



REC'D JUN 29 1987

NEWSLETTER

New Jersey Health Services Program

Volume..... P-525

June 1, 1987

TO: Chief Executive Officers - DRG Hospitals

SUBJECT: Interim Reimbursement Methodology for Outpatient Claims

PURPOSE: This newsletter is to officially inform DRG hospitals that the New Jersey Medicaid Program must change its reimbursement methodology for hospital outpatient services. Because of the loss of the Medicare outpatient waiver, which occurred January 1, 1987, Medicaid must assure that reimbursement for outpatient services does not exceed the lower of cost or charges defined and determined by Medicare principles of reimbursement.

ACTION: For claims processed on or after July 1, 1987, interim reimbursement for outpatient hospital services provided to Medicaid-eligible patients will reflect the application of a cost-to-charge ratio to the total charge submitted.

The cost-to-charge ratio, applicable to the individual hospital, will be forthcoming under separate notice from the Medicaid Fiscal Agent. Each hospital will receive a more detailed description of the finalized methodology in the near future.

Inquiries regarding this newsletter may be directed to Carl Skowronek, Administrative Analyst at 609-588-2691.



State of New Jersey
 Department of Human Services
 Division of Medical Assistance and Health Services

NEWSLETTER

New Jersey Health Services Program

Volume..... P-526.....

May 27, 1987

TO: Hospital Chief Executive Officers

SUBJECT: Skilled Nursing Facility (SNF) and Intermediate Care Facility (ICF) Per Diem Rates

EFFECTIVE: January 1, 1987

PURPOSE: This newsletter notifies hospitals of the current New Jersey Medicaid statewide weighted average SNF and ICF per diem rates.

BACKGROUND: The New Jersey Medicaid Program reimburses for services provided to hospitalized patients, who no longer require the acute level of care, at a rate commensurate with the patient's level of care while awaiting placement in a long-term care facility.

Hospitals are reminded that they must actively attempt to place the patient in a long-term care facility and these efforts must be documented. (See N.J.A.C. 10:52-1.2(a)19iii.-iv.)

ACTION: Effective since January 1, 1987, for all patient days identified as requiring SNF or ICF level of care, the weighted average SNF and ICF per diem rates are:

<u>SNF</u>	<u>ICF</u>
\$66.19	\$58.47

Please refer any questions regarding this newsletter to your Fiscal Agent:

	<u>Telephone</u>
Blue Cross and Blue Shield of New Jersey, Inc.	- 201-456-2534
or	
The Prudential Insurance Company of America	- 609-293-2254



New Jersey Health Services Program

NEWSLETTER

Volume...P-527.....

June 15, 1987

TO: All Providers

SUBJECT: Medicaid Expansion

EFFECTIVE: July 1, 1987

PURPOSE: The Division of Medical Assistance and Health Services is pleased to announce the expansion of the New Jersey Medicaid Program to include additional pregnant women and children.

ACTION: This expansion authorized by L. 1987, c.115 provides Medicaid coverage for the full range of services to eligible pregnant women and children up to age one (up to age two as of October 1, 1987) whose income is determined not to exceed 100 percent of the federal poverty level.

Women who are determined to be eligible for Medicaid under this new program will retain eligibility through sixty days following the end of pregnancy.

A sample of the "Medicaid Eligibility Card" which will be used to identify these eligible persons is shown below:

STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES		MEDICAID ELIGIBILITY IDENTIFICATION CARD 4402401	
ADDITIONAL HEALTH INSURANCE HIP of Greater New Jersey 654312071234 NO MEDICARE COVERAGE		HSP MEDICAID CASE NO PERSON NO 0130123456 VALID FROM 07-01-87 TO 07-31-87	
ELIGIBLE PERSONS PN Smith, Mary 05 Smith, James 20		SOC SEC ACCT NO DATE OF BIRTH Mary Smith 9 Elm Street Town, New Jersey 12345	
FD 731278 (REV. 10/83)		USE THIS CARD WHEN YOU NEED MEDICAL SERVICES	
		XXXXXXXXXXXXX RECIPIENT'S SIGNATURE	

VOID

All existing New Jersey Medicaid program policies and regulations apply to this new group of eligibles unless specified in this newsletter.

Any questions regarding this Medicaid expansion should be directed to the Medicaid District Office serving your area.



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

NEWSLETTER

New Jersey Health Services Program

Volume P-528

July 20, 1987

TO: All Providers

SUBJECT: Third Party Liability Insurance Coverage

EFFECTIVE: Immediately

PURPOSE: The purpose of this newsletter is to emphasize to all providers that the New Jersey Medicaid Program is the last payer when insurance coverage is available for services provided to the Medicaid-eligible individual.

BACKGROUND: Under current program policy, services provided to Medicaid-eligible individuals who are also covered by other health insurance must be billed by the provider to the other insurance carrier. This includes billing Medicare for Medicare covered services provided to individuals covered by both Medicare and Medicaid.

ACTION: Providers are reminded to review carefully the Medicaid Eligibility Identification Card (MEI) for evidence of other insurance coverage. If the third digit of the HSP(Medicaid)Case Number is a 1, 2, 5, or 7, the individual may be eligible for Medicare benefits.

For services covered by Medicare, providers are instructed to bill the Medicare Intermediary/Carrier on the appropriate claim form. Billing Medicaid for services covered by Medicare results in claim processing delays, administrative cost increases, and unnecessary correspondence.

Also, please remember that when billing for services for a Medicare/Medicaid eligible individual, both the Medicare and Medicaid numbers must be entered on the appropriate claim form. By so doing, the provider will be assured of the automatic transfer of the claim from Medicare to Medicaid. As a result claims will be processed more expeditiously.

Questions regarding this newsletter are to be directed to Murray Goldberg, Chief, Third Party Liability Programs. Telephone 609-588-3039.

REC'D JUL 24 1987



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

New Jersey Health Services Program

NEWSLETTER

Volume.....P-529.....

July 27, 1987

To: Home Health and Homemaker Agencies
Participating in the Community Care Program
for the Elderly and Disabled (CCPED) and the Personal
Care Assistant Program

Subject: Rate Increase for CCPED Homemaker Services

Effective: August 1, 1987

Background: The Division of Medical Assistance and Health Services is pleased to announce that reimbursement rates for homemaker services provided by Home Health Agencies and Homemaker Agencies will be increased effective August 1, 1987.

In addition, reimbursement to these agencies for Personal Care Assistant services will be increased at a comparable rate following adoption in the New Jersey Register in accord with the Administrative Procedure Act. A subsequent newsletter will be issued to these agencies detailing the maximum allowable rate increase for Personal Care Assistant services.

Purpose: This newsletter informs providers that Medicaid reimbursement rates for certain homemaker services provided under the Community Care Program for the Elderly and Disabled will increase for services provided on or after August 1, 1987 as follows:

Community Care Program for the Elderly and Disabled:

1. Homemaker Services - Code Z1200 -
Individual reimbursement rate - Up to \$9.00 per hour/weekday;
2. Homemaker Service - Code Z1295 -
Individual reimbursement rate - Up to \$10.00 per hour/weekend,
holiday;
3. Initial Evaluation Visit RN - Code Z1205 -
Reimbursement rate - Up to \$28.00 per visit.

Please note, the reimbursement rate for Nursing Reassessment Visit, Code Z1290, will not be increased, but will remain at the maximum allowable rate of \$20.00 per visit.

When billing for CCPED services, Home Health Agencies and Homemaker Agencies are instructed to prepare a separate claim form for services provided up to and including July 31, 1987. For services provided on and after August 1, 1987, another claim form is to be prepared in order to expedite claim processing.

Agencies are also reminded that while Medicaid reimbursement is the lower of the provider's charges or the Medicaid maximum allowable rate, the agencies are to bill using their usual and customary charge amount. Medicaid reimbursement is payment in full and may not be supplemented by additional billing to the Medicaid recipient or to anyone on behalf of the recipient.

