CHAPTER 54

PHYSICIAN SERVICES

Authority

N.J.S.A. 30:4D–6a(5); 30:4D–7, 7a, b and c; 30:4D–12; 42 CFR 440.50.

Source and Effective Date

R.1996 d.66, effective February 5, 1996.
See: 27 N.J.R. 4576(a), 28 N.J.R. 902(b).

Executive Order No. 66(1978) Expiration Date

Chapter 54, Physician Services, expires on February 5, 2001.

Chapter Historical Note

Chapter 54, Manual for Physician's Services, originally was filed and became effective prior to September 1, 1969.

Chapter 54, Manual for Physician's Services, was readopted, pursuant to Executive Order No. 66(1978), by R.1991 d.136, effective February 15, 1991. See: 22 N.J.R. 3711(b), 23 N.J.R. 858(a). Subchapter 3, Procedure Code Manual, was repealed by R.1986 d.52 and Subchapter 4, HCFA Common Procedure Coding System (HCPCS), was adopted as new rules, effective March 3, 1986. See: 17 N.J.R. 1519(b), 18 N.J.R. 478(a).

Chapter 54, Manual for Physician's Services, was repealed, and Chapter 54, Physicians Services, was adopted as new rules by R.1996 d.66, effective February 5, 1996. See: Source and Effective Date.

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SUBCHAPTER 1. GENERAL PROVISIONS

10:54–1.1 Purpose and scope

(a) The Physician Services chapter outlines the policies and procedures of the New Jersey Medicaid program for a physician who prescribes, provides directly, or personally directs medically necessary health services to Medicaid recipients. The policies and procedures in this chapter foster the delivery of services in the most efficient and cost-effective manner consistent with good medical practice.

(b) As a Medicaid provider, the physician may also participate in special programs, such as the HealthStart (Maternity and Pediatric Services), Garden State Health Plan and managed health care, which is provided to designated recipients in selected counties, in accordance with the provisions of N.J.A.C. 10:49–20 and 10:74, respectively.

(c) Medicaid rules regarding physicians who have a collaborative arrangement with certified nurse practitioners/clinical nurse specialists (CNP/CNS) may be found in the New Jersey Administrative Code at N.J.A.C. 10:58A. Medicaid rules regarding physicians who employ CNP/CNSs may be found in N.J.A.C. 10:54 (this chapter).

(b) The minimum recordkeeping requirements for services performed in the office, home, residential health care facility, nursing facility (NF), and the hospital setting shall include a progress note in the clinical record for each visit, which supports the procedure code(s) claimed.

(c) The progress note shall be placed in the clinical record and retained in the appropriate setting for the service performed.

(d) Records of Residential Health Care Facility patients shall be maintained in the physician's office.

(e) The required medical records including progress notes, shall be made available, upon their request, to the New Jersey Medicaid program or its agents.

10:54–2.7 Minimum documentation; initial visit; new patient

(a) The following minimum documentation shall be entered on the medical record, regardless of the setting where the examination is performed, for the service claimed by use of the procedure codes for Initial visit—New patient:

1. Chief complaint(s);

2. Complete history of the present illness and related systemic review, including recordings of pertinent negative findings;

3. Pertinent past medical history;

4. Pertinent family and social history;

5. A record of a full physical examination pertaining to, but not limited to, the history of the present illness and including recordings of pertinent negative findings;

6. Diagnosis(es) and the treatment plan, including ancillary services and medications ordered;

7. Laboratory, X–Rays, electrocardiograms (ECGs), and any other diagnostic tests ordered, with the results; and

8. The specific services rendered and/or modality used (for example, biopsies, injections, individual and/or group psychotherapy, and family therapy).

10:54–2.8 Minimum documentation; established patient

(a) The following minimum documentation shall be entered in the progress notes of the medical record for the service designated by the procedure codes for ESTABLISHED PATIENT:

1. In an office or Residential Health Care Facility:

i. The purpose of the visit;

ii. The pertinent physical, family and social history obtained;

iii. A record of pertinent physical findings, including pertinent negative findings based upon i and ii above;

iv. Procedures performed, if any, with results;

v. Laboratory, X–Ray, electrocardiogram (ECG), or any other diagnostic tests ordered, with the results of the tests; and

vi. Prognosis and diagnosis.

10:54–2.9 Minimum documentation; home visits and house calls

For HOME VISIT and HOUSE CALL codes, in addition to the components listed in N.J.A.C. 10:54–2.8, the office progress notes shall include treatment plan status relative to present or pre-existing illness(es), plus pertinent recommendations and actions.

10:54–2.10 Minimum documentation; hospital or nursing facility

(a) In a hospital or nursing facility, documentation shall include:

1. An update of symptoms;

2. An update of physical findings;

3. A resume of findings of procedures, if any are applicable;

4. The pertinent positive and negative findings of laboratory, X–Ray, electrocardiograms (ECGs), or other tests or consultations;

5. Any additional planned studies, if any, including the reasons for any studies; and

6. Treatment changes, if any.

10:54–2.11 Minimum documentation; hospital discharge medical summary

(a) When an inpatient is discharged from the hospital to the care of another medical facility (such as a nursing facility or a community home care agency), a legible discharge and medical summary shall be prepared and signed by the attending physician.

(b) The summary should cover the pertinent findings of the history, physical examination, diagnostic and therapeutic modalities, consultations, plan of care or therapy, medications, recommendations for follow-up care and final diagnosis related to the patient's hospitalization. Recommendations should also be made for further medical care and should be forwarded to the institution or agency to which the patient has been referred.

10:54–2.12 Minimum documentation; mental health services

(a) For each patient contact made by a physician for psychiatric therapy, 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, at a minimum, shall consist of the following:

1. The specific services rendered and modality used, for example, individual, group, and/or family therapy;

2. The date and the time services were rendered;

3. The duration of services provided, for example, one hour, or one-half hour;

4. The signature of the physician who rendered the service;

5. The setting in which services were rendered;

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

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

8. Other relevant information, which may include dates or information not included in above, yet important to the clinical picture and prognosis.

(b) Clinical progress, complications and treatment which affect prognosis and/or progress shall be documented in the patient's medical record, as well as any other information important to the clinical picture, therapy, and prognosis.

(c) For mental health services that are not specifically included in the patient's treatment regime, a detailed explanation shall be submitted with the claim form, addressed to the Office of Health Services Administration, Mental Health Services, Mail Code #18, CN–712, Trenton, New Jersey, 08625–0712, indicating how these services relate to the treatment regime and objectives in the patient's plan of care. Similarly, a detailed explanation should accompany bills for medical and remedial therapy, session or encounter that departs from the Plan of Care in terms of need, scheduling, frequency or duration of services furnished (for example, unscheduled emergency services furnished during an acute psychotic episode) explaining why this departure from the established treatment regime is necessary in order to achieve the treatment objectives.

SUBCHAPTER 3. PROVISION OF SERVICES

10:54–3.1 Medical Justification Program

(a) The Medical Justification program of the New Jersey Medicaid program defines certain surgical and diagnostic procedures which are reimbursable only when acceptable written justification by the physician accompanies the claim form. The procedures which require medical justification are identified in the HCFA Common Procedures Coding System by the indicator "M" preceding the HCPCS code. (See N.J.A.C. 10:54–9.)

(b) Physicians shall maintain written records that substantiate the use of a given procedure code. These records shall be available for review and/or inspection if requested by the New Jersey Medicaid program.

10:54–3.2 Prior authorization

(a) Prior authorization, as used in this Chapter, is the approval granted by the New Jersey Medicaid program before a service is rendered or an item provided. For additional information about prior and retroactive authorization, see also N.J.A.C. 10:49–6 and N.J.A.C. 10:54–5 and 7.

(b) Certain services require prior authorization, such as cosmetic surgery, certain psychiatric services, and all out-of-state inpatient and outpatient hospital services, except in the conditions listed in (c) below. Services rendered to Medicaid beneficiaries enrolled in a Health Maintenance Organization (HMO) may also require authorization by the Health Maintenance Organization (for details, see Managed Health Care Services in N.J.A.C. 10:74).

(c) Prior authorization shall not be required for the following:

1. Hospital covered services to any recipient who resides out of State at the discretion of the New Jersey Department of Human Services and who has a HSP (Medicaid) case number with either:

i. The first and second digits of 90; or

ii. The third and four digits of 60; or

2. Emergencies and interstate hospital transfers.

3. Any covered service that requires prior authorization as a prerequisite for payment to New Jersey Medicaid providers also requires prior authorization if it is to be provided and reimbursed by the New Jersey Medicaid program in any other state.

10:54–3.3 Authorization of reimbursement for out–of–State hospital services

(a) A request for authorization for reimbursement for out–of–State hospital services shall be directed to the Medicaid District Office (MDO) in the area where the recipient resides (see N.J.A.C. 10:49, Appendix), except that:

1. Prior authorization of out-of-state psychiatric services shall be directed to the Office of Health Services Administration, Mental Health Services Unit, and shall comply with the requirements of N.J.A.C. 10:54–7.4.

(b) The physician making the request will receive written notification of the decision regarding the request.

(c) If authorized, the authorization letter of a medical consultant of the New Jersey Medicaid program will be forwarded to the attending physician. When submitting the claim for service to the Medicaid fiscal agent, the physician shall attach the authorization letter to the claim.

10:54–3.4 Out–of–state elective services

(a) For a recipient residing in New Jersey in other than a hospital, who is to be admitted or referred to an out-of-state hospital or physician for elective inpatient or outpatient hospital services, the physician planning such action shall sign a statement that the medically necessary service is not available at a reasonable distance within the State of New Jersey and shall send the signed statement to the MDO.

(b) For a recipient traveling outside New Jersey who is to be admitted to an out–of–State hospital for elective surgery, as part of the prior authorization request, the attending physician shall justify the decision by sending to the Medicaid District Office (MDO), a signed statement that an attempt to return to a New Jersey hospital would create a significant risk to life or health or would create the need for an unreasonable amount of travel for the recipient.

10:54–3.5 Out–of–State emergencies and interstate transfers

(a) Prior authorization shall not be required for emergencies nor for interstate hospital transfers. However, in these instances, the hospital shall attach the attending physician's signed statement to the claim, attesting to the nature of the emergency; or, for a hospital interstate transfer, attesting to the unavailability of the medically necessary service within a reasonable distance within the State of New Jersey; or that the need to obtain prior authorization would result in a delay that could create a significant risk to life or health or unduly prolong hospitalization. The physician shall provide the hospital with a copy of the authorization letter to be attached to the claim from the hospital, when applicable.

(b) For prior authorization and preadmission screening for mental health and psychiatric services, see N.J.A.C. 10:54–7.1 and 7.4 of this Chapter.

SUBCHAPTER 4. BASIS OF PAYMENT

10:54–4.1 General payment methodology

(a) Payment for physician services covered under the New Jersey Medicaid or NJ KidCare program is based upon the customary charge prevailing in the community for the same service but shall not exceed a "Maximum Fee Allowance Schedule" which has been determined reasonable by the Commissioner and set forth in N.J.A.C. 10:54–9 and as limited by Federal policy relative to the payment of physicians and other licensed health care practitioners.

1. In no event shall the charge to the New Jersey Medicaid or NJ KidCare program exceed the charge by the provider for identical services to other governmental agencies or other groups or individuals in the community.

2. Effective July 20, 1998, for services provided to beneficiaries eligible for both Medicare Part B and Medicaid or NJ KidCare, including Qualified Medicare Beneficiaries, Medicaid or NJ KidCare shall reimburse physicians and practitioners the Medicare Part B coinsurance and deductible amount or the Medicaid or NJ KidCare maximum fee allowable (less any third party payments, including Medicare reimbursement), whichever is less.

(b) The "Maximum Fee Allowance Schedule" differentiates rates according to whether the physician is a specialist or nonspecialist. (See N.J.A.C. 10:54–1.2 through 1.5 of this manual for regulations for specialist.)

(c) For reimbursement for injections and immunizations, see N.J.A.C. 10:54–4.3(a)6 and N.J.A.C. 10:54–9.8(h).

(d) For reimbursement for services of certified nurse practitioners/clinical nurse specialists employed by a physician or physician group, see N.J.A.C. 10:58A–4.1 through 4.5, incorporated herein by reference.

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), inserted references to NJ KidCare throughout.
Amended by R.1998 d.382, effective July 20, 1998.
See: 30 N.J.R. 1255(b), 30 N.J.R. 2646(b).
In (a)2, inserted "Effective July 20, 1998," at the beginning, inserted references to NJ KidCare throughout, and substituted "less" for "greater" at the end.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.2 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 NJ KidCare–Plan C and copayments for NJ KidCare–Plan D are set forth at 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 when the service is provided for preventive care, prenatal care, family planning services or substance abuse treatment services.

1. An office visit is defined as a face-to-face contact with a medical professional under the supervision of the physician, which meets the documentation requirements codified at N.J.A.C. 10:52–2.6 through 2.12.

2. Office visits include physician services provided in the office, patient's home, or any other site excluding hospital where the child may have been examined by the physician. Generally, these procedure codes are in the 90000 HCPCS series of reimbursable codes codified at N.J.A.C. 10:54–9.3.

3. Physician 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) Physicians 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 primary care and specialist physician 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) Physicians shall collect the copayment specified in (d) above except for those situations outlined in (f) below. Copayments shall not be waived.

(f) Physicians shall not charge a copayment under Plan D for services provided to newborns, who are covered under fee-for-service for Plan D; or for preventive services, including well child visits, lead screening and treatment, or 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).
Former N.J.A.C. 10:54–4.2, Use of physician reimbursement codes, recodified to N.J.A.C. 10:52–4.3.
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.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).

10:54–4.3 Use of physician reimbursement codes

When the examination of the recipient is by the same physician, a practitioner, a shared health facility or group of physicians/practitioners who share a common record, the examination is considered that of a single provider.

Recodified from N.J.A.C. 10:54–4.2 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).
Former N.J.A.C. 10:54–4.3, HCPCS codes for new patients visits, recodified to N.J.A.C. 10:54–4.4.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.4 HCPCS codes for new patients visits

(a) This rule applies to office, and hospital inpatient and outpatient services to new patients (excluding preventive health care for patients through 20 years of age).

(b) When the CPT manual refers to office or hospital inpatient or outpatient services—new patient, Medicaid will consider this service an initial visit.

1. When the setting for an initial visit is an office or residential health care facility, reimbursement shall be limited to a single visit. Future requests for reimbursement which include this category of codes will be denied when the recipient is seen by the same physician, practitioner, group of physicians/practitioners, or shared health care facility sharing a common record. Reimbursement for an initial office visit precludes subsequent reimbursement for an initial residential health care facility visit and vice versa.

2. 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 twelve month period by a physician, group, shared health care facility, or practitioner sharing a common record.

(c) If the setting is a nursing facility or hospital, the initial visit concept shall still apply when considered for reimbursement purposes despite CPT reference to the terms initial hospital care as applying to a new or established patient. 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).

(d) Reimbursement for an initial hospital visit shall be disallowed to the same physician, practitioner, group of physicians/practitioners, or shared health care facility sharing a common record who submit a claim for a consultation and transfer the patient to their service. "Consultation" and "Initial Hospital Visit" shall not be billed for the same provider on the same patient on the same day of service.

(e) In order to receive reimbursement for an initial visit, the documentation requirements set forth in N.J.A.C. 10:54–2.6 through 2.12 shall be met, regardless of where the examination was performed.

Recodified from N.J.A.C. 10:54–4.3 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).
Former N.J.A.C. 10:54–4.4, Use of HCPCS codes for establishing patient visits, recodified to N.J.A.C. 10:54–4.5.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.5 Use of HCPCS codes for established patient visits

(a) This rule applies to office, inpatient or outpatient services to established patients (excluding preventive health care for patients through 20 years of age).

(b) "Routine visit" or "follow-up visit" means the care and treatment by a physician, which includes those procedures ordinarily performed during a health care visit, which is dependent upon the setting and the physician's discipline. The setting may be an office, hospital, nursing facility or residential health care facility.

1. In order to receive reimbursement for a routine visit or follow-up visit, the documentation requirements set forth in N.J.A.C. 10:54–2.3 shall be met, regardless of where the examination was performed.

Recodified from N.J.A.C. 10:54–4.4 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).
Former N.J.A.C. 10:54–4.5, Use of HCPCS codes for home visits and house calls, recodified to N.J.A.C. 10:54–4.6.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.6 Use of HCPCS codes for home visits and house calls

(a) "House call" means a physician visit limited to the provision of medical care to an individual who is too ill to go to a physician's office and/or is "home bound" due to his or her physical condition.

(b) The house call codes do not distinguish between specialist and non-specialist reimbursement. House call codes apply when a detailed history, detailed examination and medical decision making of high complexity is provided.

(c) The home visit codes shall apply when the provider visits in the home setting and the visit does not meet the criteria specified in (a) and (b) above.

(d) When billing for a second or subsequent patient treated during the same visit, the visit shall be billed as a home visit, no matter what the complexity of care.

(e) House call and home visit codes shall not apply to visits to a residential health care facility or a nursing facility setting.

(f) In order to receive reimbursement for a house call or home visit, the documentation requirements set forth in N.J.A.C. 10:54–2.8 and 2.9 shall be met.

Recodified from N.J.A.C. 10:54–4.5 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).
Former N.J.A.C. 10:54–4.6, Use of HCPCS codes for emergency department services, recodified to N.J.A.C. 10:54–4.7.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.7 Use of HCPCS codes for emergency department services

(a) When a physician sees his or her patient in the emergency room instead of his or her office, the physician shall use the same codes for the visit that would be used if the patient were seen in the physician's office (HCPCS 99211–99215 only). Records of the emergency room visit shall become part of the notes in the office chart.

(b) When a patient is seen by a hospital-based emergency room physician who is a Medicaid provider, then only the following "Visit" codes shall be used:

1. HCPCS 99281–99285.

Recodified from N.J.A.C. 10:54–4.6 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).
Former N.J.A.C. 10:54–4.7, Use of HCPCS codes for critical care services, recodified to N.J.A.C. 10:54–4.8.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.8 Use of HCPCS codes for critical care services

(a) For critical care services to be covered by the Program, the HCPCS codes 99291 and 99292 shall be used and the service shall be consistent with the following requirement in order to be reimbursed:

1. The patient's situation requires constant physician attendance which is given by the physician to the exclusion of his or her other patients and duties and, therefore, for him or her, represents what is beyond usual service. This shall be verified by the applicable records, as defined by the setting. The records shall show, in the physician's handwriting, the time of onset and time of completion of the service.

(b) HCPCS codes 99291 and 99292 may be used in all settings, such as office, hospital, home, residential health care facility and nursing facility.

(c) HCPCS codes 99291 and 99292 shall not be used simultaneously with procedure codes that pay a reimbursement for the same time or type of service. (See N.J.A.C. 10:54–9.8 for procedure codes that must not be billed with Critical Care Service codes.)

Recodified from N.J.A.C. 10:54–4.7 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).
Former N.J.A.C. 10:54–4.8, Use of HCPCS codes for neonatal intensive care, recodified to N.J.A.C. 10:54–4.9.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.9 Use of HCPCS codes for neonatal intensive care

(a) For neonatal intensive care services to be covered by the Program, the codes HCPCS 99295–99297 shall be used and the service shall be consistent with the narrative in the CPT and with the following, in order to be reimbursed:

1. The patient's situation requires constant physician attendance which shall be given by the physician to the exclusion of his or her other patients and duties and, therefore, for him or her, represents what is beyond usual service. This must be verified by the applicable records, as defined by the setting. The records shall show in the physician's handwriting the time of onset and time of completion of the service.

(b) HCPCS codes 99295–99297 shall not be used simultaneously with procedure codes that pay a reimbursement for the same time or type of service.

Recodified from N.J.A.C. 10:54–4.8 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).
Former N.J.A.C. 10:54–4.9, Use of HCPCS codes for neonatal intensive care; well baby, recodified to N.J.A.C. 10:54–4.10.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.10 Use of HCPCS codes for neonatal care; well baby

For routine hospital newborn care for a well baby, the HCPCS code 99431 requires documentation, for reimbursement purposes, of minimum routine newborn care by a physician/practitioner other than the physician(s)/practitioner(s) rendering maternity service, complete initial and discharge physical examination, conference(s) with the patient(s).

Recodified from N.J.A.C. 10:54–4.9 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).
Former N.J.A.C. 10:54–4.10, Use of HCPCS codes for neonatal intensive care; sick newborn, recodified to N.J.A.C. 10:54–4.11.
Adopted concurrent proposal, R.1998 d.487, effective .
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.11 Use of HCPCS codes for neonatal care; sick newborn

For sick newborns in a hospital inpatient setting, HCPCS code 99221 shall be used for initial hospital care. HCPCS codes 99231, 99232, and 99233 shall be used for all other hospital care. If a prolonged period of hospital inpatient care is applicable, HCPCS codes 99356 and 99357 shall be used.

Recodified from N.J.A.C. 10:54–4.10 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).
Former N.J.A.C. 10:54–4.11, Physician reimbursement in special situations, recodified to N.J.A.C. 10:54–4.12.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.12 Physician reimbursement in special situations

(a) A hospital-based physician who is salaried and whose services are reimbursed as part of the hospital's cost shall not bill fee-for-service to the New Jersey Medicaid program.

(b) A physician practicing in a hospital outpatient department whose reimbursement is not part of the hospital's cost may bill fee-for-service to the New Jersey Medicaid program, independent of the hospital charges for professional services, if the physician's arrangement with the hospital permits it.

(c) If a patient receives care from more than one member of a partnership or corporation in the same discipline, the maximum fee allowance shall be the same as that for a single attending physician.

(d) Reimbursement shall not be made for, and recipients shall not be asked to pay for, broken appointments.

(e) Reimbursement shall be made for injections (intradermal, subcutaneous, intramuscular, intravenous) which are administered by the physician according to N.J.A.C. 10:54–9.4 and N.J.A.C. 10:54–9.8.

1. Reimbursement for immunization services will be based on the formula of Average Wholesale Price (AWP) of the drug plus 15 percent, plus $2.00 for physician's cost of dispensing the immunization. For specific qualifiers for immunizations, see N.J.A.C. 10:54–9.8(a) and (i) and N.J.A.C. 10:54–9.10(f).

(f) Reimbursement for psychiatric consultation or shock therapy shall be considered as inclusive of all psychiatric services that day.

