

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 described at N.J.A.C. 10:58A-3.

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

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

“HealthStart pediatric care provider” means a group of practitioners, a hospital, an independent clinic, or practitioner approved by the New Jersey State Department of Health and Senior Services and the New Jersey Medicaid and NJ FamilyCare-Plan A programs to provide a comprehensive package of pediatric care services.

“Independent clinic” means a facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients.

“Labeler code” means a five-digit numeric code assigned by the Food and Drug Administration, which identifies the firm that manufactures or distributes a specific drug. This code is the first segment of the National Drug Code.

“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 the PASRR, 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 PASRR requirements at N.J.A.C. 10:58A-2.10.)

“National Drug Code (NDC)” – means an 11-digit number that identifies a drug product. The first five digits represent the labeler code identifying the drug manufacturer; the next four digits identify the drug product; and the last two digits identify the package size.

“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.

“Preadmission screening (PAS)” means that process by which all Medicaid eligible beneficiaries seeking admission to a Medicaid certified nursing facility (NF) and individuals who may become Medicaid eligible within six months following admission to a Medicaid certified NF, receive a comprehensive needs assessment by professional staff designated by the Department of Health and Senior Services to determine their long-term care needs and the most appropriate setting for those needs to be met.

“Pre-Admission Screening and Resident Review (PASRR)” 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. PASRR includes two levels of screening, Level I Preadmission Screening and Resident Review and Level II Preadmission Screening and Resident Review, as described at N.J.A.C. 10:58A-2.10.

“Product code” means a four-digit numeric code, assigned by a firm that manufactures and distributes a drug, which identifies a specific strength, dosage form and formulation of the drug. This code is the second segment of the National Drug Code.

“Specialty” means a health care practice within a discipline, such as pediatrics, obstetrics/gynecology or mental health. All APN specializations must be certified by the New Jersey Board of Nursing in accordance with N.J.A.C. 13:37-7.1.

“State appropriations act” means an annual New Jersey State fiscal year appropriations act.

“Unit of measure” or “UOM” means a value of measurement used to define a drug product. Acceptable UOM codes are: F2 (international measure), GM (gram), ML (milliliter) or UN (unit/each).

Amended by R.2000 d.265, effective July 3, 2000.

See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).

Substituted references for references to patients throughout; and in “Early and Periodic Screening, Diagnosis and Treatment (EPSDT)” and “HealthStart pediatric care provider”, inserted references to NJ KidCare Plan-A.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Added “Advanced practice nurse (APN)” and “Advanced practice nurse services”; deleted “Certified nurse practitioner/clinical nurse specialist (CNP/CNS)” and “Certified nurse practitioner/clinical nurse specialist (CNP/CNS) services”.

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

Rewrote definitions “Advanced practice nurse (APN),” “Concurrent care,” “Consultation,” “Early and Periodic Screening, Diagnosis and Treatment (EPSDT),” “HealthStart,” “Independent clinic” and “Specialty”; added definitions “Centers for Medicare and Medicaid Services (CMS)” and “Clinical practitioner”; deleted definition “Practitioner.”

Amended by R.2011 d.119, effective April 18, 2011.
See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

In definition "Advanced practice nurse (APN) services", inserted "registered"; in definition "Consultation", inserted "the" preceding "Division"; rewrote definition "Early and Periodic Screening, Diagnosis and Treatment (EPSDT)"; added definitions "Federal Funds Participation Upper Limit (FFPUL)", "Labeler code", "National Drug Code (NDC)", "Preadmission screening (PAS)", "Product code", "State appropriations act" and "Unit of measure"; substituted definition "Mental illness," for definition "Mental illness" and definition "Pre-Admission Screening and Resident Review (PASRR)" for definition "Pre-Admission Screening and Annual Resident Review (PASARR)"; in definition "Mental illness," deleted a comma preceding "for", substituted "the PASRR" for "PASARR" and "PASRR requirements at" for the second occurrence of "PASARR," and updated the N.J.A.C. reference; in definition "Pre-Admission Screening and Resident Review (PASRR)", inserted the last sentence; and in definition "Specialty", inserted a comma following "discipline", deleted a comma following "obstetrics/gynecology", and rewrote the last sentence.

10:58A-1.3 Provider participation

(a) In order to participate in the Medicaid and NJ FamilyCare fee-for-service programs as an APN practitioner, the APN shall apply to, and be approved by, the New Jersey Medicaid/NJ FamilyCare fee-for-service program. Application for approval by the New Jersey Medicaid/NJ FamilyCare fee-for-service program as an advanced practice nurse (APN) requires completion and submission of the "Medicaid Provider Application" (FD-20) and the "Medicaid Provider Agreement" (FD-62).

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

Molina Medicaid Solutions
Provider Enrollment
PO Box 4804
Trenton, New Jersey 08650-4804

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

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

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

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

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

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

(e) Upon signing and returning the Medicaid Provider Application, the Provider Agreement and other enrollment documents to Molina Medicaid Solutions, the fiscal agent for the New Jersey Medicaid and NJ FamilyCare fee-for-service programs, the advanced practice nurse (APN) will receive written notification of approval or disapproval. If approved, the APN will be assigned a provider identifier number. Molina Medicaid Solutions will furnish the provider identifier number and provider number.

