CHAPTER 57

PODIATRY SERVICES MANUAL

Authority

N.J.S.A. 30:4D–6b(8), 7, 7a, b and c; 30:4D–12.

Source and Effective Date

R.1991 d.129, effective February 13, 1991.
See: 22 N.J.R. 3439(b), 23 N.J.R. 858(b).

Executive Order No. 66(1978) Expiration Date

Chapter 57, Podiatry Services Manual, expires on February 13, 1996.

Chapter Historical Note

Chapter 57, Podiatry Services Manual, became effective on June 1, 1971 by R.1971 d.66. See: 3 N.J.R. 43(c), 3 N.J.R. 109(b). Pursuant to Executive Order No. 66(1978), Chapter 57 was readopted as R.1991 d.129. See: Source and Effective Date. See subchapter and section annotations for specific rulemaking activity.

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SUBCHAPTER 1. GENERAL PROVISIONS

Authority

N.J.S.A. 30:4D–6b(8), 7 and 7b.

Source and Effective Date

R.1984 d.343, effective July 25, 1984.
See: 16 N.J.R. 1441(a), 16 N.J.R. 2285(a).

Historical Note

This subchapter was filed and became effective June 1, 1971 as R.1971 d.66. See: 3 N.J.R. 43(c), 3 N.J.R. 109(b). Amendments were filed and became effective February 23, 1972 as R.1972 d.35. See: 3 N.J.R. 154(a), 4 N.J.R. 49(a). Further amendments were filed and became effective June 21, 1974 as R.1974 d.161. See: 6 N.J.R. 185(c), 6 N.J.R. 266(a). Further amendments were filed and became effective June 12, 1975 as R.1975 d.162. See: 7 N.J.R. 215(a), 7 N.J.R. 329(a). Further amendments were filed and became effective November 10, 1975 as R.1975 d.339. See: 7 N.J.R. 316(a), 7 N.J.R. 567(c). Further amendments were filed and became effective July 12, 1976 as R.1976 d.215. See: 8 N.J.R. 283(b), 8 N.J.R. 385(b). Further amendments were filed and became effective October 1, 1977 as R.1977 d.302. See: 9 N.J.R. 333(a), 9 N.J.R. 435(a). Further amendments were filed and became effective November 3, 1977 as R.1977 d.417. See: 9 N.J.R. 582(b). Further amendments were filed and became effective August 1, 1979 as R.1979 d.293. See: 11 N.J.R. 246(b), 11 N.J.R. 448(b). Further amendments were filed and became effective July 9, 1981 as R.1981 d.249. See: 13 N.J.R. 293(a), 13 N.J.R. 417(a). Further amendments were filed and became effective September 10, 1981 as R.1981 d.300. See: 13 N.J.R. 360(a), 13 N.J.R. 579(a).

10:57–1.1 Definitions

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

"Bundled drug service" means a drug that is marketed or distributed by the manufacturer or distributor as a combined package which includes in the cost the drug product and ancillary services such as, but not limited to, case management services and laboratory testing.

"Podiatrist" means any person licensed as a podiatrist by the New Jersey State Board of Medical Examiners, or similarly by a comparable agency of the state in which he practices.

"Podiatry services" means those services performed by a licensed podiatrist within the scope of practice as defined by the laws of New Jersey (N.J.S.A. 45:5–7) and which are within the scope of the services covered by the New Jersey Health Service Program.

1. A "Specialist" means one who is licensed to practice podiatry, in the state in which treatment is rendered, who limits his practice to his specialty and who:

i. Is a diplomate of the appropriate American Podiatry Association recognized board; or

ii. Has been notified of admissibility to examination by the appropriate American Podiatry Association recognized board.

2. Any podiatrist, who meets the above-cited qualifications, and desires special reimbursement, must submit written documentation to the Prudential Insurance Company, Medical Administration Division, P.O. Box 471, Data Base Systems Division, Millville, New Jersey 08332. This documentation must be as follows:

i. A copy of the specialty certificate/permit issued by the appropriate American Podiatry Association recognized board of the state in which podiatry services are to be rendered, or

ii. A copy of the notification of admissibility to examination by the appropriate American Podiatry Association recognized board.

3. Specialist reimbursement, when appropriate, will be limited to the following specialties:

i. Podiatric surgery;

ii. Podiatric orthopedics.

Amended by R.1974 d.161, effective June 21, 1974.
See: 6 N.J.R. 185(c), 6 N.J.R. 266(a).
Amended by R.1977 d.417, effective November 3, 1977.
See: 9 N.J.R. 431(a), 9 N.J.R. 582(b).
Amended by R.1979 d.293, effective August 1, 1979.
See: 11 N.J.R. 246(b), 11 N.J.R. 448(b).
Amended by R.1992 d.98, effective March 2, 1992.
See: 23 N.J.R. 281(a), 24 N.J.R. 845(a).
Added definition for "bundled drug service."

10:57–1.2 Standards

Podiatry care furnished covered persons shall be in conformity with the professional and ethical standards of the American Podiatry Association as defined by the laws of New Jersey N.J.S.A. 45:5.

As amended, R.1974 d.161, eff. June 21, 1974.
See: 6 N.J.R. 185(c), 6 N.J.R. 266(a).

10:57–1.3 Scope of services

Podiatry care under the health services program is allowable to covered persons if such services are essential. Essential podiatry care includes those services which require the professional knowledge and skill of a licensed podiatrist. For recipients in the Medically Needy Program, podiatry care is only available to pregnant women, and the aged, the blind or disabled. (For information on how to identify a covered person, please refer to N.J.A.C. 10:49–1.2).

Amended by R.1986 d.236, effective June 16, 1986 (Operative July 1, 1986).
See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a).
Added text "For recipients in ... to N.J.A.C. 10:49–1.2.)."

