

CHAPTER 61

INDEPENDENT LABORATORY SERVICES

Authority

N.J.S.A. 30:4D-6(a)3, 7, 7a, b and c, 12; 42 CFR 440.30.

Source and Effective Date

R.1991 d.138, effective February 15, 1991.
See: 22 N.J.R. 3713(a), 23 N.J.R. 858(e).

Executive Order No. 66(1978) Expiration Date

Chapter 61, Independent Laboratory Services Manual, expires on February 15, 1996.

Chapter Historical Note

The provisions of Chapter 61, Independent Laboratory Services, were filed as R.1971 d.57, effective April 21, 1971. See: 3 N.J.R. 43(a), 3 N.J.R. 83(b). Pursuant to Executive Order No. 66(1978), Chapter 61 was readopted as R.1991 d.138. See: Source and Effective Date.

See subchapter and section annotations for specific rulemaking activity.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. GENERAL PROVISIONS

- 10:61-1.1 Introduction
- 10:61-1.2 Definitions and qualifications
- 10:61-1.3 Limitations on laboratory services
- 10:61-1.4 Scope of services
- 10:61-1.5 Basis of laboratory payment
- 10:61-1.6 Laboratory rebates
- 10:61-1.7 Out-of-State laboratories
- 10:61-1.8 Right of inspection

SUBCHAPTER 2. BILLING PROCEDURES

- 10:61-2.1 General billing procedures
- 10:61-2.2 Timeliness of claim submission and claim inquiry
- 10:61-2.3 Combination Medicare/Medicaid claims
- 10:61-2.4 Health Insurance Claim Form
- 10:61-2.5 Report of services
- 10:61-2.6 Automated Data Exchange

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

- 10:61-3.1 Introduction
- 10:61-3.2 HCPCS code numbers and maximum fee schedules; pathology/laboratory (CPT-4)
- 10:61-3.3 HCPCS code numbers, procedure description and maximum fee schedule; pathology/laboratory (codes and narratives not found in CPT-4)
- 10:61-3.4 Pathology and Laboratory HCPCS Codes—Qualifiers
- 10:61-3.5 Pathology and Laboratory HCPCS Codes—Modifiers

SUBCHAPTER 1. GENERAL PROVISIONS

Authority

Unless otherwise expressly noted, all provisions of this revised subchapter were adopted pursuant to authority of N.J.S.A. 30:4D-1 et seq. and were filed and became effective August 1, 1975, as R.1975 d.224. See: 7 N.J.R. 317(a), 7 N.J.R. 420(a).

10:61-1.1 Introduction

The conditions for coverage of services of independent laboratories and related policies set forth herein, which reflect the regulations of the Department of Health and Human Services, state the specific requirements that must be met by an independent laboratory in order for its services to qualify for reimbursement under the New Jersey Health Services Program (Medicaid). The services of a qualified independent laboratory for which reimbursement may be made relate only to diagnostic tests performed in a laboratory which is independent of a physician's office, a participating hospital, or other facility. Diagnostic laboratory tests, for purposes of this section, do not include diagnostic X-ray tests.

10:61-1.2 Definitions and qualifications

(a) Independent laboratory services means professional and technical laboratory services ordered by a physician or other licensed practitioner within the scope of his practice as defined by the laws of the state in which he practices.

(b) To qualify for participation as an independent laboratory under the New Jersey Health Services Program, the following requirements must be met:

1. Licensure and/or approval by the New Jersey State Department of Health and the State Board of Medical Examiners. This includes meeting certificate of need and licensure requirements, when required, and all applicable laboratory provisions of the New Jersey State Sanitary Code;
2. Certification as an independent laboratory under the Title XVIII Medicare program;
3. Make a charge to all patients for services provided, except as provided by legislation. The charge made to Medicaid patients must not be more than that made to any other patient; and
4. Approval for participation as an independent laboratory provider by the New Jersey Health Services Program.

(c) Medicare-Medicaid relationship rules are:

1. Upon approval as an independent laboratory provider for Title XIX Medicaid participation and reimbursement, the requirements for independent laboratory services under the Title XVIII Medicare program are to be followed.

2. A laboratory approved for Medicaid participation shall only provide services and be reimbursed for the specialties and subspecialties specifically approved for Medicare participation.

(d) State, county and municipal laboratories located in New Jersey may qualify for Medicaid reimbursement provided they meet the criteria specified in (a), (b) and (c) above.

(e) The laboratory a physician maintains for performing diagnostic tests in connection with his own practice is exempt from these regulations, but if the physician runs a laboratory which performs diagnostic work referred by other physicians, such a laboratory would then be subject to these regulations. Services furnished by out-of-hospital laboratories under the direction of a physician, such as a pathologist, are considered to be subject to the conditions where the physician holds himself and the facilities of his office out to other physicians as being available primarily for the performance of diagnostic tests. Diagnostic tests furnished by out-of-hospital physicians, whose primary practice is directly attending patients and/or consultation, even though conducted partly through diagnostic procedures, are considered physician's services rather than independent clinical laboratory services. As such the office in which these services are provided is exempt from the conditions.

(f) A service laboratory is a laboratory meeting the requirements stipulated in (b) above which performs specific tests on the laboratory's own premises.

(g) A reference laboratory is a laboratory meeting the requirements stipulated in (b) above which performs specific tests at the request of another approved certified laboratory.

Amended by R.1985 d.237, effective May 20, 1985.

See: 16 N.J.R. 3162(a), 17 N.J.R. 1318(a).

(b)3 added; old 3 renumbered to 4.

(d): Text deleted and new text substituted.