(g) Reimbursement for Early and Periodic Screening, Diagnosis and Treatment shall be made in accordance with N.J.A.C. 10:54–5.5, N.J.A.C. 10:54–9.4 and 9.10(*l*)4.

(h) Reimbursement for HealthStart services shall be made in accordance with N.J.A.C. 10:54–6 and N.J.A.C. 10:54–9.10(k).

Recodified from N.J.A.C. 10:54–4.11 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).
Former N.J.A.C. 10:54–4.12, HCPCS codes for surgical procedures; general, recodified to N.J.A.C. 10:54–4.13.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.13 HCPCS codes for surgical procedures; general

(a) The New Jersey Medicaid program shall reimburse for surgical services based on a surgical package concept, which includes the following components:

1. Pre-operative care, which shall include any consultations and/or evaluations performed within 48 hours prior to surgery by the surgeon performing the surgery and routine visits (office or hospital) on the day of surgery, except that:

i. Initial hospital visits may be reimbursed on the day of surgery, unless the surgery involves certain obstetrical delivery codes (see N.J.A.C. 10:54–9.10 for a listing of these delivery codes); and

ii. When the patient is undergoing same day surgery (hospital outpatient) or surgery in an ambulatory surgical center (independent clinic), the pre-surgical history, physical examination, and risk evaluation provided on the same day may be billed by the physician. (See also N.J.A.C. 10:54–9.4.)

2. The performance of the operation (surgical procedure) itself;

3. Anesthesia services, when rendered by the operating surgeon (that is, local anesthesia or nerve blocks); and

4. Normal post-operative care.

i. A listing of surgical codes, with corresponding follow-up days, is provided in N.J.A.C. 10:54–9.4. During the corresponding follow-up days, normal follow-up post-operative care (that is, office visits) shall not be billed separately from the all inclusive operative fee. No additional reimbursement shall be made to the provider for routine care during the follow-up period.

Recodified from N.J.A.C. 10:54–4.12 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).
Former N.J.A.C. 10:54–4.13, Pre-surgery consultation and evaluation, recodified to N.J.A.C. 10:54–4.14.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.14 Pre-surgery consultation and evaluation

Consultation and evaluation services provided prior to surgery by specialists other than the surgeon performing the procedure may be separately reimbursed from the payment for surgical procedures when provided within 48 hours prior to surgery.

Recodified from N.J.A.C. 10:54–4.13 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).
Former N.J.A.C. 10:54–4.14, Simultaneous visit and other procedures, recodified to N.J.A.C. 10:54–4.15.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.15 Simultaneous visit and other procedures

(a) If the physician bills for an office/outpatient visit at the time of the surgical procedure, reimbursement may be made for either the surgical procedure, at 100 percent of the Medicaid maximum fee allowance, or for the office/hospital outpatient visit.

(b) The following situations are exceptions to (a) above:

1. Venipuncture (HCPCS 36415) may be billed once per patient visit in addition to an office/hospital outpatient visit when the visit fulfills requirements of a visit and the sample is sent to an outside laboratory for processing;

2. Aspiration or injection into joints (HCPCS 20600–20610) may be billed with an office/hospital outpatient visit;

3. Medication injected into tendon sheaths, ligament trigger points or ganglion cysts (HCPCS 20550) may be billed with an office/hospital outpatient visit; and

4. Procedure codes listed in N.J.A.C. 10:54–9.4.

(c) In order to be properly reimbursed for the surgical procedure, the physician shall bill for the surgical procedure, rather than for the office or outpatient visit, in those instances where the surgical procedure fee exceeds the office or outpatient visit.

Recodified from N.J.A.C. 10:54–4.14 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).
Former N.J.A.C. 10:54–4.15, Multiple surgical procedures; same session, recodified to N.J.A.C. 10:54–4.16.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.16 Multiple surgical procedures; same session

(a) Multiple surgical procedures during the same operative session shall be reimbursed as follows:

1. The primary surgical procedure shall be reimbursed at 100 percent of the Medicaid Maximum Allowable Fee;

2. The secondary surgical procedure(s) shall be reimbursed at 50 percent of the Medicaid Maximum Allowable Fee; and

3. The maximum reimbursement threshold for any operative procedure is 200 percent of the amount of the Maximum Fee Schedule of the primary surgical procedure.

(b) Incidental surgical procedures shall not be reimbursed in addition to any primary and/or secondary surgical procedure(s). A list of those procedure codes considered by the New Jersey Medicaid program to be incidental procedures is located in N.J.A.C. 10:54–9.11(b).

Recodified from N.J.A.C. 10:54–4.15 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).
Former N.J.A.C. 10:54–4.16, Repeat or revisitation of the surgical procedure, recodified to N.J.A.C. 10:54–4.17.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.17 Repeat or revisitation of the surgical procedure

If the recipient is returned to the operative suite for a repeat or revisitation of the operation, by the same surgeon on the same day, the billing for the operative procedure shall include the "WB" modifier for the reimbursement for the second operative session. The use of this "WB" modifier permits separate reimbursement for the second operative session.

Recodified from N.J.A.C. 10:54–4.16 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).
Former N.J.A.C. 10:54–4.17, Litigation or transection of fallopian tubes, recodified to N.J.A.C. 10:54–4.18.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.18 Ligation or transection of fallopian tubes

(a) Ligation or transection of fallopian tube(s), when done at the operative session (time) of a Caesarean Section or intra-abdominal surgery, shall be reimbursed by the New Jersey Medicaid program for additional reimbursement from the primary surgical procedure (Caesarean Section) or intra-abdominal surgery. The physician shall use HCPCS 58611 when billing for the ligation/transection of fallopian tube(s) done at the same operative session as the Caesarean Section or intra-abdominal surgery. Multiple surgery pricing shall not apply.

(b) The physician shall use HCPCS codes 58600 or 58605, when the ligation or transection of the fallopian tube(s) are not done at the same time as the operative session for intra-abdominal surgery. Multiple surgery pricing shall apply.

Recodified from N.J.A.C. 10:54–4.17 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).

Former N.J.A.C. 10:54–4.18, Anesthesiology, recodified to N.J.A.C. 10:54–4.19.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.19 Anesthesiology

(a) Anesthesiologists shall be reimbursed for anesthesia services provided to a Medicaid recipient for the total of the anesthesia base units (ABUs) plus anesthesia time.

(b) The use of a HCPCS procedure code which has anesthesia base units (ABUs) assigned requires that the "AA" modifier be utilized to allow the claim to be processed to adjudication. The physician shall enter the HCPCS procedure code and the "AA" modifier in FIELD 24D on the claim form.

(c) An "AA" modifier shall be used for either:

1. Services performed by an anesthesiologist; or

2. Services performed by a Certified Nurse Anesthetist (CRNA) personally and directly supervised by an anesthesiologist.

(d) "Anesthesia time (A.T.)" means that period which includes:

1. Those professional activities of the anesthesiologist directly related to the pre-operative preparation of the patient in the operating room or pre-induction room preceding the proposed surgery;

2. Introduction of the anesthetic agent;

3. Continuous supervision during the surgery; and

4. Continuous supervision during the immediate post-operative period until release of the patient in a satisfactory physiological state to a competent recovery room staff.

(e) Anesthesia time shall be reported in 15 minute quantities (one unit equals 15 minutes). The anesthesiologist shall convert the anesthesia time into units and the number of unit(s) shall be entered in FIELD 24F on the claim form. Do not enter the time (hours and/or minutes) in the "units" field. The anesthesia time (hours and/or minutes) shall be entered at the bottom of "FIELD 24D-Description".

(f) Reimbursement for anesthesia shall be determined by the following, unless otherwise noted:

1. The anesthesia base units assigned to the HCPCS procedure code will be automatically added to the number of the units entered by the anesthesiologist in FIELD 24F at the time the claim is processed. The total of ABUs plus the number of units in FIELD 24F will be multiplied by the Medicaid fee per unit for the total Medicaid allowance. (Do not add anesthesia base unit(s) to the unit(s) of service reported in FIELD 24F.)

2. When multiple surgical procedures are rendered during the same operative session, only the one procedure code with the highest anesthesia base unit value shall be used in calculating and billing the anesthesia allowance.

Example: For multiple surgery reimbursement calculation, if multiple surgeries are performed in one operative session within the time span of the surgery (or anesthesia time (A.T.) listed as 2 hours and 45 minutes), the reimbursement should be calculated as follows: (B.U.V.) = 7 plus (A.T.) of 11 units = 18 units multiplied by dollar amount for specialist or non-specialist = Total Anesthesia Reimbursement.

3. A list of procedure codes which do not require the AA modifier when the physician's professional services are rendered by the anesthesiologist is located under anesthesia in N.J.A.C. 10:54–9.4, HCPCS.

4. The New Jersey Medicaid Management Information system (NJMMIS) does not recognize the CPT–4 anesthesia codes (00100–01999) as valid on the procedure code file. Therefore, claims submitted using these anesthesia codes, including automatic crossover claims from the Medicare Carrier will be suspended or denied. If a new HCFA 1500 claim form with an Explanation of Medicare Benefits (EOMB) notice attached is submitted, claims will be processed.

(g) Reimbursement for anesthesia services provided by Certified Registered Nurse Anesthetists (CRNA) shall be made, provided:

1. He or she is employed by a physician who is a specialist in anesthesia who is:

i. An approved provider in the New Jersey Medicaid program; and

ii. The person who submits the claim for services rendered; and

2. The CRNA's services were performed under the personal direction of the employer anesthesiologist throughout the period of anesthesia. (See N.J.A.C. 10:54–2.2(a) and (b) for rules related to personal direction of the CRNA, as applicable).

(h) The New Jersey Medicaid program shall not reimburse a CRNA directly, nor shall it reimburse charges submitted by an anesthesiologist for services rendered by a CRNA who is not in his or her employ, but is in the employ of a health care facility.

Recodified from N.J.A.C. 10:54–4.18 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).
Former N.J.A.C. 10:54–4.19, Radiology; general, recodified to N.J.A.C. 10:54–4.20.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.20 Radiology; general

Radiological services shall ordinarily be provided only by a physician who is a specialist in radiology, nuclear medicine, and/or radiation oncology. However, a physician, other than one of those listed above, who is a specialist may provide radiological services which are related and limited to his or her own specialty field. (See N.J.A.C. 10:54–9.4, HCPCS for specific procedure codes and qualifiers for radiological services and the CPT–4.)

Recodified from N.J.A.C. 10:54–4.19 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).
Former N.J.A.C. 10:54–4.20, Radiology; diagnostic imaging and ultrasound, recodified to N.J.A.C. 10:54–4.21.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.21 Radiology; diagnostic imaging and ultrasound

(a) Reimbursement for radiological services provided by a physician(s) other than those physicians listed in N.J.A.C. 10:54–4.19 shall be limited to diagnostic radiology of long bones and/or radiological chest examination, in emergency situations to the physician's own patients, in his or her own office.

(b) The fees for routine diagnostic radiology shall include usual contrast media, equipment, materials, consultation, and written reports to the referring physician.

1. For special high risk patients who require the use of low osmolar contrast material to prevent adverse reactions, reimbursement shall be based on the volume of contrast injected, as specified in N.J.A.C. 10:54–9.4, HCPCS.

(c) For diagnostic radiology when combined procedure codes are indicated, specific procedure codes shall not be reimbursed separately when performed in conjunction with other procedure codes and shall be denied if billed together, as follows:

1. Esophagus X-rays shall not be eligible for separate reimbursement when performed in conjunction with a gastrointestinal or small bowel series.

2. Pelvic X-rays shall not be eligible for separate reimbursement when performed in conjunction with complete lumbosacral spine X-rays.

3. Bilateral hip X-rays code (HCPCS 73520) shall be used instead of separate HCPCS codes for each hip (HCPCS 73500 or 73510).

(d) The CPT narrative shall be used to define the permitted number of views to be taken in order to justify the reimbursement for any given radiological procedure.

(e) Reimbursement for radiological services (HCPCS 70000–79999) includes two components, the professional component and the technical component. (See N.J.A.C. 10:54–9.4, HCPCS):

1. The professional component (PC) (see N.J.A.C. 10:54–9) includes the services performed by the physician for Supervision and Interpretation (S & I) of the study, as well as writing the required report. (Use modifier "26" following the CPT code and specify the correct place of service on the claim form.)

2. The technical component (TC) includes the use of the equipment, supplies, routine contrast material, and the technician's time. (Specify the correct place of service on the claim form.)

3. When both the professional and technical components of the service are provided, do not use modifier "TC" or "26" with the HCPCS.

(f) Injection codes related to diagnostic radiologic services should be billed by either the radiologists or other specialists using specific HCPCS codes, as appropriate.

(g) The fee schedule for all radiological services performed in a hospital setting (as indicated in the column in the HCPCS codes) represents the professional component (PC) for those radiologists whose reimbursement is on a fee-for-service basis and not part of hospital costs. In this case, the radiologist shall bill Medicaid directly.

(h) Physician radiological services to both hospital inpatients and outpatients, for which the physician is customarily reimbursed directly by the hospital under contractual or other arrangements, shall be a reimbursable hospital cost and shall be billed by the hospital and not directly to Medicaid by the physician.

(i) No radiological services shall be provided in the outpatient hospital setting without the referral of a physician or other licensed medical practitioner, acting within his or her scope of practice.

Recodified from N.J.A.C. 10:54–4.20 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).
Former N.J.A.C. 10:54–4.21, Radiology; Computerized Tomography (CT), Magnetic Resonance Imaging (MRI) and Ultrasound, recodified to N.J.A.C. 10:54–4.22.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.22 Radiology; Computerized Tomography (CT), Magnetic Resonance Imaging (MRI) and Ultrasound

(a) For documented, necessary, combined abdominal and pelvic body scans (CT and/or MRI), reimbursement for the second or subsequent procedures shall be limited to an additional 50 percent of the payment for the first procedure.

(b) For computerized tomography scan (CT) guidance (monitoring) performed in conjunction with biopsy, aspira-

tion, puncture, injection of contrast material, or placement of a tube, drain, or other medically necessary device, the HCPCS codes with modifier for Reduced Services "–52" shall be used for billing purposes.

(c) Magnetic resonance imaging (MRI) shall be considered a covered service when provided in an inpatient or outpatient hospital setting, in an MRI consortium or in a physician's office. Reimbursement shall be contingent upon the provider of service, and place of service.

1. When a hospital submits a claim for charges for an MRI service provided to an inpatient or outpatient, the technical component (TC) shall be separated from the professional component (PC).

i. The charge for the technical component (TC) provided to a hospital inpatient shall be billed by the hospital where the patient is registered as an inpatient, irrespective of where the MRI service is performed. When a hospital is providing an MRI service to an inpatient of another hospital, the hospital providing the service bills the charge to the referring hospital for reimbursement and the referring (inpatient) hospital bills the "rebundled charge" to Medicaid.

ii. The technical component (TC) provided to a hospital outpatient shall be billed by the hospital. The charge is subject to the Medicaid cost-to-charge ratio. (See N.J.A.C. 10:52.)

iii. For both hospital inpatients and outpatients, the professional component shall be billed on the HCFA 1500 claim form, either by the physician or by the MRI-based hospital on behalf of the physician, and not on any other form.

2. MRI services provided by a consortium to a hospital inpatient shall be billed as follows:

i. For reimbursement of the "TC", the consortium shall bill charges to the hospital where the patient is registered as an inpatient, using the "TC" modifier. For reimbursement of the "PC", the consortium shall bill the amount in the "PC" column of the Medicaid maximum fee allowance, using the modifier "26."

ii. For reimbursement for MRI services provided to other than a hospital inpatient by a consortium, the professional component (PC) and technical component (TC) shall not be split. The composite (global) rate listed in N.J.A.C. 10:54–9.6 in the last column, entitled "Maximum fee allowance," shall be billed to Medicaid, using the HCFA 1500 claim form.

3. For reimbursement for MRI services provided by a physician in an office setting to a recipient who is not a hospital inpatient, the technical component (TC) and the professional component (PC) shall not be split. The composite (global) rate shall be billed to Medicaid, using the HCFA 1500 claim form.

4. For the limitations on the use of procedure codes for ultrasound services to a recipient who is pregnant (using the HCPCS 76805, 76810, and 76815 for billing) refer to the qualifier section of N.J.A.C. 10:54–9.4.

Recodified from N.J.A.C. 10:54–4.21 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).
Former N.J.A.C. 10:54–4.22, Nuclear medicine; diagnostic and therapeutic radiopharmaceuticals, recodified to N.J.A.C. 10:54–4.23.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change

10:54–4.23 Nuclear medicine; diagnostic and therapeutic radiopharmaceuticals

(a) Nuclear medicine, diagnostic and therapeutic radiopharmaceuticals shall be reimbursed separately when provided by a physician in an office setting, as applicable. (See HCPCS 78990 and 79900.)

1. Lung ventilation and perfusion study combined codes shall be used when both these studies are done on the same day, instead of the individual code for each study.

Recodified from N.J.A.C. 10:54–4.22 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).
Former N.J.A.C. 10:54–4.23, Radiation oncology; treatment planning and therapy, recodified to N.J.A.C. 10:54–4.24.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.24 Radiation oncology; treatment planning and therapy

(a) The treatment planning process shall include interpretation of special testing, tumor localization, treatment volume determination, treatment time/dosage determination, choice of treatment ports, selection of appropriate treatment devices and other procedures. Consultation services in conjunction with treatment planning shall not be separately reimbursed.

(b) Tele-radiotherapy treatment shall include the use of X-ray and other high energy modalities (such as betatron, or linear accelerator) radium, cobalt, and other radioactive substances, unless otherwise specified.

1. Reimbursement for treatment of malignancies and non-malignancies shall include 90 days follow-up care, unless otherwise specified.

2. Reimbursement for tele-radiotherapy shall include concomitant office visits, but shall not include concomitant surgical, diagnostic, radiological, or laboratory procedures.

3. Reimbursement of radium and radioisotopes shall include dosage calculation, preparation and planning of the treatment.

4. Reimbursement for radioactive drugs for treatment shall not be included in the therapeutic radiology reimbursement. Preliminary and follow-up diagnostic tests shall not be included in the reimbursement, and may be billed separately. (See the designation of particular HCPCS codes in N.J.A.C. 10:54–9.4.)

Recodified from N.J.A.C. 10:54–4.23 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).
Former N.J.A.C. 10:54–4.24, Radiology; portable and mobile diagnostic, recodified to N.J.A.C. 10:54–4.25.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.25 Radiology; portable and mobile diagnostic

(a) Portable and mobile diagnostic radiological services shall be provided only by a physician who is a specialist in radiology.

(b) Portable and mobile diagnostic radiological services may be provided to Medicaid patients in long term care settings, in an emergency situation, or in a situation in which it is not medically practical to provide such services other than by bringing equipment and personnel to the patient for whom these services are indicated. No portable or mobile diagnostic radiological services provided in a boarding home or independent clinical laboratory shall be reimbursed by Medicaid.

(c) Portable and mobile diagnostic radiological services shall conform with Federal, State and local laws and regulations.

(d) Portable radiological services shall be rendered only on the written order of a licensed health professional within the limits of his or her licensure. The physician/practitioner ordering the service shall:

1. Define the body area to be radiologically examined;

2. Provide the diagnosis(es) indicating the reason for the order;

3. Indicate the current clinical status of the patient; and

4. Indicate dates and types of previous radiological examinations within past year.

(e) Regardless of who retains the radiology film(s) after the service has been rendered (attending physician or portable radiological services);

1. Retention of such film(s) and written record(s) shall be consistent with State law.

2. Release of such film(s) and record(s) to other health professionals and/or facilities, who may subsequently be responsible for the patient's care, shall be allowed only with the written consent of the patient (or his or her legal representative) and the physician who ordered the study.

(f) Portable and mobile diagnostic radiology service records shall consist of, as a minimum:

1. Date(s) of examination;

2. Type of examination with radiologic findings and diagnosis (description of procedures ordered and performed);

3. Name of patient;

4. Place of examination;

5. Name and title of technician who performed the examination;

6. Name of radiologist who interpreted the film;

7. Name of referring physician;

8. Date report sent to referring physician; and

9. Whether film studies were retained by the service or forwarded to the referring physician with date forwarded.

(g) The professional component and technical component charges shall be combined, billed and reimbursed as one lump sum unless otherwise specified for portable X-rays. Transportation and setting up charges for portable X-rays is allowed for the first person only for an examination at a home or long term care settings. Reimbursement shall be limited to a single fee per trip at home or facility regardless of the number of persons X-rayed and shall include return for retakes due to technical errors.

(h) Reimbursement shall be made according to the Medicaid maximum fee allowance schedule for radiological services, contained N.J.A.C. 10:54–9.

(i) Reimbursement shall be all inclusive, in accordance with the schedule of allowances, and shall be payable only to the approved provider. Any subsequent arrangement for apportionment between the provider and personnel shall be consistent with standard practice of the medical profession.

(j) The provider shall identify the radiologist who interpreted the film in order to receive payment on the physician claim form (HCFA 1500) on Item 24. If the provider is a radiologist, the physician referring the patient shall also be identified on the claim form (HCFA 1500) on Item 24.

Recodified from N.J.A.C. 10:54–4.24 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).
Former N.J.A.C. 10:54–4.25, Consultation services; general, recodified to N.J.A.C. 10:54–4.26.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.26 Consultation services; general

(a) A consultation shall include a personal examination of the patient with a written report of the history, physical findings, diagnosis, and recommendations of the consultant for future management.

(b) When a consultation is requested from an approved state agency, a letter of agreement between the appropriate state agency and the New Jersey Medicaid program shall be made and the request shall be consistent with good medical practice. If there is a referral by a State agency with an appropriate contract with the New Jersey Medicaid program, the report shall be sent to the appropriate State agency and payment for a consultation may be reimbursed.

(c) If the consultation is performed in an emergency room setting and the patient is admitted within 24 hours to the consultant's service as an inpatient, either a consultation or initial visit may be billed. The Medicaid program will reimburse for only one, as appropriate. Continuing visits by the physician who has assumed the care of the patient shall be billed as subsequent hospital visits.

(d) If the patient is seen by another physician and admitted/transferred to that other physician's service, then the initial physician may continue to follow the patient and shall be reimbursed by the Medicaid program for concurrent care, if concurrent care can be justified as medically necessary. When a consultant assumes the continuing care of the patient, any subsequent services provided by him or her shall no longer be considered consultation, and these visits shall be billed as routine or follow-up visits. (See N.J.A.C. 10:54–4.7 for regulations on concurrent care.)

