

(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 or NJ KidCare 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 for 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 or NJ KidCare 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.

Amended 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).

In (a), inserted references to NJ KidCare throughout.

10:54-4.2 Personal contribution to care requirements for NJ KidCare-Plan C

(a) General policies regarding the collection of personal contribution to care for NJ KidCare-Plan C are set forth at N.J.A.C. 10:49-9.

(b) Personal contribution to care for NJ KidCare-Plan C services is \$5.00 a visit for office visits, except when the service is provided for preventive care, prenatal care, family planning services or substance abuse treatment services.

1. An office visit is defined as a face-to-face contact with a medical professional under the supervision of the physician, which meets the documentation requirements codified at N.J.A.C. 10:52-2.6 through 2.12.

2. Office visits include physician services provided in the office, patient's home, or any other site excluding hospital where the child may have been examined by the physician. Generally, these procedure codes are in the 90000 HCPCS series of reimbursable codes codified at N.J.A.C. 10:54-9.3.

3. Physician services which do not meet the requirements of an office visit as defined in this chapter, such as surgical services, immunizations, laboratory or x-ray services, do not require a personal contribution to care.

(c) Physicians shall not charge a personal contribution to care for services provided to newborns, who are covered

under fee-for-service for Plan C; for family planning services; for substance abuse treatment services; for prenatal care or for preventive services, including appropriate immunizations.

New Rule, 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. 10:54-4.2, Use of physician reimbursement codes, recodified to N.J.A.C. 10:52-4.3.

10:54-4.3 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.

Recodified from N.J.A.C. 10:54-4.2 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. 10:54-4.3, HCPCS codes for new patients visits, recodified to N.J.A.C. 10:54-4.4.

10:54-4.4 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.

Recodified from N.J.A.C. 10:54-4.3 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. 10:54-4.4, Use of HCPCS codes for establishing patient visits, recodified to N.J.A.C. 10:54-4.5.

10:54-4.5 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.

Recodified from N.J.A.C. 10:54-4.4 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. 10:54-4.5, Use of HCPCS codes for home visits and house calls, recodified to N.J.A.C. 10:54-4.6.

10:54-4.6 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.