10:61-1.3 Limitations on laboratory services

(a) Tests performed by a nonapproved laboratory are not reimbursable and it is the billing laboratory's responsibility to verify approved status.

(b) Additional payment will not be made to a laboratory for obtaining specimens, except in long-term care facilities and home visits.

(c) A laboratory shall perform only those tests that are within the categories stated in its Medicare certification and by the New Jersey State Department of Health, when required, or its counterpart in the case of out-of-State laboratories.

(d) Laboratory services provided primarily for the diagnosis or treatment of infertility are not covered by the New Jersey Medicaid program.

1. For those HCPCS procedure codes which are determined to be primarily for the diagnosis of infertility, refer to the HCPCS subchapter of this chapter and the Indicator "F".

Amended by R.1994 d.600, effective December 5, 1994.

See: 26 N.J.R. 3345(a), 26 N.J.R. 4762(a).

10:61-1.4 Scope of services

(a) Each laboratory shall provide the New Jersey Health Services Program with a listing of tests and profiles actually performed on its premises (address to be identified) and a current price list, including discounts, with an update of said list as capabilities change.

(b) All requests for laboratory services shall require a definitive order personally signed by the attending physician requesting services. This written order must contain the specific test requested, and shall be on file with the billing laboratory and available for review by Medicaid representatives along with the results of the tests billed.

(c) All files of service and reference laboratories shall be maintained for a period of five years.

As amended, R.1981 d.110, eff. May 7, 1981.

See: 13 N.J.R. 95(b), 13 N.J.R. 299(c).

(c): "Five" years was "seven".

As amended, R.1981 d.342, eff. September 10, 1981.

See: 13 N.J.R. 430(d), 13 N.J.R. 579(c).

(b): "This written order ... requested" added.

10:61-1.5 Basis of laboratory payment

(a) Reimbursement shall be on the basis of the lowest professional charge, not to exceed an allowance determined reasonable by the Commissioner of Human Services, and further limited by Federal policy relative to payment of practitioners and other individual providers. In no event shall the charge to Medicaid from a laboratory exceed the lowest charge to other providers for the specific service.

(b) Where tests are referred to an approved laboratory by another approved laboratory, the actual charges by the reference laboratory must be indicated on the claim form. Reimbursement will be limited to the actual charge of the reference laboratory which shall not exceed the lowest professional charge of the reference laboratory.

(c) The sum of any number of the components of a cluster of tests may not exceed the total charged for the group offering (profile), whether done by automation or bench testing, whether or not the equipment is available in the facility. Where clusters constitute a profile, they must be billed in that manner. A cluster of tests is considered those components of a test or series of tests which, when combined, mathematically or otherwise, comprise a finished identifiable laboratory study or studies. Examples are:

1. The components of an SMA 12/60 or other automated laboratory study;
2. Inclusive of an MCH, MCV, and so forth, as a component of a C.B.C.;
3. Inclusive of all ova and parasites in a stool examination.

As amended, R.1976 d.67, eff. March 3, 1986.
See: 7 N.J.R. 465(a), 8 N.J.R. 195(d).

10:61-1.6 Laboratory rebates

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

10:61-1.7 Out-of-State laboratories

Out-of-State laboratories must meet all applicable standards of the state in which located, including state licensure, if applicable, and certification under the Title XVIII Medicare and Title XIX Medicaid programs.

10:61-1.8 Right of inspection

The New Jersey Health Services Program shall have the right to require and to inspect all records, files and documents of in-State and Out-of-State service and reference laboratories which provide laboratory tests and services for reimbursement for eligible New Jersey Medicaid recipients.

SUBCHAPTER 2. BILLING PROCEDURES

10:61-2.1 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) The subchapter contains basic information for the proper completion and submission of a claim.

Amended by R.1986 d.219, effective June 16, 1986.
See: 18 N.J.R. 540(a), 18 N.J.R. 1293(a).
Old text deleted and new text substituted.
New Rule, R.1987 d.408, effective October 5, 1987.
See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).
Repealed rule was General policy.

10:61-2.2 Timeliness of claim submission and claim inquiry

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

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 "on the first day of each month" and substituted "monthly. Individuals under . . . quarterly validation cards."

New Rule, R.1987 d.408, effective October 5, 1987.

See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).

Repealed rule was Patient identification.

10:61-2.3 Combination Medicare/Medicaid claims

There will be many patients who also have Medicare Supplementary Medical Insurance benefits (Part B). In such cases the Health Insurance Claim Form (HCFA-1500) should be submitted to Medicare with the patient's Health Services program Case/Person Number noted in item 8.

As amended by 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 HCFA-1490 claim form.

10:61-2.4 Health Insurance Claim Form

(a) The Health Insurance Claim Form (1500 N.J.) is to be used for billing for covered independent laboratory services.

(b) Mail the original form to:

The Prudential Insurance Company of America
P.O. Box 1900
Millville, New Jersey 08332

Amended by R.1988 d.145, effective April 4, 1988.

See: 19 N.J.R. 1779(a), 20 N.J.R. 807(c).

Substituted "Health Insurance" for "Independent Laboratory".

10:61-2.5 Report of services

(a) Rules on report of services are:

1. Enter date(s) of each procedure;
2. Enter procedure code and/or narrative;
3. Independent laboratories must identify procedures by use of codes which are described in the manual appendix furnished to those eligible to provide such services;
4. Enter charge for each procedure.