Recodified from N.J.A.C. 10:54–4.25 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).
Former N.J.A.C. 10:54–4.26, Consultation; limited, recodified to N.J.A.C. 10:54–4.27.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.27 Consultation; limited

"Consultation (Limited)" refers, generally, to a single body system review and physical examination. While a limited consultation is not necessarily limited to a single body system, it does not include a complete, total, all inclusive history and complete, total, all inclusive physical examination. A written report which includes diagnosis and recommendations of future management shall be provided to the referring physician.

Recodified from N.J.A.C. 10:54–4.26 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).
Former N.J.A.C. 10:54–4.27, Consultation; comprehensive, recodified to N.J.A.C. 10:54–4.28.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.28 Consultation; comprehensive

"Consultation (Comprehensive)" means a total body system evaluation by history and physical examination, including a total body systems review and total body system physical examination. If the total body system evaluation is not performed, reimbursement for comprehensive consultation may be made, provided evidence is documented on the medical record and accompanied by a statement that the consultation utilized one or more hours of the consulting physician's personal time in performance of the consultation.

Recodified from N.J.A.C. 10:54–4.27 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).
Former N.J.A.C. 10:54–4.28, Consultation; follow-up, recodified to N.J.A.C. 10:54–4.29.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.29 Consultation; follow-up

"Consultation (Follow-up)" means the monitoring of progress, recommending management modifications or advising on a new plan of care in response to changes in the patient's status. If the physician consultant has initiated treatment at the initial consultation and participates thereafter in the patient's management, the codes for subsequent hospital care shall be used (99231–99233). Consultation (Follow-up) codes (99261–99263) shall be used for follow-up consultations provided to hospital inpatients and nursing facility residents only. For consultative services provided in other settings, the codes for office or other outpatient consultations shall be used (99241–99245).

Recodified from N.J.A.C. 10:54–4.28 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).
Former N.J.A.C. 10:54–4.29, Consultation; use of all consultation codes, recodified to N.J.A.C. 10:54–4.30.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.30 Consultation; use of all consultation codes

(a) Except where medical necessity dictates or where a hospital policy, state law or regulation dictates otherwise, multiple and simultaneous consultations in the same specialty for the same disease, illness or condition, whether in or out of a hospital, shall not be reimbursed.

(b) If there is no referring physician (such as, when the patient either makes an appointment on his own or when care is recommended by another physician who does not request a report of the specialist findings) or there is not an appropriate state agency referral, the appropriate initial office visit procedure code should be utilized rather than the code for consultation.

(c) If a consultation is performed in a nursing facility and the patient is then transferred to the service of the consultant, then the consultant shall bill for one of the consultation procedure codes or a COMPREHENSIVE NURSING FACILITY ASSESSMENTS (NEW or ESTABLISHED) for that visit and reimbursement will be for one, not both of these codes.

(d) If proper documentation is not forthcoming on the medical record, the consultation visit may be denied. One of the following statements shall be included on the medical record to indicate that a comprehensive consultation was performed by the physician.

1. "I personally performed a total (all) systems evaluation by history and physical examination"; or

2. "This consultation utilized one hour or more of my personal time."

(e) When consultative services are performed in the physician's office or the recipient's home, the name and individual Medicaid Provider Service Number (MPSN) of the referring physician or the name of the person from the State agency making the referral must be included on the claim form.

(f) When reporting consultative services, the provider shall specify whether the consultation was Limited, Comprehensive or Follow-up Consultation. Limited, Comprehensive and/or Follow-up Consultation shall be denied if performed in an office, a residential health care facility, or home setting, if the consultation has been requested by, between, or among members of the same groups, shared health care facility, or physicians sharing common records. (See N.J.A.C. 10:54–9.4 for consultation HCPCS codes.)

(g) If a prior claim for comprehensive consultation visit has been made within the preceding 12 months, then a repeat claim for this code shall be denied if made by the same physician, physician group, or shared health care facility using a common record, except in those instances where the consultation required the utilization of one hour or more of the physician's personal time. Otherwise, the applicable codes shall be the limited consultation codes, if those criteria are met.

(h) In the case of a consultation, the physician is entitled to payment for services provided, subject to the limitations listed in (a) through (g) above. If, after a consultation, a transfer of patient care is made, reimbursement for services shall only be made to the current physician.

(i) A physician may bill for a consultation initiated by a CNP/CNS, whether the CNP/CNS is employed as part of a group or whether the CNP/CNS is employed independently. However, the collaborating physician of the CNP/CNS shall not bill for consultation services provided to the CNP/CNS. When it becomes necessary to admit a patient for inpatient hospital care, or to prescribe controlled drugs, the collaborating physician may bill for concurrent care limited to a single visit for each episode.

(j) A CNP/CNS-initiated consultation with another health care professional, excluding the collaborating physician and another CNP/CNS, will be allowed under the following conditions:

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

2. Where significant medical necessity exists; and

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

Recodified from N.J.A.C. 10:54–4.29 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).
Former N.J.A.C. 10:54–4.30, Concurrent care; physicians, recodified to N.J.A.C. 10:54–4.31.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.31 Concurrent care; physicians

(a) Concurrent care shall be reimbursed where medical necessity requires the services of more than one physician of the same or differing discipline or specialty, in addition to the primary or attending physician, for example:

1. A critically ill patient with diverse medical condition requiring the services of two or more internists, that is, diabetic specialist and cardiologist; or

2. A patient requires an orthopedist for a fractured leg, a neurosurgeon for a head injury, and a general surgeon for a ruptured abdominal viscus, plus an internist for the stabilization of uncontrolled diabetes.

(b) Whether the physician is operating in a group setting or as an individual in solo practice, if concurrent care is requested, a clear demonstration of significant medical necessity must exist both for the primary and attending physician's and/or the other practitioner's services rendering the additional care.

(c) At such time as the patient's condition permits, the attending physician shall either assume sole responsibility or transfer to the practitioner supplying additional (concurrent) care.

(d) Concurrent care shall not be reimbursed in the case of an inappropriate admission to the service of an attending physician who is supplying no significant portion of the management of a patient, but acts only as a vehicle for the patient to receive the necessary services of another physician. The Medicaid program shall deny payment of the claim submitted by the physician whose services were deemed inappropriate. (See N.J.A.C. 10:54–1.2 for the definition of concurrent care.)

Recodified from N.J.A.C. 10:54–4.30 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).
Former N.J.A.C. 10:54–4.31, Concurrent care/collaboration with a CNP/CNS, recodified to N.J.A.C. 10:54–4.32.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.32 Concurrent care/collaboration with a CNP/CNS

(a) This rule applies when a physician is providing concurrent care with a certified nurse practitioner/clinical nurse

specialist whether employed as part of a group, or if the physician provides collaboration to the CNP/CNS.

(b) When a CNP/CNS is employed by a physician/practitioner group, the Medicaid program shall not reimburse both a CNP/CNS visit and, on the same day, a visit to an MD or DO within the same billing entity, except when specific circumstances require two same-day visits. In such case, the provider entity shall document the medical necessity for the second visit (see concurrent care below).

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

(d) CNP/CNS and physician concurrent care will be reimbursed under the following circumstances:

1. 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. 10:54–1.2, and

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

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

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

Recodified from N.J.A.C. 10:54–4.31 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).
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:54–4.33 Services provided in a birthing center

A physician may bill the Medicaid program directly for medical care provided in a birth center. These services may include assistance or consultation related to the delivery, or pediatric medical care or a pediatric consultation to the infant. All services provided must meet all applicable requirements for the procedure billed as otherwise required in this subchapter.

New Rule, R.1998 d.209, effective May 4, 1998.
See: 30 N.J.R. 57(a), 30 N.J.R. 1613(a).

SUBCHAPTER 5. POLICIES AND PROCEDURES FOR PROVISION OF SERVICES PRESCRIBED OR RENDERED BY A PHYSICIAN

10:54–5.1 Apnea monitors; home

(a) The New Jersey Medicaid program shall reimburse durable medical service providers for the use of home apnea monitors under the provisions of N.J.A.C. 10:59 and N.J.A.C. 10:54–5.2 and 5.3.

(b) When an order or prescription for a home apnea monitor is received by the durable medical equipment (DME) provider, the DME provider shall complete and the prescribing physician shall sign a "Home Apnea Monitor Certification" form (FD–287) and the durable medical equipment (DME) provider shall forward it along with the HCFA 1500 claim form to the appropriate Medicaid District Office (MDO) for the initial prior authorization.

1. Each request by a physician shall include written medical data for the medical necessity of the monitor based on the recent evaluation by the physician.

2. Durable medical equipment (DME) providers may use their own Medical Necessity forms in place of, or in conjunction with, the FD–287 as long as all information required on the FD–287 form appears on the Medical Necessity forms.

3. In an urgent situation requiring immediate action, the DME provider may supply the home apnea monitor. However, this action shall be documented in the written request for authorization, which shall be submitted to the MDO no later than 10 working days following the receipt of the physician's order or prescription.

4. Prior authorization shall be issued for up to three months. Failure to obtain prior authorization will result in administrative denial.

(c) When it is anticipated by the physician that the need for home apnea monitoring will exceed the period of current authorization, the prescribing physician caring for the infant's apnea problem must complete and sign the recertification portion of the FD–287 and the DME provider shall complete and submit a new Health Insurance Claim Form (HCFA 1500) with this recertification portion to the MDO. The physician should sign this recertification portion in the course of the follow-up and reassessment of the infant's need for continued apnea monitoring. It is the DME provider's responsibility to inform the infant's parent/guardian of the recertification requirement and to remind them, in the course of the follow-up of the need to take the infant to the physician for reassessment.

(d) The physician shall obtain the FD–287 from the DME provider.

(e) The required information for recertification shall include:

1. Progress of the patient's current status;
2. Number of real alarms and treatment;
3. Pneumogram results, if any; and
4. Any additional information as requested by the Division medical consultant, such as a copy of the daily logs.

(f) The durable medical equipment (DME) provider shall report to the MDO any monitored infant who has not had a physician's visit in three months.

(g) Durable medical equipment (DME) providers have certain responsibilities related to training pertinent to the use of the apnea monitor for the family, caregiver, and/or relief personnel of which the physician should be aware.

(h) Physicians who are responsible for the follow-up and treatment of the infant's apnea problem shall receive monitoring reports on at least a monthly basis from the DME provider.

10:54–5.2 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 (including the certified nurse midwife, and certified nurse practitioner/clinical nurse specialist), within the scope of his or her practice as defined by the laws of the State of New Jersey or of the state in which the physician or practitioner practices.

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

(c) All independent clinical laboratories and other entities performing clinical laboratory testing shall possess one of the following certificates:

1. Certificate of Registration or Registration Certificate;
2. Certificate of Waiver;
3. Certificate for Provider–Performed Microscopy (PPM) Procedures;

4. Certificate of Compliance; or

5. Certificate of Accreditation.

(For certification information, contact the Health Care Financing Administration, CLIA Program, P.O. Box 26689, Baltimore, MD 21207–0489.)

(d) A physician/practitioner 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 physician/practitioner shall not include in his or her claim any charges for laboratory services not performed on-site (that is, when the laboratory procedures have been performed by a clinical or hospital laboratory), except that:

i. A physician/practitioner may claim reimbursement for laboratory services when he or she has a Certificate of Registration or Registration Certificate, Certificate of Waiver, a Certificate of Provider-performed Microscopy (PPM) Procedures; a Certificate of Compliance; or a Certificate of Accreditation.

2. When clinical laboratory tests are performed on site, the venipuncture is not reimbursable as a separate procedure; its cost is included within the reimbursement for the laboratory procedure.

3. When the physician refers a laboratory test to an independent reference laboratory, the clinical laboratory shall be certified under the CLIA as described in (a), (b) and (c) above to perform the required laboratory test(s) and comply with the other requirements of N.J.A.C. 10:61. The physician shall not be reimbursed for laboratory work performed by the reference laboratory.

(e) Profiles are comprised of those components of a test or series of tests which are frequently performed or automated. Examples of identifiable laboratory profiles or studies are as follows:

1. The components of an SMA (Sequential Multichannel Automated Analysis) 12/60 or other automated laboratory study; or

2. Inclusion of an MCH (Mean Corpuscular Hemoglobin), MCV (Means Corpuscular Volume), and so forth, as a component of a CBC (Complete Blood Count).

(f) If the components of a profile are billed separately, reimbursement for the components of the profile (panel) shall not exceed the Medicaid fee allowance for the profile itself.

(g) Rebates by reference laboratory, service laboratories, physicians or other utilizers or providers of laboratory service are prohibited under the Medicaid program. This refers to rebates in the form of refunds, discounts or kickbacks, whether in the form of money, supplies, equipment, or other things of value. Laboratories shall not rent space from, or provide personnel or other considerations to, a physician or other practitioner, whether or not a rebate is involved.

10:54–5.3 Cosmetic surgery

(a) Cosmetic surgery means that surgery which is performed solely for the purpose of beautifying an individual and which has no significant redeeming medical necessity. For purposes of the New Jersey Medicaid program, cosmetic surgery is not a covered or reimbursable service, except as specified in (b) below.

(b) If significant redeeming medical necessity can be demonstrated, the medical consultant in the Medicaid District Office will consider a request from a physician for prior authorization to perform such surgery. Such requests shall be submitted in writing and shall include photographs, when indicated, to support the request. The physician shall obtain prior authorization from the Medicaid District Office (MDO) before this service is rendered. (See directory of Medicaid District Offices at N.J.A.C. 10:49, Appendix.)

(c) Repair or reconstruction of changes due to trauma, infection or surgery whose need for correction demonstrates a significant medical necessity is not considered cosmetic surgery within the intent of the New Jersey Medicaid program and therefore would not require prior authorization.

10:54–5.4 Diagnostic endoscopic procedures; general

Payment for endoscopic procedures shall be made in accordance with N.J.A.C. 10:54–5.5, 5.6, and 5.9.

10:54–5.5 Diagnostic endoscopic procedures; without biopsies

(a) For diagnostic endoscopic procedures which do not involve biopsy(ies), if an endoscopic procedure is performed as a single procedure, the maximum reimbursement shall be 100 percent of the HCPCS code.

(b) Reimbursement shall be made for either the endoscopic procedure or the office or outpatient visit, but not for both.

(c) Nasal endoscopy (HCPCS 31231–31235) without the 22 modifier (without biopsy) shall not be reimbursed in combination with other diagnostic endoscopies involving the respiratory system performed by the same physician at the same session.

(d) If two or more diagnostic endoscopic procedures are performed by the same physician during a single session and each procedure involves a different body system (as outlined in the CPT–4 classification system) each endoscopic procedure may be billed and may be reimbursed at 100 percent of the Medicaid Maximum Allowable Fee.

(e) Except as specified in (f) below, if two or more diagnostic endoscopic procedures involving the same body system (as outlined in the CPT–4 classification system) are performed by the same physician during a single session, the physician shall claim and may be reimbursed for the endoscopic procedure involving only the "deepest penetration". (Often, but not always, the higher HCPCS code number in the CPT–4 corresponds to the endoscopic procedure that has the "deeper penetration".) In this situation, only this one endoscopic procedure shall be reimbursed.

(f) When certain multiple (two or more) endoscopic procedures are defined as complex and/or involve another, different anatomical site necessitating the use of a different scope and the initiation of an independent procedure, the physician shall request reimbursement for each procedure separately at 100 percent of the Medicaid Maximum Fee Allowance. (See N.J.A.C. 10:54–9.4 on HCPCS for a list of these procedures.)

10:54–5.6 Diagnostic endoscopic procedures; with biopsy

(a) For diagnostic endoscopic procedures with biopsies, the pricing logic for multiple surgical procedures applies (see N.J.A.C. 10:54–4.15). In some instances, there is a specific CPT–4 (HCPCS) code associated with that procedure which includes the biopsy and that HCPCS code must be used when requesting reimbursement.

(b) The modifier 22 shall be used with the HCPCS which designates the diagnostic endoscopic procedures with a biopsy when the code does not specifically designate a biopsy. The multiple procedure surgical pricing logic does apply to the reimbursement of these codes. (See also N.J.A.C. 10:54–9.4 under each specific code.)

10:54–5.7 Early and Periodic Screening, Diagnosis and Treatment (EPSDT); general

(a) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a comprehensive health program for Medicaid recipients from birth through 20 years of age. The goal of the program is to assess the recipient's health needs through initial and periodic examinations (screenings); to provide health education and guidance; and to assure that health problems are prevented; or diagnosed and treated at the earliest possible time.

(b) For the certification criteria that a physician must meet in providing services to children under 21 years of age, see N.J.A.C. 10:54–1.

10:54–5.8 EPSDT; conditions of participation

(a) As a condition of participation in Medicaid, all ambulatory care facilities (including hospital outpatient departments) providing primary care to children and adolescents from birth through 20 years of age, shall participate in the EPSDT program and shall provide, at a minimum, the required EPSDT screening services.

(b) EPSDT screening services, vision services, dental services, and hearing services shall be provided at defined intervals as recommended by the appropriate professional organizations.

10:54–5.9 EPSDT; services

(a) The required EPSDT services include the following:

1. Screening services (see (f) below for components of screening services);

2. Vision services;

3. Dental services;

4. Hearing services; and,

5. Other medically necessary health care, diagnostic services and treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

i. For requirements for prior authorization for organ procurement and transplant services in general, see N.J.A.C. 10:54–5.32(a) and (d). For requirements for prior authorization for organ procurement and transplantation services for Medicaid recipients of EPSDT services, see N.J.A.C. 10:54–5.32(d).

(b) EPSDT Screening Services shall include the following components:

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

2. A developmental assessment, which should be culturally sensitive and valid. The parameters used in assessing the recipient's developmental level and behavior must be appropriate for the age. While no specific test instrument is endorsed, it is expected that an evaluation of a young child would, at a minimum, address the gross and fine motor coordination, language/vocabulary and adaptive behavior including self-help and self-care skills and social emotional development. An assessment of a school age child should include school performance; peer relationships; social activity and/or behavior; physical and/or athletic aptitude; and sexual maturation;

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

4. Appropriate immunizations according to age and health history;

5. Appropriate laboratory tests, including:

i. Hemoglobin or hemotocrit;

ii. Urinalysis;

iii. Tuberculin skin test (Mantoux), intradermal, administered annually and when medically indicated;

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

v. Additional laboratory tests which may be appropriate and medically indicated (for example, for ova and parasites) shall be obtained, as necessary.

6. Health education including anticipatory guidance.

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

8. Referral to the Special Supplemental Food program for Women, Infants and Children (WIC) for children under five years of age and for pregnant or lactating women.

10:54–5.10 EPSDT screening periodicity schedule

(a) EPSDT screening services shall be provided periodically according to the following schedule which reflects the age of the child:

1. Under six weeks; two months; four months; six months; nine months; 12 months; 15 months; 18 months; 24 months; and annually through age 20 years.

10:54–5.11 EPSDT vision screening

(a) Vision screening shall include the following:

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

2. An appropriate medical and family history;

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

4. A third examination with visual acuity testing by age three or four years.

(b) Vision testing for school aged children shall be performed at the following grades/ages:

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).

(c) Children should be referred for vision testing if they:

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.

10:54–5.12 EPSDT dental screening

(a) Dental screening shall include the following:

1. An intraoral examination which is an integral part of a general physical examination meaning observation of tooth eruption, occlusion pattern, and presence of caries or oral infection;

2. A formal referral to a dentist is recommended at one year of age; it is mandatory for children three years of age and older; and

3. Dental inspection and prophylaxis that should be carried out every six months until 17 years of age, then annually.

10:54–5.13 EPSDT hearing screening

(a) An individual hearing screening should be administered annually to all children through age eight and to all childen at risk of hearing impairment; and

(b) In addition to what is required in (a) above, after eight years of age, children shall be screened every other year.

(c) A hearing screening shall include, at a minimum, an observation of an infant's response to auditory stimuli. Speech and hearing assessment shall be part of each preventive visit for an older child. An objective audiometric test, such as a pure tone screening test, if performed as part of an EPSDT screening examination, is eligible for separate reimbursement.

10:54–5.14 EPSDT and pediatric HealthStart

(a) EPSDT providers may apply to the New Jersey Department of Health for certification as Pediatric HealthStart providers.

(b) HealthStart is a program of enhanced maternity care and preventive health care for children under 2 years of age. Certified Pediatric HealthStart providers agree to assure continuity of care by following up on referrals and missed appointments, making available 24 hour telephone access and sick care, either directly or by formal arrangement with another pediatric provider.

(c) Pediatric HealthStart providers are approved for a higher reimbursement for preventive child health examinations (screening) than other EPSDT providers, in accordance with the requirements of N.J.A.C. 10:54–6.

(d) EPSDT/HealthStart screening services are billed on the Report and Claim for EPSDT/HealthStart Screening

and Related Procedure Form using HealthStart specific procedure codes as listed in N.J.A.C. 10:54–9.4, N.J.A.C. 10:54–9.10(*l*), and N.J.A.C. 10:54–9.10(k).

(e) EPSDT/HealthStart claims shall be submitted within 30 days of the date of service.

10:54–5.15 Family planning services

(a) Payment shall be made for medically necessary family planning services, including medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling.

(b) Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office visits, drugs, laboratory services, radiological and diagnostic services, and surgical procedures are not covered by the New Jersey Medicaid program, except:

1. When a service is provided that is ordinarily considered an infertility service, but is provided for another purpose. In such case, the physician 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 Services Administration, CN 712, Mail Code #14, Trenton, New Jersey, 08625–0712.

(c) The Norplant System (NPS) is a Medicaid-covered service when provided as follows:

1. The NPS is used only in reproductive age women with established regular menstrual cycles;

2. The Food and Drug Administration (FDA)–approved physician prescribing information is followed; and

3. Patient education and counseling are provided relating to the NPS, including pre and post insertion instructions, indications, contraindications, benefits, risks, side effects, and other contraceptive modalities.

4. The physician office visit relating only to the insertion and removal of the Norplant System (NPS) is not reimbursable on the day of insertion or removal.

5. Only two insertions and two removals of the NPS per recipient are permitted during a five year continuous period.

6. The physician shall not be reimbursed for the NPS in conjunction with other forms of contraception, for example, intrauterine device.

