1. A CNM shall meet the conditions of the CLIA regulations before she or he may perform clinical laboratory testing for Medicaid/NJ FamilyCare–Plan A fee-for-service beneficiaries; and

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

(b) Profiles are components of a test or series of tests which are frequently performed or automated. Examples of identifiable laboratory profiles or studies are as follow:

1. Obstetrical Profile;

2. The components of an SMA (Sequential Multichannel Automated Analysis) 12/60 or other automated laboratory study; or

3. Inclusion of blood indices, such as MCH (Mean Corpuscular Hemoglobin), MCV (Mean Corpuscular Volume), as a component of a CBC (Complete Blood Count).

(c) If the components of a profile are billed separately, reimbursement for the components of the profile (panel) shall not exceed the Medicaid fee allowance for the profile itself.

Amended by R.1998 d.209, effective May 4, 1998.
See: 30 N.J.R. 57(a), 30 N.J.R. 1613(a).
In (a), rewrote first sentence and added a new second sentence; and added (b) and (c).
Amended by R.2001 d.204, effective June 18, 2001.
See: 33 N.J.R. 1160(a), 33 N.J.R. 2188(a).
In (a), inserted "NJ FamilyCare–Plan A fee–for–service programs" following "Medicaid" in the introductory paragraph and in 1, substituted "NJ Family Care–Plan A fee–for–service beneficiaries" for "recipients".

10:58–2.11 Clinical laboratory services; venipuncture

(a) When any part of the clinical laboratory test(s) is performed on site, the venipuncture is not reimbursable as a separate procedure: its cost is included within the reimbursement for the laboratory procedure. Venipuncture is reimbursable if the total specimen is referred to the independent clinical laboratory.

10:58–2.12 Clinical laboratory services; CNM referral to independent laboratory

(a) When the CNM refers a laboratory test to an independent clinical reference laboratory:

1. The clinical reference laboratory shall be certified under CLIA requirements to perform the required laboratory test(s) (see Section 1902(a)9 of the Social Security Act; 42 U.S.C. 1396a(a)9; 42 C.F.R. 440.30, 493);

2. The clinical laboratory shall be licensed by the New Jersey State Department of Health and Senior Services in accordance with N.J.A.C. 8:44 and 8:45, or comparable agency in the state in which the laboratory is located; and

3. The clinical laboratory shall be approved for participation as an independent laboratory provider by the New Jersey Medicaid/NJ FamilyCare–Plan A fee-for-service programs.

(b) Independent clinical laboratories shall bill the New Jersey Medicaid/NJ FamilyCare–Plan A fee-for-service programs for all reference laboratory work performed on their premises. The CNM will not be reimbursed for laboratory work performed by a reference laboratory.

Amended by R.2001 d.204, effective June 18, 2001.
See: 33 N.J.R. 1160(a), 33 N.J.R. 2188(a).
In (a)3 and (b), inserted references to NJ FamilyCare–Plan A fee-for-service.

10:58–2.13 Clinical laboratory services; rebates

Rebates by reference laboratories, service laboratories, physicians or other utilizers or providers of laboratory services are prohibited under the New Jersey Medicaid/NJ FamilyCare programs. This refers to rebates in the form of refunds, discounts or kickbacks, whether in the form of money, supplies, equipment, or other things of value. This provision prohibits laboratories from renting space from or providing personnel or other considerations to a physician or other practitioner whether or not a rebate is involved.

Amended by R.2001 d.204, effective June 18, 2001.
See: 33 N.J.R. 1160(a), 33 N.J.R. 2188(a).
Inserted a reference to NJ FamilyCare.

10:58–2.14 Family planning services; general

(a) Family planning services may be provided by the CNM, including medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling.

(b) Services provided primarily for the diagnosis and treatment of infertility, including related office visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures, are not covered by the New Jersey Medicaid/NJ FamilyCare programs, except when a service is provided that is ordinarily considered an infertility service, but is provided for another purpose. The certified nurse midwife shall submit the claim for that service, with supporting documentation, for medical review and approval of payment to the Division of Medical Assistance and Health Services, Office of Utilization Management, Mail Code #14, PO Box 712, Trenton, NJ 08625–0712.

Amended by R.2001 d.204, effective June 18, 2001.
See: 33 N.J.R. 1160(a), 33 N.J.R. 2188(a).
In (b), inserted a reference to NJ FamilyCare and substituted "Utilization Management" for "Health Service Administration".

