

**CHAPTER 66**  
**INDEPENDENT CLINIC SERVICES**

**Authority**

N.J.S.A. 30:4D-6, 7 and 12; 42 CFR 405.2401(b), 440.40(b), 440.90, 441 Subpart B, 441.20, 491 and 493.

**Source and Effective Date**

R.1998 d.577, effective November 12, 1998.  
See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).

**Executive Order No. 66(1978) Expiration Date**

Chapter 66, Independent Clinic Services, expires on November 12, 2003.

**Chapter Historical Note**

Chapter 66, Manual for Independent Clinic Services, was adopted as R.1973 d.228, effective October 1, 1973. See: 5 N.J.R. 226(c), 5 N.J.R. 339(b).

Chapter 66, Manual for Independent Clinic Services, was repealed and a new Chapter 66, Independent Clinic Services Manual, was adopted as R.1980 d.249, effective June 30, 1980. See: 12 N.J.R. 275(b), 12 N.J.R. 418(f).

Pursuant to Executive Order No. 66(1978), Chapter 66, Independent Clinic Services Manual, was readopted as R.1983 d.615, effective December 15, 1983. See: 15 N.J.R. 1732(a), 16 N.J.R. 145(a).

Pursuant to Executive Order No. 66(1978), Chapter 66, Independent Clinic Services Manual, was readopted as R.1989 d.33, effective December 15, 1988. See: 20 N.J.R. 2562(a), 21 N.J.R. 162(a).

Chapter 66, Independent Clinic Services Manual, was repealed and a new Chapter 66, Independent Clinic Services, was adopted as R.1993 d.641, effective December 6, 1993. See: 25 N.J.R. 4379(a), 25 N.J.R. 5528(c).

Pursuant to Executive Order No. 66(1978), Chapter 66, Independent Clinic Services, was readopted as R.1998 d.577, effective November 12, 1998. See: Source and Effective Date. See, also, section annotations.

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**SUBCHAPTER 1. GENERAL PROVISIONS**

**10:66-1.1 Scope of service**

(a) This chapter (N.J.A.C. 10:66) describes the policies and procedures of the New Jersey Medicaid and NJ Kid-

Care fee-for-service programs pertaining to the provision of, and reimbursement for, medically necessary Medicaid-covered and NJ KidCare-covered services in an independent clinic setting. An independent clinic setting includes, but is not limited to, clinic types such as an ambulatory care facility, ambulatory surgical center, ambulatory care/family planning facility, and a Federally qualified health center.

(b) Medically necessary services provided in an independent clinic setting shall meet all applicable State and Federal Medicaid and NJ KidCare fee-for-service laws, and all applicable policies, rules and regulations as specified in the appropriate provider services manual of the New Jersey Medicaid and NJ KidCare fee-for-service programs.

(c) Independent clinic services are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are provided by a facility (freestanding) that is not part of a hospital but is organized and operated to provide medical care to outpatients, including such services provided outside the clinic by clinic personnel to any Medicaid or NJ KidCare fee-for-service beneficiary who does not reside in a permanent dwelling or does not have a fixed home or mailing address. Clinic services do not include services provided by hospitals to outpatients.

(d) The chapter is divided into six subchapters, as follows:

1. N.J.A.C. 10:66-1 contains scope of service, definitions, provisions for provider participation, prior authorization, basis for reimbursement, and recordkeeping requirements.

2. N.J.A.C. 10:66-2 contains policies and procedures pertaining to specific Medicaid-covered and NJ KidCare-covered services provided in an independent clinic setting. Where unique characteristics or requirements exist concerning a particular Medicaid-covered or NJ KidCare-covered service, the service is separately identified and discussed.

3. N.J.A.C. 10:66-3 contains information about HealthStart, a program for pregnant women and children.

4. N.J.A.C. 10:66-4 and its Appendix contain information about Federally qualified health centers, including rules governing the provision of services; the Medicaid cost report containing the forms used by Federally qualified health centers to determine Medicaid and NJ KidCare-Plan A fee-for-service reimbursement amounts; and instructions for the proper completion of the forms contained in the cost report.

5. N.J.A.C. 10:66-5 contains information about ambulatory surgical centers, including covered services, anesthesia, medical justification, facility services, and medical records.

6. N.J.A.C. 10:66-6 pertains to the Health Care Financing Administration's Common Procedure Coding System (HCPCS). The HCPCS procedure code system contains procedure codes and maximum fee allowances corresponding to Medicaid-reimbursable services.

(e) The Appendix following N.J.A.C. 10:66-6 pertains to the Fiscal Agent Billing Supplement. The Fiscal Agent Billing Supplement contains billing instructions and samples of forms (claim forms, prior authorization forms, and consent forms) used in the billing process.

Amended by R.1998 d.577, effective December 7, 1998.

See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).

Inserted references to NJ KidCare fee-for-service and NJ KidCare-covered services throughout; in (c), substituted a reference to beneficiaries for a reference to recipients; and in (d)4, inserted a reference to NJ KidCare-Plan A fee-for-service.

### 10:66-1.2 Definitions

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

"Ambulatory care facility" means a health care facility or a distinct part of a health care facility, licensed by the New Jersey State Department of Health and Senior Services, which provides preventive, diagnostic, and treatment services to persons who come to the facility to receive services and depart from the facility on the same day.

"Ambulatory care/family planning facility" means a health care facility or a distinct part of a health care facility, licensed by the New Jersey State Department of Health and Senior Services to provide specified surgical procedures.

"Ambulatory surgical center" means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization; has an agreement with the Health Care Financing Administration (HCFA) under Medicare to participate as an ambulatory surgical center; is licensed as an ambulatory surgical center, if required, by the New Jersey State Department of Health and Senior Services; and meets the enrollment requirements as indicated in the Administration chapter at N.J.A.C. 10:49-3.2, Enrollment process, and at N.J.A.C. 10:66-1.3, Provisions for provider participation.

"Audited financial statements" are defined in requirements set forth in N.J.A.C. 10:66-4.2. This section provides a set of guidelines so that FQHC providers will know the criteria for a satisfactory audit.

"Compensated hours" means all hours for which an employee receives compensation, payment or any form of remuneration, including regular time, overtime, vacation time, sick time, personal time, educational time, and all other compensated time.

(2) All references to time parameters shall mean the practitioner's personal time in reference to the service rendered unless it is otherwise indicated.

vi. Written records in substantiation of the use of a given procedure code must be available for review and/or inspection if requested by the New Jersey Medicaid or NJ KidCare fee-for-service program.

vii. All references to performance of any or all parts of a history or physical examination shall mean that for reimbursement purposes these services were personally performed by a physician, dentist, podiatrist, optometrist, certified nurse midwife, psychologist, and other program recognized mental health professionals in a mental health clinic, whichever is applicable. (Exception: Procedure Code W9820, EPSDT, permits the services of a pediatric nurse practitioner under the direct supervision of a physician.)

2. Specific requirements concerning medicine are as follows:

i. To qualify as documentation that the service was rendered by the practitioner during an inpatient stay, the medical record must contain the practitioner's notes indicating that he or she personally:

(1) Reviewed the patient's medical history with the patient and/or his or her family, depending upon the medical situation;

(2) Performed an examination as appropriate;

(3) Confirmed or revised the diagnosis; and

(4) Visited and examined the patient on the days for which a claim for reimbursement is made.

ii. The practitioner's involvement must be clearly demonstrated in notes reflecting his or her personal involvement with the service rendered. This refers to those occasions when these notes are written into the medical record by interns, residents, other house staff members, or nurses. A counter-signature alone is not sufficient.

3. Specific requirements concerning surgery are as follows:

i. Certain of the listed procedures are commonly carried out as an integral part of a total service and, as such, do not warrant a separate charge. When such a procedure is carried out as a separate entity not immediately related to other services, the indicated value for "separate procedure" is applicable.

4. Specific requirements concerning radiology are as follows:

i. Values include usual contrast media, equipment and materials.

ii. Values include consultation and written report to the referring physician.

iii. S&I (Supervision and Interpretation) only for the procedure given. This code is used only when a procedure is performed by more than one physician. Values include consultation and written report.

iv. All films taken of an area which is to be subject to a contrast study will, for reimbursement purposes, be considered part of the contrast study unless stated otherwise.

v. The fee listed represents the combined technical and professional component of the reimbursement for the procedure code notwithstanding any statement to the contrary in the narrative. It will be paid only to one provider and will not be broken down into its component parts.

Administrative Correction.

See: 26 N.J.R. 797(a).

Amended by R.1998 d.577, effective December 7, 1998.

See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).

Inserted references to NJ KidCare fee-for-service and substituted references to CPT for references to CPT-4 throughout.

**10:66-6.2 HCPCS procedure code numbers and maximum fee allowance schedule**

(a) Evaluation and management and other procedures

\* An asterisk preceding any procedure code may also be performed in a drug treatment center.

