

CHAPTER 58A

CERTIFIED NURSE PRACTITIONER/CLINICAL
NURSE SPECIALIST

Authority

N.J.S.A. 45:11-23 et seq.; N.J.A.C. 13:37; P.L. 1991, c. 377; N.J.S.A. 30:4D-6b(17), 7a, b and c; 30:4D-12; 1905(a)21 of the Social Security Act, 42 U.S.C. 1396d(a).

Source and Effective Date

R.1995 d.501, effective September 5, 1995.
See: 27 N.J.R. 2158(a), 27 N.J.R. 3343(a).

Executive Order No. 66(1978) Expiration Date

Chapter 58A, Certified Nurse Practitioner/Clinical Nurse Specialist, expires on September 5, 2000.

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SUBCHAPTER 1. GENERAL PROVISIONS

10:58A-1.1 Introduction: certified nurse practitioner and
clinical nurse specialist

(a) This chapter is concerned with the provision of health care services by certified nurse practitioners and clinical nurse specialists (CNP/CNS), in accordance with the New Jersey Medicaid Program policies and procedures and the standards set forth by the New Jersey Legislature (N.J.S.A. 45:11-23 et al. and P.L. 1991, c.377) and by the New Jersey Board of Nursing (N.J.A.C. 13:37-7).

(b) An approved New Jersey Medicaid CNP/CNS provider may be reimbursed for medically necessary covered services provided within the scope of her or his license, and her or his approved New Jersey Medicaid Program Provider Agreement.

(c) A CNP/CNS may enroll in the New Jersey Medicaid program and provide covered, medically necessary services as an independent practitioner, or may provide such services as part of another entity, such as a hospital or clinic, physician group practice, or a mixed practitioner practice.

10:58A-1.2 Definitions

The following words and terms, as used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

“Ambulatory care facility” means a health care facility or a distinct part of a health care facility, licensed by the New Jersey State Department of Health, which provides preventive, diagnostic and treatment services to persons who come to the facility to receive services and depart from the facility on the same day.

“Certified nurse practitioner/clinical nurse specialist (CNP/CNS)” means a person currently licensed to practice as a registered professional nurse who is certified by the New Jersey State Board of Nursing in accordance with N.J.A.C. 13:37-7, and with N.J.S.A. 45:11-49a through d, or

similarly licensed and certified by a comparable agency of the state in which he or she practices.

“Certified nurse practitioner/clinical nurse specialist (CNP/CNS) services” means those services provided within the scope of practice of a licensed professional nurse (R.N.) and the certification as a CNP or CNS, defined by the laws and rules of the State of New Jersey, or if in practice in another state, by the laws and regulations of that state.

“Concurrent care” means care rendered to a patient by more than one practitioner/physician where the dictates of medical necessity require the services of one or more clinicians in addition to the attending clinician, so that appropriate and needed care may be provided to the patient.

“Consultation” means the professional evaluation of a patient from a perspective different from that of the treating practitioner, in order to bring enhanced clinical expertise for the benefit of the patient.

“Discipline” means a branch of instruction or learning, such as medicine, dentistry, advanced practice nursing, or chiropractic.

“Early and Periodic Screening, Diagnosis and Treatment (EPSDT)” means a preventive and comprehensive health program for Medicaid recipients through 20 years of age, including the assessment of an individual’s care needs through initial and periodic examinations (screenings), the provision of health education and guidance, and the assurance that any identified health problems are diagnosed and treated at the earliest possible time.

“Federally Qualified Health Center (FQHC)” means an entity that is receiving a grant under Section 329, 330, or 340 of the Public Health Service Act, section 1905(l) of the Social Security Act, 42 U.S.C. § 1396(l); or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under Section 329, 330, or 340 of the Public Health Service Act; or, based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant; or was treated by the Secretary, for purposes of Medicare Part B, as a Federally Funded Health Center as of January 1, 1990.

“HealthStart” means the program of health services provided to pregnant women, infants and small children, as defined at N.J.A.C. 10:49-1.4, Administration, and at N.J.A.C. 10:58A-3.

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

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

“HealthStart pediatric care provider” means a group of practitioners, a hospital, an independent clinic, or practitioner approved by the New Jersey State Department of Health and the New Jersey Medicaid program to provide a comprehensive package of pediatric care services.

“Independent clinic” means a facility that is not part of a hospital, but is organized and operated in accordance with N.J.A.C. 10:66-1.1 and 42 C.F.R. 440.90.

“Mental health clinic” means a freestanding independent community facility or distinct component of a multi-service ambulatory care facility, which meets the minimum standards established by the Community Mental Health Services Act implementing rules at N.J.A.C. 10:37.

“Mental illness”, for purposes of PASARR, refers to a condition which can be disabling and/or chronic, such as schizophrenia, mood disorder, paranoia, panic or other severe anxiety disorder, as described in the *International Classification of Diseases, Ninth Revision (ICD-9(M))*, and which can lead to a chronic disability. (See PASARR, N.J.A.C. 10:58A-2.9.)

“Physician” means a doctor of medicine (M.D.) or osteopathy (D.O.) licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners or similarly licensed by a comparable agency of the state in which he or she practices.

“Practitioner” refers to a certified nurse practitioner/clinical nurse specialist (CNP/CNS) as defined by this rule. Practitioners are responsible for examining, diagnosing, treating and counseling patients, and ordering medications, within their specific scope of practice, as defined by the New Jersey Board of Nursing. On occasion, this chapter defines procedures which are provided by CNP/CNSs and by physicians; in these instances, the term “practitioner/physician” is used.

“Pre-Admission Screening and Annual Resident Review (PASARR)” means an evaluation or screening to assess potential or actual nursing facility (NF) residents in respect to mental illness and/or mental retardation, in order to assure that the resident is provided with appropriate services, and to ensure that the NF admits residents whose needs can be met by the services normally provided by the facility.

“Specialty” means a health care practice within a discipline such as pediatrics, obstetrics/gynecology, orthodontics or periodontics. A list of the specializations applicable to CNP/CNSs can be found at N.J.A.C. 10:58A-1.3(e).

(d) The copayment for CNS/CNP services under NJ KidCare-Plan D shall be \$5.00 per office visit;

1. A \$10.00 copayment shall apply for services rendered during non-office hours and for home visits.
2. The \$5.00 copayment shall apply only to the first prenatal visit.

(e) CNPs/CNSs are required to collect the copayment specified in (d) above except as provided in (f) below. Copayments shall not be waived.

(f) CNPs/CNSs shall not charge a copayment for services provided to newborns, who are covered under fee-for-service for Plan D or for preventive services, including well child visits, lead screenings and treatment, and age-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).

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998. See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 with changes, effective September 21, 1998.

Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).

See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).

In (a), added reference to copayments for NJ KidCare-Plan D; added (d) through (f).

10:58A-2.3 Surgical procedures

Typically, office visits are not reimbursed in combination with surgical procedures. (When two services are rendered, for example, an office visit and a surgical procedure, the program will pay the higher fee, either the visit or the procedure.) The procedure codes within the CNP/CNS scope of practice which are excluded from the general policy are: 29105 through 29740 (see N.J.A.C. 10:58A-4.2(d), (e) and (f)), 31720, and 36415.