(b) The sum of any number of the components of a cluster of tests may not exceed the total charged for the group offering (profile), whether done by automation or bench testing, whether or not the equipment is available in the facility. Where clusters constitute a profile, they must be billed in that manner. A cluster of tests is considered those components of a test or series of tests which when

combined, mathematically or otherwise, comprise a finished identifiable laboratory study or studies. Examples:

1. The components of an SMA 12/60 or other automated laboratory study;
2. Inclusive of an MCH, MCV and so forth, as a component of a C.B.C.;
3. Inclusive of all ova and parasites in a stool examination.

(c) Where tests are referred to an approved laboratory by another laboratory, the actual charges by the reference laboratory must be indicated on the MC-13AC2.

(d) In the case where the reference laboratory performs billing, it should do so by submitting bills directly to the Prudential Insurance Company.

(e) When the service laboratory elects to bill for procedures done by the reference laboratory, a note indicating "Performed by reference lab" (name of laboratory) must accompany the identifying tests or procedures in item 24D of the claim form 1500 N.J.

R.1976 d.67, effective March 3, 1976.

See: 7 N.J.R. 465(a), 8 N.J.R. 195(d).

Amended by R.1986 d.219, effective June 16, 1986.

See: 18 N.J.R. 540(a), 18 N.J.R. 1293(a).

Form changed from MC-13A-C1 to MC-13AC2.

Amended by R.1988 d.145, effective April 4, 1988.

See: 19 N.J.R. 1779(a), 20 N.J.R. 807(c).

Changed "11c" to "24D" and changed claim form "MC-13AC2" to "1500 N.J."

10:61-2.6 Automated Data Exchange

(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
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).

Historical Note

All provisions of this subchapter "Laboratory Code Lists" became effective April 21, 1971 as R.1971 d.57. See: 3 N.J.R. 43(a), 3 N.J.R. 83(b). The subchapter was repealed and this new subchapter was adopted effective March 3, 1986 as R.1986 d.52. See: 17 N.J.R. 1519(b), 18 N.J.R. 478(a).

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 for Cytopathology fees increased from 88150-\$3.00 to \$4.50 effective August 1, 1988 and \$6.00 effective May 1, 1989 and 88155-\$4.00 to \$4.50 effective August 1, 1988 and \$6.00 effective May 1, 1988. See: 20 N.J.R. 2101(a).

As amended by R.1989 d.135, effective March 20, 1989.

See: 20 N.J.R. 2558(a), 21 N.J.R. 760(a).

Code 88151 added.

Amended by R.1992 d.327, effective August 17, 1992 (operative September 1, 1992).

See: 24 N.J.R. 917(a), 24 N.J.R. 2898(a).

Text of HCPCS for Laboratories reproduced in the New Jersey Administrative Code.

10:61-3.1 Introduction

(a) The New Jersey Medicaid Program utilizes the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology—4th Edition (CPT-4) architecture, employing a five-position code and as many as two 2-position modifiers. Unlike the CPT-4 numeric design, the HCFA assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three-level coding system.

1. Level I Codes (narratives found in CPT-4): These codes are adapted from CPT-4 for utilization primarily by Physicians, Podiatrists, Optometrists, Certified Nurse-Midwives, Independent Clinics and Independent Laboratories. CPT-4 is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians. Copy-right restrictions make it impossible to print excerpts from CPT-4 procedure narratives for Level I codes. Thus, in order to determine those narratives it is necessary to refer to CPT-4, which is incorporated herein by reference, as amended and supplemented.

2. Level II Codes (narratives found at N.J.A.C. 10:61-3.3): These codes are assigned by HCFA for physicians and non-physician services which are not in CPT-4.

3. Level III Codes (narratives found at N.J.A.C. 10:61-3.3): These codes are assigned by the Division to be used for those services not identified by CPT-4 codes or HCFA-assigned codes. Level III codes identify services unique to New Jersey.

(b) The responsibility of the provider when rendering specific services and requesting reimbursement is listed in both subchapter 1 and subchapter 2 of the Independent Laboratory Services Manual, N.J.A.C. 10:61.

(c) Regarding specific elements of HCPCS codes which require attention of provider, the lists of HCPCS code numbers for Pathology and Laboratory are arranged in tabular form with specific information for a code given under columns with titles such as: "IND", "HCPCS CODE", "MOD", "DESCRIPTION", and "MAXIMUM FEE ALLOWANCE". The information given under each column is summarized below:

Column Title	Description
IND	(Indicator-Qualifier) Lists alphabetic symbols used to refer provider to information concerning the New Jersey Medicaid Program's qualifications and requirements when a procedure or services code is used. Explanation of indicators and qualifiers used in this column are given below: "A" preceding any procedure code indicates that these tests can be and are frequently done as groups and combinations (profiles) on automated equipment. "F" preceding any procedure code indicates that the code primarily for the diagnosis and treatment of infertility, and therefore, is not covered by the New Jersey Medicaid program, in accordance with N.J.C.A. 10:61-1.3(d). "L" preceding any procedure code indicates that the complete narrative for the code is located in the Appendix A of this Pathology and Laboratory section. "M" preceding any procedure code indicates that this service is a medical necessity procedure. Refer to Appendix D of this Pathology and Laboratory section. "N" preceding any procedure code indicates that qualifiers are applicable to that code. These qualifiers are listed by procedure code number in Appendix B of this Pathology and Laboratory section.
HCPCS CODE	Lists the HCPCS procedure code numbers.
MOD	Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified

Column Title	Description
DESCRIPTION	by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid Program's recognized modifier codes are listed at N.J.A.C. 10:61-3.5. Lists the code narrative. (Narratives for Level I codes are found in CPT-4. Narratives for Level II and Level III codes are found at N.J.A.C. 10:61-3.3).
MAXIMUM FEE ALLOWANCE	Lists New Jersey Medicaid Program's maximum reimbursement schedule for Pathology and Laboratory services. If the symbols "B.R." (By Report) are listed instead of a dollar amount, it means that additional information will be required in order to properly evaluate the service. Attach a copy of the report to the MC-13AC2 claim form.

