CHAPTER 54

PHYSICIAN SERVICES

Authority

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

Source and Effective Date

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

Executive Order No. 66(1978) Expiration Date

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

Chapter Historical Note

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

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 Subchapter 3, Procedure Code Manual, was repealed by R.1986 d.52 and Subchapter 4, HCFA Common Procedure Coding System (HCPCS), was adopted as new rules, effective March 3, 1986.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

Chapter 54, Manual for Physician's Services, was repealed, and Chapter 54, Physicians Services, was adopted as new rules by R.1996 d.66, effective February 5, 1996.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

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SUBCHAPTER 1. GENERAL PROVISIONS

10:54–1.1 Purpose and scope

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

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

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

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

2. Where significant medical necessity exists; and

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

Recodified from N.J.A.C. 10:54–4.29 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998). See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:54–4.30, Concurrent care; physicians, recodified to N.J.A.C. 10:54–4.31.

10:54–4.31 Concurrent care; physicians

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

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

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

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

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

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

Recodified from N.J.A.C. 10:54–4.30 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998). See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:54–4.31, Concurrent care/collaboration with a CNP/CNS, recodified to N.J.A.C. 10:54–4.32.

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

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

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

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

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

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

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

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

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

Recodified from N.J.A.C. 10:54–4.31 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998). See: 30 N.J.R. 1060(a).

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;