Questions regarding this Newsletter are to be directed to Carol Kurland, Administrator, Office of Home Care Programs, Division of Medical Assistance and Health Services at (609) 588-2620.



AUG 13 1987

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

New Jersey Health Services Program

NEWSLETTER

Volume.....P-530.....

August 3, 1987

TO: All Providers

SUBJECT: New Jersey Medicaid Services Manual Information
SHARED HEALTH CARE FACILITIES

Attached is information to be added to Chapter 49 (Administration) of your New Jersey Medicaid Program Services Manual. It is Subchapter 9. (Requirements Applicable to Shared Health Care Facilities) of Chapter 49.

A revised Subchapter 1. of Chapter 49 was distributed by Newsletter P-492/BC-344, August 25, 1986. Other administrative areas of interest to providers will be included in subchapters to be distributed in the future.

If you have any questions about this Subchapter, please contact Peter Amato, Supervising Medical Review Analyst, Bureau of Medical Care Surveillance, Provider Unit, Division of Medical Assistance and Health Services, at 609-588-3058.

SUBCHAPTER 9. REQUIREMENTS APPLICABLE TO SHARED HEALTH CARE FACILITIES

10:49-9.1 DEFINITIONS

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

"Department" means the Department of Human Services.

"Discipline" means such things as medicine, dentistry, chiropractic, and so forth.

"Division" means the Division of Medical Assistance and Health Services.

"Patient" means anyone eligible to receive benefits from the Program.

"Program" means the New Jersey Health Services Program.

"Provider" means any person, firm, corporation or other entity providing services under the Program.

"Purveyor" means any person, firm, corporation or other entity other than a provider who, whether or not located in a building which houses a shared health care facility, directly or indirectly, engages in the business of supplying to ultimate users or providers within the shared health care facility any medical supplies, equipment and/or services for which reimbursement under the Program is received, including, but not limited to, clinical laboratory services or supplies; x-ray laboratory services; sick room supplies; physical therapy services or equipment; orthopedic or surgical appliances or supplies; drugs, medication or medical supplies; eyeglasses, lenses or other optical supplies or equipment; hearing aids or devices; and any other goods, services, supplies, equipment or procedures prescribed, ordered, recommended or suggested for medical diagnosis, care or treatment, and which amount to \$10,000 per year.

"Shared health care facility" means four or more providers, two or more of whom are practicing within different specialties and/or disciplines, either independently or in association with each other, within a single structure; and

1. Two or more of whom share any of the following:
 - i. Common waiting areas;
 - ii. Examining rooms;
 - iii. Treatment rooms;
 - iv. Equipment;
 - v. Supporting staff;
 - vi. Common records; and

2. One or more of whom receives payment on a fee-for-service basis, and where the gross Medicaid income for the facility meets or exceeds \$80,000 per year.

"Specialty" means such things as pediatrics, obstetrics/gynecology, orthodontics, periodontics, and so forth.

10:49-9.2 APPLICATION

- (a) This Subchapter shall apply to shared health care facilities as defined herein and to the providers located in a specific health care facility.
- (b) This Subchapter shall apply to purveyors, whether or not located in a building which houses a shared health care facility.
- (c) Nothing in this Subchapter shall apply to an association of health care providers delivering health services on other than a fee-for-service basis.
- (d) This Subchapter shall not apply to hospitals participating in the New Jersey Medicaid Program.

10:49-9.3 REGISTRATION OF SHARED HEALTH CARE FACILITIES

- (a) No shared health care facility shall be operated under the Program unless it has been registered with the Division.
 1. Providers within the shared health care facility shall designate one provider member who shall be responsible for registration;
 2. Said responsibility and liability by the designated provider, pursuant to paragraph 1 of this Subsection, shall be limited to timely filing of accurate reports required under this regulation.
- (b) Registration shall be made on forms furnished by the Division and shall contain the information required therein, including, but not limited to:
 1. The name of the owner or owners of the facility;
 2. The name, residence address and professional license number of every provider and purveyor working in the shared health care facility;
 3. The name, residence address and curriculum vitae of the individual designated to assume responsibility for the central coordination and management of the shared health care facility's activities, if so designated;
 4. Any owner, lessor or lessee shall furnish to the Division a copy of the lease agreement upon request;

5. The name of any person, firm or corporation providing administrative, clerical or billing services to provider in shared health care facilities, other than employees of provider;
 6. The name and address of lessor's of any space or equipment in the shared health care facility.
- (c) The registrant shall re-register on the June 1 next following initial registration, and annually thereafter on June 1.
- (d) The Division shall be notified within 30 days of any change in:
1. The owner or owners of the facility;
 2. The termination of the services of the individual designated to assume responsibility for coordination and management of the shared health care facility's activities. The Division shall also be notified within 30 days of the name, residence address and professional qualifications of any new individual appointed to assume such central administrative responsibility;
 3. Any addition or termination of any provider or purveyor in the share health care facility. Such notification shall include the name, residence address and license number of each person appointed in place of such individual.

10:49-9.4 PROHIBITED PRACTICES; ADMINISTRATIVE REQUIREMENTS

- (a) The Division shall not enter into any agreement of Medicaid participation, nor shall any payment be made to any provider in a shared health care facility where the rental fee for the letting of space or supportive professional or clerical services to a provider in a shared health care facility is calculated in whole or in part, directly or indirectly, as a percentage of earnings or billings of the provider for services rendered on the premises in which the shared health care facility is located.
- (b) No purveyor or provider, whether or not located in a building which houses a shared health care facility, shall directly or indirectly offer, pay or give, or permit or cause to be offered, paid or given to any provider or purveyor, and no provider or purveyor shall directly or indirectly solicit, request, receive or accept from any purveyor or provider any sum of money, credit or other valuable consideration for:
1. Recommending or procuring goods, services or equipment of such purveyor or provider to any other person; or
 2. Directing patronage or clientele to such purveyor or provider; or
 3. Influencing any person to refrain from using or utilizing goods, services or equipment of any purveyor or provider.

(c) Patient referral rules are:

1. No provider in a shared health care facility or person employed in such facility shall refer a patient to another provider located in such facility, unless the records of the referring provider pertaining to such patient clearly sets forth the justification for such referral;
2. Every provider practicing in a shared health care facility who treats a patient referred to him by another provider practicing in the same facility shall communicate in writing to the referring provider, the diagnostic evaluation and the therapy rendered. The referring provider shall incorporate such information into the patient's permanent record;
3. The invoice submitted to the Program by the provider to whom such patient has been referred shall contain the full name and provider number of the referring provider, and identify the medical problem which necessitated the referral.

(d) Any pharmacy maintaining a business in the same building in which a shared health care facility is located shall prominently post a notice informing patients that all pharmaceuticals prescribed in the Program may be obtained at any pharmacy of the recipient's choice.

(e) No purveyor or provider other than a physician, dentist, podiatrist, optometrist or chiropractor, who maintains a business in the building in which a shared health care facility is located, shall maintain a door or window opening into the offices or waiting room of the shared health care facility.

(f) All provider claims submitted for services rendered at a shared health care facility shall contain the registration code of the facility at which the service was performed and be signed by the provider who rendered service.

(g) In a shared health care facility, an Annual Health Maintenance Examination, or a Comprehensive Eye Examination with or without Diagnostic Fields, or an Early and Periodic Screening, Diagnosis, and Treatment may be billed only once for the same patient during any 12 month period. All referrals within the shared health care facility will be billed as Routine Visit or Follow-Up Care Visit.

1. For reimbursement purposes, an Initial Office Visit is limited to a single visit and future use of this code will be reimbursed as a Routine Visit or Follow-up Care Visit.

(h) It shall be unlawful for any provider to pay a bonus, commission or fee to any other provider based on business supplied or referred.