10:57–1.4 Noncovered services; definitions

(a) The following words and terms, when used in this section, shall have the following meanings unless the context clearly indicates otherwise.

"Flat-foot conditions" means the local condition of flattened arches regardless of the underlying etiology. Treatment of flat-foot conditions encompasses all phases of services in connection with flatfeet.

"Routine foot care" means the cutting or removal of corns, warts or calluses, the trimming of nails, routine hygienic care, and any other routine care of the feet.

"Routine hygienic care" means hygienic and preventive maintenance care of the feet of the type which is ordinarily within the realm of self-care such as observation and cleansing of the feet, use of skin creams to maintain skin tones of both ambulatory and bedfast patients, prevention and reduction of corns, calluses and warts.

"Subluxation" means the structural misalignment of the joints of the feet which do not require surgical methods of treatment and/or correction, with the exception of fractures and complete dislocations.

(b) The following foot care services are not covered:

1. Flat-foot conditions:

i. Exceptions:

(1) Treatment which is an integral part of post-fracture or postoperative treatment plan;

(2) Supportive devices (for example, arch supports, specific additions to shoes and the like) which are prescribed to palliate pain and other symptoms associated with the condition.

ii. Treatment where the talo-crural joint is involved;

iii. Treatment where there may be attachment of supportive device to a brace or bar.

2. Subluxations of the feet in which the normal relationship of the bones, tendons, ligaments and supporting muscles is disturbed and which, regardless of underlying etiology, require treatment by mechanical methods (for example, whirlpool, paraffin baths, casting, strapping, splinting, padding, shortwave or low voltage currents, physical therapy, exercise manipulation, massage, and the like):

i. Exceptions:

(1) Where treatment is an integral part of post-fracture or postoperative treatment plan;

(2) Where the talo-crural joint is involved;

(3) Where there may be attachment of a supportive device to a brace or bar.

3. Routine foot care, routine hygienic care:

i. Exceptions:

(1) Treatment of painful corns, calluses and warts;

Note: When treatments are in excess of one per month, the case must be referred for evaluation to the podiatry unit of the New Jersey Health Services Program, CN–712, Trenton, New Jersey 08625.

(2) Treatment of the foot for Medicaid recipients with metabolic, neurological, and peripheral diseases (for examples, diabetes mellitus, arteriosclerosis obliterans, Buerger's disease, chronic thrombophlebitis, peripheral neuropathies, and so forth);

(3) Treatment of fungal (mycotic) and other infections of the feet and toenails are covered services.

Note: Debridement of hypertrophic toenail treatments more frequent than once every two months must be referred to prior authorization to the Podiatry Unit of the New Jersey Health Services Program, CN–712, Trenton, New Jersey 08625.

4. Drugs dispensed by the podiatrist not reimbursable.

(c) The following guidelines limit the provision of (a)3 above:

1. The importance of preventive or hygienic care for patients with a systemic illness, such as peripheral vascular disease, diabetes, or with severe physical disability is recognized. These will be considered on an individual basis by the podiatry consultant.

2. If services ordinarily considered routine are performed at the same time as and as a necessary integral part of otherwise covered services, such as diagnosis and treatment of diabetic ulcers, wounds and infections, they are covered.

3. Fungal (mycotic) and other infections of the feet and toenails require professional services which are outside the scope of "routine foot care" as defined in subsection (a) of this section. Diagnostic and treatment services for foot infections are covered in the same manner as services performed for infections occurring elsewhere on the body, and the same type of coverage rules apply.

4. Treatment of plantar warts that are symptomatic and/or cause disability will be considered a covered service.

(d) No additional payment will be made for drugs dispensed by a podiatrist.

As amended, R.1972 d.35, eff. February 23, 1972.
See: 3 N.J.R. 154(a), 4 N.J.R. 49(a).
As amended, R.1975 d.162, eff. June 12, 1975.
See: 7 N.J.R. 215(a), 7 N.J.R. 329(a).
As amended, R.1977 d.302, eff. October 1, 1977.
See: 9 N.J.R. 333(a), 9 N.J.R. 435(a).
As amended, R.1981 d.300, eff. September 10, 1981.
See: 13 N.J.R. 360(a), 13 N.J.R. 579(a).
(b)3i(1): P.O. Box change.
(b)3i(3): Note added.

10:57–1.5 Podiatric laboratory services

(a) Payment will be allowed for laboratory services rendered by a podiatrist for his own patients with prior authorization.

(b) Services provided by an independent laboratory must be billed directly to the program by the laboratory, and not by the referring practitioner.

(c) The following provisions apply to molded shoes:

1. Prior authorization is required.

2. The podiatrist shall be allowed a service fee including casting, not to exceed program limitations. This is to be billed on a physicians' and practitioners' claim form.

3. The maximum allowable charges to the program for the shoes will be a vendor's charge, not to exceed program limitations, and shall be billed on a medical suppliers' claim form.

4. Exceptional cases will be given individual consideration by the consultant as to fee requested.

(d) Health Insurance Claim Form (HCFA–1500). The actual cost of supports shall be within the limits of the program and must be billed by the vendor on the MC–11 Medical Supplier's claim form.

As amended, R.1974 d.161, eff. June 21, 1974.
See: 6 N.J.R. 185(c), 6 N.J.R. 266(a).
As amended, R.1981 d.249, eff. July 9, 1981.
See: 13 N.J.R. 293(a), 13 N.J.R. 417(a).
(d): Incorporated billing procedures using HCFA–1500 claim form.

10:57–1.6 Clinical laboratory services

(a) "Clinical laboratory services" means professional and technical laboratory services provided to a patient by a laboratory that is qualified to participate under Title XVIII of the Social Security Act, or is determined currently to meet the requirements of such participation.