10:58A-2.4 Pharmaceutical services

(a) All covered pharmaceutical services provided by CNP/CNSs under the New Jersey Medicaid program shall be prescribed in accordance with N.J.A.C. 13:37-7.6 and 7.7; N.J.A.C. 10:49, N.J.A.C. 10:51, and this chapter.

(b) The Pharmaceutical Services manual, N.J.A.C. 10:51, sets forth the provisions for covered and non-covered pharmaceutical services, prior authorization, quantity of medication, administration of drugs, pharmaceutical dosage and directions, telephone-rendered original prescriptions, changes or additions to the original prescription, non-proprietary or generic dispensing, and prescription refill.

(c) Medicaid will reimburse the practitioner directly for the cost of the drugs described at N.J.A.C. 10:58A-4.3 and 4.4.

Amended 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).

10:58A-2.5 Medical exception process (MEP)

(a) For pharmacy claims with service dates on or after September 1, 1999, which exceed PDUR standards recommended by the New Jersey DUR Board and approved by the Commissioners of DHS and DHSS, the Division of Medical Assistance and Health Services has established a Medical Exception Process (MEP).

(b) The medical exception process (MEP) shall be administered by a contractor, referred to as the MEP contractor, under contract with the Department of Human Services.

(c) The medical exception process shall apply to all pharmacy claims, regardless of claim media, unless there is a recommended exemption by the New Jersey DUR Board which has been approved by the Commissioners of DHS and DHSS, in accordance with the rules of those Departments.

(d) The medical exception process is as follows:

1. The MEP contractor shall contact prescribers of conflicting drug therapies, or drug therapies which exceed established PDUR standards, to request written justification to determine medical necessity for continued drug utilization.

SUBCHAPTER 2. PROVISION OF SERVICES

10:58A-2.1 General provisions

(a) This subchapter describes the New Jersey Medicaid programs' policies and procedures for the provision of Medicaid-covered services by certified nurse practitioner/clinical nurse specialist providers. Services are separately identified and discussed only where unique characteristics or requirements exist. Unless indicated otherwise, reimbursement provisions are located in N.J.A.C. 10:58A-1.5, Basis for reimbursement.

(b) The New Jersey Medicaid program shall reimburse for CNP/CNS services provided only when the patient is an eligible Medicaid client at the time services are rendered. CNP/CNSs shall verify the patient's current eligibility status prior to providing services.

10:58A-2.2 Provisions concerning medical services

(a) For patient contacts where the patient presents with a chief complaint, the evaluation and management procedure codes at N.J.A.C. 10:58A-4.2(r)1 through 6 shall be applied.

(b) In the absence of patient complaints, the Preventive Medicine services codes and the Newborn Care code shall be applied for adults and for children. See N.J.A.C. 10:58A-4.2(r)7 and 8.

i. The MEP contractor shall send a Prescriber Notification Letter which includes, but may not be limited to, the beneficiary name, HSP identification number, dispense date, drug quantity, drug description. The prescriber shall be requested to provide the reason for medical exception, diagnosis, expected duration of therapy, and expiration date for medical exception.

ii. The prescriber shall provide information requested on the Prescriber Notification to the MEP contractor.

2. Following review and approval of a prescriber's written justification, if appropriate, the MEP contractor shall override existing PDUR edits through the issuance of a prior authorization number.

3. The MEP contractor shall notify the pharmacy and prescriber of the results of their review and include at a minimum, the beneficiary's name, mailing address, HSP number, the reviewer, service description, service date, and prior authorization number, if approved, the length of the approval and the appeals process if the pharmacist does not agree with the results of the review.

4. Prescribers may request a fair hearing to appeal decisions rendered by the MEP contractor concerning denied claims (see N.J.A.C. 10:49-10, Notices, Appeals and Fair Hearings).

5. Claims subject to the medical exception process which have not been justified by the prescriber within 30 calendar days shall not be authorized by the MEP contractor and shall not be covered.

New Rule, 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-2.5, Clinical laboratory services, recodified to N.J.A.C. 10:58A-2.6.

10:58A-2.6 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, within the scope of his or her practice, as defined by the laws of the State of New Jersey and/or of the state in which the 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 certification as required by CLIA 1988, and the New Jersey Department of Health rules found in N.J.A.C. 8:44 and N.J.A.C. 8:45.

(d) A CNP/CNS may claim reimbursement for clinical laboratory services performed for his or her own patients within his or her own office, subject to the following:

1. A CNP/CNS shall meet the conditions of the CLIA regulations before she or he may perform clinical laboratory testing for Medicaid recipients; and

2. The clinical laboratory tests shall be standard clinical laboratory procedures consistent with the CNP/CNS's CLIA certification, certificate of waiver or certificate of registration as an independent clinical laboratory.

(e) When the clinical laboratory test is performed on site, the venipuncture is not reimbursable as a separate procedure: its cost is included within the reimbursement for the lab procedure.

(f) When the CNP/CNS refers a laboratory test to an independent clinical reference laboratory:

1. The clinical reference laboratory shall be certified under the CLIA as described above at (a) and (b) to perform the required laboratory test(s);

2. The clinical laboratory shall be licensed by the New Jersey State Department of Health, as described above at (b) and (c), or comparable agency in the state in which the laboratory is located;

3. The clinical laboratory shall be approved for participation as an independent laboratory provider by the New Jersey Medicaid program in accordance with (b) above, and

4. Independent clinical laboratories shall bill the New Jersey Medicaid program for all reference laboratory work performed on their premises. The CNP/CNS will not be reimbursed for laboratory work performed by a reference laboratory.

Recodified from N.J.A.C. 10:58A-2.5 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-2.6, Evaluation and management services, recodified to N.J.A.C. 10:58A-2.7.

10:58A-2.7 Evaluation and management services

(a) The evaluation and management codes can indicate services performed in a practitioner's office, in nursing facilities and residential health care facilities, in clinics, in Federally qualified health centers (FQHCs), and in inpatient hospitals.

(b) 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 12 month period by the same practitioner, group of practitioners, or shared health care facility sharing a common record.

(c) Provisions for initial visits, evaluation and management, are:

1. For office visits and for other care apart from inpatient hospital, providers are permitted to bill for an initial

visit only once for a specific patient, subject to the following exceptions.

- i. When a shared health care facility, a group of physicians and/or other practitioners (CNPs or CNSs) share a common record, the Division will reimburse only one initial visit to that provider group.

- ii. Further encounters with that patient will be billed and reimbursed by means of "established patient" codes. See N.J.A.C. 10:58A-4.1 through 4.5.

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 recipient 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 and FQHCS shall only be billed by the clinic, after prior authorization in accordance with the 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 recipient (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 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.

Ordinarily only one mental health procedure shall be reimbursed per day for the same recipient 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.

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.

10:58A-2.10 PASARR, Pre-Admission Screening (PAS) and Annual Resident Review (ARR)

(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 participating nursing facilities (NFs) and an Annual Resident Review (ARR) program for residents of Medicaid 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 regional staff nurse, to determine whether the individual requires nursing facility level of care.