1. The fee listed under "Office Total Fee(s)" represents the combined technical and professional component of the reimbursement for the procedure code notwithstanding any statement to the contrary in the narrative. It will be paid only to one provider and will not be broken down into its component parts.

2. The fee schedule for all diagnostic Medical, Radiology and Pathology services performed in a hospital setting is indicated in the "Prof. Comp." and represents the professional component for those hospital based physicians whose contract is based on fee-for-service.

(d) Regarding alphabetic and numeric symbols under "IND" and "MOD", 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 physician 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.

1. These symbols and/or letters must not be ignored because in certain instances requirements are created in addition to the narrative which accompanies the CPT/HCPCS code as written in CPT-4. The provider will then be liable for the additional requirements and not just the CPT/HCPCS code narrative. These requirements must be fulfilled in order to receive reimbursement.

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

Amended by R.1994 d.600, effective December 5, 1994.
See: 26 N.J.R. 3345(a), 26 N.J.R. 4762(a).

10:61-3.2 HCPCS code numbers and maximum fee schedules; pathology/laboratory (CPT-4)

Ind	HCPCS Code	Mod	Maximum Fee Allowance	
			Office Total Fee	Prof. Comp.
>N	80002		\$ 5.00	
>N	80003		6.20	
>N	80004		6.20	
>N	80005		6.20	
>N	80006		6.20	
N	80007		7.50	
N	80008		7.50	
N	80009		7.50	
N	80010		7.50	
N	80011		7.50	

Ind	HCPCS Code	Mod	Maximum Fee Allowance			Ind	HCPCS Code	Mod	Maximum Fee Allowance		
			Office Total Fee	\$	Prof. Comp.				Office Total Fee	\$	Prof. Comp.
N	80012		7.50				82436		3.00		
N	80016		7.50			>N	82437		2.60		
N	80018		11.00				82438		3.00		
N	80019		11.00			A	82465		3.00		
	80031		4.50				82470		7.00		
	80032		4.50				82480		4.50		
	80033		4.50			>	82486		4.40		
	80052		3.00				82525		9.00		
N	80055		15.00				82526		9.00		
N	80055	22	19.00				82533		17.00		
N	80055	52	10.00				82534		17.00		
>N	80059		30.00				82540		3.00		
	80061		15.00				82545		3.00		
	80061	22	23.00				82546		3.00		
N	80070		12.00			A	82550		4.80		
N	80072		12.00			>	82552		7.80		
>	80090		28.80			>	82555		4.80		
N	81000		1.20			A	82565		3.00		
	81010		1.20				82570		3.00		
	81030		3.00				82575		4.50		
N	82011		3.90				82595		1.50		
	82024		30.00				82607		15.00		
	82030		34.00				82608		15.00		
>	82035		24.00			>	82626		37.00		
A	82040		1.80			>	82628		15.00		
	82055		4.50			>	82633		48.00		
	82060		4.50				82634		39.00		
	82065		4.50				82640		15.00		
	82070		4.50				82641		15.00		
	82087		40.00				82643		15.00		
	82088		40.00				82656		15.00		
	82089		40.00				82660		9.00		
	82112		12.60				82670		25.00		
	82137		15.00			>	82671		41.00		
	82138		15.00				82672		25.00		
	82140		6.00			>	82673		10.20		
	82141		6.00			>	82674		17.50		
	82143		4.20			>	82676		10.20		
	82145		12.00			>	82677		28.00		
	82150		4.50			>	82678		30.00		
	82155		4.50			>	82679		25.00		
	82156		2.40				82705		.60		
>	82157		29.00				82710		7.80		
>	82163		21.00				82715		7.80		
>N	82173		11.20				82728		16.00		
	82175		7.20				82730		5.70		
	82180		3.60				82746		16.00		
	82205		12.00				82785		16.00		
	82210		12.00				82791		6.00		
A	82250		3.00				82792		6.00		
A	82251		4.50				82793		6.00		
	82265		3.00				82800		5.20		
	82270		1.20				82801		3.30		
>	82273		3.70				82926		6.00		
	82290		3.00				82931		6.00		
	82291		3.00				82941		16.00		
	82308		34.00			>	82943		23.00		
A	82310		3.00			N	82946		13.00		
	82315		3.00			A	82947		3.00		
	82320		3.00				82949		.60		
	82335		.90				82954		1.50		
	82340		3.60				82955		6.00		
N	82365		9.00			A	82977		4.80		
N	82370		9.00				82985		6.60		
A	82374		3.30				82995		1.80		
	82375		6.00				82996		3.00		
	82380		6.00				82998		18.00		
	82382		12.00				83001		17.00		
	82383		12.00				83002		17.00		
	82384		18.00				83003		16.00		
	82390		6.00				83004		16.00		
A	82435		3.00			>	83008		27.00		

