CHAPTER 58A

CERTIFIED NURSE PRACTITIONER/CLINICAL NURSE SPECIALIST

Authority

N.J.S.A. 30:4D–6, 7 and 12, and Section 1902(a)10 of the Social Security Act (42 U.S.C. § 1396a), Section 1902(a)33 of the Social Security Act (42 U.S.C. § 1396a(a)33), Section 1905(a)21 of the Social Security Act (42 U.S.C. 1396d), Section 2102 of the Social Security Act (42 U.S.C. § 1397bb) and Sections 2103 and 2110 of the Social Security Act (42 U.S.C. § 1397cc and § 1397jj).

Source and Effective Date

R.2000 d.265, effective May 31, 2000.
See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).

Executive Order No. 66(1978) Expiration Date

Chapter 58A, Certified Nurse Practitioner/Clinical Nurse Specialist, expires on May 31, 2005.

Chapter Historical Note

Chapter 58A, Certified Nurse Practitioner/Clinical Nurse Specialist, was adopted as R.1995 d.501, effective September 5, 1995. See: 27 N.J.R. 2158(a), 27 N.J.R. 3343(a).

Pursuant to Executive Order No. 66(1978), Chapter 58A, Certified Nurse Practitioner/Clinical Nurse Specialist, was readopted as R.2000 d.265, effective May 31, 2000. See: Source and Effective Date. See, also, section annotations.

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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 and NJ KidCare fee-for-service programs' 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/NJ KidCare fee-for-service 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/NJ KidCare fee-for-service Program Provider Agreement.

(c) A CNP/CNS may enroll in the New Jersey Medicaid/NJ KidCare fee-for-service 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.

(d) Unless otherwise stated, the rules of this chapter apply to Medicaid and NJ KidCare–Plan A, B and C fee-for-service beneficiaries and to Medicaid and NJ KidCare–Plan A, B, C and D fee-for-service services which are not

the responsibility of the managed care organization with which the beneficiary is enrolled. Certified nurse practitioner/clinical nurse specialist services that are to be provided by the beneficiary's selected managed care organization (MCO) are governed and administered by that MCO.

Amended by R.2000 d.265, effective July 3, 2000.
See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).
Inserted references to NJ KidCare fee-for-service throughout; and added (d).

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 and Senior Services, 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 beneficiary 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 beneficiary.

"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 and NJ KidCare–Plan A beneficiaries 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 Senior Services and the New Jersey Medicaid and NJ KidCare–Plan A programs 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 beneficiaries, 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).

Amended by R.2000 d.265, effective July 3, 2000.
See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).
Substituted references to beneficiaries for references to patients throughout; and in "Early and Periodic Screening, Diagnosis and Treatment (EPSDT)" and "HealthStart pediatric care provider", inserted references to NJ KidCare Plan–A.

10:58A–1.3 Provider participation

(a) In order to participate in the Medicaid and NJ KidCare fee-for-service programs as a CNP/CNS practitioner, the CNP/CNS shall apply to, and be approved by, the New Jersey Medicaid/NJ KidCare fee-for-service program. Application for approval by the New Jersey Medicaid/ NJ KidCare fee-for-service program as a certified nurse practitioner (CNP) or a clinical nurse specialist (CNS) requires completion and submission of the "Medicaid Provider Application" (FD–20) and the "Medicaid Provider Agreement" (FD–62).

1. The FD–20 and FD–62 may be obtained from and submitted to:

Unisys Corporation
Provider Enrollment
PO Box 4804
Trenton, New Jersey 08650–4804

(b) In order to be approved as a Medicaid/NJ KidCare fee-for-service participating provider, the CNP/CNS shall be a registered professional nurse and have a current certification as a CNP or CNS, pursuant to N.J.A.C. 13:37–7.

1. An out-of-State CNP/CNS shall have comparable documentation under the applicable state requirements of the state in which the services are provided.

(c) An applicant shall provide a photocopy of the current license and current certification at the time of the application for enrollment.

(d) In addition to the requirements specified in (a) through (c) above, the following requirements shall be met, in accordance with Federal requirements (HCFA State Medicaid Manual, Section 4415, "Nurse Practitioner Services").

1. In order to participate in the Medicaid/NJ KidCare fee-for-service program as a certified pediatric nurse practitioner, a pediatric nurse practitioner shall be licensed at the time of participation in accordance with the standards for pediatric nurse practitioner established by the New Jersey Board of Nursing, N.J.A.C. 13:37–7.

2. In order to participate in the Medicaid/NJ KidCare fee-for-service program as a certified family nurse practitioner, a family nurse practitioner shall be licensed at the time of participation in accordance with the standards for family practice nurse practitioner established by the New Jersey Board of Nursing, N.J.A.C. 13:37–7.

(e) Additional areas of specialization recognized by the New Jersey Board of Nursing currently include:

1. Adult Health;
2. Family;
3. Pediatric;
4. School;
5. Gerontological;
6. Women's Health;
7. OB/GYN;
8. Neonatal;
9. Psychiatric/Mental Health;
10. Community Health;
11. Perinatal;
12. Maternity/Child;
13. Oncology;
14. Critical Care;
15. Emergency/Burns/Trauma;
16. Medical–Surgical; and
17. Rehabilitation.

(f) Upon signing and returning the Medicaid Provider Application, the Provider Agreement and other enrollment documents to Unisys, the fiscal agent for the New Jersey Medicaid and NJ KidCare fee-for-service programs, the certified nurse practitioner/clinical nurse specialist will receive written notification of approval or disapproval. If approved, the CNP/CNS will be assigned a provider identifier number. Unisys will furnish the provider identifier number and provider number.

(g) In order to participate as a provider of HealthStart services, the CNP/CNS practicing independently or as part of a group shall be a Medicaid/NJ KidCare fee-for-service provider, and shall meet the HealthStart requirements as specified at N.J.A.C. 10:66–3, and at N.J.A.C. 10:58A–3, including the provider participation criteria specified in N.J.A.C. 10:58A–3.3. The CNP/CNS shall also possess a HealthStart Certificate, issued by the New Jersey Department of Health and Senior Services.

(h) A HealthStart provider shall have a valid HealthStart Provider Certificate. An application for a HealthStart Provider Certificate is available from:

HealthStart Program
The New Jersey Department of Health and Senior Services
50 East State Street, PO Box 364
Trenton, New Jersey 08625–0364

Amended by R.2000 d.265, effective July 3, 2000.
See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).
Inserted references to NJ KidCare fee-for-service throughout; in (e), added 14 through 17; and in (h), inserted a reference to the HealthStart Program and deleted a reference to the Division of Family Health Services.

10:58A–1.4 Recordkeeping

(a) The certified nurse practitioner/clinical nurse specialist, in any and all settings, shall keep such legible individual records as are necessary to fully disclose the kind and extent of service(s) provided, the procedure code being billed, and the medical necessity for those services.

(b) Documentation of services performed by the CNP/CNS shall include, as a minimum:

1. The date of service;
2. The name of the beneficiary;
3. The beneficiary complaint, reason for visit;
4. Subjective findings;
5. Objective findings;
6. An assessment;
7. A plan of care, including, but not limited to, any orders for laboratory work, prescriptions for medications;
8. The signature of practitioner rendering the service; and
9. Other documentation appropriate to the procedure code being billed. (See N.J.A.C. 10:58A–4, HCPCS Codes.)

(c) In order to receive reimbursement for an initial visit, the following documentation, at a minimum, shall be placed on the record by the CNP/CNS, regardless of the setting where the examination was performed:

1. Chief complaint(s);
2. A complete history of the present illness and related systemic review-including recordings of pertinent negative findings;
3. Pertinent past medical history;
4. Pertinent family history;
5. A full physical examination pertaining to, but not limited to, the history of the present illness which includes recording of pertinent negative findings; and
6. Working diagnoses and treatment plan including ancillary services and drugs ordered.

(d) Written records in substantiation of the use of a given procedure code shall be available for review and/or inspection if requested by the New Jersey Medicaid/NJ KidCare fee-for-service program.

(e) Further discussion of the extent of documentation requirements can be found at N.J.A.C. 10:49–9.7, 9.8 and 9.9.

(f) Records, and the documentation of visits to beneficiaries in residential health care facilities, shall be maintained in the provider's office record. Residential health care facility records, as specified in (c) above, shall be part of the office records.

(g) In order to document the record for reimbursement purposes, the progress note for routine office visits or follow up care visits shall include the following:

1. In an office, or residential health care facility:
   i. The purpose of the visit;
   ii. Pertinent history obtained;
   iii. Pertinent physical findings, including pertinent negative physical findings based on (g)1i and ii above;
   iv. Procedures, if any, with results;
   v. Lab, X-ray, EKG, or any other test ordered, with results; and
   vi. A diagnosis.
2. In a hospital or nursing facility setting:
   i. An update of symptoms;

ii. An update of physical symptoms;

iii. A resume of findings of procedures, if any done;

iv. Pertinent positive and negative findings of lab, X-ray or any other test;

v. Additional planned studies, if any, and the reason for the studies; and

vi. Treatment changes, if any.

(h) To qualify as documentation that the service was rendered by the practitioner during an inpatient stay, the medical record shall contain the CNP/CNS's notes indicating that the practitioner personally:

1. Reviewed the beneficiary's medical history with the beneficiary and/or his or her family, depending upon the medical situation;

2. Performed an examination as appropriate;

3. Confirmed or revised the diagnosis; and

4. Visited and examined the beneficiary on the days for which a claim for reimbursement is made.

(i) The CNP/CNS's involvement shall be clearly demonstrated in notes reflecting the practitioner's personal involvement with, or participation in, the service rendered.