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				S	NS	
*N	36415			1.80		1.80
	90701			16.34		16.34
	90701	52		2.50		2.50
	90702			3.29		3.29
	90702	52		2.50		2.50
	90703			3.40		3.40
	90703	52		2.50		2.50
	90704			23.60		23.60
	90704	52		2.50		2.50
	90705			18.39		18.39
	90705	52		2.50		2.50
	90706			22.04		22.04
	90706	52		2.50		2.50
	90707			39.87		39.87
	90707	52		2.50		2.50
	90712			14.44		14.44
	90712	52		2.50		2.50
	90713			22.80		22.80
	90713	52		2.50		2.50
	90714			3.03		3.03
	90714	52		2.50		2.50
	90717			3.03		3.03
	90717	52		2.50		2.50
	90718			3.35		3.35
	90718	52		2.50		2.50
	90724			6.97		6.97
	90724	52		2.50		2.50
	90732			14.35		14.35
	90732	52		2.50		2.50
	90733			17.48		17.48
	90733	52		2.50		2.50
	90737			25.79		25.79
	90737	52		2.50		2.50
	90741			Prior authorization required		
	90742			Prior authorization required		
	90746			63.57		63.57
L	90746	52		2.50		2.50
N	90799			2.50		2.50
N	90801			37.00		26.00

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units	Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				S	NS						S	NS	
	93000			16.00	16.00		L	W9334	52		2.50	2.50	
N	99150			45.00	40.00		L	W9335			62.09	62.09	
				Per Hour	Per Hour		L	W9335	52		2.50	2.50	
N	99151			45.00	40.00		L	W9338			30.27	30.27	
				Per Hour	Per Hour		L	W9338	52		2.50	2.50	
	99173			5.00	5.00			W9820			23.00	18.00	
N	*99201			16.00	14.00								
N	*99202			16.00	14.00								
N	*99203			22.00	17.00								
N	*99204			22.00	17.00								
N	*99205			22.00	17.00								
N	*99211			16.00	14.00								
N	99211	WM		NA	11.20								
N	*99212			16.00	14.00								
N	99212	WM		NA	11.20								
N	*99213			16.00	14.00								
N	99213	WM		NA	11.20								
N	*99214			16.00	14.00								
N	99214	WM		NA	11.20								
N	*99215			16.00	14.00								
N	99215	WM		NA	11.20								
N	99241			44.00	NA								
N	99242			44.00	NA								
N	99243			44.00	NA		N	55250		30	200.00	170.00	
N	99244			62.00	NA		N	55450		30	90.00	79.00	3
N	99245			62.00	NA		N	57451		45	42.00	37.00	3
N	99251			44.00	NA		N	58301			182.00	158.00	6
N	99252			44.00	NA			58301	WM		16.40	16.40	
N	99253			44.00	NA			58301			16.40	16.40	
N	99254			62.00	NA		N	58600		45	211.00	184.00	6
N	99255			62.00	NA		N	58605		45	151.00	131.00	6
	99261			16.00	14.00		N	58982		45	182.00	158.00	6
	99262			16.00	14.00		N	58983		45	182.00	158.00	6
	99263			16.00	14.00			88150			6.00	6.00	
N	99271			44.00	NA			88151			6.00	6.00	
N	99272			44.00	NA		N	88155			6.00	6.00	
N	99273			44.00	NA			99201	WF		45.00	45.00	
N	99274			62.00	NA		N	99201	WFWM		NA	31.50	
N	99274	YY		50.00	NA		N	99202	WF		45.00	45.00	
N	99274	ZZ		50.00	NA		N	99202	WFWM		NA	31.50	
N	99275			62.00	NA		N	99203	WF		45.00	45.00	
N	99291			45.00	40.00		N	99203	WFWM		NA	31.50	
N	99292			22.50	20.00		N	99204	WF		45.00	45.00	
	99382			22.00	17.00		N	99204	WFWM		NA	31.50	
	99383			22.00	17.00		N	99205	WF		45.00	45.00	
	*99384			22.00	17.00		N	99205	WFWM		NA	31.50	
	*99385			22.00	17.00		N	99211	WF		7.60	7.60	
	*99386			22.00	17.00		N	99211	WFWM		NA	5.35	
	*99387			22.00	17.00		N	99212	WF		7.60	7.60	
	99391			16.00	14.00		N	99212	WFWM		NA	5.35	
	99392			22.00	17.00		N	99213	WF		7.60	7.60	
	99393			22.00	17.00		N	99213	WFWM		NA	5.35	
	*99394			22.00	17.00		N	99214	WF		23.00	23.00	
	*99395			22.00	17.00		N	99214	WFWM		NA	16.40	
	99396			22.00	17.00		N	99215	WF		23.00	23.00	
	99397			22.00	17.00		N	99215	WFWM		NA	16.40	
	J2790			20.40	20.40		N	99395	WF		45.00	45.00	
	J2790	22		72.07	72.07		N	99395	WFWM		NA	31.50	
L	W9050			27.00	NA		L	W0001	WF		188.00	188.00	
L	W9055			27.00	23.00		L	W0001	WFWM		NA	177.00	
L	W9060	WT		23.00	18.00		L	W0002	WF		123.00	123.00	
L	W9061	WT		23.00	18.00		L	W0002	WFWM		NA	112.00	
L	W9062	WT		23.00	18.00		L	W0004	WF		204.00	204.00	
L	W9063	WT		23.00	18.00		L	W0004	WFWM		NA	188.00	
L	W9064	WT		23.00	18.00		L	W0008	WF		139.00	139.00	
L	W9065	WT		23.00	18.00		L	W0008	WFWM		NA	123.00	
L	W9066	WT		23.00	18.00								
L	W9067	WT		23.00	18.00								
L	W9068	WT		23.00	18.00								
L	W9096			17.46	17.46								
L	W9096	52		2.50	2.50								
L	W9096	22		32.79	32.79								
L	W9096	2252		2.50	2.50								
L	W9097			17.46	17.46								
L	W9097	52		2.50	2.50								
L	W9098			32.79	32.79								
L	W9098	52		2.50	2.50								
L	W9333			27.88	27.88								
L	W9333	52		2.50	2.50								
L	W9334			27.88	27.88								

(b) Dental services (See N.J.A.C. 10:56-3).

(c) Family planning services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				S	NS	
N	11975	22	30	Direct	package plus	price
N	11976		90	100.00		85.00
N	11977	22	90	Direct	package plus	price
N	55250		30	200.00		170.00
N	55450		30	90.00		79.00
N	57451		45	42.00		37.00
N	58301			182.00		158.00
N	58301	WM		16.40		16.40
N	58301			NA		16.40
N	58600		45	211.00		184.00
N	58605		45	151.00		131.00
N	58982		45	182.00		158.00
N	58983		45	182.00		158.00
	88150			6.00		6.00
	88151			6.00		6.00
	88155			6.00		6.00
N	99201	WF		45.00		45.00
N	99201	WFWM		NA		31.50
N	99202	WF		45.00		45.00
N	99202	WFWM		NA		31.50
N	99203	WF		45.00		45.00
N	99203	WFWM		NA		31.50
N	99204	WF		45.00		45.00
N	99204	WFWM		NA		31.50
N	99205	WF		45.00		45.00
N	99205	WFWM		NA		31.50
N	99211	WF		7.60		7.60
N	99211	WFWM		NA		5.35
N	99212	WF		7.60		7.60
N	99212	WFWM		NA		5.35
N	99213	WF		7.60		7.60
N	99213	WFWM		NA		5.35
N	99214	WF		23.00		23.00
N	99214	WFWM		NA		16.40
N	99215	WF		23.00		23.00
N	99215	WFWM		NA		16.40
N	99395	WF		45.00		45.00
N	99395	WFWM		NA		31.50
L	W0001	WF		188.00		188.00
L	W0001	WFWM		NA		177.00
L	W0002	WF		123.00		123.00
L	W0002	WFWM		NA		112.00
L	W0004	WF		204.00		204.00
L	W0004	WFWM		NA		188.00
L	W0008	WF		139.00		139.00
L	W0008	WFWM		NA		123.00

(d) Laboratory services (See N.J.A.C. 10:61-3).

(e) Minor surgery:

\* An asterisk preceding any procedure code may also be performed by a podiatrist.

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				S	NS	
N	10040			18.00		16.00
*	10060					

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				S	NS	
*	10061		30	48.00	42.00	
*	10080			30.00	26.00	
*	10120			18.00	16.00	
*	10121		30	34.00	29.00	
*	10140			18.00	16.00	
*	10160			13.00	11.00	
*	11000			13.00	11.00	
*	11001			6.00	5.00	
*	11040			13.00	11.00	
*	11041			13.00	11.00	
*	11042			16.00	14.00	
*	11043			16.00	14.00	
*	11100		7	13.00	11.00	
*	11400		15	18.00	16.00	
*	11401		15	22.00	20.00	
*	11402		15	27.00	24.00	
*	11403		15	32.00	27.00	
*	11404		15	32.00	27.00	
*	11406		15	32.00	27.00	
*	11420		15	18.00	16.00	
*	11421		15	22.00	20.00	
*	11422		15	27.00	24.00	
*	11423		15	32.00	27.00	
*	11424		15	32.00	27.00	
*	11426		15	32.00	27.00	
*	11440		15	18.00	16.00	
*	11441		15	22.00	20.00	
*	11442		15	27.00	24.00	
*	11443		15	32.00	27.00	
*	11444		15	32.00	27.00	
*	11446		15	32.00	27.00	
*	11600		90	37.00	32.00	
*	11601		90	47.00	42.00	
*	11602		90	61.00	53.00	
*	11620		90	61.00	53.00	
*	11621		90	90.00	79.00	
*	11622		90	121.00	105.00	
*	11640		90	90.00	79.00	
*	11641		90	121.00	105.00	
*	11642		90	150.00	131.00	
*	11700			13.00	11.00	
*	11701			6.00	6.00	
*	11710			13.00	11.00	
*	11711			6.00	6.00	
*	11730			10.00	10.00	
*	11750		30	42.00	37.00	
*	12001			18.00	16.00	
*	12002			24.00	21.00	
*	12004			30.00	26.00	
*	12005		7	46.00	39.00	
*	12006		7	57.00	48.00	
*	12007		7	82.50	70.00	
*	12011			18.00	16.00	
*	12013			24.00	21.00	
*	12014		7	30.00	26.00	
*	12031		30	30.00	26.00	
*	12032		30	48.00	42.00	
*	12041		30	30.00	26.00	
*	12042		30	67.00	59.00	
*	12051		30	38.00	33.00	
*	12052		30	67.00	59.00	
*	13100		30	34.00	29.00	
*	13101		30	68.00	63.00	
*	13120		30	48.00	42.00	
*	13121		30	106.00	92.00	
*	13131		30	67.00	59.00	
*	13132		30	145.00	126.00	
*	13150		30	38.00	33.00	
*	13151		30	82.00	71.00	
*	13152		30	193.00	168.00	
*	17000			16.00	14.00	
*	17010			42.00	36.00	
*	17100			18.00	15.00	
*	17105			100.00	85.00	
*	17110			16.00	14.00	
*	17200			16.00	14.00	
*	17304			100.00	85.00	
L*	W1650			24.00	21.00	
L*	W1650	22		37.00	32.00	

(f) Mental health services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				S	NS	
N	90801	ZI		45.00	45.00	
N	90843	ZI		13.00	13.00	
N	90844	ZI		26.00	26.00	
N	90847	ZI		26.00	26.00	
N	90847	ZI22		32.00	32.00	
N	90862	ZI		4.50	4.50	
N	90887	ZI		13.00	13.00	
LN	H5025	ZI		8.00	8.00	
L	Z0100			22.50	22.50	
L	Z0130			25.00	25.00	
L	Z0150			8.00	8.00	
L	Z0160			15.50	15.50	
L	Z0170			46.00	46.00	
L	Z0180			77.00	77.00	

(g) Obstetrical services (maternity):

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				S	NS	
N	59400		60	468.00	403.00	4
N	59400	WM	60	NA	328.00	4
N	59410		60	320.00	272.00	4
N	59410	WM	60	NA	224.00	4
N	59420			16.00	14.00	
N	59420	WM		NA	11.20	
N	59420	22		22.00	17.00	
N	59420	WM22		NA	15.40	
N	59430		0	20.00	18.00	0
N	59430	WM	0	NA	14.00	0
N	59510		45	598.00	516.00	7
N	59515		45	450.00	385.00	7
N	59525		45	362.00	308.00	8
N	59812		45	105.00	91.00	3
L	Z0250	WM		NA	40.00	

(h) Podiatry services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				S	NS	
N	29580			18.00	16.00	3
N	99211	YR		16.00	14.00	
N	99212	YR		16.00	14.00	
N	99213	YR		16.00	14.00	
N	99214	YR		16.00	14.00	
N	99215	YR		16.00	14.00	
L	W2650			21.00	21.00	
L	W2655			5.00	5.00	

NOTE: See N.J.A.C. 10:66-6.2(f), Surgery, for additional procedures.

