, hospital outpatient departments, or physicians’ offices.

“HealthStart pediatric care provider” means a group of practitioners, a hospital, an independent clinic, or practitioner approved by the New Jersey State Department of Health and the New Jersey Medicaid program to provide a comprehensive package of pediatric care services.

“Independent clinic” means a facility that is not part of a hospital, but is organized and operated in accordance with N.J.A.C. 10:66-1.1 and 42 C.F.R. 440.90.

“Mental health clinic” means a freestanding independent community facility or distinct component of a multi-service ambulatory care facility, which meets the minimum standards established by the Community Mental Health Services Act implementing rules at N.J.A.C. 10:37.

“Mental illness”, for purposes of PASARR, refers to a condition which can be disabling and/or chronic, such as schizophrenia, mood disorder, paranoia, panic or other severe anxiety disorder, as described in the *International Classification of Diseases, Ninth Revision (ICD-9(M))*, and which can lead to a chronic disability. (See PASARR, N.J.A.C. 10:58A-2.9.)

“Physician” means a doctor of medicine (M.D.) or osteopathy (D.O.) licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners or similarly licensed by a comparable agency of the state in which he or she practices.

“Practitioner” refers to a certified nurse practitioner/clinical nurse specialist (CNP/CNS) as defined by this rule. Practitioners are responsible for examining, diagnosing, treating and counseling patients, and ordering medications, within their specific scope of practice, as defined by the New Jersey Board of Nursing. On occasion, this chapter defines procedures which are provided by CNP/CNSs and by physicians; in these instances, the term “practitioner/physician” is used.

“Pre-Admission Screening and Annual Resident Review (PASARR)” means an evaluation or screening to assess potential or actual nursing facility (NF) residents in respect to mental illness and/or mental retardation, in order to assure that the resident is provided with appropriate services, and to ensure that the NF admits residents whose needs can be met by the services normally provided by the facility.

“Specialty” means a health care practice within a discipline such as pediatrics, obstetrics/gynecology, orthodontics or periodontics. A list of the specializations applicable to CNP/CNSs can be found at N.J.A.C. 10:58A-1.3(e).

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 mecha-

nisms provided by Medicaid or NJ KidCare for reimbursement 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.

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.

See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 without change.

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 NJ KidCare-Plan C fee-for-service are set forth in N.J.A.C. 10:49-9.

(b) Personal contribution to care for NJ KidCare-Plan C services is \$5.00 a visit for office visits, except as noted in (c) below.

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).

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.

See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 with changes, effective September 21, 1998.

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.

10:58A-2.4 Pharmaceutical services

(a) All covered pharmaceutical services provided by CNP/CNSs under the New Jersey Medicaid program shall be prescribed in accordance with N.J.A.C. 13:37-7.6 and 7.7; N.J.A.C. 10:49, N.J.A.C. 10:51, and this chapter.

(b) The Pharmaceutical Services manual, N.J.A.C. 10:51, sets forth the provisions for covered and non-covered pharmaceutical services, prior authorization, quantity of medication, administration of drugs, pharmaceutical dosage and directions, telephone-rendered original prescriptions,

changes or additions to the original prescription, non-proprietary or generic dispensing, and prescription refill.

(c) Medicaid will reimburse the practitioner directly for the cost of the drugs described at N.J.A.C. 10:58A-4.3 and 4.4.

Amended by R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).

See: 31 N.J.R. 245(a), 31 N.J.R. 1956(a).

10:58A-2.5 Medical exception process (MEP)

(a) For pharmacy claims with service dates on or after September 1, 1999, which exceed PDUR standards recommended by the New Jersey DUR Board and approved by the Commissioners of DHS and DHSS, the Division of Medical Assistance and Health Services has established a Medical Exception Process (MEP).

(b) The medical exception process (MEP) shall be administered by a contractor, referred to as the MEP contractor, under contract with the Department of Human Services.

(c) The medical exception process shall apply to all pharmacy claims, regardless of claim media, unless there is a recommended exemption by the New Jersey DUR Board which has been approved by the Commissioners of DHS and DHSS, in accordance with the rules of those Departments.

(d) The medical exception process is as follows:

1. The MEP contractor shall contact prescribers of conflicting drug therapies, or drug therapies which exceed established PDUR standards, to request written justification to determine medical necessity for continued drug utilization.

i. The MEP contractor shall send a Prescriber Notification Letter which includes, but may not be limited to, the beneficiary name, HSP identification number, dispense date, drug quantity, drug description. The prescriber shall be requested to provide the reason for medical exception, diagnosis, expected duration of therapy, and expiration date for medical exception.

ii. The prescriber shall provide information requested on the Prescriber Notification to the MEP contractor.