1. After the RSN 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 services 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 spe-

cialists 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 persons residing in the community (currently at home or boarding home) who are applicants to Medicare/Medicaid 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 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 program, 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 dementias, 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-certified nursing facility, for the individual's clinical record, on the history, physical examination, and diagnostic workup, 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 Annual Resident Review of PASARR, with maximum fee allowance (CNP/CNS Psychiatric/Mental Health) of \$44.00 is used for Medicare and/or Medicaid nursing facility patients who are being evaluated by the attending physician or CNP/CNS Psychiatric/Mental Health for the purposes of an annual resident review 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 and Hospitals Psychiatric Evaluation form (DMH&H-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.

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

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

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

10:58A-2.11 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

(a) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a Federally mandated comprehensive child health program for Medicaid recipients from birth through 20 years of age. The term "EPSDT Services" means the following:

1. EPSDT Screening Services;
2. Vision Services;
3. Dental Services;

4. Hearing Services; and

5. Such necessary health care diagnostic services, treatment and other measures to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services. (See 42 CFR 441 Subpart B.)

(b) A certified nurse practitioner/clinical nurse specialist, pediatric nurse practitioner, or family nurse practitioner may provide EPSDT screening services.

(c) An EPSDT examination shall include the following:

1. A comprehensive health and developmental history including assessment of both physical and mental health development;

2. A comprehensive unclothed physical exam including vision and hearing screening, dental inspection, and nutritional assessment;

3. Appropriate immunizations according to age and health history;

4. Appropriate laboratory tests, including:

i. Hemoglobin/hematocrit;

ii. Urinalysis;

iii. Tuberculin test (Mantoux), annually;

iv. Lead screening using blood lead level determinations between 6 and 12 months, at 2 years of age, and annually up to six years of age. At all other visits, screening shall consist of verbal risk assessment and additional blood lead level testing, if indicated; and

v. Other appropriate medically necessary procedures.

5. Health education, including anticipatory guidance;

6. Vision services:

i. A newborn examination including general inspection of the eyes, visualization of the red reflex, and evaluation of ocular motility;

ii. An appropriate medical and family history;

iii. An evaluation, by age six months, of eye fixation preference, muscle imbalance, and pupillary light reflex; and

iv. A second examination with visual acuity testing by age three or four years.

v. Periodic vision testing for school aged children:

(1) Kindergarten or first grade (five or six years);

(2) Second grade (seven years);

(3) Fifth grade (10/11 years);

(4) Eighth grade (13/14 years); and

(5) Tenth or eleventh grades (15/17 years).

vi. Referral for vision screening of children who:

(1) Cannot read the majority of the 20/40 line before their fifth birthday;

(2) Have a two-line difference of visual acuity between the eyes;

(3) Have suspected strabismus; or

(4) Have an abnormal light or red reflex.

7. Hearing Services:

i. Newborn hearing screening, including risk assessment;

ii. Individual hearing screening administered annually to all children through age eight and to all children at risk of hearing impairment.

iii. Screening every other year for children age eight and older.

8. Dental Services:

i. Intraoral examination included as an integral part of a general physical examination;

ii. A formal referral to a dentist at one year of age (recommended) and mandatory for children three years of age and older;

iii. Dental inspection and prophylaxis every six months until 17 years of age, then annually.

9. Referral for further diagnosis and treatment or follow up of all correctable abnormalities, uncovered or suspected. Referral may be to the provider conducting the screening examination, or to another provider, as appropriate.

(d) Children two years of age and older are provided preventive health care services through the EPSDT program. In addition, Medicaid providers who have not been certified as HealthStart Pediatric Providers use the EPSDT procedure codes for preventive health care services for children from birth through age two when the requirements for the EPSDT examination have been met. The following schedule reflects the ages at which children shall be provided EPSDT screening:

1. Under six weeks;

2. Two months;

3. Four months;

4. Six months;

5. Nine months;

6. 12 months;

7. 15 months;

8. 18 months;

9. 24 months; and

10. Annually through age 20.

(e) Reimbursement policy for EPSDT services:

1. Each periodic EPSDT screening shall be billed only once for the same patient by the same practitioner(s) sharing a common record.

2. Reimbursement for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) examination is contingent upon the submission of a completed "Report and Claim for EPSDT/HealthStart Screening and Related Procedures (MC-19)" within 30 days of the date of service.

3. Laboratory, other diagnostic procedures, and immunizations shall be eligible for separate reimbursement. (See N.J.A.C. 10:58-2.5)

Recodified from N.J.A.C. 10:58A-2.10 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).

SUBCHAPTER 3. HEALTHSTART

10:58A-3.1 HealthStart service

The New Jersey HealthStart program provides comprehensive maternity services for pregnant women (including those determined to be presumptively eligible) and child health services for children (through two years of age) who are eligible for Medicaid benefits.

10:58A-3.10 Preventive care services by HealthStart pediatric care providers

(a) HealthStart pediatric care providers shall provide preventive health visits in accordance with the recommended guidelines of the American Academy of Pediatrics and this chapter. The schedule shall include a two to four week visit, a two month visit, a four month visit, a six month visit, a nine month visit, a 12 month visit, a 15 month visit, an 18 month visit and a 23 to 24 month visit. Each visit shall include, at a minimum, medical, family and social history, unclothed physical examination, developmental and nutritional assessment, vision and hearing screening, dental assessment, assessment of behavior and social environment, anticipatory guidance, age appropriate laboratory examinations and immunizations. Referrals shall be made as appropriate.

(b) Each provider shall provide or arrange for sick care and 24 hour telephone physician/CNP/CNS access during non-office hours. If not directly provided by the HealthStart provider, sick care and 24 hour telephone access shall be provided for each child by a single designated provider via a documented agreement. Information on care given shall be communicated to the primary HealthStart pediatric care provider. Telephone access provided exclusively via emergency room staff is not permitted. Referral to the emergency room should occur only for emergency medical care or urgent care.

(c) Case coordination, outreach and follow-up services shall include letter and/or telephone call reminders to the child's parent or guardian for preventive well-child visits and letters and/or telephone follow-up of missed appointments. Referrals for home visit services for follow-up shall be made when appropriate. For all referrals and follow-up visits, the provider shall document the completion of such referrals and/or visits. If the referral is not completed, a letter or phone call to the child's parent or guardian and/or to the referred agency shall be sent or made. All of the activity shall be recorded on the patient's chart.

10:58A-3.11 Referral services by HealthStart pediatric care providers

(a) All HealthStart CPS/CNS pediatric care providers shall make provision for consultation for specialized health and other pediatric services. Services shall include medical services, as well as social, psychological, educational and nutritional services.

1. This may include, but is not limited to: the Special Supplemental Food Program for Women, Infants and Children (WIC); Division of Youth and Family Services, Special Child Health Services Case Management Units and Child Evaluation Centers; early intervention programs; county welfare agencies/boards of social services; certified home health agencies; community mental health centers; and local and county health departments.

10:58A-3.12 Records: documentation, confidentiality and informed consent for HealthStart pediatric care providers

(a) HealthStart pediatric care providers shall have policies which protect patient confidentiality, as defined at N.J.A.C. 10:49-9.4, and provide for informed consent and document comprehensive care services in accordance with this Chapter.