10:58–2.15 Family planning services; Norplant System (NPS)

(a) The Norplant System (NPS) is a Medicaid/NJ FamilyCare covered service when provided as follows:

1. The NPS is used only in reproductive age women with established regular menstrual cycles;

2. The Food and Drug Administration (FDA)–approved physician prescribing information is followed; and

3. Patient education and counseling are provided relating to the NPS, including pre and post-insertion instructions, indications, contraindications, benefits, risks, side effects, and other contraceptive modalities.

(b) A CNM shall not be reimbursed separately for an office visit when that visit was solely for the purpose of the insertion or removal of an NPS device. A CNM shall be reimbursed for the NPS device and the insertion and/or removal of the appropriate procedure codes related to the NPS system (see N.J.A.C. 10:58–3.6(a)).

(c) Only two insertions and two removals of the NPS per beneficiary shall be reimbursed during a five-year continuous period.

(d) The CNM shall not be reimbursed for the NPS in conjunction with other forms of contraception, for example, intrauterine device.

Amended by R.2001 d.204, effective June 18, 2001.
See: 33 N.J.R. 1160(a), 33 N.J.R. 2188(a).
In (a), inserted a reference to NJ FamilyCare; in (c), substituted "beneficiary" for "recipient".

10:58–2.16 HealthStart maternity and pediatric services

(a) The purpose of HealthStart is to provide comprehensive maternity and child health care services for all pregnant women (including those determined to be presumptively eligible) and for children (under two years of age) in the State of New Jersey who are eligible for Medicaid benefits. For reimbursement for certified nurse midwives billing independently, refer to N.J.A.C. 10:58–3.2 and 3.5. For other requirements regarding HealthStart in any setting, refer to the Independent Clinic Services chapter, N.J.A.C. 10:66–3. The CNM shall not become a HealthStart Pediatric Care provider. The CNM shall be an EPSDT provider for adolescent Medicaid recipients. (See N.J.A.C. 10:58–2.2 for EPSDT services.)

(b) Separate reimbursement is available for HealthStart Maternity Care and Health Support Services procedure codes.

(c) Maternity medical care services should be billed as a total obstetrical package, when feasible, but may be billed as separate procedures.

(d) The enhanced reimbursement for the delivery and postpartum care may be claimed only for a patient who had received at least one antepartum HealthStart Maternity Care visit and had at least one health support services visit.

(e) The modifier "WM" accompanying any given procedure code in the HCPCS list of codes refers to those services provided by CNM and the modifier shall be included at the end of each code when billing for CNM services.

10:58–2.17 Pharmaceutical services; drugs prescribed and administered by a CNM

(a) All covered pharmaceutical services provided under the New Jersey Medicaid/NJ FamilyCare programs shall be provided to Medicaid/ NJ FamilyCare–Plan A fee-for-service beneficiaries within the scope of N.J.A.C. 10:49, Administration chapter; N.J.A.C. 10:51, Pharmaceutical Services; and N.J.A.C. 10:58, Certified Nurse Midwifery Services.

(b) All drugs shall be prescribed drugs. (See definition of "prescribed drugs" in N.J.A.C. 10:58–1.3.)

(c) The New Jersey Medicaid/NJ FamilyCare programs shall reimburse Medicaid/NJ FamilyCare participating pharmacies for pharmaceutical services prescribed by the certified nurse midwife if all the requirements of the New Jersey Medicaid/NJ FamilyCare–Plan A fee-for-service programs for pharmaceutical services are met.

(d) The following requirements shall be met for the following services:

Service	Requirement
Covered pharmaceutical services	N.J.A.C. 10:51–1.11
Prior-authorized services	N.J.A.C. 10:51–1.13
Quantity of medication dispensed	N.J.A.C. 10:51–1.14
Dosage and directions	N.J.A.C. 10:51–1.15
Telephone-rendered original prescription	N.J.A.C. 10:51–1.16
Changes or additions to the original prescription	N.J.A.C. 10:51–1.17
Prescription refill	N.J.A.C. 10:51–1.18
Prescription Drug Price and Quality Stabilization Act	N.J.A.C. 10:51–1.19
Non-proprietary or generic dispensing	N.J.A.C. 10:51–1.9
Drug Efficacy Study Implementation (DESI)	N.J.A.C. 10:51–1.20 N.J.A.C. 10:51, Appendix A
Drug Manufacturers' Rebate Agreement	N.J.A.C. 10:51–1.21

(e) Diabetic testing materials, including blood glucose reagent strips, urine monitoring strips, tapes, tablets, and lancets, may also be reimbursed. Electronic blood glucose monitoring devices or other devices used in the monitoring of blood glucose levels are considered medical supplies and are covered services by the Medicaid/NJ FamilyCare–Plan A fee-for service programs if they meet all applicable requirements of the New Jersey Medicaid/NJ FamilyCare programs. These services may require prior authorization from the Medicaid District Office (MDO). (See Medical Supplier Services Chapter, N.J.A.C. 10:59.)