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

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

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

Amended by R.2000 d.265, effective July 3, 2000.

See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).

Inserted references to NJ KidCare fee-for-service throughout; in (e), added 14 through 17; and in (h), inserted a reference to the HealthStart Program and deleted a reference to the Division of Family Health Services.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

In (d)2, substituted "advanced practice nurse" for "practice nurse practitioner" following "in accordance with the standards for family".

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

Deleted (e); recodified former (f)-(h) as (e)-(g).

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

In the address in (a)1, substituted "Molina Medicaid Solutions" for "Unisys Corporation"; in (c), inserted "professional registered nurse" and "APN"; and in (e), substituted "Molina Medicaid Solutions" for "Unisys" twice.

10:58A-1.4 Recordkeeping

(a) The APN, in any and all settings, shall keep such legible individual written records and/or electronic medical

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

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

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

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

3. Critical care/prolonged services will be covered when the patient’s situation requires constant clinical practitioner attendance given by the clinical practitioner to the exclusion of other patients and duties, and, therefore, 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 clinical practitioner’s authorized documentation 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 clinical 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 clinical practitioner other than the clinical practitioner(s) rendering maternity service.

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

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

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

Recodified from N.J.A.C. 10:58A-2.6 by R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).

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

Former N.J.A.C. 10:58A-2.7, Family planning services, recodified to N.J.A.C. 10:58A-2.8.

Amended by R.2000 d.265, effective July 3, 2000.

See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).

Substituted references to beneficiaries for references to patients throughout; in (d)1, substituted a reference to CPT for a reference to CPT-4; in (e)1, substituted a reference to beneficiaries for a reference to recipients; in (g), substituted a reference to the Division for a reference to this program; and in (h) and (i), inserted references to NJ KidCare fee-for-service throughout.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

Added “clinical” preceding “practitioner,” “practitioners,” “practitioner’s,” and “practitioner(s)” throughout; in (a), added “, in a patient’s home, in a boarding home,” and deleted “inpatient” preceding “hospitals”; in (i)2, substituted “APNs” for “practitioners.”

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

In (c)1i, substituted “including, but not limited to, APNs,” for “(APNs)”; in (c)3, substituted “initial visits,” for “Initial Visits”; in (c)5, substituted “initial visit” for “Initial Visit”; in (g), deleted “his or her” following “refer” and substituted the final occurrence of “the” for “his or her”; in (i)1, substituted the second occurrence of “a” for the first occurrence of “his or her”, the first occurrence of “the provider’s” for the second occurrence of “his or her” and “provider’s” for “physician’s”, and inserted “provider’s” preceding “office chart”; in the introductory paragraph of (i)3, deleted “his or her” preceding “other patients” and “for him or her” following “therefore”; and in (i)3i, substituted “authorized documentation” for “handwriting”.

10:58A-2.8 Family planning services

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

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

i. Exception: When a service is provided that is ordinarily considered an infertility service, but is provided for another purpose, the APN 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 Utilization Management, PO Box 712, (Mail Code #14), Trenton, New Jersey 08625-0712.

ii. When a prescription drug is provided that is ordinarily used for infertility, but is provided for medical conditions unrelated to infertility, the clinical practi-

tioner who prescribes this drug should clearly indicate on the prescription that the drug is being provided for a condition other than infertility, and provide a copy of this documentation to the pharmaceutical provider.

Recodified from N.J.A.C. 10:58A-2.7 by R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).

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

Former N.J.A.C. 10:58A-2.8, Mental health services, recodified to N.J.A.C. 10:58A-2.9.

Amended by R.2000 d.265, effective July 3, 2000.

See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).

Rewrote the section.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

In (a)1ii, added "clinical" preceding "practitioner"; deleted (b).

10:58A-2.9 Mental health services

(a) Advanced practice nurses who are certified in the advanced practice category of "Psychiatric/Mental Health" (APN, Psychiatric/Mental Health) are qualified to perform and be reimbursed independently for psychiatric evaluations for the New Jersey Medicaid/NJ FamilyCare fee-for-service program.

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

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

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

1. Prior authorization for inpatient hospital mental health services is not required.
2. For services provided in nursing facilities and all facilities covered under the Rooming and Boarding House Act of 1979 (RBHA '79) N.J.S.A. 55:13B-1 et seq., prior

authorization shall be required for mental health services exceeding \$400.00 in payments in any 12-month service year rendered to a Medicaid/NJ FamilyCare beneficiary residing in either a nursing facility of RBHA '79 facility. The request for prior authorization shall be submitted directly to the appropriate Medical Assistance Customer Center (MACC) that serves that nursing or RBHA '79 facility on the "Authorization of Mental Health Services and/or Mental Health Rehabilitation Services (FD-07)" and the "Request for Prior Authorization: Supplemental Information (FD-07A)" forms.

