



STATE OF NEW JERSEY
Department of Human Services
Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-209

November 1, 1977

TO: INDEPENDENT CLINICS

SUBJECT: REVISED INDEPENDENT OUTPATIENT HEALTH FACILITY CLAIM FORM (MC-14-C2),
EFFECTIVE NOVEMBER 1, 1977

Please refer to Newsletter Volume P-195 dated September 12, 1977 which announces a January 1, 1978 implementation date for the Medicaid Management Information System (MMIS). In order to incorporate federally required MMIS information, the MC-14 Claim Form has been redesigned.

Enclosed is a supply of the revised MC-14 Claim Form, which should be adequate for your current needs. For your convenience, and to expedite a reorder of claims, please use the attached reorder form.

In order that we may have operational data by the MMIS implementation date, the effective date for use of the revised claim form is November 1, 1977. If you receive your MC-14-C2 claim supply after November 1, begin using the new claim form immediately in accordance with the following instructions. Destroy all of your old claim forms.

The major changes to the form, (items 8, 11, 13C, 14, 15 and 16), are highlighted below, followed by billing instructions and a sample claim form.

HIGHLIGHTS OF REVISIONS TO MC-14 CLAIM FORM

Item 8: EPSDT Program Referral - Complete this item for recipients under age 21.

Early Periodic Screening, Diagnosis and Treatment (EPSDT), is an aspect of the Medicaid Program which ensures that recipients under 21 years of age receive early detection of disease and illness, as well as diagnostic and treatment services. If an EPSDT screening uncovers a health problem or defect, the patient may be referred to another practitioner for further diagnosis and/or treatment.

It is essential that the Medicaid Program be able to relate diagnostic and/or treatment services to the original screening. Therefore, when a patient under 21 visits your office, a reasonable effort should be made to determine whether it is as a result of an EPSDT Program referral by asking the referring physician or clinic or the patient. If you are unable to obtain the information, check "NO".

Item 11: Prior Authorization Number. This item applies to prior authorization Rehabilitation and Mental Health Services.

Follow the prior authorization procedures as described in Chapter II and III of your Medicaid Independent Clinic Services Manual.

Certain Rehabilitation and Mental Health Services require that a request for prior authorization be made on a "Request For Authorization" form, FD-06 and FD-07 respectively. If the request is approved, the Medicaid Consultant will assign a prior authorization number to the Request for

(continued)

Authorization Form. The number received must be transcribed from the Request For Authorization Form onto the MC-14 in item 11. This authorization number applies only to the service(s) for which it was assigned and the date(s) for which it was approved.

The Request For Authorization Form itself must accompany the MC-14 when submitting the claim in accordance with regulations in your Medicaid Independent Clinic Manual.

Item 13C: Nature of Illness or Injury Requiring Services

A diagnosis must be entered for all categories of treatment. Where possible, select the diagnosis from the International Classification of Diseases (Adapted for use in the United States), as published by the United States Department of Health, Education and Welfare. (Do not confuse the diagnosis with the patient's complaint or symptoms; pain, swelling, etc., is not acceptable as a diagnosis.)

IMP Number: One of the most significant changes to the claim form is the requirement to identify practitioners by an Individual Medicaid Practitioner (IMP) Number. Items 14, 15 and 16 on the revised claim refer to an IMP Number. Each Medicaid Practitioner has been assigned a unique IMP Number and has been advised of the requirement to make it available to other Medicaid practitioners and providers. (See Prudential Letter dated October 24, 1977.)

Item 14: Referring Practitioner

If a patient has been referred to the clinic by a Medicaid Practitioner, you must write the name and IMP Number of the referring practitioner in item 14. If the patient is not a referral, leave item 14 blank.

In the event that you are unable to obtain the IMP Number directly from a practitioner, you may call (800) 322-8051 or (800) 322-8052 toll-free for the information. You will need the name and address of the practitioner in order to obtain the IMP Number.

If the referring practitioner does not have an IMP Number, insert the name only and write "NON-PAR" next to the practitioner's name. You are cautioned that the term "NON-PAR" is used only when an IMP Number has not been assigned and is unavailable through the toll-free numbers mentioned above.

Item 15: Attending Practitioner

When non-surgical services billed on the claim were performed by a practitioner, he/she is the attending practitioner for that MC-14 claim. Enter his/her name and IMP Number in item 15.

When a clinic bills for services provided by a non-practitioner (e.g., physical or speech therapist, psychiatric social worker), the clinic practitioner who ordered the service(s) is considered to be the attending practitioner and his/her name and IMP Number must be entered in item 15.

Item 16: Operating Practitioner

If a clinic bills for surgical procedures, the name and IMP Number of the operating practitioner is required in item 16.

Continue to follow the procedures for submitting claims as outlined in Chapter III of your Medicaid Independent Clinic Manual.

INDEPENDENT CLINIC BILLING PROCEDURES

Instructions for Completion of Form MC-14

1. - 4. -Copy the Patient's Name, Health Services Program (HSP) Case Number, and Person Number EXACTLY as it appears on the Validation Form or Medicaid Eligibility Identification Card.
-For additional information, see Section 101. of your Medicaid Independent Clinic Services Manual.
5. -Indicate patient's age.
6. -Check appropriate block, to identify patient's sex.
7. -Check appropriate block to indicate whether the patient has other health insurance, liability coverage or No Fault Auto Coverage.
-If yes, you must attach a copy of the decline notice or a copy of the explanation of payment from the carrier.
8. -Complete this item for recipients under 21 years of age.
-Ask the patient and/or referring physician or clinic if this visit is a result of an EPSDT Screening.
-Indicate if this patient is such a referral by checking the appropriate block.
9. -This information is usually preprinted.
-If not preprinted, write in provider name, address, and provider number.
-Enter telephone number.
10. -Check as appropriate.
-If patient's illness or injury is work related enter the name and address of employer.
-Indicate whether injury resulted from auto accident.
11. -For Rehabilitation and Mental Health Services which require prior authorization, copy the prior authorization number designated by the Medicaid Consultant from the Request for Authorization Form.
-Attach Authorization Request form to claim when submitting for payment.

12. -Do not write in this space; for Division use only.
 - The Medicaid Consultant will evaluate and enter appropriate comments in item 12, on claims for services which require that a request for prior authorization be made directly on the MC-14 (see Medicaid Independent Clinic Services Manual, Chapters II and III).
 - This item does not apply to rehabilitation, mental health and dental services, which are authorized on separate forms.
- 13.A. -Enter date(s) of each visit.
- 13.B. -Enter procedure code.
- 13.C. -Enter diagnosis.
- 13.D. -Describe procedure, service and/or supply which is furnished.
- 13.E. -Check this column for each service ascribable to "Family Planning". These should include visits for infertility studies, oral, mechanical or chemical contraceptives and applicable surgical procedures.
- 13.F. -Enter your usual and customary charge for each service or procedure.
14. -If patient was referred to the clinic, you must indicate the name and Individual Medicaid Practitioner (IMP) Number of the referring practitioner.
15. -This item must be completed.
 - Enter the name and Individual Medicaid Practitioner (IMP) Number of the attending practitioner.
16. -If surgical procedures were performed, enter the name and Individual Medicaid Practitioner (IMP) Number of the operating practitioner.
17. -Under ordinary circumstances, the patient must sign the claim form when services have been received.
 - The claim form must indicate services rendered, prior to presenting it to the patient for signature.
 - If the patient's signature is unobtainable, see Chapter III in your Medicaid Independent Clinic Manual for procedures to follow.
18. -Read the Provider Certification carefully.
 - The provider must sign the MC-14 before the claim can be considered for payment.
 - Indicate the billing date which is the date the claim is mailed.



STATE OF NEW JERSEY
 Department of Human Services
 Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume

December 1, 1977

TO: HOSPITAL ADMINISTRATORS, PHYSICIANS AND INDEPENDENT CLINICS

SUBJECT: NEW STERILIZATION FORMS; DESTRUCTION OF CURRENT STERILIZATION FORMS, FD-124, FD-125 and FD-126
 (THIS NEWSLETTER SUPERCEDES THE PRUDENTIAL NEWSLETTERS VOLUMES 1-131, 1-132 AND 1-140 AND THE BLUE CROSS NEWSLETTERS VOLUME 63 AND 69)

Enclosed is an initial supply of the NEW STERILIZATION FORMS entitled:

- FD-163 Your Sterilization Operation - Vasectomy
- FD-164 Your Sterilization Operation - Hysterectomy
- FD-165 Your Sterilization Operation - Tubal Ligation

Please note that the new forms are separate and specifically worded for individualized types of sterilizations. The forms are constructed with the goal of consolidating the present dual handout oral presentation, male/female forms and the request Consent and Reaffirmation form which you have been using. The issuance of the new forms should ease the administrative procedure of securing consent of sterilization and **KEEP THE STATE OF NEW JERSEY IN COMPLIANCE WITH FEDERALLY MANDATED GUIDELINES WHICH ARE NECESSARY FOR CONTINUED MATCHING FUNDS AND CLAIM REIMBURSEMENT.** The new forms are to become effective IMMEDIATELY and all current forms should be destroyed. Claims submitted for payment without a new sterilization form for services provided on or after December 15, 1977 will be rejected.

SECURING OF CONSENT OF STERILIZATION

-Providers must begin to utilize the attached Forms: FD-163 Your Sterilization Operation - Vasectomy; FD-164 Your Sterilization Operation - Hysterectomy; FD-165 Your Sterilization Operation - Tubal Ligation.

-As in the past, a copy of the form must be given by the provider to the Medicaid recipient.

-Neither the Physician, nor the Hospital nor the Independent Clinic shall perform a Non-Therapeutic Sterilization sooner than 72 hours following the giving of informed consent.

-When submitting claims for reimbursement continue to attach a copy of the FD-163, FD-164 or FD-165 to the MC-1 Inpatient Hospital Claim Forms; or the MC-4 Outpatient Hospital Claim Forms; or the MC-8 Physicians and Practitioners Claim Forms; or the MC-14 Independent Outpatient Health Facility Claim Form for confirmation of the fact that regulations have been followed, e.g., A TRANSECTION OF FALLOPIAN TUBE, BILATERAL, ABDOMINAL OR VAGINAL APPROACH PROCEDURE-would require for reimbursement purposes both the submission of an MC-8 Physicians and Practitioners Claim Form together with the respective sterilization form, in order that the hospital be reimbursed for the inpatient stay the Inpatient Hospital Claim Form MC-1 also must be submitted together with a copy of the respective sterilization form. REIMBURSEMENT WILL NOT BE MADE TO THE PROVIDER IF A PROPERLY COMPLETED FD-163, FD-164 or FD-165 FORM IS NOT SUBMITTED WITH THE CLAIM AND IF ALL REQUIREMENTS ARE NOT MET.

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-When hospitalization is required for non-emergency sterilization procedures, the physician should instruct the Medicaid recipient to bring the FD-163, or FD-164, or FD-165 (depending on the type of sterilization to be administered) to the hospital. The hospital is required to furnish the Medicaid recipient with a copy of the individualized form retaining copies for hospital records and billing to the New Jersey Medicaid Program.

MINIMUM AGE FOR STERILIZATION REIMBURSEMENT IS 21 YEARS

MANDATORY USE OF NATIVE LANGUAGE INFORMED CONSENT

As circumstances necessitate, providers are required to adapt the language of the Medicaid recipient; e.g., Spanish, Italian, etc., either to the FD-163, or FD-164, or FD-165 in order that the Medicaid recipient may both listen to and read the information on the form in his or her own native language. Additionally, it will be necessary that the respective form be given in the Medicaid recipient's own language. This will afford a reading by the Medicaid recipient of the document and also provide him or her with a copy in accordance with Federal HEW regulations. Also, the translated document must accompany the appropriate claim form as outlined above.