(j) For all periodic health maintenance examinations for individuals under 21 years of age, the following shall be documented in the beneficiary's record and shall include:

1. A history (complete initial for new beneficiary, interval for established beneficiary) including past medical history, family history, social history, and systemic review.

2. A developmental and nutritional assessment.

3. A complete, unclothed, physical examination to include also the following:

i. Measurements: height and weight; head circumference to 25 months; blood pressure for children age three or older; and

ii. Vision and hearing screening;

4. The assessment and administration of immunizations appropriate for age and need;

5. Provisions for further diagnosis, treatment and follow-up, by referral if necessary, of all correctable abnormalities uncovered or suspected;

6. Referral to a dentist for children age three or older;

7. The laboratory procedures performed or referred if medically necessary. Recommendations for procedure are as follows:

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 board of social services.

(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.

Amended by R.2000 d.265, effective July 3, 2000.
See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).
Substituted references to beneficiaries for references to patients throughout; in (d), inserted a reference to NJ KidCare fee-for-service; in (e), changed N.J.A.C. reference; and in (j), rewrote the introductory paragraph, and substituted a reference to county boards of social services for a reference to county welfare agencies in 9.

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 fee-for-service-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. 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, or clinic.

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 beneficiary 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 beneficiary's condition permits, the primary practitioner/physician shall either resume sole responsibility or transfer the beneficiary 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 medically necessary for admitting a beneficiary 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 beneficiary 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 beneficiary of the CNP/CNS. When it becomes necessary to admit a beneficiary 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/NJ KidCare fee-for-service programs 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/NJ KidCare fee-for-service 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/NJ KidCare fee-for-service 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 Provider Servicing Number 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 and NJ KidCare fee-for-service programs 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. 10:58A–4. In no event shall the charge to the New Jersey Medicaid/NJ KidCare fee-for-service 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/NJ KidCare fee-for-service 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 Provider Billing Number and the Provider Servicing Number.

i. The Provider Billing Number and Servicing Numbers are identical when the CNP/CNS is a solo practitioner who bills Medicaid/NJ KidCare fee-for-service 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 Provider Billing Number. The number assigned to the CNP/CNS practitioner will be the 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 Provider Billing Number is the number of the employer. The identifier of the CNP/CNS practitioner rendering the service will be the Medicaid/NJ KidCare fee-for-service 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.
Amended by R.2000 d.265, effective July 3, 2000.
See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).
Substituted references to beneficiaries for references to patients and inserted references to NJ KidCare fee-for-service throughout; in (a), substituted a reference to NJ KidCare fee-for-service-eligible individuals for a reference to NJ KidCare-eligible individuals; in (c), deleted "for reimbursement of his or her services" at the end of the first sentence, and deleted a reference to hospitals in the introductory paragraph, and substituted a reference to medically necessary for a reference to necessary in 3; in (e) and (g), substituted references to Provider Servicing Numbers for reference to Medicaid Provider Servicing Numbers throughout; and in (g), substituted references to Provider Billing Numbers for references to Medicaid Provider Billing Numbers throughout.

10:58A–1.6 Personal contribution to care requirements for NJ KidCare– Plan C and copayments for NJ KidCare–Plan D

(a) General policies regarding the collection of personal contribution to care for or NJ KidCare–Plan C and copayments for NJ KidCare–Plan D 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, beneficiary'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.

(d) The copayment for CNS/CNP services under NJ KidCare–Plan D shall be $5.00 per office visit;

1. A $10.00 copayment shall apply for services rendered during non-office hours and for home visits.

2. The $5.00 copayment shall apply only to the first prenatal visit.

(e) CNPs/CNSs are required to collect the copayment specified in (d) above except as provided in (f) below. Copayments shall not be waived.

(f) CNPs/CNSs shall not charge a copayment for services provided to newborns, who are covered under fee-for-service for Plan D or for preventive services, including well child visits, lead screenings and treatment, and age-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.
Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).
See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).
In (a), added reference to copayments for NJ KidCare–Plan D; added (d) through (f).
Amended by R.2000 d.265, effective July 3, 2000.
See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).
In (b)2, substituted a reference to beneficiaries for a reference to patients throughout.

SUBCHAPTER 2. PROVISION OF SERVICES

10:58A–2.1 General provisions

(a) This subchapter describes the New Jersey Medicaid and NJ KidCare fee-for-service programs' policies and procedures for the provision of Medicaid and NJ KidCare fee-for-service 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/NJ KidCare fee-for-service program shall reimburse for CNP/CNS services provided only when the patient is an eligible Medicaid/NJ KidCare fee-for-service client at the time services are rendered. CNP/CNSs shall verify the patient's current eligibility status prior to providing services.

Amended by R.2000 d.265, effective July 3, 2000.
See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).
Inserted references to NJ KidCare fee-for-service throughout.

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

(a) 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 AV through 29740 AV (see N.J.A.C. 10:58A–4.2(d), (e) and (f)), 31720 AV, 36415 AV, 57150 AV and 59025 AV.

Amended by R.2000 d.144, effective April 3, 2000.
See: 31 N.J.R. 3968(a), 32 N.J.R. 1208(a).
In (a), changed excluded procedure codes references.

10:58A–2.4 Pharmaceutical services

(a) All covered pharmaceutical services provided by CNP/CNSs under the New Jersey Medicaid/NJ KidCare fee-for-service programs 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) The Medicaid/NJ KidCare fee-for-service programs 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).
Amended by R.2000 d.265, effective July 3, 2000.
See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).
In (a), inserted a reference to NJ KidCare fee-for-service; and in (c), substituted a reference to Medicaid and NJ KidCare fee-for-service programs for a reference to Medicaid.

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, Medicaid Eligibility identification number, dispense date, drug quantity, drug description. The prescriber shall be requested to provide the reason for the 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, Medicaid Eligibility identification 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 or prescriber 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.
Amended by R.2000 d.265, effective July 3, 2000.
See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).
In (d), substituted references to Medicaid Eligibility identification numbers for references to HSP identification numbers throughout, and inserted a reference to prescribers in 3.

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 and NJ KidCare fee-for-service programs' 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 and Senior Services 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/NJ KidCare fee-for-service beneficiaries; 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 any part of a clinical laboratory test is performed on site, by the CNP/CNS or his or her office staff, the venipuncture is not reimbursable as a separate procedure; its cost is included within the reimbursement for the laboratory 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/NJ KidCare fee-for-service program in accordance with (b) above; and

4. Independent clinical laboratories shall bill the New Jersey Medicaid/NJ KidCare fee-for-service 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.

(g) HCPCS 90780 AV and 90781 AV, related to therapeutic or diagnostic injections, shall not be used for routine IV drug injection. For these codes, reimbursement shall be contingent upon the required medical necessity, and hand written chart documentation, including the time and the indication of the practitioner's presence with the patient to the exclusion of his or her other duties.

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.
Amended by R.2000 d.265, effective July 3, 2000.
See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).
Inserted references to NJ KidCare fee-for-service throughout; in (d)1, substituted a reference to beneficiaries for a reference to patients; in (e), substituted "any part of a clinical laboratory test is performed on site, by the CNP/CNS or his or her office staff," for "the clinic laboratory test is performed on site," following "When"; and added (g).

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 (CNPs or CNSs) 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.

iii. Reimbursement for an initial office visit also precludes subsequent reimbursement to the same provider for an initial residential health care facility visit and vice versa.

2. If the setting is a nursing facility, the initial visit concept will still apply when considered for reimbursement purposes; however, subsequent readmissions to the same facility may be designated as initial visits, as long as a time interval of 30 days or more has elapsed between admissions.

3. In the inpatient hospital setting, the initial visit concept still applies for reimbursement purposes, except that subsequent readmissions to the same facility may be designated as Initial Visits as long as a time interval of 30 days or more has elapsed between admissions.

4. An initial hospital visit will be disallowed to the same practitioner, group of practitioners, shared health care facility, or practitioners sharing a common record who submit a claim for a consultation and transfer the patient to their service.

5. In order to use the HCPCS procedure code to bill for an Initial Visit, the CNP/CNS shall provide the minimal documentation in the record regardless of the setting where the examination was performed. See N.J.A.C. 10:58A–1.4(c).

(d) Provisions for office or other outpatient services–established patient, or subsequent hospital care: evaluation and management services:

1. This service is considered to be the routine office visit or follow-up care visit, and the visit will conform to the CPT description of provider involvement and time. The setting could be office, hospital, nursing facility or residential health care facility. The documentation requirements for these visits can be found at N.J.A.C. 10:58A–1.4.

(e) In the absence of patient complaints, the procedure codes identified as preventive medicine services are applied, for adults and for children.

1. Preventive medicine services codes (new patient) are comparable, in respect to reimbursement level, to an initial visit and, therefore, may only be billed once per patient. Future use of these codes will be denied when the beneficiary is seen by the same practitioner, group of practitioners, or involves a shared health care facility sharing a common record.

(f) The following apply to preventive medicine services, the annual health maintenance examination, for new or established patients under the age of 21:

1. These codes are not allowable for payment when used following an EPSDT or HealthStart pediatric examination performed within the preceding 12 months for a child older than two years of age.

2. For well-child care provided to children under the age of two, the provider is urged to use age-appropriate EPSDT or pediatric HealthStart codes.