Ind	HCPCS Code	Mod	Maximum Fee Allowance		Ind	HCPCS Code	Mod	Maximum Fee Allowance		Prof. Comp.
			Office Total Fee	\$				Office Total Fee	\$	
	83010		12.00			83830		8.40		
	83011		12.00			83835		10.20		
	83012		12.00			83840		4.50		
	83015		10.20			83915		6.00		
	83020		6.00			83970		54.00		
	83036		6.60			83971		12.60		
	83040		3.00			84005		3.00		
	83050		3.00			84030		6.00		
N	83051		1.20			84031		6.00		
>	83052		1.80		>	84045		19.00		
>N	83053		1.80		A	84060		3.60		
	83060		3.00			84065		3.60		
	83093		3.00		A	84075		3.60		
	83094		3.00			84078		3.60		
	83095		3.00			84080		3.60		
	83150		12.00			84090		3.00		
	83491		12.60		A	84100		3.00		
	83493		12.60			84105		3.00		
	83494		12.60			84106		1.80		
	83495		12.60			84110		7.50		
	83496		12.60			84118		3.00		
	83497		6.00			84119		3.00		
>	83498		30.50			84120		7.50		
>	83499		30.50			84121		7.50		
	83523		15.00		A	84132		3.90		
	83525		12.00			84133		3.90		
N	83526		10.00			84135		12.00		
	83530		6.00			84136		12.00		
A	83540		4.50			84138		12.00		
	83545		4.50			84139		12.00		
A	83550		7.20			84142		15.00		
	83555		7.20			84144		20.00		
	83570		6.00			84146		20.00		
	83571		6.00		A	84155		1.80		
	83578		12.60			84160		1.80		
	83582		6.00			84165		6.00		
	83583		12.00		A	84170		6.00		
	83586		7.50			84180		2.40		
	83587		15.00			84185		.60		
	83589		7.50			84190		7.50		
>	83590		9.40			84200		7.50		
	83593		6.00		>	84202		10.40		
>	83597		9.40			84203		3.00		
	83610		4.20			84205		15.00		
A	83615		4.20			84230		15.00		
	83620		4.20			84233		16.00		
	83625		9.00			84234		20.00		
	83626		9.00			84244		25.00		
	83629		4.20			84246		25.00		
	83631		4.20		A	84295		3.90		
	83632		16.00			84300		3.90		
	83645		3.00		M	84317		.60		
	83650		3.00			84403		32.00		
	83655		9.00		>	84405		30.00		
	83660		9.00		>	84408		15.00		
	83661		10.50			84420		15.00		
	83670		2.10			84430		3.60		
	83675		2.10			84435		6.00		
	83680		2.10			84436		6.00		
	83690		4.50			84437		6.00		
A	83700		3.00		>	84439		10.00		
	83715		7.50			84442		12.00		
	83718		8.00			84443		25.00		
	83720		10.00		A	84450		3.00		
	83725		9.00			84455		3.00		
	83727		17.00		A	84460		3.00		
	83735		4.50			84465		3.00		
	83740		4.50		A	84478		8.30		
	83755		4.50			84479		6.00		
	83760		4.50			84480		15.00		
	83795		.90			84481		15.00		
	83825		8.40			84485		3.30		

Ind	HCPCS Code	Mod	Maximum Fee Allowance			Ind	HCPCS Code	Mod	Maximum Fee Allowance		
			Office Total Fee	\$	Prof. Comp.				Office Total Fee	\$	Prof. Comp.
	84488		3.30				85700		9.00		
	84490		3.30				85730		3.00		
A	84520		3.00				85732		3.00		
	84525		3.00				86000		.90		
	84540		3.00				86002		1.80		
	84545		6.00				86004		1.80		
A	84550		3.00				86006		2.70		
	84555		3.00				86008		6.00		
	84560		3.00				86009		3.00		
	84577		6.00				86017		4.20		
	84580		2.10				86024		3.00		
	84583		2.10				86028		3.00		
	84585		12.00				86031		3.00		
	84590		6.00				86032		3.00		
	84605		3.60				86033		3.00		
	84610		3.60				86038		7.80		
	84695		12.60				86060		3.60		
>	84701		15.00				86063		1.20		
	84800		25.00				86064		7.80		
	84810		12.60				86067		7.80		
	85000		1.20				86068		4.50		
	85002		1.20			>	86077		25.00		25.00
	85005		3.00			>	86078		17.00		17.00
N	85007		2.40			>	86079		17.00		17.00
N	85009		1.20				86080		1.80		
	85012		1.80				86082		1.80		
N	85014		1.50				86090		1.80		
N	85018		1.20				86095		1.80		
	85021		1.80				86100		1.80		
>	85022		3.00				86105		1.80		
>	85027		4.80				86115		1.80		
>	85028		4.80				86120		3.00		
>N	85028	22	8.40				86140		3.00		
N	85031		3.00			N	86151		22.40		
N	85041		1.20				86162		15.60		
	85044		1.80				86163		7.80		
N	85048		1.20				86164		9.00		
>	85060		8.00		8.00		86171		4.50		
>	85095		24.00		24.00		86225		13.00		
>	85097		24.00		24.00		86244		10.20		
>	85100		53.00		48.00		86255		7.80		
>	85101		29.00		24.00		86256		9.00		
>	85102		24.00		24.00		86277		16.00		
>	85103		29.00		24.00		86280		5.40		
>	85105		24.00		24.00		86281		3.00		
	85150		1.80			>	86285		7.50		
	85170		.60				86286		10.00		
	85171		.60				86287		10.00		
	85210		3.00			>	86288		12.00		
	85345		1.80			>	86289		15.00		
	85347		3.00			>	86291		15.00		
	85348		1.20			>	86293		12.00		
	85362		3.00			>	86295		12.00		
	85363		3.00			>	86296		10.00		
	85364		8.40			>	86298		12.00		
	85376		5.70			>	86299		12.00		
	85377		5.70				86300		3.00		
	85544		6.00				86305		4.50		
	85555		4.80				86310		4.50		
	85557		4.80			>	86312		14.84		
>	85560		3.00			>	86314		32.33		
	85575		1.80				86320		10.50		
	85577		1.80				86329		16.80		
	85580		1.80				86335		6.00		
	85590		1.80				86337		12.00		
	85595		1.80				86376		6.60		
	85610		3.00				86377		6.60		
	85614		3.00			>N	86421		20.00		
	85615		4.50			>N	86422		4.00		
	85650		1.50				86423		16.00		
	85651		1.50				86430		1.80		
	85660		1.80				86490		4.00		

