

CHAPTER 58A**CERTIFIED NURSE PRACTITIONER/CLINICAL NURSE SPECIALIST****Authority**

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

Source and Effective Date

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

Executive Order No. 66(1978) Expiration Date

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

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APPENDIX**SUBCHAPTER 1. GENERAL PROVISIONS****10:58A-1.1 Introduction: certified nurse practitioner and clinical nurse specialist**

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

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

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

10:58A-1.2 Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SUBCHAPTER 2. PROVISION OF SERVICES

10:58A-2.1 General provisions

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

(b) The New Jersey Medicaid program shall reimburse for CNP/CNS services provided only when the patient is an eligible Medicaid client at the time services are rendered.

CNP/CNSs shall verify the patient's current eligibility status prior to providing services.

10:58A-2.2 Provisions concerning medical services

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

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

10:58A-2.3 Surgical procedures

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

10:58A-2.4 Provisions governing prescribing include:

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

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

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

10:58A-2.5 Clinical laboratory services

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

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

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

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

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

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

(e) When the clinical laboratory test is performed on site, the venipuncture is not reimbursable as a separate procedure:

its cost is included within the reimbursement for the lab procedure.

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

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

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

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

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

10:58A-2.6 Evaluation and management services

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

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

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

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

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

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

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

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

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

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

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

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

1. This service is considered to be the routine office visit or follow-up care visit, and the visit will conform to the CPT-4 description of provider involvement and time. The setting could be office, hospital, nursing facility or residential health care facility. The documentation requirements for these visits can be found at N.J.A.C. 10:58A-1.4.

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

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

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

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

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

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

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

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

1. For purposes of Medicaid reimbursement, "home visits" apply when the provider visits Medicaid recipients who do not qualify as "home bound."

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

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

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

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

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

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

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

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

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

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

10:58A-2.7 Family planning services

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

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

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

(b) The Norplant System (NPS) is a Medicaid-covered service provided to reproductive-age women with established regular menstrual cycles, in conformance with the prescribing information approved by the Food and Drug Administration. Patient education and counseling shall be provided relating to the NPS, including pre- and post-insertion instructions, indications, contraindications, benefits, risks, side effects, and other contraceptive modalities.

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

10:58A-2.8 Mental health services

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

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

- i. The specific services rendered and modality used, such as individual, group, and/or family therapy;
- ii. The date services were rendered;
- iii. The duration of services provided (1 hour, 1/2 hour);
- iv. The signature of the CNP/CNS, Psychiatric/Mental Health, who rendered the service;
- v. The setting in which services were rendered;
- vi. A notation of impediments, unusual occurrences or significant deviations from the treatment described in the Plan of Care;
- vii. Notations of progress, impediments, treatment, or complications; and
- viii. Other relevant information.

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

1. Prior authorization for inpatient hospital mental health services is not required.
2. For services provided in nursing facilities and all facilities covered under the Rooming and Boarding House Act of 1979 (RBHA '79), N.J.S.A. 55:13B-1 et seq., prior authorization shall be required for mental health services exceeding \$400.00 in payments in any 12-month service year rendered to a Medicaid recipient residing in either a nursing facility or RBHA '79 facility. The request for prior authorization shall be submitted directly to the appropriate Medicaid District Office that serves that nursing or RBHA '79 facility on the "Authorization of Mental Health Services (FD-07)" form.

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

4. In all other settings: prior authorization shall be required for mental health services rendered to a Medicaid recipient (within a 12-month service year commencing with the patient's initial visit) when those services are provided in a setting other than an inpatient hospital, nursing facility or RBHA '79 facility, and when the reimbursement for those services exceeds \$900.00 to the CNP/CNS, Psychiatric/Mental Health. The request for prior authorization shall be submitted directly to the Psychiatric Consultant, Mental Health Services, Office of the Medical Affairs and Provider Relations, Division of Medical Assistance and Health Services, CN-712, Trenton, New Jersey 08625 on the "Authorization of Mental Health Services (FD-07)" form.

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

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

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

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

10:58A-2.9 PASARR, Pre-Admission Screening (PAS) and Annual Resident Review (ARR)

(a) Federal legislation (1919(a)(b) of the Social Security Act, 42 U.S.C. 1396r) established Pre-Admission Screening (PAS) for MI/MR applicants to Medicaid participating nursing facilities (NFs) and an Annual Resident Review (ARR) program for residents of Medicaid participating NFs.

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

(c) The initial PAS screening is conducted by a regional staff nurse, to determine whether the individual requires nursing facility level of care.

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

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

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

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

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

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

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

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

(f) The Annual Resident Review of PASARR, with maximum fee allowance (CNP/CNS Psychiatric/Mental Health) of \$44.00 is used for Medicare and/or Medicaid nursing facility patients who are being evaluated by the attending physician or CNP/CNS Psychiatric/Mental Health for the purposes of an annual resident review to determine the need for specialized services for mental illness.

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

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

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

i. The provider shall attach a completed Division of Mental Health and Hospitals Psychiatric Evaluation form (DMH&H-1994) to the patient's clinical chart. The Nursing Facility administrator will be responsible

for providing these forms to the attending-physician or CNP/CNS Psychiatric/Mental Health.

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

10:58A-2.10 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

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

1. EPSDT Screening Services;
2. Vision Services;
3. Dental Services;
4. Hearing Services; and

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

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

(c) An EPSDT examination shall include the following:

1. A comprehensive health and developmental history including assessment of both physical and mental health development;
2. A comprehensive unclothed physical exam including vision and hearing screening, dental inspection, and nutritional assessment;
3. Appropriate immunizations according to age and health history;
4. Appropriate laboratory tests, including:
 - i. Hemoglobin/hematocrit;
 - ii. Urinalysis;
 - iii. Tuberculin test (Mantoux), annually;
 - iv. Lead screening using blood lead level determinations between 6 and 12 months, at 2 years of age, and annually up to six years of age. At all other visits, screening shall consist of verbal risk assessment and additional blood lead level testing, if indicated; and

v. Other appropriate medically necessary procedures.

5. Health education, including anticipatory guidance;

6. Vision services:

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

ii. An appropriate medical and family history;

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

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

v. Periodic vision testing for school aged children:

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

(2) Second grade (seven years);

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

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

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

vi. Referral for vision screening of children who:

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

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

(3) Have suspected strabismus; or

(4) Have an abnormal light or red reflex.

7. Hearing Services:

i. Newborn hearing screening, including risk assessment;

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

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

8. Dental Services:

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

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

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

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

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

1. Under six weeks;

2. Two months;

3. Four months;

4. Six months;

5. Nine months;

6. 12 months;

7. 15 months;

8. 18 months;

9. 24 months; and

10. Annually through age 20.

(e) Reimbursement policy for EPSDT services:

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

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

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

SUBCHAPTER 3. HEALTHSTART

10:58A-3.1 HealthStart service

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