(b) Laboratories described in (a) above include:

1. Independent clinical laboratories, including physician operated out-of-hospital laboratories which perform primarily diagnostic work referred by other physicians or practitioners, and which meet the above qualifications; and

2. Hospital laboratories holding valid certification from the New Jersey Department of Health, and which provide laboratory services to ambulatory patients as requested by a practitioner.

10:57–1.7 Hospital clinic services

All services rendered in the hospital clinic setting are considered hospital costs, including practitioners' services. For recipients in the Medically Needy Program, hospital services are not available except to pregnant women as part of their inpatient hospital services.

Amended by R.1986 d.236, effective June 16, 1986 (Operative July 1, 1986).
See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a).
Added text "For recipients in ... inpatient hospital services."

10:57–1.8 Diagnostic radiology services

Payment will be allowed for necessary radiological services by a podiatrist, subject to the limitations of his licensure. Routine X-rays for screening purposes are not reimbursable.

As amended, R.1974 d.161, eff. June 21, 1974.
See: 6 N.J.R. 185(c), 6 N.J.R. 266(a).

10:57–1.9 Prior authorization

(a) The following services need prior approval by the Podiatry Services Unit, Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625:

1. Moulded Shoes—205.1;
2. Arch Supports—205.2.
3. Routine debridement of toenails, more than once every two months.

(b) A written request for authorization (form 33030) must be submitted, identifying the case and containing sufficient information about the problem and plan of treatment to enable the unit to make a proper evaluation.

As amended, R.1974 d.161, eff. June 21, 1974.
See: 6 N.J.R. 185(c), 6 N.J.R. 266(a).
As amended, R.1981 d.300, eff. September 10, 1981.
See: 13 N.J.R. 360(a), 13 N.J.R. 579(a).
(a)3 added.

10:57–1.10 Basis of payment

Reimbursement for covered services furnished under the Health Services Program shall be on the basis of the customary charge, not to exceed an allowance determined reasonable by the Commissioner (Human Services), and further limited by Federal policy relative to payment of practitioners and other individual providers. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

10:57–1.11 Multiple visits—out of office

(a) Podiatry services rendered in a residential or medical facility (that is hospital, nursing home, extended care facility and so forth) must be based on referral by the attending physician.

(b) Multiple visits to patients in the same health facility or congregate living arrangement will be reimbursed on an out-of-office visit basis for the initial visit to each patient, and on an office visit basis for each subsequent visit to each patient receiving services.

As amended, R.1972 d.35, eff. February 23, 1972.
See: 3 N.J.R. 154(a), 4 N.J.R. 49(a).

10:57–1.12 Record keeping

(a) Podiatrists are to keep individual records as are necessary to fully disclose the kind and extent of services provided and to make such information available as the Division or its agents may request. For the initial examination, the records shall show the following as a minimum:

1. Date of service;
2. Chief complaint(s);
3. Pertinent historical and physical data;
4. Reports of diagnostic procedures ordered or performed;
5. Diagnosis;
6. Prescription (including medication) and treatment.

(b) Progress notes may be brief but shall include date(s) of service, changes in patient's condition, specific medications and/or other treatments.

As amended, R.1974 d.161, eff. June 21, 1974.
See: 6 N.J.R. 185(c), 6 N.J.R. 266(a).

10:57–1.13 Prescription policies

(a) N.J.A.C. 10:57–1.13 through 1.21, are intended to describe the practitioner's responsibilities in the writing of prescriptions in order to maintain the traditional patient-prescriber-pharmacist relationship and to insure the recipient free choice of provider. Practitioners are urged to familiarize themselves with all aspects of these sections in order to effect economics consistent with good medical practices and to facilitate prompt payment to the pharmacist.

(b) All podiatrists licensed or authorized to prescribe by the State of New Jersey and falling as indicated within policies of New Jersey Health Services Program are eligible. Out–of–State practitioners may prescribe under this program, as herein outlined, if they meet the same requirements in their state.

(c) For recipients in the Medically Needy Program, Medicaid services are available with limitations (see 10:49–1.4(b)).

As amended, R.1974 d.161, eff. June 21, 1974.
See: 6 N.J.R. 185(c), 6 N.J.R. 266(a).
Amended by R.1986 d.236, effective June 16, 1986 (Operative July 1, 1986).
See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a).
(c) added.

10:57–1.14 Prescriptions; dosage and directions

(a) The practitioner must include specific directions on all drug prescriptions or the prescription will not be eligible for payment. Nonacceptable directions, for example, "PRN", "as directed", "ad lib", and so forth, are not eligible for payment. This ruling does not apply to prescriptions for topical preparations since specific directions are seldom possible in these instances.

(b) The choice of prescription drugs remains at the discretion of the prescriber; but payment will not be made for certain drugs under specific conditions. (See sections on "Pharmaceutical Services Not Eligible for Payment" and "Pharmaceutical Services Requiring Prior Authorization".)

(c) When prescribing a trade-name multi-source drug product listed in Section I of the New Jersey Medicaid Formulary (See Appendix A), for which a designated chemically equivalent name in corresponding dosage form and strength is listed in Section II of the Formulary, the prescriber must indicate either "Formulary Alternate Permitted" or "Dispense as Written" (may be abbreviated "FAP" or "DAW") on each written or telephoned prescription.

(d) For patients in long-term care facilities, either statement or its abbreviation must appear on the patient's chart and be transposed onto the written prescription.

(e) When the prescriber indicates "Formulary Alternate Permitted" or "FAP", the pharmacy provider shall dispense an alternate product listed for the designated chemical evaluation name, and will be reimbursed based on the average wholesale price for that product. When the prescriber indicates "Dispense as Written" or "DAW", the pharmacy provider shall follow those instructions and will be reimbursed accordingly.

(f) When the drug product is prescribed by its nonproprietary or generic name, the pharmacy provider shall dispense the least expensive product of equal therapeutic effectiveness available.