(i) Radiology services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				S	NS	
	70030			15.00		
	70100			15.00		
	70110			20.00		
	70120			15.00		
	70130			20.00		
	70140			15.00		
	70150			20.00		
	70160			15.00		
	70170			20.00		
	70190			15.00		
	70200			25.00		
	70210			20.00		
	70220			25.00		
	70240			15.00		
	70250			15.00		
	70260			25.00		

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units	Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				S	NS						S	NS	
	70300				5.00			74305				25.00	
	70310				10.00			74400				35.00	
	70320				15.00			74405				50.00	
	70328				13.00			74420				35.00	
	70330				20.00			74430				15.00	
	70350				8.00			74450				20.00	
	70360				10.00			74455				20.00	
	70370				20.00			74470				20.00	
	70380				15.00		N	74710				25.00	
	70390				15.00			74740				20.00	
	70551				300.00			76000				45.00	
MN	71010				10.00			76020				15.00	
MN	71020				15.00			76040				20.00	
MN	71030				20.00			76061				35.00	
MN	71034				20.00			76062				90.00	
	71100				15.00			76080				15.00	
	71110				20.00			76090				26.00	
	71120				15.00			76091				36.00	
	71130				20.00			76100				35.00	
	72010				40.00			76100	50			50.00	
	72040				15.00			76805				55.00	
	72050				20.00			76815				25.00	
	72052				25.00			76816				25.00	
	72070				15.00								
	72080				15.00								
	72100				20.00								
	72110				25.00								
	72114				20.00								
N	72170				15.00								
	72190				20.00								
	72200				20.00								
	72220				15.00								
	73000				10.00								
	73010				15.00								
	73020				15.00								
	73030				15.00								
	73040				15.00								
	73050				18.00								
	73060				15.00		N						
	73070				15.00		N						
	73080				15.00		N						
	73085				15.00		N						
	73090				10.00								
	73092				20.00		N						
	73100				10.00								
	73110				15.00								
	73115				15.00		N						
	73120				10.00		L						
	73130				15.00		L						
	73140				5.00		L						
N	73500				18.00		L						
N	73510				20.00		L						
	73520				25.00								
	73525				15.00								
	73530				30.00								
	73540				15.00								
	73550				15.00								
	73560				15.00								
	73562				15.00								
	73580				15.00								
	73590				15.00								
	73592				20.00								
	73600				10.00		LN						
	73610				13.00		LN						
	73615				15.00								
	73620				10.00								
	73630				13.00								
	73650				10.00								
	73660				5.00								
	74000				10.00								
	74010				15.00								
	74020				15.00								
N	74220				20.00								
N	74240				40.00								
N	74241				45.00								
N	74245				50.00								
N	74250				30.00								
	74270				30.00								
	74280				40.00								
	74290				35.00								

  

(j) Rehabilitation services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				S	NS	
N	92507			7.00	7.00	
N	92552			11.00	11.00	
N	92553			14.00	14.00	
N	92557			19.00	19.00	
	92562			3.00	NA	
	92563			3.00	NA	
	92564			4.00	NA	
N	92567			5.00	NA	
N	92568			5.00	NA	
N	92572			20.00	NA	
N	92576			30.00	NA	
N	92582			14.00	14.00	
	92585			45.00	NA	
N	92589			10.00	NA	
	92590			40.00	NA	
	92591			40.00	NA	
N	97799			7.00	7.00	
L	H5300			7.00	7.00	
L	Z0270			7.00	7.00	
L	Z0280			7.00	7.00	
L	Z0300			7.00	7.00	
L	Z0310			45.00	45.00	

  

(k) Vision care services (See N.J.A.C. 10:62-4).

(l) Transportation services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				S	NS	
LN	Z0330			4.50	4.50	
LN	Z0335			9.00	9.00	

  

(m) Drug treatment center services:

\* An asterisk preceding any procedure code indicates that the procedure may only be provided to ACCAP-eligible individuals in the home.

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				S	NS	
*LN	Z1830			3.50	3.50	
*LN	Z1831			4.50	4.50	
*LN	Z1832			24.00	24.00	
*LN	Z1833			12.00	12.00	

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units	Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
				S	\$	NS						S	\$	NS	
*LN	Z1834			30.00		30.00		L	Z1605	ZI		10.23		10.23	
*LN	Z1835			22.50		22.50		L	Z1610	ZI		35.00		35.00	
LN	Z2000			22.50		22.50		L	Z1611	ZI		6.51		6.51	
LN	Z2001			15.00		15.00		L	Z1612	ZI		5.12		5.12	
LN	Z2002			4.50		4.50		L	Z1613	ZI		35.00		35.00	
LN	Z2003			16.00		16.00									
LN	Z2004			8.00		8.00									
LN	Z2005			15.00		15.00									
LN	Z2006			2.50		2.50									
LN	Z2007			8.00		8.00									
LN	Z2010			4.50		4.50									

NOTE: See N.J.A.C. 10:66-6.2(a), Evaluation and management and other procedures, for additional procedures preceded by an asterisk.

(p) Miscellaneous services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
				S	\$	NS	
	57820		15	72.00		63.00	
	58120		15	72.00		63.00	
N	59840		45	79.00		68.00	
N	59841		45	79.00		68.00	

(n) Federally qualified health care services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
				S	\$	NS	
	90844	22		150.00		150.00	
L	W9840			150.00		150.00	
L	Y3333			150.00		150.00	

Amended by R.1998 d.127, effective March 2, 1998.  
See: 29 N.J.R. 5046(a), 30 N.J.R. 827(b).

Inserted asterisks before codes 99384, 99385, 99386, 99387, 99394 and 99395.

Amended by R.2000 d.435, effective November 6, 2000.  
See: 32 N.J.R. 2690(a), 32 N.J.R. 3992(a).

In (a), inserted references to HCPCS Code 90746, and deleted references to HCPCS Code W9099.

(o) Personal care assistant services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
				S	\$	NS	
L	Z1600	ZI		13.02		13.02	

**10:66-6.3 HCPCS procedure codes and maximum fee allowance schedule for Level II & Level III codes and narratives (not located in CPT)**

(a) Evaluation and Management and other procedures

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance		
					S	\$	NS
	J2790		RhoGAM, Rho (D) Immune Globulin (Human); single dose—Micro-Dose		20.40		20.40
	J2790	22	RhoGAM, Rho (D) Immune Globulin (Human); single dose—Full dose		72.07		72.07
	W9060	WT	Under six weeks				
	W9061	WT	Six weeks to three months				
	W9062	WT	Three months to five months				
	W9063	WT	Five months to eight months				
	W9064	WT	Eight months to 11 months				
	W9065	WT	11 months to 14 months				
	W9066	WT	14 months to 17 months				
	W9067	WT	17 months to 20 months				
	W9068	WT	20 months to 24 months				
			1. History including behavior and environmental factors;				
			2. Developmental assessment; and				
			3. Complete, unclothed physical examination by a physician or a nurse practitioner under the personal supervision of a physician, to include:				
			(a) Measurements: height, weight and head circumference;				

(b) Vision and hearing screening;  
and

(c) Nutritional assessment.

4. Assessment and administration of immunizations (see appropriate HCPCS procedure codes for reimbursement amounts);

5. Anticipatory guidance;

6. Arrangement for diagnosis and treatment of medical problems uncovered during the visit. This includes self-referrals and/or referrals to other providers as medically indicated;

7. Appropriate laboratory procedures performed, or referred, in accordance with HealthStart Pediatric Care Guidelines.

(a) Sickle cell, PKU screening, as appropriate;

(b) Hemoglobin or hematocrit twice: at six to nine months and 20 to 24 months of age. (When done in conjunction with lead screening, this test is not reimbursable as a separate procedure.);

(c) Urinalysis, twice: at six to nine months and 20 to 24 months of age;

(d) Tuberculin test, twice: at 12 to 14 months and 20 to 24 months; and

(e) Lead screening (EP) at 12 to 14 months and 20 to 24 months.

8. Case coordination: referral for nutritional, psychological, social and other community services, as appropriate; and provision or arrangement for 24-hour telephone physician access and sick care; and outreach and follow-up activities in accordance with the HealthStart Pediatric Care Guidelines.

**NOTE:** Laboratory procedures performed by a physician in his or her office are not reimbursable to the physician; if such procedures are performed by an outside laboratory, the laboratory shall submit a separate claim.

W9096

Hepatitis B immunoprophylaxis with Recombivax HB, 0.25 ml dose. This code applies only to newborns of HBsAg negative mothers.