10:54–5.16 Home Care Services; general

(a) The following groups or programs of services or programs are included under Home Care Services:

1. Home Health Services (HH);

2. Personal Care Assistant Services (PCA);

3. Home and Community–Based Services Waiver programs, including:

i. Community Care Program for the Elderly and Disabled (CCPED);

ii. AIDS Community Care Alternatives program (ACCAP);

iii. Home and Community–Based Services Waivers for Blind or Disabled Children and Adults (Medicaid Model Waivers); and

iv. Home and Community–Based Services Waiver for Persons with Traumatic Brain Injury Program (TBI).

v. Home and Community–Based Services Waiver for Medically Fragile Children (ABC Program) administered by the Division of Youth and Family Services (DYFS); and

vi. Home and Community–Based Services Waiver for Mentally Retarded/Developmentally Disabled (CCW) administered by the Division of Developmental Disabilities (DDD); and

4. Home Care Expansion Program (HCEP).

(b) Services under the Home and Community Based Services Waiver programs and some other home care services require certification of the medical necessity for services by an attending physician as indicated in N.J.A.C. 10:54–5.16 through 5.28.

10:54–5.17 Home Care Services; Home Health services (HH)

(a) Medicaid reimbursement shall be limited to home health services provided by Medicare certified, New Jersey State Department of Health licensed home health agency that is a participating provider in the New Jersey Medicaid program. (See N.J.A.C. 8:42 and N.J.A.C. 10:60–1.2.)

(b) Home Health services shall be prescribed by a physician and shall be directed toward rehabilitation and/or restoration of the recipient to the optimal level of physical and/or mental functioning, self-care and independence; or directed toward maintaining the present level of functioning.

(c) Home Health services include the following: professional nursing visits; home health aide services; physical therapy; occupational therapy; speech–language pathology and audiological services; medical social work services; nutritional services; certain medical supplies and equipment; and personal care assistant services.

10:54–5.18 Home Care Services; Personal Care Assistant Services (PCA)

(a) Personal care assistant services may be provided by a Medicare certified, licensed home health agency or by an accredited proprietary or voluntary non-profit homemaker agency approved to participate as a provider of services in the New Jersey Medicaid program, in accordance with N.J.A.C. 10:60–1.2.

(b) Personal care assistant services are health related tasks performed in a recipient's home, prescribed by a physician in accordance with the patient's written plan of care, and provided by an individual who is:

1. Certified as a homemaker/home health aide by the New Jersey State Board of Nursing; and
2. Supervised by a registered professional nurse; and
3. Not a member of the patient's family.

(c) The purpose of personal care assistant services is to accommodate long-term chronic or maintenance health care, as opposed to the short-term skilled care required for some acute illnesses.

10:54–5.19 Home Care Services; Home and Community–Based Services Waiver programs eligibility

(a) Financial eligibility for Medicaid for Home and Community–Based Services Waiver programs will be determined by either the County Welfare Agency (CWA) or by the Social Security Administration.

(b) Medical eligibility for Medicaid for Home and Community-Based Services Waiver programs will be determined by the Medicaid District Office (MDO) for the appropriate level of care designation.

10:54–5.20 Home Care Services; Home and Community–Based Services Waiver programs; general

(a) Individuals served in the Home and Community–Based Services Waiver program shall be medically in need of nursing facility care, as determined by the Medicaid District Office (MDO) but elect to remain at home with services.

(b) The cost of home care services shall not exceed the cost of institutional care.

(c) Expanded services and/or a variation of services are provided within a case managed delivery system, as follows:

1. "Case Management" means a system in which a social worker or professional nurse is responsible for the planning, locating, coordinating, and monitoring of a group of services designed to meet the health needs of the Medicaid recipients being served. The case manager is responsible for the initial assessment of the need for home care services, and is the pivotal person in establishing a service plan to meet those needs.

(d) Each program targets specific groups to be served, such as the blind, the disabled, the elderly, children, or those with Acquired Immune Deficiency Disease (AIDS), or survivors of traumatic brain injuries.

(e) Certain aspects of Medicaid financial eligibility are waived, in accordance with N.J.A.C. 10:49.

10:54–5.21 Home Care Services; Home and Community–Based Waiver Services for blind and disabled children and adults (Model Waivers I, II, and III)

Home and Community–Based Waiver Services for Blind or Disabled Children and Adults (Model Waivers I, II, and III) offer all New Jersey (Title XIX) Medicaid services except nursing facility services, plus Case Management. Model Waiver III additionally offers private-duty nursing, which is defined as individual and continuous care, as differentiated from part-time or intermittent care, provided by licensed nurses.

10:54–5.22 Home Care Services; AIDS Community Care Alternatives Program (ACCAP)

(a) The AIDS Community Care Alternatives Program (ACCAP) offers all New Jersey (Title XIX) Medicaid services, except nursing facility services to children and adults with the AIDS diagnosis and to children up to the age of five who are HIV positive. In addition to all regular Medicaid services, the following services are offered as part of ACCAP:

1. Case management;
2. Private duty nursing;
3. Specialized group foster home care for children;
4. Specialized medical day care;
5. Expanded hours of personal care assistant services;
6. Certain narcotic and drug abuse treatment at home;
7. Hospice care; and
8. Intensive supervision to children who reside in Division of Youth and Family Service (DYFS) supervised foster care homes.

10:54–5.23 Home Care Services; Community Care Program for the Elderly and Disabled (CCPED)

(a) The Community Care Program for the Elderly and Disabled (CCPED) provides only the following package of services:

1. Case management;
2. Home health;
3. Homemaker;
4. Medical day care;

5. Social adult day care;
6. Non–emergency medical transportation; and
7. Respite care at home or in a nursing facility.

10:54–5.24 Home Care Services; Home and Community–Based Services Waiver Program for persons with traumatic brain injuries (TBI)

(a) The Home and Community–Based Services Waiver for Persons with Traumatic Brain Injuries (TBI) offers home and community based services to a recipient with an acquired traumatic brain injury to help him or her remain in the community, or return to the community rather than be cared for in a nursing facility. All regular Medicaid services, except nursing facility services, are offered as part of TBI program. In addition, the following services are offered:

1. Case management;
2. Personal care assistant;
3. Respite care;
4. Environmental modification;
5. Transportation;
6. Chore services;
7. Companion services;
8. Therapy services (including physical and occupational therapy, speech-language pathology and cognitive therapy services);
9. Community residential services;
10. Night supervision services;
11. Structured and supported day program services;
12. Counseling; and
13. Behavioral program services.

10:54–5.25 Home Care Services; Home and Community–Based Waiver for Medically Fragile Children (ABC Program)

The Home and Community–Based Waiver for Medically Fragile Children (the ABC Program) offers all New Jersey (Title XIX) Medicaid services, except nursing facility services, to children through 21 years of age who are under the care and supervision of the Division of Youth and Family Services (DYFS). In addition, the ABC Program offers case management, homemaker, respite care, environmental modifications, transportation, specialized medical equipment and supplies, private duty nursing, specialized nutrition, pediatric hospice, Special Home Service Provider supervision, Specialized Group Foster Home Care and non-legend drugs. DYFS has responsibility for the overall administration of the program with preadmission screening, care plan approval and monitoring by DMAHS.

10:54–5.26 Home Care Services; Home and Community–Based Waiver for Mentally Retarded/Developmentally Disabled (CCW)

The Home and Community–Based Care Waiver for Mentally Retarded/Developmentally Disabled (CCW) offers all New Jersey (Title XIX) Medicaid services, except nursing facility services, to eligible mentally retarded individuals receiving services from the Division of Developmental Disabilities (DDD). Additionally, DDD–CCW offers case management, personal care, habilitation and respite care. DDD has the responsibility for the overall administration of the program.

10:54–5.27 Home Care Services; Home Care Expansion Program (HCEP)

The Home Care Expansion Program (HCEP) is a State-only funded program serving an elderly and disabled population and includes the same services as those listed in N.J.A.C. 10:54–5.28, Home Care Services; CCPED. The HCEP differs from CCPED in that HCEP has higher income and resource program eligibility limits. Financial eligibility is determined by the Bureau of Pharmaceutical Assistance to the Aged and Disabled (PAAD), and medical necessity for HCEP is determined by the designated case manager, based on the standards contained in N.J.A.C. 10:60.

10:54–5.28 Home Care Services; private duty nursing for EPSDT

For the policy related to private duty nursing services in a home setting for Medicaid recipients of EPSDT services, see Home Care Services, N.J.A.C. 10:60–1.3(b) and N.J.A.C. 10:60–1.12(b) and (c).

10:54–5.29 Hospice services; general

(a) The New Jersey Medicaid program provides hospice services under N.J.A.C. 10:60–2.15(a)7 and N.J.A.C. 10:60–3.16(a)7, the AIDS Community Care Alternatives Program (ACCAP), and N.J.A.C. 10:53A–3.4, hospice services to other Medicaid recipients.

(b) Hospice care under the ACCAP program shall be approved by the attending physician and available to ACCAP recipients on a 24–hour a day basis, as needed, in accordance with the recipient's plan of care, by a Medicaid approved, Medicare certified hospice agency. Reimbursement shall be at an established fee paid on a per diem basis to the hospice. Hospice services under ACCAP include only:

1. Services within the home;
2. Skilled nursing visits;
3. Hospice agency medical director services;
4. Medical social service visits;

5. Occupational therapy, physical therapy and speech-language pathology services;

6. Intravenous therapy;

7. Durable medical equipment;

8. Medication related to symptom control of the terminal illness; and

9. Case management as part of the hospice service.

(c) The requirements of this rule apply to hospice services available under N.J.A.C. 10:53A and shall not apply to those services under ACCAP. The attending physician shall certify:

1. The applicant's terminal illness; and

2. That hospice services are reasonable and necessary for the palliation and management of the terminal illness or related conditions.

(d) The attending physician, who must be a doctor of medicine (M.D.) or osteopathy (D.O.), must be the physician identified by the Medicaid applicant at the time the applicant elects to receive hospice services as the primary physician in the determination and the delivery of the applicant's medical care.

(e) The written "Physician Certification/Recertification for Hospice Benefits Form, FD–385 (6/92)" for the first period of hospice coverage (see N.J.A.C. 10:53A) shall be obtained by the hospice from the attending physician within two calendar days after hospice care is initiated.

1. If the hospice does not obtain written certification from the attending physician within two days after the initiation of hospice care, a verbal certification may be obtained within these two days and a written certification no later than eight calendar days after care is initiated. If these requirements are not met, no payment can be made for any days prior to the certification.

2. The signing of the written form shall be done by the hospice Medical Director, or physician of the interdisciplinary team and the attending physician (if the applicant has an attending physician), and shall include the statement that the applicant's medical prognosis is such that the life expectancy is six months or less.

(f) If the hospice recipient revokes hospice benefit package and then reenters the hospice in any subsequent period, the hospice shall obtain, no later than seven calendar days after the beginning of that period, a written "Physician Certification/Recertification for Hospice Benefits Form, FD–385 (6/92)" prepared by the Medical Director of the hospice or the physician member of the hospice's interdisciplinary group.

(g) For subsequent recertifications, a written recertification shall be obtained no later than two business days after the period begins (after the first 90–day benefit period, after the next 90–day benefit period, and after the third 30-day period). The Medical Director of the hospice or physician member of the interdisciplinary team shall recertify that the individual is terminally ill and that hospice services are reasonable and necessary for the palliation and management of the terminal illness or related condition, and, in addition, recertify the necessity of the continuing need for hospice services.

(h) In addition, the individual's attending physician is required to recertify the terminal illness for the fourth, and unlimited, benefit period, as described below:

1. An additional "Physician Certification/Recertification for Hospice Benefits Form, FD–385 (6/92)" shall be obtained by the hospice from the attending physician prior to the fourth unlimited period, but no later than two days after the period begins.

(i) Individuals requesting or initiating hospice eligibility should be referred to a Medicaid approved hospice to complete the hospice medical eligibility requirements for hospice services.

(j) For those cases in which the disability determination for Medicaid eligibility is within the jurisdiction of the Disability Review Section, Division of Medical Assistance and Health Services, the determination of disability for the first six months of hospice services will be based solely on a physician's certification of terminal illness. (See also N.J.A.C. 10:71–3.11 through N.J.A.C. 10:71–3.13.)

(k) To ensure the continuity of hospice services after six months, the agency responsible for eligibility determination (for example, the County Welfare Agencies (CWAs)) shall inform the Disability Review Section of the recipient's eligibility for hospice services based upon the physician's certification of terminal illness and the determination of financial eligibility.

(*l*) After the initial six-month period, if it appears that a recipient will require, and elects to continue to receive, hospice services, the Disability Review Section of the Division shall be provided with, in addition to the Hospice Benefits Form (FD–385), medical documentation to validate the disability status, based on terminal illness as part of the medical recertification. The required additional documentation consists of the following:

1. A statement from the attending physician of the diagnosis(es), prognosis and the stage of illness;

2. Copies of laboratory test results, biopsy and/or pathology reports, Magnetic Resonance Imaging (MRI) and Computerized Axial Tomography (CAT) results; and

3. Copies of any other objective medical documentation which supports the diagnosis(es).

(m) Individuals who are over 65 years of age, or receiving Medicare, or receiving Social Security Disability Insurance

Benefits under Title II or Supplemental Security Income (SSI) under Title XVI, or who are on Aid to Families with Dependent Children (AFDC) are not required to be evaluated by the Medicaid Disability Review Section for hospice services.

(n) The Disability Review Section will identify and track individuals who are required to be evaluated for continuing disability and will contact the provider to initiate the enhanced recertification process.

(o) The New Jersey Medicaid program shall reimburse the hospice provider for direct patient care services furnished to Medicaid hospice recipients by a hospice physician employee, and for physician services furnished under arrangements made by the hospice, unless the physician services were provided on a volunteer basis.

(p) The administrative and general supervisory activities performed by physicians who are employees of or working under arrangements with the hospice provider, would generally be performed by the medical director and/or the physician member of the hospice interdisciplinary group.

1. Interdisciplinary group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and the establishment of governing policies. These costs are included in the per diem rate, and shall not be billed separately.

(q) Physician services furnished on a volunteer basis shall be excluded from Medicaid reimbursement. The hospice may bill for services which are not provided on a volunteer basis, but the physician shall treat Medicaid recipients on the same basis as other individuals in the hospice. For example, a physician shall not designate all physician services rendered to non-Medicaid individuals as volunteered and at the same time seek payment from the hospice for all physician services rendered to Medicaid hospice recipients.

(r) The hospice shall directly bill the fiscal agent of the New Jersey Medicaid program on behalf of the physician, only for other direct personal care physician services (beyond interdisciplinary group activities, administration and/or supervision) furnished by hospice physician employees and for the same physician services under arrangements made by the hospice provider (unless the services are provided on a volunteer basis).

(s) In determining which hospice services are furnished on a volunteer basis and which services are not, a physician shall treat the Medicaid hospice recipient on the same basis as other individuals in the hospice.

(t) The hospice provider shall reimburse the physician for physician services described in (d) above. In this instance, the costs of the direct patient care of the attending physician, as an employee of the hospice agency, shall be billed on the HCFA 1500 claim form by the hospice to the fiscal agent of the New Jersey Medicaid program.

(u) The attending physician, who is not an employee, or the hospice on behalf of the employee physician, shall bill only for direct personal care services and not for other cost of laboratory or X-rays, which are to be included in the hospice per diem rate.

(v) The costs of the attending physician services shall not be counted in determining whether the "hospice cap" has been exceeded, as these services are not part of the hospice services.

(w) The New Jersey Medicaid program shall reimburse for attending physician services and other specialty physician services (including physician consultation services) separate from the hospice per diem rates, under the following conditions:

1. The hospice shall notify the New Jersey Medicaid program by stating in the plan of care, the election of and the name of the physician who has been designated the attending physician, whenever the attending physician is not a hospice employee; and

2. The attending physician shall not be a volunteer and/or shall not be part of the administrative staff or medical director of the hospice; and

3. The attending physician shall provide direct patient care as an employee of the hospice or under arrangements with the hospice; and

4. The attending physician services related or unrelated to the individual's terminal illness.

5. Under the circumstances listed in (w)1 through 4 above, the attending physician or physician consultant shall submit the HCFA 1500 claim form directly to the fiscal agent of the New Jersey Medicaid program, and not through billing procedures of the hospice provider.

10:54–5.30 Medical supplies and durable medical equipment (DME) services

(a) "Medical supplies" means item(s) which are:

1. Consumable, expendable, disposable or non-durable;

2. Prescribed by the physician or practitioner (See N.J.A.C. 10:59–1.2 for further description); and

3. Medically necessary for use by a Medicaid recipient, (for example, suction catheters).

(b) "Durable medical equipment (DME)" means an item or apparatus, other than hearing aids and certain prosthetic and orthotic devices, which is:

1. Primarily and customarily used to serve a medical purpose and is medically necessary for the patient for whom it is requested; and

2. Generally not useful to a person in the absence of a disease, illness, injury, or handicap; and

3. Capable of withstanding repeated use (durable) and is non-expendable (for example, a hospital bed, oxygen equipment, wheelchair, walker, or suction equipment).

(c) Medical supplies and durable medical equipment that are essential for the patient's medical condition are allowable with the following limitations:

1. They are prescribed by a licensed practitioner and supplied by an approved Medicaid provider;

2. They are not reimbursable by the New Jersey Medicaid program when available at no charge from community resources (for example, the American Cancer Society, or other service organizations); and

3. Environmental equipment such as an air conditioner or an air filtering device, shall not be reimbursed under the New Jersey Medicaid program.

(d) The provider of medical supplies and durable medical equipment shall obtain prior authorization from the Medicaid District Office for the medical supplies and equipment listed in the Medical Supplier Chapter, N.J.A.C. 10:59–1.6, 1.9, and 1.10. For prior authorization for specific DME and other related services, see N.J.A.C. 10:59–2.

Case Notes

Reimbursement for purchase of HEPA Air Cleaner prohibited as device is environmental equipment; judge's allowance of reimbursement by analogy to vaporizer reversed as N.J.A.C. 10:59–1.6 specifically prohibits electrostatic air filter reimbursement (Director's Final Decision). In the Matter of M.D., 7 N.J.A.R. 254 (1980), reversed 179 N.J.Super. 541, 432 A.2d 943 (App.Div.1981), modified in part and remanded 91 N.J. 1, 449 A.2d 1235 (1982).

Determination whether easy chair lift constitutes environmental equipment. M.M. v. Division of Medical Assistance and Health Services, 2 N.J.A.R. 145 (1979).

10:54–5.31 Nursing facility services

(a) An attending physician shall prescribe, and certify in the medical record, the medical necessity for nursing facility services for a Medicaid patient.

(b) When physician services are provided to a patient in a nursing facility (formerly known as a skilled nursing facility or an intermediate care facility), reimbursement will not be made to any physician or practitioner, or for therapy or services rendered by an owner, partner, administrator, officer, or stockholder of the company or corporation or anyone who otherwise has a direct or indirect financial interest in the institution; except that:

1. A medical director who is neither an owner, partner, official, stockholder of the company or corporation, but who is reimbursed a salary by the facility for administrative purposes, may bill on a fee-for-service basis for medical services rendered by him to patients in that facility.

(c) Annual Resident Reviews (ARR) for individuals identified as having mental illness, who reside in Medicaid certified nursing facilities shall be performed by the individual's attending physician and forwarded to the Office of Health Services Administration, Mental Health Services, Division of Medical Assistance and Health Services, CN–712, Trenton, New Jersey 08635–0712, for final determination of the need for specialized services.

1. The MDO will send a nursing facility (NF) Reassessment List to the NF in the first week of every month. The reassessment date is based upon the month the individual was initially admitted to the NF. The attending physician completes the psychiatric form by the 15th of the following month on those individuals with mental illness.

2. The completed psychiatric evaluation form will be forwarded to the Division of Mental Health Services (DMHS) to be reviewed by the DMHS psychiatrists to determine the need for specialized services.

3. The results of the DMHS determination will be returned to the nursing facility to be incorporated in the patient's chart.

(d) A more detailed guideline of physician services performed in nursing facilities (NF) can be found in the Long Term Care Facility Services, N.J.A.C. 10:63 (which is usually located in the facility). Assistance is also available to the physician, on a peer basis, from the Medical consultant in the Medicaid District Office. A directory of Medicaid District Offices is located at N.J.A.C. 10:49, Appendix.

10:54–5.32 Organ procurement and transplantation services

(a) The Division covers services rendered and items dispensed or furnished in connection with organ procurement and transplantation services of kidney, heart, heart-lung, liver, bone marrow, cornea and other selected medically necessary organ transplants except those transplants categorized as experimental. (See (d) below for further information on organ procurement and transplantation.)

1. Payment for organ procurement and transplant services rendered to or items dispensed or furnished a donor will be considered a charge on behalf of the Medicaid recipient who is the transplant recipient.

(b) Federal organ procurement service requirements are listed in the Social Security Act, Section 1138 as amended by Section 9318(a) of the Omnibus Reconciliation Act of 1986 (42 U.S.C. 1320).

1. Procurement services, with the exception of bone marrow transplant and cornea procurement services, shall be covered only when the Organ Procurement Organization (OPO) meets the requirements of Section 1138 of the Social Security Act (42 U.S.C. 1320(b)–8 Note) and when the OPO is designated and certified by the Secre-

tary of the Department of Health and Human Services as the OPO for that geographical area in which the hospital is located.

(c) The covered organ transplantation procedures shall also be performed in an organ transplant center approved or certified by a nationally recognized certifying or approving body, or one designated by the Federal government. In the absence of such a certification or approval of this nationally recognized body, the approval or certification, whichever applies, shall be obtained from the appropriate body so charged in the State in which the organ transplant center is located.

(d) The candidate for transplantation shall have been accepted for the procedure by the transplant center. Such acceptance shall precede a request for prior authorization from the medical staff in the Division's Office of Health Services Administration, if applicable. All out-of-State hospitalizations for transplantations require prior authorization from the MDO serving the recipient's county of residence (see N.J.A.C. 10:49–6.2). Prior authorization shall be required for hospitalizations for organ procurement and transplantation for Medicaid recipients for anatomical sites not explicitly listed in (a) above.

(e) Organ transplantations shall be medically necessary. Transplantations, with the exception of cornea transplantations, shall be performed only to avert a potentially life-threatening situation for the patient.

1. If all factors pertinent to decision-making concerning the site of performance of a transplant procedure are essentially equal, preference shall be given to a New Jersey transplant center. However, Medicaid policy of equitable access also applies (see 42CFR 431.52(c)).