(b) An individual record shall be maintained for each patient.

(c) Each record shall be confidential and shall include at least the following: history and physical examination, results of required assessments, care plan, treatment services, laboratory reports, counseling and health instruction provided and documentation of referral and follow-up services.

(d) There shall be policies and procedures for appropriate informed consent for all HealthStart pediatric services.

10:58A-3.13 HealthStart services

(a) This section applies to CNP/CNS services provided by a CNP/CNS who has a HealthStart certificate.

(b) HealthStart pediatric care provides for up to nine preventive child health visits for a child under two years of age.

1. All preventive child health visits shall be billed using the HealthStart Preventive Child Health Visit codes appropriate to the child's age at the time of visit.

2. Claims shall be submitted using Form MC-19, EPSDT/HealthStart Screening and Related Procedures.

(c) A HealthStart pediatric preventive care visit includes the following elements:

1. A comprehensive health and developmental history including assessment of both physical and mental health development;

2. A comprehensive unclothed physical exam including vision and hearing screening, dental inspection, and nutritional assessment;

3. Appropriate immunizations according to age and health history;

4. Appropriate laboratory tests, including:

i. Hemoglobin/hematocrit;

ii. Urinalysis;

iii. Tuberculin test (Mantoux), annually;

iv. Lead screening using blood lead level determinations between six and 12 months, at two years of age, and annually up to six years of age. At all other visits, screening shall consist of verbal risk assessment and additional blood lead level testing, if indicated; and

v. Other appropriate medically necessary procedures.

5. Health education, including anticipatory guidance; and

6. Referral for further diagnosis and treatment or follow up of all correctable abnormalities, uncovered or suspected. Referral may be to the provider conducting the screening examination, or to another provider, as appropriate.

(d) The HealthStart CNP/CNS pediatric providers shall provide case coordination, including referral for nutritional, psychological, social and other community services, as appropriate; provision or arrangement for 24-hour telephone physician/CNP/CNS access and sick care; and outreach and follow-up activities in accordance with this chapter.

SUBCHAPTER 4. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:58A-4.1 Introduction to the HCPCS procedure code system

(a) The New Jersey Medicaid program uses the Health Care Financing Administration's (HCFA) Common Procedure Code System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedure Terminology-4th Edition (CPT-4), American Medical Association, P.O. Box 10950, Chicago, IL 60610 Attention: Order Department, architecture, employing a five-position code and as many as two two-position modifiers. Unlike the CPT-4 numeric design, the HCFA-assigned codes and modifiers contain alphabetic characters. Because of copyright restrictions, the CPT-4 procedure narratives for Level I codes are not included in this manual, but are hereby incorporated by reference.

(b) HCPCS has been developed as a three-level coding system, as follows.

1. Level I codes: Narratives for these codes are found in CPT-4, which is incorporated herein by reference, as amended and supplemented. The codes are adapted from CPT-4 for use primarily by physicians, podiatrists, optometrists, certified nurse-midwives, certified nurse practitioners and clinical nurse specialists, independent clinics and independent laboratories. Level I procedure codes and fees for each, which CNP/CNSs may bill, can be found at N.J.A.C. 10:58A-4.2.

2. Level II codes: These codes are assigned by HCFA for physician and non-physician services which are not in CPT-4. Narratives for these codes, and the fees for each, can be found at N.J.A.C. 10:58A-4.3.

3. Level III codes: Level III codes identify services unique to the New Jersey Medicaid program. These codes are assigned by the Division to be used for those services not identified by CPT-4 codes or HCFA-assigned codes. Narratives for these codes, and the fees paid for each, can be found at N.J.A.C. 10:58A-4.4.

(c) Specific elements of HCPCS codes require the attention of providers. The lists of HCPCS code numbers for independent clinic services are arranged in tabular form with specific information for a code given under columns with titles such as: "IND" "HCPCS CODE" "MOD", "DESCRIPTION", "FOLLOW-UP DAYS" and "MAXIMUM FEE ALLOWANCE". The information given under each column is summarized below:

1. Alphabetic and numeric symbols under "IND" & "MOD":

These symbols, when listed under the "IND" and "MOD" columns, are elements of the HCPCS coding system used as qualifiers or indicators ("IND" column) and as modifiers ("MOD" column). They assist the provider in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

i. These symbols and/or letters shall not be ignored because they reflect requirements, in addition to the narrative which accompanies the CPT/HCPCS procedure code as written in the CPT-4, for which the provider is liable. These additional requirements shall be fulfilled before reimbursement is requested.

ii. If there is no identifying symbol listed, the CPT/HCPCS procedure code narrative prevails.

IND Lists alphabetic symbols used to refer the provider to information concerning the New Jersey Medicaid program's qualifications and requirements when a procedure or service code is used.

An explanation of the indicators and qualifiers used in this column is located below and in paragraph 1, "Alphabetic and numeric symbols," as follows:

L = "L" preceding any procedure code indicates that the complete narrative for the code is located at N.J.A.C. 10:58A-4.4(b) and 4.5(c).

N = "N" preceding any procedure code means that qualifiers are applicable to that code. These qualifiers are listed by procedure code number at N.J.A.C. 10:58A-4.5.

P = "P" preceding any procedure code indicates that prior authorization is required. The appropriate form that must be used to request prior authorization is indicated in the Fiscal Agent Billing Supplement.

HCPCS

CODE = HCPCS procedure code numbers.

- MOD = Alphabetic and numeric symbols: Under certain circumstances, services and procedures may be modified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid program's modifier codes for certified nurse practitioner/certified clinical nurse specialist services are:
- AV = Certified Nurse Practitioner.
- WT = Services provided to Medicaid recipients under 21 years of age under Early Periodic Screening, Diagnosis and Treatment Program (EPSDT) as set forth at N.J.A.C. 10:58A-2.10. The "WT" modifier is used by providers who are not certified as HealthStart providers, when billing for services to children up to the age of two years. Providers certified for HealthStart should consult N.J.A.C. 10:58A-3.1 through 3.18.
- 22 = Unusual services: When the service provided is greater than that usually required for the listed procedure, it may be identified by adding the modifier "22" to the usual procedure number.
- 50 = Bilateral procedures: Unless otherwise identified in the listings, bilateral procedures requiring a separate incision which are performed during the same operative session should be identified by the appropriate five-digit code describing the first procedure. The second (bilateral) procedure is identified by adding modifier "50" to the procedure number.
- 52 = Reduced services: Under certain circumstances, a service or procedure is partially reduced or eliminated at the practitioner's election. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of the modifier "52," signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

DESCRIPTION = Code narrative:

Narratives for Level I codes are found in CPT-4.

Narratives for Level II and III codes are found at N.J.A.C. 10:58A-4.3 and 4.4, respectively.

FOLLOW-UP DAYS = Number of days for follow-up care which are considered as included as part of the procedure code for which no additional reimbursement is available.

MAXIMUM FEE ALLOWANCE = New Jersey Medicaid program's maximum reimbursement allowance. If the symbols "B.R." (By Report) are listed instead of a dollar amount, it means that additional information will be required in order to evaluate and price the service. Attach a copy of any additional information to the claim form.