3. Preventive medicine codes may be used up to six times (at ages one, two, four, six, nine and 12 months) during the patient's first year of life and up to three times (at ages 15, 18 and 24 months) during the patient's second year of life, in accordance with the periodicity schedule of preventive visits recommended by the American Academy of Pediatrics. These codes should not be used for children under two years of age participating in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) or Pediatric HealthStart program.

(g) Concerning the consultation procedures, in reference to CNP/CNSs, a consultation is eligible for reimbursement only when performed by a physician specialist recognized as such by the Division, when the request has been made by or through the patient's attending physician or CNP/CNS, and the need for such a request would be consistent with good medical practice. CNP/CNSs will not be reimbursed for consultation procedures, but mention of these procedures is included for those instances when the CNP/CNS needs to refer his or her patient(s) for consultation, to a specialist other than his or her collaborating physician.

(h) The home services recognized as "house calls" refer to a practitioner visit limited to the provision of medical care to an individual who would be too ill to go to a practitioner's office and/or is "home bound" due to his or her physical condition. These codes do not apply to the residential health care facility or nursing facility setting.

1. For purposes of Medicaid/NJ KidCare fee-for-service reimbursement, "home visits" apply when the provider visits Medicaid/NJ KidCare fee-for-service beneficiaries who do not qualify as "home bound."

(i) The following concern emergency department and inpatient hospital services:

1. When a practitioner sees his or her patient in the emergency room instead of his or her office, the practitioner shall use the same codes for the visit that would have been used if seen in the physician's office. Records of that visit should become part of the notes in the office chart.

2. When patients are seen by hospital-based emergency room practitioners who are eligible to bill the Medicaid or the NJ KidCare fee-for-service program, the appropriate HCPCS code is used. These "visit" codes are listed at N.J.A.C. 10:58A–4.2.

3. Critical care/prolonged services will be covered when the patient's situation requires constant practitioner attendance given by the practitioner to the exclusion of his or her other patients and duties, and therefore, for him or her, represents what is beyond the usual service.

i. Critical care/prolonged success shall be verified by the applicable records as defined by the setting. The records shall show in the practitioner's handwriting the time of onset and time of completion of the service. All settings are applicable such as office, hospital, home, residential health care facility and nursing facility.

ii. The reimbursement for the "critical care" or prolonged services utilizes the time parameter, and is all-inclusive, meaning that it will be the only payment for care provided by the practitioner to the patient at that time. The specific procedures performed during that patient encounter will not be reimbursed in addition to the "critical care/prolonged services" payment.

4. For reimbursement purposes, routine hospital "newborn care for a well baby" requires, as a minimum, routine newborn care by a practitioner other than the practitioner(s) rendering maternity service.

i. "Newborn care for a well baby" includes complete initial and complete discharge physical examination, and conference(s) with the parent(s). These examinations shall be documented in the newborn's medical record.

ii. This code applies to healthy newborns and the fee for this service is all-inclusive. Consequently, the provider may not bill multiple units or bill for visits made on the subsequent day or the discharge day for a healthy newborn.

iii. For sick babies, use the appropriate hospital care code, as indicated at N.J.A.C. 10:58A–4.2.

Recodified from N.J.A.C. 10:58A–2.6 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–2.7, Family planning services, recodified to N.J.A.C. 10:58A–2.8.
Amended by R.2000 d.265, effective July 3, 2000.
See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).
Substituted references to beneficiaries for references to patients throughout; in (d)1, substituted a reference to CPT for a reference to CPT-4; in (e)1, substituted a reference to beneficiaries for a reference to recipients; in (g), substituted a reference to the Division for a reference to this program; and in (h) and (i), inserted references to NJ KidCare fee-for-service throughout.

10:58A–2.8 Family planning services

(a) Family planning services include medical history and physical examination (including pelvic and breast); the ordering of diagnostic and laboratory tests; the prescribing of drugs and biologicals, medical devices and supplies; and providing continued medical supervision, counseling, and continuity of care.

1. The New Jersey Medicaid and NJ KidCare fee-for-service programs shall not reimburse for services for the diagnosis or treatment of infertility. Services provided primarily for the diagnosis and treatment of infertility, including related office visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures shall not be covered by the New Jersey Medicaid/NJ KidCare fee-for-service program.

i. Exception: When a service is provided that is ordinarily considered an infertility service, but is provided for another purpose, the CNP/CNS shall submit the claim with supporting documentation for medical review and approval of payment to the Division of Medical Assistance and Health Services, Office of Health Service Administration, PO Box 712, (Mail Code #14), Trenton, New Jersey 08625–0712.

ii. When a prescription drug is provided that is ordinarily used for infertility, but is provided for medical conditions unrelated to infertility, the practitioner who prescribes this drug should clearly indicate on the prescription that the drug is being provided for a condition other than infertility, and provide a copy of this documentation to the pharmaceutical provider.

(b) The Norplant System (NPS) is a Medicaid-covered and NJ KidCare fee-for-service-covered service provided to reproductive age women with established regular menstrual cycles, in conformance with the prescribing information approved by the Food and Drug Administration. Patient education and counseling shall be provided relating to the NPS, including pre-and post-insertion instructions, indica-

tions, contraindications, benefits, risks, side effects, and other contraceptive modalities.

1. A clinic or office visit relating only to the insertion or removal of the Norplant System (NPS) shall not be reimbursable on the day of the insertion or removal. Only two insertions and two removals of the NPS per beneficiary shall be reimbursed during a five-year continuous period. The practitioner shall not be reimbursed for the NPS in conjunction with other forms of contraception, for example, intra-uterine device or Depo–Provera injection.

2. The maximum fee allowance for HCPCS code 11975 AV 22, related to the insertion of the Norplant System, includes the cost of the kit supplied to the practitioner, the insertion of the Norplant System (six levonorgestrel implants) and the post insertion visit.

3. The maximum fee allowance for HCPCS code 11976 AV, related to the removal of the Norplant System, includes the removal of the Norplant System (six levonorgestrel implants) and for the post removal visit.

4. The maximum fee allowance for HCPCS code 11977 AV, related to the removal and reinsertion of the Norplant System, includes the removal and reinsertion of the Norplant System (six levonorgestrel implants) and the post removal/reinsertion visit.

5. The maximum fee allowance for the HCPCS code 11977 AV 22, related to the removal and reinsertion of the Norplant System, includes the cost of the kit, the removal and reinsertion of the Norplant System (six levonorgestrel implants) and the post removal/reinsertion visit.

Recodified from N.J.A.C. 10:58A–2.7 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–2.8, Mental health services, recodified to N.J.A.C. 10:58A–2.9.
Amended by R.2000 d.265, effective July 3, 2000.
See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).
Rewrote the section.

10:58A–2.9 Mental health services

(a) Certified nurse practitioners/clinical nurse specialists who are certified in the advanced practice category of "Psychiatric/Mental Health" (CNP/CNS, Psychiatric/Mental Health) are qualified to perform and be reimbursed independently for psychiatric evaluations for the New Jersey Medicaid/NJ KidCare fee-for-service program.

1. For each psychiatric therapy patient contact, written documentation shall be developed and maintained to support each medical or remedial therapy, service, activity, or session for which billing is made. The documentation shall consist of the following:

i. The specific services rendered and modality used, such as individual, group, and/or family therapy;

ii. The date services were rendered;

iii. The duration of services provided (1 hour, 1/2 hour);

iv. The signature of the CNP/CNS, Psychiatric/Mental Health, who rendered the service;

v. The setting in which services were rendered;

vi. A notation of impediments, unusual occurrences or significant deviations from the treatment described in the Plan of Care;

vii. Notations of progress, impediments, treatment, or complications; and

viii. Other relevant information.

(b) Prior authorization for mental health services shall be required when services are rendered in certain settings:

1. Prior authorization for inpatient hospital mental health services is not required.

2. For services provided in nursing facilities and all facilities covered under the Rooming and Boarding House Act of 1979 (RBHA '79) N.J.S.A. 55:13B–1 et seq., prior authorization shall be required for mental health services exceeding $400.00 in payments in any 12–month service year rendered to a Medicaid/NJ FamilyCare beneficiary residing in either a nursing facility of RBHA '79 facility. The request for prior authorization shall be submitted directly to the appropriate Medical Assistance Customer Center (MACC) that serves that nursing or RBHA '79 facility on the "Authorization of Mental Health Services and/or Mental Health Rehabilitation Services (FD–07)" and the "Request for Prior Authorization: Supplemental Information (FD–07A)" forms.

3. Services provided by a nurse practitioner in an independent clinic, including a mental health clinic or an FQHC shall only be billed by the clinic after prior authorization in accordance with the Independent Clinic Services Manual, N.J.A.C. 10:66–1.4.

4. In all other settings: prior authorization shall be required for mental health services rendered to a Medicaid/NJ FamilyCare beneficiary (within a 12–month service year commencing with the patient's initial visit) when those services are provided in a setting other than an inpatient hospital, nursing facility or RBHA '79 facility, and when the reimbursement for those services exceeds $900.00 to the CNP/CNS, Psychiatric/Mental Health. The request for prior authorization shall be submitted directly to the Medical Assistance Customer Center (MACC) that serves the county in which the services are rendered. Provider shall use the "Authorization of Mental Health Services and/or Mental Health Rehabilitation Services (FD–07)" form and the form "Request for Prior Authorization: Supplemental Information (FD–07A)" to request prior authorization for these services.