As amended, R.1974 d.161, eff. June 21, 1974.
See: 6 N.J.R. 185(c), 6 N.J.R. 266(a).
As amended, R.1975 d.339, eff. November 10, 1975.
See: 7 N.J.R. 316(a), 7 N.J.R. 567(c).

10:57–1.15 Choice of prescription drugs

(a) The choice of prescription drugs remains at the discretion of the prescribing practitioner. However, the practitioner should be aware that pharmacies will not receive payment for certain prescription drugs, under specific conditions, as listed in (b) below.

(b) The practitioner should have preference to:

1. Drugs listed in the latest edition of the U.S. Pharmacopeia (U.S.P.), National Formulary (N.F.), New Drugs, and Accepted Dental Therapeutics;

2. Oral medication when as effective as injectable preparations;

3. Nonproprietary or generic named drugs of equal therapeutic effectiveness if available at a lower cost than proprietary or brand-named drugs.

As amended, R.1974 d.161, eff. June 21, 1974.
See: 6 N.J.R. 185(c), 6 N.J.R. 266(a).

10:57–1.16 Quantity of medication

(a) The quantity prescribed should provide a sufficient amount of medication necessary for the duration of the illness or an amount sufficient to cover the interval between visits, but may not exceed a 60–day supply. Any drug used continuously (that is, daily, three times daily, every other day, and so forth) for 14 days or more is considered to be a sustaining drug or maintenance medication and should be prescribed in sufficient quantities to treat the patient for up to 60 days.

(b) In long-term medical care facilities (that is, skilled nursing facility, intermediate care facility, infirmary section of home for the aged, or public medical institution) if the quantity of sustaining drug or maintenance medication is not indicated in writing by the prescriber, the pharmacy provider must dispense a minimum of 100 tablets or capsules, a pint, or a 30–day supply, whichever is less.

As amended, R.1974 d.161, eff. June 21, 1974.
See: 6 N.J.R. 185(c), 6 N.J.R. 266(a).

10:57–1.17 Services requiring prior authorization

(a) Certain therapeutic classes and dosage forms require prior authorization obtained by the prescribing practitioner from the local medical assistance unit. If the request is approved, an authorization number will be provided and must appear on the prescriber's original prescription. The pharmacist must check the box in the space provided on the Prescription Claim form identifying a prior-authorized item, and enter the authorization number in the proper spaces in this area.

(b) The following require prior authorization;

1. Antiobescis and anorexics;

2. Protein replacement products such as (but not limited to) Probana, Portagen, Nutramigen, Neo–Mullsoy;

3. Preventive drugs and biologicals when not available through listed distributing stations.

4. Methadone.

i. Exception: Not reimbursable for use in drug detoxification or for addiction.

As amended, R.1974 d.161, eff. June 21, 1974.
See: 6 N.J.R. 185(c), 6 N.J.R. 266(a).
As amended, R.1976 d.215, eff. July 12, 1976.
See: 8 N.J.R. 283(b), 8 N.J.R. 385(b).

10:57–1.18 Pharmaceutical services not eligible for payment

(a) Pharmaceutical services not eligible for payment include:

1. Drugs for which adequate literature, such as package inserts, and price catalogues are not readily available;

2. Experimental drugs;

3. Drugs administered or directly furnished by the practitioner; (Payment for drugs will be made only when dispensed by a registered pharmacist in a licensed pharmacy.)

4. Drugs and biologicals provided without charge through programs of other public or voluntary agencies (for example, New Jersey State Department of Health, New Jersey Heart Association);

5. Medications prescribed for use by hospital inpatients;

6. Prescribed nonlegend (OTC) drugs for patients in long-term medical care facilities, such as, skilled nursing homes, infirmary sections of a home for the aged or public medical institutions:

i. Exceptions include:

(1) Insulin

(2) All vitamins, minerals, vitamin-mineral combinations.

7. Prescriptions written and dispensed with nonspecific directions;

8. Telephoned "refill" prescriptions;

9. Methadone policy: Methadone when used for drug detoxification or addiction.

10. Medication prescribed for a Title XIX (Medicaid) covered person who is receiving benefits under Part A of Title XVIII (Medicare) as a patient in an extended care facility (ECF);

11. Prescribed nonlegend drugs unless specifically listed in Appendix B (allowable nonlegend drugs) of the New Jersey Blue Cross Code Register;

12. Food supplements, milk modifiers, infant formula and therapeutic diets. Exception: Protein replacements;

13. Drugs for which final orders have been published by the Food and Drug Administration, withdrawing the approval of their new drug application (NDA):

14. Telephone ordered original prescriptions:

i. Telephone orders from the prescriber for original prescriptions, in accordance with all applicable Federal and State laws and regulations, will be permitted.

ii. The prescriber must indicate either "Formulary Alternate Permitted" or "Dispense as Written" for each prescription transmitted and the pharmacist shall transpose this information onto the written prescription.

15. Any bundled drug service shall not be eligible for reimbursement by the New Jersey Medicaid Program.

i. This provision may be waived at the discretion of the Commissioner if he or she determines that a bundled drug service is less than or equal to the total cost of the unbundled components if reimbursed separately; or

ii. The Commissioner may waive the provisions for reasons of medical necessity for a bundled drug or in accordance with terms approved by the Department as follows:

(1) Those instances where discontinuation, withdrawal, or elimination of the use of the bundled drug in someone who has been receiving bundled drug would result in deprivation of life saving or life prolonging benefits of the drug or would cause potential harm or serious exacerbation of the illness being treated; or

(2) Those instances where use of the bundled drug has shown marked improvement in the recipients clinical status reflected in alleviation of symptoms, and elevation of level of function and independence.

iii. In order to determine eligibility for reimbursement, manufacturers or distributors of a bundled drug service shall submit complete product information, including the cost to the Program of the total bundled drug service, discrete costs of each component of the bundled drug service, cost benefit analyses, and other information as requested by the Department, to the Chief Pharmaceutical Consultant, Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625–0712.

