



STATE OF NEW JERSEY

DEPARTMENT OF HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE

AND

HEALTH SERVICES

HEALTH SERVICES PROGRAM

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

New Jersey Health Services Program NEWSLETTER

Volume P.212

January 9, 1978

TO: PARTICIPATING PHYSICIANS, DENTISTS AND PODIATRISTS

SUBJECT: MAXIMUM ALLOWABLE COST (MAC) LIMITATION FOR CERTAIN DRUGS AND
PRESCRIBER'S CERTIFICATION TO OVERRULE "MAC" COST LIMITS ON PRESCRIBED
DRUGS

EFFECTIVE IMMEDIATELY

The New Jersey Medicaid Program will reimburse participating pharmacies the newly established "MAC" prices listed below, regardless of brand specified, with the following exceptions.

"LIMITATION SHALL NOT APPLY IN ANY CASE WHERE A PRESCRIBER CERTIFIES IN HIS OWN HANDWRITING THAT IN HIS MEDICAL JUDGMENT A SPECIFIC BRAND IS MEDICALLY NECESSARY FOR A PARTICULAR PATIENT. IN THIS INSTANCE, THE PRESCRIBER MUST WRITE 'BRAND NECESSARY' OR 'DISPENSE AS WRITTEN' IN HIS OWN HANDWRITING, ON EACH WRITTEN OR TELEPHONED PRESCRIPTION. TELEPHONED PRESCRIPTIONS FOR WHICH THE PHYSICIAN WISHES TO CERTIFY NECESSITY MUST BE FOLLOWED BY A WRITTEN PRESCRIPTION TO THE PHARMACY WITHIN 7 DAYS OF THE ORIGINAL ORDER".

It should be noted that preprinted statements, rubber stamp statements, check boxes, blanket statements to pharmacy providers, etc., will not be acceptable.

The Pharmaceutical Reimbursement Board of the Department of Health, Education and Welfare has established the Maximum Allowable Cost for the following drug entities:

Penicillin VK, tablets 250mg. \$0.0535 per tablet
Penicillin VK, tablets 500mg. \$0.1025 per tablet
Penicillin VK oral suspension, 125mg/5ml, \$0.0120 per ml.
Penicillin VK oral suspension, 250mg/5ml, \$0.0160 per ml.
Ampicillin oral suspension, 125mg/5ml, \$0.0145 per ml.
Ampicillin oral suspension, 250mg/5ml, \$0.0205 per ml.

Effective November 7, 1977, pharmacy providers will be reimbursed for the above, based on the lesser of;

1. the product's Average Wholesale Price (AWP) less regression if any; or
2. the established Maximum Allowable Cost as indicated above.

If you have any questions, please contact: Sanford Luger, R.Ph., Chief, Pharmaceutical Services, 324 East State Street, Trenton, New Jersey 08625. Telephone: 609-292-3756.



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

New Jersey Health Services Program NEWSLETTER

Volume P-217

December 26, 1977

TO: **PHYSICIANS, DENTISTS, PODIATRISTS, HOSPITALS, INDEPENDENT CLINICS, INDEPENDENT LABORATORIES**

SUBJECT: **MEDICAL NECESSITY PROGRAM**

The New Jersey Medicaid Program will adopt a program similar to the Blue Shield Association's - Medical Necessity Program - effective January 1, 1978, concurrent with its implementation by Blue Shield of New Jersey.

This program was designed to upgrade the quality of care and is the result of a cooperative effort begun one year ago by the Blue Shield Association and the following organizations: The American College of Surgeons, the American College of Physicians, the American College of Radiology, the American Academy of Family Practice, the Council of Medical Specialties, and the American Association of Medical Colleges.

The Medical Necessity Program defines certain Surgical and Diagnostic Procedures which are reimbursable only when acceptable written justification by the physician accompanies his/her claim.

These procedures fall into the following four categories:

- (1) New procedures of unproven value.
- (2) Established procedures of questionable current usefulness.
- (3) Procedures which tend to be redundant when performed in combination with other procedures.
- (4) Diagnostic procedures which are unlikely to provide a practitioner with additional information when they are repeated.

Routine payment will be discontinued for services provided on or after January 1, 1978 for the following Surgical Procedures unless the claim form is accompanied by an acceptable written justification supporting the medical necessity for having been performed. NOTE: These regulations apply to procedures 14 through 20 only when they are performed under the circumstances given.

- (1) Ligation of internal mammary arteries, unilateral or bilateral
- (2) Radical Hemorrhoidectomy, Whitehead type, including removal of entire pile bearing area
- (3) Omentopexy for establishing collateral circulation in portal obstruction
- (4) Kidney decapsulation, unilateral and bilateral
- (5) Perirenal insufflation
- (6) Nephropexy: fixation or suspension of kidney (independent procedure)

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- (7) Circumcision, female
- (8) Hysterotomy, non-obstetrical, vaginal
- (9) Supracervical hysterectomy: subtotal hysterectomy, with or without tubes and/or ovaries, one or both
- (10) Uterine suspension
- (11) Uterine suspension with presacral sympathectomy
- (12) Hypogastric or presacral neurectomy (independent procedure)
- (13) Ligation of thyroid arteries (independent procedure)
- (14) Fascia lata by stripper, as treatment for lower back pain
- (15) Fascia lata by incision and area exposure, with removal of sheath as treatment for lower back pain
- (16) Ligation of femoral vein, unilateral or bilateral, as treatment for post phlebitic syndrome
- (17) Excision of carotid body tumor, with or without excision of carotid artery, as treatment for asthma
- (18) Sympathectomy, thoracolumbar, unilateral or bilateral, as treatment for hypertension
- (19) Sympathectomy, lumbar, unilateral or bilateral, as treatment for hypertension
- (20) Splanchnicectomy, unilateral or bilateral, as treatment for hypertension
- (21) Fabric wrapping of abdominal aneurysm
- (22) Extra-intracranial arterial bypass for stroke

Routine payment will also be discontinued for services provided on or after January 1, 1978 for the following Diagnostic Procedures unless the claim is accompanied by an acceptable written justification supporting the medical necessity.

- (1) Basal metabolic rate (BMR)
- (2) Protein bound iodine (PBI)
- (3) Icterus index
- (4) Ballistocardiogram (BCG)
- (5) Phonocardiogram with interpretation and report, and with indirect carotid artery tracing or similar study
- (6) Angiocardiography, using CO₂ method, supervision and interpretation only
- (7) Angiocardiography, single plane, supervision and interpretation in conjunction with cineradiography
- (8) Angiocardiography, multi-plane, supervision and interpretation in conjunction with cineradiography

- (9) **Angiography-coronary, unilateral, selective injection, supervision and interpretation only, single view unless emergency**
- (10) **Angiography - extremity, unilateral, supervision and interpretation only, single view unless emergency**
- (11) **Bronchoscopy, with injection of contrast medium for bronchography**
- (12) **Bronchoscopy, with injection of radioactive substance**

Unless supporting justification for the above Surgical and Diagnostic Procedures accompanies the physician's claim, reimbursement will be denied in the following situations:

1. **If the only purpose for inpatient admission was to provide these procedures, both physician and hospital claims will be denied and if already paid will be subject to recovery.**
2. **If the only purpose for outpatient admission was to provide these procedures the hospital claim and the physician claims (if applicable) will be denied and if already paid will be subject to recovery.**
3. **If laboratory procedures (diagnostic studies 1 through 5) are performed on an ambulatory basis by an Independent laboratory or a physician such claims will be denied but may not necessarily include claims for office visits, and if already paid, will be subject to recovery.**



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

New Jersey Health Services Program NEWSLETTER

Volume P-220.....

March 20, 1978

TO: PARTICIPATING PHYSICIANS, DENTISTS AND PODIATRISTS

SUBJECT: MAXIMUM ALLOWABLE COST (MAC) LIMITATION FOR CERTAIN DRUGS AND
PRESCRIBER'S CERTIFICATION TO OVERRULE "MAC" COST LIMITS ON PRESCRIBED
DRUGS

Effective April 10, 1978 the New Jersey Medicaid Program will reimburse participating pharmacies the newly established "MAC" prices listed below, regardless of brand specified, with the following exceptions.

"LIMITATION SHALL NOT APPLY IN ANY CASE WHERE A PRESCRIBER CERTIFIES IN HIS OWN HAND-
WRITING THAT IN HIS MEDICAL JUDGMENT A SPECIFIC BRAND IS MEDICALLY NECESSARY FOR A
PARTICULAR PATIENT. IN THIS INSTANCE, THE PRESCRIBER MUST WRITE 'BRAND NECESSARY' OR
'DISPENSE AS WRITTEN' IN HIS OWN HANDWRITING, ON EACH WRITTEN OR TELEPHONED PRESCRIP-
TION. TELEPHONED PRESCRIPTIONS FOR WHICH THE PHYSICIAN WISHES TO CERTIFY MEDICAL
NECESSITY MUST BE FOLLOWED BY A WRITTEN PRESCRIPTION TO THE PHARMACY WITHIN 7 DAYS
OF THE ORIGINAL ORDER".

It should be noted that preprinted statements, rubber stamp statements, check boxes, blanket statements to pharmacy providers, etc., will not be acceptable.

The Pharmaceutical Reimbursement Board of the Department of Health, Education and Welfare has established the Maximum Allowable Cost for the following drug entities:

Chlordiazepoxide HCl, 5 mg. capsules - \$0.0270 per capsule
Chlordiazepoxide HCl, 10 mg. capsules - \$0.0378 per capsule
Chlordiazepoxide HCl, 25 mg. capsules - \$0.0640 per capsule
Propoxyphene HCl, 65 mg. capsules - \$0.0317 per capsule
Propoxyphene HCl with APC, 65 mg. capsules - \$0.0330 per capsule
Tetracycline HCl, 250 mg. capsules - \$0.0250 per capsule
Tetracycline HCl, 500 mg. capsules - \$0.0465 per capsule

Effective April 10, 1978, pharmacy providers will be reimbursed for the above, based on the lesser of:

1. the product's Average Wholesale Price (AWP) less regression if any; or
2. the established Maximum Allowable Cost as indicated above.

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Listing of MAC Drugs

Previous Newsletters concerning MAC limitations were Volume P-188 and Volume P-212. Providers are reminded that the following MAC prices are either currently in effect, or will shortly be in effect:

<u>Drug Entity</u>	<u>MAC</u>	<u>Effective Date</u>
Ampicillin, 250 mg. capsules	\$0.0725 per capsule	7/15/77
Ampicillin, 500 mg. capsules	\$0.1390 per capsule	7/15/77
Ampicillin Oral Suspension, 125 mg/5ml	\$0.0145 per ml.	11/7/77
Ampicillin Oral Suspension, 250 mg/5ml	\$0.0205 per ml.	11/7/77
Penicillin VK Oral Susp., 125 mg/5ml	\$0.0120 per ml.	11/7/77
Penicillin VK Oral Susp., 250 mg/5ml	\$0.0160 per ml.	11/7/77
Penicillin VK, 250 mg. tablets	\$0.0535 per tablet	11/7/77
Penicillin VK, 500 mg. tablets	\$0.1025 per tablet	11/7/77
Chlordiazepoxide HC1, 5 mg. capsules	\$0.0270 per capsule	4/10/78
Chlordiazepoxide HC1, 10 mg. capsules	\$0.0378 per capsule	4/10/78
Chlordiazepoxide HC1, 25 mg. capsules	\$0.0640 per capsule	4/10/78
Propoxyphene HC1, 65 mg. capsules	\$0.0317 per capsule	4/10/78
Propoxyphene HC1 with APC, 65 mg. cap.	\$0.0330 per capsule	4/10/78
Tetracycline HC1, 250 mg. capsules	\$0.0250 per capsule	4/10/78
Tetracycline HC1, 500 mg. capsules	\$0.0465 per capsule	4/10/78

If there are any questions, please contact: Sanford Luger, R.Ph., Chief, Pharmaceutical Services, 324 East State Street, Trenton, New Jersey 08625 - Telephone 609-292-3756.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

NEW JERSEY HEALTH SERVICES PROGRAM

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

May 1, 1978

TO: ALL DENTISTS AND INDEPENDENT DENTAL CLINICS

SUBJECT: REVISED MEDICAID DENTAL SERVICES MANUAL, CHAPTERS I, II, III AND IV;
REVISED DENTAL CLAIM FORM (MC-10-C5), EFFECTIVE MAY 15, 1978

READ CAREFULLY!!

Please examine the contents of this package carefully. Your package should consist of the following:

1. Revised Medicaid Dental Services Manual, Chapters I, II, III and IV.
2. A supply of revised MC-10 Dental Claim Forms - You may begin using the revised MC-10 immediately upon receipt.
3. A claim reorder form to expedite the reorder of claim forms.

Effective May 15, 1978, destroy all of your old claim forms and your outdated Dental Services Manual Chapters I, II, III and IV, and begin using the new claim forms in accordance with the policy and billing procedures in your revised chapters. Please note that the new procedure codes MUST be used for all services performed on or after May 15, 1978.

Since there have been significant changes to the Dental Services Manual, it is important that you read the enclosed chapters and become familiar with them. Your attention is particularly directed to the policies and/or changes which are highlighted on the following pages.

REVISED DENTAL CLAIM FORM (MC-10); IMP NUMBERS

Please note that the Dental Claim Form has been revised. One of the most significant changes to the form is the requirement to identify practitioners with an Individual Medicaid Practitioner (IMP) Number. A directory listing each Medicaid participating practitioner has been published and was recently mailed to you to assist you in completing your claims.

Effective May 15, 1978, you will be required to supply the IMP Number of the performing and referring practitioner on your claims. See page 3 of this coverletter for instructions to follow when a practitioner does not appear in the directory.

CHAPTER I (Completely revised)

The attached Chapter I is intended to supply you with a comprehensive and explicit statement of general Medicaid policies and regulations. It incorporates much of the General Information which has been transmitted to you in newsletters over the past several years. Additionally, it explains more fully who is eligible,

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and how to identify a covered person, since eligibility for Medicaid has changed over the years. Section 103 (Authorized Services for Covered Persons) presents a general reference for providers to determine what kinds of services are covered for a Medicaid eligible patient in New Jersey.

SOME IMPORTANT ASPECTS OF THE DENTAL SERVICES POLICY AND PROCEDURES

CHAPTER II - NEW OR REVISED POLICY

Section 202.2(1), page 16 - "NO REIMBURSEMENT WILL BE MADE FOR ANY DENTAL SERVICE PERFORMED BEYOND ONE (1) YEAR (365 DAYS) FROM THE DATE OF THE INITIAL EXAMINATION ON THAT TREATMENT PLAN".

Section 202.7, page 18 - Please note the requirements regarding patient records which must be maintained for a minimum of seven (7) years following the last date of service rendered.

Section 203.1 B.6, page 25 - Note the change in the policy regarding post-operative X-rays.

Section 203.6 B.7, page 30 - "Payment for dentures will be denied unless ALL dental procedures, in BOTH arches are completed before impressions are taken for authorized dentures".

Section 203.6 B.10, page 31 - "The patient's name. . . must be processed into all dentures during the original fabrication or where possible during any subsequent processing procedure. . .".

Section 203.7 A.1 & 2, pages 31 and 32 - Note the rules relative to extraction of teeth in conjunction with a dental prosthesis and in conjunction with orthodontic treatment carefully, since incorrect procedures may result in denial of reimbursement.

Section 203.9 A.3, pages 36 and 37 - Note the changes in the general anesthesia policy.

Section 203.9 A.4, pages 37 and 38 - Changes in policy regarding intravenous sedation are described.

Section 203.9 D.1-10, pages 38 through 43 - Familiarize yourself with the revised prescription policies.

Section 203.9 D.11, page 43 - Note details of the policy regarding medical and dental supplies.

CHAPTER II - CURRENT POLICY

Section 202.1 F, page 15 - "AUTHORIZATION FOR A DENTAL TREATMENT PLAN DOES NOT GUARANTEE ELIGIBILITY FOR PAYMENT UNDER THE NEW JERSEY MEDICAID PROGRAM." THE MEDICAID VALIDATION FORM SHOULD BE EXAMINED CAREFULLY ON EACH VISIT TO BE CERTAIN THE PATIENT IS CURRENTLY ELIGIBLE.

Section 202.2(2) C, page 17 - When a change is necessary to a treatment plan which has already been authorized, supplemental authorization must be requested, prior to performing the revised treatment. In the event that this procedure is not followed, payment may be withheld.

Section 202.8, pages 19 and 20 - "The allowable fee for a given service shall constitute full payment. No private agreement, transaction or additional charge may be made by the dentist" (clinic or outpatient department) "with, or on behalf of the covered person".

Section 202.8 F, pages 21 & 22 - "When other health or liability insurance is available, the Medicaid Program requires that such benefits be utilized first. . .".

Section 203.4 E, page 28 - Note the conditions which must be present in order that a visit for an apicoectomy may be reimbursable.

CHAPTER III - NEW OR REVISED POLICY

Section 300.2, pages 45 through 52 - Please review the billing instructions for your new Dental Claim Form (MC-10). Refer to the billing instructions in Chapter III for details in completing the following new items:

Item 10 - EPSDT Program Referral

Item 16 - Diagnosis

Item 17 - Referral

IMP Numbers - Referral If a patient has been referred to your office by another Medicaid practitioner, you must write the name and IMP Number of the referring practitioner in item 17 - Referral. Check your Directory of IMP Numbers for the practitioner's name and number.

If a practitioner does not appear in the directory, contact that practitioner to determine if an IMP Number has been assigned to him. If his IMP Number was assigned after January 23, 1978, the practitioner will receive notification of his IMP Number by letter.

If the practitioner does not participate in the Medicaid Program, he will not have an IMP Number. Enter his name on your claim and write "NON-PAR" in the space for the IMP Number.

BILLING PROCEDURES - Use of MC-10 and MC-4

The current billing procedures for Outpatient Department Dental Clinics are summarized and updated as follows. Both the complete MC-10 (Dental Claim Form) and MC-4 (Outpatient Hospital Claim Form) must be submitted to the contractor in order for the claim to be considered for payment. Where required, dental claims (MC-10) must have been prior authorized in order to be eligible for reimbursement of the visit charge.

MC-10

Items 1 through 21 must be completed on the Dental Form (MC-10). This should include a complete treatment plan initiated at the inception of treatment to include procedure codes and descriptions of services proposed. This will serve as the hospital's MASTER COPY. As treatment progresses and you wish to bill for services already completed, enter all dates of service for those procedures completed on the MASTER MC-10 and submit a photocopy of this MASTER attached to a completed MC-4. This should be submitted for payment to the appropriate contractor.

MC-4

In completing the Outpatient Hospital Claim Form (MC-4), the total charges for services rendered during the billing period (as described on the MASTER MC-10) should be placed on line 01 - "Clinic Visit" under Item 30 - "Statement of Charges". Charges for general anesthesia and laboratory costs, not included in the visit charge should be listed on the appropriate lines of Item 30.

Claims may be forwarded to your contractor on either an interim billing basis or upon completion of the entire treatment plan. Interim bills should have only those charges for services entered on the MC-4 which were rendered during that interim period. A photocopy of the MASTER MC-10 Form with all dates of service must be attached.

NOTE:

1. On the Dental Form (MC-10) completion of Items 15 C, 22 and 23 is not necessary, since the corresponding items must be completed on the MC-4.
2. The dentist who performs the dental clinic service(s) is considered to be the attending physician for the claim and his name and Individual Medicaid Practitioner (IMP) Number must be entered in Items 19 and 20 on the MC-4 Claim Form.

The contractor copy of both the MC-10 and MC-4 should be forwarded for reimbursement to the appropriate contractor at the following address:

Prudential Insurance Co. of America
Provider Services Division
P.O. Box 5000
Millville, N.J. 08332

Hospital Service Plan of N. J.
P.O. Box 700
Newark, N.J. 07102

All claims for hospital outpatient services must be received by the contractor within 12 months from the last date of service billed.

CHAPTER IV - NEW OR REVISED POLICY

It is essential for all providers to familiarize themselves with the many changes in procedure codes. Many of the codes you have been using have been changed.

New codes have been added to cover previously unlisted procedures. To facilitate authorization, processing and payment of claims, it is essential that you use proper procedure codes. The list is quite comprehensive, covering almost every procedure that is reimbursable.

MAJOR CHANGES IN PROCEDURE CODES AND/OR DESCRIPTIONS

Section 401.1 - Codes for X-rays, (pages 51 through 60)

- “ 401.2 - Codes and description for prophylaxis, additional scaling and fluoride treatment - including prophylaxis, (pages 60 and 61)
- “ 401.3 - Codes and description for restorations - silicate, acrylic, plastic and composite, (pages 61 through 63)
- “ 401.4 - Note restrictions on apicoectomy, and new codes including apicoectomy combined with single stage nerve extirpation and canal filling, (pages 65 through 67)
- “ 401.5 - Expanded periodontal codes, (pages 67 and 68)
- “ 401.6 - Additional denture codes, revision of immediate denture codes and additional repair codes, (pages 68 through 74)
- “ 401.8 - Revision of oral surgery codes, (pages 74 through 80)

SPECIAL NOTE:

Section 203.1A1b, 203.1B1 and 2, 203.2A2 and B2 - Effective May 15, 1978, the Medicaid Dental Consultant will no longer indicate authorization on the Dental Form (MC-10) for examination, bitewing and periapical X-rays, prophylaxis and fluoride treatment including prophylaxis when these services are part of a treatment plan that requires authorization.

This will not affect reimbursement as long as the procedures are performed within Program guidelines. The Medicaid Dental Consultant will authorize these services only when special circumstances exist.

QUESTIONS ON ANY ASPECT OF THE NEW DENTAL SERVICES MANUAL SHOULD BE REFERRED TO THE DENTAL CONSULTANT IN YOUR REGIONAL DENTAL FIELD OFFICE.



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

New Jersey Health Services Program

May 1, 1978

TO: DENTAL CLINIC DIRECTORS IN HOSPITAL OUTPATIENT DEPARTMENTS
HOSPITAL OUTPATIENT BILLING OFFICES

SUBJECT: REVISED MEDICAID DENTAL SERVICES MANUAL, CHAPTERS II, III AND IV;
REVISED DENTAL CLAIM FORM (MC-10-C5), EFFECTIVE MAY 15, 1978

READ CAREFULLY!!

We are pleased to forward you this dental services package. Please examine the contents carefully; your package should consist of the following:

1. Revised Medicaid Dental Services Manual, Chapters II, III and IV.
2. A supply of revised MC-10 Dental Claim Forms - You may begin using the revised MC-10 immediately upon receipt.
3. A claim reorder form to expedite the reorder of claim forms.

Effective May 15, 1978, destroy all of your old MC-10 claim forms and your outdated Dental Services Manual, Chapters I, II, III and IV, and begin using the new dental claim forms and manual. Hospital providers have received copies of Chapter I for their Medicaid Hospital Manuals. Please refer to the Hospital Manual Chapter I for general information and regulations about the Medicaid Program.

The policies and procedures stated in the enclosed Dental Services Manual are applicable to Hospital Outpatient Department Dental Clinics with the exception of references to fee for services reimbursement to the dentist and submission of claims for reimbursement. Please note that the new procedure code MUST be used for all services performed on or after May 15, 1978. See page 3 of this coverletter for instructions on how to use the MC-10 and MC-4 to bill the Medicaid Program.

Since there have been significant changes to the Dental Services Manual, it is important that you read the enclosed chapters and become familiar with them. Your attention is particularly directed to the policies and/or changes which are highlighted on the following pages.

REVISED DENTAL CLAIM FORM (MC-10); IMP NUMBERS

Please note that the Dental Claim Form has been revised. One of the most significant changes to the form is the requirement to identify practitioners with an Individual Medicaid Practitioner (IMP) Number. A directory listing each Medicaid participating practitioner has been published and was recently mailed to you to assist you in completing your claims.

Effective May 15, 1978, you will be required to supply the IMP Number of the performing and referring practitioner on your claims. See page 3 of this coverletter for instructions to follow when a practitioner does not appear in the directory.

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SOME IMPORTANT ASPECTS OF THE DENTAL SERVICES POLICY AND PROCEDURES

CHAPTER II - NEW OR REVISED POLICY

Section 202.2(1)D, page 16 - Routine services, as detailed, and the requirements for prior authorization of dental services as defined in this section apply to dental clinics in Hospital Outpatient Departments. Please note that certain services which were previously defined as routine will now require prior authorization.

Section 202.2(1), page 16 - "NO REIMBURSEMENT WILL BE MADE FOR ANY DENTAL SERVICE PERFORMED BEYOND ONE (1) YEAR (365 DAYS) FROM THE DATE OF THE INITIAL EXAMINATION ON THAT TREATMENT PLAN".

Section 202.7, page 18 - Please note the minimum requirements regarding patient records which must be maintained for at least seven (7) years following the last date of service rendered.

Section 203.1 B 6, page 25 - Note the change in the policy regarding post-operative X-rays.