(d) Listed below are general policies of the New Jersey Medicaid program that pertain to HCPCS. Specific information concerning the responsibilities of a CNP/CNS when rendering Medicaid-covered services and requesting reimbursement are located at N.J.A.C. 10:58A-1.4, Recordkeeping; 10:58A-1.5, Basis of Reimbursement; and 10:58A-2.6, Policies for the Use of Evaluation and Management Services HCPCS Codes.

1. General requirements are as follows:
 - i. When filing a claim, the appropriate HCPCS procedure codes must be used, in conjunction with modifiers when applicable.
 - ii. When billing, the provider must enter on the claim form a CPT/HCPCS procedure code as listed in this subchapter (N.J.A.C. 10:58A-4.2, 4.3, 4.4.)
 - iii. Date(s) of service(s) must be indicated on the claim form and in the provider's own record for each service billed.
 - iv. The "MAXIMUM FEE ALLOWANCE" as noted with these procedure codes represents the maximum payment for the given procedure for the CNP/CNS. When submitting a claim, the CNP/CNS must always use her or his usual and customary fee.
 - (1) Listed values for all surgical procedures include the surgery and the follow-up care included in the maximum fee allowance for the period (indicated in days) in the column titled "Follow-Up Days."
 - v. The HCPCS procedure codes that are billable in conjunction with office visit codes are listed at N.J.A.C. 10:58A-4.5, Qualifiers. (See the "N" designation in the "Indicator" column.)
 - vi. The use of a procedure code will be interpreted by the New Jersey Medicaid program as evidence that the practitioner personally furnished, as a minimum, the services for which it stands.
 - vii. For reimbursement purposes, those services with the modifier "AV" must be personally performed by the CNP/CNS who is submitting the claim.

10:58A-4.2 HCPCS procedure code numbers and maximum fee allowance schedule (Level I)

IND	HCPCS CODES	MOD	FOLLOW-UP DAYS	MAXIMUM FEE ALLOWANCE \$
(a) Surgical services:				
	10060	AV		10.50
	10120	AV		15.20
	10140	AV		15.20
	10160	AV		10.50
(b) Family planning procedures:				
N	11975	AV	30	80.70
N L†	11975	AV 22		Direct Package Price,‡ Plus 80.70
N	11976	AV	30	80.70
N	11977	AV	90	80.70
N L†	11977	AV 22		Direct Package Price,‡ Plus 161.50

† Level III code. Included here for convenience in preparing billings.

‡ Direct Package Price is the price paid by the purchaser directly to the manufacturer without going through the wholesaler.

IND	HCPCS CODES	MOD	MAXIMUM FEE ALLOWANCE
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(c) Non-complex repairs:

Wounds	12001 AV		15.20
	12002 AV		20.00
Burns	16000 AV		13.30
	16020 AV		13.30

(d) Strapping (Any age):

N	29105 AV		20.00
N	29125 AV		20.00
N	29130 AV		15.20
N	29200 AV		15.20
N	29220 AV		20.00
N	29240 AV		20.00
N	29260 AV		15.20
N	29280 AV		15.20

(e) Splints:

N	29505 AV		39.90
N	29515 AV		35.20
N	29520 AV		20.00
N	29530 AV		15.20
N	29540 AV		15.20
N	29550 AV		13.30
N	29580 AV		15.20
N	29590 AV		9.50

(f) Casts, removal or repair:

N	29700 AV		11.40
N	29705 AV		11.40
N	29710 AV		15.20
N	29715 AV		15.20
N	29720 AV		20.00
N	29730 AV		7.60
N	29740 AV		7.60

(g) Other procedures, by system:

1. Respiratory:

	30300 AV		13.30
	30901 AV		20.00
	30901 AV 50		50.40
	31720 AV		19.00

2. Vascular injection procedures:

N	36000 AV		30.00
N	36415 AV		1.80

3. Urinary System:

	51010 AV		35.20
	51700 AV		17.10
	51705 AV		17.10
N	53670 AV		13.30

4. Obstetric/Gynecologic:

N	57150 AV		13.30
	57160 AV		13.30

5. Auditory System:

69200 AV	10.50
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(h) Laboratory Services:

81002	1.00
81025	3.00
82270	1.20
82962	2.60
83026	2.00
84830	3.00
85013	1.50
85651	1.50

(i) Tuberculin Testing:

86580	4.00
86585	4.00

(j) Immunizations:

	90701	Diphtheria, tetanus toxoids and pertussis vaccine.	16.34
L	90701 52	Administration of serum only	2.50
	90702	Diphtheria and tetanus toxoids.	3.29
L	90702 52	Administration of serum only	2.50
	90703	Tetanus toxoid.	3.40
L	90703 52	Administration of serum only	2.50
	90704	Mumps virus vaccine, live.	23.60
L	90704 52	Administration of serum only	2.50
	90705	Measles virus vaccine, live, attenuated.	18.39
L	90705 52	Administration of serum only	2.50
	90706	Rubella virus vaccine, live.	22.04
L	90706 52	Administration of serum only	2.50
	90707	Measles, mumps and rubella virus vaccine, live.	39.87
L	90707 52	Administration of serum only	2.50
	90712	Poliovirus vaccine, live, oral.	14.44
L	90712 52	Administration of serum only	2.50
	90713	Poliomyelitis vaccine.	22.80
	90713 52	Administration of serum only	2.50
	90714	Typhoid vaccine.	3.03
L	90714 52	Administration of serum only	2.50
	90717	Yellow fever vaccine.	BR
L	90717 52	Administration of serum only	2.50
	90718	Tetanus and diphtheria toxoids absorbed, for adult use.	3.35
L	90718 52	Administration of serum only	2.50
	90720	Diphtheria, tetanus and pertussis and Hemophilus influenza B vaccine.	BR
L	90720 52	Administration of serum only	2.50
	90724	Influenza virus vaccine.	6.97
L	90724 52	Administration of serum only	2.50
N	90731	Hepatitis B vaccine.	32.89
L	90731 52	Administration of serum only	2.50
	90732	Pneumococcal vaccine, polyvalent.	14.35
L	90732 52	Administration of serum only	2.50
	90733	Meningococcal polysaccharide vaccine.	17.48
L	90733 52	Administration of serum only	2.50
	90737	Hemophilus influenza B.	25.79
L	90737 52	Administration of serum only	2.50
	90741	Immunization, passive; immune serum globulin, human.	BR
L	90741 52	Administration of serum only	2.50
	90742	Specific hyperimmune serum globulin (hepatitis B, measles, pertussis, rabies, Rho(D), tetanus, vaccinia, varicella-zoster).	BR
L	90742 52	Administration of serum only	2.50

(k) Infusion Therapy (Excluding Allergy, Immunization and Chemotherapy):

N	90780 AV	\$38 per hour
N	90781 AV	\$38 per hour

(l) Therapeutic or Diagnostic Injections:

	90782 AV	2.50
	90784 AV	2.50
	90788 AV	2.50

(m) Psychiatry:

N P	90801 AV	24.70
N P	90830 AV	24.70
N P	90843 AV	12.40
N P	90844 AV	24.70
N P	90847 AV	24.70
N P	†90847 AV 22	30.40
N P	90862 AV	13.30
N P	90887 AV	12.40
LNP	†H5025 AV	5.70

† Level III code, listed here for practitioner's convenience. (For narrative description of this procedure, see N.J.A.C. 10:58A-4.5(f).)