iv. If the Commissioner determines that a bundled drug is eligible for reimbursement under this section, New Jersey Medicaid recipients shall be eligible for the bundled drug service if prior authorization is requested and approved. Prior authorization shall be obtained by completing the appropriate "Request for Authorization Form" requesting medication management authorization and providing sufficient documentation to establish that it is medically necessary to continue the bundled drug services and mailing the completed form and documentation to:

Medical Director
Division of Medical Assistance and Health Services

CN 712
Trenton, NJ 08625–0712

Amended by R.1974 d.161, effective June 21, 1974.
See: 6 N.J.R. 185(c), 6 N.J.R. 266(a).
Amended by R.1975 d.339, effective November 10, 1975.
See: 7 N.J.R. 316(a), 7 N.J.R. 567(c).
Amended by R.1976 d.215, effective July 12, 1976.
See: 8 N.J.R. 283(b), 8 N.J.R. 385(b).
Amended by R.1992 d.98, effective March 2, 1992.
See: 23 N.J.R. 281(a), 23 N.J.R. 1310(a), 24 N.J.R. 845(a).
Added (a)15 on bundled drug services.

10:57–1.19 Prescription refill

(a) Refill instructions must be indicated by the practitioner.

(b) Prescription refills will be limited to two times within a six-month period if so indicated by the prescriber on the original prescription. Exception: Vitamins and vitamin-mineral combinations originally prescribed for a 100–day supply may be refilled two times within one year.

(c) Medical-surgical supplies and equipment, prosthetics, orthotics and other assistive devices are renewable only on prior authorization.

As amended, R.1974 d.161, eff. June 21, 1974.
See: 6 N.J.R. 185(c), 6 N.J.R. 266(a).

10:57–1.20 Injection policy and drugs dispensed by a podiatrist

(a) The following is the New Jersey Medicaid Program injection policy: The program will make payment for injections (intradermal, subcutaneous, intramuscular, intravenous), office or home setting.

1. Injection (intradermal, subcutaneous, intramuscular, intravenous), office or home setting:

i. Reimbursement for the above injections are on a flat fee basis and are inclusive for the cost of the service and the drug or vaccine.

Note 1: A visit for the sole purpose of an injection is reimbursable as an injection and not as an office visit plus an injection. On the other hand, if the criteria of an office or home visit are met, an injection may, if medically indicated, be considered as an add-on to the visit. 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.

Note 2: Intravenous injections are reimbursable only when performed by the podiatrist.

Note 3: No reimbursement will be made for vitamins, liver or iron injections or combinations thereof except in laboratory-proven deficiency states requiring parenteral therapy.

Note 4: No reimbursement will be made for placebos or any injections containing amphetamines or derivatives thereof.

Note 5: 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.

Note 6: Insert procedure code number 9072 as a separate item on The Health Insurance Claim Form (HCFA–1500) under section 24D. This is to be followed by the name, dose of drug and route of administration. The complete diagnosis for which the injection was given must be inserted in item 23A and referenced in section 24.

Note 7: Injectable prescription drugs are no longer a reimbursable item to the provider:

Exception:

(1) In long-term care facilities;

(2) Drugs to be administered to a patient by other than the podiatrist or his employee. Podiatrist's prescription must carry the legend "Medicaid authorized". Prior authorization is required.

R.1977 d.302, eff. October 1, 1977.
See: 9 N.J.R. 333(a), 9 N.J.R. 435(a).
As amended, R.1981 d.249, eff. July 9, 1981.
See: 13 N.J.R. 293(a), 13 N.J.R. 417(a).
(a)11 Note 6: Incorporated billing procedures using HCFA–1500 claim form.

SUBCHAPTER 2. PODIATRY BILLING PROCEDURES

Authority

Unless otherwise expressly noted, all provisions of this subchapter were adopted pursuant to authority delegated at N.J.S.A. 30:4D–1 et seq. and were filed August 12, 1974, as R.1974 d.222 to become effective September 15, 1974. See: 6 N.J.R. 264(c), 6 N.J.R. 35(c).

10:57–2.1 General billing procedures

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

(b) This subchapter contains basic information necessary for the submission of a claim. Included is a sample claim form approved for use in submitting claims for covered items or services, and appropriate instructions for the proper completion of the form.

Amended by R.1987 d.408, effective October 5, 1987.
See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).
New (a) added.

10:57–2.2 Timeliness of claim submission and claim inquiry

For timeliness of claim submission and claim inquiry, see N.J.A.C. 10:49–1.12.

New Rule, R.1987 d.408, effective October 5, 1987.
See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).
Old rule was General Policy.

10:57–2.3 Patient identification

Verify that the patient is a covered person on the first visit and each visit thereafter. This is done by viewing the patient's validation form which is issued monthly. Individuals under the jurisdiction of the Division of Youth and Family Services (DYFS) are issued quarterly validation cards. It is especially important to review a patient's validation form on each visit when extended plans of treatment have been authorized. Prior authorization is no guarantee that an individual is covered. Authorization becomes invalid upon termination of eligibility.

Amended by R.1986 d.236, effective June 16, 1986 (Operative July 1, 1986).
See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a).
Deleted text "the first day of each month" and substituted "monthly. Individuals under . . . quarterly validation cards."

10:57–2.4 Prior authorization

When submitting claims for payment, make certain all authorizations have been properly signed by the podiatry services unit and are attached.

10:57–2.5 Combination Medicare/Medicaid claims

Services covered under Medicare rendered by noninstitutional providers to a Medicare/Medicaid eligible person shall be billed on the Health Insurance Claim Form (HCFA–1500), and the claims sent directly to the Medicare Intermediary, Prudential, Medicare B Division, Post Office Box 3500, Linwood, New Jersey 08221. The provider must record the health insurance claim number in item 6, and the New Jersey Health Services case and person number in item 8 on the HCFA–1500.