Ind	HCPCS Code	Mod	Maximum Fee Allowance		Ind	HCPCS Code	Mod	Maximum Fee Allowance	
			Office Total Fee	\$ Prof. Comp.				Office Total Fee	\$ Prof. Comp.
	86510		4.00		>	88161		12.00	7.00
	86540		4.00		>	88162	BR		BR
>	86580		4.00		>	88170		30.00	30.00
	86585		4.00		>	88171		61.00	61.00
A	86592		1.50		>	88172		8.00	8.00
	86593		3.00		>	88173		25.00	25.00
	86594		6.00		>N	88260		120.00	86.00
	86595		6.00		>N	88261		120.00	86.00
	86600		7.80		>N	88262		120.00	86.00
	86650		12.00		>N	88265		85.00	41.00
	86660		12.00		>N	88267		172.00	123.00
	86662		12.00		>N	88268		172.00	60.00
>	86800		13.00		>N	88270		172.00	60.00
	86812		12.60		>	88300		9.35	7.00
	86813		12.60		>	88302		21.00	15.00
	87001		9.00		>	88304		26.00	19.00
	87015		5.10		>	88305		40.00	30.00
N	87040		9.00		>	88307		59.00	44.00
N	87045		9.00		>	88309		89.00	66.00
N	87060		9.00		>	88311		4.00	4.00
N	87070		9.00		>	88312		13.00	8.00
>	87072		6.00		>	88313		10.00	5.00
>	87075		9.00		>	88314		12.00	7.00
	87076		6.00		>	88318		7.00	7.00
>	87081		10.00		>	88319		7.00	7.00
>	87082		4.00		>	88321		28.00	28.00
>	87083		4.00		>	88323		33.00	33.00
	87084		3.00		>	88325		44.00	44.00
>	87085		4.00		>	88329		33.00	33.00
	87086		3.00		>	88331		48.00	41.00
	87087		2.70		>	88332		15.00	15.00
	87088		2.70		>	88342		9.00	7.00
	87101		8.00		>	88346		8.00	8.00
	87102		8.00		>N	88348	BR		BR
	87106		8.00			89050		.90	
>	87109		14.00			89051		.90	
	87116		6.00			89105		6.00	
	87117		9.00			89125		.60	
	87140		3.00			89132		6.00	
	87143		3.00			89135		6.00	
	87145		3.00			89136		6.00	
	87147		3.00			89141		6.00	
	87151		3.00			89160		2.10	
	87155		3.00			89205		1.20	
	87158		3.00			89300		2.40	
	87164		6.00			89310		4.80	
	87166		6.00			89320		3.00	
	87177		5.10			89329	F	31.00	
N	87184		9.00			89330	F	8.00	
	87188		6.00			89355	M	.60	
	87190		.60			89360	N	9.00	
	87205		4.20			L N	P7001	6.00	
	87206		4.20			>L	W8010	43.75	
	87207		3.00			L N	W8200	2.00	
	87208		5.10			L N	W8205	9.00	
	87210		2.40			L N	W8210	12.00	
	87211		5.10			L A	W8215	4.00	
	87220		2.40			L	W8225	18.00	
>	87250		32.00			L	W8615	7.80	
>	88104		12.00	7.00		L	W8620	7.80	
>	88106		12.00	7.00		L	W8621	12.60	
>	88107		12.00	7.00	>L	W8622	25.00		
>	88108		12.00	7.00		L	W8700	3.00	
>	88125		7.00	7.00		L	W8710	3.00	
>	88130		9.65	7.00		>L	W8720	15.00	
>	88140		4.20	3.00		>L	W8725	30.00	
>	88150		6.00	6.00		L	W8900	10.00	
N	88151		6.00	6.00		L	W8920	1.80	
>	88155		6.00	7.00		L	W8925	.60	
>	88160		7.00	7.00					

Amended by R.1994 d.600, effective December 5, 1994.
See: 26 N.J.R. 3345(a), 26 N.J.R. 4762(a).

10:61-3.3 HCPCS code numbers, procedure description and maximum fee schedule; pathology/laboratory (codes and narratives not found in CPT-4)