(c) Prior authorization for mental health services may be granted by the New Jersey Medicaid/NJ KidCare fee-for-service program for a maximum period of one year, and additional authorizations may be requested. The request for authorization shall include the diagnosis, as set forth in the ICD–9 CM (latest revision), the treatment plan and the progress report, in detail. When a request for prior authorization is denied or modified, the CNP/CNS shall be notified of the reason, in writing, by the fiscal agent.

1. When a patient's authorized treatment plan is changed because of a change in the patient's treatment needs, which results in an increase in service or change in the kind of service, a new authorization or a modification of the existing authorization shall be requested by the CNP/CNS.

2. Ordinarily only one mental health procedure shall be reimbursed per day for the same beneficiary by the same physician, group of physicians, shared health facility, psychologist or CNP/CNS (P/MH) sharing a common record. When circumstances require more than one mental health procedure, the medical necessity for the services shall be documented in the patient's chart, and a determination regarding reimbursement shall be made by the Division on a case-by-case basis.

(d) CNP/CNS(P/MH)s providing mental health services shall document those services as described above and at N.J.A.C. 10:58A–1.4, Recordkeeping.

(e) Certified nurse practitioners/clinical nurse specialists who are certified in the advanced practice category of "Psychiatric/Mental Health" (CNP/CNS, Psychiatric/Mental Health) are qualified to perform services and to be reimbursed independently for the treatment of postpartum mental health disorders in women.

1. These services are available to women during pregnancy and/or after a delivery, miscarriage, or the termination of a pregnancy.

2. The reimbursement of the specialized HCPCS procedure codes for the treatment of postpartum mental health disorders shall include an initial evaluation and no more than three subsequent visits to one practitioner. Additional services shall be billed using the regular mental health service HCPCS located at N.J.A.C. 10:58A–4.2(m).

i. The HCPCS procedure code W9853 AV shall be used for an initial evaluation visit and two subsequent visits for the treatment of postpartum mental health disorders, when the same provider provides the initial evaluation and the two subsequent visits. This specialized HCPCS procedure code is limited to one occurrence per pregnancy. If a third follow up visit is required, specialized HCPCS procedure code W9854 AV shall be used.

ii. The HCPCS procedure code W9854 AV shall be used for one additional visit for the treatment of postpartum mental disorders.

iii. The HCPCS procedure code W9857 AV shall be used for an initial evaluation visit and one subsequent visit for the treatment of postpartum mental health disorders, when the same provider provides the initial evaluation and the one subsequent visit.

3. Treatment for postpartum-related mental health disorders for Medicaid and NJ KidCare beneficiaries enrolled in managed care organizations are considered "out-of-plan" and shall be reimbursed under a fee-for-service arrangement.

4. The specialized HCPCS for the treatment for postpartum-related mental health disorders shall be exempt from prior authorization and, as such, shall be excluded from the $900.00 threshold contained in N.J.A.C. 10:58A–2.9(b)4.

(f) Mental health services provided to NJ KidCare Plan D beneficiaries shall not require prior authorization. Mental health services shall be provided to NJ KidCare Plan D beneficiaries under the following limitations:

1. Mental health services provided on an inpatient basis at a psychiatric or mental health services hospital shall be limited to 35 days during a consecutive 365–day span.

2. Mental health services provided in an outpatient hospital shall be limited to 20 visits during a consecutive 365–day span. One inpatient day may be exchanged for two additional days of outpatient services, for a maximum of 70 additional outpatient hospital visits during a consecutive 365–day span.

3. Mental health services provided in a mental health clinic shall be limited to 20 visits during a consecutive 365–day span. Up to a maximum of 10 inpatient days can be exchanged, at the rate of one inpatient for four additional outpatient days, for a total of up to 40 additional outpatient days during a consecutive 365–day span.

Recodified from N.J.A.C. 10:58A–2.8 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–2.9, PASARR, Pre-Admission Screening (PAS) and Annual Resident Review (ARR), recodified to N.J.A.C. 10:58A–2.10.
Amended by R.2000 d.265, effective July 3, 2000.
See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).
Inserted references to NJ KidCare fee-for-service and substituted references to beneficiaries for references to patients throughout; in (b)3, inserted "Independent" preceding "Clinic"; and added (e) and (f).
Amended by R.2003 d.182, effective May 5, 2003.
See: 34 N.J.R. 4303(a), 35 N.J.R. 1901(a).
Rewrote (b)2 and (b)4.

10:58A–2.10 PASARR and Pre–Admission Screening (PAS)

(a) Federal legislation (1919(a)(b) of the Social Security Act, 42 U.S.C. § 1396r) established Pre–Admission Screening (PAS) for MI/MR applicants to Medicaid/NJ KidCare-participating nursing facilities (NFs) and further reviews, as indicated by a significant change in a beneficiary's mental or physical condition, for residents of Medicaid/NJ KidCare-participating NFs.

(b) Through PASARR, NF applicants or residents of NFs are evaluated to assess the appropriateness of their admission to the facility or continued residence within the facility, in respect to whether they need specialized services for the treatment of mental illness or mental retardation. Persons in need of specialized services (active treatment) will be directed to an alternate placement.

(c) The initial PAS screening is conducted by a Department of Health and Senior Services (DHSS) staff, to determine whether the individual requires nursing facility level of care.

1. After the DHSS staff has determined that the individual needs NF-level services, an individual identified as meeting the criteria for mental retardation services is referred to the staff of the Division of Developmental Disabilities for a specialized service evaluation.

2. An individual identified as meeting criteria for mental illness is evaluated by a psychiatrist, an attending physician or a certified nurse practitioner/clinical nurse specialist, psychiatric/mental health (CNP/CNS, Psychiatric/Mental Health) to determine the need for specialized services.

(d) Professionals who are qualified to perform psychiatric evaluations for PASARR include psychiatrists, general physicians, both doctors of medicine (M.D.) and of osteopathy (D.O.), and certified nurse practitioners/clinical nurse specialists who are certified in the advanced practice category of Psychiatric/Mental Health.

(e) The initial Pre–Admission PASARR Screen shall be used for Medicare and/or Medicaid and NJ KidCare–Plan A persons residing in the community (currently at home or boarding home) who are applicants to Medicare/Medicaid/NJ KidCare nursing facilities and are being examined by an attending-physician or CNP/CNS, Psychiatric/Mental Health, to determine the need for specialized services for mental illness. Practitioners completing the screen to determine the need for specialized services shall use the 99333 and W9848 HCPCS procedure codes with a Medicaid/NJ KidCare maximum fee allowance of $44.00.

1. If the screening examination reveals the need for a more specialized examination, a psychiatric consultation may be requested by the attending physician or CNP/CNS Psychiatric/Mental Health. Existing consultation codes for limited consultation and for comprehensive consultation may be used for this purpose by the consulting psychiatrist, as appropriate. Applicants with a diagnosis of MI or MR, regardless of the payment source of their care, shall be subject to the PASARR review. For MI individuals funded through other than the New Jersey Medicaid/NJ KidCare programs, the fee for psychiatric evaluations conducted by psychiatrists or in NFs by attending physicians, CNP/CNSs Psychiatric/ Mental Health will be paid by Medicare, other third party carriers, or by the individual.

2. If the individual has a diagnosis of Alzheimer's disease or related dementia, as described in the 1987 edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM–III), documentation shall be provided to the admitting Medicaid/NJ KidCare-certified nursing facility, for the individual's clinical record, on the history, physical examination, and diagnostic work-up, to support the diagnosis. Dementia-diagnosed individuals shall have psychiatric disorders diagnosed and documented. (Neither a new examination nor a comprehensive neurological evaluation shall be required.) Individuals diagnosed as mentally retarded who are also diagnosed as having organic dementia shall be evaluated in accordance with the DDD Level II screens to determine need for specialized services.

i. The examining attending-physician or CNP/CNS Psychiatric/Mental Health shall obtain the "Division of Mental Health and Hospitals Psychiatric Evaluation" form (DMH&H–1994) from the Medicaid District Office and shall submit the completed form to the Division of Mental Health and Hospitals, PO Box 727, Trenton, New Jersey 08625–0727, Attention: PASARR Coordinator.

ii. The evaluation form shall be mailed no later than 48 hours following the consultation to prevent undue delay in patient placement.

(f) The HCPCS procedure codes and reimbursement amounts previously established by the Division for the Annual Resident Review of PASARR, shall be used for Medicare and/or Medicaid/NJ KidCare–Plan A nursing facility patients who are being evaluated by the attending physician or CNP/CNS Psychiatric/Mental Health, for the purposes of a resident review, the necessity of which was indicated by a significant change in the condition of the beneficiary, to determine the need for specialized services for mental illness.

1. If this examination reveals the need for a more specialized examination, a psychiatric consultation may be requested by the attending physician or CNP/CNS Psychiatric/Mental Health. Existing consultation codes for limited consultation and for comprehensive consultation may be used for this purpose by the consulting psychiatrist as appropriate.

2. If the individual has a diagnosis of Alzheimer's disease or related dementias, as described in the 1987 edition of the Diagnostic and Statistical Manual of Mental Disorders, once the original documentation has been obtained, that documentation supporting the diagnosis shall be kept on the resident's current clinical record. (A new examination does not have to be completed.)