Section 203.6 B 7, page 30 - "Payment for dentures will be denied unless ALL Dental procedures, in BOTH arches are completed before impressions are taken for authorized dentures".

Section 203.6 B 10, page 31 - "The patient's name. . . must be processed into all dentures during the original fabrication or where possible during any subsequent processing procedure. . .".

Section 203.7 A 1 & 2, pages 31 and 32 - Note the rules relative to extraction of teeth in conjunction with a dental prosthesis and in conjunction with orthodontic treatment carefully, since incorrect procedures may result in denial of reimbursement.

Section 203.9 D 1-10, pages 38 through 43 - Familiarize yourself with the revised prescription policies.

Section 203.9 D 11, page 43 - Note details of the policy regarding medical and dental supplies.

CHAPTER II - CURRENT POLICY

Section 202.1 F, page 15 - "AUTHORIZATION FOR A DENTAL TREATMENT PLAN DOES NOT GUARANTEE ELIGIBILITY FOR PAYMENT UNDER THE NEW JERSEY MEDICAID PROGRAM." THE MEDICAID VALIDATION FORM SHOULD BE EXAMINED CAREFULLY ON EACH VISIT TO BE CERTAIN THE PATIENT IS CURRENTLY ELIGIBLE.

Section 202.2(2) C, page 17 - When a change is necessary to a treatment plan which has already been authorized, supplemental authorization must be requested, prior to performing the revised treatment. In the event that this procedure is not followed, payment may be withheld.

Section 202.8, pages 19 & 20 - "the allowable fee" (visit charge) "for a given service shall constitute full payment. No private agreement, transaction or additional charge may be made by the dentist" (clinic or outpatient department) "with, or on behalf of the covered person".

Section 202.8 D, page 20 - "Reimbursement is not made for, and recipients may not be asked to pay for broken appointments. . .".



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

New Jersey Health Services Program NEWSLETTER

May 10, 1978

IMPORTANT NOTICE

TO: ALL PROVIDERS (DENTAL AND PHARMACEUTICAL PROVIDERS WILL RECEIVE SEPARATE NOTICE)

SUBJECT: IMP NUMBERS REQUIRED FOR ALL CLAIMS ON OR AFTER MAY 15, 1978

This newsletter is a reminder that Individual Medicaid Practitioner (IMP) Numbers will be required on Medicaid claim forms as a condition of payment, beginning May 15, 1978. Claim forms without IMP Numbers will not be processed and will be returned to you. The following information will help you to avoid having your claims rejected. READ IT CAREFULLY.

Medicaid Providers received newsletters in late 1977 explaining the new Medicaid claim forms and instructions for their completion. Please take time to carefully review those instructions. IMP Numbers will be required on claims for services performed on and after May 15, 1978, including claims spanning this date, that is, those in which treatment began before May 15, 1978, but continued beyond. Claims will be returned if all items are not completed.

The IMP Number is a practitioner identifier, comprised of 8 numbers followed by a single letter from A to J. A directory of IMP Numbers has been mailed to all providers in order to assist in the completion of their Medicaid claims. Use IMP Numbers on all of your claims to avoid rejection.

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A correction sheet for your IMP Directory is attached. Although the Medicaid Program will periodically update the IMP Directory, it is recommended that each provider compile a list of the IMP Numbers of the practitioners he deals with and update it by obtaining IMP Numbers from new practitioners as they join the program. Practitioners assigned IMP Numbers after January 23, 1978 will receive their IMP Number by letter, but it will not be listed in the directory. Providers must obtain these IMP Numbers directly from the newly participating practitioner. If after contacting the practitioner, there is still uncertainty about the IMP Number, you may call (800) 322-7713 toll free for assistance. If calling from outside of New Jersey, call 609-293-2111.

All practitioners should routinely supply their IMP Numbers to other providers when referring a Medicaid patient for services. We suggest that the practitioner's IMP Number appear on his prescriptions, so that it will not be necessary for providers to call him to obtain or verify his IMP Number.

If you need assistance in completing your claim forms, please contact the Administrator or Medical Consultant in your Local Medicaid office.

If you need a Directory of IMP Numbers, supply of claim forms, or billing instructions, please write your Contractor at the following address:

Prudential Insurance Company
Provider Reorder Unit
P. O. Box 471
Millville, N. J. 08332

New Jersey Blue Cross Plan
Mail & Supply Section
P. O. Box 420
Newark, N. J. 07101



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

New Jersey Health Services Program NEWSLETTER

Volume P-222

May 22, 1978

TO: PHYSICIAN, DENTIST, CHIROPRACTOR AND PSYCHOLOGIST GROUPS

SUBJECT: REIMBURSEMENT POLICY FOR GROUP PRACTICE

This is to announce a refinement of the New Jersey Medicaid Policy regarding reimbursement of practitioner groups in conjunction with the implementation of MMIS, the Medicaid Management Information System. Effective for services performed on or after June 1, 1978, reimbursement of practitioner groups will be based upon the status (specialist or non-specialist) of the practitioner who actually performed the billed service. To identify this group member, enter the Individual Medicaid Practitioner (IMP) Number in the Provider Certification area, Item 17 on the Physicians' and Practitioners' Claim (MC-8-A-C3), Item 23 on the Dental Services Claim (MC-10-C5).

REIMBURSEMENT

The check will continue to be made out to the group, but the amount of reimbursement will be based upon the status of the individual practitioner who actually provided the billed service.

SIGNATURE REQUIREMENT

For billing purposes, the signature of any member of the group will be accepted on the claim form.

MIXED GROUPS (SPECIALISTS AND NON-SPECIALISTS)

In a group with both specialist and non-specialist members, specialist services must be billed separately from non-specialist services. Therefore, for services provided to the same patient, a specialist and a non-specialist may not bill on the same claim form.

SERVICES PERFORMED BY MORE THAN ONE PRACTITIONER

If a claim covers services performed by more than one specialist or more than one non-specialist, the IMP Number of any one of the performing practitioners will be accepted. This number must be entered in the Provider Certification area on the claim form.



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

New Jersey Health Services Program NEWSLETTER

Volume P-234

December 26, 1978

TO: ALL PROVIDERS IN CAPE MAY, ATLANTIC, AND CUMBERLAND COUNTIES

SUBJECT: CHANGE OF JURISDICTION FOR MEDICAID RECIPIENTS IN CAPE MAY COUNTY

Effective January 15, 1979, all records concerning Medicaid recipients who reside in Cape May County will be moved to:

Division of Medical Assistance & Health Services
Cumberland County Local Medical Assistance Unit
501 Landis Avenue
Vineland, New Jersey 08360
Tel. (609) 696-0521

Begin using the new address and telephone number on January 15, 1979, for any correspondence or communications you normally have with the local Medicaid office about Cape May residents.

After that date, all Medicaid business for Cape May residents will be conducted at the new location. Please direct all inquiries and requests for prior authorization to that office.



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

New Jersey Health Services Program NEWSLETTER

Volume P-236

January 15, 1979

TO: PARTICIPATING PHYSICIANS, DENTISTS AND PODIATRISTS

SUBJECT: MAXIMUM ALLOWABLE COST (MAC) LIMITATIONS FOR CERTAIN DRUGS AND
PRESCRIBER'S CERTIFICATION TO OVERRIDE "MAC" LIMITS ON PRESCRIBED DRUGS

Effective January 25, 1979 the New Jersey Medicaid Program will reimburse participating pharmacies the newly established "MAC" prices listed below, regardless of brand specified, with the following exceptions.

"LIMITATION SHALL NOT APPLY IN ANY CASE WHERE A PRESCRIBER CERTIFIES IN HIS OWN HANDWRITING THAT IN HIS MEDICAL JUDGMENT A SPECIFIC BRAND IS MEDICALLY NECESSARY FOR A PARTICULAR PATIENT. IN THIS INSTANCE, THE PRESCRIBER MUST WRITE 'BRAND NECESSARY' OR 'DISPENSE AS WRITTEN' IN HIS OWN HANDWRITING, ON EACH WRITTEN OR TELEPHONED PRESCRIPTION. TELEPHONED PRESCRIPTIONS FOR WHICH THE PHYSICIAN WISHES TO CERTIFY MEDICAL NECESSITY MUST BE FOLLOWED BY A WRITTEN PRESCRIPTION TO THE PHARMACY WITHIN 7 DAYS OF THE ORIGINAL ORDER".

It should be noted that preprinted statements, rubber stamp statements, check boxes, blanket statements to pharmacy providers, etc., will not be acceptable.

The Pharmaceutical Reimbursement Board of the Department of Health, Education and Welfare has established the Maximum Allowable Cost for the following drug entities:

- Acetaminophen w/codeine 30 mg tablets - \$0.0780 per tablet
- Acetaminophen w/codeine 60 mg tablets - \$0.1545 per tablet
- *Ampicillin 250 mg capsules - \$0.0595 per capsule
- **Ampicillin 500 mg capsules - \$0.1103 per capsule
- Doxepin HCl 10 mg capsules - \$0.0950 per capsule
- Doxepin HCl 25 mg capsules - \$0.1161 per capsule
- Doxepin HCl 50 mg capsules - \$0.1765 per capsule
- Erythromycin Stearate 250 mg tablets - \$0.0697 per tablet
- Erythromycin Stearate 500 mg tablets - \$0.1250 per tablet
- Meprobamate 200 mg tablets - \$0.0108 per tablet
- Meprobamate 400 mg tablets - \$0.0117 per tablet
- Penicillin G Potassium 400 Mu tablets - \$0.0180 per tablet
- Penicillin G Potassium 800 Mu tablets - \$0.0265 per tablet
- Phenylbutazone 100 mg capsules - \$0.0750 per capsule
- Phenylbutazone Alka 100 mg capsules \$0.0940 per capsule
- Probenecid 0.5 gm tablets - \$0.0644 per tablet

(cont.)

Effective January 25, 1979, pharmacy providers will be reimbursed for the above, based on the lesser of:

- 1) the product's Average Wholesale Price (AWP) less regression, if any; or
- 2) the established Maximum Allowable Cost as indicated above.

Listing of MAC Drugs

Previous Newsletters concerning MAC limitations were Volumes P-220, P-212 and P-188. Providers are reminded that the following MAC prices are either currently in effect, or will shortly be in effect:

<u>Drug Entity</u>	<u>MAC</u>	<u>Effective Date</u>
Acetaminophen w/codeine, 30 mg tablets	\$0.0780 per tablet	01/25/79
Acetaminophen w/codeine, 60 mg tablets	\$0.1545 per tablet	01/25/79
*Ampicillin, 250 mg capsules	\$0.0595 per capsule	01/25/79
**Ampicillin, 500 mg capsules	\$0.1103 per capsule	01/25/79
Ampicillin Oral Suspension, 125 mg/5ml	\$0.0145 per ml	11/07/77
Ampicillin Oral Suspension, 250 mg/5ml	\$0.0205 per ml	11/07/77
Chlordiazepoxide HCl, 5 mg capsules	\$0.0270 per capsule	04/10/78
Chlordiazepoxide HCl, 10 mg capsules	\$0.0378 per capsule	04/10/78
Chlordiazepoxide HCl, 25 mg capsules	\$0.0640 per capsule	04/10/78
Doxepin HCl, 10 mg capsules	\$0.0950 per capsule	01/25/79
Doxepin HCl, 25 mg capsules	\$0.1161 per capsule	01/25/79
Doxepin HCl, 50 mg capsules	\$0.1765 per capsule	01/25/79
Erythromycin Stearate, 250 mg tablets	\$0.0697 per tablet	01/25/79
Erythromycin Stearate, 500 mg tablets	\$0.1250 per tablet	01/25/79
Meprobamate, 200 mg tablets	\$0.0108 per tablet	01/25/79
Meprobamate, 400 mg tablets	\$0.0117 per tablet	01/25/79
Penicillin G Potassium, 400 Mu tablets	\$0.0180 per tablet	01/25/79
Penicillin G Potassium, 800 Mu tablets	\$0.0265 per tablet	01/25/79
Penicillin VK Oral Susp., 125 mg/5ml	\$0.0120 per ml	11/07/77
Penicillin VK Oral Susp., 250 mg/5ml	\$0.0160 per ml	11/07/77
Penicillin VK, 250 mg tablets	\$0.0535 per tablet	11/07/77
Penicillin VK, 500 mg tablets	\$0.1025 per tablet	11/07/77
Phenylbutazone, 100 mg tablets	\$0.0750 per tablet	01/25/79
Phenylbutazone Alka, 100 mg capsules	\$0.0940 per capsule	01/25/79
Probenecid, 0.5 gm tablets	\$0.0644 per tablet	01/25/79
Propoxyphene HCl, 65 mg capsules	\$0.0317 per capsule	04/10/78
Propoxyphene HCl with APC, 65 mg cap.	\$0.0330 per capsule	04/10/78
Tetracycline HCl, 250 mg capsules	\$0.0250 per capsule	04/10/78
Tetracycline HCl, 500 mg capsules	\$0.0465 per capsule	04/10/78

*MAC reduced from \$0.0725 per capsule

**MAC reduced from \$0.1390 per capsule



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

New Jersey Health Services Program NEWSLETTER

Volume P-238

March 12, 1979

TO: PHYSICIANS, DENTISTS AND PODIATRISTS

SUBJECT: Suspension of MAC Limits on Penicillin G Potassium 400MU and 800MU

Re: Newsletter P-236

The Pharmaceutical Reimbursement Board of the Department of Health, Education and Welfare, has suspended the Maximum Allowable Cost (MAC) limits for the following drugs until further notice.

Penicillin G Potassium 400MU Tablets

Penicillin G Potassium 800MU Tablets

All other MAC prices listed in Newsletter P-236 remain in effect for Medicaid reimbursement to pharmacy providers.



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

New Jersey Health Services Program NEWSLETTER

Volume P-243

TO: ALL PROVIDERS

SUBJECT: TOLL FREE TELEPHONE SERVICE

The New Jersey Health Services Program is pleased to announce that effective May 21, 1979, toll free telephone service will be available to receive calls from Medicaid Providers calling from New Jersey. The telephone number is (800) 582-7052. The toll free service will be provided from 8:00 a.m. to 4:00 p.m. Monday through Friday, except Holidays.

As a part of Medicaid's ongoing service improvement program, a Medicaid Inquiry Unit has been organized at the Prudential Insurance Company. This unit will: (1) receive all calls; (2) answer questions of a general nature; (3) channel questions of a technical nature to the appropriate specialty areas; and (4) provide assistance for all questions pertaining to IMP numbers. All telephone calls, except as noted below, should be made to the Medicaid Inquiry Unit.

Institutions (hospitals, home health agencies and independent clinics) should only refer questions pertaining to IMP numbers to the toll free number. For all other inquiries, please continue to call your usual points of contact at the Provider Services Division, Prudential Insurance Company.

Out of State providers should refer all calls to telephone (609) 293-2324. This number replaces (609) 293-2111.

The functions of this unit are intended to complement rather than replace your usual communication channels. Therefore, if you have questions concerning three or more claims, please continue to document and submit them, in writing, to the Prudential Insurance Company.

The new toll free number, (800) 582-7052, replaces the Newark off-premise lines and the toll free (800) 322-7713 line.



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

New Jersey Health Services Program NEWSLETTER

Volume P-245.....

May 29, 1979

TO: ALL PROVIDERS LOCATED IN ESSEX COUNTY

SUBJECT: MEDICAID VALIDATION STUBS

The New Jersey Health Services Program (Medicaid) has been advised by the Essex County Welfare Board that effective June 1, 1979, all checks for recipients of Assistance to Families with Dependent Children will be alternated so that they will be received on the FIRST, THIRD AND FIFTH calendar days of each month.

As you know, the MEDICAID VALIDATION STUBS are attached to the Welfare check, which means that some recipients will not receive their Medicaid Stub until the THIRD, and still others will not receive it until the FIFTH of the month.

Recipients with the following Health Services Program Case Numbers will receive their Medicaid Validations on the FIRST of the month:

0730-000001 to 0730-005399
0730-015000 to 0730-029599
0730-056700 to 0730-068599
0730-087600 to 0730-094899

Recipients with the following Health Services Program Case Numbers will receive their Medicaid Validations on the THIRD of the month:

0730-005400 to 0730-010399
0730-029600 to 0730-042399
0730-068600 to 0730-078299
0730-094900 to 0730-101699

Recipients with the following Health Services Program Case Numbers will receive their Medicaid Validations on the FIFTH of the month:

0730-010400 to 0730-014999
0730-042400 to 0730-056699
0730-078300 to 0730-087599
0730-101700 to 0730-UP

For the time frame from the last day of one month to the THIRD or FIFTH day of the subsequent month, Providers will have to verify eligibility by contacting the Essex County Welfare Board since the recipient will not have in his/her possession a Medicaid Validation Stub.

DO NOT CONTACT THE LOCAL MEDICAL ASSISTANCE UNIT FOR ELIGIBILITY VERIFICATION, AS THEY DO NOT HAVE THE INFORMATION ON THESE CASES.

We apologize for the inconvenience this new procedure will cause you.



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

New Jersey Health Services Program NEWSLETTER

Volume P-246

June 18, 1979

TO: PARTICIPATING PHYSICIANS, DENTISTS AND PODIATRISTS

SUBJECT: MAXIMUM ALLOWABLE COST (MAC) LIMITATIONS FOR CERTAIN DRUGS AND
PRESCRIBER'S CERTIFICATION TO OVERRIDE "MAC" LIMITS ON PRESCRIBED DRUGS

Effective June 26, 1979 the New Jersey Medicaid Program will reimburse participating pharmacies the newly established "MAC" prices listed below, regardless of brand specified, with the following exceptions.

"LIMITATION SHALL NOT APPLY IN ANY CASE WHERE A PRESCRIBER CERTIFIES IN HIS OWN HANDWRITING THAT IN HIS MEDICAL JUDGEMENT A SPECIFIC BRAND IS MEDICALLY NECESSARY FOR A PARTICULAR PATIENT. IN THIS INSTANCE, THE PRESCRIBER MUST WRITE 'BRAND NECESSARY' OR 'DISPENSE AS WRITTEN' IN HIS OWN HANDWRITING, ON EACH WRITTEN OR TELEPHONED PRESCRIPTION. TELEPHONED PRESCRIPTIONS FOR WHICH THE PHYSICIAN WISHES TO CERTIFY MEDICAL NECESSITY MUST BE FOLLOWED BY A WRITTEN PRESCRIPTION TO THE PHARMACY WITHIN 7 DAYS OF THE ORIGINAL ORDER."

It should be noted that preprinted statements, rubber stamp statements, check boxes, blanket statements to pharmacy providers, etc., will not be acceptable.

The Pharmaceutical Reimbursement Board of the Department of Health, Education and Welfare has established the Maximum Allowable Cost for the following drug entities:

Amoxicillin 250mg Capsules - \$0.2108 per capsule
Amoxicillin 500mg Capsules - \$0.3942 per capsule
Amoxicillin 125mg/5cc Oral Suspension - \$0.0232 per cc
Amoxicillin 250mg/5cc Oral Suspension - \$0.0284 per cc
Hydrochlorothiazide 25mg Tablets - \$0.0250 per tablet
Hydrochlorothiazide 50mg Tablets - \$0.0306 per tablet

Effective June 26, 1979, pharmacy providers will be reimbursed for the above, based on the lesser of:

- 1) the product's Average Wholesale Price (AWP) less regression, if any; or
- 2) the established Maximum Allowable Cost as indicated above.

(continued)

Listing of MAC Drugs*

Providers are reminded that the following MAC prices are either currently in effect, or will shortly be in effect:

<u>DRUG ENTITY</u>	<u>MAC</u>	<u>EFFECTIVE DATE</u>
Acetaminophen w/codeine, 30 mg tablets	\$0.0780 tablet	01/25/79
Acetaminophen w/codeine, 60 mg tablets	\$0.1545 per tablet	01/25/79
Amoxicillin 250 mg capsules	\$0.2108 per capsule	06/28/79
Amoxicillin 500 mg capsules	\$0.3942 per capsule	06/28/79
Amoxicillin 125 mg/5cc Oral Suspension	\$0.0232 per cc	06/28/79
Amoxicillin 250 mg/5cc Oral Suspension	\$0.0284 per cc	06/28/79
Ampicillin 250 capsules	\$0.0595 per capsule	01/25/79
Ampicillin 500 mg capsules	\$0.1103 per capsule	01/25/79
Ampicillin Oral Suspension, 125 mg/5ml	\$0.0145 per ml	11/07/77
Ampicillin Oral Suspension, 250 mg/5ml	\$0.0205 per ml	11/07/77
Chlordiazepoxide HCl, 5 mg capsules	\$0.0270 per capsule	04/10/78
Chlordiazepoxide HCl, 10 mg capsules	\$0.0378 per capsule	04/10/78
Chlordiazepoxide HCl, 25 mg capsules	\$0.0640 per capsule	04/10/78
Doxepin HCl, 10 mg capsules	\$0.0950 per capsule	01/25/79
Doxepin HCl, 25 mg capsules	\$0.1161 per capsule	01/25/79
Doxepin HCl, 50 mg capsules	\$0.1765 per capsule	01/25/79
Erythromycin Stearate, 250 mg tablets	\$0.0697 per tablet	01/25/79
Erythromycin Stearate, 500 mg tablets	\$0.1250 per tablet	01/25/79
Hydrochlorothiazide 25 mg tablets	\$0.0250 per tablet	06/28/79
Hydrochlorothiazide 50 mg tablets	\$0.0306 per tablet	06/28/79
Meprobamate, 200 mg tablets	\$0.0108 per tablet	01/25/79
Meprobamate, 400 mg tablets	\$0.0117 per tablet	01/25/79
Penicillin G Potassium, 400 mu tablets	MAC Suspended 3/12/79 until further notice	
Penicillin G Potassium, 800 mu tablets	MAC Suspended 3/12/79 until further notice	
Penicillin VK Oral Susp., 125 mg/5ml	\$0.0120 per ml	11/07/77
Penicillin VK Oral Susp., 250 mg/5ml	\$0.0160 per ml	11/07/77
Penicillin VK, 250 mg tablets	\$0.0535 per tablet	11/07/77
Penicillin VK, 500 mg tablets	\$0.1025 per tablet	11/07/77
Phenylbutazone, 100 mg tablets	\$0.0750 per tablet	01/25/79
Phenylbutazone Alka, 100 mg capsules	\$0.0940 per capsule	01/25/79
Probenecid, 0.5 gm tablets	\$0.0644 per tablet	01/25/79
Propoxyphene HCl, 65 mg capsules	\$0.0317 per capsule	04/10/78
Propoxyphene HCl with APC, 65 mg cap.	\$0.0330 per capsule	04/10/78
Tetracycline HCl, 250 mg capsules	\$0.0250 per capsule	04/10/78
Tetracycline HCl, 500 mg capsules	\$0.0465 per capsule	04/10/78

*THESE MAC LIMITS DO NOT APPLY TO UNIT DOSE PACKAGING



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

New Jersey Health Services Program NEWSLETTER

Volume P-247

July 9, 1979

TO: ALL DENTISTS AND INDEPENDENT DENTAL CLINICS

SUBJECT: GENERAL ANESTHESIA PERMITS

This Newsletter is applicable to all dentists, and particularly to those who wish to be reimbursed for dental general anesthesia procedures by the New Jersey Medicaid Program. After carefully following the procedure below, please insert this page in your Dental Manual for future reference.

All dental general anesthesia permits issued by the New Jersey State Board of Dentistry will expire on October 31, 1979.

In an effort to maintain continuity of services and reimbursement for general anesthesia procedures 9220, 9221, 9222, 9223 and 9225, the New Jersey Medicaid Program requests that a copy of your renewed permit be forwarded to the following address by October 1, 1979:

The Prudential Insurance Company
Provider Maintenance Unit
Medical Administration
P.O. Box 1900
Millville, New Jersey 08332

To preclude any possible problems regarding the receipt of permits at Prudential, it is recommended that permits be sent by certified mail, return receipt requested. The Prudential Insurance Company will acknowledge receipt of your permit. Those providers who do not receive an acknowledgement within fifteen (15) days after forwarding their permits should contact the Provider Maintenance Unit at Prudential, telephone (609) 293-2164, without delay.

In order for the New Jersey Medicaid Program to reimburse a dentist for administering general anesthesia procedures, a valid copy of the permit must be on file at the Prudential Insurance Company. Permits received at Prudential after October 31, 1979 will become valid on the third work day following the date of receipt. For example: If Prudential receives a permit on 11/5/79, it will become valid on 11/8/79. In this case, claims will not be reimbursed for general anesthesia procedures administered during the period 11/1/79 through 11/7/79.

Please refer questions and/or comments to Archie F Bell, D.D.S., Director, Dental Section, Division of Medical Assistance and Health Services, telephone (609) 292-7420.