10:54–5.33 Orthopedic footwear services

(a) For purposes of the New Jersey Medicaid program, "an orthopedic shoe" means footwear, with or without accompanying appliances, used to prevent or correct gross deformities of the feet, which is properly fitted as to length and width, and consists of the following basic parts:

1. Correct straight last line;
2. Heels with sufficient bearing surface;
3. Toe with ample room for function;
4. Sole of sufficient weight for foot protection;
5. Rigid shank;
6. Properly fitting upper;
7. Smooth and protective lining; and
8. Snug fitting heel counter.

(b) Except as provided at N.J.A.C. 10:49–2.3, orthopedic footwear shall be reimbursed under the New Jersey Medicaid program when prior authorized in accordance with N.J.A.C. 10:55–1.5(c) and prescribed under the following conditions:

1. When attached to a brace or bar; and/or
2. When part of the normal (customary, usual) post-operative or post-fracture treatment program; and/or
3. When used to correct or adapt to gross foot deformities.

(c) Services for flat foot conditions (regardless of the underlying etiology and encompassing all phases of services in connection with flat feet) shall be reimbursed as a Medicaid covered service only under the following circumstances:

1. Treatment which is an integral part of post-fracture or post-operative treatment plan;
2. Supportive devices (for example, arch supports, specific additions to shoes and the like) prescribed to palliate pain and other symptoms associated with the condition;
3. Treatment where the talo-crural joint is involved;
4. Treatment where there may be attachment of supportive device to a brace or bar.

(d) Orthopedic footwear and foot orthotics require a personally signed and dated order (prescription) by the prescribing physician for prosthetic and orthotic appliances, repair and replacement of parts for custom-made prosthetic and orthotic appliances, and orthopedic footwear. The prescription shall include the following:

1. Patient's name, age, address, H.S.P. (Medicaid) Case and Person Number; and
2. Relevant diagnosis(es) (including the ICD–9 code(s)) supporting the need for the orthopedic footwear and/or foot orthotics; and
3. Detailed description of the prosthetic and orthotic appliance order. Terminology such as "leg brace", "artificial limbs", or "orthopedic shoes" on a prescription is unacceptable.

(e) Prior authorization for all orthopedic footwear and foot orthotics shall be obtained by the provider of the services from the Office of Health Services Administration, Division of Medical Assistance and Health Services, Mail Code #15, CN–712, Trenton, New Jersey, 08625–0712, except for all components of orthopedic footwear attached to a bar or brace (including the bar, brace and/or shoe) which must be obtained from the appropriate Medicaid District Office. (For a directory of the MDOs, see N.J.A.C. 10:49, Appendix K.) (See also N.J.A.C. 10:55, Prosthetic and Orthotics Services Chapter, for other prosthetic and orthotic services.)

10:54–5.34 Prosthetic and orthotic services (P & O)

(a) Custom–made prosthetic and orthotic appliances (required to replace, support or strengthen parts of the body) are allowable when prescribed by a licensed physician. For purpose of the New Jersey Medicaid program, "custom-made" means a device or appliance fabricated (constructed and/or assembled) in an approved facility under the specific direction of a prescribing physician and designed to fit and perform a useful function solely for that specific individual for whom it was ordered.

1. Custom–made appliances must be fabricated by a person certified as a prosthetist and/or orthotist by the American Board of Certification in Orthotics and Prosthetics, incorporated and fabricated in a facility accredited by the same certification board. The facility must be approved by the New Jersey Medicaid program to provide either prosthetic or orthotic (P & O) services or both to Medicaid recipients. The physician may contact the Medicaid District Office to determine which P & O dealers are eligible under the program. The P & O provider must obtain prior authorization from the Medicaid District Office to provide these services. For a listing of Medicaid District Offices, see the end of N.J.A.C. 10:49, Administration Chapter.

i. In lieu of accreditation/certification by the American Board for Certification in Orthotics and Prosthetics, certification by the Board for Certification in Pedorthotics may be accepted for providers limiting their scope of practice to shoe orthotics, custom molded shoes, and shoe modifications. (See also N.J.A.C. 10:55–1.3 incorporated herein by reference.)

(b) Prosthetic and orthotic appliances shall require a personally signed and dated order (prescription) by the prescribing physician, which includes the following:

1. Patient's name, age, address, H.S.P. (Medicaid) Case and Person Number; and

2. Relevant diagnosis(es) (including ICD–9 codes) supporting need for custom-made prosthetic and orthotic appliances; and

3. Detailed (meaningful) description of the prosthetic and orthotic appliance order. Terminology such as "leg brace", "artificial limbs", "orthopedic shoes", and so forth, on a prescription is unacceptable.

(c) The approved prosthetic and orthotic provider, upon receipt of an acceptable prescription, shall request prior authorization from the appropriate Medicaid District Office or the Podiatric Consultant, as appropriate, on a "Prior Authorization Form for Prosthetic and Orthotic Services (FD–357)".

1. In the event that a physician's prescription does not contain the prosthetic and orthotic nomenclature accepted by this Division, the facility shall transform the original prescription to conform to the accepted nomenclature. This does not imply that the physician's prescription will in any way be altered.

10:54–5.35 Rehabilitative services; general

(a) Rehabilitative services include physical therapy, occupational therapy, and speech-language pathology and audiology, including the use of such supplies and equipment as are necessary in the provision of such services. Rehabilitative services and other restorative services are provided for the purpose of attaining maximum reduction of physical or mental disability and restoration of a Medicaid recipient to his or her best functional level. Rehabilitative services shall be made available to Medicaid recipients as an integral part of a comprehensive medical program.

(b) In a physician's office, rehabilitative services shall be provided by or under the direction of a physical therapist, occupational therapist, speech-language pathologist or audiologist employed by or under contract to the physician. Each of these therapy services are discussed at N.J.A.C. 10:54–5.36, 5.37, and 5.38, respectively.

1. Physical therapy, speech-language pathology and audiology services shall be reimbursed directly to the physician only when provided in the physician's office.

2. Physical therapy and speech-language therapy treatments shall be individual and shall consist of a minimum of 30 minutes.

3. Audiology services shall be reimbursed only when services are provided in an office of an Ear, Nose and Throat Specialist.

4. Occupational therapy services shall not be reimbursed, if provided in the physician's office.

(c) A plan of treatment shall be completed during the Medicaid recipient's initial evaluation visit and retained on file.

1. The plan of treatment shall be definitive as to the type, amount, frequency, and duration of the rehabilitative services that are to be furnished and shall include the recipient's diagnosis and the anticipated goal(s) of the treatment.

10:54–5.36 Rehabilitative services; Physical therapy

(a) Physical therapy is a service prescribed by a physician and provided to a Medicaid recipient by or under the direction of a qualified physical therapist. Physical therapy does not include therapy which is purely palliative, such as the application of heat in any form; massage; routine calisthenics; group exercises; assistance in any activity; use of a simple mechanical device; or other services not requiring the special skill of a licensed physical therapist.

1. A qualified physical therapist is an individual who is:

i. Licensed by the State of New Jersey as a physical therapist in accordance with N.J.A.C. 13:39A; and

ii. A graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent.

2. If treatment or services are provided in a state other than New Jersey, the physical therapist shall meet the requirements of that state, including licensure if applicable, and all applicable Federal requirements.

10:54–5.37 Rehabilitative services; Occupational therapy

(a) Occupational therapy is a service prescribed by a physician and provided to a Medicaid recipient by or under the direction of a qualified occupational therapist and includes the necessary supplies and equipment.

1. A qualified occupational therapist is an individual who is:

i. Registered by the American Occupational Therapy Certification Board (AOTCB); or

ii. A graduate of a program in occupational therapy approved by the Committee on Allied Health Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association (AOTA).

2. If treatment or services are provided in a state other than New Jersey, the occupational therapist shall meet the requirements of that state, including licensure if applicable, and all applicable Federal requirements.

(b) Occupational therapy shall be reimbursed when provided in settings other than a physician's office.

10:54–5.38 Rehabilitative services; Speech–language pathology and audiology

(a) Speech–language pathology services and audiology services are diagnostic, screening, preventive, or corrective services prescribed by a physician and provided to a Medicaid recipient by or under the direction of a speech-language pathologist or audiologist. They include necessary supplies and equipment.

1. A speech-language pathologist or audiologist is an individual who is licensed by the State of New Jersey as a speech-language pathologist or audiologist, in accordance with N.J.A.C. 13:44C, and who meets all applicable Federal requirements including:

i. A certificate of clinical competence in Speech–Language Pathology or Audiology from the American Speech–Language–Hearing Association; or

ii. Completion of the equivalent educational requirements and work experience necessary for the certificate(s); or

iii. Completion of the academic program and is in the process of acquiring supervised work experience in order to qualify for the certificate(s).

2. If treatment or services are provided in a state other than New Jersey, the speech-language pathologist or audiologist shall meet the requirements of that state, including licensure if applicable, and all applicable Federal requirements.

10:54–5.39 Rehabilitative services; separation of therapy and office visit reimbursement

(a) No portion of the time spent on therapy treatments may be considered as part of the time parameters of an office visit. Office visits billed during the same day shall clearly and separately meet the time and other parameters described in the applicable HCPCS procedure codes, N.J.A.C. 10:54–9.

(b) When the same type of rehabilitative service is performed on a Medicaid recipient more than once on the same day, for example, two physical therapy services, reimbursement shall be made for one service only. Likewise, when the treatment performed on a Medicaid recipient is merely a different modality within the same type of rehabilitative service, reimbursement shall be made for only one service per recipient per day.

10:54–5.40 Second opinion program for elective surgical procedures—hospital inpatient and ambulatory surgical centers (ASC) services

(a) A second opinion shall be required for the elective surgical procedures listed under (b) below. The outcome of the second opinion will have no bearing on payment. Once the second opinion is rendered, the patient will retain the right to decide whether or not to proceed with the surgery; however, failure to obtain a second opinion for these procedures will result in a denial of the surgeon's claim. (See N.J.A.C. 10:54–9.11(c) and (d) for the list of HCPCS codes that require a second opinion.)

1. A second opinion shall be required for the surgery indicated below when the surgical procedure is elective. If the operating physician determines that the need for surgery is urgent or is an emergency, no opinion is required. Urgent or emergency (for second opinion purposes) includes any situation in which a delay in performing surgery in order to meet the second opinion requirement could result in a significant threat to the patient's health or life.

i. If the patient is hospitalized or admitted to an ASC, a second opinion is not required if the procedure becomes urgent or an emergency during the course of the hospitalization or admission, regardless of the patient's admitting diagnosis.

ii. Reimbursement for urgent or emergency surgery shall be made only if a specific statement is attached to the claim form by the operating physician certifying that the second opinion requirement was not met and substantiating the urgent or emergency nature of the surgery.

2. A second opinion shall be required for any of the elective procedures whenever the New Jersey Medicaid program is to be billed for any portion of the physician claim. Therefore, if a Medicaid patient is covered by other insurance (except when Medicare coverage is involved) which makes only partial payment on the claim, the New Jersey Medicaid program shall not make supplementary payment unless the second opinion requirement has been met. However, the New Jersey Medicaid program shall make payment on the claim if the operating physician receives documentation that a second opinion was arranged and paid by another insurer. A copy of this documentation must be attached to the claim.

3. A second opinion shall be required for any of the four procedures to be done on an elective basis, even if the recommendation for surgery is made during the inpatient hospital stay or ASC admission. In this case, the patient should be discharged and the regular process for obtaining a second opinion should be followed. If the patient decides to have surgery, he or she can then be scheduled for readmission since the case would have been elective in nature.

(b) The following elective surgical procedures require a second opinion by a physician under the Medicaid Second Opinion program:

1. Hernia Repair (common abdominal wall type);

i. A second opinion shall be required for any herniorrhaphy involving an adult (over 18 years of age).

ii. A second opinion shall not be required for herniorrhaphy involving a child or young adult 18 years of age or under.

2. Hysterectomy (see also N.J.A.C. 10:54–5.16(h) through (k));

3. Laminectomy;

4. Spinal fusion;

i. A second opinion shall not be required for spinal fusion for scoliosis in a child or young adult 18 years of age or under.

(c) The Medicaid Second Opinion program shall not require a second opinion for the following circumstances:

1. New Jersey Medicaid recipients with HSP (Medicaid) Case Numbers with the first and second digits of 90 or the third and fourth digits of 60 who are residing out-of-state at the discretion of the New Jersey Department of Human Services.

2. Dually eligible Medicare/Medicaid recipients, unless a second opinion is also mandatory under Medicare regulations.

(d) Medicare/Medicaid recipients may optionally, (that is, on a voluntary basis) seek "second opinions" and the cost of the service shall be reimbursed by the New Jersey Medicaid program if not covered for reimbursement by Medicare.

(e) A second opinion shall be arranged through the fiscal agent's Medicaid Second Opinion Referral Center.

1. A consultation ordered by a physician shall not, by itself, meet the program's definition of a second opinion and no "Authorization for Payment" shall be granted based on such consultation. Second opinions arranged and paid for by other third party payers, in accordance with (a)2 above, will be considered second opinions by Medicaid.

2. All second opinion providers shall be Board Certified or Board Eligible by the appropriate American specialty board or osteopathic specialty board. The Referral Center shall ensure that the second opinion physician is a Board Certified or Board Eligible Specialist in the appropriate field (General Surgery, Pediatrics, Neurology, Neurosurgery, Obstetrics/Gynecology, or Orthopedics), and has signed a Medicaid Second Opinion Provider Agreement.

i. To become approved as a Medicaid Second Opinion provider and receive a Second Opinion Provider Agreement application, contact the Medicaid Second Opinion Referral Center at the fiscal agent of the New Jersey Medicaid program.

3. The physician shall agree when completing the Second Opinion Provider Agreement not to perform surgery on the individual to whom he has given a second opinion, and not to make a referral unless requested by the patient, and then only to a surgeon with whom the second opinion has no financial involvement.

4. A second opinion shall be required, regardless of the setting in which the procedure is to be performed (inpatient hospital, outpatient hospital, independent clinic, Ambulatory Surgical Center, or physician's office).

5. In order to prevent claim denial as a result of a situation where one of the elective surgical procedures is scheduled and performed before the second opinion requirements are met, it is suggested that the elective surgery not be scheduled until after the second opinion has been rendered.

(f) At the time a recommendation for surgery is made, the first opinion physician or the patient's operating surgeon will give the patient a bilingual Medicaid Second Opinion program brochure which explains the program and the steps for obtaining a second opinion. The physician should check the appropriate box on the brochure to indicate the proce-

dure being recommended. Copies of the brochure are available from the fiscal agent of the New Jersey Medicaid program.

1. The patient shall then follow the instructions outlined in the brochure to contact the Medicaid Second Opinion Referral Center and obtain a second opinion.

2. At the time the second opinion is rendered, the second opinion physician may contact the first opinion physician or the patient's operating surgeon to discuss the patient's medical history and the result of the previous diagnostic studies.

3. The second opinion physician will document the results of the second opinion on the Medicaid Second Opinion Referral Form. A copy of this report shall be forwarded by the Medicaid Second Opinion Referral Center to the referring physician.

4. If the patient wishes to proceed with surgery after a second opinion is received, the operating physician shall contact the Referral Center to receive an "Authorization for Payment" prior to proceeding with the surgery.

i. A copy of the Second Opinion Report, as well as authorization for physician payment will then be sent to the operating physician. At the time the patient's hospital, independent clinic, or ambulatory surgical center (ASC) admission is arranged, the operating physician shall give the hospital or independent clinic or ASC its copy of the "Authorization for Payment". The second opinion is valid for one year from the date the second opinion is rendered.

(g) The physician claim associated with one of the second opinion procedures shall not be paid unless attached to the hard copy of the claim is:

1. An "Authorization for Payment", or

2. Documentation of a second opinion arranged through another insurer; or

3. A specific statement from the operating physician certifying that the second opinion requirement was not met and substantiating the urgent or emergency nature of the surgery.

(h) Reimbursement will not be made for a second opinion rendered to a patient who is not Medicaid eligible. The issuance of a "Medicaid Second Opinion Referral Form" to the patient by the Medicaid Second Opinion Referral Center does not guarantee the patient's eligibility on the date of the second opinion or subsequent surgery. The patient's eligibility must be verified by checking the patient's current New Jersey Medicaid Validation Form before rendering any service. (See N.J.A.C. 10:49–1.2, Administration on "How to identify a Medicaid recipient."

(i) Third opinion: If as a result of the second opinion, the patient is given a conflicting opinion regarding the need for the elective surgery, the patient may contact the Medicaid Second Opinion Referral Center and arrange for a third opinion. (For third opinion billing, see N.J.A.C. 10:54–9.4 under procedure code 99274 ZZ.)

(j) For physician claim submission, the operating surgeon, upon receipt of the Second Opinion "Authorization of Payment" shall go through the normal process for arranging the surgery, ensuring the hospital, independent clinic, or ASC receives its copy of the authorization.

1. If the patient should change physicians after the authorization has been released, the newly designated operating physician may contact the Medicaid Referral Center for a copy.

2. Once the surgery is performed, the physician must attach to the Physician's claim form (HCFA 1500) either the operating physician's copy of the "Authorization of Payment" or a statement certifying as to the urgent or emergency nature of the procedure.

3. No Second Opinion authorization or certification shall be required for the anesthesiologist or assistant surgeon claims.

10:54–5.41 Sterilization; general

(a) The Division covers sterilization procedures performed on Medicaid recipients based on Federal regulation. (42 CFR 441.250 through 42 CFR 441.258) and related requirements outlined in this section and in the billing instructions. For sterilization policy and procedures, see (b) through (e) below. Billing instructions are outlined in the Fiscal Agent Billing Supplement.

(b) "Sterilization" means any surgical procedure, treatment, or operation, for the purpose of rendering an individual permanently incapable of reproducing. Surgical sterilization procedures are those whose primary purpose is to render an individual incapable of reproducing. Surgical sterilization procedures require the completion of the Federal "Consent Form" for sterilization.

(c) In accordance with 42 CFR 441.258 Appendix to Subpart F (Specific Requirements for Use), the following requirements shall be be met and/or documented on the Consent Form prior to the sterilization of an individual:

1. The individual is at least 21 years of age at the time the consent is obtained;

2. The individual is not mentally incompetent. "Mentally incompetent individual" means an individual who has been declared mentally incompetent by a Federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization;

3. The individual is not institutionalized. "Institutionalized individual" means an individual who is:

i. Involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or

ii. Confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness;

4. The individual has voluntarily given informed consent;

5. At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of emergency abdominal surgery or premature delivery;

i. In the case of emergency abdominal surgery at least 72 hours shall have passed between the date he or she gave informed consent and the date of sterilization;

ii. In the case of premature delivery, informed consent shall have been given at least 30 days before the expected date of delivery and at least 72 hours have passed between the date of informed consent and the date of premature delivery.

6. In the case where a patient desires to be sterilized at the time of delivery, the Consent Form shall be signed by the patient no earlier than the 5th month of pregnancy to minimize the possibility of exceeding the 180 day limit.

(d) An individual is considered to have given informed consent for sterilization only if:

1. The person who obtained consent for the sterilization procedure offered to answer any questions the individual to be sterilized may have had or has concerning the procedure, provided a copy of the Consent Form, and provided orally all of the following information or advice to the individual to be sterilized:

i. Advice that the individual is free to withhold or withdraw consent to the procedure at any time before sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled; and

ii. A description of available alternative methods of family planning birth control; and

iii. Advice that the sterilization procedure is considered to be irreversible; and

iv. A thorough explanation of the specific sterilization procedure to be performed; and

v. A full description of the discomfort and risks that may accompany or follow the performing of the procedure, including an explanation of type and possible effects of any anesthetic to be used; and

vi. A full description of the benefits or advantages that may be expected as a result of the sterilization; and

vii. Advice that the sterilization will not be performed for at least 30 days except for emergency abdominal surgery or premature delivery.

2. Suitable arrangements were made to insure that the information specified by this rule was effectively communicated to any individual who is blind, deaf, or otherwise handicapped; and

3. An interpreter was provided if the individual to be sterilized did not understand the language used on the Consent Form or the language used by the person obtaining consent;

4. The individual to be sterilized was permitted to have a witness of his or her own choice present when consent was obtained;

5. The requirements of the Consent Form were met, such as, its contents, certification, and signatures (see (e) below).

Note: The Consent Form currently in use by the Division is a replica of the form contained in the Federal Regulations and is to be utilized by providers when submitting claims. No other consent form is permitted unless approved by the Secretary, United States Department of Health and Human Services. The form is available from the fiscal agent.

(e) In addition to completing all information (name of doctor or clinic the patient received information from, name of the operation to be performed, the patient's birth date, name of the patient, name of the physician who will perform the sterilization, the method, the language used by an interpreter, name and address of the facility the person obtaining consent is associated with, the date of the sterilization and the specific type of operation) in the appropriate spaces provided, the form must be signed and dated by hand as specified below:

1. "Consent to Sterilization" shall be signed and dated by the individual to be sterilized, prior to the sterilization operation (in accordance with the time frames specified in N.J.A.C. 10:54–5.41(c)5.

2. "Interpreter's Statement" shall be signed and dated by the interpreter, if one was provided prior to the sterilization operation. The interpreter shall certify by signing and dating the "consent form" that:

i. He or she translated the information presented orally and read the Consent Form and explained its contents to the individual to be sterilized; and

ii. To the best of the interpreter's knowledge and belief, the individual understood what the interpreter told him or her.

3. "Statement of Person Obtaining Consent" shall be signed and dated by the person who obtained the consent, prior to the sterilization operation. The person securing the Consent Form shall certify, by signing and dating the Consent Form that:

i. Before the individual signed the "consent form", he or she advised the individual to be sterilized that no Federal benefits may be withdrawn because of the decision not to be sterilized; and

ii. He or she explained orally the requirements for informed consent as set forth on the Consent Form; and

iii. To the best of his or her knowledge and belief, the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized. The name and address of the facility or physician's office with which the person obtaining consent is associated must be completed in the space provided on the form.

