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TITLE 10. HUMAN SERVICES
CHAPTER 58A. ADVANCED PRACTICE NURSE SERVICES

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N.J.A.C. 10:58A (2017)

Title 10, Chapter 58A -- Chapter Notes

CHAPTER AUTHORITY:

N.J.S.A. 30:4D-1 et seq., and 30:4J-8 et seq.

CHAPTER SOURCE AND EFFECTIVE DATE:

Effective: November 20, 2017.

See: 49 N.J.R. 4008(c).

CHAPTER EXPIRATION DATE:

Chapter 58A, Advanced Practice Nurse Services, expires on November 20, 2024.

CHAPTER HISTORICAL NOTE:

Chapter 58A, Certified Nurse Practitioner/Clinical Nurse Specialist, was adopted as R.1995 d.501, effective September 5, 1995. See: 27 N.J.R. 2158(a), 27 N.J.R. 3343(a).

Pursuant to Executive Order No. 66(1978), Chapter 58A, Certified Nurse Practitioner/Clinical Nurse Specialist, was readopted as R.2000 d.265, effective May 31, 2000. See: 32 N.J.R. 1127(a), 32 N.J.R. 2483(a).

Chapter 58A, Certified Nurse Practitioner/Clinical Nurse Specialist, was renamed Advanced Practice Nurse Services; and Subchapter 4, HCFA Common Procedure Coding System (HCPCS), was renamed Centers for Medicare & Medicaid Services Healthcare Common Procedure Coding System (HCPCS), by R.2004 d.334, effective September 7, 2004. See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Chapter 58A, Advanced Practice Nurse Services, was readopted as R.2005 d.406, effective October 25, 2005. See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

Chapter 58A, Advanced Practice Nurse Services, was readopted as R.2011 d.119, effective March 24, 2011. As a part of R.2011 d.119, Subchapter 4, Centers for Medicare & Medicaid Services Healthcare Common Procedure Coding System (HCPCS), was renamed Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS), effective April 18, 2011. See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 58A, Advanced Practice Nurse Services, was scheduled to expire on March 24, 2018. See: 43 N.J.R. 1203(a).

Chapter 58A, Advanced Practice Nurse Services, was readopted, effective November 20, 2017. See: Source and Effective Date.

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N.J.A.C. 10:58A-1.1 (2017)

§ 10:58A-1.1 Introduction: certified advanced practice nurse (APN)

(a) This chapter is concerned with the provision of health care services by certified advanced practice nurses (APNs), in accordance with the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' policies and procedures and the standards set forth by the New Jersey Legislature (N.J.S.A. 45:11-23 et seq. and P.L. 1991, c. 377, as revised by P.L. 1999, c. 85) and by the New Jersey Board of Nursing (N.J.A.C. 13:37-7). Throughout this chapter, all use of the terms "advanced practice nurse" and "APN" refer to a certified advanced practice nurse because all advanced practice nurses are required to be certified.

(b) An approved New Jersey Medicaid/NJ FamilyCare fee-for-service APN provider may be reimbursed for medically necessary covered services provided within the scope of the APNs' license and an approved New Jersey Medicaid/NJ FamilyCare fee-for-service Program Provider Agreement.

(c) An APN may enroll in the New Jersey Medicaid/NJ FamilyCare fee-for-service program and provide covered, medically necessary services as an independent APN, or may provide such services as part of another entity, such as a hospital or clinic, physician group practice, or a mixed clinical practitioner practice.

(d) Unless otherwise stated, the rules of this chapter apply to Medicaid and NJ FamilyCare fee-for-service beneficiaries and to Medicaid and NJ FamilyCare fee-for-service services that are not the responsibility of the managed care organization (MCO) with which the beneficiary is enrolled. Advanced practice nurse services that are to be provided by the beneficiary's selected MCO are governed and administered by that MCO.

HISTORY:

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

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

Inserted references to NJ KidCare fee-for-service throughout; and added (d).

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Substituted references to advanced practice nurses for references to certified nurse practitioners/clinical nurse specialists and substituted references to NJ FamilyCare for references to NJ KidCare throughout.

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

In (c), substituted " independent APN" for "independent practitioner" and added "clinical" preceding "practitioner practice."

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

Section was "Introduction: advanced practice nurse (APN)". In (a), inserted the first occurrence of "certified", substituted "et seq." for "et al.", "c. 377" for "c.377" and "c. 85" for "c.85", and inserted the last sentence; in (b), substituted "the APNs' license and an" for "her or his license, and her or his"; and in (d), substituted the first occurrence of "that" for the first occurrence of "which", inserted "(MCO)" preceding "with which" and substituted "MCO" for "managed care organization (MCO)" following "selected".

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N.J.A.C. 10:58A-1.2 (2017)

§ 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.

"Advanced practice nurse (APN)" 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. 45:11-24 and 45 through 52, or similarly licensed and certified by a comparable agency of the state in which he or she practices.

"Advanced practice nurse (APN) services" means those services provided within the scope of practice of a licensed registered professional nurse (R.N.) and the certification as an APN, 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.

"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 and Senior Services, 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.

"Centers for Medicare and Medicaid Services (CMS)" means the agency of the Federal Department of Health and Human Services which is responsible for the administration of the Medicaid program in the United States.

"Clinical practitioner" means a physician (including doctor of medicine, osteopathy, dentistry, podiatry, optometry, and chiropractic medicine), advanced practice nurse, certified nurse midwife or clinical psychologist.

"Concurrent care" means care rendered to a beneficiary by more than one clinical practitioner.

"Consultation" means the professional evaluation of a patient by a qualified specialist recognized as such by the Division of Medical Assistance and Health Services (DMAHS) that is requested by the attending clinical practitioner or an authorized State agency. A consultation requested by a beneficiary and/or family members, and not requested by the clinical practitioner or an authorized State agency, is not considered a consultation.

"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 and NJ FamilyCare-Children's Program Plan A beneficiaries under 21 years of age, including the assessment of an individual's health care needs through initial and periodic examinations (screenings), the provision of health education and guidance and the identification, diagnosis and treatment of health problems; for eligible NJ Fami-

lyCare-Children's Program Plan B and C enrollees, including early and periodic screening and diagnostic medical examinations, dental, vision, hearing and lead screening services and treatment services identified through the examination that are available under the contractor's benefit package or specified services under the fee-for-service (FFS) program (see N.J.A.C. 10:49-5.6).

"Federal Funds Participation Upper Limit (FFPUL)" means the maximum allowable cost or "MAC price" as defined by the Centers for Medicare and Medicaid Services (CMS).

"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 described 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 Senior Services and the New Jersey Medicaid and NJ FamilyCare-Plan A programs 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 to provide medical care to outpatients.

"Labeler code" means a five-digit numeric code assigned by the Food and Drug Administration, which identifies the firm that manufactures or distributes a specific drug. This code is the first segment of the National Drug Code.

"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 the PASRR, 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, for dates of service before October 1, 2015, in the International Classification of Diseases, Ninth Revision (ICD-9(M)), or for dates of service on or after October 1, 2015, as described in the International Classification of Diseases, 10th Revision (ICD-10 (F00 - F99)), and which can lead to a chronic disability. (See PASRR requirements at N.J.A.C. 10:58A-2.10.)

"National Drug Code (NDC)" - means an 11-digit number that identifies a drug product. The first five digits represent the labeler code identifying the drug manufacturer; the next four digits identify the drug product; and the last two digits identify the package size.

"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.

"Preadmission screening (PAS)" means that process by which all Medicaid eligible beneficiaries seeking admission to a Medicaid certified nursing facility (NF) and individuals who may become Medicaid eligible within six months following admission to a Medicaid certified NF, receive a comprehensive needs assessment by professional staff desig-

nated by the Department of Health and Senior Services to determine their long-term care needs and the most appropriate setting for those needs to be met.

"Pre-Admission Screening and Resident Review (PASRR)" 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. PASRR includes two levels of screening, Level I Preadmission Screening and Resident Review and Level II Preadmission Screening and Resident Review, as described at N.J.A.C. 10:58A-2.10.

"Product code" means a four-digit numeric code, assigned by a firm that manufactures and distributes a drug, which identifies a specific strength, dosage form and formulation of the drug. This code is the second segment of the National Drug Code.

"Specialty" means a health care practice within a discipline, such as pediatrics, obstetrics/gynecology or mental health. All APN specializations must be certified by the New Jersey Board of Nursing in accordance with N.J.A.C. 13:37-7.1.

"State appropriations act" means an annual New Jersey State fiscal year appropriations act.

"Unit of measure" or "UOM" means a value of measurement used to define a drug product. Acceptable UOM codes are: F2 (international measure), GM (gram), ML (milliliter) or UN (unit/each).

HISTORY:

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

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

Substituted references to beneficiaries for references to patients throughout; and in "Early and Periodic Screening, Diagnosis and Treatment (EPSDT)" and "HealthStart pediatric care provider", inserted references to NJ KidCare Plan-A.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Added "Advanced practice nurse (APN)" and "Advanced practice nurse services"; deleted "Certified nurse practitioner/clinical nurse specialist (CNP/CNS)" and "Certified nurse practitioner/clinical nurse specialist (CNP/CNS) services".

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

Rewrote definitions "Advanced practice nurse (APN)," "Concurrent care," "Consultation," "Early and Periodic Screening, Diagnosis and Treatment (EPSDT)," "HealthStart," Independent clinic" and "Specialty"; added definitions "Centers for Medicare and Medicaid Services (CMS)" and "Clinical practitioner"; deleted definition "Practitioner."

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

In definition "Advanced practice nurse (APN) services", inserted "registered"; in definition "Consultation", inserted "the" preceding "Division"; rewrote definition "Early and Periodic Screening, Diagnosis and Treatment (EPSDT)"; added definitions "Federal Funds Participation Upper Limit (FFPUL)", "Labeler code", "National Drug Code (NDC)",

"Preadmission screening (PAS)", "Product code", "State appropriations act" and "Unit of measure"; substituted definition "Mental illness," for definition "Mental illness" and definition "Pre-Admission Screening and Resident Review (PASRR)" for definition "Pre-Admission Screening and Annual Resident Review (PASARR)"; in definition "Mental illness,", deleted a comma preceding "for", substituted "the PASRR" for "PASARR" and "PASRR requirements at" for the second occurrence of "PASARR,", and updated the N.J.A.C. reference; in definition "Pre-Admission Screening and Resident Review (PASRR)", inserted the last sentence; and in definition "Specialty", inserted a comma following "discipline", deleted a comma following "obstetrics/gynecology", and rewrote the last sentence.

Amended by R.2016 d.051, effective June 6, 2016.

See: 47 N.J.R. 2041(a), 48 N.J.R. 962(b).

Rewrote definition "Mental illness".

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N.J.A.C. 10:58A-1.3 (2017)

§ 10:58A-1.3 Provider participation

(a) In order to participate in the Medicaid and NJ FamilyCare fee-for-service programs as an APN practitioner, the APN shall apply to, and be approved by, the New Jersey Medicaid/NJ FamilyCare fee-for-service program. Application for approval by the New Jersey Medicaid/NJ FamilyCare fee-for-service program as an advanced practice nurse (APN) requires completion and submission of the "Medicaid Provider Application" (FD-20) and the "Medicaid Provider Agreement" (FD-62).

1. The FD-20 and FD-62 may be obtained from and submitted to:

Molina Medicaid Solutions
Provider Enrollment
PO Box 4804
Trenton, New Jersey 08650-4804

(b) In order to be approved as a Medicaid/NJ FamilyCare fee-for-service participating provider, the APN shall be a registered professional nurse and have a current certification as an APN, pursuant to N.J.A.C. 13:37-7.

1. An out-of-State APN shall have comparable documentation under the applicable state requirements of the state in which the services are provided.

(c) An applicant shall provide a photocopy of the current professional registered nurse license and current APN certification at the time of the application for enrollment.

(d) In addition to the requirements specified in (a) through (c) above, the following requirements shall be met, in accordance with Federal requirements (CMS State Medicaid Manual, Section 4415, "Nurse Practitioner Services").

1. In order to participate in the Medicaid/NJ FamilyCare fee-for-service program as a certified pediatric advanced practice nurse, a pediatric advanced practice nurse shall be licensed at the time of participation in accordance with the standards for pediatric advanced practice nurse established by the New Jersey Board of Nursing, N.J.A.C. 13:37-7.

2. In order to participate in the Medicaid/NJ FamilyCare fee-for-service program as a certified family advanced practice nurse, a family advanced practice nurse shall be licensed at the time of participation in accordance with the standards for family advanced practice nurse established by the New Jersey Board of Nursing, N.J.A.C. 13:37-7.

(e) Upon signing and returning the Medicaid Provider Application, the Provider Agreement and other enrollment documents to Molina Medicaid Solutions, the fiscal agent for the New Jersey Medicaid and NJ FamilyCare

fee-for-service programs, the advanced practice nurse (APN) will receive written notification of approval or disapproval. If approved, the APN will be assigned a provider identifier number. Molina Medicaid Solutions will furnish the provider identifier number and provider number.