BILLING PROCEDURES

Unilateral Procedures performed on the male or female genital system are considered sterilization procedures if available documentation will support the conclusion that the procedure results in sterilization. The provider when performing a sterilization procedure must utilize the codes listed below. It is necessary in order to receive reimbursement to check off Family Planning item 12E of the MC-8 Physician and Practitioners Claim Form and it is necessary to check off item 11D of the MC-14 Independent Outpatient Health Facility Claim Form. For reimbursement to be made to the hospital, the MC-1 Inpatient Hospital Claim Form and MC-4 Outpatient Hospital Claim Form must clearly indicate that the procedure is for sterilization. The specific type sterilization form must also be attached. Item 27, "Check if Family Planning" must also be checked off on the MC-1 and MC-4 in order to receive reimbursement.

SURGICAL PROCEDURES

PROCEDURE CODE

A. <u>Female</u>	
Transection of Fallopian Tube, unilateral or bilateral, abdominal or vaginal approach	4531
Transection of Fallopian Tube, unilateral or bilateral, abdominal or vaginal approach post-partum, during same hospitalization by physician effecting delivery	4532
Salpingectomy, complete or partial, unilateral or bilateral (independent procedure)	4541
Salpingo-oophorectomy, complete or partial, unilateral or bilateral (independent procedure)	4545
Complete oophorectomy, unilateral or bilateral (independent procedure)	4569
Transection-Fulgeration of Fallopian Tubes by laparoscopy or culdoscopy; with or without dilation and curettage (independent procedure)	4549
B. <u>Male</u>	
Vasectomy, unilateral or bilateral (independent procedure)	4241
Ligation (percutaneous) of vas deferens (independent procedure)	4261

DEFINITIONS

"Nontherapeutic Sterilization" means any procedure or operation, the purpose of which is to render an individual permanently incapable of reproducing and which is not either a necessary part of the treatment of an existing illness or injury, or medically indicated as an accompaniment of an operation on the female genitourinary tract. For purposes of this paragraph mental incapacity is not considered an illness or injury.

SCOPE OF SERVICES FOR HOSPITALS, PHYSICIANS AND INDEPENDENT CLINICS

Payment will be made for sterilization services to Hospitals, Physicians and Independent Clinics subject to the following limitations:

1. No non-emergency sterilization may be performed unless:
 - a. Such sterilization is performed pursuant to a voluntary request for such services made by the person on whom the sterilization is to be performed; and,
 - b. Such person is advised at the outset and prior to the solicitation or receipt of his or her consent to such sterilization, that no benefits provided by programs or projects may be withdrawn or withheld by reason of his or her decision not to be sterilized and,
 - c. A Hospital, Physician and Independent Clinic obtains legally effective informed consent from the individual on whom the sterilization is to be performed.
2. The Hospital, Physician and Independent Clinic shall not perform a non-therapeutic sterilization sooner than 72 hours following the giving of informed consent.
3. No sterilization procedures shall be performed on a person who has been judicially declared mentally incompetent under applicable State laws to give informed and binding consent to the performance of such an operation because of mental capacity.
4. No sterilization procedure may be performed with respect to sterilization of individuals under the age of 21 or legally incapable of consenting to the sterilization.

ORDERING OF FORMS

Providers can obtain additional copies of the FD-163, FD-164 and FD-165 forms from their respective contractors by writing to Prudential Insurance Company, P.O. Box 1900, Millville, New Jersey 08332 or Blue Cross, 33 Washington Street, Newark, New Jersey 07102 as appropriate.

YOUR STERILIZATION OPERATION

HYSTERECTOMY

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

Why It's Important to You

Sterilization is a permanent form of birth control. A woman who has been sterilized can never again get pregnant. One operation that prevents pregnancy is called "hysterectomy". This notice describes the hysterectomy operation. It describes the discomforts, the risks, the benefits and the fact that it is mostly done for reasons other than birth control. You should read this notice completely. Make sure you understand all of it before you decide to have a hysterectomy.

Make your decision only after careful thought. Do you know you never want to get pregnant in the future no matter what? If the answer is "yes," you are ready to think about sterilization as your permanent form of birth control. Be sure of your decision to be sterilized. Be sure that hysterectomy is the operation you want before you sign the last page of this notice.

Making Up Your Mind

Decision is Your Free Choice

It is entirely up to you to decide about having or not having the operation. Under Federal law, no one can force you to have the operation. If you decide not to be sterilized, your decision will not affect your future care and you will not lose any help or benefits, such as welfare or social security, from programs or projects receiving Federal funds if you are eligible for them.

If you decide you want to be sterilized but begin to have doubts or change your mind later, you can and should cancel the appointment for the operation. You can take back your consent any time before the operation.

To have this operation you must be at least 21 years old. If you are married, it is important for you to discuss this operation with your husband. (Note: If consent of spouse is required by local law, substitute the following: Your husband must sign that he agrees to your operation).

Other Methods of Birth Control

Temporary Methods

Before making up your mind to be sterilized, think about the other methods of birth control that are not permanent.

The pill and the IUD (intrauterine device) are excellent temporary methods of birth control for women. Both have better than 95 percent protection from pregnancy. Temporary methods not quite so good as the pill and the IUD are:

- diaphragm
- condom
- condom and foam together
- rhythm or natural methods

All of these methods are temporary. That means after you stop using them, you can get pregnant.

Permanent Methods

Hysterectomy is usually reserved for diseases which require this type of major surgery. Women can be sterilized by simpler operations called "tubal sterilizations," which are only done for birth control reasons. One type of tubal sterilizations is:

— Laparoscopic Tubal Sterilization

This operation takes about 30 minutes. It requires a very short stay in the hospital and may be done with no overnight stay.

The doctor makes one or two very small cuts in the abdomen, and uses a special instrument, called a laparoscope, to look inside and block the tubes that carry the eggs from the ovaries to the womb.

Another type is called

— Tubal Ligation

This operation takes about 30 minutes. It is often done right after a woman has a baby. It may require a few additional days in the hospital. The doctor makes a cut in the abdomen below the navel, then ties and cuts the tubes.

There is also a sterilization operation for men called a vasectomy. It is a safe and simple operation done in a doctor's office or in a clinic.

You should find out more about these other sterilization operations before you decide to have a hysterectomy.

Facts About the Hysterectomy Operation

When you have a hysterectomy, the doctor removes your uterus (womb). You can not have a baby after your uterus is removed, and you will not have menstrual periods anymore.

HOW THE OPERATION IS DONE: First you are given an "anesthetic". An anesthetic is a drug to keep you from feeling pain during the operation.

The operation is often done under a "general anesthetic". That means you will be asleep during the operation. The drugs used are:

A gas which you inhale or,

A drug given to you by injection,

Or both.

A medical person who specializes in anesthetics does this part of the operation. He or she often puts a tube through your mouth into your windpipe after you are asleep to make sure you can breathe during the operation.

Sometimes the operation is done under a "spinal anesthetic". That means you are awake, but do not feel any pain. A spinal anesthetic is given by injection low in the spine. This type of injection makes you feel numb from the waist down during the operation. With a spinal anesthetic, you may also be given another injection to help you relax or fall into a light sleep.

You will have a chance to discuss your type of anesthetic with someone before your operation.

The operation can be done one of two ways: one way is through a cut in your abdomen below your navel (abdominal hysterectomy). The cut is about four to six inches and leaves a scar.

Another way is through a cut on the inside at the back of your vagina (vaginal hysterectomy). One advantage of a vaginal hysterectomy is that it does not leave a scar on your abdomen, but this operation is not suited for all women. Your doctor will discuss the types of hysterectomy with you before the operation.

With either method, the doctor removes your uterus and closes the incision with stitches.

Usually the ovaries are not removed. Your doctor will tell you before the operation whether he or she may need to remove one or both of your ovaries. Usually, normal, healthy ovaries are left in place. They only need to be removed if you have a disease that might be helped by removing your ovaries.

The operation, including the anesthetic, usually takes about an hour and a half. You will need to stay in the hospital 5 or more days. You should not have intercourse until your doctor tells you that you are healed inside. This will take a month or more after the operation.

If your ovaries are removed, your doctor may need to give you medication to replace the hormones you had in your ovaries.

The operation is 100% sure to make you permanently sterile. It is final and irreversible.

Discomforts

After the operation you can expect to have pain and soreness in your abdomen for several days. You can take medicine to help relieve the discomfort. If you had general anesthesia, you may have a sore throat for a day or two. This goes away quickly and it not serious.

Risks

Hysterectomies have some risks, including a small risk of death. This is true of any type of operation. Most of the time serious problems can be treated and cured by the doctor. Some problems may require a second operation to correct.

The medical problems you could have during or after a hysterectomy are:

1. You may bleed from the cuts made on your skin or in your vagina.
2. You may bleed inside your vagina or your abdomen (may require an operation to control).
Call your doctor if you have bleeding from the vagina.
3. You may get an infection on or near the stitches, inside your abdomen, in your vagina, your bladder or your kidneys.

Go back to your doctor at once if you get:

- fever
- severe pain in your abdomen
- burning or frequent urination

These could be signs that you have an infection.

4. There may be an injury to some of your other internal organs (may require an operation to repair).
5. The drugs you are given may cause problems. The anesthetic drugs used to put you to sleep or to make the operation painless may cause a bad reaction.
Serious problems are rare.

As in any other operation:

- You may vomit while under anesthesia; pneumonia may result.
- Your heart may stop beating; death may result.

6. One of your eggs could get fertilized inside your abdomen. This is extremely rare. If it does happen, the egg would have to be removed by an operation.

Sometimes a woman may be sorry she had the operation. This happens if she starts to feel she is "less of a woman" because she no longer has a uterus or gets periods. She may also be sorry if she later decides she wants to have a baby. Be sure you never want to get pregnant in the future before you have the sterilization operation, because it cannot be undone.

Benefits of the Operation

The benefits of a hysterectomy for sterilization are about the same as for other types of sterilization:

- You never have to use a temporary method of birth control again (such as the pill or the IUD). This is also true after other types of sterilization.
- You never have to worry about getting pregnant again. That brings peace of mind to many women, who may also experience greater sexual pleasure after they have been sterilized. This is also true after other types of sterilization.
- You will never have another menstrual period. This may be desirable for women who have troublesome periods or painful cramps. This is not true after other types of sterilization.

Think About These Important Facts

- A hysterectomy is a major operation. - Tubal sterilizations are simpler and safer.
- With a hysterectomy, you will have to stay in the hospital for 5 days or more. - With a tubal operation, your hospital stay is usually no more than 2 or 3 days. Sometimes you don't even have to stay overnight.
- It takes several weeks or more to recover from a hysterectomy. - After a tubal sterilization, you will feel good again in a short time, usually less than a week.
- A hysterectomy involves a greater risk of complications and a greater risk of death. - The risk of death for hysterectomy is low, but it is four times greater than for tubal sterilization.
- A hysterectomy costs much more than other sterilizations.

Some women choose to have a hysterectomy instead of a simpler operation because:

- they no longer want to have menstrual periods.
- they worry that they might get a disease of the uterus (such as cancer) when they get older.

Sometimes, a hysterectomy is the recommended operation for sterilization. Most often this operation is for women who already have some problem with their uterus. Be sure to talk to your doctor about the risks, benefits and reasons for hysterectomy. If the only reason for your operation is to be sterilized, you may prefer one of the simpler, safer less expensive sterilization operations.

SUMMARY

If you want to become permanently sterile you may want to have a hysterectomy. If there is something wrong with your uterus or if you don't want to have periods anymore or if you worry about having a disease of the uterus when you get older, a hysterectomy can be done to sterilize you. You should be sure in your own mind that you really want a hysterectomy rather than a tubal sterilization operation, which is simpler and has less risk.