(f) The New Jersey Medicaid/NJ FamilyCare fee-for-service programs shall reimburse the certified nurse midwife for certain approved drugs administered by inhalation, intradermally, subcutaneously, intramuscularly or intravenously in the office or home, as follows:

1. Certified nurse midwife-administered medications shall be reimbursed directly to the certified nurse midwife under certain situations. (See N.J.A.C. 10:58–3 for a listing of HCPCS procedure codes, "J" codes and applicable 3rd level procedure codes.)

i. An office or home visit (when the criteria for an office or home visit is met) and the procedure code for the method of drug administration may be billed in conjunction with a "J" code. The HCPCS 90782, 90784, 90785 and 90799 may be billed for intradermal, subcutaneous, intramuscular, or intravenous drug administration, respectively.

ii. The New Jersey Medicaid/NJ FamilyCare programs have assigned HCPCS procedure codes and maximum fee allowances at N.J.A.C. 10:58–3.4 and 3.5 for specific drugs. Reimbursement to the certified nurse midwife for these specific drugs shall be based on the Average Wholesale Price (AWP) of a single dose of an injectable or inhalation drug, or the CNM's acquisition cost, whichever is less.

iii. Unless otherwise indicated in N.J.A.C. 10:58–3, or (f)1iv through vii below, the Medicaid/NJ FamilyCare fee-for-service maximum fee allowance is determined based on the AWP per unit which equals one cubic centimeter (cc) or milliliter (ml) of drug volume for each unit. For drug vials with a volume equal to one cubic centimeter (cc) or milliliter (ml), the Medicaid/NJ FamilyCare fee-for-service maximum fee allowance shall be based on the cost per vial.

iv. When a certified nurse midwife 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 its administration. In these situations, there is no reimbursement for a certified nurse midwife's office or home visit. If, in addition to the certified nurse midwife's administration of a drug, the criteria of an office or home visit are met, the cost of the drug and administration may, if medically indicated, be reimbursed in addition to the visit.

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

vi. No reimbursement will be made for drugs or vaccines supplied free to the CNM, for placebos, or for any injections containing amphetamines or derivatives thereof.

vii. No reimbursement will be made for injection given as a preoperative medication or as a local anesthetic which is part of an operative or surgical procedure, since this injection would normally be included in the prescribed fee for such a procedure.

2. When a drug required for administration has not been assigned a "J" code or Level III HCPCS procedure code, the drug shall be prescribed and obtained from a pharmacy which directly bills the New Jersey Medicaid/NJ FamilyCare fee-for-service programs. In this situation, the certified nurse midwife shall bill only for the administration of the drug using HCPCS 90782, 90784, 90788 and 90799.

3. Reimbursement for immunization procedure codes includes the cost of the administration of the immunization.

(g) 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.

(h) For Hepatitis B vaccine, coverage is available for post exposure prophylaxis and for vaccination of individuals in selected high risk groups, regardless of age, in accordance with the criteria defined by the Centers for Disease Control. In all cases, the need for this vaccination shall be fully documented in the medical record by the certified nurse midwife. (See N.J.A.C. 10:58–3.5 and 3.6, respectively, for specific descriptions and qualifiers associated with each Level III procedure code.)

Amended by R.2001 d.204, effective June 18, 2001.
See: 33 N.J.R. 1160(a), 33 N.J.R. 2188(a).
In (a), inserted a reference to NJ FamilyCare and substituted "/NJ FamilyCare–Plan A fee-for-service beneficiaries" for "recipients"; in (c) and (e), inserted references to NJ FamilyCare and NJ FamilyCare–Plan A fee-for-service; in (f), inserted references to NJ FamilyCare and NJ FamilyCare fee-for-service throughout.

10:58–2.18 Birth center facility services

(a) Birth center facility services shall include, but not be limited to, administrative, nursing, and technical services related to labor and delivery.