(f) In order to participate as a provider of HealthStart services, the APN practicing independently or as part of a group shall be a Medicaid/NJ FamilyCare fee-for-service provider, and shall meet the HealthStart requirements as specified at N.J.A.C. 10:66-3, and at N.J.A.C. 10:58A-3, including the provider participation criteria specified in N.J.A.C. 10:58A-3.3. The APN shall also possess a HealthStart Certificate, issued by the New Jersey Department of Health and Senior Services.

(g) A HealthStart provider shall have a valid HealthStart Provider Certificate. An application for a HealthStart Provider Certificate is available from:

HealthStart Program
The New Jersey Department of Health and Senior Services
50 East State Street, PO Box 364
Trenton, New Jersey 08625-0364

HISTORY:

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

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

Inserted references to NJ KidCare fee-for-service throughout; in (e), added 14 through 17; and in (h), inserted a reference to the HealthStart Program and deleted a reference to the Division of Family Health Services.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

In (d)2, substituted "advanced practice nurse" for "practice nurse practitioner" following "in accordance with the standards for family".

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

Deleted (e); recodified former (f)-(h) as (e)-(g).

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

In the address in (a)1, substituted "Molina Medicaid Solutions" for "Unisys Corporation"; in (c), inserted "professional registered nurse" and "APN"; and in (e), substituted "Molina Medicaid Solutions" for "Unisys" twice.

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N.J.A.C. 10:58A-1.4 (2017)

§ 10:58A-1.4 Recordkeeping

(a) The APN, in any and all settings, shall keep such legible individual written records and/or electronic medical records (EMR) as are necessary to fully disclose the kind and extent of service(s) provided, the procedure code being billed and the medical necessity for those services.

(b) Documentation of services performed by the APN shall include, as a minimum:

1. The date of service;

2. The name of the beneficiary;

3. The beneficiary's chief complaint(s), reason for visit;

4. Review of systems;

5. Physical examination;

6. Diagnosis;

7. A plan of care, including diagnostic testing and treatment(s);

8. The signature of the APN rendering the service; and

9. Other documentation appropriate to the procedure code being billed. (See N.J.A.C. 10:58A-4, HCPCS Codes.)

(c) In order to receive reimbursement for an initial visit, the following documentation, at a minimum, shall be placed on the medical record by the APN, regardless of the setting where the examination was performed:

1. Chief complaint(s);

2. A complete history of the present illness, with current medications and review of systems, including recordings of pertinent negative findings;

3. Pertinent medical history;

4. Pertinent family and social history;

5. A complete physical examination;

6. Diagnosis; and

7. Plan of care, including diagnostic testing and treatment.

(d) Written and/or electronic medical records in substantiation of the use of a given procedure code shall be available for review and/or inspection if requested by the New Jersey Medicaid/NJ FamilyCare fee-for-service program.

(e) Further discussion of the extent of documentation requirements can be found at N.J.A.C. 10:49-9.7, 9.8 and 9.9.

(f) Records, and the documentation of visits to beneficiaries in residential health care facilities, shall be maintained in the provider's office record. Residential health care facility records, as specified in (c) above, shall be part of the office records.

(g) In order to document the record for reimbursement purposes, the progress note for routine office visits or follow up care visits shall include the following:

1. In an office or residential health care facility:

i. The beneficiary's chief complaint(s), reason for visit;

ii. Pertinent medical, family and social history obtained;

iii. Pertinent physical findings, including pertinent negative physical findings based on (g)1i and ii above;

iv. All diagnostic tests and/or procedures ordered and/or performed, if any, with results; and

v. A diagnosis.

2. In a hospital or nursing facility setting:

i. An update of symptoms;

ii. An update of physical symptoms;

iii. A resume of findings of procedures, if any done;

iv. Pertinent positive and negative findings of lab, X-ray or any other test;

v. Additional planned studies, if any, and the reason for the studies; and

vi. Treatment changes, if any.

(h) To qualify as documentation that the service was rendered by the APN during an inpatient stay, the medical record shall contain the APN's notes indicating that the APN personally:

1. Reviewed the beneficiary's medical history with the beneficiary and/or his or her family, depending upon the medical situation;

2. Performed a physical examination, as appropriate;

3. Confirmed or revised the diagnosis; and

4. Visited and examined the beneficiary on the days for which a claim for reimbursement is made.

(i) The APN's involvement shall be clearly demonstrated in notes reflecting the APN's personal involvement with, or participation in, the service rendered.

(j) For all EPSDT examinations for individuals under 21 years of age, the following shall be documented in the beneficiary's medical record and shall include:

1. A history (complete initial for new beneficiary, interval for established beneficiary) including past medical history, family history, social history, and systemic review.

2. A developmental and nutritional assessment.

3. A complete, unclothed, physical examination to also include the following:

i. Measurements: height and weight; head circumference to 25 months; blood pressure for children age three or older; and

ii. Vision, dental and hearing screening;

4. The assessment and administration of immunizations appropriate for age and need;

5. Provisions for further diagnosis, treatment and follow-up, by referral if necessary, of all correctable abnormalities uncovered or suspected;

6. Mandatory referral to a dentist for children age three or older (referral to a dentist at or after age one is recommended);

7. The laboratory procedures performed or referred if medically necessary. Recommendations for procedure are as follows:

i. Hemoglobin/Hematocrit three times: six to eight months; two to three or four to six years; and 10 to 12 years.

ii. Urinalysis a minimum of twice: 18 to 24 months and 13 to 15 years.

iii. Tuberculin test (Mantoux): nine to 12 months; and annually thereafter.

iv. Lead screening using blood lead level determinations between nine and 12 months, and again at or about two years of age, and annually up to six years of age. At all other visits, screening shall consist of verbal risk assessment and blood lead level test, as indicated; and

v. Other appropriate screening procedures, if medically necessary (for example: blood cholesterol, test for ova and parasites, STD).

8. Health education and anticipatory guidance; and

9. An offer of social service assistance; and, if requested, referral to a county welfare agency.

(k) The record and documentation of a home visit or house call shall become part of the office progress notes and shall include, as appropriate, the following information:

1. The beneficiary's chief complaint(s), reason for visit;

2. Pertinent medical, family and social history obtained;

3. Pertinent physical findings, including pertinent negative physical findings based on (k)1 and 2;

4. The procedures, if any performed, with results;

5. Lab, X-ray, ECG, etc., ordered with results; and

6. Diagnosis(es) plus treatment plan status relative to present or pre-existing illness(es) plus pertinent recommendations and actions.

HISTORY:

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

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

Substituted references to beneficiaries for references to patients throughout; in (d), inserted a reference to NJ KidCare fee-for-service; in (e), changed N.J.A.C. reference; and in (j), rewrote the introductory paragraph, and substituted a reference to county boards of social services for a reference to county welfare agencies in 9.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

In (b)8, substituted "the APN" for "practitioner"; in (c)2, added ", with current medications" and substituted "," for "-" following "review"; in the introductory paragraph of (h), substituted "APN" for "practitioner" throughout; in the introductory paragraph of (i), substituted "APN's" for "practitioner's"; in (j)7iv, substituted "nine" for "six" and added ", and again at or about."

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

In (a), substituted "APN" for "advanced practice nurse", inserted "written" and "and/or electronic medical records (EMR)" and deleted a comma following "billed"; in (b)3, substituted "beneficiary's chief complaint(s)" for "beneficiary complaint"; rewrote (b)4, (b)5 and (b)6; in (b)7, substituted "diagnostic testing and treatment(s)" for ", but not limited to, any orders for laboratory work, prescriptions for medications"; in the introductory paragraph of (c), inserted "medical"; in (c)2, substituted "review of systems" for "related systemic review"; in (c)3, deleted "past" preceding "medical"; in (c)4, inserted "and social"; rewrote (c)5 and (c)6; added (c)7; in (d), inserted "and/or electronic medical"; in the introductory paragraph of (g)1, deleted a comma following "office"; in (g)1i, substituted "beneficiary's chief complaint(s), reason for" for "purpose of the"; in (b)1ii, inserted "medical, family and social"; rewrote (g)1iv; deleted former (g)1v; and recodified former (g)1vi as (g)1v; in (h)2, substituted "a physical" for "an", and inserted a comma following "examination"; in the introductory paragraph of (j), substituted "EPSDT" for "periodic health maintenance", and inserted "medical"; in the introductory paragraph of (j)3, substituted "also include" for "include also"; in (j)3ii, inserted ", dental"; rewrote (j)6; in (j)9, substituted "welfare agency" for "board of social services"; in the introductory paragraph of (k), substituted "home visit or house call" for "Home Visit or House Call"; in (k)1, substituted "beneficiary's chief complaint(s), reason for" for "purpose of the"; and in (k)2, inserted "medical, family and social".

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N.J.A.C. 10:58A-1.5 (2017)

§ 10:58A-1.5 Basis of reimbursement

(a) A claim is a request for payment for a Medicaid-reimbursable or NJ FamilyCare-reimbursable service provided to a Medicaid-eligible or NJ FamilyCare fee-for-service eligible individual. The claim may be submitted via hard copy or by means of an approved method of automated data exchange.

(b) An approved New Jersey Medicaid or NJ FamilyCare APN provider (see N.J.A.C. 10:58A-1.3, Provisions for participation) shall be reimbursed on a fee-for-service basis in accordance with N.J.A.C. 10:58A-4. Reimbursement shall be limited to payment for medically necessary covered services provided within the appropriate scope of practice in accordance with the individual category of certification for advanced practice.

(c) APN services may be reimbursed (see N.J.A.C. 10:49-7 and 8) under either of two billing mechanisms provided by Medicaid or NJ FamilyCare. The two mechanisms are: a direct billing entity as stated in this chapter or an employee reimbursed by another Medicaid or NJ FamilyCare provider who bills Medicaid or NJ FamilyCare on behalf of the APN's services, that is, physician employer, group or clinic.

1. When an APN is employed by an APN/physician group, the Medicaid or NJ FamilyCare program does not routinely reimburse both an APN visit and, on the same day, a visit to an MD or DO within the same billing entity.

i. If specific circumstances should require the two same-day visits, however, the provider entity shall document the medical necessity for the second visit (see concurrent care in (a)2 below).

ii. If a beneficiary receives care from more than one member of a group practice, a partnership or corporation in the same specialty, the total maximum fee allowance shall be the same as that for a single practitioner.

2. Concurrent care will be reimbursed under the following circumstances:

i. 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. 10:58A-1.2; and

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

3. An APN and the collaborating physician shall not bill for concurrent care except when the concurrent care is medically necessary for admitting a beneficiary 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.

4. An APN-initiated consultation to another health care professional, excluding another APN, will be allowed under the following conditions:

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

ii. Where significant medical necessity exists; and

iii. Where, subsequent to the consultation, the primary APN will either resume sole responsibility or transfer the beneficiary to the consultant.

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

6. A collaborating physician shall not bill for a consultation for the beneficiary of the APN. When it becomes necessary to admit a beneficiary for inpatient hospital care, or to prescribe controlled drugs, the collaborating physician may bill for concurrent care. Such concurrent care is limited to a single visit for each episode.

(d) An APN shall not be reimbursed as an independent provider by the New Jersey Medicaid/NJ FamilyCare fee-for-service programs when the program is required to reimburse an approved provider through another mechanism for these same services, for example, a hospital or home health agency-salaried APN whose salary is included in the Medicaid/NJ FamilyCare fee-for-service rate.

1. If an APN is employed by a physician, a physician group, another APN or APN group, a hospital, an independent clinic or other similar health care entity who is a Medicaid/NJ FamilyCare fee-for-service provider, the APN is referred to Physician Services (N.J.A.C. 10:54) or Hospital Services (N.J.A.C. 10:52) or Independent Clinic Services (N.J.A.C. 10:66) for rules and billing instructions.

i. APNs rendering services in clinics cannot bill fee-for-service. The clinic must bill for all services rendered in the clinic setting.

(e) When billing, an APN shall use his or her assigned Medicaid/NJ FamilyCare Provider Servicing Number to identify each service performed as separate and distinct from services rendered by any other provider.

(f) APN providers shall certify that they have personally rendered any services for which they have billed.

(g) Payment for APN services covered under the New Jersey Medicaid and NJ FamilyCare fee-for-service programs is based upon the customary charge prevailing in the community for the same service but shall not exceed the "Maximum Fee Allowance Schedule" specified in N.J.A.C. 10:58A-4. In no event shall the charge to the New Jersey Medicaid/NJ FamilyCare fee-for-service program exceed the charge by the provider for identical services to other individuals, groups or governmental agencies.

1. An APN billing independently receives direct payment from Medicaid/NJ FamilyCare fee-for-service for services rendered under the provisions of this chapter. Reimbursement is on a fee-for-service basis.

