CHAPTER 54

PHYSICIAN SERVICES

Authority

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Chapter 54, Manual for Physician's Services, was repealed, and Chapter 54, Physicians Services, was adopted as new rules by R.1996 d.66, effective February 5, 1996.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

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SUBCHAPTER 1. GENERAL PROVISIONS

10:54-1.1 Purpose and scope

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

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

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

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

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

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

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

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

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

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

SUBCHAPTER 4. BASIS OF PAYMENT

10:54–4.1 General payment methodology

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

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

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

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

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

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

10:54–4.2 Use of physician reimbursement codes

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

10:54–4.3 HCPCS codes for new patients visits

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

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

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

2. Reimbursement for an initial office visit or initial residential health care facility visit will be disallowed if a preventive medicine service, EPSDT examination, or office consultation was billed within a twelve month period by a physician, group, shared health care facility, or practitioner sharing a common record.

(c) If the setting is a nursing facility or hospital, the initial visit concept shall still apply when considered for reimbursement purposes despite CPT reference to the terms initial hospital care as applying to a new or established patient. Subsequent readmissions to the same facility may be designated as initial visits (as long as a time interval of 30 days or more has elapsed between admissions).

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

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

10:54–4.4 Use of HCPCS codes for established patient visits

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

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

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

10:54–4.5 Use of HCPCS codes for home visits and house calls

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

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

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

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

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

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

10:54–4.6 Use of HCPCS codes for emergency department services

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

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

1. HCPCS 99281–99285.

10:54–4.7 Use of HCPCS codes for critical care services

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

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

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

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

10:54–4.8 Use of HCPCS codes for neonatal intensive care

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

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

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

10:54-4.9 Use of HCPCS codes for neonatal care; well baby

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

10:54-4.10 Use of HCPCS codes for neonatal care; sick newborn

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

10:54-4.11 Physician reimbursement in special situations

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

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

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

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

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

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

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

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

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

10:54-4.12 HCPCS codes for surgical procedures; general

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

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

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

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

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

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

4. Normal post-operative care.

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

10:54-4.13 Pre-surgery consultation and evaluation

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

10:54-4.14 Simultaneous visit and other procedures

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

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

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

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

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

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

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

10:54–4.15 Multiple surgical procedures; same session

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

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

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

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

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

10:54–4.16 Repeat or revisitation of the surgical procedure

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

10:54–4.17 Ligation or transection of fallopian tubes

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

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

10:54–4.18 Anesthesiology

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

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

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

1. Services performed by an anesthesiologist; or

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

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

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

2. Introduction of the anesthetic agent;

3. Continuous supervision during the surgery; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10:54–4.19 Radiology; general

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

10:54–4.20 Radiology; diagnostic imaging and ultrasound

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10:54–4.21 Radiology; Computerized Tomography (CT), Magnetic Resonance Imaging (MRI) and Ultrasound

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

(b) For computerized tomography scan (CT) guidance (monitoring) performed in conjunction with biopsy, aspiration, puncture, injection of contrast material, or placement of a tube, drain, or other medically necessary device, the HCPCS codes with modifier for Reduced Services "–52" shall be used for billing purposes.

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

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

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

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

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

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

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

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

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

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

10:54–4.22 Nuclear medicine; diagnostic and therapeutic radiopharmaceuticals

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

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

10:54–4.23 Radiation oncology; treatment planning and therapy

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

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

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

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

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

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

10:54–4.24 Radiology; portable and mobile diagnostic

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

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

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

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

1. Define the body area to be radiologically examined;

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

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

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

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

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

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

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

1. Date(s) of examination;

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

3. Name of patient;

4. Place of examination;

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

6. Name of radiologist who interpreted the film;

7. Name of referring physician;

8. Date report sent to referring physician; and

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

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

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

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

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

radiologist, the physician referring the patient shall also be identified on the claim form (HCFA 1500) on Item 24.

10:54–4.25 Consultation services; general

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

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

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

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

10:54–4.26 Consultation; limited

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

10:54–4.27 Consultation; comprehensive

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

10:54–4.28 Consultation; follow–up

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

10:54–4.29 Consultation; use of all consultation codes

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Where significant medical necessity exists; and

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

10:54–4.30 Concurrent care; physicians

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

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

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

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

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

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

10:54–4.31 Concurrent care/collaboration with a CNP/CNS

(a) This rule applies when a physician is providing concurrent care with a certified nurse practitioner/clinical nurse specialist whether employed as part of a group, or if the physician provides collaboration to the CNP/CNS.

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

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

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

1. If concurrent care is provided, it shall be clearly documented that significant medical necessity exists for more than one clinician's services, as defined at N.J.A.C. 10:54–1.2, and

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

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

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

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

10:54–5.1 Apnea monitors; home

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

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

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

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

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

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

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

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

(e) The required information for recertification shall include:

1. Progress of the patient's current status;

2. Number of real alarms and treatment;

3. Pneumogram results, if any; and

4. Any additional information as requested by the Division medical consultant, such as a copy of the daily logs.

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

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

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

10:54–5.2 Clinical laboratory services

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

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

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

1. Certificate of Registration or Registration Certificate;

2. Certificate of Waiver;

3. Certificate for Provider–Performed Microscopy (PPM) Procedures;