(b) Other services and items not directly related to the care of the patient, such as guest meals and accommodations, televisions, telephones, and similar items, are non-covered services that shall not be eligible for payment by the Division. These services and other personal items may be billed to the patient directly, provided the patient is informed and agrees to accept responsibility for personal items.

(c) Physician services provided in birth centers shall be considered as professional physician services, in accordance with N.J.A.C. 10:54. Physician services shall be reimbursed using a separate physician Medicaid/NJ FamilyCare provider number and appropriate procedure codes, in accordance with N.J.A.C. 10:54.

New Rule, R.1998 d.209, effective May 4, 1998.
See: 30 N.J.R. 57(a), 30 N.J.R. 1613(a).
Amended by R.2001 d.204, effective June 18, 2001.
See: 33 N.J.R. 1160(a), 33 N.J.R. 2188(a).
In (c), inserted a reference to NJ FamilyCare.

SUBCHAPTER 3. HEALTH CARE FINANCING ADMINISTRATION (HCFA) COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:58–3.1 Introduction

(a) The New Jersey Medicaid/NJ FamilyCare programs utilize the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology (CPT) (American Medical Association, PO Box 10950, Chicago, Illinois 60610, Attention: Order Department) using the architecture employing a five-position code and as many as two-position modifiers. Unlike the CPT numeric design, the HCFA assigned codes and modifiers contain one alphabetic character and four numeric characters. HCPCS was developed as a three-level coding system.

1. Level I Codes (Narratives found in CPT): CPT is a listing of numeric identifying codes and modifiers, and descriptive terms for reporting medical services and procedures performed by physicians.

2. Level II Codes (Narratives found in N.J.A.C. 10:58–3.4): These codes are not found in CPT and are assigned by HCFA for physician, practitioner, and non-physician services.

3. Level III Codes (Narratives found in N.J.A.C. 10:58–3.5): These codes are assigned by the Division of Medical Assistance and Health Services to be used for those services which are unique to the New Jersey Medicaid/NJ FamilyCare programs.

(b) Listed below are some of the general policies of the New Jersey Medicaid/NJ FamilyCare programs relevant to HCPCS. (The responsibility of the CNM when rendering specific services and requesting reimbursement is listed in N.J.A.C. 10:58–1.)

1. When filing a claim, the HCPCS procedure codes, including modifiers, must be used in accordance with the narratives in the CPT or N.J.A.C. 10:58–3.3, 3.4 and 3.5, whichever is applicable.

2. The use of a procedure code will be interpreted by the New Jersey Medicaid/NJ FamilyCare programs as evidence that the CNM personally furnished, as a minimum, the stated service.

Amended by R.2001 d.204, effective June 18, 2001.
See: 33 N.J.R. 1160(a), 33 N.J.R. 2188(a).

Substituted references to CPT for references to CPT–4 and inserted references to NJ FamilyCare throughout; in (b), deleted "of this chapter" following "N.J.A.C. 10:58–1" in the introductory paragraph.

10:58–3.2 Elements of HCPCS Procedure Codes which require attention of the certified nurse midwife

(a) The list of HCPCS procedure codes for nurse midwifery 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," "MAXIMUM FEE ALLOWANCE SCHEDULE" and "ANESTHESIA BASIC UNITS." The information given under each column is summarized below:

Column Title

"IND" (Indicator–Qualifier) Lists alphabetic symbols used to refer a provider to information concerning the New Jersey Medicaid/ NJ FamilyCare programs' qualifications and requirements when a HCPCS procedure code is used.
Explanation of indicators and qualifiers used in this column are given below:

"N" Preceding any procedure code means that qualifiers are applicable to that code.

"HCPCS CODES"—Lists the HCPCS procedure codes.

"MOD" Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance is identified by the addition of alphabetic and/or numeric characters affixed to the code. The modifiers are as follow:

"WM" Midwifery: Used to identify procedures performed by CNM by adding the modifier "WM" to the procedure code.

"22" Unusual Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by affixing "22" after the usual procedure number.

"52" Reduced Services: Under certain circumstances, a service or procedure is partially reduced or eliminated. 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"—Lists the code narrative for Level II and III codes. Narratives for Level I codes are found in the CPT.

"FOLLOW-UP"—Lists the number of days for follow-up.

"MAXIMUM FEE ALLOWANCE"—Lists the New Jersey Medicaid/NJ FamilyCare programs' reimbursement schedule for nurse midwifery services.

"ANESTHESIA BASIC UNITS"—B.U.V. (Basic Unit Value)

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