2. The submittal and processing of claims requires the entry of two numbers on the claim form: the Provider Billing Number and the Provider Servicing Number.

i. The Provider Billing Number and Servicing Numbers are identical when the APN is a solo practitioner who bills Medicaid/NJ FamilyCare fee-for-service directly for his or her services. The single number is entered on the claim form as the provider billing number and the identifier of the practitioner who rendered the service.

ii. If the APN is a member of an APN practitioner group, the number assigned to the practitioner group will be the Provider Billing Number. The number assigned to the APN practitioner will be the Provider Servicing Number. (See Fiscal Agent Billing Supplement for instructions for filling out the claim form.)

iii. When an employer of the APN (such as a physician, independent clinic, or similar health care organization) bills on behalf of the services rendered by an APN, the Provider Billing Number is the number of the employer. The identifier of the APN rendering the service will be the Medicaid/NJ FamilyCare fee-for-service Provider Servicing Number.

(h) Reimbursement is not made for, and beneficiaries may not be asked to pay for, broken appointments.

HISTORY:

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) through (c), inserted references to NJ KidCare throughout.

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 without change.

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

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

Substituted references to beneficiaries for references to patients and inserted references to NJ KidCare fee-for-service throughout; in (a), substituted a reference to NJ KidCare fee-for-service-eligible individuals for a reference to NJ KidCare-eligible individuals; in (c), deleted "for reimbursement of his or her services" at the end of the first sentence, and deleted a reference to hospitals in the introductory paragraph, and substituted a reference to medically necessary for a reference to necessary in 3; in (e) and (g), substituted references to Provider Servicing Numbers for reference to Medicaid Provider Servicing Numbers throughout; and in (g), substituted references to Provider Billing Numbers for references to Medicaid Provider Billing Numbers throughout.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

In (h), substituted "beneficiaries" for "clients" preceding "may not be asked".

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

Substituted "APN/physician" for "practitioner/physician" throughout (c); substituted "APN" for "practitioner" in (c)iii, (d)1 and (g)2iii; substituted "Advanced practice nurses" for "Practitioners" in (d)1i.

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

In (b), deleted the last sentence; in the introductory paragraph of (c), deleted "10:49-" preceding "8", and deleted a comma following "chapter" and "group"; in (c)3, substituted "APN" for "advanced practice nurse" and the first occurrence of "the" for "her or his", and deleted a comma following "emergency"; in the introductory paragraph of (d)1, deleted a comma following "(N.J.A.C. 10:52)", and substituted "rules" for "regulations"; (d)1i, substituted "APNs" for "Advanced practice nurses"; in (e), inserted "assigned Medicaid/NJ FamilyCare", deleted "she or he has" preceding "performed", and substituted "rendered by" for "of"; and in (g)1, deleted "his or her" preceding "services" and inserted "rendered".

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N.J.A.C. 10:58A-1.6 (2017)

§ 10:58A-1.6 Personal contribution to care requirements for NJ FamilyCare--Plan C and copayments for NJ FamilyCare--Plan D

(a) General policies regarding the collection of personal contribution to care for NJ FamilyCare--Plan C and copayments for NJ FamilyCare--Plan D fee-for-service are set forth in N.J.A.C. 10:49-9.

(b) Personal contribution to care for NJ FamilyCare-Plan C services is $ 5.00 a visit for office visits, except as noted in (c) below.

1. An office visit is defined as a face-to-face contact with a medical professional, which meets the documentation requirements at N.J.A.C. 10:58A-1.4.

2. Office visits include APN services provided in the office, beneficiary's home, or any other site, except a hospital, where the child may have been examined by the APN. Generally, these procedure codes are in the 90000 HCPCS series of reimbursable codes at N.J.A.C. 10:58A-4.

3. APN 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) APNs 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.

(d) The copayment for APN services under NJ FamilyCare-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) APNs are required to collect the copayment specified in (d) above except as provided in (f) below. Copayments shall not be waived.

(f) APNs 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.

HISTORY:

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).

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

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

In (b)2, substituted a reference to beneficiaries for a reference to patients throughout.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

In (a), deleted "or" following "to care for."

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N.J.A.C. 10:58A-2.1 (2017)

§ 10:58A-2.1 General provisions

(a) This subchapter describes the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' policies and procedures for the provision of Medicaid and NJ FamilyCare fee-for-service services by APN 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/NJ FamilyCare fee-for-service program shall reimburse for APN services provided only when the patient is an eligible Medicaid/NJ FamilyCare fee-for-service beneficiary at the time services are rendered. APNs shall verify the patient's current eligibility status prior to providing services.

HISTORY:

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

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

Inserted references to NJ KidCare fee-for-service throughout.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

In (b), substituted "beneficiary" for "client" following "fee-for-service".

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

In (a), substituted "APN" for "advanced practice nurse".

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N.J.A.C. 10:58A-2.2 (2017)

§ 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.

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N.J.A.C. 10:58A-2.3 (2017)

§ 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.) For procedure codes within the APN's scope of practice that are excluded from this general policy, see the codes listed as such at N.J.A.C. 10:58A-4.5(a).

HISTORY:

Amended by R.2000 d.144, effective April 3, 2000.

See: 31 N.J.R. 3968(a), 32 N.J.R. 1208(a).

In (a), changed excluded procedure codes references.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

Rewrote (a).

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

Deleted designation (a); and substituted "APN's" for "APN" and "that" for "which".

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N.J.A.C. 10:58A-2.4 (2017)

§ 10:58A-2.4 Pharmaceutical services--drugs prescribed and/or administered by an APN

(a) All covered pharmaceutical services provided by APNs under the New Jersey Medicaid/NJ FamilyCare fee-for-service programs shall be prescribed and administered in accordance with: N.J.A.C. 13:37-7.9 and 7.10; 10:49; 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) The Medicaid/NJ FamilyCare fee-for-service programs will reimburse the clinical practitioner directly for the cost of the drugs described at N.J.A.C. 10:58A-4.3.

(d) The Medicaid/NJ FamilyCare program will reimburse APNs for certain approved drugs administered by inhalation, intradermally, subcutaneously, intramuscularly or intravenously in the office, home or independent clinic setting according to the following reimbursement methodologies. See N.J.A.C. 10:58A-4 for a listing of HCPCS procedure codes.

1. When an APN office or home visit is made for the sole purpose of administering a drug, reimbursement shall be limited to the cost of the drug and/or its administration. In these situations, there is no reimbursement for an APN's office or home visit. If, in addition to the APN's administration of a drug, the criteria of an office or home visit are met, the cost of the drug and/or administration may, if medically indicated, be reimbursed in addition to the visit.

(e) The drug administered must be consistent with the diagnosis and conform to accepted medical and pharmacological principles in respect to dosage frequency and route of administration.

(f) In order for APN-administered drugs to be reimbursed by the Medicaid/NJ FamilyCare program, manufacturers must have in effect all rebate agreements required or directed pursuant to all applicable State and Federal laws and regulations. To confirm that a manufacturer has complied with such rebate provisions and that a particular drug manufactured by it is covered, an APN may consult the website at: https://www.njmmis.com/ndcLookup.aspx.

(g) APNs shall report the 11-digit National Drug Code (NDC), quantity of the drug administered or dispensed, and a two-digit qualifier identifying the unit of measure for the medication on the claim when requesting reimbursement. The labeler code and drug product code of the actual product dispensed must be reported on the claim form.

1. The package size code (that is, positions No. 10 and 11 of the NDC) reported may differ from the stock package size used to fill the prescription. Acceptable units of measure are limited to: F2 (international unit); GM (gram); ML (milliliter); and UN (unit/each).

(h) No reimbursement will be made for vitamins, liver or iron injections or combination thereof, except in laboratory-proven deficiency states requiring parenteral therapy.

(i) No reimbursement will be made for drugs or vaccines supplied free to the APN, for placebos, or for any injections containing amphetamines or derivatives thereof.

(j) No reimbursement will be made for injection given as a preoperative medication or as a local anesthetic that is part of an operative or surgical procedure.

(k) Where a drug required for administration has not been assigned a HCPCS procedure code, the drug shall be prescribed and dispensed by a pharmacy that directly bills the Medicaid/NJ FamilyCare program. In this situation, the APN shall bill only for the administration of the drug.

HISTORY:

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).

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

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

In (a), inserted a reference to NJ KidCare fee-for-service; and in (c), substituted a reference to Medicaid and NJ KidCare fee-for-service programs for a reference to Medicaid.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

In (c), added "clinical" preceding "practitioner."

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

Section was "Pharmaceutical services". In (a), inserted "and administered" and a colon following "with", substituted "7.9" for "7.6" and "7.10" for "7.7", and deleted "N.J.A.C." preceding "10:49" and "10:51"; in (c), deleted "and 4.4" from the end; and added (d) through (k).

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N.J.A.C. 10:58A-2.5 (2017)

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

(a) For pharmacy claims with service dates on or after September 1, 1999, which exceed prospective drug utilization review (PDUR) standards recommended by the New Jersey Drug Utilization Review Board (NJ DURB) and approved by the Commissioners of the Department of Human Services (DHS) and the Department of Health and Senior Services (DHSS), the Division of Medical Assistance and Health Services has established a medical exception process (MEP). See N.J.A.C. 10:51.

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

(c) The MEP shall apply to all pharmacy claims, regardless of claim media, unless there is a recommended exemption by the NJ DURB, which has been approved by the Commissioners of DHS and DHSS, in accordance with the rules of those Departments.

(d) The MEP is as follows:

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

i. The MEP contractor shall send a Medical Necessity Form (MNF), which includes, but may not be limited to, the beneficiary name, Health Benefits Identification (HBID) number, dispense date, drug quantity and drug description. The prescriber shall be requested to provide the reason for the medical exception, diagnosis, expected duration of therapy and expiration date for medical exception.

ii. The prescriber shall provide information requested on the MNF 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, HBID number, service description, service date and prior authorization number, if approved, the length of the approval and the appeals process if the pharmacist or prescriber 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.

HISTORY:

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.

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

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

In (d), substituted references to Medicaid Eligibility identification numbers for references to HSP identification numbers throughout, and inserted a reference to prescribers in 3.

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

Rewrote (a); in (b), substituted "MEP" for "medical exception process (MEP)"; in (c) and in the introductory paragraph of (d), substituted "MEP" for "medical exception process"; in (c), substituted "NJ DURB" for "New Jersey DUR Board"; in the introductory paragraph of (d)1, substituted "that" for "which"; in (d)1i, substituted "Medical Necessity Form (MNF)" for "Prescriber Notification Letter" and "Health Benefits Identification (HBID)" for "Medicaid Eligibility identification" and "and" for a comma following "quantity", and deleted a comma following "therapy"; in (d)1ii, substituted "MNF" for "Prescriber Notification"; and in (d)3, substituted "HBID" for "mailing address, Medicaid Eligibility identification", and deleted "the reviewer" following the first occurrence of "number" and a comma following "date".

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N.J.A.C. 10:58A-2.6 (2017)

§ 10:58A-2.6 Clinical laboratory services

(a) "Clinical laboratory services" means professional and technical laboratory services performed by a clinical laboratory certified by CMS 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 Centers for Medicare and Medicaid Services 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 and NJ FamilyCare fee-for-service programs' 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 and Senior Services rules found in N.J.A.C. 8:44 and N.J.A.C. 8:45.

(d) An APN 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. An APN shall meet the conditions of the CLIA regulations before she or he may perform clinical laboratory testing for Medicaid/NJ FamilyCare fee-for-service beneficiaries; and

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

(e) When any part of a clinical laboratory test is performed on site, by the APN or his or her office staff, the venipuncture is not reimbursable as a separate procedure; its cost is included within the reimbursement for the laboratory procedure.

(f) When the APN 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/NJ FamilyCare fee-for-service program in accordance with (b) above; and

4. Independent clinical laboratories shall bill the New Jersey Medicaid/NJ FamilyCare fee-for-service program for all reference laboratory work performed on their premises. The APN will not be reimbursed for laboratory work performed by a reference laboratory.

(g) HCPCS 96360 SA and 96361 SA, related to therapeutic or diagnostic injections, shall not be used for routine IV drug injection. For these codes, reimbursement shall be contingent upon the required medical necessity, and hand written or electronic chart documentation, including the time and the indication of the APN's presence with the patient to the exclusion of his or her other duties.

HISTORY:

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.

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

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

Inserted references to NJ KidCare fee-for-service throughout; in (d)1, substituted a reference to beneficiaries for a reference to patients; in (e), substituted "any part of a clinical laboratory test is performed on site, by the CNP/CNS or his or her office staff," for "the clinic laboratory test is performed on site," following "When"; and added (g).

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

In (a), substituted "CMS" for "HCFA".

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

In (a), substituted "CMS" for "HCFA"; in (b), substituted "Centers for Medicare and Medicaid Services" for "Health Care Financing Administration".

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

In (g), substituted "SA" for "AV" throughout and "APN's" for "practitioner's."

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

In (g), substituted "96360 SA and 96361 SA" for "90780 SA and 90781 SA", and inserted "or electronic".

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N.J.A.C. 10:58A-2.7 (2017)

§ 10:58A-2.7 Evaluation and management services

(a) The evaluation and management codes can indicate services performed in a clinical practitioner's office, in a patient's home, in a boarding home, in nursing facilities and residential health care facilities, in clinics, in Federally qualified health centers (FQHCs), and in 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 clinical practitioner, group of clinical 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 including, but not limited to, APNs, 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.

iii. Reimbursement for an initial office visit also precludes subsequent reimbursement to the same provider for an initial residential health care facility visit and vice versa.