17.46

17.46

Ind	HCPCS		Description	Follow Up Days	Maximum Fee Allowance		
	Code	Mod			\$	\$	NS
	W9096	22	Hepatitis B immunoprophylaxis with Recombivax HB, 0.5 ml does. This code applies only to newborns of HBsAg negative mothers.		32.79		32.79
	W9097		Hepatitis B immunoprophylaxis with Recombivax HB, 0.25 ml dose. This code applies only to high risk beneficiaries under 11 years of age (exclusive of newborns).		17.46		17.46
	W9098		Hepatitis B immunoprophylaxis with Recombivax HB, 0.5 ml dose. This code applies only to high risk beneficiaries 11 to 19 years of age.		32.79		32.79
	W9099		Hepatitis B immunoprophylaxis with Recombivax HB, 1.0 ml dose. This code applies only to high risk beneficiaries over 19 years of age.		63.57		63.57
	W9333		Hepatitis B immunoprophylaxis with Engerix-B, 0.5 ml does. This code applies only when immunizing newborns.		27.88		27.88
	W9334		Hepatitis B immunoprophylaxis with Engerix-B, 0.5 ml dose. This code applies only to high risk beneficiaries under 11 years of age (exclusive of newborns).		27.88		27.88
	W9335		Hepatitis B immunoprophylaxis with Engerix-B, 1.0 ml dose. This code applies only to high risk beneficiaries over 11 years of age.		62.09		62.09
	W9338		Tetramune. this code is used when administering the primary immunization series to infants and toddlers. It eliminates the need for two separate injections of DTP and Haemophilus b Conjugate Vaccine.		30.27		30.27
N	W9820		Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) through age 20. NOTE: If performed by outside independent laboratories, the laboratory must submit the claim. Blood sample for lead screening test should be sent to the New Jersey State Department of Health and Senior Services. NOTE: Procedure code W9820 shall be used only once for the same patient during any 12-month period by the same physician, group, shared health care facility, or practitioner(s) sharing a common record. Reimbursement for code W9820 is contingent upon the submission of both a completed Report and Claim For EPSDT/HealthStart Screening and Related Procedures (MC-19) and the appropriate claim form within 30 days of the date of service. In the absence of a completed MC-19 form, reimbursement will be reduced to the level of an annual health maintenance examination, that is, \$22.00-\$17.00.		23.00		18.0

(b) Dental services (See N.J.A.C. 10:56-3).

(c) Family planning services:

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance		
					S	\$	NS
	W0001	WF	Supplying and inserting the intrauterine device "Paragard" by a physician including the post-insertion visit.		188.00		188.00
	W0001	WMWF	Supplying and inserting the intrauterine device "Paragard" by a certified nurse-midwife including the post-insertion visit.		NA		177.00
	W0002	WF	Supplying and inserting the intrauterine device "Progestasert" by a physician including the post-insertion visit.		123.00		123.00
	W0002	WMWF	Supplying and inserting the intrauterine device "Progestasert" by a certified nurse-midwife including the post-insertion visit.		NA		112.00
	W0004	WF	Removal of an IUD by a physician followed at the same visit by the insertion of the IUD "Paragard" and including the post-insertion visit.		204.00		204.00
	W0004	WMWF	Removal of an IUD by a certified nurse-midwife followed at the same visit by the insertion of the IUD "Paragard" and including the post-insertion visit.		NA		188.00
	W0008	WF	Removal of an IUD by a physician followed at the same visit by the insertion of the IUD "Progestasert" and including the post-insertion visit.		139.00		139.00
	W0008	WMWF	Removal of an IUD by a certified nurse-midwife followed at the same visit by the insertion of the IUD "Progestasert" and including the post-insertion visit.		NA		123.00

(d) Laboratory services (See N.J.A.C. 10:61-3).

(e) Minor surgery:

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance		
					S	\$	NS
	W1650		Excision of plantar verruca, single site unilateral		24.00		21.00
	W1650	22	Excision of plantar verruca, multiple sites, unilateral		37.00		32.00

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance	
					S	NS
	H5025	ZI	Group therapy: Verbal or other therapy methods provided by one or more psychiatrists, or professional counselors under the direction of a psychiatrist, in a personal involvement with two or more patients, with a maximum of eight patients. A minimum session of 1½ hours is required. This includes preparation time in addition to the 1½ hours session time.		8.00	8.00
	Z0100		Off-Site Crisis Intervention—An emergency procedure by personnel of a mental health clinic to an outpatient individual at locations other than the grounds or buildings of the clinic. Request for this service shall be initiated by the patient or other interested individual to meet the immediate needs of the patient, who is unable to present himself at the clinic.		22.50	22.50
	Z0130		<p>The procedure includes rapid intervention, written evaluation and a treatment plan. Use of procedure is limited to twice in six months for any one patient. This procedure is not applicable to institutionalized patients.</p> <p>Psychological testing: Maximum of five hours of psychometric and/or projective tests with a written report.</p> <p>Partial Care: A mental health service whose primary purpose is to maximize the client's independence and community living skills in order to reduce unnecessary hospitalization. It is directed toward the acute and chronically disabled individual. Partial Care programs shall provide, as listed below, a full system of services necessary to meet the comprehensive</p>		25.00 Per Hour	25.00 Per Hour

needs of the individual client. Services shall be provided or arranged for, to meet the individual needs of participating clients. These services shall include:

- Assessment and evaluation;
- Service procurement;
- Therapy;
- Information and referral;
- Counseling;
- Daily living education;
- Community organization;
- Pre-vocational therapy;
- Recreational therapy; and
- Health related services.

Partial Care programs shall be available daily for five days a week, with additional planned activities each week during evening and/or weekend hours as needed. Individual clients need not attend every day but as needed.

Partial Care programs specifically developed for children may be available four days a week, with one evening and/or weekend activity(ies).

The staff of the Partial Care program should include a Director who shall be a qualified professional from the specialties of psychiatry, psychology, social work, psychiatric nursing, vocational rehabilitation, or a related field with training and/or experience in direct service provision and administration.

A qualified psychiatrist shall be available to the Partial Care program on a regularly scheduled basis, for consultation. Other staff deemed necessary to implement a Partial Care program which meets the requirement of this section should include qualified mental health professionals, paraprofessionals and volunteers.

In order to qualify as an approved Partial Care program the Program must be certified by the Department.

Z0170	Partial Care, half day*	46.00	46.00
	*At least three hours but less than five hours of participation in active programming exclusive of meals.		
Z0180	Partial Care, full day*	77.00	77.00
	*Five or more hours of participation in active programming exclusive of meals.		

**NOTE:** Except for transportation these rates reflect full payments with a prohibition against multiple billing for more than one service to a Medicaid patient in a given day.

(g) Obstetrical services (maternity):

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee \$	Allowance \$	NS
	Z0250	WM	Home Delivery Pack. All drugs and supplies, etc., necessary for delivery in this setting.		NA		40.00

(h) Podiatry services:

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee \$	Allowance \$	NS
	W2650		Casting for molded shoes Prior authorization is required.		21.00		21.00
	W2655		Casting for arch support Prior authorization is required.		5.00		5.00

(i) Radiology services:

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee \$	Allowance \$	NS
	W7200		Foot, complete (incl. special or calcis views)		20.00		20.00
	W7250		Colon, barium enema, with or without K.U.B. air contrast only (with fluoroscopy by the radiologist).		30.00		30.00

(j) Rehabilitation services:

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee \$	Allowance \$	NS
	H5300		Occupational therapy		7.00		7.00
	Z0270		Physical therapy—initial visit, per individual, per provider		7.00		7.00
	Z0280		Occupational therapy—initial visit, per individual, per provider		7.00		7.00
	Z0300		Speech-language therapy—initial visit, per individual, per provider		7.00		7.00

(k) Vision care services (See N.J.A.C. 10:62-4).

(l) Transportation services:

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee \$	Allowance \$	NS
	Z0330		Transportation, one way.		4.50		4.50
	Z0335		Transportation, round trip.		9.00		9.00

(m) Drug treatment center services:

\*An asterisk preceding any procedure code indicates that the procedure may only be provided to ACCAP-eligible individuals in the home.

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance		
					S	\$	NS
	*Z1830		Methadone treatment rendered by a drug treatment center at home, per visit.		3.50		3.50
	*Z1831		Urinalysis for drug addiction at home, per visit.		4.50		4.50
	*Z1832		Psychotherapy rendered by a drug treatment center at home—full session, per visit.		24.00		24.00
	*Z1833		Psychotherapy rendered by a drug treatment center at home—half session, per visit.		12.00		12.00
	*Z1834		Family therapy rendered by a drug treatment center at home, per visit.		30.00		30.00
	*Z1835		Family conference rendered by a drug treatment center at home, per visit.		22.50		22.50
	Z2000		Family therapy rendered in a drug treatment center.		22.50		22.50
	Z2001		Family conference rendered in a drug treatment center.		15.00		15.00
	Z2002		Prescription visit rendered in a drug treatment center.		4.50		4.50
	Z2003		Psychotherapy rendered in a drug treatment center—full session.		16.00		16.00
	Z2004		Group therapy rendered in a drug treatment center, per person.		8.00		8.00
	Z2005		Psychological testing rendered in a drug treatment center, per hour; maximum of five hours.		15.00		15.00
	Z2006		Methadone treatment rendered in a drug treatment center.		2.50		2.50
	Z2007		Psychotherapy rendered in a drug treatment center—half session.		8.00		8.00
	Z2010		Urinalysis for drug addiction.		4.50		4.50

(n) Federally qualified health center services:

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance		
					S	\$	NS
	W9840		Medical encounter		150.00		150.00
	Y3333		Dental encounter		150.00		150.00
	90844	22	Medical psychotherapy		150.00		150.00

(o) Personal care assistant services:

(Applicable to clinics under contract to the Division of Mental Health and Hospitals of the Department of Human Services.)

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee \$	Allowance \$	NS
	Z1600	ZI	Personal Care Assistant Services Individual, per hour		13.02		13.02
	Z1605	ZI	Personal Care Assistant Services Group, per hour		10.23		10.23
	Z1610	ZI	Personal Care Assistant Services Initial Nursing Assessment, per visit		35.00		35.00
	Z1611	ZI	Personal Care Assistant Services Individual, per hour		6.51		6.51
	Z1612	ZI	Personal Care Assistant Services Group, per hour		5.12		5.12
	Z1613	ZI	Nursing Reassessment Visit, per visit		35.00		35.00

Amended by R.1998 d.577, effective December 7, 1998.  
 Sec: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).

In (a), substituted references to beneficiaries for references to recipients throughout; and in (f), inserted a reference to NJ KidCare fee-for-service.

**10:66-6.4 HCPCS procedure codes—qualifiers**

(a) Evaluation and management and other procedures:

1. Drawing of blood: 36415.

i. Once per visit, per patient. (Not applicable if laboratory study, in any part, is performed by the clinic.)