3. The procedure can only be utilized on an annual basis by the same physician or CNP/CNS Psychiatric/Mental Health for the same patient.

i. The provider shall attach a completed Division of Mental Health Services Psychiatric Evaluation form (DMHS–1994) to the patient's clinical chart. The Nursing Facility administrator will be responsible for providing these forms to the attending physician or CNP/CNS Psychiatric/Mental Health.

ii. The attending physician or CNP/CNS Psychiatric/Mental Health will complete the psychiatric evaluation. The NF will submit a copy of the Psychiatric Evaluation to the MDO. The required annual resident review information shall be submitted to MDOs no later than the fifth day of the month in which the reassessments are due.

(g) As used in this section, a "significant change" is defined as a major change in a resident's condition that will not improve without intervention by appropriate staff, impacts on more than one area of the resident's health, mental health, and/or functioning, and requires interdisciplinary review or revision of the care plan.

Recodified from N.J.A.C. 10:58A–2.9 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–2.10, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), recodified to N.J.A.C. 10:58A–2.11.
Amended by R.2000 d.265, effective July 3, 2000.
See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).
Inserted references to NJ KidCare throughout; rewrote (a) and (f); in (c), rewrote the introductory paragraph, and substituted a reference to DHSS staff for a reference to RSN in 1; in (e), inserted a reference to NJ KidCare–Plan A in the introductory paragraph; and added (g).

10:58A–2.11 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

(a) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a Federally mandated comprehensive child health program for Medicaid/NJ KidCare–Plan A beneficiaries from birth through 20 years of age. The term "EPSDT Services" means the following:

1. EPSDT Screening Services;

2. Vision Services;

3. Dental Services;

4. Hearing Services; and

5. Such necessary health care diagnostic services, treatment and other measures to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services. (See 42 CFR 441 Subpart B.)

(b) A certified nurse practitioner/clinical nurse specialist, pediatric nurse practitioner, or family nurse practitioner may provide EPSDT screening services.

(c) An EPSDT examination shall include the following:

1. A comprehensive health and developmental history including assessment of both physical and mental health development;

2. A comprehensive unclothed physical exam including vision and hearing screening, dental inspection, and nutritional assessment;

3. Appropriate immunizations according to age and health history;

4. Appropriate laboratory tests, including:

i. Hemoglobin/hematocrit;

ii. Urinalysis;

iii. Tuberculin test (Mantoux), annually;

iv. Lead screening using blood lead level determinations between 6 and 12 months, at 2 years of age, and annually up to six years of age. At all other visits, screening shall consist of verbal risk assessment and additional blood lead level testing, if indicated; and

v. Other appropriate medically necessary procedures.

5. Health education, including anticipatory guidance;

6. Vision services:

i. A newborn examination including general inspection of the eyes, visualization of the red reflex, and evaluation of ocular motility;

ii. An appropriate medical and family history;

iii. An evaluation, by age six months, of eye fixation preference, muscle imbalance, and pupillary light reflex; and

iv. A second examination with visual acuity testing by age three or four years.

v. Periodic vision testing for school aged children:

(1) Kindergarten or first grade (five or six years);

(2) Second grade (seven years);

(3) Fifth grade (10/11 years);

(4) Eighth grade (13/14 years); and

(5) Tenth or eleventh grades (15/17 years).

vi. Referral for vision screening of children who:

(1) Cannot read the majority of the 20/40 line before their fifth birthday;

(2) Have a two-line difference of visual acuity between the eyes;

(3) Have suspected strabismus; or

(4) Have an abnormal light or red reflex.

7. Hearing Services:

i. Newborn hearing screening, including risk assessment;

ii. Individual hearing screening administered annually to all children through age eight and to all children at risk of hearing impairment.

iii. Screening every other year for children age eight and older.

8. Dental Services:

i. Intraoral examination included as an integral part of a general physical examination;

ii. A formal referral to a dentist at one year of age (recommended) and mandatory for children three years of age and older;

iii. Dental inspection and prophylaxis every six months until 17 years of age, then annually.

9. Referral for further diagnosis and treatment or follow up of all correctable abnormalities, uncovered or suspected. Referral may be to the provider conducting the screening examination, or to another provider, as appropriate.

(d) Children two years of age and older are provided preventive health care services through the EPSDT program. In addition, Medicaid/NJ KidCare fee-for-service providers who have not been certified as HealthStart Pediatric Providers use the EPSDT procedure codes for preventive health care services for children from birth through age two when the requirements for the EPSDT examination have been met. The following schedule reflects the ages at which children shall be provided EPSDT screening:

1. Under six weeks;
2. Two months;
3. Four months;
4. Six months;
5. Nine months;
6. 12 months;
7. 15 months;
8. 18 months;
9. 24 months; and
10. Annually through age 20.

(e) Reimbursement policy for EPSDT services:

1. Each periodic EPSDT screening shall be billed only once for the same patient by the same practitioner(s) sharing a common record.

2. Reimbursement for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) examination is contingent upon the submission of a completed "Report and Claim for EPSDT/HealthStart Screening and Related Procedures (MC–19)" within 30 days of the date of service.

3. Laboratory, other diagnostic procedures, and immunizations shall be eligible for separate reimbursement. (See N.J.A.C. 10:58–2.5)

Recodified from N.J.A.C. 10:58A–2.10 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).
Amended by R.2000 d.265, effective July 3, 2000.
See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).
In (a), substituted a reference to Medicaid and NJ KidCare–Plan A beneficiaries for a reference to Medicaid recipients; and in (d), inserted a reference to NJ KidCare fee-for-service providers in the introductory paragraph.

10:58A–2.12 Obstetrical/gynecological (OB/GYN) care

Reimbursement for specified OB/GYN services at N.J.A.C. 10:58A–4.4(h) provided under the Medicaid and New Jersey KidCare fee-for-service programs shall be limited to certified nurse practitioners/clinical nurse specialists who are certified in the advance practice category of "OB/GYN."

New Rule, R.2000 d.144, effective April 3, 2000.
See: 31 N.J.R. 3968(a), 32 N.J.R. 1208(a).

10:58A–2.13 New Jersey Vaccines for Children program

(a) The New Jersey Vaccines for Children (VFC) program provides free vaccines for administration to beneficiaries under 19 years of age who are eligible for New Jersey Medicaid and NJ KidCare Plan A services. Medicaid and NJ KidCare programs shall not provide reimbursement to providers for administering these vaccines exclusive of the VFC program.

1. Vaccines that have been identified as available under the VFC program include, but are not limited to, the following, individually or in combination: Diptheria, Tetanus, Pertussis; Haemophilus Influenzae Type b (Hib); Rotavirus Vaccine; Hepatitis B (Pediatric/ Adolescent); Hepatitis Type B Immunoglobulin; Hepatitis A (Pediatric); Mumps, Measles, Rubella; Oral Polio Vaccine; Varicella Vaccine; Influenzae Vaccine; and Pneumococcal Vaccine.

2. The Center for Disease Control (CDC) is expected to periodically add vaccines to the approved list for the VFC program. The Medicaid/NJ KidCare program shall not reimburse for any vaccine so added to the VFC list of approved vaccines.

(b) The vaccines listed in (a)1 above may be provided to any child without health insurance and those children who are American Indian or an Alaskan Native.

(c) CNP/CNS's shall bill the HCPCS procedure code W9356 to receive reimbursement for administering vaccines under this program. See N.J.A.C. 10:58A–4.4(b).

(d) Vaccines administered to beneficiaries 19 years of age and older shall be billed with the appropriate procedure code. See N.J.A.C. 10:58A–4.2(j).

New Rule, R.2000 d.144, effective April 3, 2000.
See: 31 N.J.R. 3968(a), 32 N.J.R. 1208(a).

SUBCHAPTER 3. HEALTHSTART

10:58A–3.1 HealthStart services

(a) The New Jersey HealthStart program provides comprehensive maternity services for pregnant women (including those determined to be presumptively eligible) and child health services for children (through two years of age) who are eligible for Medicaid/NJ KidCare fee-for-service benefits.

Amended by R.2000 d.265, effective July 3, 2000.
See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).
Inserted a reference to NJ KidCare fee-for-service benefits.

10:58A–3.2 Purpose

(a) The purpose of HealthStart is to provide for comprehensive maternity services to pregnant Medicaid/NJ KidCare fee-for-service beneficiaries, including those determined to be presumptively eligible, and preventive child health services for Medicaid/NJ KidCare fee-for-service beneficiaries up to the age of two.

1. Pediatric HealthStart services are an expansion of the EPSDT program as described at N.J.A.C. 10:58A–2.10.

(b) This subchapter describes the HealthStart services which have been determined to lie within the scope of practice of the CNP/CNS, as defined by the New Jersey Board of Nursing, and to constitute the services to be provided by the independently practicing CNP/CNS.

Amended by R.2000 d.265, effective July 3, 2000.
See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).
In (a), substituted references to Medicaid/NJ KidCare fee-for-service beneficiaries for references to Medicaid recipients throughout the introductory paragraph.

10:58A–3.3 Scope of services

(a) HealthStart maternity services provided by a HealthStart-certified CNP/CNS are health support services provided in accordance with the HealthStart guidelines. HealthStart pediatric services include up to nine preventive visits, as recommended by the American Academy of Pediatrics, provided by a HealthStart-certified provider who assumes the primary responsibility for coordination and continuity of care.