Ind	HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance
N	P7001		CULTURE, BACTERIAL, URINE; QUANTITATIVE, SENSITIVITY STUDY	6.00
>	W8010		HEPATITIS B PROFILE; HEPATITIS B SURFACE ANTIGEN; HEPATITIS B SURFACE ANTIBODY; HEPATITIS B ANTIGEN AND ANTIBODY; HEPATITIS B CORE ANTIBODY	43.75
N	W8200		GLUCOSE, SERUM (SEPARATE TUBE, GREY TOP) NOTE: SUBMITTED ON SAME CLAIM, AND PERFORMED ON SAME DATE AS CHEMISTRY PROFILES	2.00
N	W8205		3 HR. GLUCOSE TOLERANCE TEST, PER 4 SPECIMENS	9.00
N	W8210		5 HR. GLUCOSE TOLERANCE TEST, PER 6 SPECIMENS	12.00
A	W8215		T4 (THYROXINE) BY IMMUNOASSAY (ENZYME IMMUNOASSAY) (EMIT)	4.00
	W8225		THYROXINE—BINDING GLOBULIN WITH T4 (THYROBINDING—GLOBULIN WITH T4) (RIA) (TBG AND T4)	18.00
	W8615		ANTI-DNA, ANTI-DEOXYRIBONUCLEIC ACID, (CHEMICAL METHOD, NON-RIA)	7.80
	W8620		HERPES SIMPLEX ANTIBODIES: (HERPES SIMPLEX VIRUS, I OR II)	7.80
	W8621		HERPES SIMPLEX VIRUS, I AND II	12.60
>	W8622		HERPES SIMPLEX VIRUS ISOLATION AND IDENTIFICATION, TOTAL STUDY	25.00
	W8700		YEAST SCREEN (NOT DEFINITIVE) FROM URINE, VAGINAL OR THROAT CULTURES ONLY (E.G., GERM TUBE)	3.00
	W8710		TRICHOMONAS PREPARATION—SMEAR OR HANGING DROP (SMEAR NOT ELIGIBLE FOR SEPARATE REIMBURSEMENT IF PAP SMEAR DONE ON THE SAME DAY)	3.00
>	W8720		CHLAMYDIA DIRECT SPECIMEN TEST; MICROTRACK; CHLAMYDIAZIME; CHLAMYDIA A.G. DIRECT; CHLAMYDIA TITER; CHLAMYDIA CF; CHLAMYDIA ASSAYS BY IFA AND CIS; CHLAMYDIA ISOLATION; FLUORESCENT ANTIBODY FA	15.00
>	W8725		CHLAMYDIA CULTURE	30.00
	W8900		HOUSE CALL TO HOME BOUND PATIENT IN HOME OR SHELTERED BOARDING HOME FOR PURPOSE OF OBTAINING BLOOD BY VENOUS OR ARTERIAL PUNCTURE REIMBURSEMENT LIMITED TO ONCE PER TRIP REGARDLESS OF NUMBER OF PATIENTS VISIT TO OBTAIN BLOOD SPECIMENS BY VENOUS OR ARTERIAL PUNCTURE "FIRST PERSON IN NURSING HOME"	10.00
	W8920		EACH ADDITIONAL PERSON IN NURSING HOME	1.80
	W8925			.60

10:61-3.4 Pathology and Laboratory HCPCS Codes—Qualifiers

(a) Qualifiers for pathology and laboratory services are summarized below:

1. Chemistry Automated, Multichannel Tests: Applies to CPT Codes: 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018 and 80019. The following list contains those tests which can be and are frequently performed as groups and combinations (profiles) on automated multichannel equipment: Apply this methodology to the above CPT Codes. For reporting one test, regardless of method of testing, use appropriate single test code number. For any combination of tests among those listed below use the appropriate number 80002-80019. Groups of the tests listed here are distinguished from multiple tests performed individually for immediate or "stat" reporting (for handling of specimen, see 99000 and 99001).

Albumin

Alkaline Phosphatase

Bilirubin, Total

Bilirubin, Direct

Blood Urea Nitrogen (BUN)

Calcium

Carbon Dioxide (CO₂)

Chlorides (Cl)

Cholesterol

Creatinine

Gamma Glutamyl Transpeptidase (GGTP)

Glucose (Sugar)

Iron

Lactic Dehydrogenase (LDH)

Phosphorus

Potassium (K)

Protein, Total

Sodium (NA)

Total Lipids

Transaminase, Glutamic Oxalacetic (SGOT)

Transaminase, Glutamic Pyruvic (SGPT)

Triglycerides

T4 by Immune Assay (EMIT)

Uric Acid

i. If any two of the following HCPCS procedure codes are performed on the same day by automated equipment and the total reimbursement of the two chemistry tests would have exceeded \$5.00: the maximum reimbursement will not be more than \$5.00; 82251, 82374, 82801, 83540, 83545, 83610, 83615, 83620, 83629, 83631, 84075, 84078, 84080, 84132, 84133, 84295, 84300, 84478, 82977, W8215.

ii. The following calculations and ratios are not eligible for separate or additional reimbursement, and, therefore, should not be included in determining the calculations allotted to the above Procedure Codes.

A/G Ratio	Globulin
BUN/Creatinine Ratio	FTI (T7)
Free Calcium	Free Thyroxine

iii. Any additional automated multichannel chemistry tests (other than those listed) performed on same date as Codes 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018 and 80019 will be reimbursed at the current allowable fee for each added test.

iv. Code (W8200)—Glucose (separate tube, gray top) performed on the same date as the following chemistry profiles 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018 and 80019 will be paid an additional \$2.00.

2. Code 80072—Arthritis Panel should include as a minimum four of the following tests:

ASO Titer	
C-Reactive Protein (CRP)	Uric Acid
RA Latex	Alkaline Phosphatase
(Rheumatoid Arthritis factor)	Calcium

3. Code 80070—Thyroid Panel—T4 by RIA, plus T3 uptake, resin (T3RU) (RT3U).

i. The following calculations will be included in the fee for the Thyroid Panel:

“T7” Free Thyroxine
 Index (FTI), Calculated Free Thyroxine
 Index (CFT4) or Calculated Thyroxine
 Iodine (T4I)

ii. T3 by uptake, resin (T3RU) is eligible for reimbursement only when done in conjunction with T4 by RIA as part of Thyroid profile.