2. Injection (intradermal, subcutaneous, or intra-arterial): 90799.

i. Reimbursement for the above injections are on a flat-fee basis and are all inclusive for the cost of the service as well as the materials. Be advised of the following:

(1) A visit for the sole purpose of an injection is reimbursable only as an injection and not as a clinic visit and injection. However, if the criteria of a clinic visit is met, an injection may, if medically indicated, be considered as an add-on to the visit. The drug administered shall be consistent with the diagnosis and shall conform to accepted medical and pharmacological principles with respect to dosage, frequency and route of administration.

(2) Intravenous and intraarterial injections are reimbursable only when performed by the physician.

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

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

(5) No reimbursement will be made for injections given for the treatment of obesity.

(6) No reimbursement will be made for an injection given as a pre-operative medication or as a pre-operative local anesthetic which is part of an operative or surgical procedure since this injection would normally be included in the listed fee for such a procedure.

(7) Insert procedure code 90799 as a separate item on the claim, followed by the name, dose of drug, and route of administration. The complete diagnosis, for which the injection was given, shall be indicated on the claim.

3. General clinical psychiatric diagnostic or evaluative interview procedures: 90801.

i. This code requires for reimbursement purposes a minimum of 50 minutes of direct personal clinical involvement with the patient or family member. The CPT narrative otherwise remains applicable.

ii. No more than one claim for the code 90801 is reimbursable per the same beneficiary, per the same physician, per year.

4. Prolonged detention: 99150 and 99151.

i. Prolonged detention with or without critical care will be covered under CPT 99150 and 99151, but the service shall be consistent with the following narrative in order to be reimbursed:

(1) The patient's situation requires constant physician attendance which is given by the physician to the exclusion of other patients and duties. This must be verified by the applicable records as defined by the setting.

(2) Records shall show in the physician's handwriting the time of onset and time of completion of the service.

ii. This code may not be used simultaneously with procedure codes that pay a reimbursement for the same time or type of service.

iii. The basis for this type of claim should be apparent on the claim form. The listed fees of \$37.00 for specialist and \$32.00 for non-specialist are per hour.

5. Evaluation and management—new patient (excludes preventive health care for patients through 20 years of age): 99201, 99201WF, 99201WFWM, 99202, 99202WF, 99202WFWM, 99203, 99203WF, 99203WFWM, 99204, 99204WF, 99204WFWM, 99205, 99205WF, 99205WFWM and 99432.

i. When reference is made in the CPT manual to “Office—New Patient,” the intent of the Medicaid program is to consider this service as the initial visit.

ii. Reimbursement for an initial clinic visit will be disallowed, if a preventive medicine service, EPSDT examination or clinic consultation were billed within a twelve month period by a clinic.

iii. It is also to be understood that in order to receive reimbursement for an initial visit, the following minimal documentation must be on the record regardless of the setting where the examination was performed. For example:

(1) Chief complaint(s);

(2) Complete history of the present illness and related systemic review, including recordings of pertinent negative findings;

(3) Pertinent past medical history;

(4) Pertinent family history;

(5) A full physical examination pertaining to but not limited to the history of the present illness and includes recording of pertinent negative findings; and

(6) Working diagnoses and treatment plan including ancillary services and drugs ordered.

6. Evaluation and management services—established patient (excludes preventive health care for patients through 20 years of age): 99211, 99211WM, 99211WF, 99211WFWM, 99212, 99212WF, 99212WFWM, 99212WM, 99213, 99213WF, 99213WFWM, 99213WM, 99214, 99214WF, 99214WFWM, 99214WM, 99215, 99215WF, 99215WFWM, and 99215WM.

i. Routine visit or follow-up care visit is defined for purposes of Medicaid and NJ KidCare fee-for-service reimbursement as the care and treatment by a physician or certified nurse-midwife, as appropriate, which includes those procedures ordinarily performed during a health care visit, which are dependent upon the setting and the physician's discipline.

ii. In order to document the record for reimbursement purposes, a progress note for the noted visits should include the following:

(1) Purpose of visit;

(2) Pertinent history obtained;

(3) Pertinent physical findings including pertinent negative findings based on the above;

(4) Procedures, if any, with results;

(5) Lab, X-ray, EKG, etc., ordered with results; and

(6) Diagnosis.

7. Consultations: A consultation is recognized for reimbursement only when performed by a specialist recognized as such by this Program and the request has been made by or through the patient's attending physician and the need for such a request would be consistent with good medical practice.

i. Comprehensive consultation: 99244, 99245, 99254, 99255, 99274 and 99275.

(1) In order to receive reimbursement for these HCPCS codes, the performance of a total systems evaluation by history and physical examination, including a total systems review and total system physical examination are required.

(2) An alternative to (a)7i(1) above would be the utilization of one or more hours of the consulting physician's personal time in the performance of the consultation.

(3) Reimbursement for HCPCS codes 99244, 99245, 99254, 99255, 99274 and 99275 (Comprehensive Consultation) requires the following applicable statements, or language essentially similar to those statements, to be inserted in the “remarks section” of the claim form. The form is to be signed by the provider who performed the consultation.

(A) I personally performed a total (all) systems evaluation by history and physical examination; or

(B) This consultation utilized 60 or more minutes of my personal time.

(4) The following rules regarding consultations shall also be recognized.

(A) If a consultation is performed and the patient is then transferred to the consultant's service during the course of that illness, the provider may not, in addition, bill for an Initial Visit if he or she has or intends to bill for the consultation.

(B) If there is no referring physician, then an Initial Visit code should be used instead of a consultation code.

(C) If the patient is seen for the same illness on repeated visits, by the same consultant, then these visits are considered as routine visits or follow-up care visits and not as consultations.

(D) Consultation codes will be declined in a clinic setting if the consultation has been requested by or between members of the same group, shared health care facility or physicians sharing common records. A routine visit code is applicable under these circumstances.

(E) If a prior claim for comprehensive consultation visit has been made within the preceding 12 months, then a repeat claim for this code will be denied if made by the clinic except in those instances where the consultation required the utilization of one hour or more of the physician's personal time. Otherwise, applicable codes would be limited consultation code if their criteria are met.

ii. Limited consultation: 99241, 99242, 99243, 99251, 99252, 99253, 99271, 99272, and 99273.

(1) The area being covered for reimbursement purposes is "limited" in the sense that it requires less than the requirements designated as "comprehensive" as noted above.

iii. Second opinion program consultation: 99274YY.

(1) A consultation to satisfy the requirements of the mandated "Second Opinion" program will be reimbursed only if the requirements of that program are met and the consultation has been performed by the appropriate board certified specialist who has signed a separate provider agreement and whose selection has been through the Second Opinion Referral Service (1-800-676-6562).

iv. Third opinion consultation: 99274ZZ.

(1) In the event that a patient receives two different points of view relative to a "Second Opinion" procedure, he or she may, if unable to reach a decision, request a third opinion.

(2) A third opinion consultation must be at the patient's request and under the circumstances described.

8. Critical care services: 99291 and 99292.

i. Critical care is reimbursable under codes 99291 and 99292 if the service is consistent with the following:

(1) The patient's situation requires constant physician attendance which is given by the physician to the exclusion of his or her other patients and duties and, therefore, represents what is beyond the usual service. This must be verified by the applicable records as defined by the setting and which records must show in the physician's handwriting the time of onset and time of completion of the service.

(2) All settings are applicable, such as clinic and hospital.

(3) These codes may not be used simultaneously with procedure codes that pay a reimbursement for the same time or type of service.

(b) Dental services (See N.J.A.C. 10:56-3).

(c) Family planning services:

1. Norplant—insertion, implantable contraceptive capsules: 1197522.

i. The maximum fee allowance includes the cost of the NPS kit, the insertion of the "Norplant System" (six levonorgestrel implants), and the post-insertion visit.

ii. Modifier "22" indicates that the billing includes the cost of the kit.

2. Norplant—removal, implantable contraceptive capsules: 11976.

i. The maximum fee allowance includes the removal of the "Norplant System" (six levonorgestrel implants) and the post-removal visit.

3. Norplant—removal with reinsertion, implantable contraceptive capsules: 1197722.

i. The maximum fee allowance includes the removal/insertion of the "Norplant System" (six levonorgestrel implants) and post-removal/reinsertion visit.

4. Sterilization (male): 55250 and 55450.

i. Primary sterilization (family planning) procedure.

ii. A completed consent form shall be attached to the claim form, in accordance with N.J.A.C. 10:66-2.3.

5. Sterilization (female): 58600, 58605, 58982, and 58983.

i. These procedures are always considered a sterilization procedure. Therefore, a completed consent form shall be attached to the claim form, in accordance with N.J.A.C. 10:66-2.3.

ii. 57451: If the procedure is performed for sterilization purposes, a completed consent form shall be attached to the claim form, in accordance with N.J.A.C. 10:66-2.3.

6. Initial medical visit: 99201WF, 99201WFWM, 99202WF, 99202WFWM, 99203WF, 99203WFWM, 99204WF, 99204WFWM, 99205WF, and 99205WFWM.

i. Family planning to include each of the following:

(1) Medical, social, obstetrical history

(2) Complete pelvic examination—including visual inspection of the cervix

(3) Breast examination

(4) Papanicolaou smear (excludes cytology study)