4. "Physician's Statement" shall be signed and dated by the physician who performed the sterilization operation, after the surgery has been performed. (A date prior to surgery is not acceptable.) The physician performing the sterilization shall certify, by signing and dating the Consent Form, that within 24 hours before the performance of the sterilization operation:

i. The physician advised the individual to be sterilized that no Federal benefits may be withdrawn from the patient because of the decision not to be sterilized; and

ii. The physician explained orally the requirements for informed consent as set forth on the Consent Form; and

iii. To the best of the physician's knowledge and belief, the individual appeared mentally competent, and knowingly and voluntarily consented to be sterilized; and

iv. That at least 30 days have passed between the date of the individual's signature on the Consent Form and certified the date upon which the sterilization was performed, except in the case of emergency abdominal surgery or premature delivery; and

v. In the case of emergency abdominal surgery or premature delivery performed within 30 days of consent, the physician must certify that the sterilization was performed less than 30 days, but not less than 72 hours after informed consent was obtained, and in the case of abdominal surgery must describe the emergency, or in the case of premature delivery, must state the expected date of delivery.

5. Any additional requirement of State or local law for obtaining consent, except a requirement for spousal consent, was followed.

6. Informed consent may not be obtained while the individual to be sterilized is:

i. In labor or childbirth; or

ii. Seeking to obtain or obtaining an abortion; or

iii. Under the influence of alcohol or other substances that affect the individual's state of awareness.

(f) Any New Jersey physician with electronic billing capabilities shall submit a "hard copy" of the HCFA 1500 claim form (including for inpatient and outpatient services) for all sterilization claims with the "Consent Form" attached to the HCFA 1500 claim form and must not submit the claim through EMC claim processing.

10:54–5.42 Hysterectomy

(a) The Division will cover hysterectomy procedures performed on Medicaid recipients based on Federal regulation (42 CFR 441.250 through 42 CFR 441.258) and related requirements outlined in the billing instructions. For billing instructions, see Fiscal Agent Billing Supplement, Appendix B.

(b) "Hysterectomy" means an operation for the purpose of removing the uterus.

1. A hysterectomy shall not be performed solely for the purpose of rendering an individual permanently incapable of reproducing. A hysterectomy shall be covered as a surgical procedure if performed primarily for the purpose of removing a pathological organ.

(c) Certain hysterectomy procedures require the completion of the "Hysterectomy Receipt of Information Form (FD–189, Rev. 7/83) or, under certain conditions, (see (d)1iii, below) a physician certification.

(d) The specific requirements to be met and/or documented on the Hysterectomy Receipt of Information Form (FD–189, Rev. 7/83) or, under certain conditions, a physician certification are:

1. A hysterectomy on a female of any age may be performed when medically necessary for a pathological indication provided the person who secured authorization to perform the hysterectomy has:

i. Informed the individual and her representative (if any), both orally and in writing, that the hysterectomy will render the individual permanently incapable of reproducing; and

ii. Ensured that the "Hysterectomy Receipt of Information" (FD–189, Rev. 7/83) is completed and the individual or her representative has signed and dated a written acknowledgement of receipt of that information utilizing the "Hysterectomy Receipt of Information Form" (FD–189, Rev. 7/83); or

iii. The physician who performed the hysterectomy certifies, in writing, that the individual:

(1) Was sterile before the hysterectomy (include cause of sterility); or

(2) Required a hysterectomy because of a life-threatening emergency in which the physician determined that prior acknowledgement was not possible (include description of the nature of the emergency); or

(3) Was operated on during a period of the person's retroactive Medicaid eligibility (see N.J.A.C. 10:49–2.7) and the individual was informed, before the operation, that the hysterectomy would make her permanently incapable of reproducing or one of the conditions described in (1) or (2) above was applicable (include a statement that the individual was informed or describe which condition was applicable).

(e) Although a physician certification is acceptable for situations described in (d)1iii above, the Division recommends that the Hysterectomy Receipt of Information Form (FD–189) be used whenever possible.

(f) There is no 30 day waiting period required before a medically necessary hysterectomy may be performed. The standard procedure for surgical consent forms will prevail.

(g) Any New Jersey physician with electronic billing capabilities shall submit a "hard copy" of the HCFA 1500 claim form for all hysterectomy claims with the FD–189 form attached to the claim form and must not submit the claim through the EMC claims processing.

10:54–5.43 Termination of pregnancy

(a) The Division shall reimburse for medically necessary termination of pregnancy procedures on Medicaid recipients when performed by a physician in accordance with N.J.A.C. 13:35–4.2, of the rules of the New Jersey State Department of Law and Safety, Division of Consumer Affairs, Board of Medical Examiners.

(b) A physician may take the following factors into consideration in determining whether a termination of pregnancy is medically necessary on a Medicaid recipient:

1. To save the life of the mother; or

2. That the pregnancy was the result of an act of rape; or

3. That the pregnancy was the result of an act of incest; or

4. That in the physician's professional judgement, the termination was medically necessary and consistent with the Federal court ruling that a physician may take the following factors into consideration in determining whether a termination of pregnancy is medically necessary:

i. Physical, emotional, and psychological factors;

ii. Family reasons; and,

iii. Age.

(c) The determination of medical necessity shall be subject to review by Medicaid in accordance with existing rules and regulations of the Medicaid program and consistent with the New Jersey State Department of Law and Safety, Division of Consumer Affairs, Board of Medical Examiners, N.J.A.C. 13:35–4.2.

(d) A "Physician Certification" (Form FD–179) shall be attached to the hospital's Medicaid claim form, either for inpatient or outpatient services, if any of the procedures on the claim relate to a voluntary elective abortion.

1. A copy of the completed FD–179 shall also be attached to:

i. The physician's Medicaid claim form, as appropriate; and,

ii. The anesthesiologist's Medicaid claim form.

(e) Any New Jersey physician with electronic billing capabilities must submit a "hard copy" of the HCFA 1500 claim form (for inpatient or outpatient services) for all termination of pregnancy claims with the "Physician Certification" attached to the claim form and must not submit the claim through EMC claim processing.

10:54–5.44 Transportation services

(a) The Division recognizes transportation services as covered services when a recipient is transported for the purpose of obtaining a Medicaid-covered service. The mode of transportation is based upon the recipient's medical condition, as follows:

1. An ambulatory patient who does not require assistance or supervision may be referred to the County Welfare Agency (CWA) for "lower mode" transportation (that is, car, bus, train, or taxi). No prior authorization shall be required from the Medicaid District Office (MDO).

2. A wheelchair-bound patient who does not need emergency ambulance service and/or a patient who is physically unable to use public conveyances may be referred to a provider of invalid coach service or to the appropriate MDO. Prior authorization shall be obtained from the MDO for invalid coach service, except when a patient is transported to or from a nursing facility (NF).

3. When emergency service is needed or the recipient is stretcher-bound, the recipient may obtain ambulance service directly from a provider of ambulance service, including Mobile Intensive Care Unit (MICU) service or air ambulance service when these modes of transportation are medically justified. Authorization shall be obtained from the MDO for the payment of air ambulance service.

4. In all cases, the least expensive mode of transportation appropriate to the recipient's medical needs shall be used.

(b) For further information on prior authorization for transportation services contact the appropriate MDO. (See N.J.A.C. 10:49, Appendix A, and N.J.A.C. 10:50.)

10:54–5.45 Vision care services

(a) The Division recognizes vision care services, and optical appliances and services provided only by the following eligible providers, within the restrictions of their respective licensure or requirements in the state in which they are located.

1. An ophthalmologist means a licensed physician who is a diplomate of the American Board of Ophthalmology or who has been recognized by the New Jersey Medicaid program as a specialist in ophthalmology.

2. An optometrist means a person who is licensed by the New Jersey State Board of Optometry to engage in the practice of optometry, or similarly licensed by a comparable agency of the state in which he or she performs such functions.

3. An optician means a person licensed by the New Jersey State Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians, or similarly licensed by a comparable agency of the state in which he or she performs such functions.

4. A recognized ocularist who provides artificial eyes, upon the recommendation of a prescribing practitioner. (See Vision Care Services Chapter, N.J.A.C. 10:62–3.)

5. An independent clinic approved by the Division to render eye care services; or a

6. Hospital meeting the definition of an approved general hospital, approved special hospital, or approved private or state and county governmental psychiatric hospital, as adhering the conditions of participation as described in the Hospital Services Chapter in N.J.A.C. 10:52.

7. An ophthalmologist, optometrist, optician, and ocularist practicing in another state who are duly licensed or meet the requirements of the State in which they are practicing with regard to dispensing optical appliances.

(b) Covered professional (ophthalmologist and optometrist) vision care services include office visits for evaluation and management, comprehensive eye examinations, low vision examinations, low vision work-ups, vision training work-ups, and vision training program visits.

1. When providing professional vision care services, the ophthalmologist and optometrist shall comply with *N.J.A.C. 10:62.*

(c) For Medicaid purposes, prior authorization shall be required for a low vision work-up, vision training work-up, and vision training. The Vision Care Services Chapter at N.J.A.C. 10:62–2.5, lists the optical appliances that require prior authorization.

1. Prior authorization (Form MC–9(A)) shall be requested in writing from the Vision Care Services, Office of Health Services Administration, Division of Medical Assistance and Health Services, Mail Code #16, CN–712, Trenton, New Jersey 08625–0712.

SUBCHAPTER 6. HEALTHSTART—MATERNITY AND PEDIATRIC CARE SERVICES

10:54–6.1 Purpose

The purpose of HealthStart shall be to provide comprehensive maternity and child health care services for all pregnant women (including those determined to be presumptively eligible) and for children (under two years of age) in the State of New Jersey who are eligible for Medicaid benefits.

10:54–6.2 Scope of services

(a) HealthStart maternity care services shall include all medical services recommended by the American College of Obstetricians and Gynecologists (ACOG) and the American College of Nurse Midwives (ACNM), as well as a program of health support services. HealthStart pediatric care services shall include the nine preventive visits recommended by the American Academy of Pediatrics and all of the necessary immunizations. This subchapter includes provisions for provider participation, standards for service delivery, procedure codes from the HCFA Common Procedure Coding System (HCPCS), and directions for submitting claims.

(b) HealthStart Comprehensive Maternity Care includes two components; Maternity Medical Care Services and Health Support Services as follows:

1. Maternity Medical Care Services include, but are not limited to:

i. Ambulatory prenatal services;

ii. Admission arrangements for delivery;

iii. Obstetrical delivery services; and

iv. Postpartum medical services.

2. Health Support Services include, but are not limited to:

i. Case coordination services, including the follow-through on Medicaid eligibility determination on the mother and infant, and informing a Medicaid eligible pregnant woman about the availability of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for the newborn;

ii. Health education assessment and counseling services;

iii. Home visitation;

iv. Nutrition education assessment and counseling services;

v. Outreach, referral and follow-up services;

vi. Social–psychological assessment and counseling 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.

10:54–6.3 HealthStart provider participation criteria

(a) Providers that are eligible to participate as HealthStart providers shall be: independent clinics (including local health departments meeting the New Jersey Department of Health Improved Pregnancy Outcome criteria); hospital outpatient departments; Federally Qualified Health Centers; physicians; certified nurse midwives; certified nurse practitioners/clinical nurse specialists (CNP/CNS); and physician and/or practitioner groups, approved as providers in the New Jersey Medicaid program in accordance with N.J.A.C. 10:49 and N.J.A.C. 10:54–6.3.

(b) In addition to New Jersey Medicaid program rules applicable to provider participation, HealthStart providers shall:

1. Sign an Addendum to the New Jersey Medicaid Program Provider Agreement;

2. Have a valid "HealthStart Maternity Care Certificate" or a "HealthStart Maternity Medical Care Certificate" and/or a Pediatric Care Certificate; and

3. Provide maternity medical care and/or health support services, if applicable, or pediatric care services, in accordance with the requirements for issuance of a "HealthStart Comprehensive Maternity Care Certificate" or "HealthStart Maternity Medical Care Certificate," and/or a "HealthStart Pediatric Care Certificate", and in accordance with the New Jersey State Department of Health Guidelines for HealthStart Maternity Care Providers and HealthStart Pediatric Care Providers at N.J.A.C. 10:66–3.

4. Shall participate in program evaluation and training activities, including, but not limited to, site monitoring, agency and patient record review, and submission of required summary information on each patient according to the "New Jersey State Department of Health Guidelines for HealthStart Providers," as delineated in N.J.A.C. 10:66–3; and

5. Determine presumptive eligibility for the New Jersey Medicaid program, if approved to perform such determinations by the Division of Medical Assistance and Health Services.

(c) In addition to (a) and (b) above, HealthStart Comprehensive Maternity Care providers with more than one care site or more than one maternity clinic at the same site that uses different staff, shall apply for a separate HealthStart Comprehensive Maternity Care Certificate for each separate site. Within an agency, only those sites which hold a certificate shall be reimbursed for HealthStart services.

(d) In addition to (a) and (b) above, HealthStart Pediatric Care Providers shall:

1. Participate in program evaluation and training activities, including but not limited to, submission of Pediatric Preventive Child Health forms and documentation of outreach and follow-up activities in the patient's record; and

2. Enroll eligible children in Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Hospital outpatient departments shall be excluded from this requirement.

3. Provide all components of the Child Health screening services within one clinic when the HealthStart Pediatric Care Provider is the outpatient department of a hospital. Referral to other clinics for screening shall be prohibited.

(e) An applicant's ability to meet the standards for HealthStart certificates in appropriate areas and to provide services in accordance with the "New Jersey State Department of Health Guidelines for HealthStart Providers" (N.J.A.C. 10:66–3) in appropriate areas will be assessed via a site review.

(f) HealthStart Provider Certificates will be reviewed by the New Jersey State Department of Health at least every 18 months form the date of issuance.

(g) Applications for HealthStart Provider Certificates are available from:

HealthStart Program
New Jersey State Department of Health
CN 360
Trenton, NJ 08625–0360

(h) Applications for New Jersey Medicaid HealthStart Provider agreements are available from:

Unisys Corporation
Provider Enrollment Unit
P.O. Box 4804
Trenton, New Jersey 08650–4804

10:54–6.4 Termination of HealthStart certificate

(a) The New Jersey State Department of Health will be 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.

1. Failure to comply with HealthStart Certificate Standards shall be cause for termination of the HealthStart provider certificate. Providers who are terminated shall have the right to request a hearing pursuant to the procedures in N.J.A.C. 10:49–10.10.

10:54–6.5 Standards for a HealthStart comprehensive maternity care provider certificate

(a) HealthStart maternity care services shall be integrated and coordinated.

(b) HealthStart Maternity Care providers shall provide for comprehensive maternity care services, that is, maternity medical and health support services, as follows:

1. Providers shall provide directly or through approved agreements, at one contiguous site, the following services:

i. Ambulatory prenatal and postpartum care;

ii. Case coordination services;

iii. Nutrition assessment;

iv. Guidance and counseling services;

v. Health education assessment and instruction; and

vi. Social–psychological assessment, guidance and counseling.

2. Providers may provide just the Maternity Medical Care component as long as they have entered into a written agreement with a single HealthStart provider who shall provide the HealthStart Health Support services component. This agreement shall delineate which party shall take primary responsibility for the provision of all HealthStart services.

3. Independent clinics, hospital outpatient departments, home health agencies, and local health departments may provide just the HealthStart Health Support services component only when they have entered into a written agreement with a private practitioner(s) who shall provide the HealthStart Maternity Medical services component. This agreement shall delineate which party shall take primary responsibility for provision of all HealthStart services.

4. A separate certificate for each component will be issued by the New Jersey State Department of Health.

5. Two sites may be utilized only when one site for the provision of services is not feasible.

i. If two sites are utilized, a summary report, including pertinent findings, identification of problem(s), follow-up needs and amendments to the Plan of Care shall be communicated and documented between the case coordinator and obstetrical provider following each visit and postpartum.

ii. A case conference on each patient, including, but not limited to, the maternity medical care provider and case coordinator, shall occur whenever there is a change in the Plan of Care, but at least once a trimester.

(c) In addition to (a) and (b) above, the provider shall also:

1. Provide, or arrange for,the admission of patients to the hospital or birthing center which reflects the appropriate level for all obstetrical care delivery services;

2. Provide or arrange for all necessary laboratory services;

3. Coordinate and/or provide prenatal and postpartum home visits for each high risk patient when determined appropriate by the case coordinator, maternity medical care provider, and/or appropriate practitioner. These visits may be arranged through another provider under a purchase arrangement, or a letter of agreement but with no additional cost to the Division. The HealthStart Health Support services provider shall document the reports of the visits;

4. Adopt procedures and policies which assure the delivery of coordinated, integrated and comprehensive care;

5. Provide or arrange for the appropriate level of care for all obstetrical and medical services;

6. Provide and document referral and follow-up services, which shall include but not be limited to, referral for skilled nursing care services; specialized evaluation, counseling and treatment for extensive social, psychological, nutrition and medical needs; and

7. Be responsible for linking the mother and newborn infant to a pediatric care provider. If feasible, the linkage shall be with a HealthStart Pediatric Care provider.

10:54–6.6 HealthStart maternity care certificate; physicians or nurse midwives in private practice

(a) Physicians and certified nurse midwives in private practice shall meet the requirements in N.J.A.C. 10:54–6.5, except they may provide just the medical care component as long as they have entered into a written agreement with a single HealthStart provider who shall provide the HealthStart Health Support Services component. This agreement shall delineate which party shall take primary responsibility for the provision of all HealthStart services.

1. Separate certificates for each component shall be issued.

2. Two sites may be utilized only when one site for the provision of services is not feasible.

(b) If two sites are utilized, a case conference on each patient, including but not limited to, the medical practitioner and case coordinator, shall occur whenever there is a change in the Care Plan, but at least once a trimester.

(c) Additionally, if two sites are utilized, following each visit, a summary report, including pertinent findings, identification of problem(s), follow-up needs and amendments to the Care Plan shall be communicated and documented between the case coordinator and obstetrical provider.

10:54–6.7 Access to service

(a) All HealthStart services shall be accessible to patients.

(b) HealthStart Maternity Care providers shall facilitate patient access to services by scheduling appointments for the HealthStart enrollment visit, the initial antepartum maternity medical care and other health support assessments within two weeks of the patient's first request for services. The initial antepartum maternity medical care visit shall be completed within two weeks of the patient's first visit and shall include, at a minimum, the following:

1. The medical history;
2. A risk assessment;
3. Collection of laboratory specimens;
4. A plan for continuing services;
5. A comprehensive physical examination; and
6. Routine counseling and treatment.

(c) HealthStart Maternity Care and Maternity Medical Care providers shall provide or arrange for 24 hour access to case coordination and medical services for emergency situations.

(d) HealthStart Maternity Care providers shall provide or arrange for language translation and/or interpretation services on site during clinic times to assure that patients understand the care and the treatment plan.

(e) HealthStart Maternity Care providers may implement presumptive eligibility determinations if they are approved by the Division of Medical Assistance and Health Services to institute this process. (See also N.J.A.C. 10:49–2.) At the onset of presumptive eligibility determination, the provider shall inform the applicant of the importance of applying for Medicaid eligibility at the County Welfare Agency to ensure that her Medicaid eligibility extends beyond the limited presumptive eligibility period.

(f) HealthStart Maternity Care providers shall undertake community outreach activities to encourage women to seek early prenatal care and increase awareness of the availability of maternity care services.

10:54–6.8 Plan of care

(a) Definition: A Plan of Care is a written document available to and used by all providers for the purpose of assuring the provision of comprehensive and coordinated care. The Plan of Care documents: the identified patient needs for medical, nutritional, social/psychological services (including financial assessment/Medicaid eligibility status); and health education services. It also shall document what services are to be provided and by whom; when the services are to be provided; and document when the services are completed.

(b) A Plan of Care shall be initiated during the first visit. The initial Plan of Care shall be completed after a case conference by the case coordinator and no later than one month after the initial maternity medical care visit.

(c) A Plan of Care shall include but not be limited to: identification of risk conditions and/or problems; prioritization of needs; outcome objectives; planned interventions; time frames; referrals and follow-up activities; and the identification of staff persons responsible for the services and for executing the Plan of Care.

(d) The Plan of Care shall be developed and maintained by the case coordinator for each patient in consultation with the patient and staff providing services.

(e) The Plan of Care shall be reviewed, updated and revised throughout the pregnancy, but at least once during each trimester and in the postpartum period.

10:54–6.9 HealthStart Maternity Medical Care Services

(a) Maternity medical care services shall include antepartum, intra-partum and postpartum care provided by the obstetrical care practitioner(s) in accordance with the "New Jersey State Department of Health Guidelines for HealthStart Maternity Care Providers."

(b) Prenatal services are as follows:

1. The frequency of prenatal visits for an uncomplicated pregnancy shall be every four weeks during the first 28 weeks; then every two weeks until 36 weeks; and weekly thereafter; or in accordance with the standards recommended by the American College of Obstetrics and Gynecologists (ACOG) and/or the American College of Nurse Midwives (ACNM). Additional prenatal visits for complications should be scheduled as needed.

2. Initial prenatal visit content shall include, but not be limited to, the following:

i. History;

ii. Review of systems;

iii. Comprehensive physical examination;

iv. Risk assessment;

v. Patient counseling;

vi. Routine laboratory tests;

vii. Development of the Plan of Care;

viii. Special tests and/or procedures as medically indicated; and

ix. Determination of and arrangements for the delivery site.

3. Subsequent prenatal visit content shall include, but not be limited to, the following:

i. Review and revision of the patient Plan of Care;

ii. Interim history;

iii. Physical examination;

iv. Patient counseling and treatment;

v. Laboratory tests;

vi. Special tests and/or procedures which are medically indicated;

vii. Identification of new or developing problems;

viii. Management, including the transfer of any new or persistent problems;

ix. Review and update of the arrangements for the delivery site.

4. Transfer of prenatal records to the labor and delivery unit no later than 34 weeks gestation.

(c) Obstetrical delivery services shall include, but not be limited to, the following:

1. Attendance at or provision for obstetrical delivery by a qualified physician or certified nurse midwife;

2. Medical treatment during the postpartum stay; and,

3. Completion of the hospital discharge summary.

(d) A postpartum visit shall be provided by the 60th day after delivery, and shall include but not be limited to the:

1. History;

2. Review of the prenatal, labor and delivery record;

3. Physical examination;

4. Patient counseling and treatment;

5. Parent/infant assessment;

6. Referral/consultation, as indicated; and

7. Procedures/tests, as indicated.

(e) All HealthStart Maternity Care providers shall have policies and protocols consistent with national standards regarding consultation, and/or transfer of medically high risk patients to tertiary level maternity care facilities or specialists, and to genetic counseling and testing facilities.