4. Code 80055-52—Obstetric profile.

i. At least four of the following tests must be included in the profile:

Blood Group (ABO)
 RH Factor

Antibody screen (Atypical Antibody Identification)

Complete Blood Count (CBC) (with or without differential)

Serology (STS, VDRL, RPR)

5. Code 80055—Obstetric profile with Rubella HI Antibody Titer.

6. Code 80055-22—Expanded Obstetric profile.

i. For reimbursement purposes the following must be included:

Blood Group (ABO)
 RH Factor
 Antibody screen (Atypical Antibody Identification)
 Complete Blood Count (CBC) (with or without differential)

Serology (STS, VDRL, RPR)

Cytology (Pap smear)

Urinalysis

Urea Nitrogen (BUN)

Glucose

Sickle Cell with Rubella II Antibody Titer

7. Code 81000—Urinalysis.

i. Stick, dip or tablet tests done on urine are considered part of the urinalysis, and therefore, are not eligible for separate reimbursement. Microscopy is required for reimbursement.

8. Code 86151—(CEA-RIA) Carcinoembryonic Antigen.

i. “CEA is not useful to diagnose cancer. Claims are eligible for reimbursement only when CEA is used to follow treated cases of cancer (for example, gastrointestinal, breast, lung) primary detection of recurrence, or for estimate of prognosis in certain cases.” (Documentation required)

9. Code 88155—pap smear.

i. Obtaining a specimen is not a separate eligible service.

10. Cultures, Codes 87040, 87045, 87060, 87070, 87184, P7001.

i. These codes may only be billed when a pathogenic microorganism is reported. A culture that indicates no growth or normal flora must be billed as a presumptive culture.

11. Code 82173 and 82946—Glucagon Tolerance Test.

i. Total payment is not to exceed \$65.00.

12. Code 83526—Insulin Tolerance Test.

- i. Total payment is not to exceed \$70.00 (RIA).
13. Code 85031—Complete Blood Count—CBC.
- i. Components of a CBC—the maximum fee for any of the following combinations of components is \$3.00. (83051, 83053, 85007, 85009, 85014, 85018, 85041, 85048).
- ii. For reimbursement purposes, CBC testing is all-inclusive and covers tests performed either by automation or manually.
14. Code 82365 and 82370—Calculus (stone), Quantitative: (Infra-red spectroscopy) X-ray diffraction.
- i. Reimbursement for this code is not eligible for chemical methods.
15. Code 82437 and 89360—Sweat (without iontophoresis) Test.
- i. Reimbursement for this code is not eligible for qualitative tests.
16. Code 82011—Salicylates, quantitative only.
- i. Reimbursement for this code is not eligible for screening (Qualitative) tests for salicylates (82012).
17. Code W8205 and W8210—Glucose Tolerance.
- i. For reimbursement purposes includes all urines for sugar.
18. Code 88260, 88261 and 88262—Chromosome Analysis: Peripheral blood.
- i. Rule out numerical and structural abnormalities.
- ii. For Medicaid reimbursement purposes. The provider must include an average of 20 cells and two or three karyotypes analyzed, including banding.
19. Code 88265—Chromosome Analysis: Various leukemias, bone marrow and peripheral blood (includes Philadelphia Chromosome study).
- i. For reimbursement purposes. The provider must include a minimum of 10 cells and two karyotypes analyzed, including banding.
20. Code 88267—Chromosome Analysis: Amniotic Fluid Cells (Prenatal Chromosome Analysis).
- i. For reimbursement purposes. The provider must include 20 cells and two or three karyotypes analyzed, including banding.
21. Code 88268 and 88270—Chromosome Analysis: Tissue Biopsy, Abortuses, etc. (Documentation report required).
- i. For reimbursement purposes as a minimum, the provider must include 15-20 cells and two or three karyotypes analyzed, including banding.
22. Code 88280, 88285.
- i. Additional karyotyping and cells counted are not reimbursable for Medicaid payment.
23. Code 80059—Hepatitis Panel: For reimbursement purposes includes:
- i. Hepatitis Profile:
- Hepatitis B Surface Antigen (Australian)
- Hepatitis B Surface Antigen Antibody
- Hepatitis B Core Antibody
- Hepatitis A Antibody
24. Code 85028-22 (8630) Hemogram 22—Service Greater than Usual.
- i. The definition of a complete Hemogram is: supravital morphological study of the formed elements of the blood, hematocrit, reticulocyte count, platelet count, hemoglobin, total white count, supravital differential or phase, regular differential, total red count and indices, MCV, MCH, MCHC. A Hemogram will be reimbursed at \$8.40. Providers must indicate on the claim form what components are part of their Hemogram and use the Modifier 22.
25. Code 86421 (8525) Radioallergosorbent Test (Rast); up to five Antigens.
- i. For reimbursement purposes, payment for each individual Antigen is \$4.00 up to the first five Antigens. List number of Antigens in the appropriate box of the claim form.
26. Code 86422 (8526) Six or more Antigens.
- i. For reimbursement purposes, payment is per each additional Antigen.
27. Code 88348.
- i. Not reimbursable when used as a research tool.
- ii. For payment purposes, the Department will pay for the above diagnostic scanning procedure when it pertains to x-ray microanalysis for identification of asbestos particles and heavy metals, that is, gold, mercury, etc., and also when examining tissue specimens in occasional cases of malabsorption.

10:61-3.5 Pathology and Laboratory HCPS Codes— Modifiers

(a) Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid Program's recognized modifier codes are:

Modifier Code	Description
22	Unusual Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '22' to the usual procedure number.

Modifier Code	Description	Modifier Code	Description
52	Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician'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 ser-	90	vices without disturbing the identification of the basic service. Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding the modifier '90' to the usual procedure number.