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

New Jersey Health Services Program NEWSLETTER

Volume P-249

August 20, 1979

TO: PARTICIPATING PHYSICIANS, DENTISTS AND PODIATRISTS

SUBJECT: LIST OF INTERCHANGEABLE DRUG PRODUCTS, NEW JERSEY DRUG UTILIZATION
REVIEW COUNCIL

RE: PROHIBITION OF MEDICAID/PAA PAYMENTS FOR CERTAIN NON-LEGEND INTER-
CHANGEABLE PRODUCTS AND CERTAIN LEGEND GENERIC EQUIVALENTS

NON-LEGEND DRUGS

Until further notice, non-legend interchangeable products appearing in the subject List of Interchangeable Drug Products will not be eligible for payment in the New Jersey Medicaid Program, unless such products have previously been listed in Chapter II, Section 210.4 of the New Jersey Medicaid Pharmacy Manual, entitled "General Non-legend Drugs".

This ruling is necessary due to the fact that numerous interchangeable non-legend products included in the subject list are not commercially available in the package sizes indicated for each such non-legend entity, and due to other inconsistencies in package sizes and federal legal status of certain other listed non-legend products.

Only those non-legend drugs listed in Pharmacy Manual Chapter II, Section 210.4, also known as "Appendix B", will be reimbursable in the Medicaid Program until further notice.

LEGEND DRUGS

Due to unavailability of adequate coding, pricing and/or other complete product literature as prescribed by Section 206.1, Section 605.1 and N.J.A.C. Title 10-Chapter 51, Section 6.15 (a)1. of the New Jersey Medicaid and PAA Manuals, the distributors products listed in the attached pages will not be eligible for payment in the New Jersey Medicaid/PAA Programs. We have indicated the drug entity, trade name and distributor's name for each product so affected.

GENERIC LEGEND DRUGSNOT ELIGIBLE FOR MEDICAID/PAA REIMBURSEMENT

<u>DRUG ENTITY</u>	<u>TRADE NAME</u>	<u>DISTRIBUTOR NAME</u>
Acetaminophen with Codeine Phosphate 300 mg-15 mg	Same	Barr
"	"	Lederle
APC with Codeine Phosphate 15 mg	Same	Barr
APC with Codeine Phosphate 30 mg	Same	Barr
APC with Codeine Phosphate 60 mg	Same	Barr
Belladonna Alk. with Phenobarbital	Spasomine	Bowman
"	Same	Trust
Brompheniramine Mal with Phenylephrine HCl & Phenylpropanolamine HCl	Claytapp	Clay-Park
Chloral Hydrate Caps 250 mg	Same	Banner
"	"	Chase
"	"	Scherer
Chloral Hydrate Caps 500 mg	Same	Banner
"	"	Chase
"	"	Pharmacaps
Dicyclomine HCl Caps 10 mg	Same	Generic
Dicyclomine HCl Caps 20 mg	Same	Generic
Dicyclomine HCl Caps 20 mg	Same	Tablicaps
Diphenoxylate HCl with Atropine Sulf. Tabs	Same	Generic
"	Low-Quei	Blue Cross
"	Same	Mylan

<u>DRUG ENTITY</u>	<u>TRADE NAME</u>	<u>DISTRIBUTOR NAME</u>
Folic Acid Tabs 1 mg	Same	Tablicaps
Meprobamate Tabs 400 mg	Neuramate	Blue Cross
Methocarbamol Tabs 500 mg	Same	Generic
“	Same	Mylan
Methocarbamol Tabs 75 mg	Same	Generic
“	Same	Mylan
Penicillin G Pot. Tabs. 200,000 Units	Same	Mylan
Penicillin G Pot. for Sol'n 200,000 U/5 ml	Same	Mylan
Penicillin G Pot. Tabs. 400,000 Units	Same	Mylan
Penicillin G Pot. for Sol'n 400,000 U/5 mg	Same	Mylan
Penicillin G Pot. Tabs. 800,000 Units	Same	Mylan
“	Same	Steri-Med
Penicillin VK for Sol'n 125 mg/5 mg	Same	Mylan
Phenazopyridine HCl Tabs 100 mg	Same	Tablicaps
Potassium Chloride Liquid 10%	Same	Bowman
“	Same	Clay-Park
Propantheline Br Tabs 15 mg	Same	Mylan
Propoxyphene HCl Caps 65 mg	Same	Mylan
Propoxyphene HCl with Acetaminophen Tabs 65 mg/650 mg	Same	Mylan
Propoxyphene HCl with APC Caps. 65 mg	Same	Mylan
Tetracycline HCl Caps. 500 mg	Same	Mylan

DRUG ENTITYTRADE NAMEDISTRIBUTOR NAME

Triamcinolone
Acetonide
Cream 0.025%

Same

Clay-Park

Triamcinolone
Acetonide
Cream 0.1%

Same

Clay-Park

Triamcinolone
Acetonide
Cream 0.5%

Same

Clay-Park



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

New Jersey Health Services Program NEWSLETTER

Volume P-250

TO: ALL PROVIDERS
 SUBJECT: MEDICAID ELIGIBILITY ID

IMPORTANT !!!

Beginning October 1, 1979 some children who are Medicaid eligible persons will receive a new Medicaid ID which will be valid for three months.

THIS MEDICAID ID WILL BE ISSUED TO SOME OF THE CHILDREN WHO ARE UNDER THE SUPERVISION OF THE DIVISION OF YOUTH AND FAMILY SERVICES, (DYFS), AND HAVE 60 AS THE THIRD AND FOURTH DIGITS OF THEIR HEALTH SERVICES PROGRAM CASE NUMBER. E.G. 12 60 004371. THE PERSON NUMBER WILL ALSO APPEAR ON THE ID AND IS TO BE UTILIZED BY PROVIDERS WHEN COMPLETING MEDICAID CLAIMS.

The new ID which is identified in the upper right corner on the front of the card as an FD-178, is similar in format to the Medicaid ID used for Supplemental Security Income (S.S.I.) beneficiaries and which has been in use since January 1, 1974. That form is identified as FD-73 in the upper right hand corner.

12 60 004371-21 <small>HSP CASE NO. PER NO.</small>		STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES MEDICAID ELIGIBILITY IDENTIFICATION	FD-178 (7-78)
VALID: FROM: 10-1-79 TO: 12-31-79	PROVIDER: Ask cardholder if he or she has other health insurance or MEDICARE coverage. (Please see other side)		
SAMPLE	10/2/64 <small>DATE OF BIRTH</small>		
	123-45-6789 <small>SOCIAL SECURITY ACCOUNT NO.</small>		
	Mary Smith <small>RECIPIENT'S SIGNATURE</small>		

SAMPLE

NOTICE:

Immediate attention is required:

1. Have the child sign on the face of this card.
2. If this card is lost, notify:
The Division of Youth & Family Services
1 So. Montgomery St., Trenton, N.J. 08625
Attn: Program Support
3. If the Medicaid child no longer resides in your home please return this card to the Division of Youth and Family Services caseworker who has been visiting the child.

LOANING OR OTHER ABUSE OF THIS CARD IS SUBJECT TO PROSECUTION UNDER THE LAW.

NOTICE TO PROVIDERS:

The name which appears directly above the line for "Recipient's Signature" on this card is the MEDICAID eligible person. This card identifies ONLY that person as being eligible for MEDICAID benefits within the period shown. If another name appears on this card, that person is a "Representative Payee" and is not eligible for MEDICAID benefits. If cardholder indicates there is health insurance or MEDICARE coverage, you are to bill MEDICAID only AFTER receiving denial or partial payment from the other insurance company.

BACK

Major differences are

1. On the FD-73, the Supplemental Security Income (S.S.I.) card the printing is in black ink.

THE PRINT IS IN BLUE INK ON THE DYFS ELIGIBILITY CARD.

2. The information on the reverse side of the Supplemental Security (S.S.I.) card refers to the Hospital Service Plan of New Jersey and the Social Security office.

THE INFORMATION ON THE REVERSE SIDE REFERS TO THE DIVISION OF YOUTH AND FAMILY SERVICES.

In addition to the quarterly validation card, issued to children who are in foster care placement, the Division of Youth and Family Service will continue to issue a monthly validation card, DYFS 16-36 to the remainder of the DYFS population, who are not in foster care placement.

Child's No.	Name	Case No.
22	John Brown	1160 001234

VALID ONLY FOR MONTH OF
PLACEMENT REFERENCE

SAMPLE

STATE OF NEW JERSEY
DIVISION OF YOUTH AND FAMILY SERVICES

V A L I D A T I O N
FOR HEALTH SERVICES PROGRAM

DYFS 16-38
(rev. 3/78)

NOTICE TO CLIENT

THIS VALIDATION FORM INDICATES ELIGIBILITY FOR AUTHORIZED HEALTH SERVICES PROVIDED UNDER THE NEW JERSEY HEALTH SERVICES PROGRAM.

THIS VALIDATION MUST BE PRESENTED TO THE PROVIDER OF MEDICAL SERVICES ALONG WITH THE PLASTIC IDENTIFICATION CARD.

NOTICE TO PROVIDER OF MEDICAL SERVICES

THE CASE NUMBER AND NAME ON THIS FORM MUST BE COMPARED TO THAT SHOWN ON THE PLASTIC IDENTIFICATION CARD ISSUED TO THE BEARER.

THE CLAIM FOR PAYMENT OF HEALTH SERVICES IS TO BE SUBMITTED TO THE APPROPRIATE CONTRACTOR FOR THE STATE OF NEW JERSEY ON THE REQUIRED VENDOR CLAIM FORM.

PLEASE REPORT THE CASE NAME, CASE NUMBER AND PERSON NUMBER **ACCURATELY** ON ALL CLAIM FORMS AND OTHER COMMUNICATIONS RELATING TO THE CLAIM.

Any questions concerning the use of these cards should be directed to your local Medicaid office.

Questions concerning the eligibility status of recipients who are coded as "60" should be directed to the Division of Youth and Family Service District Office.



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

New Jersey Health Services Program NEWSLETTER

Volume P-252

October 15, 1979

TO: PARTICIPATING PHYSICIANS, DENTISTS AND PODIATRISTS

SUBJECT: MAXIMUM ALLOWABLE COST (MAC) LIMITATIONS FOR CERTAIN DRUGS AND PRESCRIBER'S CERTIFICATION TO OVERRIDE "MAC" LIMITS ON PRESCRIBED DRUGS

Effective October 15, 1979 the New Jersey Medicaid Program will reimburse participating pharmacies the newly established "MAC" prices listed below, regardless of brand specified, with the following exceptions.

"LIMITATION SHALL NOT APPLY IN ANY CASE WHERE A PRESCRIBER CERTIFIES IN HIS OWN HANDWRITING THAT IN HIS MEDICAL JUDGEMENT A SPECIFIC BRAND IS MEDICALLY NECESSARY FOR A PARTICULAR PATIENT. IN THIS INSTANCE, THE PRESCRIBER MUST WRITE 'BRAND NECESSARY' OR 'MEDICALLY NECESSARY' IN HIS OWN HANDWRITING, ON EACH WRITTEN OR TELEPHONED PRESCRIPTION. TELEPHONED PRESCRIPTIONS FOR WHICH THE PHYSICIAN WISHES TO CERTIFY MEDICAL NECESSITY MUST BE FOLLOWED BY A WRITTEN PRESCRIPTION TO THE PHARMACY WITHIN 7 DAYS OF THE ORIGINAL ORDER."

It should be noted that preprinted statements, rubber stamp statements, check boxes, blanket statements to pharmacy providers, etc., will not be acceptable

The Pharmaceutical Reimbursement Board of the Department of Health, Education and Welfare has established the Maximum Allowable Cost for the following drug entities:

Chlordiazepoxide HCl, 5mg Capsules	- \$0.0140 per capsule
Chlordiazepoxide HCl, 10mg Capsules	- \$0.0211 per capsule
Chlordiazepoxide HCl, 25mg Capsules	- \$0.0438 per capsule
Diphenoxylate HCl with Atropine Sulfate 2.5mg/0.025mg Tablets	- \$0.0491 per tablet
Doxepin HCl, 100mg Capsules	- \$0.2900 per capsule
Methocarbamol, 500mg Tablets	- \$0.0496 per tablet
Methocarbamol, 750mg Tablets	- \$0.0640 per tablet
Oxyphenbutazone, 100mg Tablets	- \$0.0847 per tablet
Penicillin G, 400 MU Tablets	- \$0.0237 per tablet
Penicillin G, 800 MU Tablets	- \$0.0640 per tablet
Sulfisoxazole, 500mg Tablets	- \$0.0273 per tablet
Tetracycline HCl, 125/5ml Syrup	- \$0.0104 per ml

Effective October 15, 1979, pharmacy providers will be reimbursed for the above, based on the lesser of:

1. the product's Average Wholesale Price (AWP) less regression, if any; or
2. the established Maximum Allowable Cost as indicated above.

NOTE: Only the terms "Brand Necessary" or "Medically Necessary" are valid for establishing Medical Certification. No other terminology is acceptable.

(continued)

Listing of MAC Drugs

Providers of Pharmaceutical Services are reminded that the following MAC's are either currently in effect, or will shortly be in effect:

<u>DRUG ENTITY</u>	<u>MAC</u>	<u>EFFECTIVE DATE</u>
Acetaminophen w/codeine, 30mg tablets	\$0.0780 per tablet	01/25/79
Acetaminophen w/codeine, 60mg tablets	\$0.1545 per tablet	01/25/79
Amoxicillin 250mg capsules	\$0.2108 per capsule	06/28/79
Amoxicillin 500mg capsules	\$0.3942 per capsule	06/28/79
Ampicillin 250mg capsules	\$0.0595 per capsule	01/25/79
Ampicillin 500mg capsules	\$0.1103 per capsule	01/25/79
Ampicillin Oral Suspension, 125mg/5ml	\$0.0145 per ml	11/07/77
Ampicillin Oral Suspension, 250mg/5ml	\$0.0205 per ml	11/07/77
*Chlordiazepoxide HCl, 5mg capsules	\$0.0104 per capsule**	10/15/79
*Chlordiazepoxide HCl, 10mg capsules	\$0.0211 per capsule**	10/15/79
*Chlordiazepoxide HCl, 25mg capsules	\$0.0438 per capsule**	10/15/79
*Diphenoxylate HCl with Atropine Sulfate 2.5mg/0.025mg tablets	\$0.0491 per tablet	10/15/79
Doxepin HCl, 10mg capsules	\$0.0950 per capsule	01/25/79
Doxepin HCl, 25mg capsules	\$0.1161 per capsule	01/25/79
Doxepin HCl, 50mg capsules	\$0.1765 per capsule	01/25/79
*Doxepin HCl, 100mg capsules	\$0.2900 per capsule	10/15/79
Erythromycin Stearate, 250mg tablets	\$0.0697 per tablet	01/25/79
Erythromycin Stearate, 500mg tablets	\$0.1250 per tablet	01/25/79
Hydrochlorothiazide 25mg tablets	\$0.0250 per tablet	06/28/79
Hydrochlorothiazide 50mg tablets	\$0.0306 per tablet	06/28/79
Meprobamate, 200mg tablets	\$0.0108 per tablet	01/25/79
Meprobamate, 400mg tablets	\$0.0117 per tablet	01/25/79
*Methocarbamol, 500mg tablets	\$0.0496 per tablet	10/15/79
*Methocarbamol, 750mg tablets	\$0.0640 per tablet	10/15/79
*Oxyphenbutazone, 100mg tablets	\$0.0847 per tablet	10/15/79
*Penicillin G Potassium, 400mu tablets	\$0.0237 per tablet	10/15/79
*Penicillin G Potassium 800mu tablets	\$0.0640 per tablet	10/15/79
Penicillin VK Oral Susp., 125mg/5ml	\$0.0120 per ml	11/07/77
Penicillin VK Oral Susp., 250mg/5ml	\$0.0160 per ml	11/07/77
Penicillin VK, 250mg tablets	\$0.0535 per tablet	11/07/77
Penicillin VK, 500mg tablets	\$0.1025 per tablet	11/07/77
Phenylbutazone, 100mg tablets	\$0.0750 per tablet	01/25/79
Phenylbutazone Alka, 100mg capsules	\$0.0940 per capsule	01/25/79
Probenecid, 0.5 gm tablets	\$0.0644 per tablet	01/25/79
Propoxyphene HCl, 65mg capsules	\$0.0317 per capsule	04/10/78
Propoxyphene HCl with APC, 65mg cap.	\$0.0330 per capsule	04/10/78
*Sulfisoxazole, 500mg tablets	\$0.0273 per tablet	10/15/79
Tetracycline HCl, 250mg capsules	\$0.0250 per capsule	04/10/78
Tetracycline HCl, 500mg capsules	\$0.0465 per capsule	04/10/78
*Tetracycline HCl, 125mg/5ml syrup	\$0.0104 per ml	10/15/79

*THESE MAC LIMITS DO NOT APPLY TO UNIT DOSE PACKAGING

**REVISION OF MAC SET 4/10/78



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

New Jersey Health Services Program NEWSLETTER

Volume P-254

January 1, 1980

TO: ALL PROVIDERS

SUBJECT: AUTOMATED SYSTEM FOR RESUPPLYING MEDICAID CLAIM FORMS

We are pleased to announce the implementation of an automated system for resupplying your Medicaid claim forms.

This unique system is designed to help you in the following ways:

1. Eliminate the need for inventory control;
2. Minimize clerical effort;
3. Eliminate any delays you may have experienced with the reorder cards; and
4. Automatically provide, on a timely basis, an adequate supply of the forms you require.

System Details

1. Based on average of claims submitted in 1978, an individual quarterly resupply level will be established.
2. The volume of processed claims will be deducted from the resupply level until the balance reaches a preset reorder indicator.
3. The indicator will trigger an automatic generation of a new supply of claim forms.
4. Adjustments to your resupply levels will be made as your pattern of claim submission changes.

Claim Form Data

The new system will supply 8 1/2" x 11" forms, standard pinfeed continuous format, with 1/2" crimped side stubs. Horizontal spacing has been adjusted to accommodate computer printing of provider information, including the individual Medicaid Practitioner (IMP) Number of solo practitioners.

The following additions have been made to certain claim forms:

1. Patient Certification
 - Date of signature
 - A check box to identify relationship of non-recipient signature
2. Provider Certification
 - A check box to indicate that IMP Number is identical to that preprinted in Provider Information area.

(Continued)

Please examine your new claim forms carefully. Remember that to insure efficient processing, all items must be completed and each claim must be submitted as a single sheet.

The system will be implemented with your next shipment of claims. The actual date and volume of the shipment will be determined by the size of the previous order and a history of submitted claims. Begin using the new forms once your existing stock has been depleted. Subsequent resupply will be completely automatic. However, provisions have been made for special orders, which may be necessary with change of address, sudden stock depletion, or significant numbers of claims held for additional information. Such requests may be addressed to:

Prudential Insurance Company
Provider Reorder Unit
P. O. Box 471
Millville, New Jersey 08332
(609) 293-2317



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

New Jersey Health Services Program NEWSLETTER

Volume P-257

January 28, 1980

TO: ALL DENTISTS
INDEPENDENT DENTAL CLINICS

SUBJECT: EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM REVISED
REGULATIONS - DENTAL SERVICES

Federal Regulations

As a result of new federal regulations, there has been a significant change in the dental component of the EPSDT screening examination. Effective October 1, 1979, the New Jersey Medicaid Program is required to:

1. Refer all children who request EPSDT medical screening, age 3 through 20, directly to a dentist for diagnosis and treatment; and
2. Demonstrate that dental services are delivered within 120 days of a request.

Accordingly, when a client accepts the EPSDT screening, direct referrals to a dentist are now being initiated by a County Welfare or Division of Youth and Family Services social services worker. The Medicaid Program has developed a computer tracking system to insure that the dental services are actually delivered.

Prompt Billing

Submission of your claim form is the key to the effective functioning of this referral and tracking network. Therefore, we ask your cooperation by:

1. Completing your treatment plan as quickly as possible;
2. Submitting the claim form immediately upon completion of treatment; and
3. Checking the appropriate block on the claim form (Item No. 10 on the MC-10), when your services were performed as a result of an EPSDT referral.



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

New Jersey Health Services Program

NEWSLETTER

Volume P-266

April 21, 1980

TO: PARTICIPATING PHYSICIANS, DENTISTS AND PODIATRISTS

SUBJECT: MAXIMUM ALLOWABLE COST (MAC) LIMITATIONS FOR CERTAIN DRUGS AND
PRESCRIBER'S CERTIFICATION TO OVERRIDE "MAC" LIMITS ON PRESCRIBED DRUGS

Effective March 31, 1980 the New Jersey Medicaid Program will reimburse participating pharmacies the newly established "MAC" prices listed below, regardless of brand specified, with the following exceptions.

"LIMITATION SHALL NOT APPLY IN ANY CASE WHERE A PRESCRIBER CERTIFIES IN HIS OWN HANDWRITING THAT IN HIS MEDICAL JUDGEMENT A SPECIFIC BRAND IS MEDICALLY NECESSARY FOR A PARTICULAR PATIENT. IN THIS INSTANCE, THE PRESCRIBER MUST WRITE 'BRAND NECESSARY' OR 'MEDICALLY NECESSARY' IN HIS OWN HANDWRITING, ON EACH WRITTEN OR TELEPHONED PRESCRIPTION. TELEPHONED PRESCRIPTIONS FOR WHICH THE PHYSICIAN WISHES TO CERTIFY MEDICAL NECESSITY MUST BE FOLLOWED BY A WRITTEN PRESCRIPTION TO THE PHARMACY WITHIN 7 DAYS OF THE ORIGINAL ORDER."

It should be noted that preprinted statements, rubber stamp statements, check boxes, blanket statements to pharmacy providers, etc. will not be acceptable.

The Pharmaceutical Reimbursement Board of the Department of Health, Education and Welfare has established the Maximum Allowable Cost for the following drug entities:

Hydralazine HCl, 25mg Tablets	\$0.0279
Hydralazine HCl, 50mg Tablets	\$0.0384

Effective March 31, 1980, pharmacy providers will be reimbursed for the above, based on the lesser of:

1. the product's Average Wholesale Price (AWP) less regression, if any; or
2. the established Maximum Allowable Cost as indicated above.

NOTE: Only the terms "Brand Necessary" or "Medically Necessary" are valid for establishing Medical Certification. No other terminology is acceptable.

(Continued)

LISTING OF MAC DRUGS

Providers of Pharmaceutical Services are reminded that the following MAC's are either currently in effect, or will shortly be in effect:

<u>Drug Entity</u>	<u>MAC</u>	<u>Effective Date</u>
Acetaminophen w/codeine, 30mg tablets	\$0.0780 per tablet	01/25/79
Acetaminophen w/codeine, 60mg tablets	\$0.1545 per tablet	01/25/79
Amoxicillin 250mg capsules	\$0.2108 per tablet	06/28/79
Amoxicillin 500mg capsules	\$0.3942 per capsule	06/28/79
Ampicillin 250mg capsules	\$0.0595 per capsule	01/25/79
Ampicillin 500mg capsules	\$0.1103 per capsule	01/25/79
Ampicillin Oral Suspension, 125mg/5ml	\$0.0145 per ml	11/07/77
Ampicillin Oral Suspension, 250mg/5ml	\$0.0205 per ml	11/07/77
*Chlordiazepoxide HCl, 5mg capsules	\$0.0140 per capsule	10/15/79
*Chlordiazepoxide HCl, 10mg capsules	\$0.0211 per capsule	10/15/79
*Chlordiazepoxide HCl, 25mg capsules	\$0.0438 per capsule	10/15/79
*Diphenoxylate HCl with Atropine Sulfate 2.5mg/0.025mg tablets	\$0.0491 per tablet	10/15/79
Doxepin HCl, 10mg capsules	\$0.0950 per capsule	01/25/79
Doxepin HCl, 25mg capsules	\$0.1161 per capsule	01/25/79
Doxepin HCl, 50mg capsules	\$0.1765 per capsule	01/25/79
*Doxepin HCl, 100mg capsules	\$0.2900 per capsule	10/15/79
Erythromycin Stearate, 250mg tablets	\$0.0697 per tablet	01/25/79
Erythromycin Stearate, 500mg tablets	\$0.1250 per tablet	01/25/79
*Hydralazine HCl, 25mg tablets	\$0.0279 per tablet	03/31/80
*Hydralazine HCl, 50mg tablets	\$0.0384 per tablet	03/31/80
Hydrochlorothiazide 25mg tablets	\$0.0250 per tablet	06/28/79
Hydrochlorothiazide 50mg tablets	\$0.0306 per tablet	06/28/79
Meprobamate, 200mg tablets	\$0.0108 per tablet	01/25/79
Meprobamate, 400mg tablets	\$0.0117 per tablet	01/25/79
*Methocarbamol, 500mg tablets	\$0.0496 per tablet	10/15/79
*Methocarbamol, 750mg tablets	\$0.0640 per tablet	10/15/79
*Oxyphenbutazone, 100mg tablets	\$0.0847 per tablet	10/15/79
*Penicillin G Potassium, 400mu tablets	\$0.0237 per tablet	10/15/79
*Penicillin G Potassium, 800mu tablets	\$0.0640 per tablet	10/15/79
Penicillin VK Oral Susp., 125mg/5ml	\$0.0120 per ml	11/07/77
Penicillin VK Oral Susp., 250mg/5ml	\$0.0160 per ml	11/07/77
Penicillin VK, 250mg tablets	\$0.0535 per tablet	11/07/77
Penicillin VK, 500mg tablets	\$0.1025 per tablet	11/07/77
Phenylbutazone, 100mg tablets	\$0.0750 per tablet	01/25/79
Phenylbutazone Alka, 100mg capsules	\$0.0940 per capsule	01/25/79
Probenecid, 0.5gm tablets	\$0.0644 per tablet	01/25/79
Propoxyphene HCl, 65mg capsules	\$0.0317 per capsule	04/10/78
Propoxyphene HCl with APC, 65mg cap.	\$0.0330 per capsule	04/10/78
*Sulfisoxazole, 500mg tablets	\$0.0273 per tablet	10/15/79
Tetracycline HCl, 250mg capsules	\$0.0250 per capsule	04/10/78
Tetracycline HCl, 500mg capsules	\$0.0465 per capsule	04/10/78
*Tetracycline HCl, 125mg/5ml syrup	\$0.0104 per ml	10/15/79

*THESE MAC LIMITS DO NOT APPLY TO UNIT DOSE PACKAGING



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

New Jersey Health Services Program NEWSLETTER

Volume P-267

April 30, 1980

TO: ALL ESSEX COUNTY MEDICAID PROVIDERS OF HEALTH CARE

SUBJECT: PHASE OUT OF THE NEWARK COMPREHENSIVE HEALTH SERVICES PLAN (NCHSP)

Please be advised that, as of April 30, 1980, Compre Health will be phasing out its operation and, as a result, will cease to provide health care services to Medicaid eligibles who chose to transfer to Compre Health during the past twenty-seven month demonstration period of the program.