10:49-9.5 QUALITY OF CARE REQUIREMENTS

(a) To ensure quality, continuity and proper coordination of medical care, each shared health care facility shall:

1. Where feasible, designate an individual who, on a full-time basis, shall coordinate and manage the facility's activities;
2. Devise an appropriate means of insuring that patients will be scheduled to return for appropriate follow-up care and will be treated by a provider familiar with the patient's medical history;
3. Post conspicuously the names and scheduled office hours of all providers practicing in the facility;
4. Maintain proper records. Such records shall contain at least the following information;
 - i. The full name, address and HSP (Medicaid) Case Number of the patient;
 - ii. The dates of all visits to all providers in the shared health care facility;
 - iii. The chief complaint for each visit to each provider in the shared health care facility;
 - iv. Pertinent history and all physical examinations rendered by each provider in the shared health care facility;
 - v. Diagnostic impressions for each visit to any provider in the shared health care facility;
 - vi. All medications prescribed at each visit to any provider in the shared health care facility who is qualified to issue prescriptions;
 - vii. The precise dosage and prescription regimens for each medication prescribed by a provider in the shared health care facility;
 - viii. All x-ray, laboratory work and electrocardiograms ordered at each visit by any provider in the shared health care facility;
 - ix. The results of all x-ray, laboratory work and electrocardiograms ordered as in subparagraph viii. above;
 - x. All referrals by providers in the shared health care facility to other medical providers and the reason for such referrals, and date of referral;
 - xi. A statement as to whether or not the patient is expected to return for further treatment.
5. The Division shall have the right to inspect the business records, patient records, leases and other contracts executed by any provider in a shared health care facility. Such

inspections may be by site visits to the shared health care facility;

6. If any provision of this regulation or the application thereof to any person or circumstance is enjoined or otherwise held invalid, such invalidity shall not affect other provisions or application of the regulation which can be given effect, and to this end the provisions of this regulation are considered severable.



AUG 10 1987

New Jersey Health Services Program

NEWSLETTER

Volume..... P- 531

August 10, 1987

TO: Independent Clinic Providers

SUBJECT: Codes for Speech-Language Pathology Evaluation

EFFECTIVE: Immediately

PURPOSE: The New Jersey Medicaid Program wishes to bring to your attention a change in the description under Code Z0300 and an addition of a new code to the rehabilitation procedure codes.

<u>HCPCS CODE</u>	<u>DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>
Z0300	Speech-Language Pathology - Initial Visit Screening Examination, per individual, per provider	\$ 7.00
	(Please note that the description for the code "Z0300" replaces the one which appears in Subchapter 3 (HCPCS CODES FOR INDEPENDENT CLINIC SERVICES) in Appendix A/8.)	
Z0310	Initial Comprehensive Speech-Language Pathology Evaluation by a licensed speech-language pathologist to assess and diagnose a problem, or problems, in any of the following areas: language competence and performance, phonological development or articulation skills, and/or physical integrity and performance of the speech mechanism including the respiratory, phonatory and articulation systems. <u>Such evaluation requires 3 hours on the average.</u> Discussion and consultation with the patient and/or family regarding findings, and a written report, are considered an integral part of the evaluation.	\$ 45.00

NOTE: It is the intent of the Program to reimburse for either a screening examination

HCPCS CODE

DESCRIPTION

MAXIMUM FEE ALLOWANCE

or a comprehensive speech-language evaluation rendered the patient, not both. If, as a result of the screening examination, it is believed that a comprehensive evaluation is necessary, it should be completed at that time, or at the earliest mutual convenience of the patient and the provider. The screening examination, in this instance, becomes an integral part of the comprehensive evaluation and the claim submitted to the Program should be for a comprehensive speech-language evaluation. If, however, the documentation reveals that the screening examination did not support the need for a comprehensive evaluation, the code will be downgraded to Z0300 Speech-Language Pathology - Initial Visit Screening Examination.

If you have any questions regarding this Newsletter, please contact Danuta Buzdygan, M.D., Pediatric Consultant, Division of Medical Assistance and Health Services at 609-588-2718.

AUG 10 1987



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

NEWSLETTER

New Jersey Health Services Program

Volume..... P-532.....

August 10, 1987

TO: Medical Day Care Providers

SUBJECT: Codes for Speech-Language Pathology Evaluation

EFFECTIVE: Immediately

PURPOSE: The New Jersey Medicaid Program wishes to bring to your attention a change in the description under Code Z0300 and an addition of a new code to the rehabilitation procedure codes.

<u>HCPCS CODE</u>	<u>DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>
Z0300	Speech-Language Pathology - Initial Visit Screening Examination, per individual, per provider	\$ 7.00
Z0310	Initial Comprehensive Speech-Language Pathology Evaluation by a licensed speech-language pathologist to assess and diagnose a problem, or problems, in any of the following areas: language competence and performance, phonological development or articulation skills, and/or physical integrity and performance of the speech mechanism including the respiratory, phonatory and articulation systems. <u>Such evaluation requires 3 hours on the average.</u> Discussion and consultation with the patient and/or family regarding findings, and a written report, are considered an integral part of the evaluation.	\$ 45.00

NOTE: It is the intent of the Program to reimburse for either a screening examination or a comprehensive speech-language evaluation rendered the patient, not both.

HCPCS CODE

DESCRIPTION

MAXIMUM FEE ALLOWANCE

If, as a result of the screening examination, it is believed that a comprehensive evaluation is necessary, it should be completed at that time, or at the earliest mutual convenience of the patient and the provider. The screening examination, in this instance, becomes an integral part of the comprehensive evaluation and the claim submitted to the Program should be for a comprehensive speech-language evaluation. If, however, the documentation reveals that the screening examination did not support the need for a comprehensive evaluation, the code will be downgraded to Z0300 Speech-Language Pathology - Initial Visit Screening Examination.

If you have any questions regarding this Newsletter, please contact Danuta Buzdygan, M.D., Pediatric Consultant, Division of Medical Assistance and Health Services at 609-588-2718.



AUG 14 1987

New Jersey Health Services Program

NEWSLETTER

Volume..... P-534.....

August 10, 1987

TO: Administrators - Ambulatory Surgical Centers

SUBJECT: Intraocular Lenses

PURPOSE: The Division of Medical Assistance and Health Services is pleased to inform Ambulatory Surgical Center (ASC) providers that they may be reimbursed for providing intraocular lenses.

BACKGROUND: An ASC may seek reimbursement as a provider of optical appliances in the instance in which the facility provides the intraocular lens for the physician performing eye surgery in the ASC. The intraocular lens used in conjunction with cataract surgery is reimbursed at actual invoice cost to the ASC or the physician but not to both. Invoice cost is defined as the net amount paid by the provider and is reflective of all discounts or special purchase agreements.

ACTION:

1. To become eligible for reimbursement for intraocular lenses the ASC must request The Prudential Insurance Company of America to list the ASC as an Optical Appliance Provider for the New Jersey Medicaid Program, with the intent to supply intraocular lenses only.

Write or telephone your request to:

The Prudential Insurance Company of America
Post Office Box 5007
Millville, New Jersey 08332
1-800-582-7052

2. The Prudential Insurance Company of America will assign the ASC an Optical Appliance Provider number and forward to the ASC preprinted MC-9 claim forms (Request for Authorization and Payment - Optical Appliances) with instructions for completing the claim form. Complete the MC-9 claim form and attach to it the invoice supplied by the manufacturer of the intraocular lens. Forward both to:

Vision Care Unit
Division of Medical Assistance
and Health Services
CN-712
Trenton, New Jersey 08625

The Vision Care Unit will do a postservice, prepayment review of the MC-9 claim form and if found in order, will then forward it to the Prudential Insurance Company of America for payment. If the claim is denied, the provider will be notified of the reason, in writing, by the Vision Care Consultant. The ASC will use the MC-9 claim form only for requesting reimbursement of intraocular lenses.

3. The ASC will continue to bill for the facility fee on an MC-14 claim form (Independent Outpatient Health Facility).

Any questions concerning this Newsletter may be referred to A. F. Senaldi, O.D., Vision Care Consultant, Division of Medical Assistance and Health Services, at (609) 588-2745.