2. If the setting is a nursing facility, the initial visit concept will still apply when considered for reimbursement purposes; however, 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.

3. In the inpatient hospital setting, the initial visit concept still applies for reimbursement purposes, except that 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.

4. An initial hospital visit will be disallowed to the same clinical practitioner, group of clinical practitioners, shared health care facility, or clinical practitioners sharing a common record who submit a claim for a consultation and transfer the patient to their service.

5. In order to use the HCPCS procedure code to bill for an initial visit, the APN shall provide the minimal documentation in the record regardless of the setting where the examination was performed. See N.J.A.C. 10:58A-1.4(c).

(d) Provisions for office or other outpatient services-established patient, or subsequent hospital care: evaluation and management services:

1. This service is considered to be the routine office visit or follow-up care visit, and the visit will conform to the CPT description of provider involvement and time. The setting could be office, hospital, nursing facility or residential health care facility. The documentation requirements for these visits can be found at N.J.A.C. 10:58A-1.4.

(e) In the absence of patient complaints, the procedure codes identified as preventive medicine services are applied, for adults and for children.

1. Preventive medicine services codes (new patient) are comparable, in respect to reimbursement level, to an initial visit and, therefore, may only be billed once per patient. Future use of these codes will be denied when the beneficiary is seen by the same clinical practitioner, group of clinical practitioners, or involves a shared health care facility sharing a common record.

(f) The following apply to preventive medicine services, the annual health maintenance examination, for new or established patients under the age of 21:

1. These codes are not allowable for payment when used following an EPSDT or HealthStart pediatric examination performed within the preceding 12 months for a child older than two years of age.

2. For well-child care provided to children under the age of two, the provider is urged to use age-appropriate EPSDT or pediatric HealthStart codes.

3. Preventive medicine codes may be used up to six times (at ages one, two, four, six, nine and 12 months) during the patient's first year of life and up to three times (at ages 15, 18 and 24 months) during the patient's second year of life, in accordance with the periodicity schedule of preventive visits recommended by the American Academy of Pediatrics. These codes should not be used for children under two years of age participating in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) or Pediatric HealthStart program.

(g) Concerning the consultation procedures, in reference to APNs, a consultation is eligible for reimbursement only when performed by a physician specialist recognized as such by the Division, when the request has been made by or through the patient's attending physician or APN, and the need for such a request would be consistent with good medical practice. APNs will not be reimbursed for consultation procedures, but mention of these procedures is included for those instances when the APN needs to refer patient(s) for consultation, to a specialist other than the collaborating physician.

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

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

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

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

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

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

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

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

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

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

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

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

HISTORY:

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

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

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

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

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

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

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

Added "clinical" preceding "practitioner," "practitioners," "practitioner's," and "practitioner(s)" throughout; in (a), added ", in a patient's home, in a boarding home," and deleted "impatient" preceding "hospitals"; in (i)2, substituted "APNs" for "practitioners."

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

In (c)1i, substituted "including, but not limited to, APNs," for "(APNs)"; in (c)3, substituted "initial visits," for "Initial Visits"; in (c)5, substituted "initial visit" for "Initial Visit"; in (g), deleted "his or her" following "refer" and substituted the final occurrence of "the" for "his or her"; in (i)1, substituted the second occurrence of "a" for the first occurrence of "his or her", the first occurrence of "the provider's" for the second occurrence of "his or her" and "provider's"

for "physician's", and inserted "provider's" preceding "office chart"; in the introductory paragraph of (i)3, deleted "his or her" preceding "other patients" and "for him or her" following "therefore"; and in (i)3i, substituted "authorized documentation" for "handwriting".

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N.J.A.C. 10:58A-2.8 (2017)

§ 10:58A-2.8 Family planning services

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

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

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

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

HISTORY:

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

See: 31 New Jersey Register 245(a), 31 New Jersey Register 1956(a).

Former N.J.A.C. 10:58A-2.8, Mental health services, recodified to N.J.A.C. 10:58A-2.9.
Amended by R.2000 d.265, effective July 3, 2000.

See: 32 New Jersey Register 1127(a), 32 New Jersey Register 2483(a).

Rewrote the section.
Amended by R.2004 d.334, effective September 7, 2004.

See: 36 New Jersey Register 312(a), 36 New Jersey Register 4136(a).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 New Jersey Register 4977(a), 36 New Jersey Register 4968(a).
Amended by R.2005 d.406, effective November 21, 2005.

See: 37 New Jersey Register 2329(a), 37 New Jersey Register 4445(a).

In (a)1ii, added "clinical" preceding "practitioner"; deleted (b).

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N.J.A.C. 10:58A-2.9 (2017)

§ 10:58A-2.9 Mental health services

(a) Advanced practice nurses who are certified in the advanced practice category of "Psychiatric/Mental Health" (APN, Psychiatric/Mental Health) are qualified to perform and be reimbursed independently for psychiatric evaluations for the New Jersey Medicaid/NJ FamilyCare fee-for-service program.

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

i. The specific services rendered and modality used, such as individual, group, and/or family therapy;

ii. The date services were rendered;

iii. The duration of services provided (1 hour, 1/2 hour);

iv. The signature of the APN, Psychiatric/Mental Health, who rendered the service;

v. The setting in which services were rendered;

vi. A notation of impediments, unusual occurrences or significant deviations from the treatment described in the Plan of Care;

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

viii. Other relevant information.

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

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

2. For services provided in nursing facilities and all facilities covered under the Rooming and Boarding House Act of 1979 (RBHA '79) N.J.S.A. 55:13B-1 et seq., prior authorization shall be required for mental health services exceeding $ 400.00 in payments in any 12-month service year rendered to a Medicaid/NJ FamilyCare beneficiary residing in either a nursing facility of RBHA '79 facility. The request for prior authorization shall be submitted directly to the appropriate Medical Assistance Customer Center (MACC) that serves that nursing or RBHA '79 facility on the "Authorization of Mental Health Services and/or Mental Health Rehabilitation Services (FD-07)" and the "Request for Prior Authorization: Supplemental Information (FD-07A)" forms.

3. Services provided by an APN in an independent clinic, including a mental health clinic or an FQHC shall only be billed by the clinic after prior authorization in accordance with the Independent Clinic Services Manual, N.J.A.C. 10:66-1.4.

4. In all other settings: prior authorization shall be required for mental health services rendered to a Medicaid/NJ FamilyCare beneficiary (within a 12-month service year commencing with the patient's initial visit) when those services are provided in a setting other than an inpatient hospital, nursing facility or RBHA '79 facility, and when the reimbursement for those services exceeds $ 900.00 to the APN, Psychiatric/Mental Health. The request for prior authorization shall be submitted directly to the Medical Assistance Customer Center (MACC) that serves the county in which the services are rendered. Provider shall use the "Authorization of Mental Health Services and/or Mental Health Rehabilitation Services (FD-07)" form and the form "Request for Prior Authorization: Supplemental Information (FD-07A)" to request prior authorization for these services.

(c) Prior authorization for mental health services may be granted by the New Jersey Medicaid/NJ FamilyCare fee-for-service program for a maximum period of one year, and additional authorizations may be requested. The request for authorization shall include the diagnosis, as set forth, for dates of service before October 1, 2015, in the ICD-9-CM, or for dates of service on or after October 1, 2015, in the ICD-10-CM, the treatment plan and the progress report, in detail. When a request for prior authorization is denied or modified, the APN 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 APN.

2. Ordinarily only one mental health procedure shall be reimbursed per day for the same beneficiary by the same physician, group of physicians, shared health facility, psychologist or APN, Psychiatric/Mental Health 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) An APN, Psychiatric/Mental Health providing mental health services shall document those services as described above and at N.J.A.C. 10:58A-1.4, Recordkeeping.

(e) Advanced practice nurses who are certified in the advanced practice category of "Psychiatric/Mental Health" (APN, Psychiatric/Mental Health) are qualified to perform services and to be reimbursed independently for the treatment of postpartum mental health disorders in women.

1. These services are available to women during pregnancy and/or after a delivery, miscarriage or the termination of a pregnancy. The services shall be billed using the regular mental health service HCPCS located at N.J.A.C. 10:58A-4.2(n).

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

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

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

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

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

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

HISTORY:

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

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

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

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

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

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

Amended by R.2003 d.182, effective May 5, 2003.

See: 34 N.J.R. 4303(a), 35 N.J.R. 1901(a).

Rewrote (b)2 and (b)4.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

In (b)3, substituted "an APN" for "a nurse practitioner."

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

In (e)1, deleted a comma following "miscarriage" and inserted the last sentence; deleted former (e)2; recodified former (e)3 and (e)4 as (e)2 and (e)3; and in (e)3, deleted "specialized" preceding "HCPCS".

Amended by R.2016 d.051, effective June 6, 2016.

See: 47 N.J.R. 2041(a), 48 N.J.R. 962(b).

In the introductory paragraph of (c), inserted ", for dates of service before October 1, 2015,", and substituted "ICD-9-CM, or for dates of service on or after October 1, 2015, in the ICD-10-CM" for "ICD-9 CM (latest revision)".

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N.J.A.C. 10:58A-2.10 (2017)

§ 10:58A-2.10 Pre-Admission Screening and Resident Review (PASRR) and Pre-Admission Screening (PAS)

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

(b) Through PASRR, 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 will be directed to an alternate placement.

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

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

2. An individual identified as meeting criteria for mental illness is evaluated by a psychiatrist, an attending physician or an APN who is certified in the advanced practice category of Psychiatric/Mental Health to determine the need for specialized services.

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

(e) The initial Pre-Admission PASRR Screen shall be used for Medicare and/or Medicaid and NJ FamilyCare--Plan A persons residing in the community (currently at home or boarding home) who are applicants to Medicare/Medicaid/NJ FamilyCare nursing facilities and are being examined by an attending-physician or APN, Psychiatric/Mental Health, to determine the need for specialized services for mental illness. Clinical practitioners completing the screen to determine the need for specialized services shall use the 99333 HCPCS procedure code with a Medicaid/NJ FamilyCare maximum fee allowance as listed in N.J.A.C. 10:58A-4.

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

priate. Applicants with a diagnosis of MI or MR, regardless of the payment source of their care, shall be subject to the PASRR review. For MI individuals funded through other than the New Jersey Medicaid/NJ FamilyCare programs, the fee for psychiatric evaluations conducted by psychiatrists or in NFs by attending physicians or APN, Psychiatric/Mental Health will be paid by Medicare, other third party carriers or by the individual.

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

i. The examining attending-physician or APN, Psychiatric/Mental Health shall obtain the "Division of Mental Health Services Psychiatric Evaluation" form from the nursing home administrator and shall fax the completed form to (609) 777-0662 or mail the form to the Division of Mental Health Services, PO Box 727, Trenton, New Jersey 08625-0727, Attention: PASRR Coordinator.

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

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

1. If this examination reveals the need for a more specialized examination, a psychiatric consultation may be requested by the attending physician or APN, 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 APN, Psychiatric/Mental Health for the same patient.

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

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

(g) As used in this section, a "significant change" is defined as a major change in a resident's condition that will not improve without intervention by appropriate staff, impacts on more than one area of the resident's health, mental health, and/or functioning, and requires interdisciplinary review or revision of the care plan.

HISTORY:

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.

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

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

Inserted references to NJ KidCare throughout; rewrote (a) and (f); in (c), rewrote the introductory paragraph, and substituted a reference to DHSS staff for a reference to RSN in 1; in (e), inserted a reference to NJ KidCare-Plan A in the introductory paragraph; and added (g).

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

In (e) and (f), substituted references to Medical Assistance Customer Center (MACC) for references to Medicaid District Office (MDO).

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

In (d), substituted "advanced practice nurses" for "certified nurse practitioners/clinical nurse specialists"; in the introductory paragraph of (e), substituted "Clinical practitioners" for "Practitioners", deleted "and W9848" and changed "codes" to "code"; rewrote (e)2i.

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

Section was "PASARR and Pre-Admission Screening (PAS)". In (a), deleted "(a)(b)" following "1919", substituted "§ 1396r" for "§ 1396r", and inserted "and Resident Review (PASRR)"; in (b), and in (d) through (f), substituted "PASRR" for "PASARR" throughout; in (b), deleted "(active treatment)" preceding "will"; in the introductory paragraph of (c), substituted "Preadmission Screening (PAS)" for "PAS" and "professional staff designated by the New Jersey" for "a", and deleted "staff" following "(DHSS)"; in (c)1, substituted "professional staff designated by DHSS" for "DHSS staff", "meets the criteria for the" for "needs" and "of care" for the first occurrence of "services"; rewrote (c)2; in (d), deleted a comma following "(D.O.)" and substituted "APNs" for "advanced practice nurses"; and in (e)1, substituted "or" for a comma following "attending physicians", and deleted a comma following "carriers".