10:54–6.10 HealthStart health support services

(a) Case coordination services shall facilitate the delivery of continuous, coordinated and comprehensive services for each patient in accordance with the "New Jersey State Department of Health Guidelines for HealthStart Maternity Care Providers," as follows:

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

2. Prenatal case coordination responsibilities shall be clearly defined and shall include the accountability of the case coordinator for the provision of all services. These responsibilities shall include, but not be limited to, the following:

i. Orienting the patient to all services;

ii. Developing, maintaining and coordinating the Plan of Care in consultation with the patient and appropriate medical practitioners;

iii. Coordinating and monitoring the delivery of all services and referrals;

iv. Monitoring and facilitating the patient entry into and continuation with maternity services;

v. Facilitating and providing advocacy for obtaining referral services;

vi. Reinforcing health teachings and providing support;

vii. Providing vigorous follow-up for missed appointments and referrals;

viii. Arranging home visits;

ix. Meeting with the patient and coordinating patient care conferences;

x. Reviewing, monitoring and updating the patient's complete record;

xi. Vigorous follow-up for referrals; and

xii. Vigorous follow-up for final Medicaid eligibility determination.

3. Postpartum case coordination activities shall include, but not be limited to, the following:

i. Arranging and coordinating the postpartum visit and any home visit;

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

iii. Linking the patient to appropriate service agencies including: the Special Supplemental Food Program for Woman, Infants and Children Program (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;

iv. Arranging for the transfer of pertinent information and records to the pediatric care and/or future family planning service providers when authorized by the patient;

v. Coordinating referrals and following up on missed appointments and referrals; and

vi. Reinforcing health instruction for mother and baby.

4. The case coordinator shall complete at the time of the termination of services and submit a Maternity Services Summary Data form to the New Jersey State Department of Health, HealthStart Program, per recipient for each pregnancy. Copies of this form are available from the New Jersey State Department of Health, HealthStart Program.

(b) Nutrition assessment and basic guidance services shall be provided to orient and educate patients to nutritional needs during pregnancy and to educate patient to good dietary practices during pregnancy, at least initially, and at intervals of each trimester and postpartum. The results of the nutritional assessment and basic guidance services shall be integrated into the Plan of Care. Specialized nutrition assessment and counseling shall be provided to women with additional needs. Services shall be provided as follows:

1. Initial assessment services which shall include, but are not limited to, the following:

i. Review of patient's chart and plotting of the weight;

ii. Identification of dental problems which may interfere with nutrition;

iii. Nutrition history;

iv. Current nutritional status;

v. Determination of participation in the Special Supplement Food Program for Women, Infants and Children (WIC) or other food supplement programs;

vi. Provision of, or arrangement for, specialized nutrition counseling and intervention services identified through assessment; and

vii. Development of the nutrition component of the Plan of Care.

2. Subsequent nutrition assessment which shall include, but not be limited to, the following:

i. Monitoring and plotting of weight gain/loss;

ii. Identification of special dietary needs;

iii. Identification of need for specialized nutrition counseling services; and

iv. Integration of the nutritional component into the Plan of Care.

3. Prenatal nutrition basic guidance which shall include, but not be limited to, the following:

i. Basic instruction on nutritional needs during pregnancy including balanced diet, vitamins and recommended daily allowances;

ii. Review and reinforcement of other nutrition and dietary counseling services the patient may be receiving;

iii. Instruction on food purchase, storage and preparation;

iv. Instruction on food substitutions, as indicated;

v. Discussion of infant feeding and nutritional needs; and

vi. Referral to food supplementation programs through the case coordinator.

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

5. 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

6. Postpartum nutrition assessment and basic guidance services which shall include, but not be limited to, the following:

i. Review and reinforcement of good dietary practices;

ii. Review of instruction on dietary requirement changes; and,

iii. Instruction on breast feeding and/or formula preparation and feeding.

(c) Social–psychological assessment and basic guidance services shall be provided to all patients, initially, each trimester, and postpartum, and the results shall be integrated into the Plan of Care to assist the patient in resolving social-psychological needs, in accordance with the "New Jersey State Department of Health Guidelines for HealthStart Maternity Care Providers." Specialized social-psychological assessment and short-term counseling shall be pro-

vided to those women with additional needs. Services shall be provided as follows:

1. Initial social-psychological assessment services which shall include, but are not limited to, the following:

i. Determining financial resources and living conditions;

ii. Determining the patient's personal support system;

iii. Determining the patient's attitudes and concerns regarding the pregnancy;

iv. Ascertaining present and prior involvement by the patient with other social programs or agencies and current social service needs;

v. Ascertaining educational and/or employment status and needs; and

vi. Identifying the need for specialized social-psychological and/or mental health evaluation and counseling services.

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

i. Determining patient's reaction to pregnancy;

ii. Ascertaining the reaction of family, friend and actual support person(s) to the pregnancy;

iii. Identifying the need for social service interventions and advocacy; and

iv. Identifying the need for specialized social-psychological and/or mental health evaluation and counseling.

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

i. Orientation and information on available community resources;

ii. Orientation regarding stress and stress reduction during pregnancy; and

iii. Assistance with arrangements for transportation, child care and financial needs.

4. 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.

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

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

i. Review of prenatal, labor, delivery and postpartum course;

ii. Assessment of patient's current social-psychological status, including mother and infant bonding and father/family acceptance of the infant, as applicable;

iii. Identification of the need for additional social-psychological services;

iv. Review of available community resources for mother and infant, as applicable;

v. Counseling regarding fetal loss or infant death, if applicable;

vi. Counseling regarding school and employment planning.

(d) Health education assessment and instruction shall be provided to all patients at intervals throughout the pregnancy, based on the patient's needs and as described in the "New Jersey State Department of Health Guidelines for HealthStart Maternity Care Providers." Services shall be provided as follows:

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

i. Identification of general educational background;

ii. Identification of patient's health education needs; and,

iii. Identification of previous education and experience concerning pregnancy, birth and infant care.

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

i. Normal course of pregnancy;

ii. Fetal growth and development;

iii. Warning signs, such as signs of pre-term labor, and identification of emergency situations;

iv. Personal hygiene;

v. Exercise and activity;

vi. Child birth preparation, including management of labor and delivery;

vii. Preparation for hospital admission;

viii. Substance/occupational/environmental hazards;

ix. Need for continuing medical and dental care;

x. Future family planning;

xi. Parenting, basic infant care and development;

xii. Availability of pediatric and family medical care in the community; and,

xiii. Normal postpartum physical and emotional changes.

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

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

(e) Providers shall provide, or arrange for, one or more home visits for each high risk patient, as described in the "New Jersey State Department of Health Guidelines for HealthStart Maternity Care Providers" (N.J.A.C. 10:66–3).

(f) One face-to-face preventive health care contact shall be provided or arranged for during the time after hospital discharge and prior to the required medical postpartum visit in accordance with the "New Jersey State Department of Health Guidelines for HealthStart Maternity Care Providers," as follows:

1. This contact shall include, but not be limited to, the following:

i. Review of the mother's health status;

ii. Review of the infant's health status;

iii. Review of mother and infant interaction;

iv. Status of the basic nutrition of mother and infant;

v. An assessment of social-psychological and counseling services for referral;

vi. Revision of the Plan of Care; and

vii. Provision of additional services, including referrals, indicated.

(g) HealthStart Maternity Care providers must utilize existing community services to enhance the maternity care services.

(h) HealthStart Maternity Care Providers shall have written procedures which identify specific agencies or practitioners and criteria for referral of patients requiring services which are extensive, complex or expected to extend beyond the pregnancy. These shall include but are not limited to: nutrition and food supplementation services, substance abuse treatment facilities, mental health services, county/local social and welfare agencies, parenting and child care educational programs, future family planning services, fetal alcohol syndrome and AIDS counseling services.

10:54–6.11 Professional staff requirements for HealthStart comprehensive maternity services

(a) All HealthStart Maternity Care services shall be delivered through an integrated approach by qualified professionals.

(b) Physicians and/or certified nurse midwives shall be Medicaid providers and have obstetrical admitting privileges at a licensed maternity care facility.

(c) Case coordinators shall have, as a minimum, a license as a registered nurse; or a Bachelor's degree in social work, health, or a behavioral science.

(d) Case coordinators shall discharge their responsibilities as defined in the "New Jersey State Department of Health Guidelines for HealthStart Maternity Care Providers" (N.J.A.C. 10:66–3).

(e) Health professionals shall have a valid license to practice their professions as required by the State.

(f) All other professionals, for whom no license to practice is required, shall meet generally accepted professional standards for qualification.

(g) Paraprofessionals must be familiar with the local community, have knowledge and/or skill in maternal and child health services and work under the direction of a health professional.

(h) Prenatal, delivery, and postpartum medical services must be delivered by physicians and/or certified nurse midwives.

(i) Nutrition, social-psychological and health education assessment and portions of the Plan of Care must be completed by the appropriate professionals in each of the specialty areas, or by case coordinators or maternity medical care professionals in accordance with the "New Jersey State Department of Health Guidelines for HealthStart Maternity Care Providers" (N.J.A.C. 10:66–3).

(j) Nutrition and social-psychological basic counseling shall be provided by case coordinators with at least one year experience providing care to maternity patients or by an appropriate specialist in each of the areas, or by registered nurses, or obstetrical care providers.

(k) Short–term specialized social-psychological and nutrition counseling services shall be provided by social workers and nutritionists, respectively. Social workers and nutritionists shall be available on site during patient visits.

(*l*) There shall be adequate professional, paraprofessional and clerical staff to provide, in a timely manner, maternity care services as described herein. Maternity medical care services which meet the needs of the patients shall be provided in accordance with the "New Jersey State Department of Health Guidelines for HealthStart Maternity Care Providers."

10:54–6.12 Records: documentation, confidentiality and informed consent for HealthStart maternity care providers

(a) HealthStart Maternity Medical Care providers must have policies and procedures which protect patient confidentiality, provide for informed consent and document prenatal, labor, delivery and postpartum services in accordance with the "New Jersey State Department of Health Guidelines for HealthStart Maternity Care Providers" (N.J.A.C. 10:66–3).

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

(c) Each record must be confidential and must include at least the following: history and physical examination findings; assessment; a Plan of Care; treatment services; laboratory reports; counseling and health instructions; documentation of referral and follow-up services; and the Medicaid eligibility status, including presumptive eligibility determination and follow-up, as appropriate.

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

10:54–6.13 Standards for HealthStart pediatric care certificate

(a) Pediatric care services shall be comprehensive, integrated and coordinated.

(b) HealthStart Pediatric Care providers shall be Medicaid providers and shall:

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

2. Directly provide or arrange for non-emergency room based, 24–hour physician telephone access to patients.

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

10:54–6.14 Professional Requirements for HealthStart Pediatric Care Providers

(a) HealthStart Pediatric Care Providers shall be primary care physicians or have a physician on staff who possesses a knowledge of pediatrics. This may be demonstrated by eligibility for board certification by the American Academy of Pediatrics, and/or having hospital admitting privileges in pediatrics, or by documentation of a formal arrangement with a physician who is board certified in pediatrics or family practice.

(b) Any HealthStart certified nurse practitioner/clinical nurse specialist pediatric provider shall be a primary care provider who possesses a certificate as a CNP/CNS with a specialization in pediatrics issued by the New Jersey State Board of Nursing, and by having hospital admitting privileges in pediatrics, or by the documentation of a formal arrangement with a physician who is board certified in pediatrics or family practice.

10:54–6.15 Preventive care services for 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 the New Jersey State Department of Health Guidelines for HealthStart Pediatric Care (N.J.A.C. 10:66–3). The schedule shall include a 2–4 week visit, 2 month visit, 4 month visit, 6 month visit, 9 month visit, 12 month visit, 15 month visit, 18 month visit and 23–24 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. The HealthStart Child Health Preventive Visit form shall be completed for each HealthStart preventive visit.

(b) Each provider shall provide or arrange for sick care and twenty-four hour telephone physician access during non-office hours. If not directly provided by the HealthStart provider, sick care and twenty-four 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 shall not be permitted. Referral to the emergency room shall 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, encouraging the follow through of the referral. All of the activity shall be recorded on the patient's chart.

10:54–6.16 Referral services for HealthStart pediatric care providers

All HealthStart 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 nutrition services. This may include, but is not limited to: the Supplemental Special Food Program for Women, Infants and Children program (WIC), the Division of Youth and Family Services, Special Child Health Services Case Management Units and Child Evaluation Centers, the early intervention programs, County Welfare Agencies/Board of Social Services, certified home health agencies, community mental health centers, local and county health departments.

10:54–6.17 Records; documentation; confidentiality and informed consent for HealthStart pediatric care providers

(a) HealthStart Pediatric Care providers shall have policies which protect patient confidentiality, provide for informed consent and document comprehensive care services in accordance with New Jersey State Department of Health Guidelines for HealthStart Pediatric Care Providers.

(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.

10:54–6.18 Policy for reimbursement for HealthStart providers

(a) The HealthStart HCPCS procedure codes listed in this subchapter are governed by the same policies and rules that appear in the HCPCS subchapter of each chapter concerning non-institutional provider services. (See the Chapters on Independent Clinic Services, (N.J.A.C. 10:66), Physician Services, (N.J.A.C. 10:54)) and the Nurse Midwivery Services, (N.J.A.C. 10:58). The maximum fee allowance schedule and reimbursement requirements for HCPCS HealthStart Maternity Codes (Medical Care and Health Support Services) and HCPCS HealthStart Pediatric Codes are listed under N.J.A.C. 10:49–8.19 and 8.20 respectively.

(b) A HealthStart Provider shall submit the same claim form presently in use for the type of service provided.

Physician services	HCFA 1500 Claim Form
Nurse Midwifery services	HCFA 1500 Claim Form
Independent clinics	HCFA 1500 Claim Form
Local Health Departments	HCFA 1500 Claim Form

Hospital Outpatient Departments—Use present procedure for billing except for HealthStart Health Support Services (W9040–W9043) and the HealthStart Pediatric Continuity of Care (W9070) which are billed on the HCFA 1500 claim form.

10:54–6.19 HealthStart maternity care code requirements

(a) HealthStart Maternity Care code requirements are as follows:

1. Separate reimbursement shall be available for Maternity Medical Care Services and Maternity Health Support Services.

2. Maternity Medical Care Services shall be billed as a total obstetrical package, when feasible, but may be billed as separate procedures.

3. The enhanced reimbursement for the delivery and postpartum care may be claimed only for a patient who had received at least one antepartum HealthStart Maternity Medical or Health Support Service.

4. The modifier "WM" in the HCPCS list of procedure codes refers to those services provided by certified nurse midwives who shall include the modifier at the end of each code.

5. Laboratory and other diagnostic procedures and all necessary medical consultations shall be eligible for separate reimbursement.

(b) HealthStart Maternity Medical Care procedure codes are provided in N.J.A.C. 10:54–9.10(k) and (*l*), Health Care Financing Administration Common Procedure Coding System (HCPCS).

SUBCHAPTER 7. PHYSICIAN SERVICES PROVIDED IN HOSPITALS AND NURSING FACILITIES

10:54–7.1 Pre-admission screening for nursing facility (NF) placement

(a) The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise.

"Pre–admission screening" (PAS) means that process by which all Medicaid recipients and individuals who may become Medicaid recipients within six months following admission to a Medicaid certified nursing facility (NF), who are seeking admission to a Medicaid certified NF, receive pre-admission screening by the Medicaid District Office to determine the appropriateness of placement prior to admission to a NF, pursuant to N.J.S.A. 30:4D–17.10. (P.L. 1988, c.97.)

"Pre–admission screening and annual resident review (PASARR)" means that process by which mentally ill (MI) or mentally retarded (MR) individuals, applying for admission or continued stay are screened to determine the need for specialized services and for appropriateness of NF services.

"PASARR Level I" means the identification of individuals diagnosed with a serious mental illness (MI) or mental retardation (MR).

"PASARR Level II" is the function of evaluating and determining whether nursing facility (NF) services and specialized services are needed.

"PASARR specialized services for mentally ill individuals" means requiring inpatient psychiatric care.

"Health Services Delivery Plan (HSDP)" means an initial plan of care prepared by the Medicaid Regional Staff Nurse (RSN) during the Pre-admission Screening (PAS) assessment process. The HSDP reflects each patient's current or potential problems, required care needs, and the Track of Care, and shall be forwarded to the authorized care setting.

"Nursing facility (NF)" means an institution (or distinct part of an institution) certified by the State Department of Health for participation in Title XIX Medicaid and primarily engaged in providing:

1. Nursing care and related services for recipients who require medical, nursing care, and social services;

2. Rehabilitative services for the rehabilitation of injured, disabled, or sick; or,

3. Health related care and services on a regular basis to recipients who, because of mental or physical condition, require care and services above the level of room and board; and for the care and treatment of mental disease.

"Regional Staff Nurse (RSN)" means a registered professional nurse employed by the Division who performs health needs assessments as required by the regulations of the Division.

"Track of care" means the setting and scope of Medicaid services approved by the RSN following assessment of the Medicaid recipient or potential Medicaid recipient, as follows:

1. "Track I" means long-term NF care;

2. "Track II" means short-term NF care; and,

3. "Track III" means long-term care services in a community setting.

(b) The determination of the necessity of NF services shall be performed through the Pre-admission Screening (PAS) as mandated by N.J.S.A. 30:4D–17.10. Pre–admission Screening (PAS) authorization is required prior to admission to a Medicaid certified NF for a Medicaid recipient or an individual who may become a Medicaid recipient within six months following placement in a Medicaid certified NF and for individuals identified as meeting PASARR Level I criteria. The Medicaid Regional Staff Nurse (RSN) shall assess each individual's need for long term care services, evaluate the appropriate setting for the delivery of services, and authorize appropriate placement (Track of Care).

(c) PAS authorization shall be required for the Pre-admission Screening and Annual Resident Review (PASARR) of individuals identified as having mental illness or mental retardation. The PASARR assessment and authorization process shall be subsumed within the State's PAS protocols. (See N.J.A.C. 10:52–1.9(d)).

10:54–7.2 Pre–admission Screening and Annual Resident Review (PASARR); Level I

(a) PASARR Level I Identification Screens shall be required for individuals diagnosed as mentally ill, mentally retarded or with related conditions.

(b) An individual is considered to have a mental illness if he or she has a "serious mental illness such as: schizophrenia; mood disorder; paranoia; panic or other severe anxiety disorder;" listed in the Diagnostic and Statistical Manual, Third Edition revised in 1987 (DSM–III–R) which leads to a chronic disability and which meet the PASARR requirements on Diagnosis, Level of Impairment and Duration of Illness found in the PASARR Identification Criteria for Serious Mental Illness (SMI) and MR at N.J.A.C. 10:54–7.3.

1. An individual is considered to have dementia if he or she has a primary diagnosis of dementia, as described in the Diagnostic and Statistical Manual of Mental Disorders (Latest Edition).

(c) An individual is considered to have mental retardation if he or she has a level of retardation (mild, moderate, severe or profound) described in the "American Association on Mental Deficiency's, Manual on Classification in Mental Retardation (1983)" or a related condition as defined by and pursuant to Section 1905(d) of the Social Security Act (Omnibus Budget Reconciliation Act of 1987—P.L. 100–203); 42 U.S.C. 1396(d). An individual with a diagnosis of MR or a related condition, as described in (d) below, and a diagnosis of dementia, shall receive a PASARR Level II Screen.

(d) "Persons with related conditions" means individuals who have severe, chronic disability that:

1. Is attributable to cerebral palsy or epilepsy; or any other condition (other than mental illness) found to be closely related to mental retardation (developmentally disabled) because this condition (the mental and/or physical impairment) results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons;

2. Is manifested before the person reaches the age 22 years;

3. Is likely to continue indefinitely; and

4. Results in substantial functional limitations in three or more of the following areas of major life activity:

i. Self–care;

ii. Understanding and use of language;

iii. Learning;

iv. Mobility;

v. Self–direction;

vi. Capacity for independent living; and,

vii. Economic self-sufficiency.

10:54–7.3 PASARR Level I; PASARR Identification criteria for serious mental illness (SMI) and mental retardation

(a) The criteria for serious mental illness includes:

1. A diagnosis of a mental illness that may lead to chronic disability, such as, schizophrenia, mood disorder, paranoia, panic or other severe anxiety disorder, somataform disorder, personality disorder, or other psychotic disorder.

2. A disability showing that within the past 3 to 6 months, mental disorder has resulted in functional limitations in major life activities that would be appropriate for the client's developmental stage.

3. During the past two years and due to a mental illness, either or both of the following have occurred:

i. There were two or more treatment episodes of greater intensity than outpatient services, such as, inpatient, emergency or partial hospitalization care (include also single episodes lasting three months or more); and/or

ii. The normal living situation has been disrupted to the point that supportive services were required to maintain that client in that home or residence, or housing or law enforcement officials intervened.

NOTE: Psychotic drug use no longer constitutes a mandatory criteria for a PASARR Screen.

(b) The criteria for mental retardation or related conditions includes:

1. The individual has a diagnosis of mental retardation or other developmental disability, such as, cerebral palsy, epilepsy, autism, spinal bifida, head injury or other neurological impairment; and

2. The individual's history or past records show that the onset of the mental retardation or related conditions occurred prior to age 22; and

3. The individual's disability is severe and chronic in nature.

10:54–7.4 PASARR Level II Screens

(a) PASARR Level II screens shall be conducted for mentally ill or mentally retarded individuals only if the RSN's assessment results in authorization for NF placement.

(b) Level II screens require that a psychiatric examination be performed by a Medicaid participating psychiatrist to determine the need for specialized services. (See N.J.A.C. 10:52–1.9(e).)

(c) Level II screens for mentally retarded individuals will be performed by the Division of Developmental Disabilities (DDD) to determine the need for specialized services. (See N.J.A.C. 10:52–1.9(d).)

10:54–7.5 PASARR Level II; Readmission following psychiatric hospitalization

Readmission of an individual to a nursing facility following hospitalization in a psychiatric unit of an acute care hospital or from a psychiatric hospital for treatment of an acute episode of a serious mental illness is exempt from preadmission NF and Specialized Services screens. If the Minimum Data Set (MDS), which must be completed on admission, indicates a significant change in the resident's mental or behavioral status, the NF must immediately secure an ARR screen. If the resident's mental condition is stabilized, the ARR may be performed in the normal 12 cycle. In addition, if a resident is transferred from one NF to another, the discharging NF must forward to the admitting facility a copy of the most recent MDS, a copy of the most recent PASARR NF authorization letter and Specialized Services determination outcome.