Both the Essex County Welfare Agency and Compre Health have arranged to transfer Compre Health members who are still Medicaid eligible back to the regular Medicaid Program as their Compre Health membership expires. These individuals will receive regular Medicaid Cards from the Essex County Welfare Agency and providers will be paid through the regular Medicaid system.

Effective April 30, 1980, all contracts between Compre Health and health care providers will terminate and providers will not be reimbursed for any services provided after April 30, 1980.

If additional information is needed, please contact Lawrence Strand, Acting Chief, Bureau of Prepaid Health Plans. Telephone number (648-6133).



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

New Jersey Health Services Program NEWSLETTER

Volume P-269

May 12, 1980

TO: ALL PROVIDERS

SUBJECT: DISCLOSURE OF INFORMATION

As a result of new Federal regulations, there are changes in requirements for disclosure of information by providers who wish to participate in the New Jersey Health Services Program. The Federal regulations became effective October 15, 1979 and require that:

1. All Medicaid providers, except an individual practitioner and/or a group of practitioners, must complete a Health Care Financing Administration (HCFA) Form 1513, Ownership and Control Interest Disclosure Statement; and
2. All Medicaid providers must allow authorized agencies, as designated by the Secretary of Health, Education and Welfare (HEW), access to Medicaid providers' records.

In order to be in compliance with the new Federal regulations, the Commissioner of the Department of Human Services amended N.J.A.C. 10;49-1.3(a) (New Jersey Health Services Program Provider Manuals, Chapter 1, paragraph 102). The amendments were proposed in the January 1980 New Jersey Register and subsequently adopted.

This Newsletter does not require providers to take any action unless a specific request is made in writing by the New Jersey Medicaid Program and/or other agencies as designated by the Secretary of HEW.

The Provider Agreement (FD-62) has been revised. The revised agreement will be used exclusively, effective March 10, 1980.

Please review this Newsletter and insert it in your Medicaid manual.

If you or your staff have any questions, they should be directed to Mr. Alfred A. Belcher, Chief, Provider Enrollment, telephone (609) 292-0812.



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

New Jersey Health Services Program NEWSLETTER

Volume P-275

June 23, 1980

TO: ALL PROVIDERS (EXCEPT HOSPITALS AND HOME HEALTH AGENCIES)

SUBJECT: 1. TIMELY SUBMISSION OF CLAIMS (REVISED FEDERAL REGULATIONS)

2. TIMELY CLAIM INQUIRIES

The prompt payment of provider claims is a primary objective of the New Jersey Medicaid Program. In order to achieve this goal, claims and inquiries concerning claims must be submitted promptly. Based upon recent federal regulations, the time limits for submission of claims have been modified, as outlined below. Additionally, time limits for the submission of claim inquiries have been developed.

CLAIMS SUBMISSION

All Medicaid claims for payment of goods or services must be received by the Contractor, the Prudential Insurance Company, no later than:

1. Ninety (90) days after the last date the goods or services were provided; and
2. Twelve (12) months from the earliest date of service as indicated on the claim form.

Claims for services beyond these time limits will not be payable unless the provider can document valid extenuating circumstances.

For Example:

<u>Date(s) of Service:</u>	<u>Must Be Received by:</u>
(1) 1/1/80	4/1/80
..... 90 days	
(2) 7/1/79 9/12/79 4/1/80	7/1/80
..... 12 months	
 90 days

This means that a claim must be received within 90 days of the last date of service. If more than one service is listed on a claim, the earliest date of service can be no more than 12 months from the date the claim is received by the Contractor.

(Continued)

CLAIM INQUIRIES

Effective July 1, 1980 any inquiries concerning processed Medicaid claims or claims for which you have not received a reply must be made to the Contractor within the time frames outlined below :

1. Processed Claims - Inquiries must be received no later than 180 days after the adjudication date on the Statement of Claims Payment or Denial Letter.
2. Claim Submitted, No Response Received - Inquiries must be received no later than 180 days after the last date of services entered on the queried claim.

As instructed in the New Jersey Health Services Program Newsletter P-243, inquiries concerning less than three claims can be made through the Medicaid Inquiry Unit by calling, toll free, (800) 582-7052. For questions concerning three or more claims, continue to utilize your usual channels of written communication.

Please file this Newsletter in your provider manual Chapter 1, Section III.



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

New Jersey Health Services Program NEWSLETTER

Volume P-282

December 8, 1980

TO: PARTICIPATING PHYSICIANS, DENTISTS AND PODIATRISTS

SUBJECT: I. MAXIMUM ALLOWABLE COST (MAC) LIMITATIONS AND PRESCRIBER'S CERTIFICATION TO OVERRIDE MAC LIMITS ON PRESCRIBED DRUGS
 II. PRESCRIBING OF MAC DRUGS IN THE N.J. PAA PROGRAM
 III. PRESCRIBING OF NON-LEGEND DRUGS IN THE N.J. MEDICAID PROGRAM

I. MAXIMUM ALLOWABLE COST (MAC) LIMITATIONS AND PRESCRIBER'S CERTIFICATION TO OVERRIDE MAC LIMITS ON PRESCRIBED DRUGS

Effective December 15, 1980, the New Jersey Medicaid Program will reimburse participating pharmacies the newly established "MAC" prices listed below, regardless of brand specified, with the following exceptions.

"LIMITATION SHALL NOT APPLY IN ANY CASE WHERE A PRESCRIBER CERTIFIES IN HIS OWN HANDWRITING THAT IN HIS MEDICAL JUDGEMENT A SPECIFIC BRAND IS MEDICALLY NECESSARY FOR A PARTICULAR PATIENT. IN THIS INSTANCE, THE PRESCRIBER MUST WRITE "BRAND NECESSARY" OR "BRAND MEDICALLY NECESSARY IN HIS OWN HANDWRITING, ON EACH WRITTEN OR TELEPHONED PRESCRIPTION. TELEPHONED PRESCRIPTIONS FOR WHICH THE PHYSICIAN WISHES TO CERTIFY MEDICAL NECESSITY MUST BE FOLLOWED BY A WRITTEN PRESCRIPTION TO THE PHARMACY WITHIN 7 DAYS OF THE ORIGINAL ORDER."

It should be noted that preprinted statements, rubber stamp statements, check boxes, blanket statements to pharmacy providers, etc. will not be acceptable.

The Pharmaceutical Reimbursement Board of the Department of Health and Human Services has established the Maximum Allowable Cost for the following drug entities:

<u>DRUG</u>	<u>MAC Limit</u>
Potassium chloride, oral liquid, 10%	\$0.0030 per ml.
Griseofulvin, microcrystalline, oral tablet 500mg	\$0.2818 per Tablet
Dicloxacillin Sodium oral capsules, 250mg	\$0.2690 per Capsule
Quinidine sulfate, oral tablets 200mg	\$0.0688 per Tablet
Hydrochlorothiazide, oral tablet, 25mg	\$0.0152 per Tablet
Hydrochlorothiazide, oral tablet, 50mg	\$0.0194 per Tablet

Effective December 15, 1980, pharmacy providers will be reimbursed for the above, based on the lesser of:

1. the product's Average Wholesale Price (AWP) less regression, if any; or
2. the established Maximum Allowable Cost as indicated above.

II. PRESCRIBING OF MAC DRUGS IN THE N.J. PAA PROGRAM

Effective November 1, 1980, Maximum Allowable Cost (MAC) prices apply to all prescriptions written for PAA beneficiaries.

When a drug is prescribed from the MAC list for a PAA beneficiary, the prescriber must specify whether substitution may or may not **take place**.

If the prescriber allows substitution to take place, the pharmacist shall dispense to the PAA beneficiary the lower cost therapeutically equivalent product from the N. J. Drug Utilization Review Council Formulary. The pharmacist can only dispense the brand name drug when the prescriber has specified that substitution is not permitted. If the prescriber does not specify that substitution is not permitted and the PAA beneficiary demands the brand name drug, the PAA beneficiary must pay the difference between the brand name drug and the MAC price of the generic drug, as required by NJSA-30:4D-22.

NJSA-24:6E-7 et seq. states in part: "Every prescription blank shall be imprinted with the words "Substitution Permissible" or "Do Not Substitute" and shall contain space for the physician's or other authorized prescriber's initials next to the chosen option...." The prescriber may use the method described in NJSA-24:6E-7 or any other method allowed by law.

However, it is suggested that the prescriber can cover all situations where substitution should not take place by writing "Brand Necessary" or "Brand Medically Necessary" on the prescription. This method simplifies the procedure and accomplishes the desired result.

III. PRESCRIBING OF NON-LEGEND DRUGS IN THE N.J. MEDICAID PROGRAM

Prescriptions for non-legend drugs should be written for standard shelf package sizes (i.e. 100 tabs or capsules, 120cc liquid, etc.). This will allow the pharmacist to dispense the prescription in the original container and help reduce cost.

All participating physicians, dentists and podiatrists are reminded that effective November 1, 1980, the following non-legend drugs are no longer reimbursable under the N. J. Medicaid Program.

DELETED NON-LEGEND DRUGS

ACID MANTLE CREAM
ACNE DOME CLEANSER
ACNE DOME CREAM
ACNE DOME LOTION
ACNOMEL CREAM
A & D CREAM WHITES
A & D OINTMENT, WHITES
ALMA TAR LIQUID
ALPHA KERI LIQUID
ALPHA KERI SPRAY
ALPHALIN GELS 25,000U
ALPHOSYL CREAM
ALPHOSYL GEL
ALPHOSYL LOTION
ALUMINUN PASTE/OINT.
ALZINOX SUSP
AMMONIATED MERC OINT GENERIC 5%
AMMONIATED MERC OINT LILLY 5%
AMPHOJEL TABS 600MG
ANALGESIC BALM GENERIC
ANALGESIC BALM LILLY
AQUACARE CR
AQUACARE LOTION
AQUACARE HP CR
AQUACARE HP LOTION
AQUASOL A CREAM
ARTHROPAN LIQUID
AVEENO LOTION
AVEENO OATMEAL
AVEENO OILATED
BACITRACIN OINTMENT GENERIC 114GM
BALNETAR LIQUID
BANALG LINIMENT
BENADRYL CREAM
BETADINE DOUCHE
BETADINE GAUZE PADS
BETADINE OINTMENT
BETADINE SHAMPOO
BETADINE SKIN CLEANSER
BETADINE SOLUTION
BLU-BORO PACKETS
BO-CAR-AL POWDER
BRASIVOL BASE
BRASIVOL FINE
BRASIVOL MEDIUM
BRASIVOL ROUGH
BRASIVOL-2 BASE
BRASIVOL-2 FINE
BRASIVOL-2 MEDIUM
BRASIVOL-2 ROUGH
BUR VEEN PACKETS
BURO SOL POWDER PACKETS
BUTESIN PICRATE OINTMENT
BUTYN DENTAL OINTMENT
CALADRYL LOTION
CALADRYL SPRAY
CARMOL-10 LOTION
CARMOL-20 CREAM
CETAPHIL LOTION
CHOLAN-DH
CORICIDIN COUGH FORMULA
D-FEDA SYRUP
D.S.S. PLUS CAPS
DERMOPLAST SPRAY
DESENEX OINTMENT
DESENEX POWDER
DESENEX SOL 81CC
DOMBORO POWDER PACKETS
DOMBORO TABLETS
ELDOPAQUE OINTMENT 2%
ELDOPAQUE OINTMENT FORTE
ELDOPAQUE CREAM
ELDOQUIN LOTION
EMPIRIN COMPOUND TABS
EPI CLEAR KIT
EPI CLEAR CLEANSER FINE
EPI CLEAR CLEANSER MEDIUM
EPI CLEAR CLEANSER COARSE
EPI CLEAR LOTION
EPI CLEAR ANTISEP LOTION 5%
EPI CLEAR ANTISEP LOTION 10%
FLEETS BISACODY ENEMA
FLEETS BISACODY SUPP
FLEETS BISACODY TABS
FLEETS PHOSPH-SODA
FLEETS PREP KIT #1
FLEETS PREP KIT #2
FLEETS PREP KIT #3
FOMAC FOAM
FOSTEX CREAM/SHAMPOO
FOSTEX LIQUID
FOSTRIL LOTION
GENTIAN VIOLET 1% 15CC SIZE
GENTIAN VIOLET 2% 15CC SIZE
IMMUNOVAC ORAL TABS
IODEX OINT
IODEX W/METHYL SALICYLATE OINT
IONIL SHAMPOO
IONIL T SHAMPOO
KERI CREAM

DELETED NON-LEGEND DRUGS

KERI LOTION
KLARON LOTION
KOMED LOTION
KOMED MILD LOTION
LANTEEN POWDER
LIQUIMAT LOTION ANY SHADE
LOTIO ALSULFA
LOTIOBLANC
LUBATH
LUBIDERM CREAM
LUBIDERM LOTION
MASSENGILL DOUCHE POWDER
MASSENGILL LIQUID
METASEP LIQUID
METED SHAMPOO
METHAKOTE CREAM
MICROSYN LOTION
MOL IRON PRENATAL
MULTICEBRIN JR
MYOFLEX CREAM
NEOCHOLAN TABS
NUPERCAINAL CREAM (PAIN RELIEF)
NUPERCAINAL OINT, LOZ
NUPERCAINAL PAIN, RELIEF SPRAY
NUTRADERM CREAM
NUTRADERM LOTION
PABIRIN CAPS
PANTHODERM CREAM
PHISOAC CREAM
PHISODAN
PHISODERM REGULAR
PHISODERM DRY
PHISODERM OILY
POLYTAR SHAMPOO
PRACTIFLEX ANALGESIC CREAM
PRACTIMIN E CREAM
PRAGMATAR OINTMENT
QUOTANE LOTION
QUOTANE OINTMENT
RESULIN LOTION ANY SHADE
REZAMID CREAM
REZAMID LOTION
REZAMID SHAMPOO
RHULICREAM
RHULIGEL
RHULIHIST LOTION
SASTID
SASTID-AL
SCADAN LOTION
SEBAVEEN SHAMPOO
SEBICAL CREAM SHAMPOO
SEBUCARE LOTION
SEBULEX CREAM
SEBULEX SHAMPOO
SEBUTONE CREAM
SEBUTONE SHAMPOO
SELSUN BLUE SHAMPOO
SOPRONOL OINTMENT
SOPRONOL POWDER

SOPRONOL SOLUTION
STOMASEPTINE POWDER
STRASCOGESIC TABS
SULFORCIN LOTION
SURFACAIN CREAM
SURFADIL CREAM
SURFADIL LOTION
SYNTEX CREAM
SYNTEX LOTION
SYNTEX OIL
TARBONIS CREAM
THERMAL CREAM
TOPIC GEL
TRANSACT JELL
TRICHOTINE LIQUID
TRICHOTINE POWDER
TRICHOTINE D
TRONOTHANE CREAM 1%
VASISEC LIQUID
VANSEB CREAM/SHAMPOO TUBE
VANSEB T CREAM/SHAMPOO
VLEM DOME PACKETS
WHITFIELDS OINTMENT GENERIC
WHITFIELDS OINTMENT LILLY
YUVRAL CAPS
ZETAR SHAMPOO
ZINCON SHAMPOO

DELETED NON-LEGEND DRUGS-LISTED
PACKAGE SIZE ONLY

ABDEC DROPS	15cc
ADC DROPS	15cc
DECA VI SOL DROPS	15cc
DECA VI SOL DROPS	30cc
INITIA DROPS	15cc
ISOPTO TEARS	30cc
LIQUIPRIN DROPS	120cc
LIQUIPRIN DROPS	50cc
METAMUCIL POWDER	600gm
NOVACEBRIN DROPS	50cc & 56cc
POLY-VI-SOL DROPS	30cc
PREPARATION H OINT	105gm
PREPARATION H SUPP	24S & 48S
PRIVINE NASAL SOL	30cc
PRIVINE NASAL SPRAY	20cc
SURFACAIN JELLY	142gm
TINACTUI	120gm
TRI VI SOL DROPS	30cc
VI DAYLIN DROPS	30cc
VI DAYLIN ADC DROPS	30cc
VI PENTA	15cc
VI PENTA MULTAVITANUN	15cc
ZYMADROPS	15cc
ZYMADROPS	30cc
ZYMATIC DROPS	30cc

LISTING OF MAC DRUGS

Physicians, dentists and podiatrists are reminded that the following MAC's are either currently in effect or will shortly be in effect:

<u>DRUG ENTITY</u>	<u>MAC</u>	<u>EFFECTIVE DATE</u>
Acetaminophen w/codeine, 30mg Tablets	\$0.0780 per Tablet	01/25/79
Acetaminophen w/codeine, 60mg Tablets	\$0.1545 per Tablet	01/25/79
Amoxicillin 250mg capsules	\$0.2108 per Tablet	06/28/79
Amoxicillin 500mg capsules	\$0.3942 per Capsule	06/28/79
Ampicillin 250mg capsules	\$0.0595 per Capsule	01/25/79
Ampicillin 500mg capsules	\$0.1103 per Capsule	01/25/79
Ampicillin Oral Suspension, 125mg/5ml	\$0.0145 per ml	11/07/77
Ampicillin Oral Suspension, 250mg/5ml	\$0.0205 per ml	11/07/77
*Chlordiazepoxide HCl, 5mg capsules	\$0.0140 per Capsule	10/15/79
*Chlordiazepoxide HCl, 10mg capsules	\$0.0211 per Capsule	10/15/79
*Chlordiazepoxide HCl, 25mg capsules	\$0.0438 per Capsule	10/15/79
Dicloxacillin Sodium, 250mg capsules	\$0.2690 per Capsule	12/15/80
*Diphenoxylate HCl with Atropine Sulfate 2.5mg/0.025mg tablets	\$0.0491 per Tablet	10/15/79
Doxepin HCl, 10mg capsules	\$0.0950 per Capsule	01/25/79
Doxepin HCl, 25mg capsules	\$0.1161 per Capsule	01/25/79
Doxepin HCl, 50mg capsules	\$0.1765 per Capsule	01/25/79
*Doxepin HCl, 100mg capsules	\$0.2900 per Capsule	10/15/79
Erythromycin Stearate, 250mg tablets	\$0.0697 per Tablet	01/25/79
Erythromycin Stearate, 500mg tablets	\$0.1250 per Tablet	01/25/79

<u>DRUG ENTITY</u>	<u>MAC</u>	<u>EFFECTIVE DATE</u>
Griseofulvin, 500mg Tablets	\$0.2818 per Tablet	12/15/80
*Hydralazine HCl, 25mg Tablets	\$0.0279 per Tablet	03/31/80
*Hydralazine HCl, 50mg Tablets	\$0.0384 per Tablet	03/31/80
Hydrochlorothiazide 25mg Tablets	\$0.0152 per Tablet**	06/28/79
Hydrochlorothiazide 50mg Tablets	\$0.0194 per Tablet**	06/28/79
Meprobamate, 200mg Tablets	\$0.0108 per Tablet	01/25/79
Meprobamate, 400mg Tablets	\$0.0117 per Tablet	01/25/79
*Methocarbamol, 500mg Tablets	\$0.0496 per Tablet	10/15/79
*Methocarbamol, 750mg Tablets	\$0.0640 per Tablet	10/15/79
*Penicillin G Potassium, 400mu Tablets	\$0.0237 per Tablet	10/15/79
*Penicillin G Potassium, 800mu Tablets	\$0.0640 per Tablet	10/15/79
Penicillin VK Oral Susp., 125mg/5ml	\$0.0120 per ml	11/07/77
Penicillin VK Oral Susp., 250mg/5ml	\$0.0160 per ml	11/07/77
Penicillin VK, 250mg Tablets	\$0.0535 per Tablet	11/07/77
Penicillin VK, 500mg Tablets	\$0.1025 per Tablet	11/07/77
Potassium Chloride, oral liquid 10%	\$0.0030 per ml	12/15/80
Probenecid, 0.5gm Tablets	\$0.0644 per Tablet	01/25/79
Propoxyphene HCl, 65mg Capsules	\$0.0317 per Capsule	04/10/78
Propoxyphene HCl with APC, 65mg Cap.	\$0.0330 per Capsule	04/10/78
Quinidine Sulfate, 200mg Tablets	\$0.0688 per Tablet	12/15/80
*Sulfisoxazole, 500mg Tablets	\$0.0273 per Tablet	10/15/79
Tetracycline HCl, 250mg Capsules	\$0.0250 per Capsule	04/10/78
Tetracycline HCl, 500mg Capsules	\$0.0465 per Capsule	04/10/78
*Tetracycline HCl, 125mg/5ml Syrup	\$0.0104 per ml	10/15/79

*THESE MAC LIMITS DO NOT APPLY TO UNIT DOSE PACKAGING

**Revised MAC 12/15/80



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

New Jersey Health Services Program NEWSLETTER

VolumeP-285.....

December 15, 1980

TO: ALL PROVIDERS

SUBJECT: MEDICAID-ID SPECIAL STATUS CARDS

EFFECTIVE: January 1, 1981

PURPOSE:

The New Jersey Medicaid Program will implement a new procedure and issue new Medicaid-ID Special Status Cards to certain Medicaid-eligible persons. The new cards will be different in appearance, color and content from the currently used Medicaid-ID check stub. The Special Status Cards will be issued to clients determined by Medicaid to have misused, abused or overused their Medicaid benefits.

ACTION:

Clients will be issued one of the new Medicaid-ID Special Status Cards monthly, in place of the Medicaid-ID check stub, for a period of six months. The two new cards, which are illustrated on the reverse side of this Newsletter, are as follows:

1. Card #1 is yellow in color and identifies clients whose Medicaid ID check stub has been used by individuals not eligible for Medicaid benefits.

This card will alert providers to carefully check the personal identification of the holder of the card to prevent the card's unauthorized use.

2. Card #2 is red in color and identifies clients who have misused Medicaid benefits.

This card restricts the client to the specific physician and/or pharmacy that is listed on the card. All other Medicaid services will not be affected by this restriction and will be available as usual.

Note: A red card may also be issued if it is determined that a recipient's actions in a card-loaning incident were willful and/or involved mis-utilization of drugs.

The back of the Medicaid-ID Special Status Card will remain the same as the current Medicaid-ID check stub.

If you have any questions regarding the Medicaid-ID Special Status Cards, please contact Boniface J. Damiano, Chief, Bureau of Medical Care Surveillance, New Jersey Medicaid Program, at 609-292-2042.

This card will be yellow in color and will be a warning to providers to check the identification of recipients whose cards have been used by unauthorized persons.

CARD NO.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
MEDICAID-ID SPECIAL STATUS CARD

VALID ONLY FOR THE MONTH OF
MEDICAID HSP NO.

ELIGIBLE PERSONS	PER #	ELIGIBLE PERSONS	PER #
1		11	
2		12	
3		13	
4		14	
5		15	
6		16	
7		17	
8		18	
9		19	
10		20	

NOTICE TO PROVIDERS

THIS RECIPIENT'S MEDICAID ID CARD HAS BEEN USED BY UNAUTHORIZED PERSONS.