August 17, 1987

- TO:** Dentists, Independent Dental Clinics, and
Chief Executive Officers - Hospitals
- SUBJECT:** Use of HCPCS Dental Codes which became
Effective April 1, 1987 (Dental Services Claim form MC-10)
- PURPOSE:** This Newsletter is to remind providers of dental services that
dental claims must include the applicable HCPCS dental codes.
- BACKGROUND:** Newsletters P-511 or BC-364, dated March 2, 1987, officially
notified providers of dental services that the New Jersey
Medicaid Program would convert to the Health Care Financing Administration's
Common Procedure Coding System (HCPCS). Attached to this Newsletter was a
revised Subchapter 3. (Ed. 4/87), listing new dental procedure codes which were
to replace the June, 1984 revision. The Newsletter stated that all claims
submitted on or after April 1, 1987, must include the applicable HCPCS dental
codes. Many providers have not complied with this regulation.
- Since the New Jersey Medicaid Program's Fiscal Agent (The Prudential Insurance
Company of America) made all the necessary changes to the claim processing
system to become effective April 1, 1987, failure to use the new HCPCS dental
codes interferes with prompt reimbursement to the provider.
- ACTION:** Claims received on or after September 15, 1987, submitted on
Dental Services Claim form MC-10, which do not include the
applicable HCPCS dental codes will not be processed but will be returned to the
provider for correction.
- PLEASE NOTE:** Dental providers who may not have received the revised Dental
Services Manual Subchapter 3. relevant to the new HCPCS dental codes
(Newsletter P-511/BC-364, dated March 2, 1987) can order this material directly
by calling the Provider Reorder Section: 609-293-2317. A toll-free line is
also available: 1-800-582-7052.

Any questions concerning this Newsletter should be directed to Archie H. Bell,
D.D.S., Chief, Bureau of Dental Services, Division of Medical Assistance and
Health Services, telephone 609-588-7136.



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

New Jersey Health Services Program

NEWSLETTER

Volume.....P-537.....

September 28, 1987

TO: Medical Day Care Centers

SUBJECT: Documentation Requirement Changes

EFFECTIVE: Immediately

In a continuing effort to ensure that the needs of each Medicaid medical day care center participant are appropriately met, the New Jersey Medicaid Program recently made changes to the documentation requirements for medical day care centers. This will not only ensure uniformity but will result in a more comprehensive record.

Medical day care centers must complete the record of each medical day care center participant, i.e., plan of care, nursing assessment, social history, activity assessment, after the first five days of attendance or within one month, whichever is less; thereafter, all records must be updated every 90 days with input from each professional discipline. This does not preclude the completion, by the nurse, of event-triggered documentation as often as necessary to assure consistent follow-up to care needs.

MANUAL MAINTENANCE: The enclosed pages, 7, 9, and 10, dated Rev. 9/87, replace the same page numbers, dated 5/84 in the Medical Day Care Services Manual.

If there are any questions concerning this Newsletter, please contact Carol H. Kurland, Administrator, Office of Home Care Programs, Division of Medical Assistance and Health Services at (609) 588-2620.

MEDICAL DAY CARE SERVICES MANUAL

- iii. Occupational therapy shall be included in the per diem costs for Medical Day Care.

1.5 STAFF

- (a) The Center shall have adequate staff capability to provide supervision to the participants at all times. The composition of the staff shall depend in part on the needs of the participants and on the number of participants the program is serving. As a minimum, the Center must have a Medical Day Care Center Director, a registered Professional Nurse, a Social Worker, an Activities Coordinator and a Medical Director. If the freestanding facility has no Medical Director, a licensed physician shall be appointed to serve in this capacity.

1. Medical Day Care Center Director

The Director of the Center is responsible for the overall conduct and management of all program activities on a full-time basis. The Director shall:

- i. Be a qualified health professional, such as a Nursing Home Administrator, licensed nurse, physician, licensed physical therapist, certified eligible occupational or speech-language pathologist or social worker.
- ii. Be experienced in the care of the elderly and disabled and knowledgeable regarding their physical, social and medical health needs.

2. Registered Professional Nurse

The Registered Professional Nurse is a person who is licensed by the New Jersey Board of Nursing pursuant to N.J.S.A. 45:11-26 et seq. and has at least one year full-time or full-time equivalent experience in a health care setting.

3. Social Worker

The Social Worker shall possess a Master's degree in Social Work from an accredited graduate school of Social Work plus one year of full-time or full-time equivalent social work experience in a health care setting. If a designate is utilized, the designate shall possess a Bachelor's degree in the social sciences plus one year of social work experience in a health care setting. A designate must have available on-site consultation from a qualified social worker, a person with a Master's degree in Social Work from an accredited School of Social Work in accordance with the Department of Health's standards. (See N.J.A.C. 8:39-12.2).

4. Activities Coordinator

An Activities Coordinator is a person who has:

- i. A bachelor's degree from an accredited college with a major in recreation, occupational therapy, or a field related to

MEDICAL DAY CARE SERVICES MANUAL

Assistance and Health Services before an applicant for Medical Day Care can be considered medically eligible for the service within the New Jersey Medicaid Program.

- (b) A Request for Medical Day Care Authorization or Reauthorization Form FD-140, (Exhibit IV) must be submitted by the Medical Day Care Center for each potential participant as a basis for determining a prior authorization or reauthorization for Medical Day Care Services. In order to avoid delay in approval, all information must be individualized, complete and comprehensive. The FD-140 will be reviewed by the Medical Evaluation Team, consisting of the Medical Consultant, Regional Staff Nurse, and Medicaid Social Worker and a determination will be made as to the person's eligibility for the Medical Day Care. The maximum duration for an initial authorization is 90 days (or less); reauthorization may be for a period up to six months.
- (c) While an authorization/reauthorization for Medical Day Care services is in effect and the condition of the patient changes, indicating the need for additional or decreased services, the Medical Day Care Center after consultation with the attending physician may submit a revised FD-140.
- (d) The Medical Day Care Center may bill the Medicaid Fiscal Agent, Prudential Insurance Company, for one initial visit evaluation for eligible recipients without prior authorization.

1.7 PARTICIPANT REVIEW AND EVALUATION

- (a) Each participant in the Medical Day Care Program shall be seen by his/her attending physician, as needed but at least every 90 days. A record of the physician's visit, findings, and recommendations shall be documented on the participant's chart.
- (b) Every 90 days the participant's individualized plan of care shall be updated by the Medical Day Care Center staff to reflect the needs of the participant for Medical Day Care. This plan shall become part of the patient's permanent record at the center.

1.8 RECORDS

- (a) As a minimum, the participant's chart shall contain the following information:
 - 1. Application for admission form;
 - 2. Individualized plan of care; performed after the first five days of attendance or within a period of one month (whichever is less) and updated every 90 days, with input from each discipline;
 - 3. Medical history, record of physical examination, and medication record as recorded initially by the attending physician and updated every 90 days thereafter, citing general medical condition, disabilities and limitations. Also included shall be any consultations and laboratory reports performed;

MEDICAL DAY CARE SERVICES MANUAL

4. Nursing assessment to be completed after the first five days of attendance or within a period of a month (whichever is less); daily nursing observations for the first five days of attendance and nursing progress notes; care plan, and short-term goals at least every 90 days thereafter; long-term goals to be revised annually;
 - i. This does not preclude the completion, by the nurse, of event-triggered documentation as often as necessary to assure consistent follow-up to care needs.
5. Social history to be completed after the first five days of attendance or within a period of one month (whichever is less); social service progress notes every 90 days;
6. Activity assessment and plan to be completed after the first five days of attendance or within a period of a month (whichever is less); activity progress notes every 90 days;
7. Physical, Speech-language pathology, and Occupational Therapy and dietary progress notes as indicated;
8. Discharge Plan.