YOUR QUESTIONS AND ANSWERS GIVEN

If there is anything that is not clear to you, or anything you are worried about, it is important that you bring up these questions. All of your questions should be answered to your satisfaction before the operation.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from (_____).
name of clinic or physician

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my future care and I will not lose any help or benefits from programs or projects receiving Federal funds that I am or may become eligible for.

I talked to (_____) about sterilization. (_____) discussed it with me
name of responsible person(s) She/he/they
and gave me a chance to ask questions and answered them for me.

I have read all of this notice. I agree that it is a true description of what was explained to me by
(_____) of (_____) and that all my questions were answered
name of staff member name of clinic
to my satisfaction.

I understand that the operation will not be done until at least three days (72 hours) after I sign this form and I can change my mind at any time before the operation.

I am 21 years old or older.

I, _____ hereby consent of my own free will to be sterilized by
_____ and/or associate(s) or assistant(s) of his or her choice by a method
called "hysterectomy". I understand that there are other types of sterilization that are simpler to perform than
hysterectomy. I understand that simpler sterilization operations may have fewer medical risks than hysterectomy.
I have freely chosen to have the hysterectomy instead of any other type of sterilization.

I consent to any other medical treatment that the doctor thinks is necessary to preserve my health.

I consent to have (_____) anesthesia before the operation.
general/spinal

I also consent to the release of this form and other medical records about the operation to representatives of the Department of Health, Education and Welfare or employees of programs or projects funded by that Department but only for purposes of determining if Federal laws were observed.

_____ am pm
Patient's Signature Date Month/Day/Year

State of New Jersey
11/77

YOUR STERILIZATION OPERATION

TUBAL LIGATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

Why It's Important to You

Sterilization is an operation. A woman who has been sterilized can never again get pregnant. This notice describes a sterilization operation, called a "tubal ligation". It describes the operation, its benefits, its discomforts and its risks, so you should read this pamphlet completely. Make sure you understand all of it before you decide to have a post-partum tubal ligation.

Make your decision only after careful thought. Do you know you never want to get pregnant in the future no matter what? If the answer is "yes" you are ready to think about sterilization as your permanent method of birth control. Be sure of your decision before you sign the last page of this notice and agree to have the operation.

Making Up Your Mind

Decision is Your Free Choice

It is entirely up to you to decide about having or not having the operation. Under Federal law, no one can force you to have the operation. If you decide not to be sterilized, your decision will not affect your future care and you will not lose any help or benefits, such as welfare or social security, from programs or projects receiving Federal funds, if you are eligible for them.

If you decide you want to be sterilized but begin to have doubts or change your mind later, you can and should cancel the appointment for the operation. You can take back your consent any time before the operation.

To have this operation you must be at least 21 years old. If you are married, it is important that you discuss this operation with your husband. (Note: If consent of spouse is required by local law, substitute the following: Your husband must sign that he agrees to your operation.)

Other Methods of Birth Control

Before making up your mind to be sterilized, think about the other methods of birth control. For example, there is a sterilization operation for men called a vasectomy. The pill and the IUD (intrauterine device) are excellent temporary methods of birth control for women. Both have better than 95 percent protection from pregnancy. Temporary methods not quite as good as the pill and the IUD are:

- diaphragm with jelly or cream
- condom
- foam
- condom and foam together
- rhythm or natural method

All of these methods are temporary. That means after you stop using them you can get pregnant.

Facts About the Operation

The operation you would have is called a tubal ligation. It is also known as "tying of the tubes". It is often done within a few days after childbirth but can be performed at any time that is convenient and safe for you. In this operation the doctor separates or blocks each fallopian tube so that your egg cannot travel from your ovary to your uterus or womb. Blocking the tubes makes pregnancy impossible.

HOW THE OPERATION IS DONE: First, you are given an "anesthetic". An anesthetic is a drug to keep you from feeling pain during the operation. The operation is often done under a "general anesthetic". That means you will be asleep during the operation. The drugs used are (1) a gas which you inhale -or- (2) a drug given to you by injection.

A medical person who specializes in anesthetics does this part of the operation. He or she often puts a tube through your mouth into your windpipe after you are asleep to make sure you can breathe during the operation.

Sometimes the operation is done under a "local anesthetic" or a "spinal anesthetic". That means you are awake, but do not feel any pain. Local anesthetic is given by injection into the skin of the lower abdomen.

Spinal anesthetic is given by injection low in the spine. This type of injection makes you feel numb from the waist down.

With a local or spinal anesthetic, you may also be given pills or another injection to help you relax.

You will have a chance to discuss your type of anesthetic with someone before your operation, and to state which type you prefer.

If the operation is done soon after childbirth, the doctor makes a small cut just below your navel. At other times, the cut is made just above the pubic region. In either case the cut is two to three inches long, and will leave a thin scar. Your doctor will tell you the exact type of cut to be made, and the type of scar you can expect.

The doctor then closes off a section of each tube using surgical threads. After the tubes are "tied", and the section between the ties removed, the cut is stitched.

The operation, including the anesthetic, usually takes about 30 minutes. If you have the operation after you have your baby, your hospital stay will be one to three days longer. At other times you can expect to stay in the hospital about five days.

The operation is almost 100 percent sure to make you permanently sterile, and you should consider it to be final and irreversible.

Discomforts and Risks

After the operation you can expect to feel pain and soreness in your abdomen for a few days. You can take medicine to help relieve the discomfort.

If you had general anesthesia, you may have a sore throat for a day or two. This goes away quickly and is not serious.

Sterilization operations have some risks, including a very small risk of death. This is true of any type of operation. Serious problems happen to one woman for every thousand women who have the operation. Most of the time serious problems can be treated and cured by the doctor; some problems may require an operation to correct the problem.

The medical problems you could have during or after a sterilization operation are:

1. You may bleed from the cuts made on your skin.
2. You may bleed inside your abdomen (may require an operation to control).
3. You may get an infection on or near the stitches or inside your abdomen. Go back to your doctor at once if you get (1) fever -or- (2) severe pain in your abdomen. Either of these could be signs that you have an infection.
4. The operation may not make you sterile. The operation cannot be guaranteed 100 percent to make you sterile. About one in one thousand women get pregnant after the operation.
5. The drugs you are given may cause problems. The anesthetic drugs used to put you to sleep or to make the operation painless may cause a bad reaction.

Serious Problems Are Very Rare. As in other operations:

1. You may vomit while under anesthesia; pneumonia may result.
2. Your heart may stop beating; death may result.

Sometimes a woman may be sorry she had the operation. This happens if she later decides she wants to get pregnant. Be sure you never want to get pregnant in the future before you have the sterilization operation, because it can be undone only by another operation and less than 40 percent of such operations are successful.

Benefits of the Operation

The Benefits of Sterilization are: You never have to use a temporary method of birth control again (such as the pill or the IUD). You never have to worry about getting pregnant again. That brings peace of mind to many women, who may also experience greater sexual pleasure after they have been sterilized.

SUMMARY

If you want to become permanently sterile, the "tubal ligation" is an excellent operation. It requires a relatively brief stay in the hospital. Problems are rare.

YOUR QUESTIONS AND THE ANSWERS GIVEN

If there is anything that is not clear to you, or anything you are worried about, it is important that you bring up these questions. All of your questions should be answered to your satisfaction before the operation.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from (_____). When
name of clinic or physician

I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my future care and I will not lose any help or benefits from programs or projects receiving Federal funds that I am or may become eligible for.

I talked to (_____) about sterilization. (_____) discussed it with me and gave
name of responsible person(s) She/he/they
me a chance to ask questions and answered them for me.

I have read all of this notice. I agree that it is a true description of what was explained to me by
(_____) of (_____) and that all my questions were answered to
name of staff member name of clinic
my satisfaction.

I understand that the operation will not be done until at least three days (72 hours) after I sign this form and I can change my mind at any time.

I am 21 years old or older.

I, _____ hereby consent of my own free will to be sterilized by
_____ and/or associate(s) or assistant(s) of his or her choice by a method
called tubal ligation.

I consent to any other medical treatment that the doctor thinks is necessary to preserve my health.

YOUR STERILIZATION OPERATION

VASECTOMY

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

Why It's Important to You

Sterilization is an operation. A man who has been sterilized can never again make a woman pregnant. This notice describes a sterilization operation called a "bilateral vasectomy". It describes the operation, its benefits, its discomforts and its risks, so you should read this notice completely. Make sure you understand all of it before you decide to have a bilateral vasectomy.

Make your decision only after careful thought. Do you know you never want to father a child in the future no matter what? If the answer is "yes" you are ready to think about sterilization as your permanent method of birth control. Be sure of your decision before you sign the last page of this pamphlet and agree to have the operation.

Making Up Your Mind

Decision is Your Free Choice

It is entirely up to you to decide about having or not having the operation. Under Federal law, no one can force you to have the operation. If you decide not to be sterilized, your decision will not affect your future care and you will not lose any help or benefits, such as welfare or social security, from programs or projects receiving Federal funds, if you are eligible for them.

If you decide you want to be sterilized but begin to have doubts or change your mind later, you can and should cancel the appointment for the operation. You can take back your consent any time before the operation.

To have this operation you must be at least 21 years old. If you are married, it is important to you to discuss this operation with your wife. (Note: If consent of spouse is required by local law, substitute the following: Your wife must sign that she agrees to your operation.)

Other Methods of Birth Control

Before making up your mind to be sterilized, think about the other methods of birth control. For example, there are sterilization operations for women. They can also use the pill or IUD-temporary methods that give better than 95 percent protection from pregnancy. Temporary methods not quite as good as the pill and the IUD are:

- diaphragm with jelly or cream
- condom
- foam
- condom and foam together
- rhythm or natural method

All of these methods are temporary. That means if they are not used, you can make a woman pregnant.

Facts About the Operation

The operation you would have is called bilateral vasectomy. In this operation, the doctor closes off the sperm ducts so that sperm cannot get through these tubes into the ejaculate. When there are no sperm in the ejaculate, you cannot cause a pregnancy.

HOW THE OPERATION IS DONE: First, you are given a "local anesthetic". A local anesthetic is a drug to keep you from feeling pain during the operation even though you stay awake. The anesthetic is injected just below the skin on each side of the scrotum. You will feel mild pain, like a pin prick, and then the scrotum will become numb.

The doctor makes a small cut in each side of the scrotum. The cut is about half an inch long and allows the doctor to reach the two sperm ducts, cut them, and close them off. The cut is then closed with stitches. The scar is invisible. The operation, including the anesthetic, usually takes about 20 minutes, and is done in the doctor's office.

It's important to know that you do not become sterile right after the operation. You must use another form of birth control until tests of your semen show that there are no live sperm. You will be told where to go for the tests, which will show when you have become permanently sterile. The growing back of the cut ends of the tubes is possible, but rare. You should consider the operation to be final and irreversible.

Discomforts and Risks

As operations go, vasectomy is safe. It is a minor operation, but there is a chance that you will have some medical problems afterwards. One of the problems you should expect is soreness after the operation. This is not serious and will go away after several days.

Some medical problems may be serious. Most of the time serious problems can be treated and cured by the doctor; some problems may require another operation.

The medical problems you could have are:

1. You may have swelling around the cut made on the skin. This happens right after the operation and usually goes away in a few days.
2. You may have bleeding under the skin, which causes a bruise. This usually clears up by itself.
3. You may get an infection either on the skin or inside the scrotum.

Go back to your doctor at once if:

- Swelling lasts for more than a few days.
- You have a fever.
- You have severe pain.