> Note: In cases where prior authorization is required for the Health Services Program, it must be obtained and submitted with the Medicare claim. The Health Insurance Claim Form (HCFA–1500) may be obtained from Prudential.

As amended, R.1981 d.249, eff. July 9, 1981.
See: 13 N.J.R. 293(a), 13 N.J.R. 417(a).
Incorporated billing procedures using HCFA–1500 claim form.

10:57–2.6 Health Insurance Claim Form (HCFA–1500)

This form is used for the purpose of billing for covered services of physicians, podiatrists, optometrists, psychologists and chiropractors. Billing should be done on a monthly basis and submitted for payment as soon after the end of the month as is possible. (See N.J.A.C. 10:49–1.12)

> Note: Any laboratory services rendered by the physician or practitioner to his own patients in his own office should be billed on this form. However, any laboratory services provided by an independent laboratory, should be billed directly to the program by the laboratory and not by the physician or practitioner.

As amended, R.1981 d.249, eff. July 9, 1981.
See: 13 N.J.R. 293(a), 13 N.J.R. 417(a).
Incorporated billing procedures using HCFA–1500 claim form and deleted reference to Form MC–8.

10:57–2.7 Mailing instructions

Mail the original copy Health Insurance Claim form (Contractor's copy) together with the authorization form 33030 (where appropriate) to:

> The Prudential Insurance Company of America
> P.O. Box 471
> Data Base Systems Division
> Millville, New Jersey 08332

As amended, R.1981 d.249, eff. July 1, 1981.
See: 13 N.J.R. 293(a), 13 N.J.R. 417(a).
Deleted form MC–8 reference and incorporated billing procedures using HCFA claim form.

> Editor's Note: In addition to the above, rules concerning a listing of the directory of Medicaid District Offices as well as instructions for completing form 1500 N.J. Ed. 11–82 were filed with the rules. Further information concerning these excluded materials may be obtained from the Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625.

10:57–2.8 Automated Data Exchange Billing

(a) Any approved provider may request approval to submit claims for reimbursement via an approved method of Automated Data Exchange. All costs of rental/purchase of a terminal, installation, maintenance, and usage of telephone lines are the responsibility of the provider.

(b) Requests for approval must be submitted to the appropriate Contractor:

> The Prudential Insurance Co.
> P.O. Box 471
> Data Base Systems Division
> Millville, New Jersey 08332
>
> OR
>
> Blue Cross of New Jersey
> 33 Washington Street
> Newark, New Jersey 07102

(c) Any provider approved for an Automated Data Exchange claim submission system must comply with all regulations and restrictions set forth by The New Jersey Medicaid Program.

(d) A random billing sample will be audited after a three month period. The review to compare data received via the Automated Data Exchange against the medical records will consist primarily of statement of charges, nature of services rendered, employment or accident related, other coverage, patient/provider signature, and verification that charges and procedure codes match services performed.

1. Subsequent audits will be scheduled at six-month intervals if the error rate is acceptable.

R.1981 d.250, eff. July 9, 1981.
See: 13 N.J.R. 296(a), 13 N.J.R. 418(a).

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

Authority

N.J.S.A. 30:4D–6a–(3)(4)b(5); 6b(1)(3)(5)(6)(7)(8)(10)(12)(15)(16); 7, 7a, 7b, 7c.

Source and Effective Date

R.1986 d.52, effective March 3, 1986.
See: 17 N.J.R. 1519(b), 18 N.J.R. 478(a).

Editor's Note: The Division of Medical Assistance and Health Services has adopted the HCPCS coding system for the majority of fee-for-service providers participating in the New Jersey Medicaid Program. The HCPCS will not be reproduced in the Code but may be obtained by contacting:

Administrative Practice Officer
Division of Medical Assistance & Health Services
Quakerbridge Plaza, Building No. 7
CN 712
Trenton, New Jersey 08625
OR
Office of Administrative Law
Rules and Publications
Quakerbridge Plaza, Building No. 9
CN 301
Trenton, New Jersey 08625

Public Notice: Pursuant to the provisions of N.J.S.A. 30:4D–2, 3, 5, 6 and 7 and the New Jersey Appropriations Act (P.L. 1988 c.47), maximum fee allowance increased for routine visits effective August 1, 1988 and May 1, 1988; consultation effective October 1, 1988, January 1, 1989 and April 1, 1989; house calls effective August 1, 1988.
See: 20 N.J.R. 2101(a).