(b) HealthStart maternity health support services include:

1. Case coordination services;

2. Health education assessment and counseling services;

3. Nutrition assessment and counseling services;

4. Social–psychological assessment and counseling services.

5. Home visitation; and

6. Outreach, referral and follow-up services.

(c) HealthStart comprehensive pediatric care includes nine preventive child health visits; all the recommended immunizations; case coordination and continuity of care including, but not limited to, the provision or arrangement for sick care, 24 hour telephone access, and referral and follow-up for complex or extensive medical, social, psychological, and nutritional needs.

10:58A–3.4 HealthStart provider participation criteria

(a) The following Medicaid-enrolled or NJ KidCare fee-for-service-enrolled provider types are eligible to participate as HealthStart providers: independent clinics, hospital outpatient departments, local health departments meeting the New Jersey State Department of Health and Senior Services' Improved Pregnancy Outcome criteria and/or approved as Child Health Conferences, physicians and physician groups, certified nurse midwives and CNP/CNSs.

(b) In addition to New Jersey Medicaid/NJ KidCare fee-for-service program rules applicable to provider participation, HealthStart CNP/CNS providers shall:

1. Sign an Addendum to the New Jersey Medicaid and NJ KidCare fee-for-service programs' Provider Agreement;

2. Have a valid HealthStart Provider Certificate; and

3. Provide maternity health support services and/or pediatric services in accordance with this subchapter.

(c) In addition to (a) and (b) above, a HealthStart CNP/CNS pediatric care provider shall participate in program evaluation and training activities including, but not limited to, documentation of outreach and follow-up activities in the patient's record.

(d) A site review may be required to ascertain an applicant's ability to meet the standards for a HealthStart Provider Certificate and to provide services in accordance with the New Jersey State Department of Health and Senior Services' Guidelines for HealthStart Providers in the appropriate area.

(e) A HealthStart Provider Certificate will be reviewed by the New Jersey State Department of Health and Senior Services at least every 18 months from the date of issuance.

(f) An application for a HealthStart Provider Certificate is available from:

HealthStart Program
New Jersey State Department of Health and Senior Services
50 East State Street
PO Box 364
Trenton, NJ 08625–0364

(g) Guidelines for HealthStart services, when rendered by a CNP/CNS employed by a clinic, physician or hospital, can be found at Independent Clinic Services, N.J.A.C. 10:66; Physician Services, N.J.A.C. 10:54; or Hospital Services, N.J.A.C. 10:52; respectively, and the guidelines for qualifications of HealthStart providers can be found at N.J.A.C. 10:66, Independent Clinic Services.

Amended by R.2000 d.265, effective July 3, 2000.
See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).

In (a) and (b), inserted references to NJ KidCare fee-for-service throughout.

10:58A–3.5 Termination of HealthStart Provider Certificate

(a) The New Jersey State Department of Health and Senior Services is responsible for enforcement of its requirements for HealthStart Provider Certificates and for evaluation and enforcement of its requirements within the Standards and Guidelines for HealthStart Providers.

(b) Causes for termination of the HealthStart Provider Certificate by the New Jersey State Department of Health and Senior Services are as follows:

1. Failure to comply with HealthStart standards;

2. Failure to complete the recertification process; and/or

3. Voluntary withdrawal from the HealthStart program.

(c) Termination of the HealthStart Provider Certificate shall result in the termination of the HealthStart Provider Agreement with the New Jersey Medicaid/NJ KidCare fee-for-service program. Providers who are decertified by HealthStart continue to be eligible to provide regular Medicaid/NJ KidCare fee-for-service services, at regular Medicaid/NJ KidCare fee-for-service reimbursement rates.

Amended by R.2000 d.265, effective July 3, 2000.
See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).
In (c), inserted references to NJ KidCare fee-for-service throughout.

10:58A–3.6 Records: documentation, confidentiality and informed consent for HealthStart maternity care providers

(a) HealthStart CNP/CNS maternity care providers shall have policies which protect patient confidentiality, provide for informed consent, and document health support services in accordance with the New Jersey State Department of Health and Senior Services' Guidelines for HealthStart Maternity Care Providers.

(b) An individual record shall be maintained for each patient throughout the pregnancy.

(c) Each record shall be confidential and shall include at least the following: history and physical examination findings, assessment, a care plan, treatment services, laboratory reports, counseling and health instructions provided, and documentation of referral and follow-up services.

(d) There shall be policies and procedures for informed consent for all HealthStart services.

Amended by R.2000 d.265, effective July 3, 2000.
See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).

10:58A–3.7 Health support services

(a) Health support services are a component of comprehensive maternity care. In order to render HealthStart health support services, a CNP/CNS provider must be affiliated with, or have a formal agreement with an obstetrical provider rendering the medical maternity care component. Health support services are provided as follows:

1. Case coordination services shall facilitate the delivery of continuous, coordinated and comprehensive services for each patient in accordance with this subchapter and as follows:

i. A permanent case coordinator shall be assigned to each patient no later than two weeks after the HealthStart enrollment visit;

ii. Prenatal case coordination activities shall include, but not be limited to:

(1) Orienting the patient to all services;

(2) Developing, maintaining and coordinating the care plan in consultation with the patient;

(3) Coordinating and monitoring the delivery of all services and referrals;

(4) Monitoring and facilitating the patient's entry into and continuation with maternity services;

(5) Facilitating and providing advocacy for obtaining referral services;

(6) Reinforcing health teachings and providing support;

(7) Providing vigorous follow up for missed appointments and referrals;

(8) Arranging home visits;

(9) Meeting with the patient and coordinating patient care conferences; and

(10) Reviewing, monitoring and updating the patient's complete record;

iii. Postpartum care coordination activities shall include, but not be limited to:

(1) Arranging and coordinating the postpartum visit and any home visit;

(2) Arranging with the obstetrical care provider to obtain the labor, delivery and postpartum hospital summary record information no later than two weeks after delivery;

(3) Linking the patient to appropriate service agencies including: the Special Supplemental Food Program for Women, Infants and Children (WIC), pediatric care (preferably with a HealthStart pediatric care provider), future family planning, Special Child Health Services County Case Management Unit, and other health and social agencies, if needed;

(4) Arranging for the transfer of pertinent information or records to the pediatric care and/or future family planning service providers;

(5) Coordinating referrals and following up on missed appointments and referrals; and

(6) Reinforcing health instructions for mother and baby.

2. Nutrition assessment and basic guidance services shall be provided to orient and educate all patients to nutritional needs during pregnancy and educate the patient to good dietary practices in accordance with this subchapter. Specialized nutrition assessment and counseling shall be provided to those women with additional needs. Services shall be provided as follows:

i. Initial assessment services, which shall include, but not be limited to:

(1) Review of the patient's chart;

(2) Identification of dental problems which may interfere with nutrition;

(3) Nutritional history;

(4) Current nutritional status;

(5) Determination of participation in WIC or other food supplement programs; and

(6) Identification of need for specialized nutritional counseling;

ii. Subsequent nutritional assessment, which shall include, but not be limited to:

(1) Monitoring of weight gain/loss;

(2) Identification of special dietary needs; and

(3) Identification of need for specialized nutritional counseling services;

iii. Prenatal nutritional guidance, which shall include, but not be limited to:

(1) Basic instruction on nutritional needs during pregnancy including balanced diet, vitamins and recommended daily allowances;

(2) Review and reinforcement of other nutritional and dietary counseling services the patient may be receiving;

(3) Instruction on food purchase, storage and preparation;

(4) Instruction on food substitutions, as indicated;

(5) Discussion of infant feeding and nutritional needs; and

(6) Referral to food supplementation programs through the case coordinator;

iv. Specialized nutrition assessment and counseling, which shall be provided to those women with additional needs;

v. Referral for extensive specialized nutritional services which shall be initiated by the medical care provider or the nutritionist under the supervision of the medical care provider in coordination with the case coordinator; and

vi. Postpartum nutritional assessment and basic guidance services which shall include, but not be limited to:

(1) Review and reinforcement of good dietary practices;

(2) Review of instruction on dietary requirement changes; and

(3) Instruction on breast feeding and/or formula preparation and feeding.

3. Social–psychological assessment and basic guidance services shall be provided to all patients to assist the patient in resolving social-psychological needs, in accordance with this subchapter. Specialized social-psychological assessment and short-term counseling shall be provided to those women with additional needs. Services shall be provided as follows:

i. Initial social-psychological assessment services which shall include, but not be limited to:

(1) Determining financial resources and living conditions;

(2) Determining the patient's personal support system;

(3) Determining the patient's attitudes and concerns regarding the pregnancy;

(4) Ascertaining present and prior involvement by the patient with other social programs or agencies and current social service needs;

(5) Ascertaining educational and/or employment status and needs; and

(6) Identification of the need for specialized social-psychological and/or mental health evaluation and counseling services;

ii. Subsequent social-psychological assessment services which shall include, but not be limited to:

(1) Determination of patient's reaction to pregnancy;

(2) Ascertaining the reaction of family, friends and actual support person to the pregnancy;

(3) Identification of the need for social service interventions and advocacy; and

(4) Identification of the need for specialized social-psychological and/or mental health evaluation and counseling;

iii. Basic social-psychological guidance, which shall include, but not be limited to:

(1) Orientation and information on available community resources;

(2) Orientation regarding stress and stress reduction during pregnancy; and

(3) Assistance with arrangements for transportation, child care and financial needs;

iv. Specialized, short-term social-psychological counseling, which shall be provided to women who are identified through assessment or basic counseling as having need for more intense service;

v. Referral for extensive specialized social-psychological services, which shall be initiated by the medical care provider or by the social worker under the supervision of the medical care provider and in coordination with the case coordinator; and

vi. Postpartum social-psychological assessment and guidance which shall include, but not be limited to:

(1) Review of prenatal, labor, delivery and postpartum course;

(2) Assessment of the patient's current social-psychological status, including mother and infant bonding and the acceptance of the infant by the father and/or family, as applicable;

(3) Identification of the need for additional social-psychological services;

(4) Review of available community resources for mother and infant, as applicable;

(5) Counseling regarding fetal loss or infant death, if applicable; and

(6) Counseling regarding school/employment planning.