A very few men (four out of every 1000 who have had the operation) have said they have had sexual problems after the operation. These were either decreased sexual desire or inability to have an erection. There is no medical explanation for these rare symptoms, and they are believed to be emotional.

Sometimes a man may be sorry he had the operation because he later wants to have more children. Be sure you never want to father children in the future before you have the operation.

Benefits of the Operation

The Benefits of Sterilization are: You never have to use a temporary method of birth control again. You never have to worry about making someone pregnant. That brings peace of mind to many men who may also experience greater sexual desire after they have been sterilized.

SUMMARY

If you want to be permanently sterile, a "bilateral vasectomy" is an excellent operation. It can be done in a doctor's office. There is little pain or soreness. Problems are rare.

FOREWORD

The New Jersey Medical Assistance and Health Services Act (Chapter 413, Laws of 1968) established a program of assistance and services for defined groups of persons to enable them to secure quality medical care. This is the New Jersey version of a program commonly known as "Medicaid" or "Title XIX". In identifying persons eligible for such assistance and services this will be known as the New Jersey Health Services Program.

This manual is designed for use by providers billing for services furnished under the Program. It contains informational and procedural material needed to assist the provider in prompt and efficient payment of claims and to answer questions which patients may ask about the program. The procedures described in this manual have been devised to achieve the goals of the Program with due consideration to the needs of the covered persons and effective relationships with providers.

A careful effort has been made to insure that the provisions of the law and the regulations are accurately reflected. This issuance should help to assure that the law is uniformly applied without regard to where covered services are furnished.

The manual is designed to accommodate new pages as administrative changes in procedure are made. Accordingly, revised sections, pages, or chapters will be issued as the need presents itself.

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GENERAL INFORMATION ABOUT THE PROGRAM

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CHAPTER I

GENERAL INFORMATION ABOUT THE PROGRAM

100. WHO IS ELIGIBLE

In general, Medical Assistance will be available to the following individuals:

All individuals receiving financial assistance under the State programs of Old Age Assistance, Assistance for Dependent Children, Aid to the Blind and Assistance to the Permanently and Totally Disabled. (These are referred to as "categorical assistance" programs.)

Persons who would be eligible for financial assistance under one of the above programs except for a requirement that is specifically prohibited by Federal law or regulations, such as execution of a reimbursement agreement.

Persons who meet the standard of need applicable to their circumstances under one of the categorical assistance programs, but who are not receiving and do not apply for such assistance.

Children between 18 and 21 who, except for school attendance requirements, would be eligible for the State program of Assistance for Dependent Children.

Children under 21 years of age in foster placement under supervision of the Bureau of Children's Services for whom maintenance is being paid in whole or in part from public funds.

The spouse of a recipient of old age assistance, assistance for the permanently and totally disabled, or assistance for the blind who is living with such recipient and whose needs are taken into account in determining the amount of financial assistance for the recipient.

GENERAL INFORMATION

101. HOW TO IDENTIFY A COVERED PERSON

101.1 Plastic Identification Card (Exhibit I)

This card identifies an individual or head of a family group found eligible for payment for authorized health services under the New Jersey Health Services Program administered by the Division of Medical Assistance and Health Services, Department of Institutions and Agencies. It will contain the name of the individual or head of the household and the Health Services Program Case Number. This card is issued by the Division of Medical Assistance and Health Services. It will serve as an identification card only.

NOTE: THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, BUT MUST BE ACCOMPANIED BY A CURRENT MONTH VALIDATION FORM ISSUED BY A COUNTY WELFARE BOARD OR THE STATE OF NEW JERSEY (SEE SECTION 101.2).

Exhibit I



101.2 Validation Form (Exhibit II)

This validation for health services form is issued by the appropriate County or State Agency monthly and indicates the individual is currently eligible for coverage.

NOTE: THIS FORM IS THE SOLE INDICATOR OF ELIGIBILITY. THE PLASTIC IDENTIFICATION CARD ALONE IS NOT SUFFICIENT.

The sample shown contains all of the required information. However, the form itself may vary from county to county.

IMPORTANT: Be sure to enter name, H.S.P. Case Number, and Person Number, EXACTLY as it appears on the Validation form on all Requests for Authorization and claim forms.

GENERAL INFORMATION

102. AUTHORIZED SERVICES FOR COVERED PERSONS

The items and services provided to covered persons will not normally be limited in duration or amount. Any limitations imposed will be consistent with the medical necessity of the patient's condition, as determined by the attending physician or other practitioner, in accordance with standards generally recognized by health professionals and promulgated through the Division of Medical Assistance and Health Services. The following items and services, more specifically defined in subsequent sections of the appropriate manual, are authorized under the Program:

- (a) Inpatient hospital services, other than services in an institution for tuberculosis or mental diseases;
- (b) Inpatient hospital services for persons 65 and older in a public institution for tuberculosis or mental diseases;
- (c) Outpatient hospital services;
- (d) Clinic services, i.e., health services provided by an outpatient facility not administered or operated by a hospital;
- (e) Laboratory and x-ray services;
- (f) Skilled nursing home services;
- (g) Physicians' services, whether furnished in the office, patient's home, hospital, skilled nursing home or elsewhere;
- (h) Other practitioners' services, limited by State law to podiatrists and optometrists;
- (i) Dental services, including dentures;
- (j) Home health care services;
- (k) Pharmaceutical services - prescribed drugs (legend and non-legend)
- (l) Prosthetic devices and appliances, medical supplies and equipment; eyeglasses and hearing aids;
- (m) Rehabilitation services;
- (n) Transportation, i.e., ambulance service to and from a medical facility when the patient's condition precludes the use of other means of transportation.

GENERAL INFORMATION

103. ELIGIBLE PROVIDERS

Providers of services means any individual, partnership, association, corporation, institution, or public agency designated below, meeting applicable requirements and standards for participation in the Program:

Medical and Surgical Supply Dealers;

Certified Independent Clinical laboratories;

Dentists;

Hearing Aid Dealers;

Home Health Agencies;

Hospitals;

Skilled Nursing Homes;

Opticians;

Optometrists;

Approved Clinics (Independent Outpatient Health Facilities);

Certified Orthotists;

Pharmacies;

Physicians;

Podiatrists;

Certified Prosthetists; (excluding dental)

Providers of Medical Transportation.

104. FREE CHOICE BY COVERED PERSONS

A covered person is free to choose qualified facilities, practitioners and providers of service which meet the Program standards. In the event that the patient has no personal practitioner, or none is available, the Local Medical Assistance Unit may assist in obtaining an appropriate practitioner or health resource.

GENERAL INFORMATION

105. CONTRACTORS

The Division of Medical Assistance and Health Services will process and make payment of claims for services by skilled nursing homes and eligible state and county mental and tuberculosis hospitals.

Contracts have been negotiated on behalf of the State of New Jersey with the Hospital Service Plan of New Jersey and the Prudential Insurance Company of America to function as its contractors.

The Hospital Service Plan of New Jersey will be responsible for the processing and payment of hospital inpatient, hospital outpatient, and home health agency claims for those providers who have selected the Plan as their intermediary under Title XVIII (MEDICARE). In addition, the Hospital Service Plan of New Jersey will process and pay all pharmaceutical services claims (i.e., legend and non-legend drugs), and claims for out of state hospitals and home health agencies. Hospitals who have not participated in Title XVIII are assigned to the Hospital Service Plan.

The Prudential Insurance Company of America will handle the processing and payment of hospital inpatient, outpatient and home health agency claims for those providers who have selected Prudential as their intermediary under Title XVIII (MEDICARE). In addition, the Prudential Insurance Company will process and make payment for all other health services covered by the program.

106. PRIOR AUTHORIZATION

Under the Program, payment for certain services will require prior authorization from the Local Medical Assistance Unit, except in an emergency. It is the responsibility of the specified person or institution providing such service to obtain prior authorization before furnishing or rendering service. Specific instructions are detailed in the appropriate manual sections.

107. POLICY ON OUT OF STATE MEDICAL CARE AND SERVICES

Prior approval of the Local Medical Assistance Unit shall be required for medical care and services which are to be provided outside New Jersey, except in the following situations:

1. Where necessary medical care is provided to a patient who is temporarily absent from the state.

GENERAL INFORMATION

2. When it is customary for persons in the area generally to use medical care resources and facilities outside the State of New Jersey.
3. When out of state care was provided in an emergency.

108. GENERAL EXCLUSIONS

The items listed here are general exclusions. There are certain additional specific exclusions and limitations which are detailed in the appropriate manual sections.

Payment is not made for:

1. Any service, admission or item which is not medically required for diagnosis or treatment of a disease, injury or condition;
2. Any services or items furnished in connection with elective cosmetic procedures;

Note: There are certain exceptions to this rule.

A written certification of medical necessity and a treatment plan must be submitted by the practitioner to the Local Medical Assistance Unit for consideration, and Prior Authorization is required.

3. Private duty nursing service;
4. Services or items furnished for any sickness or injury occurring while the Covered Person is on active duty in the military;
5. Services or items furnished for any condition or accidental injury arising out of and in the course of employment, for which any benefits are available under the provisions of any Workmen's Compensation Law, Temporary Disability Benefits Law, Occupational Disease Law or similar legislation, whether or not the Covered Person claims or receives benefits thereunder, and whether or not any recovery is had against a third party for resulting damages;
6. That part of any benefits which are covered or payable under any health, accident, or other insurance policy, any other private or governmental health benefit system, or through any similar third party liability;
7. Services or items furnished prior to January 1, 1970, or prior to the period for which the patient presents evidence of eligibility for coverage;

GENERAL INFORMATION

8. Services or items furnished after the last day of the month in which the patient ceases to be eligible for coverage;
9. Any services or items furnished for which the Provider does not normally charge;
10. Any admission, service or item requiring Prior Authorization, where authorization has not been obtained or has been denied;
11. Services furnished by an immediate relative or member of the covered person's household.

109. CONFIDENTIALITY OF RECORDS

All individual medical records of covered persons acquired under this Program shall be confidential and shall not be released without the written consent of the covered person or his personal representative. This shall not preclude the release of statistical or summary data or information in which covered persons are not, and cannot be, identified, nor shall it preclude exchange of information between individuals or institutions providing care, Contractors and State or local official agencies.

110. UTILIZATION OF INSURANCE BENEFITS

Health, hospital, workmen's compensation, or accident insurance benefits shall be used to the fullest in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

1. Title XVIII

For those individuals who are covered under Medicare, responsibility for payment by the New Jersey Health Services Program will be limited to the unsatisfied deductible to the extent that the payments do not exceed the maximum allowable under the Program in the absence of other coverage.

2. Workmen's Compensation

No Program payments shall be made for a patient covered by workmen's compensation.

3. Other Health Insurance

When a covered person has other health insurance, the Program requires that such benefits be used. Supplementation shall be made by the Program when necessary, but the combined total shall not exceed the amount payable under the Program in the absence of other coverage.

GENERAL INFORMATION

111. MEDICAL REVIEW AND EVALUATION (by Local Medical Assistance Units)

Under the provisions of Federal and State Law, the Division of Medical Assistance and Health Services must provide for continuing review and evaluation of the care and services provided in the Program. This will include review of utilization of services of practitioners and other providers.

112. PROVISION FOR APPEALS - FAIR HEARING

All providers of service or covered persons will be given the opportunity for a fair hearing concerning grievances arising from the claims payment process.

113. FRAUD

The State Agency will establish and maintain methods for identifying situations in which a question of fraud in the program may exist, and referring to law enforcement officials situations in which there is valid reason to suspect that fraud has been practiced.