- (5) Contraceptive counseling with referral as indicated.
- ii. Includes the cost of birth control drugs dispensed. A prescription cannot be substituted.
- iii. These procedure codes (initial medical visit) will be disallowed if procedure codes 99201, 99201WF, 99201WFWM, 99202, 99202WF, 99202WFWM, 99203, 99203WF, 99203WFWM, 99204, 99204WF, 99204WFWM, 99205, 99205WF, 99205WFWM and 99432 have been performed during the prior 12 months by the same provider.
7. Routine or follow-up visit—brief: 99211WF, 99211WFWM, 99212WF, 99212WFWM, 99213WF, and 99213WFWM.
- i. May include pelvic examination, changes in method or physician's or certified nurse-midwife's instructions at a minimum average time of five minutes, or a visit solely for a refill supply of birth control drugs for which a prescription cannot be substituted and professional contact is not necessary.
8. Medical revisit—family planning: 99214WF and 99214WFWM.
- i. May include pelvic examination or changes in method or physician's or certified nurse-midwife's instructions. This code includes the cost of birth control drugs dispensed. A prescription cannot be substituted.
9. Routine or follow-up visit—prolonged: 99215WF and 99215WFWM.
- i. May include pelvic examination or changes in method or physician's or certified nurse-midwife's instructions. Involves 20 or more minutes of personal time in patient contact, including documentation of time as well as adequate significant progress notes on the clinic record. This procedure code includes the cost of birth control drugs dispensed. A prescription cannot be substituted.
10. Annual medical revisit: 99395WF and 99395WFWM.
- i. Family planning to include each of the following:
- (1) Updating medical, social, obstetrical history;
  - (2) Complete pelvic examination including visual inspection of cervix;
  - (3) Breast examination; and
  - (4) Papanicolaou smear (excludes cytology study) with referral when indicated.
- ii. This code includes the cost of birth control drugs dispensed. A prescription cannot be substituted.
- iii. Procedure code 99395WF will be disallowed if procedure codes 99201, 99201WF, 99201WFWM, 99202, 99202WF, 99202WFWM, 99203, 99203WF, 99203WFWM, 99204, 99204WF, 99204WFWM, 99205, 99205WF, 99205WFWM and 99432 have been performed during the prior 12 months by the same provider.
- (d) Laboratory services (See N.J.A.C. 10:61-3).
- (c) Minor surgery:
1. Acne surgery (for example, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules): 10040.
    - i. Excision must involve the use of a scalpel and an expressor, but not an expressor alone. This code is limited to severe acne. For less than severe acne, utilize the procedure codes for routine office visits.
- (f) Mental health services:
1. Comprehensive intake evaluation: 90801ZI.
    - i. An initial procedure performed at a mental health clinic to assess a new patient and recommend an appropriate treatment plan or additional diagnostic studies. The procedure includes initial interviews with the patient and other involved individuals, conferences with referral sources, examination of written material provided by the patient or others, staff conferences and written evaluation and treatment plan including recommendations for further consultations, studies or additional information.
    - ii. Although this procedure may be performed by a single individual, it is expected that it should be a team approach and of one and one-half hours duration. Use of procedure is limited to once per year for any one patient.
  2. Individual psychotherapy—25 minute session: 90843ZI.
    - i. This code requires, for reimbursement purposes, a minimum of 25 minutes of direct personal clinical involvement with the patient and/or family member.
  3. Individual psychotherapy—50 minute session: 90844ZI.
    - i. This code requires, for reimbursement purposes, a minimum of 50 minutes of direct personal clinical involvement with the patient and/or family member.
  4. Family therapy: 90847ZI.
    - i. This code requires, for reimbursement purposes, a minimum of 50 minutes of direct personal clinical involvement with the patient and/or family member. The CPT narrative otherwise remains applicable.
  5. Family therapy: 90847ZI22.

i. This code requires, for reimbursement purposes, a minimum of 80 minutes of direct personal clinical involvement with the patient and/or family member. The CPT narrative otherwise remains applicable.

6. Family conference: 90887Z1.

i. This code requires, for reimbursement purposes, a minimum of 25 minutes of direct personal clinical involvement with patient, family member or caretaker. The CPT narrative otherwise remains applicable.

7. Group psychotherapy: H5025Z1.

i. This code requires, for reimbursement purposes, a minimum of 90 minutes of direct clinical involvement with the patient as a member of a group of which 10 minutes can be used for documentation. The maximum number of the group is eight and the reimbursement is per person, per group session.

(g) Obstetrical services (maternity):

1. Total obstetrical care: 59400.

i. Antepartum care consisting of initial antepartum visits and seven subsequent antepartum visits. Specific date of all visits are to be listed on the claim form.

(1) Reimbursement will be decreased by the fee for the initial antepartum visit (5942022) if not seen for this visit. The total fee will also be decreased by the reimbursement sum for each subsequent antepartum visit (59420) which is less than seven.

(2) If medical necessity dictates, corroborated by the record, additional visits above seven antepartum may be reimbursed under the procedure codes for routine or follow-up clinic visit. The claim form shall clearly indicate the reason for the medical necessity and date for each listed.

ii. Obstetrical delivery with in-hospital postpartum care (with or without low forceps and/or episiotomy or a vaginal delivery full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours).

(1) This shall also include one visit between the 15th and 60th day postpartum day following delivery and out of hospital. Include name of hospital and delivery date on the claim.

2. Vaginal delivery: 59410.

i. Vaginal delivery full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours.

ii. This shall also include one visit between the 15th and 60th postpartum day following delivery and out of hospital. Include name of hospital and delivery date on the claim.

3. Subsequent antepartum visit: 59420.

i. Subsequent antepartum visit (separate procedure). Indicate specific dates of service.

4. Initial antepartum visit: 5942022.

i. Initial antepartum visit (separate procedure).

5. Postpartum care: 59430.

i. Postpartum care (other than delivery physician).

ii. This shall also include one visit between 15th and 60th postpartum day following delivery and out of hospital. Include name of hospital and delivery date on the claim.

6. Total obstetrical care by a certified nurse-midwife: 59400WM.

i. Total obstetrical care when given by a certified nurse-midwife, including:

(1) Antepartum care consisting of initial antepartum visit and seven subsequent antepartum visits. Specific dates of all visits are to be listed on the claim form.

(2) Reimbursement will be decreased by the fee for the initial antepartum visit (code 5942022WM) if patient not seen for this visit. The total fee will also be decreased by the reimbursement sum for each subsequent antepartum visit (code 59420WM) which is less than seven.

(3) If medical necessity dictates, corroborated by the record, additional visits above seven antepartum may be reimbursed under the procedure codes for routine or follow-up visit. The claim shall clearly indicate the reason for the medical necessity and date for each code listed.

ii. Obstetrical delivery per vagina with or without episiotomy include postpartum care when provided by the certified nurse-midwife in the home, birthing center or in the hospital (inpatient setting).

(1) This applies to a vaginal delivery at full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours.

(2) This shall also include one visit between the 15th and 42nd postpartum day following delivery and out of the hospital. Include delivery date on the claim form.

7. Vaginal delivery by a certified nurse-midwife: 59410WM.

i. Obstetrical delivery per vagina with or without episiotomy including postpartum care when provided by the certified nurse-midwife in the home, birthing center or in the hospital (inpatient setting).

(1) This applies to a vaginal delivery at full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours.

(2) This shall also include one visit between the 15th and 42nd post-partum day following delivery and out of hospital. Include delivery date on the claim form.

8. Subsequent antepartum visit provided by a certified nurse-midwife: 59420WM.

i. Indicate specific date of service.

9. Initial antepartum visit provided by a certified nurse-midwife: 59420WM22.

i. Initial antepartum visit provided by a certified nurse-midwife (separate procedure).

10. Postpartum care provided by a certified nurse-midwife: 59430WM.

i. Postpartum care provided by a certified nurse-midwife who is other than the individual who performed the delivery and who is not related to this individual by any financial or contractual arrangement, e.g., group, clinic, employee, etc.

ii. One visit between the 15th and 60th postpartum day following delivery. Include delivery date on the claim (separate procedure).

(h) Podiatry services:

1. Routine or follow-up clinic visit: 99211YR, 99212YR, 99213YR, 99214YR, and 99215YR.

i. Routine or follow-up clinic visit. A podiatry service consisting of routine care and treatment by the podiatrist.

ii. Include significant written progress notes and office records which demonstrate positive findings and treatment changes.

2. See N.J.A.C. 10:66-6.4(f), Surgery, for additional procedures.

(i) Radiology services:

1. Chest: 71010, 71020, 71030, and 71034.

i. Routine chest X-rays without medical necessity in an office (clinic) are not reimbursable under Program guidelines.

2. Pelvis: 72170.

i. Pelvis X-ray is not eligible for separate payment when performed in conjunction with Complete Lumbosacral Spine X-rays (72110).

3. Hip: 73500 and 73510.

i. Procedure 73520 should be used for bilateral hip X-rays when both hips are X-rayed instead of billing separately for each hip (73500 and 73510).

4. Esophagus (with fluoroscopy by the radiologist): 74220.

i. Not eligible for separate payment when performed in conjunction with a GI or Small Bowel Series (74240, 74241, 74245, and 74250).

5. Pelvimetry: 74710.

i. Use of the code for pelvimetry requires written evidence of medical necessity to accompany the claim.

(j) Rehabilitation services:

1. Speech therapy: 92507.

i. Minimum time, 30 minutes. Prior authorization required.

ii. Prescribed by a licensed physician, performed by a qualified speech-language pathologist.

2. Audiometric tests: 92552, 92553, 92557, 92567, 92568, 92572, 92576, 92582, and 92589.

i. May be reimbursed when prescribed by a physician and performed by an audiologist.

ii. Tympanometry (92567) and acoustic reflex testing (92568) are reimbursable only to a specialist.

iii. Acoustic reflex testing, 92568, shall include at least two frequencies per ear. Brief reflex screening at one frequency per ear is not reimbursable. Documentation of these tests shall appear in the patient's record.

3. Physical therapy: 97799.

i. Individual treatment session—minimum time, 30 minutes. No more than three patients can be treated simultaneously.

ii. Prior authorization required. Consists of any one or a combination of the following modalities, prescribed by a licensed physician, performed by a qualified physical therapist and related to the patient's active treatment regimen.

(1) Appropriate use of accepted mechanical device (such as parallel bar, weights, pulley system, friction wheels, steps, etc.).

(2) Graduated range of motion exercises.

(3) Therapeutic ultrasound, only when included as part of other forms of accepted therapy.

(4) Therapeutic use of physical agents (other than drugs) including heat, light, water, electricity and radiation.

(5) Instructions to responsible persons for follow-up procedures between therapy visits.

4. Occupational therapy: H5300.

i. Minimum time, 30 minutes. Prior authorization required.

ii. Prescribed by a licensed physician, performed by a qualified occupational therapist.

(k) Vision care services (See N.J.A.C. 10:62-4).

(l) Transportation services:

1. Transportation, one way: Z0330.

i. Applicable when the clinic transports a beneficiary either to or from the clinic in any one day.

ii. Reimbursement is limited to two trips per day for the same beneficiary by the same clinic.

2. Transportation, round trip: Z0335.

i. Applicable when the clinic transports a beneficiary on a round trip basis to/from the clinic in any one day.

ii. Reimbursement is limited to one round trip per day for the same beneficiary by the same clinic.

(m) Drug treatment center services:

1. Methadone treatment rendered by a drug treatment center for an ACCAP-eligible individual at home, per visit: Z1830.

i. A per diem payment based on the number of days a beneficiary is supplied methadone during the billing period. This rate includes the cost of the drug, packaging, nursing time, and administrative costs.