10:54–7.6 PASARR Level II; Alzheimer's or related dementias

For individuals diagnosed with Alzheimer's or related dementias, documentation must be provided to the admitting Medicaid certified nursing facility for the individual's clinical record on the history, physical examination, and diagnostic workup to support the diagnosis of dementia, Alzheimer's disease or related dementias.

10:54–7.7 PASARR and PAS Screens; Necessity for nursing facility services

(a) The determination of the necessity for NF services shall be performed through Pre-admission Screening (PAS) as mandated by N.J.S.A. 30:4D–17.10. The Medicaid Regional Staff Nurse (RSN) shall determine the necessity for nursing facility services for Medicaid recipients and for individuals who may become Medicaid recipients within six months following admission to a Medicaid certified facility and for individuals identified as meeting PASARR Level I criteria.

(b) The PASARR Level II Screen prior to NF admission shall be performed by a psychiatrist and forwarded to the Division of Mental Health Services (DMHS) for final determination of the need for specialized services.

1. The hospital discharge planning unit and/or social services department shall immediately arrange through the individual's attending physician, a consultation by a board eligible or board certified hospital staff psychiatrist, who shall also be a Medicaid participating provider, to conduct the active treatment review and complete the "Psychiatric Evaluation" form. (The "Psychiatric Evaluation" form is not to be completed until such time as the RSN has approved placement in a NF.)

2. Within 48 hours of the psychiatrist's review of the recipient or potential Medicaid recipient, the completed "Psychiatric Evaluation" form shall be sent to the Division of Mental Health Services, PO Box 727, Trenton, New Jersey 08625–0727, Attention: PASARR Coordinator.

i. A supply of the "Psychiatric Evaluation" form may be ordered from the PASARR Coordinator in the Division of Mental Health Services.

(c) Annual Resident Reviews (ARR) for individuals identified as having mental illness residing in Medicaid certified nursing facilities shall be performed by the individual's attending physician and forwarded to the Division of Mental Health Services for final determination of the need for specialized services.

1. The MDO will send a NF PASARR Reassessment List to the NF in the first week of every month. The reassessment date is based upon the month the individual was initially admitted to the NF. The attending physician completes the psychiatric evaluation form by the fifteenth of the following month on those individuals with mental illness.

2. The completed psychiatric evaluation form will be forwarded to the DMHS to be reviewed by DMHS psychiatrists to determine the need for specialized services.

3. The results of the DMHS determination will be returned to the nursing facility to be incorporated in the patient's chart.

10:54–7.8 Physician services to hospital patients

(a) Physician services that are rendered to a patient registered in the hospital outpatient department that are reimbursed as part of hospital costs shall not be billed directly by the physician to the Medicaid program. Any arrangement, contractual, employment, grant or otherwise, for payment of the physician(s) providing a service(s) to such a registered clinic patient is between the hospital and the physician(s). Physician services provided in the hospital outpatient department to Medicaid recipients that are not included in hospital costs may be billed by the physician directly to the New Jersey Medicaid program.

(b) For the hospital based physician providing services to an ambulatory non-registered (private) patient, the following applies:

1. This type of patient shall be considered to be the private ambulatory patient of a physician who has referred the patient to the hospital for the services provided, in part or whole, by a hospital based physician (for example, radiologist, pathologist, electrocardiographer, and so forth);

2. Such specific services are considered hospital costs when provided by the physician who is customarily reimbursed directly by the hospital, contractually or otherwise, and are not reimbursable directly to the referring physician.

(c) Direct patient care physician services which are considered the professional component of hospital care, (that is, for some emergency room physicians, radiologists, pathologists, and electrocardiographers), may be reimbursed when the physician bills directly by the fiscal agent under the following circumstances:

1. The physician shall be under contract with the individual hospital for the performance of the specific services;

2. The services are not part of the hospital costs; and

3. The professional component of the services are not reimbursed to the physician in whole or in part by the hospital.

10:54–7.9 Psychiatric services; inpatient services

(a) The New Jersey Medicaid program recognizes as a covered service, a medically necessary inpatient service which is provided to a Medicaid recipient in an approved private psychiatric hospital or the psychiatric section of an approved general hospital with the following limitation. (See N.J.A.C. 10:49–2.3(b) for the Medically Needy program and the Hospital Services Chapter, N.J.A.C. 10:52–1.15, 10:52–2.9 and 10:52–4.2) for policies and procedures for hospital outpatient psychiatric services).

1. Reimbursement for either a psychiatric consultation, individual psychotherapy, family or group psychotherapy, or shock therapy shall be considered as inclusive for all psychiatric services performed on that day.

(b) When hospitalization is out-of-State, prior authorization is required for elective psychiatric hospitalizations but not for emergency hospitalizations.

1. When prior authorization is required, the request shall be submitted from the referring physician to the Office of Health Services Administration, Mental Health Services, Division of Medical Assistance and Health Services, Mail Code #18, PO Box 712, Trenton, New Jersey 08625–0712, attached to the claim form.

2. The request shall include the following:

i. The diagnosis, as set forth in the Diagnostic and Statistical Manual of the American Psychiatric Association (Latest edition);

ii. A brief history and present clinical status;

iii. A treatment proposal;

iv. A summary of previous treatment and hospitalizations;

v. The anticipated length of hospitalization; and

vi. Evidence that suitable placement within New Jersey and/or within a reasonable distance of the patient's home is not available.

3. A request for retroactive authorization will be considered only when the request has been delayed by circumstances beyond the control of the hospital.

4. When the request for authorization is approved, both the request letter and the provider's claim form will be returned to the provider. When a claim is submitted for reimbursement, the provider must attach the request for approval and the approval to the UB–92 (HCFA–1450), the hospital claim form.

5. If request for prior authorization is denied, the physician and/or hospital shall be notified of the reason, in writing, by the Central Office, Mental Health Services Unit, Office of Health Services Administration, Division of Medical Assistance and Health Services, PO Box 712, Trenton, New Jersey 08625–0712.

10:54–7.10 Psychiatric services (including prior authorization); Hospital outpatient and other settings

(a) The following policies and procedures were developed to help ensure the appropriate utilization of hospital outpatient psychiatric services. These include the role of the evaluation team in relation to the patient's treatment regimen, with emphasis placed on intake evaluation, development of a Plan of Care (PoC), performance of periodic review for evaluation purposes, and supportive documentation for services rendered. (See N.J.A.C. 10:52–2.3 Recordkeeping and N.J.A.C. 10:66–2.5 for more specific policies and procedures for psychiatric (mental health services).

(b) Psychiatric services which are medically necessary rendered in an approved hospital outpatient department or in other settings, to a registered patient who is a Medicaid recipient, shall not require prior authorization, except in the following situations:

1. Prior authorization is required for partial hospitalization after the first 90 calendar days. Each authorization for this service may be granted for a maximum period of six months. Additional authorization may be requested. A new prior authorization request for partial hospitalization is required when a departure from the Plan of Care (PoC) is made because a change in the patient's clinical condition may necessitate an increase in the frequency and intensity of services, or a change which exceeds the type of services authorized.

2. Prior authorization is required for mental health services exceeding $900.00 in reimbursement to the physician rendered to a Medicaid recipient in any 12–month service year, commencing with the patient's initial visit, when provided in other than an inpatient hospital setting. Reimbursement shall not be paid by the program for physician psychiatric services rendered to a registered hospital outpatient.

3. Prior authorization shall be required for mental health services exceeding $400.00 in payments in any 12–month service year rendered to a Medicaid recipient residing in either a nursing facility or a residential health care facility.

(c) The request for authorization shall include the diagnosis, as set forth in the ICD–9 (latest revision), and also must include the treatment plan and progress report in detail. No post facto authorization will be granted.

1. For those Medicaid recipients who do not reside in a nursing facility and live in a community setting, including a residential health care facility, or for those receiving mental health services in the outpatient department of a hospital, an independent clinic or a physicians office, the request for prior authorization shall be submitted directly to Office of Health Services Administration, Mental Services Unit, Division of Medical Assistance and Health Services, PO Box 712, Mail Code #18, Trenton, New Jersey 08635–0712 on the "Authorization of Mental Health Services (FD–07)" form.

2. For a Medicaid recipient residing in a nursing facility, the request for prior authorization shall be submitted directly to the appropriate Medicaid District Office that serves that nursing facility on the "Authorization of Mental Health Services (FD–07)" form.

3. When approved by the New Jersey Medicaid program, each authorization may be granted for a maximum period of one year except as listed in (c)3i and ii below. Additional authorizations may be requested.

i. Authorization for partial care and partial hospitalization shall be limited to a maximum period of six months.

ii. Prior authorization shall be required for partial hospitalization after the first 90 calendar days. (See N.J.A.C. 10:52–2.9—Hospital Services Chapter, for further policies and procedures.)

4. The Division shall not reimburse the physician and/or hospital for both mental health services provided in the office and/or hospital or any other setting and medical day care center services provided to the same recipient on the same day. The Division shall also not reimburse the physician and/or hospital for both mental

health services and partial hospitalization services provided to the same patient on the same day.

SUBCHAPTER 8. PHARMACEUTICAL SERVICES

10:54–8.1 Pharmaceutical; Conditions for participation as provider of pharmaceutical services

(a) All covered pharmaceutical services shall be provided under the New Jersey Medicaid program shall be provided to Medicaid recipients within the scope of N.J.A.C. 10:49, Administration; N.J.A.C. 10:51, Pharmaceutical Services; and N.J.A.C. 10:54–8, Physician Services.

(b) All drugs shall be prescribed.

1. "Prescribed drugs" means simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance, that are:

i. Prescribed by a practitioner licensed or authorized by the State of New Jersey, or the state in which he or she practices, to prescribe drugs and medicine within the scope of his or her license and practice:

ii. Dispensed by licensed pharmacists in accordance with regulations promulgated by the New Jersey Board of Pharmacy, N.J.A.C. 13:39; and

iii. Dispensed by licensed pharmacists on the basis of a written prescription that is maintained in the pharmacist's records.

10:54–8.2 Pharmaceutical; program restrictions affecting payment for prescribed drugs

(a) The choice of prescribed drugs shall be at the discretion of the prescriber within the limits of applicable laws. However, the prescriber's discretion is limited for certain drugs. Reimbursement may be denied if the requirements of the following rules are not met:

1. Covered and non-covered pharmaceutical services as listed in the Pharmaceutical Services Chapter, N.J.A.C. 10:51–1.11 and 10:51–1.12, respectively, incorporated herein by reference;

2. Pharmaceutical services requiring prior authorization, (see N.J.A.C. 10:51–1.13, incorporated herein by reference);

3. Quality of medication (see N.J.A.C. 10:51–1.14, incorporated herein by reference);

4. Dosage and directions (see N.J.A.C. 10:51–1.15, incorporated herein by reference);

5. Telephone-rendered original prescriptions (see N.J.A.C. 10:51–1.16, incorporated herein by reference);

6. Changes or additions to the original prescription (see N.J.A.C. 10:51–1.17, incorporated herein by reference);

7. Prescription refill (see N.J.A.C. 10:51–1.18, incorporated herein by reference);

8. Prescription Drug Price and Quality Stabilization Act (N.J.S.A. 24:6E–1 et seq.) (see N.J.A.C. 10:51–1.19 incorporated herein by reference);

i. Products listed in the current New Jersey Drug Utilization Review Council (DURC) Formulary, (hereafter referred to as "the Formulary"), and all subsequent revisions, distributed to all prescribers and pharmacists; and

ii. Non-proprietary or generic dispensing (see N.J.A.C. 10:51–1.9, incorporated herein by reference).

9. Federal regulations (42 CFR 447.301, 331–333) that set the aggregate upper limits on payment for certain multi-source drugs if Federal Financial Participation (FFP) is to be made available. The limit applies to all "maximum allowable cost" drugs (see N.J.A.C. 10:51–1.5, Basis of payment, incorporated herein by reference);

10. Drug Efficacy Study Implementation (DESI): "Less than effective drugs" subject to a Notice of Opportunity for Hearing (NOOH) by the Federal Food and Drug Administration (see N.J.A.C. 10:51–1.20 and listing of DESI drugs in Appendix A of N.J.A.C. 10:51, incorporated herein by reference);

11. Drug Manufacturers' Rebate Agreement with the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services (see N.J.A.C. 10:51–1.21, incorporated herein by reference);

12. Medical exception process (MEP) (see N.J.A.C. 10:54–8.3); and

13. In addition, diabetic testing materials, including blood glucose reagent strips, urine monitoring strips, tapes, tablets, and lancets. Electronic blood glucose monitoring devices or other devices used in the monitoring of blood glucose levels are considered medical supplies and are covered services by Medicaid. These services may require prior authorization from the Medicaid District Office (MDO). (See Medical Supplier Services, N.J.A.C. 10:59.)

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).
In (a), inserted a new 12, and recodified former 12 as 13.

10:54–8.3 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 shall be administered by a contractor, referred to as the MEP contractor, under a 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 (MEP) is as follows:

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

i. The MEP contractor shall send a Prescriber Notification Letter which includes, but may not be limited to, the beneficiary name, HSP identification number, dispense date, drug quantity, and 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 the review and include, at a minimum, the beneficiary's name, mailing address, HSP number, the reviewer, service description, service date, and prior authorization number, if approved, the length of the approval and the appeals process if the pharmacist does not agree with the results of the review.

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

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

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. 10:54–8.3, Pharmaceutical; Physician-administered drugs, recodified to N.J.A.C. 10:54–8.4.

10:54–8.4 Pharmaceutical; Physician-administered drugs

(a) The New Jersey Medicaid program shall reimburse physicians for certain approved drugs administered by inhalation, intradermally, subcutaneously, intramuscularly or intravenously in the office, home, or independent clinic setting according to the following reimbursement methodologies:

1. Physician-administered medications shall be reimbursed directly to the physician under certain situations. (See N.J.A.C. 10:54–9.8 for a listing of HCPCS procedure codes, "J" codes and applicable Level III procedure codes with a few exceptions such as, immunizations). For this methodology, the physician is required to bill the appropriate "J" code, Level III, HCPCS procedure code.

i. A "J" code may be billed in conjunction with an office, home, or independent clinic visit when the criteria for an office or home visit is met and the procedure code for the method of drug administration. The HCPCS 90799 may be billed for intradermal, subcutaneous, intramuscular, or intravenous drug administration. Other HCPCS procedure codes may be billed for the administration of allergy, chemotherapy or inhalation drugs.

ii. The New Jersey Medicaid program has assigned HCPCS procedure codes and Medicaid maximum fee allowances to certain, selected drugs for which reimbursement to the physician is based on the Average Wholesale Price (AWP) of a single dose of an injectable or inhalation drug, or the physician's acquisition cost, whichever is less.

iii. Unless otherwise indicated in Subchapter 8 or under the exception listed in (a)2 and 3 below, the Medicaid maximum fee allowance is determined based on the AWP per unit which equals one cubic centimeter (cc) or milliliter (ml) of drug volume for each unit. For drug vials with a volume equal to one cubic centimeter (cc) or milliliter (ml), the Medicaid maximum fee allowance shall be based on the cost per vial.

iv. When a physician office, home, or independent clinic visit is for the sole purpose of administering a drug, the reimbursement shall include the cost of the drug and administration. In these situations, there is no reimbursement for a physician office, home, or independent clinic visit. If, in addition to the physician administration of a drug, the criteria of an office, home, or independent clinic visit is met, the cost of the drug and administration may, if medically indicated, be reimbursed in addition to the visit.

v. No reimbursement will be made for vitamins, liver or iron injections or combination thereof; except in laboratory-proven deficiency states requiring parenteral therapy.

vi. No reimbursement will be made for placebos or any injections containing amphetamines or derivatives thereof.

vii. No reimbursement will be made for injection given as a preoperative medication or as a local anesthetic which is part of an operative or surgical proce-

dure, since this injection would normally be included in the prescribed fee for such a procedure.

2. The second method of reimbursement shall be limited to situations where a drug required for administration has not been assigned a "J" code, Level III HCPCS procedure code. In these situations, the drug shall be prescribed and obtained from a pharmacy which directly bills the New Jersey Medicaid program. In this situation, the physician shall bill only for the administration of the drug using HCPCS 90799.

3. Separate reimbursement shall be available for the administration of drug(s) in accordance with the appropriate procedure codes listed in the Physician's Current Procedural Terminology (CPT).

(b) The drug administered shall be consistent with the diagnosis and conform to accepted medical and pharmacological principles in respect to dosage frequency and route of administration.

Recodified from N.J.A.C. 10:54–8.3 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).

SUBCHAPTER 9. HEALTH CARE FINANCING ADMINISTRATION (HCFA) COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:54–9.1 Introduction

(a) The New Jersey Medicaid program utilizes the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physician's Current Procedural Terminology—4th Edition (CPT–4) architecture, employing a five-position code and as many as two 2–position modifiers. Unlike the CPT–4 numeric design, the HCFA assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three-level coding system.

1. Level I Codes: The narratives for these codes are found in CPT–4. CPT–4 is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians.

2. Level II Codes: The narratives for Level II codes are found in N.J.A.C. 10:54–9.10. These codes are not found in the CPT–4 and are assigned by HCFA for use by physicians and other practitioners.

3. Level III Codes: The narratives for Level III codes are found in N.J.A.C. 10:54–9.10. These codes are assigned by the Division of Medical Assistance and Health Services to be used for those services which are unique to the New Jersey Medicaid program.

(b) General policies regarding the use of HCPCS for procedures and services are listed below:

1. The responsibilities of physicians when rendering specific services is located in N.J.A.C. 10:54–1 through N.J.A.C. 10:54–8.

2. When filing a claim, the HCPCS procedure codes, including modifiers and qualifiers, must be used in accordance with the narratives in CPT–4 and the narratives and descriptions listed in this Subchapter 9, whichever is applicable.

3. The use of a procedure code, which describes the service, will be interpreted by the New Jersey Medicaid program, as evidence that the physician or practitioner personally furnished, as a minimum, the stated service. He or she will sign the claim as the servicing provider with the Medicaid Servicing Provider Number (MSPN) as evidence of the validity of the use of the procedure code reflecting the service provided.

4. Listed in the following sections are specific policies of the New Jersey Medicaid program relevant to HCPCS. This is to specifically call to the attention of physicians and practitioners the uniqueness of the policies in this subchapter and the need to incorporate these instructions when filing a claim for services provided to Medicaid recipients. (See also the Fiscal Agent Billing Supplement.)

5. Additional requirements of the provider when rendering specific services and requesting reimbursement are listed in the subchapters on prior authorization, recordkeeping, basis of payment, EPSDT, and other specific services.

10:54–9.2 Elements of HCPCS procedure codes which require attention

(a) The lists of HCPCS procedure code for use of physicians and other practitioners are arranged in tabular form with specific information for a code given under columns with titles such as "IND", "HCPCS CODES", "MOD", "DESCRIPTION", "FOLLOW-UP DAYS", "MAXIMUM FEE ALLOWANCE" AND "ANES BASIC UNITS". The information given under each column is summarized below:

Column	Title
"IND"	(Indicator-Qualifier) Lists alphabetic symbols used to refer provider to information concerning the New Jersey Medicaid program's qualifications and requirements when a HCPCS procedure code is used. Explanation of indicators and qualifiers used in this column are given below:
"A"	preceding any procedure code indicates that these tests can be and are frequently done as groups and combinations (profiles) on automated equipment.
"C"	preceding any procedure code indicates that cosmetic surgery is not payable by Medicaid unless prior authorization is received by the provider. (See also N.J.A.C. 10:54-5.3 and 9.10(g).)

Column Title

"E" preceding any procedure code indicates that these procedures are excluded from multiple surgery pricing and, as such, should be reimbursed at 100% of the Medicaid maximum fee allowance even if the procedure is done on the same patient by the same surgeon at the same operative 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. 10:54-9.10(f).)

"F" preceding any procedure code indicates that this code, when used primarily for the diagnosis and treatment of infertility, is not covered by the New Jersey Medicaid program.

"I" preceding any procedure code indicates that certain surgical procedures when performed incidental to other surgical procedures by the operating surgeon or assistant are covered in the reimbursement allowance for the primary procedure. (See N.J.A.C. 10:54-9.10(b).)

"L" preceding any procedure code indicates that the complete narrative for the code is located in N.J.A.C. 10:54-9.10 of this chapter.

"M" preceding any procedure code indicates that this service is medically necessary under the Medical Justification Program. (See N.J.A.C. 10:54-3.2.)

"N" preceding any procedure code means that qualifiers are applicable to that code.

"S" preceding any procedure code indicates that a second opinion by another physician is required for this procedure. (See N.J.A.C. 10:54-9.10(b).)

"HCPCS CODES"—Lists the HCPCS procedure code numbers.

"MOD" Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of alphabetic and/or numeric characters affixed to the procedure code. The New Jersey Medicaid program's recognized modifier codes are listed in N.J.A.C. 10:54-9.3.

"DESCRIPTION"—Lists the code narrative for Level II and III procedure codes. Narratives for Level I are in CPT–4.

"FOLLOW-UP DAYS"—Lists the number of days for follow-up care.

"MAXIMUM FEE ALLOWANCE"—Lists New Jersey Medicaid program's maximum fee allowance schedule. 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 properly evaluate the service. Attach a copy of the report to the claim form. If the symbol "N.A." (Not Applicable) are listed instead of a dollar amount, it means that service is not reimbursable.

Column Title

"ANES BASIC UNITS"—B.U.V. (Basic Unit Value) + A.T. (Anesthesia Time per Unit) × $6.30 (specialist) or $5.50 (non–specialist) equals reimbursement.

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 (as in the "IND" column) and as modifiers (as in the "MOD" column). They assist the physician or practitioner 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 must not be ignored because in certain instances requirements are created in addition to the narrative which accompanies the HCPCS code as described in the CPT–4. THE PROVIDER WILL THEN BE SUBJECT TO THE ADDITIONAL REQUIREMENTS AND NOT JUST THE CPT/HCPCS CODE NARRATIVE. These requirements must be fulfilled in order to receive reimbursement.

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

(b) The following statements are requirements for billing and for using HCPCS:

1. When filing a claim, the appropriate HCPCS Codes must be used in conjunction with modifiers, when applicable.

2. The use of a procedure code will be interpreted by the New Jersey Medicaid program as evidence that the physician or practitioner personally furnished, as a minimum, the service for which it stands.