114. CIVIL RIGHTS

Federal regulations require that services provided to covered persons are given without discrimination on the basis of race, color, religious belief, or national origin. Therefore, payments are limited to providers of service who are in compliance with the non-discrimination requirements of Title VI of the Civil Rights Act.

115. OBSERVANCE OF RELIGIOUS BELIEF

Nothing in the Program shall be construed to require any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under the Program for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health) if such person or his parent or guardian objects thereto on religious grounds.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

NEW JERSEY HEALTH SERVICES PROGRAM

Governmental Health Programs Department, P.O. Box 1900, Millville, N. J. 08332

October 1, 1973

TO: ALL INDEPENDENT CLINICS

Please remove and destroy Chapters II and III of the New Jersey Health Services Program Independent Clinic Manual and replace them with the attached pages.

We strongly urge you to read the attached material as there have been several changes in Medicaid policy and all the changes are reflected in these pages. Pay particular attention to the prior authorization requirements.

Exhibit IV represents a new form (FD-06) which is to be utilized by clinics requesting prior authorization for rehabilitation services.

Contact your Local Medical Assistance Unit or the Central office Medicaid Consultant (Dental Clinics, Mental Health Clinics etc.) if you have any questions.

CHAPTER II
INDEPENDENT CLINIC SERVICES

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CHAPTER II

INDEPENDENT CLINIC SERVICES

200. DEFINITIONS

200.1 Clinic Services

"Clinic Services" means preventive, diagnostic, therapeutic, rehabilitative or maintenance items or services furnished under the direction of a licensed professional practitioner (physician, dentist, optometrist, podiatrist) in a (non-profit) facility not administered by a hospital but organized and operated to provide health services on an outpatient basis.

200.2 Independent Clinic (New Jersey Based)

Each independent clinic including all satellites must be individually approved by the New Jersey Division of Medical Assistance and Health Services as a provider before they will be reimbursed for services rendered to Medicaid patients. Before being considered by the Division of Medical Assistance and Health Services certain types of clinics must be approved by other State agencies. (See B below). Application for approval (Form FD-20) is to be submitted to:

Chief Medical Care Administrator
Division of Medical Assistance
and Health Services
P.O. Box 2486
Trenton, New Jersey 08625

A. Organization

In order to be approved as a Medicaid provider, all independent clinics must:

1. Possess a certificate of need from the New Jersey Department of Health.
2. Be a voluntary, non-profit, organization; and,
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.
4. Sign the agreement to participate in the New Jersey Health Services Program (Form FD-62).

B. Approval From Other State Agencies

In addition to A above the following types of clinics must also be approved by the State agency indicated below before they can obtain Medicaid approval.

1. Mental Health Clinics

Be approved to provide psychiatric services by the New Jersey Department of Institutions and Agencies, Division of Mental Health and Hospitals.

2. Dental Clinics

Be approved to provide dental services by the New Jersey State Board of Dentistry.

3. Family Planning, Neighborhood Health Centers, Child Evaluation Centers, Cerebral Palsy Clinics, Easter Seal Clinics, etc.

Meet the minimum standards of the New Jersey Department of Health, to qualify as an "Independent Outpatient Health Facility" in the speciality (ies) provided.

4. Other Types of Clinics

Clinics other than those described in 1, 2, 3 above who wish to become providers under the Medicaid Program, must submit their request to the Division of Medical Assistance and Health Services together with the following information:

- a. Services provided.
- b. Organizational structure.
- c. Relationships with other governmental or health agencies.
- d. Finances (budgets, charges, income, costs).

5. Satellite Clinics

Each branch location or satellite of an approved clinic must also be approved by Medicaid before they can be reimbursed. Approval of the parent organization does not constitute approval for all branches or satellites of the same organization.

Each branch or satellite will be assigned a separate provider number, which will appear on claim forms to be used for that particular facility. Billing may be performed from one central location, however, the appropriate claim forms are to be utilized for each approved satellite facility.

C. Medicaid Approval

If approved as a provider by the Division of Medical Assistance and Health Services, the clinic will receive written notification and be asked to sign a participation agreement. Upon signing the participation agreement and return to the Division, the clinic will receive a provider number, manual and a supply of claim forms pre-printed with the name of the clinic from Prudential, and will be added to the Medicaid Directory of Independent Clinics. It shall be the responsibility of each approved clinic to notify Medicaid of the relocation of or the closing of any of its facilities.

200.3 Out-of-State Clinics

In general no ongoing relationships will be established with out-of-state independent clinics. As such, none of these clinics will be added to the Directory of Independent Clinics Eligible to Participate in the New Jersey Health Services Program. However, such clinics which are voluntary, non-profit organizations and make a charge to the patient may be reimbursed for services provided under the following circumstances:

1. If the services are provided to Division of Youth and Family Services children residing out of state.
2. If the services are provided in an emergency or
3. If the provider submits an acceptable claim to the appropriate Contractor (Prudential).

Out-of-State clinics will be reimbursed on the same basis as in-state clinics of the same discipline or specialty. In the absence of a negotiated rate for a certain specialty clinic, reimbursement will be made at the rate of \$5.00 per diem per patient.

200.4 Qualified Physical Therapist

"A qualified physical therapist is one who:

1. Has graduated from a physical therapy curriculum approved by--
 - a. The American Physical Therapy Association; or
 - b. The Council on Medical Education and Hospitals of the American Medical Association; or
 - c. The Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association; or
2. Prior to January 1, 1966--
 - a. Has been admitted to membership by the American Physical Therapy Association; or

- b. Has been admitted to registration by the American Registry of Physical Therapist; or
 - c. Has graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education, is licensed or registered as a physical therapist, and where appropriate, has passed a state examination for licensure as a physical therapist; or
3. If he is currently licensed or registered to practice physical therapy pursuant to State law, he:
- a. Was licensed or registered prior to January 1, 1970, and has achieved a satisfactory grade through the examination conducted by or under the sponsorship of the Public Health Service; or
 - b. Was licensed or registered prior to January 1, 1966, and prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which he rendered services upon the order of and under the direction of attending and referring physicians; or
4. If trained outside the United States --
- a. Has graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy; and
 - b. Is a member of a member organization of the World Confederation for Physical Therapy; and
 - c. Has completed 1 year's experience under the supervision of an active member of the American Physical Therapy Association; and
 - d. Has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association."

200.5 Qualified Speech Therapist

Is certified by the American Speech and Hearing Association, or has completed the academic requirements and is in the process of accumulating the necessary supervised work experience required for certification.

200.6 Qualified Occupational Therapist

Is registered by the American Occupational Therapy Association, or is graduate of a program in occupation therapy approved by the Council on Medical Education of the American Medical Association

and is engaged in obtaining the required supplemental clinical experience prerequisite to registration by the American Occupational Therapy Association.

201. PRIOR AUTHORIZATION

Definition: Prior authorization means approval by a Consultant of the New Jersey Health Services Program before a service is rendered. This generally applies to prescribed non-emergency services. Delayed or retroactive requests for authorization after the service has been performed will not be honored.

There is no limitation on the duration or number of visits available to an eligible person when dictated by medical necessity. However, it is required that prior authorization be obtained by Clinics for those services for which such authorization is a standard prerequisite as described in Section 202. below e.g., rehabilitation services, transportation services (for approved invalid coach providers), podiatry services, family planning services (for more than six (6) visits in 12 months), certain dental services, mental health services (exceeding \$300. in 12 months), and vision care services. All prior authorizations will be included on the Independent Out-patient Health Facility Claim form (MC-14 C1) Exceptions: Dental Clinics use MC-10, Mental Health Clinics use both MC-14 C1 and FD-07, clinics providing rehabilitation services use both MC-14 C1 and FD-06.

202. SCOPE OF SERVICES

Approved Clinics may, to the extent of their specialty, licensure, and/or approved program, provide the following services when medically necessary:

202.1 Examination and Treatment

Examination, diagnostic evaluation and/or treatment by or under direct personal supervision of a physician, dentist or other practitioner eligible to participate in the New Jersey Health Services Program.

202.2 Rehabilitation Services

Includes physical therapy, occupational therapy, speech therapy, and other restorative services provided for the purpose of attaining maximum reduction of physical or mental disability and restoration of the patient to his best possible functional level. It does not include physical medicine procedures administered directly by a physician, or physical therapy which is purely palliative, such as the application of heat per se, in any form, massage, routine calisthenics or group exercises, assistance in any activity or use of a simple mechanical device not requiring the special skill of a qualified physical therapist.

Rehabilitation services shall be made available to covered persons as an integral part of a comprehensive medical care program. Such services include not only intermittent or part-time service to the patient, but also instructions to responsible members of the family in follow-up procedures necessary for the care of the patient.

All therapy must be provided under the directly personal supervision and in the presence of the qualified therapist. Prior authorization from the Local Medical Assistance Unit is required for services beyond the initial visit except in approved Child Evaluation Centers where prior authorization is not required.

A. Initial Authorization

Initial authorization shall not exceed 60 calendar days and shall be granted only when the following conditions are met:

1. All rehabilitation services of any type shall be supported by a written recommendation of a licensed physician, including a statement covering the medical necessity for therapy, the objective of treatment, a therapy prescription, the estimated number and frequency of treatments and projected duration of therapy. Form FD-06 may be utilized for this purpose.
2. Therapy prescriptions must be definitive as to type and scope of procedures to be rendered. Prescriptions such as "Physical therapy 3X a week," will not be accepted.

In order to obtain prior authorization the clinic is to submit three copies of the "Request for Authorization or Reauthorization for Prescribed Rehabilitation Treatment Program" (form FD-06) to the appropriate Local Medical Assistance Unit. The clinic is responsible for total completion of the "Patient Information", "Medical Information and Therapy Requested" and "Prescriber Signature" portions of the form. If the request is for initial authorization of rehabilitation services it is not necessary to complete item 13 of the form. NOTE: If form FD-06 is completed by the therapist, the prescribing physician's prescription must accompany the form. If authorized, the clinic will receive both the Billing and Provider copies of the FD-06 with appropriate comments and signature in the "Authorization Information" section. Upon completion of the authorized service(s) complete the Independent Outpatient Health Facility Claim (form MC-14 C1) and submit the Contractor copy together with the Billing copy of the FD-06 to Prudential for payment. The Provider copies of the MC-14 C1 and FD-06 should be retained for your records. See Section 310 for Billing Instructions and Exhibit IV for a sample FD-06.

If authorization is denied the clinic will receive notification of the reason(s) for the denial.

B. Subsequent Authorization

Subsequent authorization shall not exceed 60 calendar days. Item 13 of form FD-06 must be completed by the clinic. Follow the same procedure as in A above to obtain prior authorization.

202.3 Transportation Services

Transportation arranged by a treating facility to transport eligible persons from place of residence or a designated central point to the medical care facility will be included in the established per diem rate. Prior authorization is not required.

EXCEPTION: Certain facilities have been approved as providers of invalid coach services. This service requires prior authorization for all but emergency services and a separate negotiated rate for the service has been established. These facilities receive the Medicaid Transportation Manual.

To obtain prior authorization for Invalid Coach services submit all three copies of the MC-14 C1 to the appropriate Local Medical Assistance Unit together with a certification of medical necessity from the prescribing physician. If authorized the clinic will receive the Provider and Contractor copies of the MC-14 C1 with appropriate comments in item 10. After the authorized service has been rendered enter the date(s) of service, etc. in item 11 and submit the Contractors copy to Prudential for payment.

If not authorized the Clinic will receive written notification of the reason(s) for the denial.