2. Urinalysis for drug addiction for an ACCAP-eligible individual at home, per visit: Z1831.

i. To be used only when the drug treatment center is approved for this service; to determine what level if any, a drug is present in the urine.

3. Psychotherapy rendered by a drug treatment center for an ACCAP-eligible individual at home—full session, per visit: Z1832.

i. Verbal, drug augmented, or other therapy methods provided by a physician, or a professional counsellor under the direction of a physician, in a personal involvement with one patient to the exclusion of other patients and/or duties.

ii. A minimum of 50 minutes personal involvement with the patient is required. This includes a prescription visit when necessary.

4. Psychotherapy rendered by a drug treatment center for an ACCAP-eligible individual at home—half session, per visit: Z1833.

i. Verbal, drug augmented, or other therapy methods provided by a physician, or a professional counsellor under the direction of a physician in a personal involvement with one patient to the exclusion of other patients and/or duties.

ii. A minimum of 25 minutes personal involvement with the patient is required. This includes a prescription visit when necessary.

5. Family therapy rendered by a drug treatment center for an ACCAP-eligible individual at home, per visit: Z1834.

i. Therapy with the patient and with one or more family members present. Verbal or other therapy methods are provided by a physician, or a professional counsellor under the direction of a physician, in personal involvement with the patient and the family to the exclusion of other patients and/or duties.

ii. A minimum session of one and one half hours is required with a minimum of 80 minutes personal involvement with the patient and the family and up to 10 minutes for the recording of data.

iii. The clinic may bill only for the patient and not for other family members.

6. Family conference rendered by a drug treatment center for an ACCAP-eligible individual at home, per visit: Z1835.

i. Meeting with the family or other significant persons to interpret or explain medical, psychiatric or psychological examinations and procedures, other accumulated data and/or advice to the family or other significant persons on how to assist the patient.

ii. A minimum of 50 minutes of personal involvement with the family is required. The clinic may bill only for the patient and not for other family members.

7. Family therapy rendered in a drug treatment center: Z2000.

i. Therapy with the patient and with one or more family members present. Verbal or other therapy methods are provided by a physician, or a professional counsellor under the direction of a physician, in personal involvement with the patient and the family to the exclusion of other patients and/or duties.

ii. A minimum session of one and one half hours is required with a minimum of 80 minutes personal involvement with the patient and the family and up to 10 minutes for the recording of data.

iii. The clinic may bill only for the patient and not for other family members.

8. Family conference rendered in a drug treatment center: Z2001.

i. Meeting with the family or other significant persons to interpret or explain medical, psychiatric or psychological examinations and procedures, other accumulated data and/or advice to the family or other significant persons on how to assist the patient.

ii. A minimum of 50 minutes of personal involvement with the family is required. The clinic may bill only for the patient and not for other family members.

9. Prescription visit rendered in a drug treatment center: Z2002.

i. A visit with a physician for review and evaluation of the medication history of the patient and the writing, or renewal of prescription, as necessary.

10. Psychotherapy rendered in a drug treatment center—full session: Z2003.

i. Verbal, drug augmented, or other therapy methods provided by a physician, or a professional counsellor under the direction of a physician, in a personal involvement with one patient to the exclusion of other patients and/or duties.

ii. A minimum of 50 minutes personal involvement with the patient is required. This includes a prescription visit when necessary.

11. Group therapy rendered in a drug treatment center, per person: Z2004.

i. Verbal or other therapy methods provided by one or more physicians, or professional counsellors under the direction of physician, in a personal involvement with two or more patients, with a maximum of eight patients.

ii. A minimum session of one and one half hours is required. This includes preparation time in addition to the one and one half hours session time.

12. Psychological testing rendered in a drug treatment center, per hour; maximum of five hours: Z2005.

i. Psychometric and/or projective tests with a written report.

13. Methadone treatment rendered in a drug treatment center: Z2006.

i. A per diem payment based on the number of days a beneficiary is supplied methadone during the billing period. This rate includes the cost of the drug, packaging, nursing time, and administrative costs.

14. Psychotherapy rendered in a drug treatment center—half session: Z2007.

i. Verbal, drug augmented, or other therapy methods provided by a physician, or a professional counsellor under the direction of a physician in a personal involvement with one patient to the exclusion of other patients and/or duties.

ii. A minimum of 25 minutes personal involvement with the patient is required. This includes a prescription visit when necessary.

15. Urinalysis for drug addiction: Z2010.

i. To determine what level, if any, a drug is present in the urine.

ii. To be used only by a drug treatment center specifically approved by the Program to provide this service.

16. Drawing of blood; see CPT-4 for narrative: 36415.

i. Once per visit per patient. Not applicable if lab study, in any part, is to be performed by the clinic.

(n) Miscellaneous services:

1. Abortion: 59840 and 59841.

i. See N.J.A.C. 10:66-2.8; FD-179 form shall be attached to the claim form.

ii. For claims submitted by ambulatory surgical centers only, the trimester of pregnancy shall be identified on the claim form by using modifier “WY” for first trimester or “WZ” for second trimester.

Administrative Correction.

26 N.J.R. 797(a).

Amended by R.1998 d.577, effective December 7, 1998.

See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).

Substituted references to beneficiaries for references to recipients throughout; and in (a)6i, inserted a reference to NJ KidCare fee-for-service.

**10:66-6.5 HealthStart**

(a) HealthStart Maternity Care code requirements are as follows:

1. Separate reimbursement shall be available for Maternity Medical Care Services and Maternity Health Support Services.

2. Maternity Medical Care Services shall be billed as a total obstetrical package when feasible, but may also be billed as separate services.

3. The enhanced reimbursement (that is, HealthStart procedure codes) for delivery and postpartum care shall be claimed only for a patient who received at least one antepartum HealthStart Maternity Medical or Health Support Service.

4. The modifier “WM” in the HCPCS lists of codes refers to those services provided by certified nurse midwives; include the modifier at the end of each code.

5. Laboratory, other diagnostic procedures, and all necessary medical consultations are eligible for separate reimbursement.

i. Laboratory procedures performed by an outside laboratory shall be reimbursed to the laboratory. The clinic may submit a claim for a venipuncture using procedure code 36415 when necessary to collect blood specimens.

6. HealthStart Maternity Medical Care Services codes are as follows:

HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance		
			\$	\$ NS	\$ WM
W9025		HealthStart Initial Antepartum Maternity Medical Care Visit	72.00	69.00	

HCPCS Code	Mod	Procedure Description	S	Maximum Fee Allowance		WM
				\$	NS \$	
W9025	WM	HealthStart Initial Antepartum Maternity Medical Care Visit by Certified Nurse Midwife 1. History, including system review 2. Complete physical examination 3. Risk assessment 4. Initial care plan 5. Patient counseling and treatment 6. Routine and special laboratory tests on site, or by referral, as appropriate 7. Referral for other medical consultations, as appropriate (including dental) 8. Coordination with the HealthStart Health Support Services provider, as applicable.				67.00
W9026		HealthStart Subsequent Antepartum Maternity Medical Care Visit	22.00		21.00	
W9026	WM	HealthStart Subsequent Antepartum Maternity Medical Care Visit by Certified Nurse Midwife 1. Interim history 2. Physical examination 3. Risk assessment 4. Review of plan of care 5. Patient counseling and treatment 6. Laboratory services on site or by referral, as appropriate 7. Referrals for other medical consultations, as appropriate 8. Coordination with HealthStart case coordinator. <b>NOTE:</b> This code may be billed only for the 2nd through 15th antepartum visit. <b>NOTE:</b> If medical necessity dictates, corroborated by the record, additional visits above the fifteenth visit may be reimbursed under procedure code, that is, 99211, 99211WM, 99212, 99212WM, 99213, 99213WM, 99214, 99214WM, 99215, and 99215WM. The date and place of service shall be included on each claim detail line on the 1500 N.J. claim form. The claim form should clearly indicate the reason for the medical necessity and date for each additional visit.				19.00
W9027		HealthStart Regular Delivery	465.00		418.00	
W9027	WM	HealthStart Regular Delivery by Certified Nurse Midwife 1. Admission history 2. Complete physical examination 3. Vaginal delivery with or without episiotomy and/or forceps 4. Inpatient postpartum care				371.00

HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance	
			\$	NS \$
		5. Referral to postpartum follow-up care provider including: (a) Mother's hospital discharge summary and the (b) Infant's discharge summary, as appropriate <b>NOTE:</b> Obstetrical delivery applies to a full term or premature vaginal delivery and includes care in the home, birthing center or in the hospital (inpatient setting). Include the delivery date on the HCFA 1500 claim form in Item 24A.		
W9028		HealthStart Postpartum Care Visit	22.00	21.00
W9028	WM	HealthStart Postpartum Care Visit by Certified Nurse Midwife		
		1. Outpatient postpartum care by the 60th day after the vaginal or caesarean section delivery (a) Review of prenatal, labor and delivery course (b) Interim history, including information on feeding and care of the newborn (c) Physical examination (d) Referral for laboratory services, as appropriate (e) Referral for ongoing medical care when appropriate (f) Patient counseling and treatment <b>NOTE:</b> The postpartum visit shall be made by the 60th postpartum day. Include the delivery date on the HCFA 1500 claim form in Item 24A.		19.00
W9029		HealthStart Regular Delivery and Postpartum	487.00	439.00
W9029	WM	HealthStart Regular Delivery and Postpartum by Certified Nurse Midwife includes:		390.00
		1. Admission history 2. Complete physical examination 3. Vaginal delivery with or without episiotomy and/or forceps 4. Inpatient postpartum care 5. Referral to postpartum follow-up care provider including: (a) Mother's hospital discharge summary (b) Infant's discharge summary, as appropriate 6. Outpatient postpartum care by the 60th day after the delivery (a) Review of prenatal, labor and delivery course (b) Interim history, including information on feeding and care of the newborn (c) Physical examination (d) Referral for laboratory services, as appropriate		