PRIOR TO PROVIDING SERVICES, YOU ARE REQUIRED TO CHECK PERSONAL IDENTIFICATION OF THE HOLDER OF THIS CARD.

This card will be red in color and will restrict recipients in a specific manner, such as to one physician and/or one pharmacy indicated on the right-hand side of the card.

CARD NO.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
MEDICAID-ID SPECIAL STATUS CARD

VALID ONLY FOR THE MONTH OF
MEDICAID *HSP NO.

ELIGIBLE PERSONS	PER #	ELIGIBLE PERSONS	PER #
1		11	
2		12	
3		13	
4		14	
5		15	
6		16	
7		17	
8		18	
9		19	
10		20	

NOTICE TO PROVIDERS

RESTRICTIONS

REIMBURSEMENT FOR ALL PHARMACEUTICAL SERVICES FOR THIS MEDICAID FAMILY IS LIMITED TO:
XYZ Pharmacy



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

New Jersey Health Services Program NEWSLETTER

Volume P-286

TO: All Providers December 29, 1980

SUBJECT: Reductions In Medicaid Services

In order to allow the Department of Human Services to remain within the current budgetary appropriation, certain reductions in the New Jersey Medicaid Program's covered services have been proposed.

Listed below is a summary of the proposed reductions. If adopted, individual Newsletters will be issued to each affected provider group.

Effective February 10, 1981 the following services will be entirely eliminated:

1. Pharmacy Services, including all legend and non-legend drugs.
2. Prosthetic and Orthotic Services, including orthopedic shoes and shoe appliances, including repairs.
3. Podiatry Services.
4. Medical Supplies and Equipment, including wheelchairs, hospital beds, walkers, and crutches.
5. Independent Clinic Services, such as Family Planning, Mental Health, and Rehabilitation.
6. Psychological Services.
7. Chiropractic Services.

Effective February 10, 1981 the following services will be reduced:

1. Physical, Speech and Occupational Therapies
Direct reimbursement for physical, speech, and occupational therapies will be limited to hospital, for in-patient and out-patient services.
2. Dental, Hearing, and Vision Care Services
Dental, Hearing, and Vision Care Services will be limited to EPSDT related services mandated for certain individuals under age 21.
 - A. Hearing and Vision Services
A copy of a referral (a physician's prescription is acceptable) from the physician who performed the EPSDT screening examination which states that the child is being referred for further diagnosis and/or treatment of a vision or hearing defect detected during an EPSDT screening examination will be required to be attached to each Physician's and Practitioner's Claim Form (MC-8), Request For Authorization and Payment-Optical Appliances Claim Form (MC-9), and Medical Supplies and Equipment Claim Form (MC-11) submitted for reimbursement for vision care and hearing services provided.

B. Dental Services

Dental providers will be required to attach a copy of the EPSDT Dental Referral Report (MC-19D) to each Dental Services Claim Form (MC-10) submitted for reimbursement.

3. Hospital Services, Acute Care and Special Hospitals

Reimbursement for in-patient hospital stays, will be limited to payment for the first 12 days per admission, including those days covered completely or partially by any third party liability for all Medicaid eligibles. Reimbursement will not be made for any hospital stay when the date of readmission immediately follows the date of discharge of the previous admission. Exception: Prior authorization will be required for all hospital stays in excess of 12 days in Class B Special Hospitals.

Reimbursement for out-patient hospital visits, including out-patient clinics, out-patient pharmacy, or emergency room services, will be limited to one visit per month, per recipient, regardless of the type of visit, and to 50% of the lower of costs or charges.

4. Transportation Services

A co-payment will be required from each Medicaid recipient for each ambulance and invalid coach transportation service provided according to the following schedule:

TRANSPORTATION CO-PAYMENT SCHEDULE

<u>MEDICAID PAYMENT FOR THE SERVICE</u>	<u>CO-PAYMENT DUE FROM THE RECIPIENT</u>
\$10.99 or less	\$.50
\$11.00 to \$25.99	1.00
\$26.00 to \$50.99	2.00
\$51 or more	3.00

Collection of the co-payment will be mandatory. Failure to collect the co-payment will result in a retroactive reduction in payment by an amount equivalent to the co-payment or portion there-of, whichever is applicable. The co-payment will automatically be deducted from each transportation claim when the claim is processed for payment. Co-payment will be required for all services rendered on and after February 10, 1981.

Any service affected by these proposed reductions which is prior authorized in December, 1980, or January, 1981 must be completed and/or dispensed by February 9, 1981. Services provided on or after February 10, 1981 will be declined for payment.

Reimbursement for services previously authorized for periods extending beyond February 9, 1981, will be limited to services provided on or before February 9, 1981.

All requests for prior authorization, received after February 9, 1981, for a service which will be discontinued will be declined.

Exception: Requests for prior authorization of eliminated or reduced services received after February 10, 1981 when the services were rendered prior to February 10, 1981, but had been submitted to a third party payor (Medicare, other insurance company, etc.,) are to be considered for authorization.

Questions about these proposed reductions should be referred to the Local Medicaid Office servicing your area.



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

New Jersey Health Services Program **NEWSLETTER**

Volume P-295

April 20, 1981

TO: ALL DENTISTS AND INDEPENDENT CLINICS

SUBJECT: CHANGE IN FEE SCHEDULE FOR COMPREHENSIVE ORTHODONTIC TREATMENT
 AND CHANGE OF ADDRESS

EFFECTIVE: For Services authorized on or after May 1, 1981

BACKGROUND

The New Jersey Medicaid Program has revised the fee schedule for comprehensive orthodontic treatment. The revised fee schedule shifts a larger proportion of the total payment to the early stages of the treatment program. This applies only to those cases authorized on or after May 1, 1981. The overall reimbursement for the total treatment program remains unchanged.

ACTION

Dentists should continue to use the appropriate procedure codes to bill for comprehensive orthodontic treatment. Cases authorized on or after May 1, 1981 will be reimbursed under the revised fee schedule. Cases authorized prior to May 1, 1981 will continue to be reimbursed according to the current fee schedule.

Reimbursement is based on one or more visits to the orthodontist during any calendar month for which the monthly fee is requested. The procedure codes, narrative, current and revised fee schedule are outlined below:

<u>Code</u>	<u>Narrative</u>	<u>Current Schedule</u>	<u>Revised Schedule</u>
8410	Appliances	126.00	162.00
8420	First through 12th month of treatment (to start on day insertion of appliance(s) is completed), per month	28.00	30.00
8420	13th through 24th month of treatment, per month	28.00	28.00
8440	25th through 30th month of treatment, per month	21.00	11.00
8450	31st through 36th month (maximum of treatment), per month	11.00	11.00

Please carefully review the changes outlined. This Newsletter should be filed with your Dental Services Manual for future reference.

The mailing address for the Bureau of Dental Services has been changed and should reflect the newly assigned "CN-713", replacing the present Post Office Box Number. The new address is as follows:

Division of Medical Assistance
and Health Services
Bureau of Dental Services
CN-713
Trenton, New Jersey 08625

This address is used for requests for prior authorization from out-of-state providers, orthodontists and all correspondence directed to the Chief, Bureau of Dental Services.

If you have any questions regarding these changes contact Archie H. Béll, D.D.S., Chief, Bureau of Dental Services, telephone (609) 292-7420.



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

New Jersey Health Services Program **NEWSLETTER**

VolumeP-295...(Correction)

May 26, 1981

TO: ALL DENTISTS AND INDEPENDENT CLINICS

SUBJECT: CHANGE IN FEE SCHEDULE FOR COMPREHENSIVE ORTHODONTIC TREATMENT AND CHANGE OF ADDRESS

Effective: For services authorized on or after May 1, 1981

BACKGROUND

The New Jersey Medicaid Program has revised the fee schedule for comprehensive orthodontic treatment. The revised fee schedule shifts a larger proportion of the total payment to the early stages of the treatment program. This applies only to those cases authorized on or after May 1, 1981. The overall reimbursement for the total treatment program remains unchanged.

ACTION

Dentists should continue to use the appropriate procedure codes to bill for comprehensive orthodontic treatment. Cases authorized on or after May 1, 1981 will be reimbursed under the revised fee schedule. Cases authorized prior to May 1, 1981 will continue to be reimbursed according to the current fee schedule.

Reimbursement is based on one or more visits to the orthodontist during any calendar month for which the monthly fee is requested. The procedure codes, narrative, current and revised fee schedule are outlined below:

<u>Code</u>	<u>Narrative</u>	<u>Current Schedule</u>	<u>Revised Schedule</u>
8410	Appliances	126.00	162.00
8420	First through 12th month of treatment (to start on day insertion of appliance(s) is completed), per month	28.00	30.00
(8430)	13th through 24th month of treatment, per month	28.00	28.00
8440	25th through 30th month of treatment, per month	21.00	11.00
8450	31st through 36th month (maximum of treatment), per month	11.00	11.00

Please carefully review the changes outlined. This Newsletter should be filed with your Dental Services Manual for future reference.

Over...

The mailing address for the Bureau of Dental Services has been changed and should reflect the newly assigned "CN-713," replacing the present Post Office Box number. The new address is as follows:

Division of Medical Assistance
and Health Services
Bureau of Dental Services
CN-713
Trenton, New Jersey 08625

This address is used for requests for prior authorization from out-of-state providers, orthodontists and all correspondence directed to the Chief, Bureau of Dental Services.

If you have any questions regarding these changes contact Archie H. Bell, D.D.S., Chief, Bureau of Dental Services, telephone (609) 292-7420.



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

New Jersey Health Services Program NEWSLETTER

Volume P-300

TO: ALL PROVIDERS LOCATED IN ESSEX COUNTY

IMPORTANT NOTICE!!

The New Jersey Medicaid Program has been advised by the Essex County Welfare Agency that effective the month of June, 1981 the Medicaid ID (identification) will be in a format different from the check stubs previously used by that agency. A sample of the new format used by the Essex County Welfare Agency is shown:

DEPARTMENT OF HUMAN SERVICES MEDICAID-ID			
VALID ONLY FOR THE MONTH OF MEDICAID HSP #		NOTICE TO PROVIDER	
ELIGIBLE PERSONS	PER #	ELIGIBLE PERSONS	PER #
1	11		
2	12		
3	13		
4	14		
5	15		
6	16		
7	17		
8	18		
9	19		
10	20		

VOID

REQUEST PERSONAL IDENTIFICATION IF YOU DO NOT KNOW THE PATIENT.

PLEASE REPORT THE CASE NAME, CASE NUMBER, AND PERSON NUMBER ACCURATELY ON ALL CLAIM FORMS AND OTHER COMMUNICATIONS RELATING TO THE CLAIM.

There will be no change to the current method used by the Essex County Welfare Agency of cycling the receipt of the assistance checks on the first, third, and fifth of each calendar month.

If you have any questions regarding this Newsletter, contact the Essex County Welfare Office, (201)733-3000.



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

New Jersey Health Services Program NEWSLETTER

Volume P-303

TO: DENTISTS JUNE 22, 1981

SUBJECT: DENTAL SERVICES FOR LONG-TERM CARE FACILITY (LTCF) PATIENTS

1. REIMBURSEMENT REQUIREMENTS
2. DOCUMENTATION REQUIREMENTS

EFFECTIVE: AUGUST 1, 1981

BACKGROUND

The New Jersey Medicaid Program requires all long-term care facilities to assist patients in obtaining necessary dental services. The purpose of this Newsletter is to clarify the Program's reimbursement policy and outline the revised documentation requirements regarding dental services for long-term care facility patients.

REIMBURSEMENT REQUIREMENTS FOR DENTAL ADMISSION EXAMINATIONS

When examining a long-term care facility patient, the dentist who wishes to receive Medicaid reimbursement must fulfill the requirements set forth by the New Jersey Medicaid Program. These requirements are listed below:

1. The dentist who examines the patient must provide the treatment necessary unless the examination indicates that a specialist is needed.
2. The examination must be a comprehensive and thorough inspection of the oral cavity.
3. The dentist must chart existing conditions in the mouth, marking all abnormalities (cavities, missing teeth, etc.).
4. The dentist must develop and record on the Medicaid Dental Services Claim (form MC-10) a complete treatment plan (Item #15) including a diagnosis where necessary (Item #16). If no treatment is indicated, this fact must be noted in the diagnosis box (Item #16) of the Form MC-10.
5. Either at the time of examination or at the completion of treatment, it is mandatory that the dentist establish a time frame for the next periodic examination. The time frame entered on the clinical record may be for six months, one year, two years, three years, or any other time period that the attending dentist has established per his knowledge of the patient.
6. The dentist must complete all other appropriate items on the Form MC-10.

The New Jersey Medicaid Program will not process for payment any Dental Services Claims (form MC-10) submitted for patients listed as "uncooperative" whom the dentist is unable to completely examine.

REQUIRED DOCUMENTATION

The regulations of the New Jersey Medicaid Program, as well as those of New Jersey State Department of Health, require a dentist to document the patient's dental status/treatment in the clinical record at the Long-Term Care Facility regardless of the place of service. A dentist must also maintain his office records as outlined in section 202.7 of the Medicaid Dental Services Manual.

The required information to be documented on the patient's clinical record at the long-term care facility consists of:

1. An admission record of the patient's dental status. If a current examination is required within six (6) months of a previous examination performed by the same provider and billed to Medicaid, the results of the original examination should be entered into the clinical record as the current dental status.
2. A record of the dental care provided at each visit. A photocopy of the completed and signed Medicaid Dental Services Claim (form MC-10) will be accepted in lieu of a separate entry in the records for examination and/or treatment. If individual treatments preceded or followed the "dates of service" entered on the Form MC-10, they must be listed separately on the patient's clinical record.
3. The time frame established by the dentist for the next periodic examination.

Please carefully review this Newsletter and insert it in your Medicaid provider manual for future reference.

If you have any questions, please contact Archie H. Bell, D.D.S., Chief, Bureau of Dental Services, Division of Medical Assistance and Health Services, telephone (609) 292-7420.



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

New Jersey Health Services Program NEWSLETTER

VolumeP-305.....

TO: ALL PROVIDERS LOCATED IN HUDSON COUNTY

June 29, 1981

IMPORTANT NOTICE !!

The New Jersey Medicaid Program has been advised by the Hudson County Welfare Agency that effective the month of July 1981 the Medicaid ID (identification) will be in a format different from the check stubs previously used by that agency. A sample of the new format used by the Hudson County Welfare Agency is shown:

STUB NO. 18012419

DEPARTMENT OF HUMAN SERVICES
 MEDICAID ID

VALID ONLY FOR THE MONTH OF _____ MEDICAID HSP # _____

NOTICE TO PROVIDER

ELIGIBLE PERSONS		PER #	ELIGIBLE PERSONS		PER #
1		11			
2		12			
3		13			
4		14			
5		15			
6		16			
7		17			
8		18			
9		19			
10		20			

REQUEST PERSONAL IDENTIFICATION IF YOU DO NOT KNOW THE PATIENT.

PLEASE REPORT THE CASE NAME, CASE NUMBER, AND PERSON NUMBER ACCURATELY ON ALL CLAIM FORMS AND OTHER COMMUNICATIONS RELATING TO THE CLAIM.

FD-152

If you have any questions regarding this Newsletter, contact the Hudson County Welfare Office, (201) 420-3000.



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

New Jersey Health Services Program NEWSLETTER

Volume P-309

September 1, 1981

TO: All Providers
SUBJECT: Medicaid Program Provider Suspensions
EFFECTIVE: October 1, 1981

This Newsletter is to inform all providers of a clarification of existing Federal and State regulations regarding suspensions, debarments and disqualifications from Medicaid Program participation.

Any individual, including but not limited to owners, officers, administrators, assistant administrators, employees, accountants, attorneys, and management services who have been suspended, debarred or disqualified from Medicaid Program participation for any reason shall not be involved in any activity relating to the New Jersey Medicaid Program.

Providers reimbursed on a cost-related basis may not claim as allowable costs any amounts paid or credited to such individuals, and such amounts shall not be reimbursed by the Medicaid Program.

Providers reimbursed on a fee-for-service basis may not submit claims and shall not be reimbursed for any goods supplied or services rendered by such individuals.

The above policy will apply only for the period during which such individuals are suspended, debarred or disqualified from Medicaid participation.

If you have any questions regarding this Newsletter, contact Leon Bartol, Chief, Bureau of Administrative Control at (609) 292-7155.



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

New Jersey Health Services Program NEWSLETTER

Volume P-310

September 7, 1981

TO: All Providers

EFFECTIVE: September 10, 1981

SUBJECT: I. Medical and Health Care Record Documentation
II. Prescribing Specific Laboratory Test

The New Jersey Medicaid Program has amended the New Jersey Administrative Code in Chapter 49, Administration; Chapter 54, Physicians Services; and Chapter 61, Independent Laboratories.

I. Medical and Health Care Record Documentation

- a. Chapter 49, Administration: requires the provider's health care records to both adequately and legibly document all required elements of the procedure described and the procedure code utilized by the billing provider, as specified in the Provider Manual. The provider agrees to keep legible records as are necessary to disclose fully the extent of services provided, as well as the medical necessity for those services, and to furnish information for such services as the program may request. The provider agrees that where such records do not legibly document the extent of services billed, as well as the medical necessity of services billed, payment adjustments will be necessary.
- b. Chapter 54, Physicians Services: requires physicians to legibly document in the individual records the kind and extent of services provided, as well as the medical necessity for those services.

II. Prescribing Specific Laboratory Test

Chapter 61, Independent Laboratories: requires that all requests for laboratory services include specific test requested in addition to personal signature of attending physician requesting services. This order is to be kept on file with the billing laboratory and available for review by Medicaid representatives along with the test results.



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

New Jersey Health Services Program NEWSLETTER

Volume P-316

September 17, 1981

TO: ALL PROVIDERS LOCATED IN ESSEX COUNTY

SUBJECT: DISTRIBUTION OF MEDICAID - ID

The New Jersey Health Services Program (Medicaid) has been advised by the Essex County Welfare Agency that effective October 1, 1981, the schedule is updated for alternating delivery of checks for recipients of Assistance to Families with Dependent Children so that they will be received on the FIRST, THIRD AND FIFTH calendar days of each month.

As you know, the MEDICAID - ID is attached to the Assistance check, which means that some recipients do not receive their Medicaid - ID until the THIRD, and still others will not receive it until the FIFTH of the month. Also, please note that the Medicaid ID will be one of four colors: gray, yellow, green or pink.

Recipients with the following Health Services Program Case Numbers will receive their Medicaid Validations on the FIRST of the month:

	Color of Medicaid ID
0730000001 thru 0730008499	-
0730021500 thru 0730036999	- gray
0730068700 thru 0730080999	- yellow
0730099500 thru 0730106399	- green
	- pink

Recipients with the following Health Services Program Case Numbers will receive their Medicaid Validations on the THIRD of the month:

0730008500 thru 0730015599	-
0730037000 thru 0730054499	- gray
0730081000 thru 0730091299	- yellow
0730106400 thru 0730113299	- green
	- pink

Recipients with the following Health Services Program Case Numbers will receive their Medicaid Validations on the FIFTH of the month:

0730015600 thru 0730021499	-
0730054500 thru 0730068699	- gray
0730091300 thru 0730099499	- yellow
0730113300 and 0730-UP	- green
	- pink

For the time frame from the last day of one month to the THIRD or FIFTH day of the subsequent month, Providers will have to verify eligibility by contacting the Essex County Welfare Agency since the recipient will not have in his/her possession a Medicaid Validation Stub.

DO NOT CONTACT THE LOCAL MEDICAL ASSISTANCE UNIT FOR ELIGIBILITY VERIFICATION, AS THEY DO NOT HAVE THE INFORMATION ON THESE CASES.

New Jersey Medicaid has appreciated your cooperation in the use of this system.

Please discard New Jersey Health Services Program Newsletter BC-148 or P-245, depending on which version you received, dated May 29, 1979.



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

New Jersey Health Services Program NEWSLETTER

Volume P-321

November 23, 1981

- TO: Pharmacy Providers, Hospital Administrators, Physicians, Dentists, Podiatrists, and Independent Clinics
- SUBJECT: Drug Products and Known Related Drug Products that Lack Substantial Evidence of Effectiveness
- EFFECTIVE: For Subject Drugs Dispensed on or after December 3, 1981
- ACTION: As of December 3, 1981, the Division of Medical Assistance and Health Services will cease reimbursement for all drugs that the Federal Food and Drug Administration (FDA) has proposed to withdraw from the market.

This applies to the Medicaid and General Assistance Programs. The PAA Program is not affected at this time.

The attached list of drugs represents those products that were known to the Division of Medical Assistance and Health Services and the Health Care Financing Administration (HCFA) at the time of printing. However, Section 2103 of the Omnibus Reconciliation Act requires this action for all identical, related, or similar drugs. Some brands of the subject drugs do not appear on the list nor do all manufacturers or distributors of the products.

It is the provider's responsibility to monitor his/her inventory carefully, to avoid submitting claims for the drugs no longer reimbursable. Use the "Active Ingredients" portion of the list to make your determinations regarding drugs which do not appear on the list.

Please note that compounded prescriptions containing combinations of ingredients the same as, related to, or similar to the formulations in the non-reimbursable list will require PRIOR AUTHORIZATION from the Local Medical Assistance Unit (LMAU), obtained by the PRESCRIBER, before claims may be submitted.

Enclosed is a notice for Pharmacy Providers to display for recipient information, which should be prominently displayed in all participating pharmacies.

Any inquiry regarding this Newsletter should be directed to Bureau of Pharmacy Services, Division of Medical Assistance and Health Services. Telephone (609) 292-3756.