(b) Individualized Plan of Care

An Individualized Plan of Care shall be written for each participant, with input from the participant, family, and interested community agencies. The plan shall state medical needs of the participant as evaluated by the attending physician, and nursing, social service, activity and other service needs as determined by the Center Staff, with in-put from community agencies. Overall goals and services to be provided by the Center to fulfill the needs expressed should be indicated.

1. The Individualized Plan of Care shall be signed by the physician and by all Center Staff preparing the report.
2. Up-date of this plan shall be made at least every 90 days.
3. This Individualized Plan of Care is not part of the authorization/reauthorization process. Therefore, it should not be sent to the Medicaid District Office with the FD-140 form, which is to be used for the authorization/reauthorization only.

1.9 DISASTER PLAN

The Facility Disaster Plan shall be posted at the Nurses' station and other conspicuous locations throughout the Medical Day Care Center.



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

OCT 20 1987

NEWSLETTER

New Jersey Health Services Program

Volume...P:- 5.38.....

October 1, 1987

To: Independent Mental Health Clinics Participating in the Personal Care Assistant Program Under Contract to the Department of Human Services, Division of Mental Health and Hospitals

Subject: Rate Increase for Personal Care Assistant Services

Effective: October 1, 1987

Purpose: The Division of Medical Assistance and Health Services is pleased to announce that reimbursement rates for Personal Care Assistant services have been increased as follows:

Personal Care Assistant Services

1. Individual Reimbursement Rate - Up to \$8.34 per hour - Code Z1600ZI;
2. Group Reimbursement Rate - Up to \$6.76 per hour - Code Z1605ZI;
3. Individual Reimbursement Rate - Up to \$4.17 per half-hour - Code Z1611ZI;
4. Group Reimbursement Rate - Up to \$3.38 per half-hour - Code Z1612ZI; and
5. Initial Nursing Assessment Visit - Up to \$28.00 per visit - Code Z1610ZI.

Please note, the reimbursement rate for the Nursing Reassessment Visit, Code Z1613ZI, will not be increased, but will remain at the maximum allowable rate of \$20.00 per visit.

Claim Processing:

It is to be noted also that for data purposes only, Personal Care Assistant codes for services provided in an Independent Clinic setting, now have a modifier, ZI, added to their codes to identify Independent Clinics as the setting for services provided as opposed to other providers of Personal Care Assistant services. The Independent Outpatient Health Facility, MC-14 form, (Item 13B) is to be completed in the usual and customary manner, except that the code now will be a 7 digit entry, such as Z1600ZI, etc.

When billing for Personal Care Assistant services, providers are instructed to prepare a separate claim form for services provided up to and including September 30, 1987. For services provided on or after October 1, 1987, another claim form is to be prepared in order to expedite claim processing.

Questions regarding this newsletter are to be directed to Carol Kurland, Administrator, Office of Home Care Programs, Division of Medical Assistance and Health Services, at (609) 588-2620.



OCT 20 1987

New Jersey Health Services Program

NEWSLETTER

Volume P-539.....

October 1, 1987

To: Home Health and Homemaker Agencies
Subject: Rate Increase for Personal Care Assistant Services
Effective: October 1, 1987

Purpose: The Division of Medical Assistance and Health Services is pleased to announce that reimbursement rates for Personal Care Assistant services have been increased as follows:

Personal Care Assistant Services

1. Individual Reimbursement Rate - Weekday
Up to \$9.00 per hour - Code Z1600;
2. Individual Reimbursement Rate - Weekday
Up to \$4.50 per half-hour - Code Z1611;
3. Group Reimbursement Rate - Weekday
Up to \$6.76 per hour - Code Z1605;
4. Group Reimbursement Rate - Weekday
Up to \$3.38 per half-hour - Code Z1612;
5. Individual Reimbursement Rate - Weekend/Holiday
Up to \$10.00 per hour - Code Z1614;
6. Individual Reimbursement Rate - Weekend/Holiday
Up to \$5.00 per half-hour - Code Z1615;
7. Group Reimbursement Rate - Weekend/Holiday
Up to \$7.76 per hour - Code Z1616
8. Group Reimbursement Rate - Weekend/Holiday
Up to \$3.88 per half-hour - Code Z1617; and
9. Initial Nursing Assessment Visit
Up to \$28.00 - Code Z1610.

Please note, the reimbursement rate for the Nursing Reassessment Visit, Code Z1613, will not be increased, but will remain at the maximum allowable rate of \$20.00 per visit.

Agencies are reminded that a personal care assistant means a person who has successfully completed the 60 hour home health aide training and certification requirements of the New Jersey State Department of Health. Also, homemaker services provided under the Community Care Program for the Elderly and Disabled (CCPED) must be provided by a certified homemaker/home health aide.

Claim Processing:

When billing for Personal Care Assistant services, the providers are instructed to prepare a separate claim form for services provided up to and including September 30, 1987. For services provided on or after October 1, 1987, another claim form is to be prepared in order to expedite claim processing.

Questions regarding this newsletter are to be directed to Carol Kurland, Administrator, Office of Home Care Programs, Division of Medical Assistance and Health Services at (609) 588-2620.



OCT 19 1987

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

NEWSLETTER

New Jersey Health Services Program

Volume..... P-540.....

October 12, 1987

TO: All Dentists and Independent Dental Clinics

SUBJECT: Renewal of General Anesthesia Permits

EFFECTIVE: November 1, 1987

BACKGROUND: All dental general anesthesia permits issued by the New Jersey State Board of Dentistry will expire on October 31, 1987. In order for the New Jersey Medicaid Program to reimburse a dentist for administering general anesthesia after that date, a valid copy of the permit must be on file at the Prudential Insurance Company.

ACTION: Please forward a copy of your renewed permit by CERTIFIED MAIL-RETURN RECEIPT REQUESTED to the following address before October 26, 1987.

Prudential Insurance Company of America
Medicaid Claims Division II
P. O. Box 1900
Millville, New Jersey 08332
Attention: Linda Deliberis, Associate Manager

On or after November 1, 1987, reimbursement for claims submitted for general anesthesia will be limited to those dental providers having a currently valid general anesthesia permit on file with the Prudential Insurance Company. If you are unable to submit your permit by November 1, 1987, please hold any claims with dates of service on or after that date until your permit has been received at the Prudential Insurance Company. The date of receipt will appear on the green, Certified Mail - Return Receipt Card (PS Form 3811 - February 1986), which will be returned to you by the United States Postal Service. Then you may submit your claims for payment.

Any questions regarding this Newsletter should be directed to Archie H. Bell, D.D.S., Chief, Bureau of Dental Services, Division of Medical Assistance and Health Services, Telephone (609) 588-7136.



TO: Providers of Pharmaceutical Services,
Physicians, Podiatrists, Dentists and,
Independent Clinics

OCT 26 1987

SUBJECT: New Upper Limits on Payments for Drugs under the New Jersey
Medicaid/PAAD/General Assistance Pharmaceutical Services
Programs

EFFECTIVE: October 29, 1987

BACKGROUND: The New Jersey Medicaid/PAAD Programs revised existing rules and established procedures for setting aggregate upper limits on payments for covered drugs in the pharmaceutical services programs. This change is based on revision of 42CFR 447.301, 331, 332 and 333 by which the Health Care Financing Administration (HCFA) of U.S. Department of Health and Human Services (DHHS) eliminated the Federal MAC program and substituted new methods for determining specific upper limits for certain multiple source drugs but essentially retained the estimated acquisition cost (EAC) provisions intact.

On July 31, 1987, the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services (DHHS) promulgated final rules regarding Federal Financial Participation (FFP) in reimbursement for drugs. In order for the State to continue to get FFP, it may not pay more, in the aggregate, than the upper limits established by the rules.

The concept of aggregate upper limits allows the State a certain flexibility in determining specific upper payment limits on individual drugs. In order to assure that Medicaid does not exceed the aggregate limits, adjustment in the limits may be required. For now, the State has adopted the HCFA list in its entirety; if necessary, the Program will make periodic adjustments, up or down, in specific limits in order to maintain equilibrium.