(n) Audiological function tests:

	92552 AV	11.00
	92553 AV	14.00
	92567 AV	5.00

(o) Cardiovascular services:

	92950	30.40
	93005	11.00

(p) Pulmonary services:

	94010	18.00
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(q) Chemotherapy:

	96400	3.80
	96408	13.30
	96410	29.90
	96412	29.90
	96414	13.30
	96420	13.30
	96422	26.60
	96423	13.30
	96425	13.30
	96520	13.30
	96530	13.30

(r) Evaluation and Management Services:

1. Office and Other Outpatient Services:

New patient:

N	99201 AV	13.30
N	99202 AV	13.30
N	99203 AV	16.20
N	99204 AV	16.20

Established patient:

N	99212 AV	13.30
N	99213 AV	13.30

N	99214 AV	13.30
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2. Hospital inpatient services:

Initial hospital care, new or established patient

N	99221 AV	16.20
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Subsequent hospital care:

N	99231 AV	13.30
N	99232 AV	13.30

3. Hospital emergency department:

Emergency department services, new or established patient

N	99281 AV	6.70
N	99282 AV	6.70
N	99283 AV	6.70
N	99284 AV	6.70

4. Nursing home visit:

Comprehensive nursing facility assessments, new or established patient:

N	99301 AV	16.20
N	99302 AV	16.20
N	99303 AV	16.20

Subsequent nursing facility care, new or established patient:

N	99311 AV	13.30
N	99312 AV	13.30

Pre-Admission Screening and Annual Resident Review:

	99313 AV	14.00
	99333 AV	14.00
N L	†W9848 AV	30.00
N L	†W9849 AV	30.00

† Level III code; included here for convenience in billing.

5. Domiciliary, rest home (for example, boarding home), or custodial care services:

New patient

N	99321 AV	16.20
N	99322 AV	16.20

Established patient

N	99331 AV	13.30
N	99332 AV	13.30

6. Home visit:

New patient

N	99341 AV	13.30
N	99342 AV	13.30

Home visit, cont.

Established patient

N	99351 AV	13.30
N	99352 AV	13.30

7. Newborn care:

N	99431 AV	21.90
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8. Preventive medicine:

New patient

N	99382 AV	16.20
N	99383 AV	16.20
N	99384 AV	16.20
N	99385 AV	16.20
N	99386 AV	16.20
N	99387 AV	16.20

Established patient

N	99392 AV	16.20
N	99393 AV	16.20
N	99394 AV	16.20
N	99395 AV	16.20
N	99396 AV	16.20
N	99397 AV	16.20

10:58A-4.3 HCPCS procedure codes and maximum fee allowance schedule for Level II codes and narratives

(a) CNP/CNS Administered Drugs:

IND	HCPCS CODES	MOD	MAXIMUM FEE ALLOWANCE
	J0690	Cefazolin 500 mg	1.92
	J0696	Ceftriaxone 250 mg	10.24
	J1100	Dexamethasone 4 mg	0.80
	J1200	Diphenhydramine 50 mg	0.55
	J2550	Promethazine 50 mg	0.42
	J2680	Fluphenazine decanoate 25 mg	9.50
	J2790	RhoGRAM, Rho (D) Immune Globulin (Human) Single dose: Micro-Dose.	20.40
	J2790 22	RhoGRAM, Rho (D) Immune Globulin (Human) (22-Services greater than usual): Full dose.	72.07
	J9000	Doxorubicin 10 mg	42.00
	J9010	Doxorubicin 50 mg	195.50
	J9020	Asparaginase 10,000 units	50.36
	J9031	BCG live vaccine 27 mg	152.13
	J9040	Bleomycin sulfate 15 units	255.08
	J9045	Carboplatin 50 mg	72.01
	J9060	Cisplatin powder or solution 10 mg	30.33
	J9070	Cyclophosphamide 100 mg	4.91
	J9100	Cytarabine 100 mg	6.72
	J9130	Dacarbazine 100 mg	12.00
	J9190	Fluorouracil 50 mg	0.18
	J9217	Lupron 7.5 mg	451.25
	J9230	Mechlorethamide HCl 10 mg	10.10
	J9240	Medroxyprogesterone 100 mg	9.05
	J9240 22	Medroxyprogesterone 400 mg	31.50
	J9260	Methotrexate sodium 50 mg	4.75
	J9280	Mitomycin 5 mg	119.08
	J9360	Vinblastine sulfate 1 mg	3.25
	J9370	Vincristine sulfane 1 mg	27.50

10:58A-4.4 HCPCS procedure codes and maximum fee allowance schedule for Level III codes and narratives

(a) CNP/CNS Administered Drugs:

IND	HCPCS CODES	MOD	MAXIMUM FEE ALLOWANCE
	J2550	Promethazine 50 mg	0.42
	J2680	Fluphenazine Decanoate 25mg	9.50
	J9240	Medroxyprogesterone 100 mg	9.05
	J9240 22	Medroxyprogesterone 400 mg	31.50
	W9336	Medroxyprogesterone Acetate 150 mg	36.90
	W9337	Cephadrine 250 mg	2.34
	W9339	Lupron 3.75 mg	360.63
	W9343	Lupron Depot Pediatric 7.5 mg	451.25
	W9344	Lupron Depot Pediatric 11.25 mg	811.25
	W9345	Lupron Depot Pediatric 15 mg	902.50

(b) Immunizations: See N.J.A.C. 10:58A-4.5(c).

N W9096	Hepatitis B immunoprophylaxis with Recombivax HB,0.25 ml dose.	17.46
N W9096 22	Hepatitis B immunoprophylaxis with Recombivax HB,0.5 ml dose.	32.79
W9096 52 22	Administration of vaccine only.	2.50
N W9097	Hepatitis B immunoprophylaxis with Recombivax HB,0.25 ml dose.	17.46
W9097 52	Administration of vaccine only.	2.50
N W9098	Hepatitis B immunoprophylaxis with Recombivax HB,0.5 ml dose.	32.79
W9098 52	Administration of vaccine only.	2.50
N W9099	Hepatitis B immunoprophylaxis with Recombivax HB,1.0 ml dose.	63.57
W9099 52	Administration of vaccine only.	2.50
N W9333	Hepatitis B immunoprophylaxis with Energix-B,0.5 ml dose.	27.88
W9333 52	Administration of vaccine only.	2.50
N W9334	Hepatitis B immunoprophylaxis with Energix-B,0.5 ml dose.	27.88
W9334 52	Administration of vaccine only.	2.50
N W9335	Hepatitis B immunoprophylaxis with Energix-B,0.5 ml dose.	62.09
W9335 52	Administration of vaccine only.	2.50
W9338	Immunization, active; Tetramune	30.27
W9338 52	Administration of vaccine only.	2.50
†L 90701 52	Diphtheria, Tetanus toxoids and pertussis vaccine. Administration of vaccine only.	2.50
†L 90702 52	Diphtheria and Tetanus toxoids. Administration of vaccine only.	2.50
†L 90703 52	Tetanus toxoid. Administration of vaccine only.	2.50
†L 90704 52	Mumps virus vaccine, live. Administration of vaccine only.	2.50
†L 90705 52	Measles virus vaccine, live, attenuated. Administration of vaccine only.	2.50
†L 90706 52	Rubella virus vaccine, live. Administration of vaccine only.	2.50
†L 90707 52	Measles, mumps and rubella virus vaccine, live. Administration of vaccine only.	2.50
†L 90712 52	Poliovirus vaccine, live, oral. Administration of vaccine only.	2.50
†L 90713 52	Poliomyelitis vaccine. Administration of vaccine only.	2.50