DRUG EFFICACY STUDY IMPLEMENTATION (DESI)
 DESI DRUG PRODUCTS AND KNOWN RELATED DRUG PRODUCTS THAT LACK SUBSTANTIAL
 EVIDENCE OF EFFECTIVENESS

<u>Trade Name</u>	<u>Active Ingredient</u>	<u>Dosage Form/Route</u>	<u>Firm</u>	<u>Remarks</u>
Adrenosem Salicylate	Carbazochrome Salicylate	Tab/Oral Sol/IM	Beecham Labs	
Alevaire	Tyloxapol	Sol/Inh	Breon Winthrop	
Amesec	Aminophylline Amobarbital Ephedrine Hydrochloride	ECT/Oral Cap/Oral	Lilly	
Aminophylline & Amytal	Aminophylline Amobarbital	Cap/Oral	Lilly	
Amphocortrin	Calcium Amphomycin Hydrocortisone Acetate Neomycin Sulfate	Crm/Top	Warner-Lambert Co./ Warner-Chilcott	
Ananase	Bromelains	ETC/Oral	Rorer	
Antora-B.T.D	Pentaerythritol Tetranitrate Secobarbital	Cap/Oral	Mayrand	
Arlidin	Nylidrin Hydrochloride	Tab/Oral	USV	
Avazyme	Chymotrypsin	ECT/Oral	Wallace	
Azo Gantanol	Phenazopyridine Hydrochloride Sulfamethoxazole	Tab/Oral	Roche	
Bentyl/Phenobarbital	Dicyclomine Hydrochloride Phenobarbital	Cap/Oral Tab/Oral	Merrell Dow Pharmaceuticals	NOOH does not apply to syrup
Betadine Vaginal Gel	Povidone-Iodine	Gel/Vag	Purdue Frederick	

<u>Trade Name</u>	<u>Active Ingredient</u>	<u>Dosage Form/Route</u>	<u>Firm</u>	<u>Remarks</u>
Brophed	Ephedrine Sulfate Hydroxyzine Hydrochloride Theophylline	Tab/Oral	Cord	
Butazolidin Alka	Aluminum Hydroxide Magnesium Trisilicate Phenylbutazone	Cap/Oral	Geigy	
Cantil w/Phenobarbital	Mepenzolate Bromide Phenobarbital	Tab/Oral	Merrell Dow Pharmaceuticals	
Caldecort	Calcium Undecylenate Hydrocortisone Acetate	Ont/Top	Pennwalt	
Caldecort	Calcium Undecylenate Hydrocortisone Acetate Neomycin Sulfate	Ont/Top	Pennwalt	
Carbrital	Carbromal Sodium Pentobarbital	Cap/Oral Elx/Oral	Warner-Lambert Co./ Parke-Davis	
Cartrax	Hydroxyzine Hydrochloride Pentaerythritol Tetranitrate	Tab/Oral	Roerig	
Celestone w/ Neomycin	Betamethasone Neomycin Sulfate	Crm/Top	Schering	
Cetacaine	Benzocaine Tetracaine Hydrochloride	AER/Top Ont/Top Gel/Top Liq/Top	Cetylite	
Chymoral	Chymotrypsin Trypsin	ECT/Oral	Armour Pharm	
Combid	Isopropamide Iodide Prochlorperazine Maleate	SRC/Oral	SKF	
Car-Tar-Quin	Coal Tar Solution Diiodohydroxyquin Hydrocortisone	Crm/Top Lot/Top	Dome	

<u>Trade Name</u>	<u>Active Ingredient</u>	<u>Dosage Form/Route</u>	<u>Firm</u>	<u>Remarks</u>
Cordran-N	Flurandrenolide Neomycin Sulfate	Ont/Top Crm/Top Lot/Top	Lilly	
Corovas	Pentaerythritol Tetranitrate Secobarbital	SRC/Oral	Amfre-Grant	
Cortisporin	Gramicidin Hydrocortisone Neomycin Sulfate Polymyxin B Sulfate	Crm/Top	Burroughs-Wellcome	
Cortomycin	Hydrocortisone Neomycin Sulfate	Ont/Top	Bryant Pharmaceutical	
Cyclospasmol	Cyclandelate	Tab/Oral Cap/Oral	Ives	
Dainite	Aminophylline Benzocaine Dried Aluminum Hydroxide Gel Ephedrine Hydrochloride Phenobarbital	Tab/Oral	Wallace	
Dainite-KI	Aminophylline Benzocaine Dried Aluminum Hydroxide Gel Ephedrine Hydrochloride Phenobarbital Potassium Iodide	Tab/Oral	Wallace	
Daricon PB	Oxyphencylimine Hydrochloride Phenobarbital	Tab/Oral	Beecham Labs	
Deaner	Deanol Acetamidobenzoate	Tab/Oral	Riker	
Deprol	Benactyzine Hydrochloride Meprobamate	Tab/Oral	Wallace	

<u>Trade Name</u>	<u>Active Ingredient</u>	<u>Dosage Form/Route</u>	<u>Firm</u>	<u>Remarks</u>
Di-Ademil-K	Hydroflumethiazide Potassium Chloride	Tab/Oral	Squibb	
Dibenzyline	Phenoxybenzamine Hydrochloride	Cap/Oral	SKF	NOOH does not apply to "pheochromocytoma" indication
Diutensen	Methyclothiazide Cryptenamine Tannates	Tab/Oral	Wallace	
Donnatal Extentabs	Atropine Sulfate Hyoscine Hydrobromide Hyoscyamine Sulfate Phenobarbital	SRT/Oral	Robins	NOOH applies only to controlled release product
Equagesic	Aspirin Meprobamate Ethoheptazine Citrate	Tab/Oral	Wyeth	
Equanitrates	Meprobamate Pentaerythritol Tetranitrate	Tab/Oral	Wyeth	
Erythrocin	Erythromycin	Ont/Top	Abbott	
Erythromycin	Erythromycin	Ont/Top	Upjohn	
Florinef	Fludrocortisone Acetate Gramicidin Neomycin Sulfate	Lot/Top	Squibb	
Hydrocortisone-Neomycin	Hydrocortisone Acetate Neomycin Sulfate	Crm/Top	Byk-Gulden	
Hydromet	Hydrocortisone Neomycin Sulfate	Lot/Top	Merck Sharp & Dohme	

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<u>Trade Name</u>	<u>Active Ingredient</u>	<u>Dosage Form/Route</u>	<u>Firm</u>	<u>Remarks</u>
Ilotycin No. 90	Erythromycin	Ont/Top	Lilly	
Iodochlorhydroxyquin w/ Hydrocortisone	Hydrocortisone Iodochlorhydroxyquin	Crn/Top	Byk-Gulden	
Isordil w/Phenobarbital	Isosorbide Dinitrate Phenobarbital	Tab/Oral	Ives	
Isoxsuprine HCL	Isoxsuprine Hydrochloride	Tab/Oral	Cord Premo	
Librax	Chlordiazepoxide Hydrochloride Clidinium Bromide	Cap/Oral	Roche	
Lufyllin-EPG	Dyphline Ephedrine Hydrochloride Guaifenesin Phenobarbital	Tab/Oral Elx/Oral	Wallace	
Luftodil	Ephedrine Hydrochloride Guaifenesin Phenobarbital Theophylline	Tab/Oral	Wallace	
Kenalog-S	Gramicidin Neomycin Sulfate Triamcinolone Acetonide	Ont/Top Crn/Top Lot/Top	Squibb	
Marax	Theophylline Ephedrine Sulfate Hydroxyzine Hydrochloride	Tab/Oral Syr/Oral	Roerig	Includes Marax-DF
Mepergan Fortis	Meperidine Hydrochloride Promethazine Hydrochloride	Cap/Oral	Wyeth	
Meti-Derm w/Neomycin	Neomycin Sulfate Prednisolone	Ont/Top Aer/Top	Schering	

<u>Trade Name</u>	<u>Active Ingredient</u>	<u>Dosage Form/Route</u>	<u>Firm</u>	<u>Remarks</u>
Midrin	Acetaminophen Dichloralphenazone Isometheptene	Cap/Oral	Reed & Carnrick	
Migral	Caffeine Cyclizine Hydrochloride Ergotamine Tartrate	Tab/Oral	Burroughs Wellcome	
Milpath	Meprobamate Tridihexethyl Chloride	Tab/Oral	Wallace	
Miltrate	Meprobamate Pentaerythritol Tetranitrate	Tab/Oral	Wallace	
Myco Triacet	Gramicidin Neomycin Sulfate Nystatin Triamcinolone Acetonide	Ont/Top	Premo	
Mycolog	Gramicidin Neomycin Sulfate Nystatin Triamcinolone Acetonide	Ont/Top Crm/Top	Squibb	
Myconef	Fludrocortisone Acetate Gramicidin Neomycin Sulfate Nystatin	Ont/Top	Squibb	
Naturetin w/K	Bendroflumethiazide Potassium Chloride	Tab/Oral	Squibb	
Neo-Aristocort	Neomycin Sulfate Triamcinolone Acetonide	Crm/Top Ont/Top	Lederle	
Neo-Aristoderm	Neomycin Sulfate Triamcinolone Acetonide	Aer/Top	Lederle	
Neo-Cort-Dome	Hydrocortisone Neomycin Sulfate	Lot/Top Crm/Top	Dome	

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<u>Trade Name</u>	<u>Active Ingredient</u>	<u>Dosage Form/Route</u>	<u>Firm</u>	<u>Remarks</u>
Neo-Cortef	Hydrocortisone Acetate Neomycin Sulfate	Ont/Top Lot/Top Crm/Top	Upjohn	
Neo-Decadron	Dexamethasone Sodium Neomycin Sulfate	Crm/Top	Merck Sharp & Dohme	
Neo-Decaspray	Dexamethasone Neomycin Sulfate	Aer/Top	Merck Sharp & Dohme	
Neo-Delta-Cortef	Neomycin Sulfate Prednisolone Acetate	Ont/Top Lot/Top	Upjohn	
Neo-Diloderm	Dichlorisone Neomycin Sulfate	Crm/Top	Schering	
Neo-Domeform-HC	Hydrocortisone Iodochlorhydroxyquin Neomycin Sulfate	Crm/Top	Dome	
Neo-Hydeltrasol	Neomycin Sulfate Prednisolone Sodium Phosphate	Lot/Top Ont/Top	Merck Sharp & Dohme	
Neo-Hytone	Hydrocortisone Neomycin Sulfate	Crm/Top	Dermik Labs	
Neo-Magnacort	Hydrocortamate Hydrochloride Neomycin Sulfate	Ont/Top	Pfizer	
Neo-Medrol Acetate	Methylprednisolone Acetate Neomycin Sulfate	Crm/Top	Upjohn	
Neo-Nysta-Cort	Hydrocortisone Neomycin Sulfate Nystatin	Ont/Top	Dome	
Neo-Oxylone	Fluorometholone Neomycin Sulfate	Ont/Top	Upjohn	

<u>Trade Name</u>	<u>Active Ingredient</u>	<u>Dosage Form/Route</u>	<u>Firm</u>	<u>Remarks</u>
Neo-Resulin-F	Hydrocortisone Neomycin Sulfate Resorcinol Monoacetate Sulfur	Crm/Top	Schieffelin	
Neo-Synalar	Fluocinolone Acetonide Neomycin Sulfate	Crm/Top	Syntex	
Neo-Tarcortin	Coal Tar Extract Hydrocortisone Neomycin Sulfate	Ont/Top	Reed & Carnrick	
NeoDecadron	Dexamethasone Sodium Phosphate Neomycin Sulfate	Crm/Top	Merck Sharp & Dohme	
Neomycin Sulfate- Hydrocortamate Hydrochloride	Hydrocortamate Hydrochloride Neomycin Sulfate	Ont/Top	Ulmer Pharmacal	
Neomycin Sulfate- Hydrocortisone	Hydrocortisone Neomycin Sulfate	Ont/Top	Kasco-Efco Labs Byk-Gluden Premo Doak Pharmacal Ferndale Labs Clay-Park Labs	
Neomycin Sulfate- Hydrocortisone Acetate	Hydrocortisone Acetate Neomycin Sulfate	Ont/Top	American Pharmaceutical Biocraft Labs Ambix Labs	
Neosporin	Neomycin Sulfate Polymyxin B Sulfate	Lot/Top	Burroughs-Wellcome	
Neosporin-G	Gramicidin Neomycin Sulfate Polymyxin B Sulfate	Crm/Top	Burroughs-Wellcome	
Nycin-HC	Hydrocortisone Neomycin Sulfate	Ont/Top	Schlicksup Drug	
Nylidrin HCL	Nylidrin Hydrochloride	Tab/Oral	Cord	

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<u>Trade Name</u>	<u>Active Ingredient</u>	<u>Dosage Form/Route</u>	<u>Firm</u>	<u>Remarks</u>
Nysta-Cort	Hydrocortisone Nystatin	Lot/Top	Dome	
Nystaform-HC	Hydrocortisone Iodochlorhydroxyquin Nystatin	Ont/Top Lot/Top	Dome	
Nystatin-Neomycin Sulfate-Gramicidin- Triamcinolone Acetonide	Gramicidin Neomycin Sulfate Nystatin Triamcinolone Acetonide	Crm/Top	Premo Byk-Gluden	
Nystatin-Neomycin Sulfate-Gramicidin- Triamcinolone Acetonide	Gramicidin Neomycin Sulfate Nystatin Triamcinolone Acetonide	Ont/Top	Byk-Gluden Clay-Park	
Onycho-Phytex	Alcohol Boric Acid Salicylic Acid Tannic Acid	Sol/Top	Unimed	
Orenzyme	Trypsin Chymotrypsin	ECT/Oral	Merrell Dow Pharmaceuticals	
Oxalne M	Aluminum Hydroxide Gel Magnesium Hydroxide Oxethazaine	Sus/Oral	Wyeth	
Papase	Proteolytic Enzymes from Carica Papaya	Chewable Tab/ Oral or Bucc	Warner-Lambert Co./Parke-Davis	
Pathibamate	Meprobamate Tridihexethyl Chloride	Tab/Oral	Lederle	
Pathilon Sequels	Tridihexethyl Chloride	SRC/Oral	Lederle	NOOH does not apply to conventional dosage forms of Pathilon

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<u>Trade Name</u>	<u>Active Ingredient</u>	<u>Dosage Form/Route</u>	<u>Firm</u>	<u>Remarks</u>
Pathilon/Phenobarbital	Phenobarbital Tridihexethyl Chloride	Tab/oral SRC/Oral	Lederle	
Peritrate w/ Phenobarbital	Phenobarbital Pentaerythritol Tetranitrate	SRT/Oral Tab/Oral	Warner-Lambert Co/Parke-Davis	
Pentylentetrazol containing products				
Aminobrain-PT			Pan Americana	
Cenalene			Central	
Cenalene-M			Central	
D-Vasco			Dunhall	
Gevizol			Saron	
Halizol			Halsom	
Metrazol			Knoll	
Mivert			Misemer	
Nialene			Winston	
Nialex			Mallard	
Nico-Metrazol			Knoll	
Nicozol			Hyrex-K	
Nioric			B.F. Asher	
Pansol Forte			Pan American	
Panalate			Mayrand	
Pentylentetrazol			Chromalloy	
Pentylentetrazol & Niacin			Chromalloy	
Ru-Vert			Rucker	
Senilex			O'Neal	
Senilezol			Edwards	
Su-Ton Liquid			Rucker	
Su-Zol Liquid			Rucker	
T-Lex			Thera-Medic	
Tenaplex			Blaine	
Trela			O'Neal	
Vasotim			Dunhall	
Vertab			UAD	
Vita-Metrazol			Knoll	
Vital			Daniels	

<u>Trade Name</u>	<u>Active Ingredient</u>	<u>Dosage Form/Route</u>	<u>Firm</u>	<u>Remarks</u>
Potaba	Aminobenzoate Potassium	Tab/Oral Cap/Oral Pwr/Oral	Glenwood	
Priscoline	Tolazoline Hydrochloride	Sol/IM-IV-SC	Ciba	
Pro-Banthine/ Phenobarbital	Phenobarbital Propanthelline Bromide	Tab/Oral	Searle	
Propazine	Isopropamide Iodide Prochlorperazine	Cap/Oral	Cord	
Propion Gel	Propionate Calcium Propionate Sodium	Gel/Vag	Wyeth	
Quadrinal	Ephedrine Hydrochloride Phenobarbital Potassium Iodide Theophylline Calcium Salicylate	Tab/Oral Sus/Oral	Knoll	
Quibron Plus	Butabarbital Ephedrine Hydrochloride Guafenesin Theophylline	Cap/Oral Elx/Oral	Mead Johnson	
Racet	Hydrocortisone Iodochlorhydroxyquin	Crn/Top	Lemmon Parmacal	
Rautrax	Flumethiazide Potassium Chloride Rauwolfia Serpentina	Tab/Oral	Squibb	
Rautrax Improved	Hydroflumethiazide Potassium Chloride Rauwolfia Serpentina	Tab/Oral	Squibb	
Rautrax-N	Bendroflumethiazide Potassium Chloride Rauwolfia Serpentina	Tab/Oral	Squibb	

<u>Trade Name</u>	<u>Active Ingredient</u>	<u>Dosage Form/Route</u>	<u>Firm</u>	<u>Remarks</u>
Rautrax-N Modified	Bendroflumethiazide Potassium Chloride Rauwolfia Serpentina	Tab/Oral	Squibb	
Roniacol	Nicotinyl Alcohol Tartrate	Tab/Oral SRT/Oral	Roche	
	Nicotinyl Alcohol	Elx/Oral		
Ruhexatal Pb	Mannitol Hexanitate Phenobarbital	Tab/Oral	Lemmon	
Ruhexatal & Reserpine	Mannitol Hexanitate Reserpine	Tab/Oral	Lemmon	
Sterazolidin	Dried Aluminum Hydroxide Gel Magnesium Trisilicate Phenylbutazone Prednisone	Cap/Oral	Geigy	
Supertah H-C	Coal Tar Hydrocortisone	Ont/Top	Purdue Frederick	
Synalgos	Aspirin Caffeine Promethazine Hydrochloride	Cap/Oral	Ives	
Synalgos DC	Aspirin Caffeine Dihydrocodeine Bitartrate Promethazine Hydrochloride	Cap/Oral	Ives	
T.C.M.	Meprobamate Tridihexethylchloride	Tab/Oral	Zenith	
Terra-Cortril	Hydrocortisone Oxytetracycline Hydrochloride	Ont/Top	Pfizer	

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<u>Trade Name</u>	<u>Active Ingredient</u>	<u>Dosage Form/Route</u>	<u>Firm</u>	<u>Remarks</u>
Terra-Cortril	Hydrocortisone Oxytetracycline Hydrochloride Polymyxin B Sulfate	Aer/Top	Pfizer	
Tigan	Trimethobenzamide Hydrochloride	Cap/Oral Supp/Rectal	Beecham	NOOH does not apply to capsules in 200 mg or 400 mg strengths
Tri-Statin	Gramicidin Neomycin Sulfate Nystatin Triamcinolone Acetonide	Crm/Top	Clay-Park	
Trocinate	Thiphenamil Hydrochloride	Tab/Oral	Poythress	
Valpin PB	Anisotropine Methylbromide Phenobarbital	Tab/Oral	Endo	Includes Valpin 50PB
Vasocon-A	Antazoline phosphate Naphazoline Hydrochloride	Sol/Oph	Cooper	
Vasodilan	Isoxsuprine Hydrochloride	Tab/Oral Sol/IM	Mead Johnson	
Vioform-Hydrocortisone	Hydrocortisone Iodochlorhydroxyquin	Crm/Top Ont/Top Lot/Top	Ciba	
Vytone	Diiodohydroxyquin Hydrocortisone	Crm/Top	Dermik Labs	

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<u>Trade Name</u>	<u>Active Ingredient</u>	<u>Dosage Form/Route</u>	<u>Firm</u>	<u>Remarks</u>
Wyanoids HC	Belladonna Extract Bismuth Subcarbonate Bismuth Oxyiodide Boric Acid Ephedrine Sulfate Hydrocortisone Acetate Peruvian Balsam Zinc Oxide	Sup/Rtl	Wyeth	
Zactane	Ethoheptazine Citrate	Tab/Oral	Wyeth	
Zactirin	Aspirin Ethoheptazine Citrate	Tab/Oral	Wyeth	
Zactrin Compound 100	Aspirin Caffeine Ethoheptazine Phenacetin	Tab/Oral	Wyeth	
Ze-Tar-Quin	Coal Tar Diiodohydroxyquin Hydrocortisone	Crn/Top	Dermik Labs	
Zetone	Coal Tar Hydrocortisone	Crn/Top	Dermik Labs	

ABBREVIATIONS

Dosage Forms

Aer	Aerosol
Cap	Capsule
Crm	Cream
Dps	Drops
ECT	Enteric coated tablets
Elx	Elixir
Liq	Liquid
Lot	Lotion
Ont	Ointment
Pwr	Powder
Pwr Recon	Powder for reconstitution
SRC	Sustained release capsule
SRT	Sustained release tablet
Sol	Solution
Sup	Suppositories
Sus	Suspension
Syr	Syrup
Tab	Tablet

Routes of Administration

Bucc	Buccal
IM	Intramuscular
IV	Intravenous
Inh	Inhalation
Oph	Ophthalmic
Rtl	Rectal
SC	Subcutaneous
Top	Topical
Vag	Vaginal



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

New Jersey Health Services Program NEWSLETTER

Volume P-322

TO: Hospital Administrators DATE: November 30, 1981

SUBJECT: Outpatient Dental Services

EFFECTIVE: For claims processed on or after January 1, 1982

PURPOSE: To notify hospital administrators that facilities will now be reimbursed on a fee-for-service basis for dental care rendered in the outpatient hospital setting.

BACKGROUND: This change as proposed and adopted in the New Jersey Register, 1. will insure a uniform reimbursement policy for all segments of the dental provider community, 2. will incorporate all dental treatment rendered to Medicaid recipients in the outpatient department into the dental history profile maintained by the Medicaid Program, and 3. will permit application of the Tooth Allocation Map Inquiry (TAMI) and Replacement Denture (RD) Systems.

ACTION: 1. Effective January 1, 1982, all claims for dental services performed in hospital outpatient departments will be processed by the Prudential Insurance Company and will be reimbursed on a fee-for-service basis. These fees are determined by the Commissioner of the Department of Human Services and based on the same fees utilized for the reimbursement of community-based dentists. The only exception will be for emergency dental care provided under special circumstances in a Hospital Emergency Room (refer to item 7).

2. Hospitals must notify the Prudential Insurance Company within 30 days of the date of this Newsletter if they are a provider of outpatient dental care in order to receive reimbursement under the new regulations. This applies to all hospitals regardless of whether its usual hospital Contractor is Blue Cross or Prudential.

3. In order to insure proper reimbursement based on the specialty status of the dental practitioner performing the service, the hospital must include with this notification, the name and Individual Medicaid Practitioner (IMP) Numbers of all dentists providing services in their OPD. When an intern or resident performs the service, the IMP number of the staff dentist who directly supervises the intern or resident is to be used.

If any dentist providing services in the OPD does not have an IMP

number, he/she should send a letter to the Prudential Insurance Company, Provider Enrollment Unit, P.O. Box 1900, Millville, New Jersey 08332, requesting that an IMP Number be assigned and indicating the hospital where he/she is performing dental services. The dentist must include his/her Social Security Number in the letter of request. Any dental specialist, as defined in the attached Medicaid Dental Manual, must also have his/her specialty permit on file at Prudential if the hospital is to be reimbursed on a specialty basis.

4. Each hospital that notifies Prudential, as outlined above, will receive a supply of Dental Service Claims (form MC-10) with the Provider information preprinted. For OPD dental services only, the Hospital's Provider Number will now consist of a 12 digit number: three zeros, followed by the hospital 6 digit identification number, followed by either the letters "PRU" or "BLU" depending on which is the hospital's regular Contractor.

5. For claims processed on or after January 1, hospitals providing OPD dental care must submit only a Dental Services Claim (form MC-10) to Prudential Insurance Company, Medicaid Claims Division, P.O. Box 1900, Millville, New Jersey 08332. Instructions for proper completion of the MC-10 are contained in the attached Dental Manual. The Outpatient Hospital Claim (form MC-4) is no longer required except for emergencies (See item 7).

6. Hospitals will receive from Prudential, on a weekly basis, a statement and payment in the non-institutional format, which is one statement and check for every 32 claim line items submitted.

NOTE: If there is an extended course of treatment in progress which spans the effective date of this policy, the claim will be paid the full procedure code allowance (fee-for-service) on a one-time basis regardless of whether the hospital previously received partial reimbursement on a charge basis. This will be done only when the service is completed. Exception: Orthodontic Services

7. Emergency dental care performed in any hospital emergency room will be reimbursed based on charges. Emergency room charges will not be reimbursed if the dental clinic is open.

In order to receive payment based on charges for emergency services, the hospital must forward for review both a hard-copy Outpatient Hospital Claim (form MC-4), completed in the normal fashion, and a Dental Services Claim (form MC-10) to the Chief, Bureau of Dental Services, 324 East State Street, CN 713, Trenton, New Jersey 08625.

Following review, the MC-4 will be returned to the hospital. The hospital will then submit the MC-4 claim to its regular hospital Contractor (Blue Cross or Prudential) for payment. The Medicaid Bureau of Dental Services will forward the MC-10 containing the treatment information to the Prudential Insurance Company for data collection purposes.

If you have any questions regarding this Newsletter, please contact Archie H. Bell, D.D.S., Chief, Bureau of Dental Services, Division of Medical Assistance and Health Services, Telephone (609) 292-7420. After December 17, 1981, please use Telephone (609) 984-7863.



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

New Jersey Health Services Program

NEWSLETTER

Volume P-323.....

DATE: December 14, 1981

A T T E N T I O N !

TO: All Dentists and Independent Dental Clinics
SUBJECT: CURRENTLY VALID GENERAL ANESTHESIA PERMITS

A copy of a currently valid General Anesthesia permit issued on or after November 1, 1981, by the New Jersey State Board of Dentistry must be forwarded immediately by Certified Mail to:

Prudential Insurance Company of America
Medicaid Claims Division II
P.O. Box 1900
Millville, New Jersey 08332

Attn: Janet M. Sciuto, Associate Manager

The New Jersey State Board of Dentistry has informed the N.J. Medicaid Program of those dentists who have been permitted to administer General Anesthesia subsequent to November 1, 1981, and reimbursement for that service will continue on that basis until January 31, 1982.

Anyone who has not submitted a currently valid General Anesthesia permit and whose continued reimbursement had been based on information received from the N.J. State Board of Dentistry will be denied reimbursement for that service on or after February 1, 1982.

On or after February 1, 1982, reimbursement for General Anesthesia will be limited to those having a currently valid General Anesthesia permit on file with the Prudential Insurance Company.

Any questions regarding this Newsletter after December 17, 1981 should be directed to Archie H. Bell, D.D.S., Chief, Bureau of Dental Services, Telephone (609) 984-7863.

FOREWORD

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

The New Jersey Medicaid Program is administered by the Division of Medical Assistance and Health Services through its central office and through Local Medical Assistance Units located throughout the State of New Jersey.

Reimbursement for services provided under the Program is accomplished by third party payments, in conformity with Title XIX regulations. Payments are obtained through the Division's Bureau of Claims and Accounts or through either of its two Contractors, Hospital Service Plan of New Jersey (Blue Cross) and Prudential Insurance Company of America, depending upon the type of service being reimbursed.

This manual is designed for use by a provider who is billing for services furnished under the Program. It contains informational and procedural material needed to assist the provider to understand the rules and regulations of participation in the Program and to insure prompt and efficient payment of claims. The procedures described in this manual have been developed to achieve the goals of the Program with due consideration to the needs of the covered persons and to promote effective relationships with providers.

This manual has been written in accordance with Federal and State laws, rules and regulations and with the intent to assure that such laws, rules and regulations are uniformly applied.

As a supplement to this manual, a Newsletter system is utilized for the prompt dissemination of information concerning policy clarification and/or changes to the New Jersey Medicaid Program. Additionally, manual page revisions are updated as administrative changes occur. Periodically, therefore, revised sections, entire pages, and entire chapters will be issued accordingly. It is recommended that these Newsletters, Manual page revisions, etc., be filed with your manual at the time of receipt of such documents.