Reimbursement is set by HCFA for certain multiple source drugs at 150% of the lowest priced equivalent product found in national pricing compendia (i.e. Red Book, Blue Book, Medispan) as long as three products are available in the marketplace. For single source products and multiple source products not listed by HCFA, the State is to estimate acquisition cost (EAC) for the most commonly purchased package size, as determined by the State. Single source drugs and multiple source drugs not included on the attached list are subject to the EAC limits set forth in 10:51-1.16 and 10:51-5.18 of your Pharmaceutical Services Manual (AWP less store specific discount).

As in the past, these reimbursement levels apply also to the PAAD Program, as well as Medicaid, despite the fact that PAAD is not federally funded. This is to maintain a uniform, cost effective claims payment system which benefits both the providers and the agency because of administrative simplicity and economies of scale.

To aid in the transition, New Jersey has decided to continue to use the term "MAC" drug for the listed multi-source products. Claims filing requirements are essentially the same as under the old federal MAC Program.

The new program will continue to be referred to as the "MAC" Program for the sake of continuity. It differs from the previous program in the method of determining the upper limits of payment (i.e. MAC prices) for certain multiple source drugs.

The MAC Program is intended to act as an incentive to pharmacists to dispense less costly, generically equivalent products when the prescriber does not specifically certify, in his/her own handwriting, that the prescribed brand is medically necessary. The incentive is built into the MAC upper limit and with certain exceptions, the limits are based on 150% of the price of the least costly FDA approved generic product which is available from at least 3 manufacturers. If a prescriber allows substitution and the pharmacist is a prudent purchaser and can obtain the generic at a price below the MAC, the pharmacist may bill the Program at the MAC price and retain the difference. The regressive discounts do not apply to MAC drugs as they did under the old MAC Program. This Program affords the pharmacist ample opportunity to apply sound purchasing principles to maximize profitability.

Attached is a MAC list (Rev. 10/87) of multiple source drugs for which new upper payment limits have been established by the State. This list replaces the list dated March 1986 and will be updated periodically.

ACTION: 1. Certain drugs in the attached listing of MAC drugs are not contained in the D.U.R.C. Formulary and are currently not substitutable in New Jersey unless specific notice is given to the prescriber. These are identified by an asterisk.

The following procedures will apply to the asterisked products.

- a. If the physician (or other licensed prescriber) prescribes an asterisked (non-formulary) product by its generic name, the pharmacist must dispense the generic and bill the usual and customary price and the Program will pay lower of usual and customary price or the calculation based on the MAC price.
- b. If the asterisked product is prescribed by its brand name and the prescriber allows substitution, the pharmacist shall contact the prescriber to obtain authority to dispense a generic, if one is available (see the D.U.R.C. Formulary, page 6, #A2b.), and bill the usual and customary price and the Program will pay lower of usual and customary price or the calculation based on the MAC price. The pharmacist should document the authority on the prescription.
- c. If the prescriber indicates on the prescription that substitution is not permitted, the pharmacist should check the MAC certification box on the MC-6 claim form and may dispense and bill the Program for the brand name drug.

NOTE: The Division is temporarily suspending the requirement for a handwritten certification of medical necessity on asterisked items only. The D.U.R.C. will be asked to consider all non-listed asterisked products for inclusion in the formulary as expeditiously as possible.

With the exception of asterisked products, the rule regarding physician certification that the brand is medically necessary (see 10:51-1.6) applies to all other products in the attached list. As asterisked products become listed in the D.U.R.C. Formulary, the certification rule will apply.

2. If the prescriber indicates "Do not substitute" for non-MAC multiple source drugs subject to the EAC provision and which are contained in the N.J. D.U.R.C. Formulary, the pharmacist is now required to indicate this by checking "Medical Certification" on the MC-6 claim form. As this requirement is subject to audit, proper documentation to support billing for the brand name drug must be maintained.
3. Providers are reminded that New Jersey law (N.J.S.A. 24:6E-1 et. seq.) mandates substitution from the D.U.R.C. Formulary when not specifically precluded by the prescriber. If substitution is refused by the recipient, providers are subject to the provisions of 10:51-1.6 or 10:51-5.9. Strict compliance is required.
4. These rules are effective as of 10/29/87. The legend drug reimbursement will not exceed in the aggregate the lowest of:
 - a. The maximum allowable cost (MAC) of the drug, as established by 42.CFR 447.331 et. seq. for certain multiple source drugs (generic drugs), plus a dispensing fee; or
 - b. The estimated acquisition cost (EAC) of the drug (the price generally and currently paid by providers for a particular drug in the package size most frequently purchased by providers, as outlined in 10:51-1.16), plus a dispensing fee; or
 - c. The provider's usual and customary charge to the public for the drug; or
 - d. Other third party prescription plan payment.

If there are any questions concerning this Newsletter please call the New Jersey Medicaid Program, Chief Pharmaceutical Consultant, at (609) 588-2724 or your Medicaid District Office.



**STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES**

LISTING OF MAC DRUGS

<u>DRUG ENTITY</u>	<u>Generic Upper Limit/Unit</u>
Acetaminophen;Butalbital; Caffeine 325mg; 50mg; 40mg	
*Capsules	\$.0315
*Tablets	.0251
Acetaminophen; Codeine	
300mg; 15mg Tablets #2	.0493
300mg; 30mg Tablets #3	.0743
300mg; 60mg Tablets #4	.1335
Acetaminophen and Hydrocodone Bitartrate	
*500mg; 5mg Tablets	.1620
Acetaminophen; Oxycodone Hydrochloride	
*325mg; 5mg Tablets	.1125
Acetic Acid, Glacial 2%	
Solution/Drops Otic 15ml	3.53
Acetic Acid Glacial; Hydrocortisone	
2%; 1% Solution/Drops Otic 10ml	5.63
Acetaminophen;Propoxyphene Hydrochloride	
650mg; 65mg	.0864
Acetaminophen;Propoxyphene Napsylate	
650mg; 50mg Tablets	.1343
650mg; 100mg Tablets	.2395

Please note: These MAC Limits do not apply to unit dose packaging. Rev. 10/87

*Non-Formulary

Acetazolamide		
250mg Tablets		.0600
Allopurinol		
100mg Tablets		.0704
300mg Tablets		.1383
Amantadine Hydrochloride		
100mg Capsules		.3293
Aminophylline		
Solution oral 105mg/5ml		
8oz		5.40
Amoxicillin		
250mg Capsules		.1260
500mg Capsules 50's		.2490
125mg/5ml 80ml		2.10
125mg/5ml 100ml		2.24
125mg/5ml 150ml		2.93
250mg/5ml 80ml		2.97
250mg/5ml 100ml		3.75
250mg/5ml 150ml		4.45
Ampicillin/Ampicillin Trihydrate		
250mg Capsules		.0793
500mg Capsules		.1448
125mg/5ml 100ml		1.65
125mg/5ml 200ml		3.15
250mg/5ml 100ml		2.63
250mg/5ml 200ml		4.58
Aspirin; Butalbital; Caffeine		
325mg; 50mg; 40mg Tablets		.0261
Aspirin; Caffeine; Propoxyphene Hydrochloride		
389mg; 32.4mg; 65mg Capsules		.0713
Aspirin, Oxycodone Hydrochloride; Oxycodone Terephthalate		
*325mg 4.5mg 0.38mg Tablets		.1125
Atropine Sulfate; Diphenoxylate Hydrochloride		
0.025mg/5mg; 2.5mg/5ml 60ml		3.38
0.025mg; 2.5mg Tablets		.0185
Please note: These MAC Limits do not apply to unit dose packaging.		2 Rev. 10/87
*Non-Formulary		

Bacitracin

*Ointment; Ophthalmic
500 units/gm
0.12oz

1.80

Bacitracin Zinc; Neomycin
Sulfate; Polymyxin B Sulfate
400 units/gm;
eq 3.5mg Base/gm
Ointment; Ophthalmic
0.12oz