†L 90714 52	Typhoid vaccine. Administration of vaccine only.	2.50
†L 90717 52	Yellow fever vaccine. Administration of vaccine only.	2.50
†L 90718 52	Tetanus and diphtheria toxoids absorbed, for adult use. Administration of vaccine only.	2.50
†L 90720 52	Diphtheria, tetanus and pertussis and Hemophilus influenza B vaccine. Administration of vaccine only.	2.50
†L 90724 52	Influenza virus vaccine. Administration of vaccine only.	2.50
†L 90731 52	Hepatitis B vaccine. Administration of vaccine only.	2.50
†L 90732 52	Pneumococcal vaccine, polyvalent. Administration of vaccine only.	2.50
†L 90733 52	Meningococcal polysaccharide vaccine. Administration of vaccine only.	2.50
†L 90737 52	Hemophilus influenza B. Administration of vaccine only.	2.50
†L 90741 52	Immunization, passive; immune serum globulin, human. administration of vaccine only.	2.50
†L 90742 52	Specific hyperimmune serum globulin (hepatitis B, measles, pertussis, rabies, Rho(D), tetanus, vaccinia, varicella-zoster). Administration of vaccine only.	2.50

† Administration of serum only. These "52" injection codes are Level III codes but are given here for the convenience of the individual preparing billings.

(c) Intra-uterine devices:

W0001 AV	Supplying and inserting the intrauterine device "Paragard" by a CNP/CNS, including the post insertion visit.	172.00
W0002 AV	Supplying and inserting the intrauterine device "Progestasert" by a CNP/CNS, including post insertion visit.	110.20
W0004 AV	Removal of an IUD by a CNP/CNS, followed at the same visit by the insertion of the IUD "Paragard" and including the post insertion visit.	185.20
W0008 AV	Removal of an IUD by a CNP/CNS followed at the same visit by the insertion of the IUD "Progestasert" and including the post insertion visit.	123.50

(d) Norplant System: See N.J.A.C. 10:58A-4.5(a).

	Direct package price
11975 AV 22	plus \$80.70
11977 AV 22	plus \$161.50

NOTE: The Level I procedure codes for Norplant System are found at N.J.A.C. 10:58A-3.2(b).

(e) EPSDT Screening Examinations (See N.J.A.C. 10:58A-2.10 for EPSDT requirements.) (See N.J.A.C. 10:58A-4.5(m)).

W9820 AV	Early and Periodic Screening, Diagnosis and Treatment (EPSDT) through age 20.	\$ 18.00
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The following age-specific HCPCS procedure codes apply to EPSDT screening services:

W9060 WT AV	EPSDT-under six weeks	\$ 18.00
W9061 WT AV	EPSDT-six weeks to three months	18.00
W9062 WT AV	EPSDT-three months to five months	18.00
W9063 WT AV	EPSDT-five months to 8 months	18.00
W9064 WT AV	EPSDT-8-11 months	18.00

W9065 WT AV	EPSDT-11-14 months	18.00
W9066 WT AV	EPSDT-14-17 months	18.00
W9067 WT AV	EPSDT-17-20 months	18.00
W9068 WT AV	EPSDT-20-24 months	18.00

For explanation of EPSDT requirements, refer to W9820 above, and to N.J.A.C. 10:58A-2.6.

(f) HealthStart Pediatric Preventive Care:

1. HealthStart Pediatric Preventive Care codes represent visits based on an infant's age according to the following schedule:

HCPCS CODE	DESCRIPTION	MAXIMUM FEE ALLOWANCE
W9060 AV	Under six weeks	26.00
W9061 AV	Six weeks to three months	26.00
W9062 AV	Three months to five months	26.00
W9063 AV	Five months to eight months	26.00
W9064 AV	Eight months to 11 months	26.00
W9065 AV	11 months to 14 months	26.00
W9066 AV	14 months to 17 months	26.00
W9067 AV	17 months to 20 months	26.00
W9068 AV	20 months to 24 months	26.00

2. Claims for HealthStart Preventive Care visits shall include a completed Health Insurance Claim Form, 1500 N.J., and a completed "Report and Claim for EPSDT/HealthStart Screening and Related Procedures (MC-19)" form.

(g) Psychiatry:

N P	†90847 AV 22	30.40
	90862 AV	13.30
N P	90887 AV	11.70
L N P	†H5025 AV	5.70

† See N.J.A.C. 10:58A-4.5(f).

10:58A-4.5 HCPCS procedure codes—qualifiers

HCPCS	MOD	DESCRIPTIONS
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(a) Surgical Services, Norplant System:

11975 AV	QUALIFIER: Reimbursed for the insertion or reinsertion of the "Norplant System" (six levonorgestrel implants) and the post insertion visit when provided in a hospital setting, when the CNP/CNS bills for the service. When using this procedure code, the CNP/CNS will not be reimbursed for the cost of the kit. The supplier of the kit to the CNP/CNS will be reimbursed directly for the cost of the kit.
11975 AV 22	QUALIFIER: The maximum fee allowance includes the cost of the kit supplied to the CNP/CNS, the insertion of the "Norplant System" (six levonorgestrel implants) and the post insertion visit. NOTE: The "22" modifier indicates the inclusion of the cost of the kit.
11976 AV	QUALIFIER: The maximum fee allowance is reimbursed for the removal of the "Norplant System" (six levonorgestrel implants) and for the post removal visit.
11977 AV	QUALIFIER: The maximum fee allowance is reimbursed for the removal and reinsertion of the "Norplant System" (six levonorgestrel implants) and for the post-removal/reinsertion visit.

11977 AV 22 QUALIFIER: The maximum fee allowance is reimbursed for the removal and reinsertion of the "Norplant System" (six levonorgestrel implants) and for the post-removal/reinsertion visit.

NOTE: Modifier "22" indicates that the billing includes the cost of the NPS kit.

(b) Laboratory services:

36415 QUALIFIER: Once per visit, per patient. Not applicable if laboratory study, in any part, is performed by the office staff of the CNP/CNS or by him or herself. When the clinical laboratory test is performed on site, the venipuncture is not reimbursable as a separate procedure; its cost is included within the reimbursement for the lab procedure.