202.4 Podiatry Services

When recommended by the supervising physician or supervising podiatrist as an integral part of the patient's medical care plan, and provided by a licensed podiatrist. Except in an emergency, prior authorization from the Podiatry Services Unit, Division of Medical Assistance and Health Services, P.O. Box 2485, Trenton, New Jersey 08625 is required for all treatments beyond the initial examination and evaluation. A written request identifying the case and containing sufficient information about the problem and plan of treatment to enable the Unit to make an evaluation must be submitted together with all three copies of claim form MC-14 C1 to the Podiatry Services Unit. Items 1-9 of the MC-14 C1 must be completed by the Clinic. If authorized the Clinic will receive the Provider and Contractor copies of the MC-14 C1 with appropriate comments in item 10. Upon completion of the authorized service(s), complete items 11, 12 and 13 and submit the Contractor copy to Prudential for payment. If not authorized the Clinic will receive notification of the reason(s) for the denial.

202.5 Family Planning Services

Includes but is not limited to professional contraceptive counseling; medical history; medical examination, including pelvic and breast; necessary laboratory tests; prescribed supplies; devices; drugs or medicines; continued medical supervision and/or care; and voluntary vasectomy.

Annual Papanicolaou smear, cytology reading, and appropriate referral when indicated by report is required.

No prior authorization shall be required for family planning clinic services, provided that not more than six (6) visits are made within the year.

NOTE: A year shall be defined as twelve (12) months following the initial visit or annual revisit.

To obtain prior authorization if more than six (6) visits are made within the year submit a completed MC-14 C1 (all three copies) to the appropriate Local Medical Assistance Unit identifying the number of additional visits requested. Supporting documents justifying the need for the additional visits MUST accompany the claim form. If authorized the Clinic will receive the Provider and Contractor copy of the MC-14 C1 with appropriate comments. Upon completion of authorized service(s), complete items 11, 12 and 13 and submit the Contractors copy to Prudential for payment.

If not authorized the Clinic will receive notification of the reason(s) for the denial.

All family planning procedures for which reimbursement is made in the Health Services Program must involve physicians' services.

LIST OF ALLOWABLE FAMILY PLANNING SERVICES

	<u>Procedure Code</u>
<u>Initial Medical Visit - Family Planning</u>	0001
Includes:	
Medical, social, obstetrical history	
Complete pelvic examination - including visual inspection of cervix	
Breast examination	
Papanicolaou smear (excludes cytology study)	
Contraceptive counseling	
Referral as indicated	
Includes costs of birth control drugs dispensed	
<u>Insertion of Intrauterine Device</u>	4583
Includes cost of device and necessary post-procedural follow-up.	
<u>Laboratory, Cytology Study (Papanicolaou Smear)</u>	8917

Medical Revisit - Family Planning

0002

May include pelvic examination, changes in method
or physicians' instructions
Includes costs of birth control drugs dispensed

Annual Medical Revisit - Family Planning

0006

Includes:

Updating medical, social, obstetrical history
Complete pelvic examination including visual
inspection of cervix
Breast examination
Papanicolaou smear (excludes cytology study)
Referral when indicated
Includes costs of birth control drugs dispensed

Vasectomy

4241

202.6 Dental Services

Includes diagnostic, preventive and restorative dental treatments performed by a qualified dentist. All approved Clinics providing Dental Services will be reimbursed on a fee-for-service basis. The mechanism for reimbursement will be to pay billed charges up to 60% of the Health Services Program Schedule of Maximum Dental Allowances.

Clinics are instructed to charge their regular and customary fee for each service. Prudential will pay the billed charges or 60% of the Health Services Program Schedule of Maximum Dental Allowances, whichever is less.

A. No Prior Authorization Required

The following "routine" dental services do not require prior authorization up to a maximum of \$75.00:

1. Diagnostic examination and required radiography (Limit \$25.00).
2. Initial "routine" emergency treatment with required radiography as defined below: (See item 3 for routine procedures.)

Initial "routine" emergencies are defined as those emergencies (limited to procedures in 3, e, f, below) which initially bring the patient to the dentist's office and which, following an examination with required radiography, generate a plan of treatment. Emergencies of this nature must be included on the claim for "routine" services and the charges are applied toward the \$75.00 maximum.

3. "Routine" procedures are limited to those designated below:

a. Oral Prophylaxis

b. Topical flouride application for persons twenty (20) years of age and under

NOTE: This is not a covered service for persons 21 and over.

c. Restoration of carious permanent and deciduous teeth with silver amalgam, silicate cement, composite and other plastic materials.

d. Pulp capping for permanent and deciduous teeth.

e. Pulpotomy for permanent and deciduous teeth. If more than one pulpotomy is necessary, prior authorization of the complete treatment plan is necessary.

f. Extraction of non-restorable teeth. Where multiple extractions are recommended and a dental prosthesis will be needed, prior authorization will be necessary.

The above services may be billed directly to Prudential, P.O. Box 5000, Millville, New Jersey 08332, on the new Dental Claim (form MC-10) without prior authorization if performed by the same provider for a recipient up to a maximum of seventy-five dollars (\$75.00) with the following limitations:

1. That all such "routine" services should be completed within 90 days of the date of the initial visit, and

2. That any such "routine" services may not be initiated again within six (6) months from the date of last service, and

3. All initial emergency, examination and routine denistry services are to be included on one claim. Interim or split bills will be reviewed for compliance with limitations #1 and 2 above.

NOTE: If you are submitting a claim for payment before completion of your treatment plan because the recipient has broken appointments, you must indicate this on the claim. In the event the same recipient returns to you at a later date to complete the "routine" treatment you may submit the second claim to Prudential without prior authorization provided that the total amount of the initial and second claims does not exceed \$75.00 and the second claim is marked "continuation of established treatment plan".

Procedures for "Routine" Dental Services

1. Following verification of the recipient validation card, Dentist examines patient, takes necessary X-rays, performs

emergency treatment if any, and develops a treatment plan on the Dental Claim (MC-10) (Exhibit II) using procedure codes supplied in Appendix A.

2. Treatment is completed by provider (should be within 90 days from initial visit).
 - a. Post-treatment X-rays as necessary are taken.
3. Dental Claim MC-10 (Contractor Copy) sent to Prudential within 90 days of last date of service. Clinic retains provider copy. Pre-treatment and Post-treatment X-rays must be retained by clinic for a minimum of three (3) years from the last date of service and must be available upon request of the Health Services Program or any of its agents.

B. Prior Authorization Required

The following services require prior authorization from the Central Office, Division of Medical Assistance and Health Services.

1. Claims for routine services exceeding \$75.00.
2. Claims for additional routine services excluding emergencies rendered within six months from the date of last service.
3. All claims involving a combination of routine and non-routine services.
4. All claims for non-routine services.

In order to obtain prior authorization, the clinic should examine the patient, develop a treatment plan on claim form MC-10 and submit the MC-10 (Contractor and Provider copies) together with pre-treatment X-rays to: Dental Director, New Jersey Division of Medical Assistance and Health Services, Post Office Box 2706, Trenton, New Jersey 08625. If authorized, both copies of the MC-10 and the X-rays will be returned to the clinic. Upon completion of the authorized treatment the clinic should submit the MC-10 (Contractor's Copy) to Prudential for payment within 90 days from date of last service. Pre-treatment and Post-treatment X-rays must be retained by the clinic for a minimum of three years from the last date of service and must be available upon request of the Health Services Program or any of its agents.

DENTAL CLINICS WILL UTILIZE ONLY THE DENTAL CLAIM (MC-10) AND NOT THE CLINIC SERVICES CLAIM (MC-14). It is recommended that Dental Clinics also request the New Jersey Health Services Program Dental Manual to supplement this publication.

202.7 Mental Health Services

Includes individual and group therapy by and/or under the direct personal supervision of a psychiatrist.

Payment for psychiatric services exceeding a limit of \$300. per eligible recipient in any 12-month period commencing from the date of the patient's initial visit requires submission of a request for prior authorization. When prior authorization is required for psychiatric services, the request is to be submitted in quadruplicate on a Request for Authorization of Psychiatric Services form (FD-07), (Exhibit III) to the Chief of Mental Health Services, Division of Medical Assistance and Health Services, P.O. Box 2486, Trenton, New Jersey 08625. The patient's name, home address, present address if different than home address, H.S.P. case number, Patient person number, age, sex, beginning date of requested authorization and the clinic's name, address etc., are to be inserted on the FD-07 form. Additionally the request must include the diagnosis as set forth in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (latest edition), treatment plan and progress report in detail and prognosis. No post facto authorization will be granted.

When a request for prior authorization is approved, the Chief of Mental Health Services shall provide the clinic with written confirmation for continued care by signing form FD-07 (Request for Authorization of Psychiatric Services) and returning two copies to the clinic. The original copy of the authorization (FD-07) must be attached to the Clinic Services Claim (MC-14) when submitting the claim for payment. The other copy should be retained for your records. When a request for prior authorization is denied, the clinic shall be notified in writing by the Chief of Mental Health Services of the reason.

202.8 Vision Care Clinics

All Vision Care Clinics must be approved by the Division of Medical Assistance and Health Services in accordance with Section 200.2 of this manual. At the time of approval eligible services and a per diem reimbursement rate will be established. Approved clinics are to function in accordance with these procedures and the New Jersey Health Services Program Vision Care Manual, which will also be supplied.

A. No Prior Authorization Required

No prior authorization is required for Screening Examinations, Comprehensive Eye Examinations or Subnormal Vision Examinations.

Exception: Screening examinations performed more frequently than once every two years for persons 16 years of age or over or more frequently than once a year for persons less than 16 years of age require prior authorization.

B. Billing Procedures For Services Not Requiring Prior Authorization

Upon completion of services, clinic submits claim form MC-14 C1 to Prudential for payment. Per diem charges, costs of optical appliances, identification of materials used e.g., type and manufacturer of lenses, name, size, color and manufacturer of frames and the prescription are to be included on the claim.

C. Prior Authorization Required

Prior authorization is required for Vision Training, Contact Lenses, Artificial Eyes, Subnormal Vision Devices, Examinations performed more frequently than the Exception noted in A above, and optical appliances provided more frequently than the Exception noted in A above.

To obtain prior authorization, enter the appropriate information on the claim (MC-14 C1) and submit all three copies to the Vision Care Unit, Division of Medical Assistance and Health Services, P.O. Box 2485 Trenton, New Jersey 08625. If authorized the Provider and Contractor copies will be returned to the Clinic with appropriate comments. Upon completion of authorized services, complete items 11, 12 and 13 and submit the Contractor's Copy of the MC-14 C1 to Prudential.

If not authorized the Clinic will receive written notification of reason(s) for the denial.

203. Basis for Reimbursement

Except where otherwise indicated reimbursement for covered services furnished under the Health Services Program shall be the customary charge of the provider not to exceed a \$5.00 all-inclusive per diem rate unless a rate has been negotiated. In no event shall the payment exceed the customary charge to other individuals receiving the specific service.

The above per diem rate shall include transportation when provided (See Transportation Services 202.3).

CHAPTER III

INDEPENDENT CLINIC BILLING PROCEDURES

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CHAPTER III
BILLING PROCEDURES
INDEPENDENT CLINIC SERVICES

300. BILLING PROCEDURES

This chapter contains basic information necessary for the submission of claims. Included as exhibits are samples of the approved claim and authorization request forms utilized by different types of Independent Clinics, e.g., MC-14 C1 (Independent Outpatient Health Facility), MC-10 C1 (Dental Services) and FD-07 (Request for Authorization of Psychiatric Services). Also included are appropriate instructions for the proper completion of the forms.

301. GENERAL POLICY

Billing should be done on a monthly basis. In all cases, claims must be submitted no later than ninety (90) days after the last date items or services are furnished.

302. 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. 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 an eligible recipient.

To identify patients from State Institutions, see Section 304.1.