1.65

Betamethasone Valerate

0.1% base cream

15gm

2.40

45gm

4.49

0.1% base lotion

60ml

8.16

0.1% base ointment

15gm

2.87

45gm

5.10

Bethanechol Chloride

25mg Tablets

.0375

Butabarbital Sodium

Elixir 480ml

.0063

15mg Tablets 1000's

.0069

30mg Tablets 1000's

.0080

Caffeine; Ergotamine Tartrate

*100mg; 1mg Tablets

.2625

Carbamazepine

200mg Tablets

.2063

Carisoprodol

350mg Tablets

.0675

Chloramphenicol

Ointment; Ophthalmic 1%

0.12oz

1.80

Solution/drops Ophthalmic .5%

7.5ml

2.40

Chlordiazepoxide Hydrochloride

5mg Capsules	.0173
10mg Capsules	.0188
25mg Capsules	.0270

Chlorothiazide

500mg Tablets	.0576
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Chlorpropamide

100mg Tablets	.0225
250mg Tablets	.0375

Chlorthalidone

25mg Tablets	.0375
50mg Tablets	.0464

Clofibrate

500mg Capsules	.2093
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Clonidine Hydrochloride

0.1mg Tablets	.0443
0.2mg Tablets	.0548
0.3mg Tablets	.0758

Cloxacillin Sodium

250mg Capsules	.2978
500mg Capsules	.5363
125mg/5ml 100ml	4.80

Codeine Phosphate; Phenylephrine
Hydrochloride; Promethazine
Hydrochloride 10mg/5ml; 5mg/5ml;
6.25mg/5ml

Syrup 480ml	.0119
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Codeine Phosphate; Promethazine
Hydrochloride

Syrup 480ml	.0113
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Codeine Phosphate; Pseudoephedrine
Hydrochloride; Triprolidine
Hydrochloride 10mg/5ml;
30mg/5ml; 1.25mg/5ml

Syrup 480ml	.0127
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Cyproheptadine Hydrochloride

4mg Tablets .0245

Dextromethorphan Hydrobromide;
Promethazine Hydrochloride 15mg/5ml
6.25mg/5ml

Syrup .0127

Dexamethasone; Neomycin Sulfate;
Polymyxin B Sulfate 0.12%; EQ
3.5mg Base/gm; 10,000 units/gm

Ointment; Ophthalmic
0.12oz 4.50

Suspension/Drops; Ophthalmic
5ml 4.13

Dexamethasone Sodium Phosphate;
Neomycin Sulfate EQ 0.1%
Phosphate; EQ 3.5% Base/ml

Solution/drops Ophthalmic
5ml 7.63

Diazepam

2mg Tablets .0395
5mg Tablets .0600
10mg Tablets .1024

Dicloxacillin Sodium

250mg Capsules .3150
500mg Capsules .5400

Dicyclomine Hydrochloride

10mg Capsules .0225
20mg Tablets .0192

Diethylpropion Hydrochloride

*25mg Tablets .0360

Diphenhydramine Hydrochloride

25mg Capsules	.0203
50mg Capsules	.0210
Elixir 12.5mg/5ml Pint	.0045

Disopyramide Phosphate

100mg Capsules	.2330
500mg Capsules	.3111

Doxepin Hydrochloride

10mg Capsules	.0893
25mg Capsules	.1178
50mg Capsules	.1280
75mg Capsules	.2478
100mg Capsules	.2993

Doxycycline Hyclate

100mg Capsules, 50's	.1580
100mg Tablets, 50's	.1594

Ergocalciferol

*50,000 iu Capsules, 500's	.0240
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Ergoloid Mesylates

1mg Tablets, Sublingual	.0945
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Erythromycin

*250mg Enteric Coated Tablets	.0960
*Ointment; Ophthalmic 5mg/gm 0.12oz	1.88
Solution; Topical 2%, 2oz	3.60
Solution; Topical 1.5%, 2oz	3.45

Erythromycin Estolate

125mg/5ml 480ml	.0263
250mg/5ml 480ml	.0459

Erythromycin Ethylsuccinate

200mg/5ml 480ml	.0338
400mg/5ml 480ml	.0664
400mg Tablets	.1950

Erythromycin Stearate

250mg Tablets	.0938
500mg Tablets	.1619

Fluocinolone Acetonide

Cream; Topical 0.01%
15gm 1.35
60gm 2.63

Ointment; Topical 0.025%

15gm 4.50
60gm 10.80

Fluocinolone Acetonide
Solution Topical 0.01%

20ml 3.83
60ml 7.13

Fluocinonide

Cream Topical 0.05%

15gm 6.08
30gm 8.33

Flurazepam Hydrochloride

15mg Capsules .2100
30mg Capsules .2250

Folic Acid

*1mg Tablets .0113

Furosemide

20mg Tablets .0225
40mg Tablets .0300
80mg Tablets .1200

Gentamicin Sulfate

Cream; Topical EQ 1mg
Base/gm 15gm 1.94
Ointment; Ophthalmic EQ 3mg
Base/gm 0.12oz 4.50
Ointment; Topical EQ 1mg
Base/gm 15gm 1.94

Gramicidin; Neomycin Sulfate;
Polymyxin B Sulfate

Solution/Drops; Ophthalmic
10ml 5.03

Haloperidol

0.5mg Tablets	.1083
1mg Tablets	.2364
2mg Tablets	.3298
5mg Tablets	.3611

Haloperidol Lactate

Oral Concentrate 2mg/ml 120ml	26.93
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Homatropine Methylbromide;
Hydrocodone Bitartrate
1.5mg/5ml;5mg/5ml

480ml	.0167
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Hydralazine Hydrochloride

10mg Tablets	.0188
25mg Tablets	.0195
50mg Tablets	.0263
100mg Tablets	.0480

Hydralazine Hydrochloride;
Hydrochlorothiazide

25mg; 25mg Capsules	.1043
50mg; 50mg Capsules	.1619
100mg; 50mg Capsules	.2363

Hydrochlorothiazide

25mg Tablets	.0113
50mg Tablets	.0128
100mg Tablets	.0210

Hydrochlorothiazide;Methyldopa

15mg; 250mg Tablets	.2235
25mg; 250mg Tablets	.2535

Hydrochlorothiazide; Propranolol

25mg; 40mg Tablets	.3000
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Hydrochlorothiazide;
Spironolactone

25mg; 25mg Tablets	.0450
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Hydrocortisone

Lotion; Topical 1% 4oz	6.90
Ointment; Topical 1% 20gm	1.58
2.5% 20gm	3.30

Hydrocortisone; Neomycin Sulfate;
Polymyxin B Sulfate 1%

Solution/Drops; Otic 10ml	4.50
Suspension; Otic 1% 10ml	4.93

Hydroxyzine Hydrochloride

10mg Tablets	.0593
25mg Tablets	.0750
50mg Tablets	.0975
Oral Syrup 10mg/5ml	.0166

Hydroxyzine Pamoate

25mg Capsules	.0793
50mg Capsules	.1200

Ibuprofen

400mg Tablets	.0938
600mg Tablets	.1313
800mg Tablets	.2063

Imipramine Hydrochloride

25mg Tablets	.0315
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Indomethacin

25mg Capsules	.0845
50mg Capsules	.1407

Isoetharine Solution 1% for
Inhalation 10ml

2.67

Isoniazid

300mg Tablets	.0218
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Lidocaine

*Ointment; Topical 5%

35gm	2.43
50gm	2.25

Lindane	
Lotion; Topical 1% 2oz	1.95
Shampoo; Topical 1% 2oz	2.18
Lithium Carbonate	
*300mg Capsules	.0584
*300mg Tablets	.0525
Lithium Citrate	
*300mg/5ml 480ml	.0228
Lorazepam	
0.5mg Tablets	.1138
1mg Tablets	.1515
2mg Tablets	.2273
Meclizine Hydrochloride	
12.5mg Tablets	.0165
25mg Tablets	.0188
Meclofenamate Sodium	
50mg Capsules	.2681
100mg Capsules	.4510
Meperidine Hydrochloride	
*50mg Tablets	.1493
*100mg Tablets	.2993
Meprobamate	
200mg Tablets	.0158
400mg Tablets	.0195
Methocarbamol	
500mg Tablets	.0503
750mg Tablets	.0713
Methyclothiazide	
2.5mg Tablets	.0563
5mg Tablets	.0788
Methyldopa	
250mg Tablets	.1260
500mg Tablets	.2363