HCPCS Code	Mod	Procedure Description	S	Maximum Fee Allowance \$ NS	WM
		(e) Referral for ongoing medical care when appropriate			
		(f) Patient counseling and treatment			
		<b>NOTE:</b> This code applies to a full term or premature vaginal delivery and includes care in the home, birthing center or in the hospital (inpatient setting). Include delivery date on the HCFA 1500 claim form in Item 24A.			
W9030		HealthStart Total Obstetrical Care	867.00	802.00	
W9030	WM	HealthStart Total Obstetrical Care by Certified Nurse Midwife			723.00
		Total obstetrical care consists of:			
		1. Initial antepartum visit and 14 subsequent antepartum visits. Specific dates are to be listed on the claim form.			
		<b>NOTE:</b> Reimbursement will be denied if the services delivered do not meet the criteria for the visits.			
		The elements of the visits shall include the following:			
		a. History (initial or review), including system review			
		b. Complete physical examination			
		c. Risk assessment			
		d. Initial and ongoing care plan			
		e. Patient counseling and treatment			
		f. Routine and special laboratory tests on site, or by referral, as appropriate			
		g. Referral for other medical consultations, as appropriate (including dental)			
		h. Coordination with the HealthStart Health Support Services provider, as applicable.			
		2. Regular vaginal delivery by certified nurse midwife:			
		The elements of the care shall include the following:			
		a. Admission History			
		b. Complete physical examination			
		c. Vaginal delivery with or without episiotomy and/or forceps			
		d. Inpatient postpartum care			
		<b>NOTE:</b> Include the delivery date on the HCFA 1500 claim form in Item 24A.			
		3. Postpartum care visit by certified nurse midwife: Outpatient postpartum care by the 60th day after the vaginal delivery (full term or premature):			

HCPCS Code	Mod	Procedure Description	S	Maximum Fee Allowance		WM
				\$	NS \$	
		<ul style="list-style-type: none"> <li>a. Review of prenatal, labor and delivery course</li> <li>b. Interim history, including information on feeding and care of the newborn</li> <li>c. Physical examination</li> <li>d. Referral for laboratory services, as appropriate</li> <li>e. Referral for ongoing medical care when appropriate</li> <li>f. Patient counseling and treatment</li> </ul>				
W9031		<p>HealthStart Cesarean Section Delivery</p> <ul style="list-style-type: none"> <li>1. Admission history</li> <li>2. Complete physical examination</li> <li>3. Cesarean section delivery</li> <li>4. Inpatient postpartum care</li> <li>5. Referral to postpartum follow-up care provider, including:                             <ul style="list-style-type: none"> <li>a. Mother's hospital discharge summary</li> <li>b. Infant's discharge summary, as appropriate</li> </ul> </li> </ul> <p><b>NOTE:</b> Include the delivery date on the claim form.</p>	595.00	531.00		
W9040		<p>HealthStart enrollment process</p> <ul style="list-style-type: none"> <li>1. Assistance with the presumptive eligibility determination for Maternity Care beneficiaries, when and if applicable</li> <li>2. Patient registration and scheduling of the initial appointments</li> <li>3. Counseling and referral for WIC, food stamps, and other community-based services</li> <li>4. Assignment of HealthStart case coordinator</li> <li>5. Outreach and follow-up on missed appointments</li> </ul> <p><b>NOTE:</b> This code may be billed only once during pregnancy by the same provider.</p>	30.00			
W9041		<p>HealthStart Development of Maternity Plan of Care</p> <ul style="list-style-type: none"> <li>1. Case coordination services</li> <li>2. Initial assessments                             <ul style="list-style-type: none"> <li>a. nutrition</li> <li>b. health education</li> <li>c. social/psychological</li> </ul> </li> <li>3. Case conference with Maternity Medical Care provider</li> <li>4. Initial plan of care developed by the HealthStart case coordinator</li> <li>5. Basic guidance and health education services</li> <li>6. Referral for other needed services including follow-up with County Boards of Social Services</li> <li>7. Outreach, referral and follow-up activities including phone calls and letters.</li> </ul>	120.00			

HCPCS Code	Mod	Procedure Description	S	Maximum Fee Allowance		WM
				\$	NS \$	
		<b>NOTE:</b> This code may be billed only once during the pregnancy by the same provider.				
W9042		HealthStart Subsequent Maternity Health Support Services Visit 1. Case coordination 2. Review and update of care plan 3. Coordination with maternity medical care provider 4. Health education instruction 5. Social/psychological guidance 6. Nutrition guidance 7. Home visit for high risk clients 8. Outreach, referral and follow-up activities including phone calls and letters.	50.00			
		<b>NOTE:</b> This code may be billed only once per trimester and not more than twice per pregnancy.				
W9043		HealthStart Postpartum Maternity Health Support Services 1. Case coordination services 2. Review of the plan of care 3. Review of the summary of hospital stay records and current medical status 4. Nutrition assessment and counseling 5. Social/psychological assessment and counseling 6. Health education assessment and instruction 7. Home visit(s) as applicable 8. Referral, outreach and follow-up services 9. Referral for pediatric preventive care and follow-up 10. Transfer of pertinent information to pediatric, future family planning and medical care providers 11. Completion of the plan of care	100.00			

(b) HealthStart Pediatric Preventive Care code requirements are as follows:

1. HealthStart Pediatric Care Guidelines provide for up to nine preventive child health visits for a child under two years of age.

i. All preventive child health visits shall be billed using the HealthStart Preventive Child Health Visit codes appropriate to the child's age at the time of visit. Each preventive child health visit HCPCS procedure code may be claimed only once per child.

ii. Claims shall be submitted using Form MC-19, EPSDT/HealthStart Screening and Related Procedures.

2. Laboratory, other diagnostic procedures, and all necessary medical consultations shall be eligible for separate reimbursement.

i. Laboratory procedures performed by an outside laboratory shall be reimbursed to the laboratory. The clinic may submit a claim for a venipuncture using procedure code 36415 when necessary to collect blood specimens.

3. HealthStart Pediatric Preventive Care codes represent visits based on an infant's age according to the following schedule:

HCPCS Code	Mod	Procedure Description	S	Maximum Fee Allowance		WM
				\$	NS \$	
W9060		Under six weeks	31.00		26.00	
W9061		Six weeks to three months	31.00		26.00	
W9062		Three months to five months	31.00		26.00	

HCPCS Code	Mod	Procedure Description	S	Maximum Fee Allowance		WM
				\$	NS	
W9063		Five months to eight months	31.00		26.00	
W9064		Eight months to 11 months	31.00		26.00	
W9065		11 months to 14 months	31.00		26.00	
W9066		14 months to 17 months	31.00		26.00	
W9067		17 months to 20 months	31.00		26.00	
W9068		20 months to 24 months	31.00		26.00	

4. A HealthStart Pediatric Preventive Care Visit includes the following elements:

- i. History including behavior and environmental factors;
- ii. Developmental assessment; and
- iii. Complete, unclothed physical examination by a physician or a nurse practitioner under the personal supervision of a physician, to include:
  - (1) Measurements: height, weight and head circumference;
  - (2) Vision and hearing screening; and
  - (3) Nutritional assessment.
- iv. Assessment and administration of immunizations (see appropriate HCPCS procedure codes for reimbursement amounts);
- v. Anticipatory guidance;
- vi. Arrangement for diagnosis and treatment of medical problems uncovered during the visit. This includes self-referrals and/or referrals to other providers, as medically indicated;
- vii. Appropriate laboratory procedures performed, or referred, in accordance with HealthStart Pediatric Care Guidelines.

- (1) Sick cell, PKU screening, as appropriate;
- (2) Hemoglobin or hematocrit twice, at six to nine months and 20 to 24 months of age;
- (3) Urinalysis, twice: at six to nine months and 20 to 24 months of age;
- (4) Tuberculin test, twice: at 12 to 14 months and 20 to 24 months; and
- (5) Lead screening at six to 12 months and annually thereafter, or more often if clinically indicated.

viii. Case coordination: referral for nutritional, psychological, social and other community services, as appropriate; provision or arrangement for 24-hour telephone physician access and sick care; and outreach and follow-up activities in accordance with the HealthStart Pediatric Care Guidelines.

NOTE: As indicated in N.J.A.C. 10:66-2.4(b), laboratory procedures performed by a clinic are reimbursable to the clinic; if such procedures are performed by an outside laboratory, the laboratory shall submit a separate claim.

NOTE: As indicated in N.J.A.C. 10:66-Appendix, as referenced in N.J.A.C. 10:66-1.1(e), claims for HealthStart Preventive Care visits shall include a completed Health Insurance Claim Form, HCFA 1500, and a HealthStart Preventive Child Health Form.

HCPCS Code	Mod	Procedure Description	S	Maximum Fee Allowance		WM
				\$	NS	
W9070		HealthStart Pediatric Continuity of Care This is a service by a certified HealthStart Pediatric Care Services Provider which is a hospital outpatient department where physicians do not bill Medicaid or NJ KidCare fee-for-service program independently for professional services. This code shall include reimbursement for the following service components: —Assignment of a case coordinator responsible for outreach, referral and follow-up activities; —24-hour telephone access for medical consultation outside clinic hours; and —Provision or arrangement for sick care. (Referral to the emergency room shall only occur for emergency medical care or urgent care as recommended by the physician responsible for sick care.)	13.00		13.00	

HCPCS Code	Mod	Procedure Description	S	Maximum Fee Allowance		WM
				\$	NS \$	
		<b>NOTE:</b> This code may be billed only in conjunction with a pediatric preventive health care visit provided in accordance with HealthStart Regulations and Guidelines for HealthStart Providers. Claims shall be submitted using Form MC-19, EPSDT/HealthStart Screening and Related Procedures.				

Administrative Correction.  
 See: 26 N.J.R. 235(a).  
 Amended by R.1998 d.577, effective December 7, 1998.  
 See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).  
 Substituted references to HCFA 1500 claim forms for references to 1500 NJ claim forms throughout; and in (b), inserted a reference to NJ KidCare fee-for-service throughout.

For a copy of the Fiscal Agent Billing Supplement, write to:

Unisys  
 PO Box 4801  
 Trenton, New Jersey 08650-4801  
 or contact:  
 Office of Administrative Law  
 Quakerbridge Plaza, Bldg. 9  
 PO Box 049  
 Trenton, New Jersey 08625-0049

**APPENDIX**

**FISCAL AGENT BILLING SUPPLEMENT**

**AGENCY NOTE:** The Fiscal Agent Billing Supplement is appended as a part of this chapter but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages shall be distributed to providers and copies shall be filed with the Office of Administrative Law.

Amended by R.1998 d.577, effective December 7, 1998.  
 See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).  
 Updates addresses.