303. PRIOR AUTHORIZATION

When submitting claims which require prior authorization for payment, make certain that all authorizations have been properly signed. For all clinic services, except dental and mental health, the MC-14 C1 is used to obtain prior authorization when required.

See Section 201. and 202. to determine those services requiring prior authorizations and procedures for obtaining such authorizations.

304. JURISDICTION FOR AUTHORIZATION OF SERVICES:
DIRECTORY OF LOCAL MEDICAL ASSISTANCE UNITS

As a rule, requests for prior authorization are to be made to the Local Medical Assistance Unit (LMAU) serving the county(ies) identified by the first two digits of the eligible person's Health Services Program Case Number. A list of LMAU's and the counties which they serve is listed below:

EXCEPTIONS:

A. Patients in Long Term Care Institutions, (e.g., skilled nursing facilities, sheltered boarding homes, special hospitals)

Requests for authorization are to be referred to the LMAU serving the county wherein the long term care facility is located.

B. Children Identified by a Code 60 as the 3rd and 4th Digits of the Health Services Program Case Number (e.g., 1260001234)

These children are under the jurisdiction of the New Jersey Division of Youth and Family Services (formerly Bureau of Childrens Services). Requests for authorization are to be referred to the LMAU serving the county wherein the child is residing.

County Code	County	Street Address	Municipality	Zip Code	P.O. Box	Telephone
01	Atlantic	1601 Atlantic Ave.	Atlantic City	08404	1970	609-344-2861
05	Cape May	" " "	" "	"	"	" " "
02	Bergen	50 Main Street	Hackensack	07601		201-488-5667
03	Burlington	Chesley & Alloway Bldg. Rt. 38 & Eayrestown Rd.	Mt. Holly	08060		609-261-0448
04	Camden	530 Cooper Street	Camden	08101	19	609-365-3926
06	Cumberland	7 E. Broad Street	Bridgeton	08302	440	609-451-6550
07	Essex	796 Broad Street	Newark	07101	1576	201-648-2470
08	Gloucester	42 Delaware Avenue	Woodbury	08096	1900	609-845-7185
17	Salem	" " "	"	"	"	" " "
09	Hudson	100 Newkirk Street	Jersey City	07306		201-792-6390
10	Hunterdon	6 Court Street	Flemington	08822		201-782-1130
18	Somerset	" " "	"	"	"	" " "
21	Warren	" " "	"	"	"	" " "
11	Mercer	324 E. State Street	Trenton	08625	2465	609-292-7315
12	Middlesex	75 Paterson Street	New Brunswick	08903	1274	201-246-0653
13	Monmouth	320 Broad Street	Red Bank	07701		201-842-6440
14	Morris	4 Court Street	Morristown	07960		201-267-1700
19	Sussex	" " "	"	"	"	" " "
15	Ocean	1851 Hooper Ave.	Toms River	08753		201-255-6226
16	Passaic	152 Market Street	Paterson	07509	2863	201-523-2800
20	Union	7 Bridge Street	Elizabeth	07201		201-355-8860

C. Patients from State Institutions

For eligible Medicaid recipients from State institutions the first two digits of the Health Services Program Identification Number identify the institution. Specific Local Medical Assistance Units have been assigned to handle prior authorization requests for patients from each institution:

IF PATIENT'S
IDENTIFICATION
NUMBER BEGINS WITH:

RESIDENCE IS
IN:

CONTACT THE LOCAL
MEDICAL ASSISTANCE UNIT
BELOW

31Greystone Park Psychiatric HospMorris LMAU

32	Trenton Psychiatric Hospital	Mercer
33	Marlboro Psychiatric Hospital	Monmouth
34	Ancora Psychiatric Hospital	Camden
35	N.J. Neuropsychiatric Institute	Hunterdon
36	Arthur Brisbane Child Center	Monmouth
41	Vineland State School	Cumberland
42	North Jersey Training School Totowa	Passaic
44	Woodbine State School	Atlantic
45	New Lisbon State School	Burlington
46	E. R. Johnstone Training & Research Center	Burlington
47	Woodbridge State School	Middlesex
48	Hunterdon State School	Hunterdon
90	Family Care	Mercer

304.1 Eligibility of Patients from State Institutions

Medicaid eligibility for patients/residents of State Institutions is determined by the New Jersey Division of Public Welfare's Bureau of Local Operations Area Offices. There are four Area Offices servicing the entire State. Eligibility problems should be referred to the appropriate office as designated below:

AREA OFFICE	INSTITUTION NO. (SEE ABOVE)
Area 1 Bureau of Local Operations Institutional Services Section 1479 Route No. 23 Wayne, N.J. 07470 201-696-6868	#31
	#42
Area 2 Bureau of Local Operations Institutional Services Section P.O. Box 118 Marlboro, N.J. 07746 201-946-9770	#33
	#36
	#47
Area 3 Bureau of Local Operations Institutional Services Section 211 E. State Street Trenton, N.J. 08625 609-292-5931	#32
	#35
	#46
	#48
Area 4 Bureau of Local Operations Institutional Services Section 1170 White Horse Pike Hammonton, N.J. 08037 609-556-2589	#90
	#34
	#41
	#44
	#45

305. CLINIC SERVICES CLAIM FORM MC-14 C1

This form is utilized for the purpose of billing for most covered clinic services, except for dental services in which the Dental Services claim form (MC-10 C1) is used.

The MC-14 C1 is a three-part form including a Contractor's Copy, a Provider's Copy and a Medicaid Copy and is, in effect a combination request for authorization (as required) and billing form.

Supplies of the MC-14 C1 as well as the MC-10 C1, FD-06 and FD-07 may be obtained from:

Manager - Provider Services Division
Prudential Insurance Company of America
P.O. Box 5000
Millville, New Jersey 08332

Billing should be done on a monthly basis, and submitted for payment as soon after the end of the month as is possible.

305.1 Instructions for Completion of Form MC-14 C1 (See Exhibit I)

- 1-4. NAME, ADDRESS, CASE NO. and PERSON NO. - Copy Patient's Name H.S.P. Case Number and Patient Person Number EXACTLY as it appears on the monthly Validation Form. (See Section 101.)
- 5-6. Self-explanatory.
7. OTHER INSURANCE OR LIABILITY COVERAGE - If patient has other Health Insurance or Liability coverage, check appropriate block, provide the name and address of the carrier(s) and show amount paid.
8. EMPLOYMENT RELATED - If patient's illness or injury is work related, enter name and address of employer.
9. NAME AND ADDRESS OF PROVIDER - (This information may be pre-printed).
10. AUTHORIZATION - This space is for office use only and is to be completed by the medical consultant. Not applicable to Psychiatric nor Dental Services, which are authorized on separate forms.
11. REPORT OF SERVICES -
 - A. Enter date(s) of each visit.
 - B. Procedure Code (Optional Appliances only available in Vision Care Manual).
 - C. Describe services rendered.
 - D. Check if Family Planning service provided.
 - E. Enter charge for each service.
12. PATIENT'S CERTIFICATION - Under ordinary circumstances, the patient must sign the claim form when services have been received. The claim form to be signed should indicate services rendered, and the patient must not sign a blank claim form prior to receiving services or as a condition for receiving services.

However when the patient's signature is unobtainable, the following procedure may be used:

A. Illiterate Patient

The patient may sign by mark (X), and the signature must be witnessed by another person including the provider of service who signs his name and address on the same line.

B. Other

If a patient is physically or mentally incapable of signing, a minor child, deceased, or for other reasons the patient's signature is not obtainable through reasonable effort, the form may be signed on his behalf by:

1. A parent, or
2. A legal guardian, or
3. A relative, or
4. A friend, or
5. An individual provider, or
6. A representative of an institution providing care or support, or
7. A representative of a governmental agency providing assistance.

Attached to the claim form or written directly on the form should be a brief explanation of reason patient was not personally able to sign and relationship of signee to the patient-recipient.

13. PROVIDER'S CERTIFICATION - The provider MUST sign and date the form before the claim may be considered.

305.2 Mailing Instructions (No Prior Authorization Necessary)

Mail the Original Copy (Contractor's Copy) to:

The Prudential Insurance Company of America
P.O. Box 5000
Millville, New Jersey 08332

306. INDEPENDENT OUTPATIENT HEALTH FACILITIES FURNISHING OPTICAL APPLIANCES

306.1 Instructions for Completion of Form MC-14 C1

Complete Independent Outpatient Health Facility Claim form, MC-14 C1 (Per Section 305.1). When recording items and services provided, ENTER ITEM CODES FROM MANUAL SUPPLEMENT FURNISHED TO THOSE ELIGIBLE TO PROVIDE SUCH SERVICES.

306.2 Mailing Instructions

- A. When authorization is needed for an optical appliance, the entire 3-part MC-14 C1 packet is mailed to:

Vision Care Unit
Division of Medical Assistance & Health Services
P.O. Box 2486
Trenton, New Jersey 08625

Do not detach any copies. The Vision Care Unit will retain the "Medicaid" Copy.

- B. On return of the remaining two copies, keep the Provider Copy and mail the authorized Contractor's Copy for payment to:

Prudential Insurance Company of America
P.O. Box 5000
Millville, New Jersey 08332

307. INDEPENDENT OUTPATIENT HEALTH FACILITIES FURNISHING DENTAL SERVICES

307.1 Dental Services Claim MC-10 C1

This claim is to be used when billing for all dental services.

307.2 Instructions for Completion of Form MC-10 C1 (Exhibit II)

Item 1-8

Copy patient's name, Health Services Program Case Number and Patient Person Number EXACTLY as it appears on the current monthly validation stub.

Obtain from patient, his present address and telephone number.

If patient has other health insurance, liability coverage, or if there may be third party liability e.g., accident, etc., check appropriate block and provide name of carrier(s). Bill other carrier first and attach to your Medicaid claim an explanation of payment received (or not received if they do not pay) from other carrier.

If patient's treatment is work related, check appropriate block and enter address of patient's employer.

Item 9. Check off place where services are rendered.

Item 10. If not preprinted enter your name, address, Social Security or employer I.D. number and your telephone number.

Item 11. Check appropriate block if patient has existing dentures and complete questions below.

Item 12. Insert the number of pre-treatment and post-treatment X-rays taken.

Item 13. Insert date initial impressions were taken if applicable.

Item 14.

- A. Dates of Service - Record date each service is performed.

- B. Procedure Code - Record procedure code as it appears in Chapter IV of your Dental Manual.
- C. Tooth Code - Record the code of the tooth the procedure is performed on.
- D. Surface - Clearly indicate surface(s) involved using the following abbreviations:

B - Buccal	F - Facial	L - Lingual
D - Distal	I - Incisal	M - Mesial
		O - Occlusal

- E. Description of Service - Include materials used and all pertinent information using the following abbreviations when appropriate:

AM - Amalgam	G - Gold	CC - Chrome Cobalt
AC - Plastic	S - Silicate	SS - Stainless Steel
DR - Defective	C - Composite	
Restoration		

Authorization Column - Do not use this column, it is to be used by the Medicaid Dental Consultant to authorize services (not fees) that require prior authorization under the Dental Program. (See Section 201., 202.)

- F. Fee Requested - Record the fee you are requesting for each procedure performed.

Item 15. This section is to be completed in accordance with Section 305.1 Item 12.

Item 16. Dentist must sign Provider Certification before claim is submitted for payment.

307.3 Mailing Instructions

Mail Contractor's Copy to:

The Prudential Insurance Company of America
P.O. Box 5000
Millville, New Jersey 08332

308. INDEPENDENT OUTPATIENT HEALTH FACILITIES FURNISHING MENTAL HEALTH SERVICES

308.1 Instructions for Completion of Form MC-14 C1

Complete Independent Outpatient Health Facility Claim Form MC-14 C1 (Per Section 305.1).