APPENDIX A

NEW JERSEY MEDICAID FORMULARY

SECTION I

TRADE NAME AND COMPANY	DESIGNATED CHEMICALLY EQUIVALENT NAME
ACHROMYCIN-V (LEDERLE)	TETRACYCLINE
ALPEN (LEDERLE)	AMPICILLIN
AMCILL (PARKE-DAVIS)	AMPICILLIN
AMNESTROGEN (SQUIBB)	ESTROGENS, ESTERIFIED
BENADRYL (PARKE-DAVIS)	DIPHENHYDRAMINE
BETAPEN VK (BRISTOL)	PENICILLIN-V POT.
BRISTACYCLINE (BRISTOL)	TETRACYCLINE
BRISTAMYCIN (BRISTOL)	ERYTHROMYCIN
CHLOR-PZ (USV)	CHLORPROMAZINE
CHLOR-TRIMETON (SCHERING)	CHLORPHENIRAMINE
COMPOCILLIN-VK (ABBOTT-ROSS)	PENICILLIN-V POT.
CONESTRON (WYETH)	ESTROGENS, CONJUGATED
COSEA (ALCON)	CHLORPHENIRAMINE
CYCLOPAR (PARKE-DAVIS)	TETRACYCLINE
DARVON (LILLY)	PROPOXYPHENE
DARVON COMPOUND-65 (LILLY)	PROPOXYPHENE COMPOUND-65
DOLENE (LEDERLE)	PROPOXYPHENE
DOLENE COMPOUND-65 (LEDERLE)	PROPOXYPHENE COMPOUND-65
DOWMYCIN-E (DOW)	ERYTHROMYCIN
DOXY-II (USV)	DOXYCYCLINE
EQUANIL (WYETH)	MEPROBAMATE
ERYPAR (PARKE-DAVIS)	ERYTHROMYCIN
ERYTHROCIN (ABBOTT)	ERYTHROMYCIN
ESIDRIX (CIBA)	HYDROCHLOROTHIAZIDE
ETHRIL (SQUIBB)	ERYTHROMYCIN
EVEX (SYNTEX)	ESTROGENS, ESTERIFIED
GANTRISIN (ROCHE)	SULFISOXAZOLE
HISTASPAN (USV)	CHLORPHENIRAMINE
HYDRODIURIL (MS & D)	HYDROCHLOROTHIAZINE
ILOSONE (DISTA)	ERYTHROMYCIN
IMAVATE (ROBINS)	IMIPRAMINE
JANIMINE (ABBOTT)	IMIPRAMINE
LEDERCILLIN VK (LEDERLE)	PENICILLIN-V POT.
MENEST (BEECHAM)	ESTROGENS, ESTERIFIED
MILTOWN (WALLACE)	MEPROBAMATE
OMNIPEN (WYETH)	AMPICILLIN
ORETIC (ABBOTT)	HYDROCHLOROTHIAZINE
OXLOPAR (PARKE-DAVIS)	OXYTETRACYCLINE
PANMYCIN (UPJOHN)	TETRACYCLINE
PEN-A (PFIZER)	AMPICILLIN
PENAPAR VK (PARKE-DAVIS)	PENICILLIN-V POT.
PENBRITIN (AYERST)	AMPICILLIN
PENSYN (UPJOHN)	AMPICILLIN
PENTIDS (SQUIBB)	PENICILLIN-G
PEN VEE K (WYETH)	PENICILLIN-V POT.
PFIZER-E (PFIZER)	ERYTHROMYCIN
PFIZERPEN (PFIZER)	PENICILLIN-G
PFIZERPEN VK (PFIZER)	PENICILLIN-V POT.
POLYCILLIN (BRISTOL)	AMPICILLIN
PREMARIN (AYERST)	ESTROGENS, CONJUGATED
PRESAMINE (USV)	IMIPRAMINE
PRINCIPEN (SQUIBB)	AMPICILLIN
PROMAPAR (PARKE-DAVIS)	CHLORPROMAZINE
QIDAMP (MALLINCRODT)	AMPICILLIN
QIDMYCIN (MALLINCRODT)	ERYTHROMYCIN
QIDPEN VK (MALLINCRODT)	PENICILLIN-V POT.
QIDTET (MALLINCRODT)	TETRACYCLINE
ROBICILLIN VK (ROBINS)	PENICILLIN-V POT.
ROBIMYCIN (ROBINS)	ERYTHROMYCIN
ROBITET (ROBINS)	TETRACYCLINE
SK-AMPICILLIN (SKF)	AMPICILLIN
SK-BAMATE (SKF)	MEPROBAMATE
SK-ERYTHROMYCIN (SKF)	ERYTHROMYCIN
SK-ESTROGENS (SKF)	ESTROGENS, ESTERIFIED
SK-PENICILLIN VK (SKF)	PENICILLIN-V POT.
SK-PRAMINE (SKF)	IMIPRAMINE
SK-SOXAZOLE (SKF)	SULFISOXAZOLE
SK-TETRACYCLINE (SKF)	TETRACYCLINE

TRADE NAME AND COMPANY	DESIGNATED CHEMICALLY EQUIVALENT NAME
SK–65 (SKF)	PROPOXYPHENE
SK–65 COMPOUND (SKF)	PROPOXYPHENE COMPOUND–65
SOXOMIDE (UPJOHN)	SULFISOXAZOLE
SULFALAR (PARKE–DAVIS)	SULFISOXAZOLE
SUMYCIN (SQUIBB)	TETRACYCLINE
TELDRIN (SKF)	CHLORPHENIRAMINE
TERRAMYCIN (PFIZER)	OXYTETRACYCLINE
TETRACYN (ROERIG)	TETRACYCLINE
TETREX (BRISTOL)	TETRACYCLINE
TETREX BID (BRISTOL)	TETRACYCLINE
TETREX–S (BRISTOL)	TETRACYCLINE
THIURETIC (PARKE–DAVIS)	HYDROCHLOROTHIAZIDE
THORAZINE (SKF)	CHLORPROMAZINE
TOFRANIL (GEIGY)	IMIPRAMINE
TOTACILLIN (BEECHAM)	AMPICILLIN
UTICILLIN VK (UPJOHN)	PENICILLIN–V POT.
V CILLIN–(LILLY)	PENICILLIN–V POT.
VEETIDS (SQUIBB)	PENICILLIN–V POT.
VIBRAMYCIN (PFIZER)	DOXYCYCLINE