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100. WHO IS ELIGIBLE FOR MEDICAID

Medical and health services will be available to the following General Groups which are not all inclusive:

Persons who are eligible to receive Supplemental Security Income (SSI) payments as determined by the Social Security Administration. Such persons are the aged (65 and over), the blind and the disabled.

Persons who qualify under the Supplemental Security Income (SSI) Program as an "ineligible spouse" of an SSI recipient as determined by the Social Security Administration.

Persons who are eligible to receive financial assistance as determined by the County Welfare Agency. Such persons are: families with dependent children including children 18 through 21; families of the working poor; Cuban and Indo-Chinese Refugees.

Persons who meet the income standards of need applicable to their circumstances under one of the financial assistance programs referred to above but who are not receiving or do not apply for such cash assistance. Such persons are eligible for "Medicaid Only" under the New Jersey Medicaid Program.

Persons 65 years of age and over who do not meet eligibility standards of the categorically-related assistance programs, but whose medical needs qualify under the New Jersey State Medical Assistance to the Aged Program (MAA).

Children in foster care and under sponsorship of the Division of Youth and Family Services (DYFS).

Certain persons in State and County Psychiatric Hospitals and/or State Schools for Mental Retardation as determined eligible by the Department of Human Services.

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

100.1 Newborn Infant Eligibility

Although the mother of a newborn infant may be an eligible recipient on the date of delivery, the newborn infant is not immediately determined eligible. However, in order to expedite payment to practitioners and hospitals for in-hospital services rendered to newborns during the mother's confinement, allowance has been made to reimburse providers using the mother's Health Services Program Number and Patient Person Number. When the mother is discharged from the hospital, services to the newborn can no longer be claimed by the practitioner or hospital under the mother's Person Number, and an application on behalf of the newborn infant must be made by the recipient to the County Welfare Agency, which will assign a Person Number. It is the duty of the practitioner or the hospital to contact the County Welfare Agency to obtain the newborn's Person Number for billing purposes.

100.2 Assistance to Patients Possibly Eligible for Benefits

If a patient has not applied for benefits, is unable to pay for services rendered, and appears to meet the requirements for eligibility for the New Jersey Medicaid Program, the provider should encourage the patient or his representative to apply for benefits through the County Welfare Agency or Social Security Administration which will accept and process the application and notify the patient of the resulting determination.

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A patient receiving services prior to the notification of eligibility should be informed that he is considered responsible for all charges incurred until proof of eligibility is verified. Once eligibility is verified, the provider may not bill the patient for any portion of the costs of allowable services.

100.3 Retroactive Eligibility for Medicaid

Persons applying for Medicaid benefits will be asked if they have unpaid medical bills incurred within the three month period immediately prior to the month of application for Medicaid. Persons indicating that they do have such bills will complete an Application for Retroactive Medicaid Eligibility (FD-74) and will forward the application, all outstanding unpaid bills to the Medicaid Retroactive Eligibility Unit in Trenton. Applications for Retroactive Eligibility (FD-74) may be obtained by the applicant and/or his/her authorized agent from the County Welfare Agency, the Local Medical Assistance Unit or the Retroactive Eligibility Unit, Medicaid Central Office, Trenton.

If the New Jersey Medicaid Program determines that the person was eligible for Medicaid at the time the service/item was rendered, providers will be notified directly that the unpaid bills for any service/item covered by the New Jersey Medicaid Program will be reimbursable in accordance with standard Medicaid reimbursement procedures. The provider will then complete a regular Medicaid Claim form and submit it to the Retroactive Eligibility Unit for consideration and authorization of payment.

100.4 Benefits After Termination of Recipient Eligibility

It is in the best interest of the provider to review monthly the eligibility of patients receiving continuing services. There is no reimbursement for services performed after termination of eligibility other than by exceptional circumstances.

101. HOW TO IDENTIFY A COVERED PERSON

All eligible persons as described below have a Health Services Program (HSP) Number identified on their validation stub as well as a two-digit individual Person Number.

A HSP Number, as currently assigned, consists of twelve digits.

- A. The first two positions designate the agency under which the case is supervised, i.e., either the County Welfare Agency, the district office of the Division of Youth and Family Services (DYFS), or the Institutional Services code for State Bureau of Local Operations.

County Welfare Agencies:

01 - Atlantic	08 - Gloucester	15 - Ocean
02 - Bergen	09 - Hudson	16 - Passaic
03 - Burlington	10 - Hunterdon	17 - Salem
04 - Camden	11 - Mercer	18 - Somerset
05 - Cape May	12 - Middlesex	19 - Sussex
06 - Cumberland	13 - Monmouth	20 - Union
07 - Essex	14 - Morris	21 - Warren

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State Institutions:

31 - Greystone	42 - Totowa
32 - Trenton	44 - Woodbine
33 - Marlboro	45 - New Lisbon
34 - Ancora	46 - E. R. Johnstone Training Research Center
35 - N.J. Neuropsychiatric Institute	47 - Woodbridge
36 - Brisbane	48 - Hunterdon
41 - Vineland	90 - Special Residence

B. The next third and fourth digits designate the category under which a person is determined eligible for the New Jersey Medicaid Program.

10 - Old Age Assistance
20 - Disability Assistance
30 - Aid to Families with Dependent Children
50 - Blind Assistance
60 - Children in Foster Care
70 - Medical Assistance for Aged - A New Jersey State Program
80 - Refugee Program

C. The next six digits designate the sequential case number of the recipient.

D. The last two digits designate the specific numbers assigned to each individual within the case.

01 - 09	Adult (any age)
10 - 19	Essential Person (any age)
20 - 49	Children under 21

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GENERAL INFORMATION ABOUT THE PROGRAM

101.1 County Welfare Agency Identification. (Exhibit I)

SAMPLE

NOTICE TO CLIENT

THIS VALIDATION FORM INDICATES ELIGIBILITY FOR AUTHORIZED HEALTH SERVICES PROVIDED UNDER THE NEW JERSEY HEALTH SERVICES PROGRAM.

THIS VALIDATION MUST BE PRESENTED TO THE PROVIDER OF MEDICAL SERVICES ALONG WITH THE PLASTIC IDENTIFICATION CARD.

BURLINGTON COUNTY WELFARE BOARD
MOUNT HOLLY, N. J.

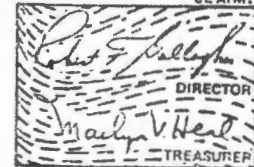
VALIDATION FOR HEALTH SERVICES PROGRAM
VALID ONLY FOR MONTH OF

DEC 1 1976

DOE 03 30 000000

01 JOHN 20 SUSAN 21 CAROL

SAMPLE



NOTICE TO PROVIDER OF MEDICAL SERVICES

THE CASE NUMBER AND NAME ON THIS FORM MUST BE COMPARED TO THAT SHOWN ON THE PLASTIC IDENTIFICATION CARD ISSUED TO THE BEARER.

THE CLAIM FOR PAYMENT OF HEALTH SERVICES IS TO BE SUBMITTED TO THE APPROPRIATE CONTRACTOR FOR THE STATE OF NEW JERSEY ON THE REQUIRED VENDOR CLAIM FORM.

PLEASE REPORT THE CASE NAME, CASE NUMBER, AND PERSON NUMBER ACCURATELY ON ALL CLAIM FORMS AND OTHER COMMUNICATIONS RELATING TO THE CLAIM.

This validation form is issued by the appropriate County Welfare Agency monthly to recipients of Aid to Families with Dependent Children and to eligible persons under the Cuban, Indo-Chinese Refugee, and "Medicaid Only" programs. The form indicates that the individual(s) is/are currently eligible for coverage for the month shown on the form. The validation form must be retained by the eligible person to whom it is issued.

NOTE: THIS FORM IS THE SOLE INDICATOR OF MEDICAID ELIGIBILITY FOR PERSONS LISTED ON THE FORM.

IMPORTANT: Be sure to enter the Name, Health Service Program Number, the Patient Person Number, EXACTLY AS IT APPEARS ON THE VALIDATION FORM ON ALL REQUESTS FOR AUTHORIZATION AND CLAIM FORMS.

CHAPTER I

GENERAL INFORMATION ABOUT THE PROGRAM

101.2 Division of Youth and Family Services Identification - (Exhibit II)

Child's No. Name Case No.

VALID ONLY FOR MONTH OF

PLACEMENT REFERENCE

STATE OF NEW JERSEY

DIVISION OF YOUTH AND FAMILY SERVICES

VALIDATION

FOR HEALTH SERVICES PROGRAM

DYFS 16-36
(rev. 3/73)

NOTICE TO CLIENT

THIS VALIDATION FORM INDICATES ELIGIBILITY FOR AUTHORIZED HEALTH SERVICES PROVIDED UNDER THE NEW JERSEY HEALTH SERVICES PROGRAM.

THIS VALIDATION MUST BE PRESENTED TO THE PROVIDER OF MEDICAL SERVICES ALONG WITH THE PLASTIC IDENTIFICATION CARD.

NOTICE TO PROVIDER OF MEDICAL SERVICES

THE CASE NUMBER AND NAME ON THIS FORM MUST BE COMPARED TO THAT SHOWN ON THE PLASTIC IDENTIFICATION CARD ISSUED TO THE BEARER.

THE CLAIM FOR PAYMENT OF HEALTH SERVICES IS TO BE SUBMITTED TO THE APPROPRIATE CONTRACTOR FOR THE STATE OF NEW JERSEY ON THE REQUIRED VENDOR CLAIM FORM.

PLEASE REPORT THE CASE NAME, CASE NUMBER AND PERSON NUMBER **ACCURATELY** ON ALL CLAIM FORMS AND OTHER COMMUNICATIONS RELATING TO THE CLAIM.

This validation form is issued by the Division of Youth and Family Services monthly to eligible children. This form indicates eligibility for covered health services during the month shown on the form itself.

The validation form must be retained by the person to whom it was issued.

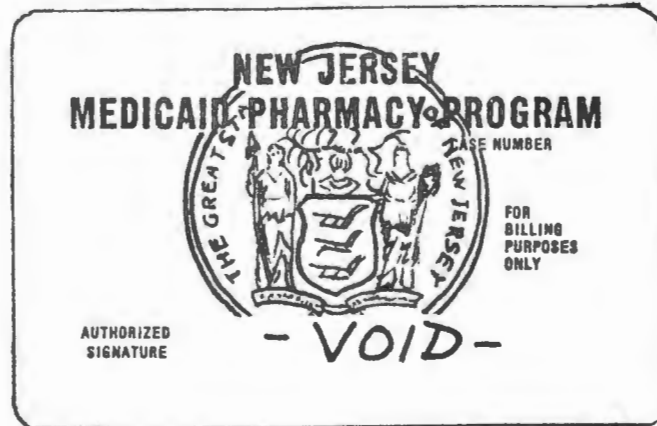
NOTE: THIS FORM IS THE SOLE INDICATOR FOR THIS GROUP OF CHILDREN.

IMPORTANT: Be sure to enter Name, Health Service Program Number, and Patient Person Number, EXACTLY AS IT APPEARS ON THE VALIDATION FORM ON ALL REQUESTS FOR AUTHORIZATION AND CLAIM FORMS.

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101.3 New Jersey Medicaid Pharmacy Program Plastic Card - (Exhibit III)



For purposes of facilitating Pharmacy Services billing, the Program issues a "New Jersey Medicaid Pharmacy Program Plastic Card". This is for billing purposes only and not for proof of eligibility.

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GENERAL INFORMATION ABOUT THE PROGRAM

101.4 Institution Population Identification - (Exhibit IV)

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

_____	_____	_____	_____	_____
Last Name	First Name	Mi	Health Services Program Case No.	Person Number

NOTICE TO PROVIDERS

This form identifies the person listed above as eligible for authorized services under the New Jersey Health Services Program (Medicaid).

This form also serves as a validation of eligibility for up to 31 days from date of issue. All policies and procedures specific in the appropriate New Jersey Health Services Program Provider Manual are to be followed by providers when rendering services to this person.

The signature, title and telephone number of an authorized representative of the State Institution listed below must be included to validate this form.

THIS FORM IS THE PROPERTY OF THE STATE OF NEW JERSEY AND MUST BE RETURNED WITH THE PATIENT.

Signature and Title of State
Institution Representative

Date of
Issue

Name of State Institution

Telephone No.

FD-34 Rev. 5/72

The validation form is prepared and completed by the authorized Medicaid representative at the State/County Institution following determination of eligibility by the Department of Human Services. It is valid for a period of up to 31 days from the date of issue to an eligible patient/resident in State/County Psychiatric Hospitals and Mental Retardation Institutions for use in obtaining Medicaid covered services outside of the institutional setting. The form must be returned with the patient.

This validation also requires the inclusion of the signature, title, and telephone number of the authorized representative at the institution.

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The resident or patient of State Institutions receiving covered health services in the community is identified as follows:

The eligible patient/resident has a twelve digit Health Service Program Number in which the first two digits identify the institution (not the County, as with other Medicaid recipients).

<u>The Psychiatric Hospitals:</u>	<u>2 Digit Code</u>	<u>The Schools for the Retarded:</u>	<u>2 Digit Code</u>
Greystone Park Psychiatric Hospital	31	Vineland State School	41
Trenton Psychiatric Hospital	32	N.J. Neuro-psychiatric Institute	35
Marlboro Psychiatric Hospital	33	North Jersey Training School Totowa	42
Ancora Psychiatric Hospital	34	Woodbine State School	44
Arthur Brisbane Child Center	36	E.R. Johnstone Training Research Center	45
		Woodbridge State School	47
		Hunterdon State School	48
		Special Residence	90

EXAMPLE: A disabled person from Greystone Park Psychiatric Hospital would have a Health Service Program Number as follows:

31 20 001234-01

All policies and procedures specified in the appropriate New Jersey Health Services Program Provider Manual are to be followed when rendering services to this group of eligibles.

Prior Authorization Procedure for Institution Population

Because of the elimination of the two-digit County identification number and substitution of the two-digit institutional identification number, the Medicaid Program has designated specific Local Medical Assistance Units (see List of LMAU's in Section 123) to handle the prior authorization requests for patients/residents from each institution and the Family Care residents under the Division of Mental Retardation. For example, a recipient with an identification number beginning with 31 would be a Greystone Park patient, and all necessary requests for prior authorization should be submitted to the Morris County Local Medical Assistance Unit. (Exception: DENTAL, PRIOR AUTHORIZATIONS ARE HANDLED DIFFERENTLY, SEE CHAPTER II OF THE DENTAL MANUAL.)

If Patient's HSP Number Begins With:

31
32
33
34
36
41
42
44

Contact:

Morris Local Medical Assistance Unit
Mercer Local Medical Assistance Unit
Monmouth Local Medical Assistance Unit
Camden Local Medical Assistance Unit
Monmouth Local Medical Assistance Unit
Cumberland Local Medical Assistance Unit
Passaic Local Medical Assistance Unit
Atlantic Local Medical Assistance Unit

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If Patient's HSP Number
Begins With: _____

Contact:

45
47
48
90

Burlington Local Medical Assistance Unit
Middlesex Local Medical Assistance Unit
Hunterdon Local Medical Assistance Unit
Ocean Local Medical Assistance Unit

101.5 Supplemental Security Income Identification - (See Exhibit V)

This card is issued after Supplemental Security Income (SSI) eligibility determination is made by the Social Security Administration. It is issued on a calendar quarterly basis to individuals (the Aged, Blind and the Disabled) determined to be eligible for Supplemental Security Income (SSI) which automatically qualifies the persons as eligible for Medicaid.

- A. This MEDICAID ELIGIBILITY IDENTIFICATION CARD (FD-73) is good for ONLY ONE PERSON.
- B. This CARD requires the eligible person's signature to be valid.
- C. This CARD includes, in addition to the eligible cardholder's address, his/her date of birth and Social Security Account Number.
- D. There is a message on the card instructing the provider to ask the cardholder if he/she has Medicare or other health insurance coverage. If the patient indicates there is other health insurance, the provider is to bill Medicaid only after receiving denial or partial payment from the other insurance carrier. If the patient has Medicare, following the billing instructions in this manual under COMBINATION MEDICARE/MEDICAID cases for submission of Medicare/Medicaid claims.

The Medicaid Eligibility Identification Card (FD-73) must be retained by the person to whom it is issued.

101.6 Temporary Identification and Validation Form - MAP-16 - (See Exhibit VI)

In certain circumstances the County Welfare Agency will issue a temporary identification and validation form. This form will identify the case as eligible for health services for 30 days from the date of issue. This may include the parts of two consecutive months.

EXHIBIT V

Front

1110002346 01
HSP CASE NO. PER NO.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES
MEDICAID ELIGIBILITY IDENTIFICATION



VALID: FROM: 10-1-76
TO: 12-31-76

PROVIDER: Ask cardholder if he or she has other health insurance or MEDICARE coverage.

(Please see other side)

SAMPLE

John Brown
19 Rose Street
Trenton, N.J.

4-23-18

DATE OF BIRTH

135-50-3097

SOCIAL SECURITY ACCOUNT NO.

John Brown

RECIPIENT'S SIGNATURE

Back

NOTICE TO CARDHOLDER:

Your immediate attention is required:

1. Sign your name on the face of this card.
2. If this card is lost, notify:
Hospital Service Plan of New Jersey
P. O. Box 528
Newark, N. J. 07102
3. If you move, notify your Local Social Security Office immediately.

LOANING OR OTHER ABUSE OF THIS CARD IS SUBJECT TO PROSECUTION UNDER THE LAW.

SAMPLE

NOTICE TO PROVIDERS:

The name which appears directly above the line for "Recipient's Signature" on this card is the MEDICAID eligible person. This card identifies ONLY that person as being eligible for MEDICAID benefits within the period shown. If another name appears on this card, that person is a "Representative Payee" and is not eligible for MEDICAID benefits. If cardholder indicates there is health insurance or MEDICARE coverage, you are to bill MEDICAID only AFTER receiving denial or partial payment from the other insurance company.

EXHIBIT VI

STATE OF NEW JERSEY
 DEPARTMENT OF HUMAN SERVICES
 DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
TEMPORARY IDENTIFICATION AND VALIDATION OF ELIGIBILITY

CURRENT CASE NO.			EFFECTIVE DATE		
CTY	PROG	NUMBER	MO	DAY	YR

1
2
3
4
5
6
7
8
9

LAST NAME	FIRST NAME	M.I.	BIRTH DATE		
			MO.	DAY	YR

SAMPLE

NOTICE TO PROVIDER OF HEALTH SERVICES:

This form, when signed by or on behalf of the person whose name is first listed, identifies the person(s) listed as eligible for payment for authorized health services under the New Jersey Health Services Program.

This form also serves as a temporary validation of eligibility for a period not exceeding 30 days from the effective date entered above.

The information appearing on this form should be used in completing the claim form to be submitted to the appropriate Contractor for the State of New Jersey.

NOTICE TO CLIENT:

This form must be signed on the line below marked "Signature" by or on behalf of the person whose name is first listed. This form must be presented to the provider of health services to prove eligibility for payment. DO NOT USE this form after receiving your plastic identification card and your monthly "Validation for Health Services".

Signature _____

Prepared By _____ Date _____
 Approved By _____ Date _____

GENERAL INFORMATION ABOUT THE PROGRAM

102. ELIGIBLE PROVIDERS

An eligible provider of services is any individual, partnership, association, corporation, institution or any other public or private entity designated below, meeting applicable requirements and standards for participation in the New Jersey Medicaid Program. Providers are required to complete a provider application form, to sign a Provider Participation Agreement (FD-62) or a specialized agreement, depending on the nature of the provider. See Exhibit VII at the end of this Section. Providers prior to 1973 were not required to utilize provider agreement forms.

Providers Eligible to Participate in the New Jersey Medicaid Program:

Medical and Surgical Supply Dealers;
Certified Independent Clinical Laboratories;
Dentists and/or Dental Groups;
Hearing Aid Dealers;
Home Health Agencies;
General Hospitals;
Special Hospitals;
Long Term Care Facilities (limited to skilled nursing and intermediate care facilities);
Opticians;
Optometrists;
Approved Clinics (Independent Outpatient Health Facilities);
Certified Orthotists;
Certified Prosthetists;
Pharmacies;
Physicians and/or Physician Groups;
Podiatrists and/or Podiatric Groups;
Psychologists and/or Psychology Groups;
Chiropractors and/or Chiropractic Groups;
Transportation Providers (limited to ambulance & invalid coach)

EXHIBIT VII



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

NEW JERSEY HEALTH SERVICES PROGRAM
TITLE XIX (MEDICAID)

PROVIDER AGREEMENT
BETWEEN
NEW JERSEY DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
AND

PROVIDER

PROVIDER AGREES:

1. To comply with all applicable State and Federal "Medicaid" laws and policy, and rules and regulations promulgated pursuant thereto;
2. To keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the Medicaid Program;
3. To furnish the Division of Medical Assistance and Health Services with such information regarding any payments claimed for providing services under the Medicaid Program as the Division may from time to time request.

The provider may, on thirty days written notice to the Division, terminate this Agreement.

Date

Signature of Provider

Title

CHAPTER I

GENERAL INFORMATION ABOUT THE PROGRAM

103. AUTHORIZED SERVICES FOR COVERED PERSONS

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

<u>Services Provided</u>	<u>Explanatory Comment</u>
<p>1. Inpatient Hospital Services</p> <p>a. In General Hospitals</p> <p>b. In Institutions for Tuberculosis</p> <p>c. In Institutions for Mental Diseases</p>	<p>Unlimited service with the exclusion of elective cosmetic surgery and diet therapy for exogenous obesity. Need for initial hospitalization must be certified to by attending physician. The initial number of days of hospitalization approved depends on the diagnosed condition for which the patient is treated.</p> <p>Limited to persons age 65 or older.</p> <p>Limited to persons age 65 or older and children 21 years of age and under.</p>
<p>2. Outpatient Hospital Services</p>	<p>No limitations, except for exclusion of elective cosmetic surgery. Take home drugs dispensed by hospital pharmacy are included.</p>
<p>3. Other Laboratory and X-ray Services</p>	<p>No limitations. Services must be ordered by attending practitioner.</p>
<p>4. Long Term Care (Skilled and Intermediate Care) Nursing Services - General</p>	<p>For persons of all ages. No durational limitations. <u>Prior Authorization</u> from local medical assistance unit required for admission except where patient is transferred to facility direct from an acute care hospital or Class A Special Hospital.</p>
<p>5. Early and Periodic Screening, Diagnosis and Treatment for Individuals Under Age 21. (EPSDT)</p>	<p>A periodic preventative health care program for persons under age 21 designed for early detection, diagnosis and treatment of correctable abnormalities. This program supplements the general medical services otherwise available.</p>
<p>6. Physician's Services (M.D. and D.O.)</p>	<p>No limitations. <u>Prior Authorization</u> is required for elective cosmetic surgery and for psychiatric treatment when payment for services rendered to any single patient exceeds \$300 in a 12-month period.</p>

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<u>Services Provided</u>	<u>Explanatory Comment</u>
<p>7. Dental Services</p> <p>a. Comprehensive Services</p> <p>b. Dentures</p>	<p>Comprehensive spectrum of dental services provided. Services defined as "routine" do not require <u>Prior Authorization</u>. Other services require authorization of dental consultants in Regional Dental Field Office.</p> <p>Partial or complete dentures are provided only when masticatory deficiencies are likely to impair general health of the patient. Replacement limited to once every five years. <u>Prior Authorization</u> is required for initial or replacement request.</p>
<p>8. Services of Licensed other Practitioners</p> <p>a. Podiatrists</p> <p>b. Optometrists</p> <p>c. Psychologists</p> <p>d. Chiropractors</p>	<p>Routine care must be qualified by medical necessity of professional treatment.</p> <p>Treatment of subluxations must be qualified. Treatment of flat feet not covered with exceptions:</p> <ol style="list-style-type: none"> 1. Supportive devices for symptoms and pain. 2. When talo crural (ankle) joint is involved. 3. Post operative or post fracture treatment is part of plan. <p>Orthotic devices require <u>Prior Authorization</u>.</p> <p>Services include optometric examination, optical appliances, contact lenses, artificial eyes and vision training. <u>Prior Authorization</u> is required for contact lenses, artificial eyes, vision training and subnormal vision devices.</p> <p><u>Prior Authorization</u> is required when payment for services rendered to any single patient exceeds \$300 in a given 12-month period.</p> <p>Services are limited to manual manipulation of the spine provided personally by the chiropractor. It includes services furnished in the office, the patient's home, skilled nursing facility, intermediate care facility, and sheltered boarding home. Not a covered out-of-state service.</p>

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GENERAL INFORMATION ABOUT THE PROGRAM

<u>Services Provided</u>	<u>Explanatory Comment</u>
<p>9. Home Health Care Services</p>	<p>The following services are provided to recipient while at home:</p> <p>Nursing and related services furnished by home health agency to homebound patient, pursuant to physician's order and in accordance with a plan of treatment. <u>Prior Authorization</u> is required for services beyond initial evaluation visit.</p>
<p>10. Medical Supplies and Equipment</p>	<p>Medical supplies, equipment, and appliances are provided, including purchase or rental of hospital beds, wheelchairs, and other durable medical equipment; bandages, surgical dressings, catheters, and other medical supplies. In all other cases <u>Prior Authorization</u> by local office required for items when the cost exceeds \$30.00.</p>
<p>11. Clinic Services (Other than Hospital)</p>	<p>Provided in non-profit facilities meeting standards of New Jersey Department of Health or other agencies to qualify as Independent Outpatient Health Facility. <u>Prior Authorization</u> required for certain clinic services.</p>
<p>12. Physical Therapy and Related Services</p> <p>a. Physical Therapy</p> <p>b. Occupational Therapy</p> <p>c. Speech Therapy</p>	<p><u>Prior Authorization</u> is required when provided by a Home Health Agency, Independent Clinic, or Long Term Care Facility. Services may also be provided in a Hospital Outpatient Department or in a physician's office. No payments to privately practicing therapists. No other limitations.</p> <p><u>Prior Authorization</u> is required when provided by a Home Health Agency, Independent Outpatient Health Clinic, or Long Term Care Facility. Services may also be provided in a Hospital Outpatient Department. No payments to privately practicing therapists. No other limitations.</p> <p><u>Prior Authorization</u> is required when provided by Home Health Agency, Independent Outpatient Health Clinic, or Long Term Care Facility. Services may also be provided in a Hospital Outpatient Department. No payments to privately practicing therapists. No other limitations.</p>

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Services Provided

Explanatory Comment

b. Invalid Coach

Invalid coach specifically designed for medical transportation is provided when patient does not need ambulance service and is physically unable to use public conveyances. Prior Authorization is required except in emergency conditions.

c. Other transportation

Contact County Welfare Agency.