(c) Immunizations:

N W9096 QUALIFIER: This code applies only to newborns of HBsAg negative mothers.
 N W9096 22 QUALIFIER: This code applies only to newborns of HBsAg positive mothers.
 N W9097 QUALIFIER: This code applies only to high risk recipients under 11 years of age (exclusive of newborns).
 N W9098 QUALIFIER: This code applies only to high risk recipients 11-19 years of age.
 N W9099 QUALIFIER: This code applies only to high risk recipients over 19 years of age.
 N W9333 QUALIFIER: This applies only when immunizing newborns.
 N W9334 QUALIFIER: This applies only to high risk recipients under 11 years of age (exclusive of newborns).
 N W9335 QUALIFIER: This applies only to high risk recipients over 11 years of age.
 90731 QUALIFIER: This code applies only to the treatment of newborns with a history of perinatal exposure to hepatitis B virus.
 90741 QUALIFIER: Prior authorization from the Medical Consultant at the Medicaid District Office is required.
 90742 QUALIFIER: Prior authorization from the Medical Consultant at the Medicaid District Office is required.

(d) Infusion therapy (excluding allergy, immunizations and chemotherapy):

90780 AV QUALIFIER: Not to be used for routine IV drug injection or infusion. Reimbursement is contingent upon the required medical necessity, hand written chart documentation including time and indication of the physician's presence with the patient to the exclusion of his or her other duties.
 90781 AV QUALIFIER: Not to be used for routine IV drug injection or infusion. Reimbursement is contingent upon the required medical necessity, hand written chart documentation including time and indication of the physician's presence with the patient to the exclusion of his or her other duties.

(e) Therapeutic or diagnostic injections:

There are no qualifiers for therapeutic or diagnostic injections.

(f) Mental health services:

QUALIFIER: Only under exceptional circumstances will more than one mental health procedure be reimbursed per day for the same recipient by the same CNP/CNS, group of CNP/CNSs, shared health facility, or providers 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.
 H5025 AV Psychotherapy, group-90 minute session 5.70
 QUALIFIER: Maximum of eight (8) persons per group, including the recipient for whom the service is billed. This code requires the direct professional participation of the practitioner for a minimum of 90 minutes, of which 10 minutes can be used for documentation.
 90801 AV 24.70
 QUALIFIER: This code requires for reimbursement purposes a minimum of 50 minutes of direct personal clinical involvement with the patient or family member. No more than one claim is reimbursable per the same patient, per the same physician or practitioner, per year.
 90843 AV Individual Psychotherapy -25 minute session 12.40
 QUALIFIER: This code requires, for reimbursement purposes, a minimum of 25 minutes of direct personal clinical involvement with the patient or family member.
 90844 AV Individual Psychotherapy -50 minute session 24.70
 QUALIFIER: This code requires, for reimbursement purposes, a minimum of 50 minutes of direct personal clinical involvement with the patient or family member.
 90847 AV Family Therapy -50 minute session 24.70
 QUALIFIER: This code requires, for reimbursement purposes, a minimum of 50 minutes of direct personal clinical involvement with the patient or family member.
 90847 AV 22 Family Therapy -80 minute session 30.40
 QUALIFIER: This code requires, for reimbursement purposes, a minimum of 80 minutes of direct personal clinical involvement with the patient or family member.
 90887 AV Family Conference -25 minute session 12.40
 QUALIFIER: This code requires, for reimbursement purposes, a minimum of 25 minutes of direct personal clinical involvement with the patient or family member. The CPT narrative otherwise remains applicable.

(g) Pre-Admission Screening/Annual Resident Review (PAS/ARR)

W9848 \$ 30.00
 W9849 30.00

(h) Evaluation and management services:

99201, 99202

Initial Visit

i. QUALIFIER: An Initial Office Visit, or an Initial Residential Health Care Visit, is limited to a single visit. Future use of this category of codes will be denied when the recipient is seen by the same practitioner, group of practitioners, or member of the same shared health care facility.

- ii. QUALIFIER: HCPCS procedure codes 99201 and 99202 are exceptions to the requirements outlined in the qualifier for the initial visit. For codes 99201 and 99202, the provider is expected to follow the qualifier applied to routine visit or follow-up care visit for reimbursement purposes.
- iii. QUALIFIER: As described at N.J.A.C. 10:58A-1.4, Evaluation and Management services pertain to patients presenting with symptoms, and as such, exclude Preventive Health Care. Preventive services for patients including newborns through persons 20 years of age are billed under EPSDT, when the procedure requirements are met, as described at N.J.A.C. 10:58A-2.10. Preventive Health Care for adults is described below, at Section (j) of this Chapter.

99203, 99204

Office or other outpatient services: new patient

99221

Hospital inpatient services: initial hospital care;

- iv. QUALIFIER: When reference is made in the CPT-4 manual to the procedures listed above, the intent of Medicaid is to consider this service as the Initial Visit.
- v. QUALIFIER: 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 were billed within a twelve month period by a practitioner, group, shared health care facility, or practitioners sharing a common record.
- vi. QUALIFIER: In reference to a nursing facility or hospital, the Initial Visit concept will still apply for reimbursement purposes. Subsequent readmissions to the same facility may be reimbursed as Initial Visits, if the readmission occurs more than 30 days from a previous discharge from the same facility by the same provider. When the readmission occurs within 30 days from a previous discharge, the provider shall bill the relevant HCPCS procedure codes specified under the headings Subsequent Hospital Care or Subsequent Nursing Facility Care.
- vii. QUALIFIER: Initial Hospital Visit during a single admission will be disallowed to the same practitioner, group, shared health care facility, or practitioners sharing a common record who submit a claim for a consultation and transfer the patient to their service.

2. Follow-up visit:

99212, 99213, 99214

Office or other outpatient services: established patient; 99231, 99232

Hospital inpatient services: subsequent hospital care; 99313

Nursing facility services: subsequent nursing facility care; 99333

Domiciliary, rest home or custodial care services: established patient; and

99351, 99352

Home visit.

- i. QUALIFIER: When reference is made in the CPT manual to the services specified above, the intent of Medicaid is to consider this service as the Routine Visit or Follow-Up Care visit. The setting could be office, hospital, nursing facility or residential health care facility.

(i) Preventive Medicine Services: Annual Health Maintenance Examination

<u>New Patient</u>	<u>Established Patient</u>
99382 AV	99392 AV
99383 AV	99393 AV
99384 AV	99394 AV
99385 AV	99395 AV
99386 AV	99396 AV
99387 AV	99397 AV

QUALIFIER: Preventive medicine services codes (new patient) 99382, 99383, 99384, 99385, 99386, and 99387 may only be billed once within 12 months when the recipient is seen by the same practitioner, group of practitioners sharing a common record, or member(s) of a shared health care facility. These codes will also be automatically denied for payment when used following an EPSDT examination (procedure code W9820) performed within the preceding 12 months.

QUALIFIER: Preventive medicine services codes (established patient) 99392, 99393, 99394, 99395, 99396 and 99397 may be used only once in a 12-month period for any individual over 2 years of age. For well-child care provided to children under the age of two, it is suggested that the provider bill for an EPSDT examination.

QUALIFIER: Preventive medicine services code 99392 may be used up to 5 times during the patient's first year of life and up to 3 times during the patient's second year of life, respectively, in accordance with the periodicity sched-

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