NEW JERSEY MEDICAID FORMULARY
SECTION II

DESIGNATED CHEMICAL EQUIVALENT DOSAGE FORM AND STRENGTH	ACCEPTED ALTERNATE PRODUCT NAME AND COMPANY
AMPICILLIN, CAPS 250MG	PEN–A (PFIZER)
AMPICILLIN, CAPS 500MG	PEN–A (PFIZER)
AMPICILLIN, SUSP 125MG 100CC	PEN–A (PFIZER)
AMPICILLIN, SUSP 125MG 200CC	PEN–A (PFIZER)
AMPICILLIN, SUSP 250MG 100CC	PEN–A (PFIZER)
AMPICILLIN, SUSP 250MG 200CC	PEN–A (PFIZER)
CHLORPHENIRAMINE SUST TABS/ CAPS 8MG	CHLORPHENIRAMINE (LEDERLE)
CHLORPHENIRAMINE SUST TABS/ CAPS 12MG	CHLORPHENIRAMINE (LEDERLE)
CHLORPROMAZINE TABS 10 MG	CHLOR–PZ (USV) CHLORPROMAZINE (LEDERLE)
CHLORPROMAZINE TABS 25MG	CHLOR–PZ (USV) CHLORPROMAZINE (LEDERLE) CHLORPROMAZINE (ABBOTT)
CHLOROROMAZINE TABS 50MG	CHLOR–PZ (USV) CHLORPROMAZINE (LEDERLE) CHLORPROMAZINE (ABBOTT)
CHLORPROMAZINE TABS 100MG	CHLOR–PZ (USV) CHLORPROMAZINE (LEDERLE) CHLORPROMAZINE (ABBOTT)
CHLORPROMAZINE TABS 200MG	CHLOR–PZ (USV) CHLORPROMAZINE (LEDERLE) CHLORPROMAZINE (ABBOTT)
DIPHENHYDRAMINE CAPS 25MG	DIPHENHYDRAMINE (LEDERLE)
DIPHENHYDRAMINE CAPS 50MG	DIPHENHYDRAMINE (LEDERLE)
DOXYCYCLINE CAPS 50MG	DOXY–II (USV)
DOXYCYCLINE CAPS 100MG	DOXY–II (USV)
DOXYCLINE ORAL SUSP 25MG/5CC	DOXY–II (USV)
ERYTHROMYCIN TABS/CAPS 250MG	PFIZER–E (PFIZER)
ERYTHROMYCIN TABS/CAPS 500MG	PFIZER–E (PFIZER)
ESTROGENS, CONJ TABS 0.625MG	ESTROGENS, CONJUGATED (LEDERLE)
ESTROGENS, CONJ TABS 1.25MG	ESTROGENS, CONJUGATED (LEDERLE)
ESTROGENS, ESTERIFIED TABS 0.625MG	SK–ESTROGENS (SKF)
ESTROGENS, ESTERIFIED TABS 1.25MG	SK–ESTROGENS (SKF)
ESTROGENS, ESTERIFIED TABS 2.5MG.	SK–ESTROGENS (SKF)
HYDROCHLOROTHIAZIDE TABS 50MG	ORETIC (ABBOTT) THIURETIC (PARKE–DAVIS)
IMIPRAMINE TABS 10MG	IMIPRAMINE (LEDERLE) SK–PARMINE (SKF)
IMIPRAMINE TABS 25MG	IMIPRAMINE (LEDERLE) SK–PRAMINE (SKF)
IMIPRAMINE TABS 50 MG	IMIPRAMINE (LEDERLE) JANIMINE (ABBOTT) SK–PRAMINE (SKF)
MEPROBAMATE TABS 200MG	SK–BAMATE (SKF)
MEPROBAMATE TABS 400MG	SK–BAMATE (SKF) MEPROBAMATE (LEDERLE)
OXYTETRACYCLINE CAPS 250MG	OXLOPAR (PARKE–DAVIS)
PENICILLIN–G TABS 200,000U	PFIZERPEN (PFIZER) PENICILLIN–G (WYETH)
PENICILLIN–G TABS 250,000U	PFIZERPEN (PFIZER) PENICILLIN–G (WYETH)
PENICILLIN–G TABS 400,000U	PFIZERPEN (PFIZER) PENICILLIN–G (WYETH)
PENICILLIN–G LIQ. 250MG 100CC	PFIZERPEN (PFIZER)
PENICILLIN–G LIQ. 250MG 200CC	PFIZERPEN (PFIZER)
PENICILLIN–V POT. TABS 125MG	COMPOCILLIN VK (ABBOTT–ROSS) V CILLIN–K (LILLY)
PENICILLIN–V POT. TABS 250MG	PFIZERPEN VK (PFIZER) QIDPEN K (MALLINCRODT) SK–PENICILLIN VK (SKF)
PENICILLIN–V POT. TABS 500MG	PFIZERPEN VK (PFIZER)
PENICILLIN–V POT. LIQ. 125MG 100CC	PFIZERPEN VK (PFIZER) QIDPEN VK (MALLINCRODT)
PENICILLIN–V POT. LIQ. 125MG 200CC	PFIZERPEN VK (PFIZER) QIDPEN VK (MALLINCRODT)
PENICILLIN–V POT. LIQ. 250MG 100CC	PFIZERPEN VK (PFIZER) QIDPEN VK (MALLINCRODT)
PENICILLIN–V POT. LIQ. 250MG 200CC	PFIZERPEN VK (PFIZER) SK–65 (SKF)
PROPOXYPHENE CAPS 65MG	SK–65 COMPOUND (SKF)
PROPOXYPHENE COMPD–65 CAPS	SK–SOXAZOLE (SKF)
SULFISOXAZOLE TABS	SULFISOXAZOLE (LEDERLE)
TETRACYCLINE CAPS/TABS 250MG	ROBITET (ROBINS) SK–TETRACYCLINE (SKF) TETRACYN (ROERIG) TETRACYCLINE (WYETH)
TETRACYCLINE CAPS/TABS 500MG	ROBITET (ROBINS) SK–TETRACYCLINE (SKF) TETRACYN (ROERIG) TETRACYCLINE (WYETH)
TETRACYCLINE SUSP 125MG/5CC	PANMYCIN (UPJOHN) ROBITET (ROBINS) SK–TETRACYCLINE (SKF)

R.1975 d.339, eff. November 10, 1975.
See: 7 N.J.R. 316(a), 7 N.J.R. 567(c).