Methylphenidate Hydrochloride

*5mg Tablets	.0713
*10mg Tablets	.0975
*20mg Tablets	.1388

Metoclopramide Hydrochloride

10mg Tablets	.0675
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Metronidazole

250mg Tablets	.0609
500mg Tablets 50's	.1732

Naphazoline Hydrochloride

Solution/Drops; Ophthalmic 0.1% 15ml	3.90
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Nystatin

100,000 Units/ml 60ml	5.70
500,000 Units Oral Tablets	.1343
Cream; Topical	
100,000 Units/gm	
15gm	1.65
30gm	2.40
Ointment; Topical	
100,000 Units/gm	
15gm	1.65
30gm	3.00

Nystatin; Triamcinolone Acetonide

100,000 Units/gm; 0.1% Cream; Topical	
15gm	3.10
30gm	6.15
60gm	10.83
Ointment; Topical	
15gm	2.85
30gm	5.40
60gm	8.70

Oxtriphylline

*200mg Tablets	.0885
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Penicillin G Potassium

200mu Tablets	.0270
250mu Tablets	.0300
400mu Tablets	.0485
500mu Tablets	.0525

Penicillin V Potassium

125mg/5ml 200ml	2.18
250mg/5ml 200ml	2.97
250mg Tablets	.0411
500mg Tablets	.0720

Phendimetrazine Tartrate

*35mg Tablets, 1000's	.0089
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Phentermine Hydrochloride

*30mg Capsules	.0309
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Phenylbutazone

100mg Tablets	.0563
100mg Capsules	.0863

Phenytoin Sodium, Extended

100mg Capsules	.0825
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Prednisolone Acetate;Sulfacetamide
Sodium 0.5%; 10%
Suspension/Drops Ophthalmic
5ml

2.03

Primidone

250mg Tablets	.0570
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Probenecid

500mg Tablets	.0763
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Procainamide Hydrochloride

250mg Capsules	.0398
375mg Capsules	.0550
500mg Capsules	.0690

Prochlorperazine Maleate

5mg Tablets	.0900
10mg Tablets	.1200
25mg Tablets	.1485

Promethazine Hydrochloride

6.25mg/5ml 480ml	.0055
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Propantheline Bromide

15mg Tablets	.0235
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Please note: These MAC Limits do not apply to unit dose
packaging.

Rev. 10/87

*Non-Formulary

Proparacaine Hydrochloride	
*Solution/Drops; Ophthalmic 0.5% 15ml	3.95
Propoxyphene Hydrochloride	
65mg Capsules	.0375
Propranolol Hydrochloride	
10mg Tablets	.0368
20mg Tablets	.0491
40mg Tablets	.0720
60mg Tablets	.0797
80mg Tablets	.1073
Quinidine Gluconate	
324mg Tablets	.2228
Quinidine Sulfate	
*100mg Tablets	.0718
*200mg Tablets	.0675
*300mg Tablets	.1418
Selenium Sulfide	
Lotion/Shampoo; Topical 2.5%; 4oz	2.65
Spironolactone	
25mg Tablets	.0447
Sulfacetamide Sodium	
Ointment; Ophthalmic 10% 0.12oz	1.58
Solution/Drops; Ophthalmic 10% 15ml	2.03
Sulfamethoxazole	
500mg Tablets	.0728
Sulfamethoxazole; Trimethoprim	
200mg/5ml; 40mg/5ml 480ml	.0209
400mg; 80mg Tablets	.1116
800mg; 160mg DS Tablets	.1313

Temazepam

15mg Capsules	.1988
30mg Capsules	.2225

Tetracycline Hydrochloride

125mg/5ml Syrup 480ml	.0109
250mg Capsules	.0323
500mg Capsules	.0547

Theophylline

80mg/15ml Elixer 480ml	.0046
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Thioridazine Hydrochloride

10mg Tablets	.0523
15mg Tablets	.0788
25mg Tablets	.0876
50mg Tablets	.1343
100mg Tablets	.1575

Tolazamide

100mg Tablets	.0998
250mg Tablets	.1966
500mg Tablets	.3762

Tolbutamide

500mg Tablets	.0345
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Trazodone Hydrochloride

50mg Tablets	.2841
100mg Tablets	.4643

Triamcinolone Acetonide

Cream; Topical	
0.025% 15gm	.98
80gm	2.68
0.1% 15gm	1.28
80gm	4.13
Ointment; Topical	
0.1% 15gm	1.28
80gm	4.13

Trifluoperazine Hydrochloride

2mg Tablets	.0893
5mg Tablets	.0988
10mg Tablets	.1398

Trihexyphenidyl Hydrochloride

2mg Tablets	.0135
5mg Tablets	.0165

Valproic Acid

250mg Capsules	.2490
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Verapamil Hydrochloride

80mg Tablets	.2243
120mg Tablets	.2993



October 30, 1987

OCT 27 1987

TO: All Providers

SUBJECT: Timeliness of Claim Submission and Claim Inquiry

EFFECTIVE: Immediately

PURPOSE: This Newsletter is to inform providers that the time frames to submit a claim for reimbursement, make a follow-up inquiry, or supply additional information to the appropriate New Jersey Medicaid Program Fiscal Agent, have been revised.

ACTION: As applicable, it is the responsibility of each provider to comply with the time frames outlined below.

A claim submitted outside the time frames indicated will not be reimbursed by the New Jersey Medicaid Program. This policy also applies to inquiries concerning a claim or claim related information supplied outside the time frames indicated.

I. INSTITUTIONAL CLAIM SUBMITTAL POLICY:

- A. An institutional claim is a claim submitted by a hospital, a special hospital, a home health agency, or a long-term care facility.
- B. A claim for payment of an institutional service must be submitted to the appropriate Fiscal Agent within:
 - 1. One year of the date of discharge on an inpatient hospital claim, or
 - 2. One year of the date of service entered on an outpatient hospital claim or home health claim, or
 - 3. One year of the earliest date of service entered on an outpatient hospital claim if a claim carries more than one date of service.

II. NONINSTITUTIONAL CLAIM SUBMITTAL POLICY:

- A. A noninstitutional claim is a claim submitted by all providers except a hospital, a special hospital, a home health agency, or a long-term care facility.
- B. A claim for payment of a noninstitutional service (excluding a pharmaceutical service) must be submitted to The Prudential Insurance Company of America within:
 - 1. One year of the date of service, or
 - 2. One year of the earliest date of service entered on the claim form if the claim carries more than one date of service.
- C. A claim for payment of a pharmaceutical service must be submitted to Blue Cross and Blue Shield of New Jersey, Inc., within 180 days of the dispensing date.

III. FOLLOW-UP INQUIRY POLICY:

- A. A provider may inquire about a claim that has been paid or denied but must make the inquiry within 90 days of the date of adjudication as indicated on the Statement of Payment Voucher.
- B. A provider may inquire about the status of a claim for which neither payment nor denial has been received. The inquiry may be made at any time after the claim is submitted, but not more than 90 days after the end of the timely submission period.
- C. If additional information is required in order to process the claim, the provider should supply the information as soon as possible, but not more than 90 days after the end of the timely submission period.

Any questions concerning this Newsletter should be directed to the New Jersey Medicaid Program Fiscal Agent.

Medicaid Fiscal Agents

Telephone

Blue Cross and Blue Shield of New Jersey, Inc. - 201-456-2534

or

The Prudential Insurance Company of America - 1-800-582-7052