4. Health education assessment and instruction shall be provided to all patients at intervals throughout the pregnancy, based on the patient's needs and in accordance with this subchapter and as follows:

i. Initial assessment of health educational needs, which shall include, but not be limited to:

(1) Identification of general educational background;

(2) Patient's health education needs; and

(3) Previous education and experience concerning pregnancy, birth and infant care;

ii. Health education instruction, which shall be provided for all patients based on their identified health education needs, shall include at least the following:

(1) Normal course of pregnancy;

(2) Fetal growth and development;

(3) Warning signs, such as signs of pre-term labor, and identification of emergency situations;

(4) Personal hygiene;

(5) Exercise and activity;

(6) Child birth preparation, including management of labor and delivery;

(7) Preparation for hospital admission;

(8) Substance, occupational and environmental hazards;

(9) Need for continuing medical and dental care;

(10) Future family planning;

(11) Parenting, basic infant care and development;

(12) Availability of pediatric and family medical care in the community; and

(13) Normal postpartum physical and emotional changes;

iii. Health education services, which shall include guidance in decision making and in the implementation of decisions concerning pregnancy, birth and infant care; and

iv. Postpartum assessment of health education needs shall be conducted.

5. One face-to-face preventive health care contact shall be provided or arranged for after the mother's discharge from the hospital and prior to the required medical postpartum visit, as follows:

i. This contact shall include, but not be limited to:

(1) Review of the mother's health status;

(2) Review of the infant's health status;

(3) Review of mother/infant interaction;

(4) Revision of the care plan; and

(5) Provision of additional services, as indicated.

ii. The provider shall provide or arrange for one or more home visits for each high risk patient in accordance with the requirements of this chapter. (See also N.J.A.C. 10:58A–4.5(j).)

10:58A–3.8 Standards for HealthStart pediatric care certificate

(a) CNP/CNS pediatric care services shall be comprehensive, integrated and coordinated.

(b) HealthStart CNP/CNS pediatric care providers shall:

1. Directly provide preventive child health care, maintenance of complete patient history, outreach for preventive care, initiation of referrals for appropriate medical, educational, social, psychological and nutritional services, and follow-up of referrals and sick care;

2. Directly provide or arrange for non emergency room-based, 24–hour practitioner telephone access for eligible patients; and

3. Directly provide or arrange for sick care and emergency care.

10:58A–3.9 Professional requirements for HealthStart pediatric care providers

All HealthStart CNP/CNS pediatric care providers shall be primary care providers who possess a knowledge of pediatrics. This may be demonstrated by certification by the New Jersey Board of Nursing, or by hospital admitting privileges in pediatrics or by documentation of a formal arrangement with a physician who is board certified in pediatrics or family practice.

10:58A–3.10 Preventive care services by HealthStart pediatric care providers

(a) HealthStart pediatric care providers shall provide preventive health visits in accordance with the recommended guidelines of the American Academy of Pediatrics and this chapter. The schedule shall include a two to four week visit, a two month visit, a four month visit, a six month visit, a nine month visit, a 12 month visit, a 15 month visit, an 18 month visit and a 23 to 24 month visit. Each visit shall include, at a minimum, medical, family and social history, unclothed physical examination, developmental and nutritional assessment, vision and hearing screening, dental assessment, assessment of behavior and social environment, anticipatory guidance, age appropriate laboratory examinations and immunizations. Referrals shall be made as appropriate.

(b) Each provider shall provide or arrange for sick care and 24 hour telephone physician/CNP/CNS access during non-office hours. If not directly provided by the HealthStart provider, sick care and 24 hour telephone access shall be provided for each child by a single designated provider via a documented agreement. Information on care given shall be communicated to the primary HealthStart pediatric care provider. Telephone access provided exclusively via emergency room staff is not permitted. Referral to the emergency room should occur only for emergency medical care or urgent care.

(c) Case coordination, outreach and follow-up services shall include letter and/or telephone call reminders to the child's parent or guardian for preventive well-child visits and letters and/or telephone follow-up of missed appointments. Referrals for home visit services for follow-up shall be made when appropriate. For all referrals and follow-up visits, the provider shall document the completion of such referrals and/or visits. If the referral is not completed, a letter or phone call to the child's parent or guardian and/or to the referred agency shall be sent or made. All of the activity shall be recorded on the patient's chart.

10:58A–3.11 Referral services by HealthStart pediatric care providers

(a) All HealthStart CPS/CNS pediatric care providers shall make provision for consultation for specialized health and other pediatric services. Services shall include medical services, as well as social, psychological, educational and nutritional services.

1. This may include, but is not limited to: the Special Supplemental Food Program for Women, Infants and Children (WIC); Division of Youth and Family Services, Special Child Health Services Case Management Units and Child Evaluation Centers; early intervention programs; county welfare agencies/boards of social services; certified home health agencies; community mental health centers; and local and county health departments.

10:58A–3.12 Records: documentation, confidentiality and informed consent for HealthStart pediatric care providers

(a) HealthStart pediatric care providers shall have policies which protect patient confidentiality, as defined at N.J.A.C. 10:49–9.4, and provide for informed consent and document comprehensive care services in accordance with this Chapter.

(b) An individual record shall be maintained for each patient.

(c) Each record shall be confidential and shall include at least the following: history and physical examination, results of required assessments, care plan, treatment services, laboratory reports, counseling and health instruction provided and documentation of referral and follow-up services.

(d) There shall be policies and procedures for appropriate informed consent for all HealthStart pediatric services.

10:58A–3.13 HealthStart services

(a) This section applies to CNP/CNS services provided by a CNP/CNS who has a HealthStart certificate.

(b) HealthStart pediatric care provides for up to nine preventive child health visits for a child under two years of age.

1. All preventive child health visits shall be billed using the HealthStart Preventive Child Health Visit codes appropriate to the child's age at the time of visit.

2. Claims shall be submitted using Form MC–19, EPSDT/HealthStart Screening and Related Procedures.

(c) A HealthStart pediatric preventive care visit includes the following elements:

1. A comprehensive health and developmental history including assessment of both physical and mental health development;

2. A comprehensive unclothed physical exam including vision and hearing screening, dental inspection, and nutritional assessment;

3. Appropriate immunizations according to age and health history;

4. Appropriate laboratory tests, including:

i. Hemoglobin/hematocrit;

ii. Urinalysis;

iii. Tuberculin test (Mantoux), annually;

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 additional blood lead level testing, if indicated; and

v. Other appropriate medically necessary procedures.

5. Health education, including anticipatory guidance; and

6. Referral for further diagnosis and treatment or follow up of all correctable abnormalities, uncovered or suspected. Referral may be to the provider conducting the screening examination, or to another provider, as appropriate.

(d) The HealthStart CNP/CNS pediatric providers shall provide case coordination, including referral for nutritional, psychological, social and other community services, as appropriate; provision or arrangement for 24–hour telephone physician/CNP/CNS access and sick care; and outreach and follow-up activities in accordance with this chapter.

SUBCHAPTER 4. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:58A–4.1 Introduction to the HCPCS procedure code system

(a) The New Jersey Medicaid and NJ KidCare fee-for-service programs use the Health Care Financing Administration's (HCFA) Common Procedure Code System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedure Terminology (CPT) architecture, employing a five-position code and as many as two two-position modifiers. Unlike the CPT numeric design, the HCFA-assigned codes and modifiers contain alphabetic characters. Because of copyright restrictions, the CPT procedure narratives for Level I codes are not included in this subchapter, but are hereby incorporated by reference.

1. Copies of the CPT may be ordered from the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

(b) HCPCS has been developed as a three-level coding system, as follows:

1. Level I codes: Narratives for these codes are found in CPT, which is incorporated herein by reference, as amended and supplemented. The codes are adapted from CPT for use primarily by physicians, podiatrists, optometrists, certified nurse-midwives, certified nurse practitioners and clinical nurse specialists, independent clinics and independent laboratories. Level I procedure codes, and fees for each, for which CNP/CNSs may bill, can be found at N.J.A.C. 10:58A–4.2.

2. Level II codes: These codes are assigned by HCFA for physician and non-physician services which are not in CPT. Narratives for these codes, and the fees for each, can be found at N.J.A.C. 10:58A–4.3.

3. Level III codes: Level III codes identify services unique to the New Jersey Medicaid and NJ KidCare fee-for-service programs. These codes are assigned by the Division to be used for those services not identified by CPT codes or HCFA-assigned codes. Narratives for these codes, and the fees paid for each, can be found at N.J.A.C. 10:58A–4.4.