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

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

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

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

2. Ordinarily only one mental health procedure shall be reimbursed per day for the same beneficiary by the same physician, group of physicians, shared health facility, psychologist or APN, Psychiatric/Mental Health 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) An APN, Psychiatric/Mental Health providing mental health services shall document those services as described above and at N.J.A.C. 10:58A-1.4, Recordkeeping.

(e) Advanced practice nurses who are certified in the advanced practice category of "Psychiatric/Mental Health" (APN, Psychiatric/Mental Health) are qualified to perform services and to be reimbursed independently for the treatment of postpartum mental health disorders in women.

1. These services are available to women during pregnancy and/or after a delivery, miscarriage or the termination of a pregnancy. The services shall be billed using the regular mental health service HCPCS located at N.J.A.C. 10:58A-4.2(n).

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

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

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

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

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

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

Recodified from N.J.A.C. 10:58A-2.8 by R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).

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

Former N.J.A.C. 10:58A-2.9, PASARR, Pre-Admission Screening (PAS) and Annual Resident Review (ARR), recodified to N.J.A.C. 10:58A-2.10.

Amended by R.2000 d.265, effective July 3, 2000.

See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).

Inserted references to NJ KidCare fee-for-service and substituted references to beneficiaries for references to patients throughout; in (b)3, inserted "Independent" preceding "Clinic"; and added (e) and (f).

Amended by R.2003 d.182, effective May 5, 2003.

See: 34 N.J.R. 4303(a), 35 N.J.R. 1901(a).

Rewrote (b)2 and (b)4.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

In (b)3, substituted "an APN" for "a nurse practitioner."

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

In (e)1, deleted a comma following "miscarriage" and inserted the last sentence; deleted former (e)2; recodified former (e)3 and (e)4 as (e)2 and (e)3; and in (e)3, deleted "specialized" preceding "HCPCS".

10:58A-2.10 Pre-Admission Screening and Resident Review (PASRR) and Pre-Admission Screening (PAS)

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

(b) Through PASRR, 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 will be directed to an alternate placement.

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

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

2. An individual identified as meeting criteria for mental illness is evaluated by a psychiatrist, an attending physician or an APN who is certified in the advanced practice category of Psychiatric/Mental Health to determine the need for specialized services.

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

(e) The initial Pre-Admission PASRR Screen shall be used for Medicare and/or Medicaid and NJ FamilyCare—Plan A persons residing in the community (currently at home or boarding home) who are applicants to Medicare/Medicaid/NJ FamilyCare nursing facilities and are being examined by an

attending-physician or APN, Psychiatric/Mental Health, to determine the need for specialized services for mental illness. Clinical practitioners completing the screen to determine the need for specialized services shall use the 99333 HCPCS procedure code with a Medicaid/NJ FamilyCare maximum fee allowance as listed in N.J.A.C. 10:58A-4.

1. If the screening examination reveals the need for a more specialized examination, a psychiatric consultation may be requested by the attending physician or APN, 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 PASRR review. For MI individuals funded through other than the New Jersey Medicaid/NJ FamilyCare programs, the fee for psychiatric evaluations conducted by psychiatrists or in NFs by attending physicians or APN, Psychiatric/Mental Health will be paid by Medicare, other third party carriers or by the individual.

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

i. The examining attending-physician or APN, Psychiatric/Mental Health shall obtain the "Division of Mental Health Services Psychiatric Evaluation" form from the nursing home administrator and shall fax the completed form to (609) 777-0662 or mail the form to the Division of Mental Health Services, PO Box 727, Trenton, New Jersey 08625-0727, Attention: PASRR Coordinator.

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

(f) The HCPCS procedure codes and reimbursement amounts previously established by the Division for the Annual Resident Review of PASRR, shall be used for Medicare and/or Medicaid/NJ FamilyCare-Plan A nursing facility patients who are being evaluated by the attending physician or APN, Psychiatric/Mental Health, for the purposes of a resident review, the necessity of which was indicated by a significant change in the condition of the

beneficiary, to determine the need for specialized services for mental illness.

1. If this examination reveals the need for a more specialized examination, a psychiatric consultation may be requested by the attending physician or APN, 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 APN, Psychiatric/Mental Health for the same patient.

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

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

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

Recodified from N.J.A.C. 10:58A-2.9 by R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).

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

Former N.J.A.C. 10:58A-2.10, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), recodified to N.J.A.C. 10:58A-2.11.

Amended by R.2000 d.265, effective July 3, 2000.

See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).

Inserted references to NJ KidCare throughout; rewrote (a) and (f); in (c), rewrote the introductory paragraph, and substituted a reference to DHSS staff for a reference to RSN in 1; in (e), inserted a reference to NJ KidCare-Plan A in the introductory paragraph; and added (g).

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

In (e) and (f), substituted references to Medical Assistance Customer Center (MACC) for references to Medicaid District Office (MDO).

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).