308.2 Mailing Instructions

Same as 305.2

308.3 Request for Authorization of Psychiatric Services FD-07 (Exhibit III)

This authorization request form is submitted when billed charges for psychiatric services during a period of 12 months exceeds \$300, and continued treatment is deemed necessary. The completed original copy of the FD-07 form and three attached copies are mailed to:

Chief, Bureau of Mental Health Services
Division of Medical Assistance and Health Services
P.O. Box 2486
Trenton, New Jersey 08625

On approval, two copies of the FD-07 will be returned. The original copy must be attached to the Independent Outpatient Health Facility Claim Form (MC-14 C1) when it is sent to the Contractor for payment. The second copy is retained by the Provider.

309. INDEPENDENT OUTPATIENT HEALTH FACILITIES FURNISHING OTHER SERVICES REQUIRING PRIOR AUTHORIZATION.

309.1 Instructions for Completion of Form MC-14 C1

Complete Independent Outpatient Health Facility Claim Form MC-14 C1 (Per Section 305.1) indicating services to be provided.

309.2 Mailing Instructions

Mail three copies of the MC-14 C1 Form to the appropriate Local Medical Assistance Unit, according to the County Code as indicated in Section 304.

On approval, two copies of the MC-14 C1 will be returned. The original copy noting prior authorization is sent to the Contractor for payment, with the second copy retained by the Provider.

310. INDEPENDENT OUTPATIENT HEALTH FACILITIES FURNISHING REHABILITATION SERVICES

310.1 Instructions For Completion of Form MC-14 C1

Complete Independent Outpatient Health Facility Claim Form (See Section 305.1)

310.2 Mailing Instructions

Same as 305.2

310.3 Request for Authorization or Reauthorization for Prescribed Rehabilitation Treatment Program FD-06 (Exhibit IV)

This authorization request form is to be submitted to the appropriate Local Medical Assistance Unit to request authorization for rehabilitation services. The "Patient Information", "Medical Information and Therapy Requested" and "Prescriber Signature" portions of the form must be completed and all three copies are to be submitted to the Local Medical Assistance Unit. NOTE: If the therapist has signed the FD-06, the prescribing practitioner's prescription must accompany the form.

On approval two copies of the FD-06 will be returned. The original (Billing copy) is to be attached to the Independent Outpatient Health Facility Claim Form (MC-14 C1) when it is sent to the Contractor (Prudential) for payment. The second copy (Provider copy) is to be retained by the provider.

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APPENDIX A

PROCEDURE CODES CLASSIFIED AS "ROUTINE" OR WHICH MAY BE USED IN CONJUNCTION WITH "ROUTINE" CODES

<u>PROCEDURE NUMBER</u>	<u>DESCRIPTION</u>
	DIAGNOSTIC
0110	EXAMINATION OF ORAL CAVITY AND COMPLETION OF TREATMENT PLANNING FORM
0130	EMERGENCY ORAL EXAMINATION - FOR TREATMENT AND OBSERVATION OF INJURIES TO TEETH AND SUP- PORTING STRUCTURES, INCLUDING COMPLETE WRITTEN REPORT AND ONE X-RAY (Not applicable when performed as an adjunct to any reimbursable service)
	<u>RADIOGRAPHS</u>
0210	COMPLETE INTRAORAL SERIES OF PERIAPICAL RADIOGRAPHS, INCLUD- ING 2 ADDITIONAL BITE-WING X-RAYS - 16 FILMS
0220	INTRAORAL PERIAPICAL OR BITE- WING RADIOGRAPH, SINGLE VIEW
0230	EACH ADDITIONAL SINGLE PERIA- PICAL OR BITE-WING RADIOGRAM
0240	INTRAORAL RADIOGRAPH, OCCLUSAL MAXILLARY OR MANDIBULAR, SINGLE VIEW

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<u>PROCEDURE NUMBER</u>	<u>DESCRIPTION</u>
	<u>PREVENTIVE</u>
	<u>DENTAL PROPHYLAXIS</u>
1110	ADULTS - OVER 15 YEAR OS AGE, DEPENDING ON SEVERITY
1120	CHILDREN - UP TO AND INCLUDING 15 YEARS OF AGE
	<u>FLUORIDE TREATMENTS</u>
1220	TOPICAL APPLICATION OF STANNOUS FLUORIDE, ONE TREAT- MENT (Excluding Prophylaxis)
1230	TOPICAL APPLICATION OF ACID FLUORIDE PHOSPHATE, ONE TREATMENT (Excluding Prophylaxis)
	<u>RESTORATIVE</u>
	<u>AMALGAM RESTORATIONS</u>
2110	AMALGAM - ONE SURFACE - DECIDUOUS
2120	AMALGAM - TWO SURFACE - DECIDUOUS
2130	AMALGAM - THREE SURFACE - DECIDUOUS
2131	AMALGAM - FOUR OR MORE SURFACES - DECIDUOUS
2140	AMALGAM - ONE SURFACE - PERMANENT

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<u>PROCEDURE NUMBER</u>	<u>DESCRIPTION</u>
2150	AMALGAM - TWO SURFACES, PERMANENT
2160	AMALGAM - THREE SURFACES, PERMANENT
2161	AMALGAM - FOUR OR MORE SUR- FACES, PERMANENT
	<u>SILICATE, ACRYLIC, PLASTIC, AND COMPOSITE RESTORATIONS</u>
2211	SILICATE, ACRYLIC, OR PLASTIC RESTORATIONS (Class III or V) MAXIMUM PER TOOTH
2212	COMPOSITE RESTORATIONS (Class III or V) MAXIMUM PER TOOTH
2213	ACRYLIC, PLASTIC, OR COMPOSITE (INVOLVING INCISAL ANGLE CLASS IV) MAXIMUM PER TOOTH
2214	COMPOSITE RESTORATIONS (POST- ERIOR TOOTH), TWO SURFACES
2215	COMPOSITE RESTORATIONS (POST- ERIOR TOOTH) THREE SURFACES
	NOTE: Composite restorations may be provided on mesial, occlusal, and buccal surfaces of maxillary first bicuspids, however, the distal surface may also be provided but only in conjunction with the mesial and occlusal surfaces.

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<u>PROCEDURE NUMBER</u>	<u>DESCRIPTION</u>
	<u>OTHER RESTORATIVE SERVICES</u>
2951	REINFORCEMENT PINS, PER PIN (Maximum reimbursable three (3) pins)
	<u>ENDODONTICS</u>
	PULP CAPPING (Excluding final restoration)
3110	PULP CAP DIRECT (Excluding final restoration)
	<u>PULPOTOMY</u>
3220	VITAL PULPOTOMY (Limited to one)
	<u>ORAL SURGERY</u>
	<u>ROUTINE EXTRACTIONS</u>
7110	PERMANENT TOOTH OR TEETH
7115	DECIDUOUS TOOTH OR TEETH



1. Patient's last name		First name		2. Patient's street address		Telephone number		
3. Patient's services program case no.		4. Patient Person #	5. Age	6. Sex <input type="checkbox"/> Female <input type="checkbox"/> Male		City,	State	ZIP code

7. Patient's present address if different from above. _____ Telephone number _____

8. Past psychiatric history _____

9. History of Present Psychiatric Illness or Interim Progress Report (Include the date patient first consulted you. If additional space is needed, please use reverse side). _____

10. Diagnosis (Must conform with Diagnostic and Statistical Manual II) _____

11. Treatment Plan

a. Chemotherapy Yes..... No..... If yes, specify medication (include dosage, route and frequency of administration, length of time on RX)

b. Psychotherapy Yes..... No..... If yes, complete applicable information below.

Group (Maximum of 8 patients, minimum session 1½ hours) Frequency of sessions

Individual..... Frequency of sessions Length of sessions: Full (60 min.)..... Half (30 min.).....

Describe type of psychotherapy used:

Other types of therapy: (Specify).....

Effective beginning date of requested services Anticipated duration of treatment months. Prognosis

Reimbursement is to be within the limits of the Program and will not be made for broken appointments or for periods when eligibility is not current.

12. From: Name and address of provider	Social Security or Employer I.D. number	Telephone number
	Provider signature	Date

For Office Use Only

Authorization

TO: : You are authorized to submit a request for payment for
 which shall commence and terminate

Date

.....
 Chief, Bureau of Mental Health Services



REQUEST FOR AUTHORIZATION OR REAUTHORIZATION FOR PRESCRIBED REHABILITATION TREATMENT PROGRAM

PATIENT INFORMATION:

LAST NAME	FIRST NAME	PATIENT'S FULL ADDRESS	
HEALTH SERVICES PROGRAM CASE NO.	PERSON NO.	AGE	M or F SEX

PROVIDER IDENTIFICATION (NAME & ADDRESS)	SOCIAL SECURITY OR EMPLOYER I.D. NO.
	TELEPHONE NO.

MEDICAL INFORMATION AND THERAPY REQUESTED

- TYPE OF THERAPY REQUESTED: () PHYSICAL () OCCUPATIONAL () SPEECH
- HAS PATIENT PREVIOUSLY RECEIVED THERAPY FOR PRESENT ILLNESS? () YES () NO IF YES WHEN _____
- PERTINENT DIAGNOSES (BOTH MEDICAL & THOSE REQUIRING REHAB. SERVICES) _____
- DATE OF ONSET OF MEDICAL DX. _____ OF REHAB. DX. _____ 5. PROGNOSIS _____
- PROSTHETIC OR ORTHOTIC DEVICE IN USE? () YES () NO 7. WAS PATIENT ABLE TO AMBULATE PRIOR TO ONSET OF PRESENT ILLNESS? () YES () NO
- PRESENT FUNCTIONAL STATUS OR DEGREE OF INCAPACITY (CHECK APPROPRIATE SECTION)
 () BEDRIDDEN () CHAIRFAST () AMBULATE WITH ASSISTANCE () INDEPENDENT AMBULATION
 () ABLE TO SUPPLY PERSONAL NEEDS 9. DOES PATIENT'S MENTAL OR PHYSICAL STATUS PERMIT SUGGESTED THERAPY? () YES () NO
- DESCRIBE SPECIFIC TREATMENT AND MODALITIES RECOMMENDED _____
- FREQUENCY OF TREATMENT: _____ TIMES PER WEEK; _____ NUMBER OF WEEKS;
 STARTING DATE _____ ENDING DATE _____ TOTAL NUMBER OF TREATMENTS _____
- ULTIMATE GOAL OF TREATMENT _____
- REAUTHORIZATION REQUEST (COMPLETE THIS SECTION ONLY IF THIS IS A REQUEST FOR CONTINUATION OF PREVIOUSLY AUTHORIZED THERAPY)
 TO REQUEST REAUTHORIZATION DESCRIBE BELOW THE MEDICAL REASONS FOR REQUESTING ADDITIONAL REHABILITATION SERVICES _____

PRESCRIBER SIGNATURE _____ (TO BE COMPLETED FOR INITIAL AND REAUTHORIZATION REQUEST)

ATTENDING PHYSICIAN OR THERAPIST * SIGNATURE _____ (DATE) _____

* IF THERAPIST COMPLETES THIS FORM THE ATTENDING PHYSICIAN'S RX MUST BE ATTACHED

FOR DIVISION USE ONLY

AUTHORIZATION INFORMATION:

() AUTHORIZATION GRANTED () AUTHORIZATION DENIED, LETTER ATTACHED

PHYSICAL, OCCUPATIONAL, SPEECH THERAPY IS AUTHORIZED _____ TIMES PER WEEK
 CIRCLE ONE

FROM _____ TO _____ FOR A TOTAL OF _____ TREATMENTS

AUTHORIZED BY:	SIGNATURE	TITLE	DATE
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