(c) Specific elements of HCPCS codes require the attention of providers. The lists of HCPCS code numbers for independent clinic services are arranged in tabular form with specific information for a code given under columns with titles such as: "IND" "HCPCS CODE" "MOD," "DESCRIPTION," "FOLLOW–UP DAYS" and "MAXIMUM FEE ALLOWANCE." The information given under each column is summarized below:

1. Alphabetic and numeric symbols under "IND" & "MOD":

These symbols, when listed under the "IND" and "MOD" columns, are elements of the HCPCS coding system used as qualifiers or indicators ("IND" column) and as modifiers ("MOD" column). They assist the provider in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

i. These symbols and/or letters shall not be ignored because they reflect requirements, in addition to the narrative which accompanies the CPT/HCPCS procedure code as written in the CPT, for which the provider is liable. These additional requirements shall be fulfilled before reimbursement is requested.

ii. If there is no identifying symbol listed, the CPT/HCPCS procedure code narrative prevails.

IND Lists alphabetic symbols used to refer the provider to information concerning the New Jersey Medicaid/NJ KidCare fee-for-service program's qualifications and requirements when a procedure or service code is used.

An explanation of the indicators and qualifiers used in this column is located below and in paragraph 1, "Alphabetic and numeric symbols," as follows:

E = "E" preceding any procedure code indicates that these procedures are excluded from multiple surgery pricing and, as such, should be reimbursed at 100 percent of the program maximum fee allowance, even if the procedure is done on the same patient, by the same provider, at the same session and also that the procedure codes are excluded from the policy indicating that office visit codes are not reimbursed in addition to procedure codes for surgical procedures. (See N.J.A.C. 10:58A–4.6(a)).

L = "L" preceding any procedure code indicates that the complete narrative for the code is located at N.J.A.C. 10:58A-4.4(b) and 4.5(c).

N = "N" preceding any procedure code means that qualifiers are applicable to that code. These qualifiers are listed by procedure code number at N.J.A.C. 10:58A-4.5.

P = "P" preceding any procedure code indicates that prior authorization is required. The appropriate form that must be used to request prior authorization is indicated in the Fiscal Agent Billing Supplement.

HCPCS
CODE = HCPCS procedure code numbers.
MOD = Alphabetic and numeric symbols: Under certain circumstances, services and procedures may be modified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid and NJ KidCare fee-for-service programs' modifier codes for certified nurse practitioner/certified clinical nurse specialist services are:
AV = Certified Nurse Practitioner.
TC = Technical component: When applicable, a charge may be made for the technical component alone. Under these circumstances, the technical component charge is identified by adding the modifier "TC" to the usual procedure code.
WT = Services provided to Medicaid/NJ KidCare fee-for-service beneficiaries under 21 years of age under Early Periodic Screening, Diagnosis and Treatment Program (EPSDT) as set forth at N.J.A.C. 10:58A–2.10. The "WT" modifier is used by providers who are not certified as HealthStart providers, when billing for services to children up to the age of two years. Providers certified for HealthStart should consult N.J.A.C. 10:58A–3.1 through 3.18.
22 = Unusual services: When the service provided is greater than that usually required for the listed procedure, it may be identified by adding the modifier "22" to the usual procedure number.
26 = Professional Component: Certain procedures are a combination of a professional and a technical component. When the professional component is reported separately, the service may be identified by adding the modifier "26" to the usual procedure number. If a professional type service is keyed without a "26" modifier and a manual pricing edit is received, resolve the edit by adding a 26 modifier.
50 = Bilateral procedures: Unless otherwise identified in the listings, bilateral procedures requiring a separate incision which are performed during the same operative session should be identified by the appropriate five-digit code describing the first procedure. The second (bilateral) procedure is identified by adding modifier "50" to the procedure code.
52 = Reduced services: Under certain circumstances, a service or procedure is partially reduced or eliminated at the practitioner's election. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of the modifier "52," signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.
DESCRIPTION = Code narrative:
Narratives for Level I codes are found in CPT.
Narratives for Level II and III codes are found at N.J.A.C. 10:58A–4.3 and 4.4, respectively.
FOLLOW–UP DAYS = Number of days for follow-up care which are considered as included as part of the procedure code for which no additional reimbursement is available.
MAXIMUM FEE ALLOWANCE = New Jersey Medicaid/NJ KidCare
fee-for-service program's maximum reimbursement allowance. If the symbols "B.R." (By Report) are listed instead of a dollar amount, it means that additional information will be required in order to evaluate and price the service. Attach a copy of any additional information to the claim form.

(d) Listed below are general policies of the New Jersey Medicaid and NJ KidCare fee-for-service programs that pertain to HCPCS. Specific information concerning the responsibilities of a CNP/CNS when rendering Medicaid and NJ KidCare fee-for-service-covered services and requesting reimbursement are located at N.J.A.C. 10:58A–1.4, Recordkeeping; 10:58A–1.5, Basis of Reimbursement; and 10:58A–2.6, Policies for the Use of Evaluation and Management Services HCPCS Codes.

1. General requirements are as follows:

i. When filing a claim, the appropriate HCPCS procedure codes must be used, in conjunction with modifiers when applicable.

ii. When billing, the provider must enter on the claim form a CPT/HCPCS procedure code as listed in this subchapter (N.J.A.C. 10:58A–4.2, 4.3, 4.4.)

iii. Date(s) of service(s) must be indicated on the claim form and in the provider's own record for each service billed.

iv. The "MAXIMUM FEE ALLOWANCE" as noted with these procedure codes represents the maximum payment for the given procedure for the CNP/CNS. When submitting a claim, the CNP/CNS shall enter the practitioner's usual and customary fee.

(1) Listed values for all surgical procedures include the surgery and the follow-up care included in the maximum fee allowance for the period (indicated in days) in the column titled "Follow-Up Days."

v. The HCPCS procedure codes that are billable in conjunction with office visit codes are listed at N.J.A.C. 10:58A–4.5, Qualifiers. (See the "N" designation in the "Indicator" column.)

vi. The use of a procedure code will be interpreted by the New Jersey Medicaid/NJ KidCare fee-for-service program as evidence that the practitioner personally furnished, as a minimum, the services for which it stands.

vii. For reimbursement purposes, those services with the modifier "AV" must be personally performed by the CNP/CNS who is submitting the claim.

Amended by R.2000 d.144, effective April 3, 2000.
See: 31 N.J.R. 3968(a), 32 N.J.R. 1208(a).
In (c)1, substituted a reference to CPT for a reference to CPT–4 in i, inserted a reference to NJ KidCare programs in IND description, and inserted a reference to "E".
Amended by R.2000 d.265, effective July 3, 2000.
See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).
Inserted references to NJ KidCare fee-for-service and substituted references to CPT for references to CPT-4 throughout; in (a), deleted a reference to the American Medical Association and substituted a reference to this subchapter for a reference to this manual in the introductory paragraph, and added 1; and in (c), inserted references to TC and 26.

10:58A–4.2 HCPCS procedure code numbers and maximum fee allowance schedule (Level I)

IND	HCPCS Codes	MOD	Follow-up Days	Maximum Fee Allowance $
(a) Surgical services:				
	10060	AV		10.50
	10120	AV		15.20
	10140	AV		15.20
	10160	AV		10.50
	11055	AV		10.45
	11056	AV		13.30
	11057	AV		13.30
	11719	AV		4.75
(b) Family planning procedures:				
N	11975	AV	30	80.70
N L†	11975	AV 22		Direct Package Price,‡ Plus
			30	80.70
N	11976	AV	90	80.70
N	11977	AV	90	161.50
N L†	11977	AV 22	90	Direct Package Price‡, Plus 161.50
				161.50

† Level III code. Included here for convenience in preparing billings.

‡ Direct Package Price is the price paid by the purchaser directly to the manufacturer without going through the wholesaler.

IND	HCPCS CODES	MOD	MAXIMUM FEE ALLOWANCE $
(c) Non–complex repairs:			
Wounds	12001	AV	15.20
	12002	AV	20.00
Burns	16000	AV	13.30
	16020	AV	13.30
(d) Strapping (Any age):			
E N	29105	AV	20.00
E N	29125	AV	20.00
E N	29130	AV	15.20
E N	29200	AV	15.20
E N	29220	AV	20.00
E N	29240	AV	20.00
E N	29260	AV	15.20
E N	29280	AV	15.20
(e) Splints:			
E N	29505	AV	39.90
E N	29515	AV	35.20
E N	29520	AV	20.00
E N	29530	AV	15.20
E N	29540	AV	15.20
E N	29550	AV	13.30
E N	29580	AV	15.20
E N	29590	AV	9.50
(f) Casts, removal or repair:			
E N	29700	AV	11.40
E N	29705	AV	11.40
E N	29710	AV	15.20
E N	29715	AV	15.20
E N	29720	AV	20.00
E N	29730	AV	7.60
E N	29740	AV	7.60
(g) Other procedures, by system:			
1. Respiratory:			
	30300	AV	13.30
	30901	AV	20.00
	30901	AV 50	50.40
E	31720	AV	19.00
2. Vascular Injection Procedures:			
	36000	AV	30.00
E N	36415	AV	1.80
3. Urinary System:			
	51010	AV	35.20
	51700	AV	17.10
	51705	AV	17.10
E N	53670	AV	13.30
4. Obstetric/Gynecologic:			
E N	57150	AV	13.30
	57160	AV	13.30
E N	58301	AV	16.40
E N	59025	AV	18.00
E N	59025 26	AV	16.00
E N	59430	AV	17.10
5. Auditory System:			
	69200	AV	10.50
(h) Laboratory Services:			
	81002		1.00
	81025		3.00
	82270		1.20
	82962		2.60
	83026		2.00
	84830		3.00
	85013		1.50
	85651		1.50
(i) Tuberculin Testing:			
	86580		4.00
	86585		4.00
(j) Immunizations:			