2. Following review and approval of a prescriber's written justification, if appropriate, the MEP contractor shall override existing PDUR edits through the issuance of a prior authorization number.

3. The MEP contractor shall notify the pharmacy and prescriber of the results of their review and include at a minimum, the beneficiary's name, mailing address, HSP number, the reviewer, service description, service date, and prior authorization number, if approved, the length of the approval and the appeals process if the pharmacist does not agree with the results of the review.

4. Prescribers may request a fair hearing to appeal decisions rendered by the MEP contractor concerning denied claims (see N.J.A.C. 10:49-10, Notices, Appeals and Fair Hearings).

5. Claims subject to the medical exception process which have not been justified by the prescriber within 30 calendar days shall not be authorized by the MEP contractor and shall not be covered.

New Rule, R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).

See: 31 N.J.R. 245(a), 31 N.J.R. 1956(a).

Former N.J.A.C. 10:58A-2.5, Clinical laboratory services, recodified to N.J.A.C. 10:58A-2.6.

10:58A-2.6 Clinical laboratory services

(a) "Clinical laboratory services" means professional and technical laboratory services performed by a clinical laboratory certified by HCFA in accordance with the Clinical Laboratory Improvement Act (CLIA) and ordered by a physician or other licensed practitioner, within the scope of his or her practice, as defined by the laws of the State of New Jersey and/or of the state in which the practitioner practices.

(b) Clinical laboratory services are furnished by clinical laboratories and by physician office laboratories (POLs) that meet the Health Care Financing Administration regulations pertaining to clinical laboratory services defined in the Clinical Laboratory Improvement Amendments (CLIA) of 1988, section 1902(a)(9) of the Social Security Act, 42 U.S.C. § 1396(a)(9), and as indicated at N.J.A.C. 10:61-1.2, the Medicaid program's Independent Clinical Laboratory Services manual, and N.J.A.C. 8:44 and N.J.A.C. 8:45.

(c) All independent clinical laboratories and other entities performing clinical laboratory testing shall possess certification as required by CLIA 1988, and the New Jersey Department of Health rules found in N.J.A.C. 8:44 and N.J.A.C. 8:45.

(d) A CNP/CNS may claim reimbursement for clinical laboratory services performed for his or her own patients within his or her own office, subject to the following:

1. A CNP/CNS shall meet the conditions of the CLIA regulations before she or he may perform clinical laboratory testing for Medicaid recipients; and

2. The clinical laboratory tests shall be standard clinical laboratory procedures consistent with the CNP/CNS's CLIA certification, certificate of waiver or certificate of registration as an independent clinical laboratory.

(e) When the clinical laboratory test is performed on site, the venipuncture is not reimbursable as a separate procedure: its cost is included within the reimbursement for the lab procedure.

(f) When the CNP/CNS refers a laboratory test to an independent clinical reference laboratory:

1. The clinical reference laboratory shall be certified under the CLIA as described above at (a) and (b) to perform the required laboratory test(s);

2. The clinical laboratory shall be licensed by the New Jersey State Department of Health, as described above at (b) and (c), or comparable agency in the state in which the laboratory is located;

3. The clinical laboratory shall be approved for participation as an independent laboratory provider by the New Jersey Medicaid program in accordance with (b) above, and

4. Independent clinical laboratories shall bill the New Jersey Medicaid program for all reference laboratory work performed on their premises. The CNP/CNS will not be reimbursed for laboratory work performed by a reference laboratory.

Recodified from N.J.A.C. 10:58A-2.5 by R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).

See: 31 N.J.R. 245(a), 31 N.J.R. 1956(a).

Former N.J.A.C. 10:58A-2.6, Evaluation and management services, recodified to N.J.A.C. 10:58A-2.7.

10:58A-2.7 Evaluation and management services

(a) The evaluation and management codes can indicate services performed in a practitioner's office, in nursing facilities and residential health care facilities, in clinics, in Federally qualified health centers (FQHCs), and in inpatient hospitals.

(b) Reimbursement for an initial office visit or initial residential health care facility visit will be disallowed, if a preventive medicine service, EPSDT examination or office consultation was billed within a 12 month period by the same practitioner, group of practitioners, or shared health care facility sharing a common record.

(c) Provisions for initial visits, evaluation and management, are:

1. For office visits and for other care apart from inpatient hospital, providers are permitted to bill for an initial visit only once for a specific patient, subject to the following exceptions.

i. When a shared health care facility, a group of physicians and/or other practitioners (CNP's or CNS's) share a common record, the Division will reimburse only one initial visit to that provider group.

ii. Further encounters with that patient will be billed and reimbursed by means of "established patient" codes. See N.J.A.C. 10:58A-4.1 through 4.5.