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N.J.A.C. 10:58A-2.11 (2017)

§ 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/NJ FamilyCare-Plan A beneficiaries under 21 years of age. The Omnibus Budget Reconciliation Act of 1989 (OBRA '89) codified EPSDT. The term "EPSDT Services" means a preventive and comprehensive health program: for Medicaid and NJ FamilyCare--Plan A beneficiaries under 21 years of age for the purpose of assessing a beneficiary's health needs through initial and periodic examinations, health education and guidance and identification, diagnosis and treatment of health problems; for eligible NJ FamilyCare B and C enrollees, covering early and periodic screening and diagnostic medical examinations, dental, vision, hearing and lead screening services, and those treatment services identified through the examination that are available under the MCO contractor's benefit package or specified services under the FFS program (see N.J.A.C. 10:49-5.6). EPSDT service shall include, at a minimum, 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) An APN who is certified in the advanced practice category of pediatrics or family health 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, but not limited to:

i. Hemoglobin/hematocrit;

ii. Urinalysis;

iii. Tuberculin test (Mantoux);

iv. Lead screening using blood lead level determinations between 9 and 18 months of age, preferably at 1 year of age, once between 18 and 26 months of age, preferably at 2 years of age and for any child between 2 and 6 years of age not previously tested or at 6 months of age or younger, if indicated. 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 screening:

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 repeat eye examination and visual screening 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 by an optometrist or ophthalmologist if the child:

(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 screening:

i. Newborn hearing screening, including risk assessment;

ii. Individual hearing screenings shall be included in all EPSDT periodic examinations.

iii. Audiometric testing shall be administered annually to all children between three and eight years of age. At age eight, children shall be tested every other year.

8. Dental screening:

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 while under 21 years of age. In addition, Medicaid/NJ FamilyCare fee-for-service 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 clinical 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. 10:58A-4)

HISTORY:

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).

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

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

In (a), substituted a reference to Medicaid and NJ KidCare-Plan A beneficiaries for a reference to Medicaid recipients; and in (d), inserted a reference to NJ KidCare fee-for-service providers in the introductory paragraph.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Rewrote (b).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

In (b), changed "pediatric" to "pediatrics"; in (e)1, added "clinical" preceding "practitioner(s)."

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

Section was "Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)". Rewrote the introductory paragraph of (a); in (b), substituted "APN" for "advanced practice nurse"; in the introductory paragraph of (c)4, inserted ", but not limited to"; in (c)4iii, deleted ", annually" from the end; rewrote (c)4iv; in the introductory paragraph of (c)6, substituted "screening" for "services"; in (c)6iv, substituted "repeat eye" for "second" and inserted "and visual screening"; in (c)6vi, substituted "by an optometrist or ophthalmologist if the child" for "of children who"; in the introductory paragraph of (c)7, substituted "screening" for "Services"; rewrote (c)7ii and (c)7iii; in the introductory paragraph of (c)8, substituted "screening" for "Services"; in the introductory paragraph of (d), inserted "while under 21 years of age"; and in (e)3, deleted a comma following "procedures" and updated the N.J.A.C. reference.

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N.J.A.C. 10:58A-2.12 (2017)

§ 10:58A-2.12 Obstetrical/gynecological (OB/GYN) care

Reimbursement for specified OB/GYN services at N.J.A.C. 10:58A-4.2(g) provided under the Medicaid and NJ FamilyCare fee-for-service programs shall be limited to advanced practice nurses who are certified in the advanced practice category of "OB/GYN."

HISTORY:

New Rule, R.2000 d.144, effective April 3, 2000.

See: 31 N.J.R. 3968(a), 32 N.J.R. 1208(a).

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

Substituted "4.4(g)" for "4.4(h)."

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

Updated the N.J.A.C. reference.

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N.J.A.C. 10:58A-2.13 (2017)

§ 10:58A-2.13 New Jersey Vaccines for Children program

(a) The New Jersey Vaccines for Children (VFC) program provides free vaccines for administration to beneficiaries under 19 years of age who are eligible for New Jersey Medicaid and NJ FamilyCare services. Medicaid and NJ FamilyCare programs shall not provide reimbursement to providers for administering these vaccines exclusive of the VFC program.

1. The Center for Disease Control (CDC) is expected to periodically add vaccines to the approved list for the VFC program. This list, "VFC Resolutions," is hereby incorporated by reference, as amended and supplemented. The VFC Resolutions lists the vaccines provided by the VFC Program for individuals under age 19. The Medicaid/NJ FamilyCare program shall not reimburse for any vaccine so added to the VFC Resolutions that are not obtained from the VFC program. Providers can access the VFC Resolutions on the CDC website at http://www.cdc.gov/vaccines/.

i. Any change to the reimbursement amount for the administration of vaccines administered under the VFC Program and/or the reimbursement amounts for such vaccines that are also appropriate for and administered to individuals who are not under age 19 and are, therefore, ineligible to receive them under the VFC Program, will be made by rulemaking in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

2. Providers shall receive an administration fee for the administration of vaccines ordered directly from the VFC Program. The Medicaid/NJ FamilyCare program shall not provide reimbursement to providers for administering vaccines that are not obtained from the VFC program.

(b) The vaccines listed in (a)1 above may be provided to any child without health insurance and those children who are American Indian or an Alaskan Native.

(c) APNs shall bill the HCPCS procedure codes 90465, 90466, 90467, 90468, 90471, 90472, 90473 or 90474 to receive reimbursement for administering vaccines under this program, as appropriate. See N.J.A.C. 10:58A-4.5(c).

(d) Vaccines that are covered by the VFC program but are administered to beneficiaries 19 years of age and older shall be billed with only the appropriate procedure code and be reimbursed the fee-for-service rate. The administration fee is included in the reimbursement for the vaccine. See N.J.A.C. 10:58A-4.2(j).

HISTORY:

New Rule, R.2000 d.144, effective April 3, 2000.

See: 31 N.J.R. 3968(a), 32 N.J.R. 1208(a).

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

In (c), substituted "90471 and 90472" for "W9356".

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

In the introductory paragraph of (a), deleted "-Plan A" following the first occurrence of "FamilyCare"; deleted former (a)1; recodified former (a)2 as (a)1; rewrote (a)1; added new (a)2; in (c), inserted "90465, 90466, 90467, 90468,", ", 90473 or 90474", and ", as appropriate", substituted a comma for "and" following "90471" and updated the N.J.A.C. reference; and rewrote (d).

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N.J.A.C. 10:58A-3.1 (2017)

§ 10:58A-3.1 HealthStart services

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/NJ FamilyCare fee-for-service benefits.

HISTORY:

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

See: 32 New Jersey Register 1127(a), 32 New Jersey Register 2483(a).

Inserted a reference to NJ KidCare fee-for-service benefits.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 New Jersey Register 312(a), 36 New Jersey Register 4136(a).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 New Jersey Register 4977(a), 36 New Jersey Register 4968(a).

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N.J.A.C. 10:58A-3.2 (2017)

§ 10:58A-3.2 Purpose

(a) The purpose of HealthStart is to provide for comprehensive maternity services to pregnant Medicaid/NJ FamilyCare fee-for-service beneficiaries, including those determined to be presumptively eligible and preventive child health services for Medicaid/NJ FamilyCare fee-for-service beneficiaries up to the age of two.

1. Pediatric HealthStart services are an expansion of the EPSDT program as described at N.J.A.C. 10:58A-2.11.

(b) This subchapter describes the HealthStart services which have been determined to lie within the scope of practice of the APN, as defined by the New Jersey Board of Nursing, and to constitute the services to be provided by the independently practicing APN.

HISTORY:

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

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

In (a), substituted references to Medicaid/NJ KidCare fee-for-service beneficiaries for references to Medicaid recipients throughout the introductory paragraph.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

In the introductory paragraph of (a), deleted a comma following "eligible"; and in (a)1, updated the N.J.A.C. reference.

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N.J.A.C. 10:58A-3.3 (2017)

§ 10:58A-3.3 Scope of services

(a) HealthStart maternity services provided by a HealthStart-certified APN are health support services provided in accordance with the HealthStart guidelines. HealthStart pediatric services include up to nine preventive visits, as recommended by the American Academy of Pediatrics, provided by a HealthStart-certified provider who assumes the primary responsibility for coordination and continuity of care.

(b) HealthStart maternity health support services include:

1. Case coordination services;

2. Health education assessment and counseling services;

3. Nutrition assessment and counseling services;

4. Social-psychological assessment and counseling services.

5. Home visitation; and

6. Outreach, referral and follow-up services.

(c) HealthStart comprehensive pediatric care includes nine preventive child health visits; all the recommended immunizations; case coordination and continuity of care including, but not limited to, the provision or arrangement for sick care, 24 hour telephone access, and referral and follow-up for complex or extensive medical, social, psychological, and nutritional needs.

HISTORY:

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 New Jersey Register 312(a), 36 New Jersey Register 4136(a).

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N.J.A.C. 10:58A-3.4 (2017)

§ 10:58A-3.4 HealthStart provider participation criteria

(a) The following Medicaid-enrolled or NJ FamilyCare fee-for-service enrolled provider types are eligible to participate as HealthStart providers: independent clinics, hospital outpatient departments, local health departments meeting the New Jersey State Department of Health and Senior Services' Improved Pregnancy Outcome criteria and/or approved as Child Health Conferences, physicians and physician groups, certified nurse midwives and APNs.

(b) In addition to New Jersey Medicaid/NJ FamilyCare fee-for-service program rules applicable to provider participation, HealthStart APN providers shall:

1. Sign an Addendum to the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' Provider Agreement;

2. Have a valid HealthStart Provider Certificate; and

3. Provide maternity health support services and/or pediatric services in accordance with this subchapter.

(c) In addition to (a) and (b) above, a HealthStart APN pediatric care provider shall participate in program evaluation and training activities including, but not limited to, documentation of outreach and follow-up activities in the patient's record.

(d) A site review may be required to ascertain an applicant's ability to meet the standards for a HealthStart Provider Certificate and to provide services in accordance with the New Jersey State Department of Health and Senior Services' Guidelines for HealthStart Providers in the appropriate area.

(e) A HealthStart Provider Certificate will be reviewed by the New Jersey State Department of Health and Senior Services at least every 18 months from the date of issuance.

(f) An application for a HealthStart Provider Certificate can be downloaded free of charge from the New Jersey State Department of Health and Senior Services' website at http://web.doh.state.nj.us/apps2/forms/subforms.aspx?pro=fhs#healthstart. Persons who do not have access to the internet please contact the address below to request a copy of the application:

HealthStart Program
New Jersey State Department of Health and Senior Services
50 East State Street
PO Box 364

Trenton, NJ 08625-0364

(g) Guidelines for HealthStart services, when rendered by an APN employed by a clinic, physician or hospital, can be found at Independent Clinic Services, N.J.A.C. 10:66; Physician Services, N.J.A.C. 10:54; or Hospital Services, N.J.A.C. 10:52; respectively, and the guidelines for qualifications of HealthStart providers can be found at N.J.A.C. 10:66, Independent Clinic Services.

HISTORY:

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

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

In (a) and (b), inserted references to NJ KidCare fee-for-service throughout.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

Rewrote the introductory paragraph of (f).

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N.J.A.C. 10:58A-3.5 (2017)

§ 10:58A-3.5 Termination of HealthStart Provider Certificate

(a) The New Jersey State Department of Health and Senior Services is responsible for enforcement of its requirements for HealthStart Provider Certificates and for evaluation and enforcement of its requirements within the Standards and Guidelines for HealthStart Providers.

(b) Causes for termination of the HealthStart Provider Certificate by the New Jersey State Department of Health and Senior Services are as follows:

1. Failure to comply with HealthStart standards;

2. Failure to complete the recertification process; and/or

3. Voluntary withdrawal from the HealthStart program.

(c) Termination of the HealthStart Provider Certificate shall result in the termination of the HealthStart Provider Agreement with the New Jersey Medicaid/NJ FamilyCare fee-for-service program. Providers who are decertified by HealthStart continue to be eligible to provide regular Medicaid/NJ FamilyCare fee-for-service services, at regular Medicaid/NJ FamilyCare fee-for-service reimbursement rates.

HISTORY:

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

See: 32 New Jersey Register 1127(a), 32 New Jersey Register 2483(a).

In (c), inserted references to NJ KidCare fee-for-service throughout.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 New Jersey Register 312(a), 36 New Jersey Register 4136(a).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 New Jersey Register 4977(a), 36 New Jersey Register 4968(a).

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N.J.A.C. 10:58A-3.6 (2017)

§ 10:58A-3.6 Records: documentation, confidentiality and informed consent for HealthStart maternity care providers

(a) HealthStart APN maternity care providers shall have policies which protect patient confidentiality, provide for informed consent, and document health support services in accordance with the New Jersey State Department of Health and Senior Services' Guidelines for HealthStart Maternity Care Providers.

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

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

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

HISTORY:

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

See: 32 New Jersey Register 1127(a), 32 New Jersey Register 2483(a).

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 New Jersey Register 312(a), 36 New Jersey Register 4136(a).

