

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10:58A-2.8 Family planning services

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

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

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

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

(b) The Norplant System (NPS) is a Medicaid-covered and NJ KidCare fee-for-service-covered service provided to reproductive age women with established regular menstrual cycles, in conformance with the prescribing information approved by the Food and Drug Administration. Patient education and counseling shall be provided relating to the NPS, including pre-and post-insertion instructions, 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 beneficiary shall be reimbursed during a five-year continuous period. The practitioner shall not be reimbursed for the NPS in conjunction with other forms of contraception, for example, intra-uterine device or Depo-Provera injection.

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

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

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

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

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

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

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

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

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

Rewrote the section.

10:58A-2.9 Mental health services

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

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

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

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

viii. Other relevant information.

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

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

2. For services provided in nursing facilities and all facilities covered under the Rooming and Boarding House Act of 1979 (RBHA '79) N.J.S.A. 55:13B-1 et seq., prior authorization shall be required for mental health services exceeding \$400.00 in payments in any 12-month service year rendered to a Medicaid/NJ KidCare fee-for-service beneficiary 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 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 KidCare fee-for-service beneficiary (within a 12-month service year commencing with the patient's initial visit) when those services are provided in a setting other than an inpatient hospital, nursing facility or RBHA '79 facility, and when the reimbursement for those services exceeds \$900.00 to the CNP/CNS, Psychiatric/Mental Health. The request for prior authorization shall be submitted directly to the Psychiatric Consultant, Mental Health Services, Office of the Medical Affairs and Provider Relations, Division of Medical Assistance and Health Services, PO Box 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/NJ KidCare fee-for-service program for a maximum period of one year, and additional authorizations may be requested. The request for authorization shall include the diagnosis, as set forth in the ICD-9 CM (latest revision), the treatment plan and the progress report, in detail. When a request for prior authorization is denied or modified, the CNP/CNS shall be notified of the reason, in writing, by the fiscal agent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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