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N.J.A.C. 10:58A-3.7 (2017)

§ 10:58A-3.7 Health support services

(a) Health support services are a component of comprehensive maternity care. In order to render HealthStart health support services, an APN provider must be affiliated with, or have a formal agreement with an obstetrical provider rendering the medical maternity care component. Health support services are provided as follows:

1. Case coordination services shall facilitate the delivery of continuous, coordinated and comprehensive services for each patient in accordance with this subchapter and as follows:

i. A permanent case coordinator shall be assigned to each patient no later than two weeks after the HealthStart enrollment visit;

ii. Prenatal case coordination activities shall include, but not be limited to:

(1) Orienting the patient to all services;

(2) Developing, maintaining and coordinating the care plan in consultation with the patient;

(3) Coordinating and monitoring the delivery of all services and referrals;

(4) Monitoring and facilitating the patient's entry into and continuation with maternity services;

(5) Facilitating and providing advocacy for obtaining referral services;

(6) Reinforcing health teachings and providing support;

(7) Providing vigorous follow up for missed appointments and referrals;

(8) Arranging home visits;

(9) Meeting with the patient and coordinating patient care conferences; and

(10) Reviewing, monitoring and updating the patient's complete record;

iii. Postpartum care coordination activities shall include, but not be limited to:

(1) Arranging and coordinating the postpartum visit and any home visit;

(2) Arranging with the obstetrical care provider to obtain the labor, delivery and postpartum hospital summary record information no later than two weeks after delivery;

(3) Linking the patient to appropriate service agencies including: the Special Supplemental Food Program for Women, Infants and Children (WIC), pediatric care (preferably with a HealthStart pediatric care provider), future family planning, Special Child Health Services County Case Management Unit, and other health and social agencies, if needed;

(4) Arranging for the transfer of pertinent information or records to the pediatric care and/or future family planning service providers;

(5) Coordinating referrals and following up on missed appointments and referrals; and

(6) Reinforcing health instructions for mother and baby.

2. Nutrition assessment and basic guidance services shall be provided to orient and educate all patients to nutritional needs during pregnancy and educate the patient to good dietary practices in accordance with this subchapter. Specialized nutrition assessment and counseling shall be provided to those women with additional needs. Services shall be provided as follows:

i. Initial assessment services, which shall include, but not be limited to:

(1) Review of the patient's chart;

(2) Identification of dental problems which may interfere with nutrition;

(3) Nutritional history;

(4) Current nutritional status;

(5) Determination of participation in WIC or other food supplement programs; and

(6) Identification of need for specialized nutritional counseling;

ii. Subsequent nutritional assessment, which shall include, but not be limited to:

(1) Monitoring of weight gain/loss;

(2) Identification of special dietary needs; and

(3) Identification of need for specialized nutritional counseling services;

iii. Prenatal nutritional guidance, which shall include, but not be limited to:

(1) Basic instruction on nutritional needs during pregnancy including balanced diet, vitamins and recommended daily allowances;

(2) Review and reinforcement of other nutritional and dietary counseling services the patient may be receiving;

(3) Instruction on food purchase, storage and preparation;

(4) Instruction on food substitutions, as indicated;

(5) Discussion of infant feeding and nutritional needs; and

(6) Referral to food supplementation programs through the case coordinator;

iv. Specialized nutrition assessment and counseling, which shall be provided to those women with additional needs;

v. Referral for extensive specialized nutritional services which shall be initiated by the medical care provider or the nutritionist under the supervision of the medical care provider in coordination with the case coordinator; and

vi. Postpartum nutritional assessment and basic guidance services which shall include, but not be limited to:

(1) Review and reinforcement of good dietary practices;

(2) Review of instruction on dietary requirement changes; and

(3) Instruction on breast feeding and/or formula preparation and feeding.

3. Social-psychological assessment and basic guidance services shall be provided to all patients to assist the patient in resolving social-psychological needs, in accordance with this subchapter. Specialized social-psychological assessment and short-term counseling shall be provided to those women with additional needs. Services shall be provided as follows:

i. Initial social-psychological assessment services which shall include, but not be limited to:

(1) Determining financial resources and living conditions;

(2) Determining the patient's personal support system;

(3) Determining the patient's attitudes and concerns regarding the pregnancy;

(4) Ascertaining present and prior involvement by the patient with other social programs or agencies and current social service needs;

(5) Ascertaining educational and/or employment status and needs; and

(6) Identification of the need for specialized social-psychological and/or mental health evaluation and counseling services;

ii. Subsequent social-psychological assessment services which shall include, but not be limited to:

(1) Determination of patient's reaction to pregnancy;

(2) Ascertaining the reaction of family, friends and actual support person to the pregnancy;

(3) Identification of the need for social service interventions and advocacy; and

(4) Identification of the need for specialized social-psychological and/or mental health evaluation and counseling;

iii. Basic social-psychological guidance, which shall include, but not be limited to:

(1) Orientation and information on available community resources;

(2) Orientation regarding stress and stress reduction during pregnancy; and

(3) Assistance with arrangements for transportation, child care and financial needs;

iv. Specialized, short-term social-psychological counseling, which shall be provided to women who are identified through assessment or basic counseling as having need for more intense service;

v. Referral for extensive specialized social-psychological services, which shall be initiated by the medical care provider or by the social worker under the supervision of the medical care provider and in coordination with the case coordinator; and

vi. Postpartum social-psychological assessment and guidance which shall include, but not be limited to:

(1) Review of prenatal, labor, delivery and postpartum course;

(2) Assessment of the patient's current social-psychological status, including mother and infant bonding and the acceptance of the infant by the father and/or family, as applicable;

(3) Identification of the need for additional social-psychological services;

(4) Review of available community resources for mother and infant, as applicable;

(5) Counseling regarding fetal loss or infant death, if applicable; and

(6) Counseling regarding school/employment planning.

4. Health education assessment and instruction shall be provided to all patients at intervals throughout the pregnancy, based on the patient's needs and in accordance with this subchapter and as follows:

i. Initial assessment of health educational needs, which shall include, but not be limited to:

(1) Identification of general educational background;

(2) Patient's health education needs; and

(3) Previous education and experience concerning pregnancy, birth and infant care;

ii. Health education instruction, which shall be provided for all patients based on their identified health education needs, shall include at least the following:

(1) Normal course of pregnancy;

(2) Fetal growth and development;

(3) Warning signs, such as signs of pre-term labor, and identification of emergency situations;

(4) Personal hygiene;

(5) Exercise and activity;

(6) Child birth preparation, including management of labor and delivery;

(7) Preparation for hospital admission;

(8) Substance, occupational and environmental hazards;

(9) Need for continuing medical and dental care;

(10) Future family planning;

(11) Parenting, basic infant care and development;

(12) Availability of pediatric and family medical care in the community; and

(13) Normal postpartum physical and emotional changes;

iii. Health education services, which shall include guidance in decision making and in the implementation of decisions concerning pregnancy, birth and infant care; and

iv. Postpartum assessment of health education needs shall be conducted.

5. One face-to-face preventive health care contact shall be provided or arranged for after the mother's discharge from the hospital and prior to the required medical postpartum visit, as follows:

i. This contact shall include, but not be limited to:

(1) Review of the mother's health status;

(2) Review of the infant's health status;

(3) Review of mother/infant interaction;

(4) Revision of the care plan; and

(5) Provision of additional services, as indicated.

ii. The provider shall provide or arrange for one or more home visits for each high risk patient in accordance with the requirements of this chapter. (See also N.J.A.C. 10:58A-4.5(j).)

HISTORY:

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 New Jersey Register 312(a), 36 New Jersey Register 4136(a).

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N.J.A.C. 10:58A-3.8 (2017)

§ 10:58A-3.8 Standards for HealthStart pediatric care certificate

(a) APN pediatric care services shall be comprehensive, integrated and coordinated.

(b) HealthStart APN pediatric care providers shall:

1. Directly provide preventive child health care, maintenance of complete patient history, outreach for preventive care, initiation of referrals for appropriate medical, educational, social, psychological and nutritional services, and follow-up of referrals and sick care;

2. Directly provide or arrange for non emergency room-based, 24-hour practitioner telephone access for eligible patients; and

3. Directly provide or arrange for sick care and emergency care.

HISTORY:

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 New Jersey Register 312(a), 36 New Jersey Register 4136(a).

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N.J.A.C. 10:58A-3.9 (2017)

§ 10:58A-3.9 Professional requirements for HealthStart pediatric care providers

All HealthStart APN pediatric care providers shall be certified in the practice of pediatrics or family practice. This may be demonstrated by certification by the New Jersey Board of Nursing, or by hospital admitting privileges in pediatrics or family practice or by documentation of a formal arrangement with a physician who is board certified in pediatrics or family practice.

HISTORY:

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

Substituted "certified in the practice" for "primary care providers who possess a knowledge" and inserted "or family practice" twice.

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N.J.A.C. 10:58A-3.10 (2017)

§ 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/APN 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.

HISTORY:

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 New Jersey Register 312(a), 36 New Jersey Register 4136(a).

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N.J.A.C. 10:58A-3.11 (2017)

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

(a) All HealthStart APN 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.

HISTORY:

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 New Jersey Register 312(a), 36 New Jersey Register 4136(a).

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N.J.A.C. 10:58A-3.12 (2017)

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

(a) HealthStart pediatric care providers shall have policies that protect patient confidentiality, as defined at N.J.A.C. 10:49-9.7, 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.

HISTORY:

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

In (a), substituted "that" for "which" and updated the N.J.A.C. reference.

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N.J.A.C. 10:58A-3.13 (2017)

§ 10:58A-3.13 HealthStart services

(a) This section applies to APN services provided by an APN 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 APN 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/APN access and sick care; and outreach and follow-up activities in accordance with this chapter.

HISTORY:

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 New Jersey Register 312(a), 36 New Jersey Register 4136(a).

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N.J.A.C. 10:58A-4.1 (2017)

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

(a) The New Jersey Medicaid and NJ FamilyCare fee-for-service programs use the Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Code System (HCPCS) for 2009, established and maintained by CMS in accordance with the Health Insurance Portability and Accountability Act of 1996, Pub.L. 104-191, and incorporated herein by reference, as amended and supplemented, and as published by PMIC, 4727 Wilshire Blvd., Suite 300, Los Angeles, CA 90010. Revisions to the Healthcare Common Procedure Coding System made by CMS (code additions, code deletions and replacement codes) will be reflected in this subchapter through publication of a notice of administrative change in the New Jersey Register. Revisions to existing reimbursement amounts specified by the Department and specification of new reimbursement amounts for new codes will be made by rulemaking in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. HCPCS follows the American Medical Association's Physicians' Current Procedure Terminology (CPT) architecture, employing a five-position code and as many as two two-position modifiers. Unlike the CPT numeric design, the CMS-assigned codes and modifiers contain alphabetic characters. Because of copyright restrictions, the CPT procedure narratives for Level I codes are not included in this subchapter, but are hereby incorporated by reference.

1. Copies of the CPT may be ordered from the American Medical Association, P.O. Box 10950, Chicago, IL 60610 or by accessing www.ama-assn.org. An updated copy of the HCPCS (Level II) codes may be obtained by accessing the HCPCS website at www.cms.hhs.gov/TransactionCodeSetsStands/ or by contacting PMIC, 4727 Wilshire Blvd., Suite 300, Los Angeles, CA 90010.

(b) HCPCS has been developed as a two-level coding system, as follows:

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

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

(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, 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/NJ FamilyCare fee-for-service program's qualifications and requirements when a procedure or service code is used.

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

E =	"E" preceding any procedure code indicates that these procedures are excluded from multiple surgery pricing and, as such, should be reimbursed at 100 percent of the program maximum fee allowance, even if the procedure is done on the same patient, by the same provider, at the same session and also that the procedure codes are excluded from the policy indicating that office visit codes are not reimbursed in addition to procedure codes for surgical procedures. (See N.J.A.C. 10:58A-4.5(a)).
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 and NJ FamilyCare fee-for-service programs' modifier codes for certified nurse practitioner/certified clinical nurse specialist services are:
EP =	Services provided to Medicaid/NJ FamilyCare fee-for-service beneficiaries under 21 years of age under Early Periodic Screening, Diagnosis and Treatment Program (EPSDT) as set forth at N.J.A.C. 10:58A-2.11.

SA =	Advanced Practice Nurse.
TC =	Technical component: When applicable, a charge may be made for the technical component alone. Under these circumstances, the technical component charge is identified by adding the modifier "TC" to the usual procedure code.
UD =	Abortion-related services
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.
26 =	Professional Component: Certain procedures are a combination of a professional and a technical component When the professional component is reported separately, the service may be identified by adding the modifier "26" to the usual procedure number. If a professional type service is keyed without a "26" modifier and a manual pricing edit is received, resolve the edit by adding a 26 modifier.
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 code.
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.

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/NJ FamilyCare fee-for-service program's maximum reimbursement allowance. If the symbols "BR" (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 and NJ FamilyCare fee-for-service programs that pertain to HCPCS. Specific information concerning the responsibilities of an APN when rendering Medicaid and NJ FamilyCare fee-for-service covered services and requesting reimbursement are located at N.J.A.C. 10:58A-1.4, Recordkeeping; 1.5, Basis of reimbursement; and 2.7, Evaluation and management services.

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 and 4.3.)

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 APN. When submitting a claim, the APN shall enter the APN's 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/NJ FamilyCare fee-for-service program as evidence that the APN personally furnished, as a minimum, the services for which it stands.

vii. For reimbursement purposes, those services with the modifier "SA" must be personally performed by the APN who is submitting the claim.

HISTORY:

Amended by R.2000 d.144, effective April 3, 2000.

See: 31 N.J.R. 3968(a), 32 N.J.R. 1208(a).

In (c)1, substituted a reference to CPT for a reference to CPT-4 in i, inserted a reference to NJ KidCare programs in IND description, and inserted a reference to "E".

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

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

Inserted references to NJ KidCare fee-for-service and substituted references to CPT for references to CPT-4 throughout; in (a), deleted a reference to the American Medical Association and substituted a reference to this subchapter for a reference to this manual in the introductory paragraph, and added 1; and in (c), inserted references to TC and 26.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

Rewrote (a); in (b)2, substituted "CMS" for "HCFA".

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

Rewrote the section.

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

Rewrote (a); in the introductory paragraph of (b), substituted "two" for "three"; in (b)1, inserted "(APNs)"; deleted (b)3; in the introductory paragraph of (d), deleted "10:58A-" preceding "1.5" and "2.7"; and substituted "reimbursement" for "Reimbursement" and "management services" for "Management Services"; and in (d)1ii, substituted "and" for a comma following "4.2", and deleted ", 4.4" following "4.3".

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N.J.A.C. 10:58A-4.2 (2017)

§ 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 SA			10.50
	10120 SA			15.20
	10140 SA			15.20
	10160 SA			10.50
	11055 SA			10.45
	11056 SA			13.30
	11057 SA			13.30
	11719 SA			4.75
(b) Family planning procedures:				
N	11975 SA		30	80.77
N	11976 SA		90	80.70
N	11977 SA		90	161.50
(c) Non-complex repairs:				
Wounds				
	12001 SA			15.20
	12002 SA			20.00
Burns				
	16000 SA			13.30
	16020 SA			13.30
(d) Strapping (Any age):				
E N	29105 SA			20.00
E N	29125 SA			20.00
E N	29130 SA			15.20
E N	29200 SA			15.20

IND	HCPCS CODES	MOD	FOLLOW-UP DAYS	MAXIMUM FEE ALLOWANCE
E N	29220 SA			20.00
E N	29240 SA			20.00
E N	29260 SA			15.20
E N	29280 SA			15.20
(e) Splints:				
E N	29505 SA			39.90
E N	29515 SA			35.20
E N	29520 SA			20.00
E N	29530 SA			15.20
E N	29540 SA			15.20
E N	29550 SA			13.30
E N	29580 SA			15.20
E N	29590 SA			9.50
(f) Casts, removal or repair:				
E N	29700 SA			11.40
E N	29705 SA			11.40
E N	29710 SA			15.20
E N	29715 SA			15.20
E N	29720 SA			20.00
E N	29730 SA			7.60
E N	29740 SA			7.60
(g) Other procedures, by system:				
1. Respiratory:				
	30300 SA			13.30
	30901 SA			20.00
	30901 SA 50			50.40
E	31720 SA			19.00
2. Vascular Injection Procedures:				
	36000 SA			30.00
E N	36415 SA			1.80
	36416 SA			1.80
3. Urinary System:				
	51700 SA			17.10
	51701 SA			34.20
	51701 26 SA			9.50
	51702 SA			34.20
	51702 26 SA			9.50
	51705 SA			17.10
4. Obstetric/Gynecologic:				
E N	57150 SA			13.30
	57160 SA			13.30
	58100 SA			15.20
E	58300 SA 30			29.85
E N	58301 SA			16.40
E N	59025 SA			18.00
E N	59025 SA 26			16.00
	59425 SA			13.30

IND	HCPCS CODES	MOD	FOLLOW-UP DAYS	MAXIMUM FEE ALLOWANCE
	59426 SA			13.30
E N	59430 SA			17.10
5. Auditory System:				
	69200 SA			10.50
	69210 SA			11.00
(h) Laboratory Services:				
	81002			1.00
	81025			3.00
	82270			3.63
	82962			2.60
	83026			2.00
	84830			3.00
	85013			1.50
	85651			1.50
(i) Tuberculin Testing:				
	86580			4.00
(j) Immunizations:				
+	90632			80.95
+	90633			38.24
	90636			103.04
+	90647			31.52
+	90648			30.85
	90649			165.49
+	90655			19.33
+	90656			20.64
+	90657			9.41
+	90658			17.56
+	90660			25.69
+	90669			94.62
	90675			B.R.
+	90680			88.64
	90681			130.44
	90691			79.90
+	90696			61.75
+	90698			92.70
+	90700			30.73
	90702			31.56
+	90703			17.72
+	90704			29.08
+	90705			24.21
+	90706			25.37
+	90707			62.33
+	90712			B.R.
+	90713			34.52
+	90714			26.05
+	90715			47.25
+	90716			105.50

IND	HCPCS CODES	MOD	FOLLOW-UP DAYS	MAXIMUM FEE ALLOWANCE
	90717			81.35
+	90718			17.50
+	90721			57.85
+	90723			90.90
	90725			BR
+	90727			BR
+	90732			35.76
+	90733			127.85
+	90734			125.46
+	90736			188.66
+	90740			209.86
+	90743			74.28
+	90744			29.62
+	90746			65.25
+	90748			56.20
	90749			BR

+ Indicates that this vaccine is covered under the Federally-funded Vaccines for Children (VFC) Program. Providers must report both the appropriate VFC administration code and the associated HCPCS procedure code when requesting payment for the administration fee(s) for VFC vaccines to ensure appropriate reimbursement. (See N.J.A.C. 10:58A-2.13.)

(k) Vaccines For Children Program Administration Codes:

N	90465			16.18
N	90466			11.50
N	90467			11.44
N	90468			8.77
N	90471			16.18
N	90472			11.50
N	90473			12.12
N	90474			8.43
	G9141			11.50
	G9141	52		5.00

(*l*) Infusion Therapy (Excluding Allergy, Immunization and Chemotherapy):

N	96360 SA			27.20
N	96361 SA			8.14
	96365 SA			33.21
	96366 SA			10.17
	96367 SA			16.82
	96368 SA			9.56
	96369 SA			71.77
	96370 SA			7.00
	96371 SA			32.31

(m) Therapeutic or Diagnostic Injections:

	96372 SA			2.50
	96374 SA			26.02
	96375 SA			11.41
	96376 SA			11.41

IND	HCPCS CODES	MOD	FOLLOW-UP DAYS	MAXIMUM FEE ALLOWANCE
	96379 SA			2.50
(n) Psychiatry:				
N P	90801 SA			24.70
N P	90804 SA			12.40
N P	90805 SA			12.40
N P	90806 SA			24.70
N P	90807 SA			24.70
N P	90847 SA			24.70
N P	+90847 SA 22			30.40
	90853 SA			5.70
	90862 SA			13.30
N P	90887 SA			12.40
+ Code listed here for practitioner's convenience. (For narrative description of this procedure, see N.J.A.C. 10:58A-4.5(f).)				
(*o*) Audiological function tests:				
	92552 SA			11.00
	92553 SA			14.00
	92567 SA			5.00
	92568 SA			5.00
(p) Cardiovascular services:				
	92950 SA			30.40
	93000 SA			16.00
	93005 SA			11.00
	93010 SA			5.00
	93235 SA			53.00
	93236 SA			35.00
	93237 SA			18.00
(q) Pulmonary services:				
	94010 SA			18.00
	94010 SA 26			8.00
	94010 SA TC		10.00	
	94060 SA			41.00
	94060 SA 26			11.00
	94060 SA TC		30.00	
(r) Health and behavioral assessment/interventions:				
	96125 SA			41.02
	96125 SA 26			34.63
	96150 SA			11.40
	96151 SA			11.40
	96152 SA			10.45
	96153 SA			3.80
	96154 SA			10.45
	96155 SA			9.50
(s) Chemotherapy:				

IND	HCPCS CODES	MOD	FOLLOW-UP DAYS	MAXIMUM FEE ALLOWANCE
	96401 SA			30.40
	96402 SA			16.49
	96409 SA			50.53
	96411 SA			28.77
	96413 SA			66.71
	96415 SA			15.01
	96416 SA			72.87
	96417 SA			33.18
	96420 SA			13.30
	96422 SA			26.60
	96423 SA			13.30
	96425 SA			13.30
	96521 SA			57.45
	96522 SA			48.76
	96523 SA			11.43

(t) Evaluation and Management Services:

1. Office and Other Outpatient Services:

New patient:

N	99201 SA			19.60
N	99202 SA			19.60
N	99203 SA			23.80
N	99203 SA UD			23.80
N	99204 SA			23.80

Established patient:

N	99211 SA			13.30
N	99212 SA			19.60
N	99213 SA			19.60
N	99213 SA UD			19.60
N	99214 SA			19.60
N	99215 SA			19.60

2. Hospital inpatient services:

Initial hospital care, new or established patient:

N	99221 SA			23.80

Subsequent hospital care:

N	99231 SA			19.60
N	99232 SA			19.60
N	99238 SA			19.60

3. Hospital emergency department:

Emergency department services, new or established patient:

N	99281 SA			13.30
N	99282 SA			19.60
N	99283 SA			19.60
N	99284 SA			23.80

4. Nursing home visit:

Comprehensive nursing facility assessments, new or established patient:

N	99304 SA			23.80
N	99305 SA			23.80
N	99306 SA			23.80

IND	HCPCS CODES	MOD	FOLLOW-UP DAYS	MAXIMUM FEE ALLOWANCE
Subsequent nursing facility care, new or established patient:				
N	99307 SA			19.60
N	99308 SA			19.60
N	99309 SA			19.60
N	99310 SA			19.60
5. Nursing facility discharge services:				
N	99315 SA			19.60
N	99316 SA			27.90
6. Nursing facility assessment (annual):				
N	99318 SA			23.80
7. Domiciliary, rest home (for example, boarding home), or custodial care services:				
New patient:				
N	99324 SA			23.80
N	99325 SA			23.80
N	99326 SA			23.80
N	99327 SA			23.80
N	99328 SA			23.80
Established patient:				
N	99334 SA			19.60
N	99335 SA			19.60
N	99336 SA			19.60
N	99337 SA			19.60
8. Home visit:				
New patient:				
N	99341 SA			19.60
N	99342 SA			19.60
N	99344 SA			48.90
N	99345 SA			19.60
Established patient:				
N	99347 SA			33.30
N	99348 SA			48.90
N	99349 SA			48.90
N	99350 SA			48.90
N	99354 SA			55.90
N	99355 SA			19.60
N	99365 SA			19.60
N	99375 SA			19.60
9. Preventive medicine:				
New patient:				
N	99381 SA			23.80
N	99382 SA			23.80
N	99383 SA			23.80
N	99384 SA			23.80
N	99385 SA			23.80
N	99386 SA			23.80
N	99387 SA			23.80
Established patient:				
N	99391 SA			51.72

IND	HCPCS CODES	MOD	FOLLOW-UP DAYS	MAXIMUM FEE ALLOWANCE
N	99392 SA			23.80
N	99393 SA			23.80
N	99394 SA			23.80
N	99395 SA			23.80
N	99396 SA			23.80
N	99397 SA			23.80
10. Newborn care:				
N	99460 SA			41.48
N	99462 SA			21.79
N	99463 SA			35.89
N	99464 SA			52.60
N	99465 SA			103.15
N	99502 SA			33.25
(u) Physical medicine and rehabilitation:				
N	97001 SA			7.00
	97002 SA			7.00
	97003 SA			7.00
	97004 SA			7.00

HISTORY:

Amended by R.2000 d.144, effective April 3, 2000.

See: 31 N.J.R. 3968(a), 32 N.J.R. 1208(a).

Rewrote (a), (g)4, (j), (m) and (r); in (b), inserted follow up days in 11977 AV and 11977 AV 22 references; in (*o*) and (q), inserted "AV" in procedure code references; and added (s).

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

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

In (d) through (f), changed IND references; in (j), added footnote; and in (m), (*o*), (p) and (r), changed HCPCS Code references.

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

Rewrote the section.

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

Rewrote the section.

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

Rewrote the section.

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NEW JERSEY ADMINISTRATIVE CODE

*** This file includes all Regulations adopted and published through the ***
*** New Jersey Register, Vol. 49 No. 24, December 18, 2017 ***

TITLE 10. HUMAN SERVICES
CHAPTER 58A. ADVANCED PRACTICE NURSE SERVICES
SUBCHAPTER 4. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

Go to the New Jersey Administrative Code Archive Directory

N.J.A.C. 10:58A-4.3 (2017)

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

An error occurred in the processing of a table at this point in the document. Please refer to the table in the online document.

HISTORY:

Amended by R.2000 d.144, effective April 3, 2000.

See: 31 N.J.R. 3968(a), 32 N.J.R. 1208(a).

Rewrote the section.

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

Rewrote the section.

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

Rewrote the section.

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

Rewrote the section.

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NEW JERSEY ADMINISTRATIVE CODE

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Go to the New Jersey Administrative Code Archive Directory

N.J.A.C. 10:58A-4.4 (2017)

§ 10:58A-4.4 (Reserved)

HISTORY:

Amended by R.2000 d.144, effective April 3, 2000.

See: 31 N.J.R. 3968(a), 32 N.J.R. 1208(a).

Rewrote (a); in (b), inserted W9356 reference; in (c), changed procedure code references and fee allowances throughout; and added (h).

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

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

Rewrote (a), (b) and (g); and in (f)2, deleted a reference to Health Insurance Claim Forms.

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

In (a), deleted references to Lupron Depot Pediatric; in (b), deleted the VFC Vaccine Administration Fee.

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

Rewrote the section.

Repealed by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

Section was "HCPCS procedure codes and maximum fee allowance schedule for Level III codes and narratives".

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NEW JERSEY ADMINISTRATIVE CODE

*** This file includes all Regulations adopted and published through the ***
*** New Jersey Register, Vol. 49 No. 24, December 18, 2017 ***

TITLE 10. HUMAN SERVICES
CHAPTER 58A. ADVANCED PRACTICE NURSE SERVICES
SUBCHAPTER 4. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

Go to the New Jersey Administrative Code Archive Directory

N.J.A.C. 10:58A-4.5 (2017)

§ 10:58A-4.5 HCPCS procedure codes--qualifiers

HCPCS CODES	MOD	DESCRIPTIONS
(a) Surgical Services		
11975	SA	QUALIFIER: Reimbursed for the insertion or reinsertion of implantable contraceptive capsules and the post insertion visit when the APN bills for the service.
11976	SA	QUALIFIER: The maximum fee allowance is reimbursed for the removal of implantable contraceptive capsules and for the post removal visit.
11977	SA	QUALIFIER: The maximum fee allowance is reimbursed for the removal and reinsertion of implantable contraceptive capsules and for the post-removal/reinsertion visit.
HCPCS CODES	MOD	DESCRIPTIONS
E 29105, E 29125, E 29130, E 29200, E 29220, E 29240, E 29260, E 29280, E 29505, E 29515, E 29520, E 29530, E 29540, E 29550, E 29580, E 29590, E 29700, E 29705, E 29710, E 29715, E 29720, E 29730, E 29740, E 31720, E 36415, E 57150, E 58300, E 58301, E 59025, E 59430	SA	QUALIFIER: These HCPCS are excluded from multiple surgical pricing and as such shall be reimbursed like the

	primary procedure at 100 percent of the program maximum fee allowance even when the procedure is performed on the same beneficiary, by the same provider, at the same session.

(b) Laboratory services:

36415 SA	QUALIFIER: Once per visit, per patient

(c) Immunizations:

N 90746	QUALIFIER: This applies only to high risk beneficiaries over 19 years of age.
90465, 90466, 90467, 90468, 90471, 90472, 90473, 90474	QUALIFIER: These codes apply only to the administration of vaccines to beneficiaries under 19 years of age who qualify for the Vaccine for Children (VFC) program. See N.J.A.C. 10:58A-2.13 and 4.2(k).

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

96360 SA	QUALIFIER: Not to be used for routine IV drug injection or infusion.
96361 SA	QUALIFIER: Not to be used for routine IV drug injection or infusion.

(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 beneficiary by the same APN, group of APNs 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.
HCPCS CODES	MOD	DESCRIPTIONS
90801 SA		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.	
90804 SA	Individual Psychotherapy-- 25 minute session QUALIFIER: This code requires for reimbursement purposes a minimum of 25 minutes of direct personal clinical involvement with the patient or family member.	12.40
90805 SA	QUALIFIER: This code requires for reimbursement purposes a minimum of 25 minutes direct personal clinical involvement with the patient or family, including medicine evaluation and management services.	
90806 SA	Individual Psychotherapy--50 minute session QUALIFIER: This code requires for reimbursement purposes a minimum of 50 minutes of direct personal clinical involvement with the patient or family member.	24.70
90807 SA	QUALIFIER: This code requires for reimbursement purposes a minimum of 50 minutes direct personal clinical involvement with the patient or family, including medicine evaluation and management services.	24.70
90847 SA	Family Therapy--50 minute session QUALIFIER: This code requires, for reimbursement purposes, a minimum of 50 minutes of direct personal clinical involvement with the patient or family member.	24.70
90847 SA 22	Family Therapy--80 minute session QUALIFIER: This code requires, for reimbursement purposes, a minimum of 80 minutes of direct personal clinical involvement with the patient or family member.	30.40
90887 SA	Family Conference--25 minute session 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.	12.40

(g) Evaluation and management services:

1. Office or other outpatient services: new patient

99201 SA, 99202 SA

99203 SA, 99204 SA

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 beneficiary is seen by the same clinical practitioner, group of clinical practitioners, or member of the same shared health care facility.

ii. QUALIFIER: HCPCS procedure codes 99201 SA and 99202 SA are exceptions to the requirements outlined in the qualifier for the initial visit. For the codes 99201 SA and 99202 SA, 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-2.11.

99221 SA	Hospital inpatient services: initial hospital care
99301 SA, 99302 SA, 99303 SA, 99321 SA, 99322 SA	Nursing facility services, initial care, new or established patient Domiciliary or rest home services: new patient
99341 SA, 99342 SA, 99343 SA, 99344 SA, 99345 SA	Home visit: new patient

iv. QUALIFIER: When reference is made in the CPT manual to the procedures listed above, the intent of the Medicaid and NJ FamilyCare fee-for-service programs 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 clinical practitioner, group, shared health care facility, or clinical 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 clinical practitioner, group, shared health care facility, or clinical practitioners sharing a common record who submit a claim for a consultation and transfer the patient to their service.

2. Follow-up visit:

99212 SA, 99213 SA, 99214 SA, 92215 SA,	Office or other outpatient services: established patient;
99231 SA, 99232 SA, 99311 SA, 99312 SA	Hospital inpatient services: subsequent hospital care; subsequent hospital care;
99313 SA, 99238 SA	Nursing facility services subsequent nursing facility care; subsequent nursing facility care;
99331 SA, 99332 SA, 99333 SA, 99347 SA, 99348 SA, 99349 SA,	Domiciliary, rest home or custodial care services: established patient; and
99350 SA	Home visit: established patient

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

(h) Preventive Medicine Services: Annual Health Maintenance Examination

1. New Patient	Established Patient
99382 SA	99392 SA
99383 SA	99393 SA
99384 SA	99394 SA
99385 SA	99395 SA
99386 SA	99396 SA
99387 SA	99397 SA

QUALIFIER: Preventive medicine services codes (new patient) 99382, 99383, 99384, 99385, 99386, and 99387 may only be billed once within 12 months when the beneficiary is seen by the same clinical practitioner, group of clinical 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 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 two 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 schedule of preventive visits recommended by the American Academy of Pediatrics. This code does not apply to children under 2 years of age participating in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. EPSDT providers bill for these services using the program appropriate codes 99381 22, 99391 22, 99382 22, 99392 22 (Infant, age under 1 year) or 99381 22 EP, 99391 22 EP, 99382 EP, 99392 22 EP (Early childhood, age 1 through 4 years).

2. 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.

3. Preventive medicine services code 99391 and 99392 may be used up to five times during the patient's first year of life and up to three times during the patient's second year of life respectively, in accordance with the periodicity schedule of preventive visits recommended by the American Academy of Pediatrics. These codes do not apply to children under two years of age participating in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. EPSDT providers bill for these services using the program appropriate codes 99381 22, 99391 22, 99382 22, 99392 22 (Infant, age under 1 year) or 99381 22 EP, 99391 22 EP, 99382 22 EP, 99392 22 EP (Early childhood, age 1 through 4 years).

(i) Home Services and House Calls:

The "House Call" code does not distinguish between specialist and non-specialist. These codes do not apply to residential health care facility or nursing facility settings. These codes refer to a clinical practitioner visit limited to the provision of medical care to an individual who would be too ill to go to a clinical practitioner's office and/or is "home bound" due to his or her physical condition. When billing for a second or subsequent patient treated during the same visit, the visit should be billed as a home visit.

99341 SA, 99342 SA	19.60	19.60
99344 SA, 99345 SA	48.90	48.90
99347 SA, 99348 SA,	33.30	48.90
99349 SA, 99350 SA	48.90	48.90

For purposes of Medicaid/NJ FamilyCare fee-for-service reimbursement, these codes apply when the provider visits Medicaid/NJ FamilyCare fee-for-service beneficiaries in the home setting and the visit does not meet the criteria specified under House Call listed above.

(j) Emergency room services:

APN's Use of Emergency Room Instead of Office:

99211 SA, 99212 SA, 99213 SA, 99214 SA

When an APN sees the patient in the emergency room instead of the office, the APN shall use the same codes for the visit that would have been used if seen in the APN's office (99211, 99212, 99213, 99214 or 99215 only). Records of that visit should become part of the notes in the office chart.

99281 SA, 99282 SA, 99283 SA, 99284 SA

Emergency room visits (Refer to the CPT) Hospital-based emergency room APNs:

When patients are seen by hospital-based emergency room APNs who are eligible to bill the Medicaid/NJ FamilyCare fee-for-service program, the appropriate HCPCS code is used. The "Visit" codes are limited to 99281 SA, 99282 SA, 99283 SA, 99284 SA and 99285 SA.

(k) Newborn care:

99460 SA, 99462 SA, 99463 SA, 99464 SA, 99465 SA	Routine and subsequent hospital newborn care--"Well" baby

QUALIFIER: For reimbursement purposes, the above codes require, as a minimum, routine newborn care by an APN other than the clinical practitioner rendering maternity service, including complete initial and complete discharge physical examination, conference(s) with the patient(s). This must be documented in the newborn's medical record.

	Newborn care--"Sick" baby
99221 SA	Initial hospital care
99231 SA	Subsequent hospital care
99232 SA	(For sick babies, use appropriate hospital care code.)

(*l*) Early and Periodic Screening

99381 SA-99385 SA or 99391 SA-99395 SA	Diagnosis and Treatment (EPSDT) through age 20

QUALIFIER: Procedure codes 99381 SA through 99385 SA or 99391 SA through 99395 SA shall be used only once for the same patient during any 12-month period by the same clinical practitioner(s) sharing a common record.

QUALIFIER: Reimbursement for codes 99381 EP through 99385 EP or 99391 EP through 99395 EP (under age 1 or age 1 through 19 years) is contingent upon the submission of both a completed "Report and Claim for EPSDT Screening and Related Procedures (MC-19)" within 30 days of the date of service. In the absence of a completed MC-19 form, reimbursement will be to the level of an annual health maintenance examination.

HISTORY:

Amended by R.2000 d.144, effective April 3, 2000.

See: 31 N.J.R. 3968(a), 32 N.J.R. 1208(a).

Rewrote (a), (h) and (j); in (c), inserted a reference to W9356; in (f), (g), (k) and (*l*), changed procedure code references throughout; and in (k), substituted references to practitioners for references to physicians throughout, and substituted a reference to CPT for a reference to CPT-4.

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

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

Rewrote the section.

Amended by R.2004 d.409, effective November 1, 2004.

See: 35 N.J.R. 4977(a), 36 N.J.R. 4968(a).

Rewrote the section.

Amended by R.2005 d.406, effective November 21, 2005.

See: 37 N.J.R. 2329(a), 37 N.J.R. 4445(a).

Rewrote the section.

Amended by R.2007 d.188, effective June 18, 2007.

See: 39 N.J.R. 337(a), 39 N.J.R. 2360(a).

In the table in (f), in the Qualifier paragraph for the entry for 90801 SA, deleted the final sentence.

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

Rewrote the section.

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NEW JERSEY ADMINISTRATIVE CODE

*** This file includes all Regulations adopted and published through the ***
*** New Jersey Register, Vol. 49 No. 24, December 18, 2017 ***

TITLE 10. HUMAN SERVICES
CHAPTER 58A. ADVANCED PRACTICE NURSE SERVICES

Go to the New Jersey Administrative Code Archive Directory

N.J.A.C. 10:58A, Appx. (2017)

APPENDIX

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as a part of this chapter but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, a revised version will be placed on www.njmmis.com and shall be filed with the Office of Administrative Law.

If you do not have internet access and would like to request a copy of the Fiscal Agent Billing Supplement, write to:

Molina Medicaid Solutions
PO Box 4801
Trenton, New Jersey 08650-4801

or contact:

Office of Administrative Law
Quakerbridge Plaza, Bldg. 9
PO Box 049
Trenton, New Jersey 08625-0049

HISTORY:

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

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

Amended by R.2011 d.119, effective April 18, 2011.

See: 42 N.J.R. 2890(a), 43 N.J.R. 1015(a).

Rewrote the first two paragraphs of the AGENCY NOTE; and in the first address, substituted "Molina Medicaid Solutions" for "Unisys".