104. GENERAL EXCLUSIONS

The items listed here are general exclusions from New Jersey Medicaid coverage. There are certain additional specific exclusions and limitations which are detailed in the appropriate provider manual sections. Payment is not made for:

1. Any service, admission or item which is not medically required for diagnosis or treatment of a disease, injury or condition;

2. Any services or items furnished in connection with elective cosmetic procedures;

NOTE: There are certain exceptions to this rule. A written certification of medical necessity and a treatment plan must be submitted by the physician to the Local Medical Assistance Unit for consideration as Prior Authorization is required;

3. Private duty nursing services;

4. Services rendered by Chiropractors and Psychologists not licensed by the State of New Jersey;

5. Services or items furnished for any sickness or injury occurring while the Covered Person is on active duty in the military;

6. Services or items furnished for any condition or accidental injury arising out of and in the course of employment, for which any benefits are available under the provisions of any Worker Compensation Law, Temporary Disability Benefits Law, Occupational Disease Law or similar legislation, whether or not the Covered Person claims or receives benefits thereunder.

7. That part of any benefits which are covered or payable under any health, accident, or other insurance policy (including any benefits payable under the "New Jersey Automobile Reparation Act", P.L. 1972, c.70), any other private or governmental health benefit system, or through any similar third party liability; which also includes the provision of the Unsatisfied Claim and Judgment Fund;

8. Services or items furnished prior to or after the period for which the patient presents evidence of eligibility for coverage;

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EXCEPTION: Retroactive Eligibility, See Section 100.3.

9. Any services or items furnished for which the Provider does not normally charge;
10. Any admission, service or item requiring Prior Authorization, where authorization has not been obtained or has been denied;
11. Services furnished by an immediate relative or member of the covered person(s) household.
12. Services billed for which the corresponding health care records do not adequately document all required elements of the procedure described or procedure code utilized by the billing provider, as specified in the Provider Manual. Final payment will be made for the procedure code fee which most closely corresponds to the procedure code which is documented in the provider's health care record. Therefore, any difference between the amount paid to the provider and the procedure code documented in the provider's record may be recouped by the Division of Medical Assistance and Health Services.

105. FREE SERVICES

Services provided to all persons without charge may not be billed to the Medicaid Program. Services and items provided without charge through programs of other public or voluntary agencies (e.g., New Jersey State Department of Health, New Jersey Heart Association, First Aid or Rescue Squads, etc.) shall be utilized to the fullest extent possible.

106. UTILIZATION OF INSURANCE BENEFITS

Medicaid benefits are last payment benefits. All health and accident insurance benefits, including Medicare, Workers' Compensation, and "No Fault Auto Insurance", shall be used first and to the fullest extent in meeting the medical needs of the covered person. Since Medicare covers aged and certain disabled persons, providers should inquire about Medicare eligibility when rendering Medicare covered services to a person with Program Code 10 or 20. Supplementation of available benefits shall be as follows:

1. Title XVIII (Medicare)

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

(EXCEPTIONS: Co-insurance is reimbursable for hospital billings, durable medical equipment and supplies, and prosthetic and orthotic devices).

2. Workers' Compensation

No Program payments shall be made for a patient covered by Workers' Compensation.

3. Other Health Insurance

When a covered person has other health insurance, the Program requires that such benefits be used first and to the fullest extent. Supplementation may be made by the Program, but the

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combined total paid shall not exceed the amount payable under the Program in the absence of other coverage. The Program will not supplement covered services rendered by a participating or contracting practitioner with any private health coverage program where the private plan calls for the practitioner to accept said plan's payment as payment in full. When other health insurance is involved, supplementation claims shall not be filed with the Program unless accompanied by a statement of payment or denial from the other carrier. Attachment of such information will expedite Medicaid claim processing. For exceptions see Section 106, Sub-section 1.

4. Claims Collectible under New Jersey "No Fault" Law

No Program payments will be made for services that are payable under the New Jersey Automobile Reparation Reform Act PL 1972, C70. This includes claims payable under the Unsatisfied Claim and Judgment Fund where no private automobile insurance policy exists.

107. PRIOR AUTHORIZATION (general)

Under the Program, payment for certain services will require Prior Authorization except in an emergency. It is the responsibility of the provider to obtain prior authorization before furnishing or rendering service. Specific instructions are detailed in the appropriate provider manual sections.

108. POLICY ON OUT-OF-STATE MEDICAL CARE AND SERVICES

Prior Authorization from the New Jersey Medicaid Program is required for medical care and services which are to be provided outside New Jersey, except in the following situations:

1. Where the health of the Medicaid eligible individual would be endangered if the care and services are postponed until the individual returns to New Jersey, or where the individual's health would be endangered if the individual undertook travel to return to New Jersey.
2. When medically necessary covered services are obtained by a New Jersey Medicaid eligible individual in the States of New York, Pennsylvania or Delaware.

NOTE: Any covered service that requires prior authorization as a prerequisite for reimbursement to New Jersey providers, also requires prior authorization if it is to be provided in any other state. Services which require prior authorization are described in the specific Medicaid provider manual.

3. When out-of-state care was provided in an emergency.

109. CONTRACTORS

The New Jersey Medicaid Program directly processes and makes payments of claims for services by Long Term Care Facilities and eligible state and county mental hospitals.

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

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Blue Cross of New Jersey is responsible for the processing and payment of hospital inpatient, hospital outpatient, and home health agency claims for those providers who have selected Blue Cross as their intermediary under Title XVIII (MEDICARE). In addition, Blue Cross processes and pays pharmaceutical services claims, and claims for out-of-state hospitals. Hospitals who have not participated in Title XVIII are assigned to the Hospital Service Plan.

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

110. MEDICAL REVIEW AND EVALUATION

Under the provisions of Federal and State Law, the Division of Medical Assistance and Health Services provides for continuing review and evaluation of the care and services provided under the Program. This includes utilization review of services of practitioners and other providers.

111. TIMELY SUBMISSION OF CLAIMS

Non-Institutional Provider Claims - 90 Day Time Limitation

This policy applies to all providers except Hospitals, Special Hospitals, Home Health Agencies and Long Term Care Facilities.

All claims for payment of non-institutional goods and services must be submitted to the Contractor no later than 90 days after the last date the goods or services were rendered.

Long Term Care Provider Claims - 6 Month Time Limitation

This policy applies to Long Term Care Facilities (LTCF) only:

Claims for Long Term Care Facility Services (Skilled Nursing or Intermediate Care Facilities) and/or authorized therapies provided in a (LTCF) that are older than 6 billing months will be rejected.

The New Jersey Medicaid Program will accept all legitimately authorized charges submitted within 5 months from the last day of the billing month in which services were provided.

Institutional Provider Claim - 12 Month Time Limitation

This policy applies to Hospital and Special Hospitals and Home Health Agencies:

All claims for inpatient and outpatient Hospital Services and Home Health Agency Services rendered to eligible Medicaid recipients must be received by the Contractor within 12 months from the day of discharge (inpatient) or the last day of service billed (outpatient and Home Health Agency).

112. PROHIBITION OF FACTORING

No provider participating in the Medicaid Program shall enter into any factoring contract, agreement, or other understanding, whether oral or written with any person, corporation, service bureau, management

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agency, or other entity, the purpose or effect of which is to cause any Medicaid claim payment or portion thereof to be assigned, discounted, diverted or made payable to any party other than the participating provider who rendered the services or supplies in question.

113. USE OF SERVICE BUREAU AND/OR MANAGEMENT AGENCY

In those cases in which a service bureau, management agency, or other organization is utilized by a provider to perform management, clerical, and/or other services relating to the claim payment process, standard Medicaid claim forms, or exact authorized replicas thereof, must be utilized, except where tape-to-tape claims processing is approved. If standard Medicaid forms are not utilized, the service bureau or management agency must obtain authorization from Medicaid to use the forms and must assume the entire cost of printing duplicate forms.

If a participating provider designates an agency as its agent for the purposes set forth in the preceding paragraph, said service bureau or management agency may act as agent for the provider for purposes of rendering services in relation to the claims payment process (including the signing of Medicaid claim forms on behalf of said provider) only if an appropriate power-of-attorney is executed by the provider and the agent, and only if the power-of-attorney and the agreement or other understanding between said provider and its agent contains a detailed statement of the powers and duties of the agent (including the power to sign Medicaid claim forms on behalf of the provider), and then only if the requirements set forth in paragraph one and Section 112 above relating to non-diversion of Medicaid claim payments and appropriate use of Medicaid claim forms are specifically incorporated into said power-of-attorney and said contract, agreement, or understanding. Both the power-of-attorney and the contract, agreement, or understanding, shall be filed with and meet the approval of the New Jersey Medicaid Program.

114. FRAUD AND ABUSE

The New Jersey Medicaid Program employs methods to identify situations in which a question of fraud and/or abuse in the Program may exist. The Division refers to law enforcement officials situations in which there is valid reason to suspect that fraud has been practiced.

115. PROVISIONS FOR APPEALS - FAIR HEARINGS

Pursuant to the New Jersey Administration Code (N.J.A.C. 10:49-5.1 et. seq.), both providers and Medicaid eligible persons with the New Jersey Medicaid Program have the right to file for fair hearings.

A provider may be granted a hearing because of the denial of a Prior Authorization request or issues involving the provider's status; e.g., termination, debarment, suspension, etc. as described in Section 116., or issues arising out of the claims payment process.

A Medicaid eligible person may be granted a hearing because his claim for medical assistance is denied or is not acted upon with reasonable promptness, or because he is agrieved by any other agency action effecting receipt, termination, reduction or suspension of such assistance.

In order to obtain a fair hearing, the provider or the eligible person should submit a request in writing to the Director, Division of Medical Assistance and Health Services, P. O. Box 2486, Trenton, New Jersey 08625, outlining the reason for the request.

116. PROGRAM PARTICIPATION

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116.1 Authority

These regulations are adopted and issued pursuant to Executive Order No. 34 of Governor Brendan T. Byrne dated March 29, 1976 and the authority vested in the Division of Medical Assistance and Health Services to implement the Medical Assistance Program by rules and regulations set forth in Section 30:4D-5 of the New Jersey Statutes Annotated.

116.2 Declaration of Purpose

Debarment, suspension and disqualification are measures which shall be invoked by the Division of Medical Assistance and Health Services to exclude or render ineligible certain persons from participation in contracts and subcontracts with the Division or in projects or contracts performed with the assistance of and subject to the approval of the Division, on the basis of a lack of responsibility. These measures shall be used for the purpose of protecting the interests of the Division and not for punishment. To assure the Division the benefits to be derived from the full and free competition between and among such persons and to maximize the opportunity for honest competition and performance, these measures shall not be invoked for any time longer than deemed necessary to protect the interests of the Division.

116.3 Definitions

As used in these Regulations:

- (a) Debarment - means an exclusion from State contracting, on the basis of a lack of responsibility evidenced by an offense, failure, or inadequacy of performance, for a reasonable period of time commensurate with the seriousness of the offense, failure, or inadequacy of performance.
- (b) Suspension - means an exclusion from State contracting for a temporary period of time, pending the completion of an investigation or legal proceedings.
- (c) Disqualification - means a debarment or a suspension which denies or revokes a qualification to bid or otherwise engage in State contracting which has been granted or applied for pursuant to statute, or rules and regulations.
- (d) State - means the State of New Jersey, or any of the departments or agencies in the Executive Branch of government with the lawful authority to engage in contracting.
- (e) Person - means any natural person, company, firm, association, corporation, or other entity.
- (f) State Contracting - means any arrangement giving rise to an obligation to supply anything to or perform any service for the State, other than by virtue of State employment, or to supply anything to or perform any service for a private person where the State provides substantial financial assistance and retains the right to approve or disapprove the nature or quality of the goods or service or the persons who may supply or perform the same.
- (g) Provider - means any person, public or private institution, agency or business concern lawfully providing medical care, services, goods and supplies authorized under the New Jersey Medical Assistance and Health Services Act (P.L. 1968, c.413) as amended, holding, where applicable, a current valid license to provide such services or to dispense such goods or supplies.
- (h) Affiliates - means persons having an overt or covert relationship such that anyone of them directly or indirectly controls or has the power to control another.

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- (i) **Contractors** - means the Hospital Service Plan of New Jersey (Blue Cross) and The Prudential Insurance Company of America, or their successors.
- (j) **Division** - means the New Jersey Division of Medical Assistance and Health Services.

116.4 Causes for Debarment, Suspension, or Disqualification

Any of the following, inter alia, shall constitute a good cause for debarment, suspension or disqualification of a person engaged in State contracting, as defined herein, by the Division of Medical Assistance and Health Services:

- (a) Commission of a criminal offense as an incident to obtaining or attempting to obtain a public or private contract, or subcontract thereunder, or in the performance of such contract or subcontract.
- (b) Violation of the Federal Organized Crime Control Act of 1970, or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, perjury, false swearing, receiving stolen property, obstruction of justice, or any other offense indicating a lack of business integrity or honesty.
- (c) Violation of the Federal or State Antitrust Statutes, or of the Federal Anti-Kickback Act (18 U.S.C. 874, 40 U.S.C. 276 b, c).
- (d) Violations of any of the laws governing the conduct of elections of the State of New Jersey or of its political subdivisions.
- (e) Violation of the "Law Against Discrimination" (P.L. 1945, c.169, C.10:5-1 et seq., as supplemented by P.L. 1975, c.127), or of the act banning discrimination in public works employment (C.10:2-1 et seq.) or of the "Act prohibiting discrimination by industries engaged in defense work in the employment of persons therein" (C.114, L. 1942, C.10:1-10 et seq.).
- (f) Violations of any laws governing hours of labor, minimum wage standards, prevailing wage standards, discrimination in wages, or child labor.
- (g) Violations of any laws, regulations or Code of Ethics governing the conduct of occupations or professions or regulated industries.
- (h) Willful failure to perform in accordance with contract specifications or within contractual time limits.
- (i) A record of failure to perform or of unsatisfactory performance in accordance with the terms of one or more contracts, provided that such failure or unsatisfactory performance has occurred within a reasonable time preceding the determination to debar and was caused by acts within the control of the person debarred.
- (j) Violation of contractual or statutory provisions regulating contingent fees.
- (k) Presentment for allowance or payment of any false or fraudulent claim for services or merchandise.
- (l) Submitting false information for the purpose of obtaining greater compensation than to which the person is legally entitled.
- (m) Submitting false information for the purpose of obtaining authorization requirements.

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- (n) Failure to disclose or make available to the Division of Medical Assistance and Health Services or its authorized agent, records of services provided to Medicaid recipients and records of payments made therefore.
- (o) Failure to provide and maintain quality services to Medicaid recipients within accepted medical community standards as adjudged by a body of Peers.
- (p) Engaging in a course of conduct or performing an act deemed improper or abusive of the New Jersey Medicaid Program following notification that said conduct should cease.
- (q) Breach of the terms of the Medicaid provider agreement entered into with the Division or failure to comply with the terms of the provider certification on the Medicaid claim form.
- (r) Over-utilizing the New Jersey Medicaid Program by inducing, furnishing, or otherwise causing an individual to receive service(s) or merchandise not otherwise required or requested by the recipient.
- (s) Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral.
- (t) Violating any provision of P.L. 1968, c.413 (New Jersey Medical Assistance and Health Services Act) as amended, or any rule or regulation promulgated by the Commissioner of Human Services Agencies pursuant thereto.
- (u) Conviction of any crime involving moral turpitude.
- (v) Submission of a false or fraudulent application for provider status to the Division or to its contractors.
- (w) Any other cause affecting responsibility as a State contractor of such serious and compelling nature as may be determined by the Division to warrant debarment, including such conduct as may be prescribed by the laws or contracts enumerated in this paragraph even if such conduct has not been or may not be prosecuted as violations of such laws or contracts.
- (x) Debarment by some other department or agency in the Executive Branch.

116.5 Conditions for Debarment

- (a) Debarment shall be made only upon approval of the Director of the Division, except as otherwise provided by law.
- (b) The existence of any of the causes set forth in Section 116.4 of this Regulation shall not necessarily require that a person be debarred. In each instance, the decision to debar shall be made within the discretion of the Director of the Division unless otherwise required by law, and shall be rendered in the best interests of the Division.
- (c) All mitigating factors shall be considered in determining the seriousness of the offense, failure or inadequacy of performance and in deciding whether debarment is warranted.
- (d) The existence of a cause set forth in subparagraphs (a), (b), (c), (d), (e), (f), and (g) of Section 116.4 of this Regulation shall be established upon the rendering of a final judgment or conviction by a court of competent jurisdiction or by an administrative agency empowered to render such judgment. In the event an appeal taken from such judgment or conviction results

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in reversal thereof, the debarment shall be removed upon the request of the debarred person unless other cause for debarment exists.

- (e) The existence of a cause set forth in subparagraphs (h), (i), (j), and (w) of Section 116.4 of this Regulation shall be established by evidence which the Division or agency determines to be clear and convincing in nature.
- (f) The existence of a cause set forth in subparagraphs (a), (b), (c), (d), (e), (f), (g), (k), (l), (m), (n), (o), (p), (q), (r), (s), (t), (u), (v), and (x) of Section 116.4 of this Regulation shall be established by a preponderance of the believable evidence.
- (g) Debarment for the cause set forth in subparagraph (x) of Section 116.4 of this Regulation shall be proper provided that one of the causes set forth in subparagraph 4(a) through (w) was the basis for debarment by the original debarring agency. Such debarment may be based entirely on the record of facts obtained by the original debarring agency, or upon a combination of such facts and additional facts.

116.6 Procedures for Debarment

If the Division seeks to debar a person or his affiliates, the Division shall furnish such party with a written notice: (i) stating that debarment is being considered, (ii) setting forth the reasons for the proposed debarment, and (iii) indicating that such party will be accorded an opportunity for a hearing if he so requests within a stated period of time. All such hearings shall be conducted in accordance with the provisions of the Administrative Procedures Act. However, where one department or agency has imposed debarment upon a party, a second department or agency may also impose a similar debarment without according an opportunity for a hearing, provided that the second agency furnishes notice of the proposed similar debarment to that party, and accords that party an opportunity to present information in his behalf to explain why the proposed similar debarment should not be imposed in whole or in part.

116.7 Period of Debarment

Debarment shall be for a reasonable, definitely stated period of time which as a general rule shall not exceed five years. Debarment for an additional period shall be permitted provided that notice thereof is furnished and the party is accorded an opportunity to present information in his behalf to explain why the additional period of debarment should not be imposed.

116.8 Scope of Debarment

- (a) Except as otherwise provided by law, a debarment may be removed or the period thereof may be reduced in the discretion of the debarring agency upon the submission of a good faith application under oath, supported by documentary evidence, setting forth substantial and appropriate grounds for the granting of relief, such as newly discovered material evidence, reversal of a conviction or judgment, actual change of ownership, management or control, or the elimination of the causes for which the debarment was imposed.
- (b) A debarment may include all known affiliates of a person, provided that each decision to include an affiliate is made on a case by case basis after giving due regard to all relevant facts and circumstances. The offense, failure or inadequacy of performance of an individual may be imputed to a person with whom he is affiliated, where such conduct was accomplished within the course of his official duty or was effected by him with the knowledge or approval of such person.

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- (c) Debarment by the Director of any provider of service shall preclude such provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association to the Division of Medical Assistance and Health Services or its contractors for any services or supplies he has provided under the New Jersey Medicaid Program, except for services or supplies provided prior to the debarment. No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the Division or its contractors for any services or supplies provided by a person within such organization who has been debarred by the Director, except for services or supplies provided prior to the debarment.
- (d) When the provisions of this Regulation are violated by a provider of service which is a clinic, group, corporation or other association, the Director may debar such organization and/or any individual person within said organization who is responsible for such violation.

116.9 Cause for Suspension

The Division may suspend a person in the public interest for any cause specified in Section 116.4 of this Regulation, or upon a reasonable suspicion that such cause exists, or when, in the opinion of the Director, such action is necessary to protect the public welfare and the interests of the Medical Assistance Program.

116.10 Conditions for Suspension

- (a) Suspension shall be imposed only upon approval of the Director of the Division and upon approval of the Attorney General, except as otherwise provided by law.
- (b) The existence of any cause for suspension shall not require that a suspension be imposed, and a decision to suspend shall be made at the discretion of the Director of the Division and of the Attorney General, and shall be rendered in the best interests of the Division.
- (c) Suspension shall not be based upon unsupported accusation, but upon adequate evidence that cause exists or upon evidence adequate to create a reasonable suspicion that cause exists.
- (d) In assessing whether adequate evidence exists, consideration shall be given to the amount of credible evidence which is available, to the existence or absence of corroboration as to important allegations, and to inferences which may properly be drawn from the existence or absence of affirmative facts.
- (e) Reasonable suspicion of the existence of a cause described in subparagraphs (a) through (x) of Section 116.4 of this Regulation may be established by the rendering of a final judgment or conviction by a court or administrative agency of competent jurisdiction, by grand jury indictment, or by evidence that such violations of civil or criminal law did in fact occur.
- (f) A suspension invoked by the Division for any of the causes described in subparagraphs (a) through (x) of Section 116.4 of this Regulation may be the basis for the imposition of a concurrent suspension by another agency, which may impose such suspension without the approval of the Attorney General.

116.11 Procedures for Suspension

The Division may suspend a person or his affiliates, provided that within ten days after the effective date of the suspension, the Division provides such party with a written notice: (i) stating that a suspension has been imposed and its effective date, (ii) setting forth the reasons for the suspension to the extent that the Attorney

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General determines that such reasons may be properly disclosed, (iii) stating that the suspension is for a temporary period pending the completion of an investigation and such legal proceedings as may ensue, and (iv) indicating that, if such legal proceedings are not commenced or the suspension removed within sixty days of the date of such notice, the party will be given either a statement of the reasons for the suspension and an opportunity for a hearing if he so requests, or a statement declining to give such reasons and setting forth the agency's position regarding the continuation of the suspension. Where a suspension by the Division has been the basis for suspension by another agency, the latter shall note that fact as a reason for its suspension.

116.12 Period of Suspension

A suspension shall not continue beyond eighteen months from its effective date unless civil or criminal action regarding the alleged violation shall have been initiated within that period, or unless debarment action has been commenced. Whenever prosecution or debarment action has been initiated, the suspension may continue until the legal proceedings are completed.

116.13 Scope of Suspension

- (a) A suspension may include all known affiliates of a person, provided that each decision to include an affiliate is made on a case by case basis after giving due regard to all relevant facts and circumstances. The offense, failure or inadequacy of performance of an individual may be imputed to a person with whom he is affiliated, where such conduct was accomplished within the course of his official duty or was effectuated by him with the knowledge or approval of such person.
- (b) Suspension by the Director of any provider of service shall preclude such provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association to the Division of Medical Assistance and Health Services or its contractors for any services or supplies he has provided under the New Jersey Medicaid Program, except for services or supplies provided prior to the suspension. No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the Division or its contractors for any services or supplies provided by a person within such organization who has been suspended by the Director, except for services or supplies provided prior to the suspension.
- (c) When the provisions of this Regulation are violated by a provider of service which is a clinic, group, corporation or other association, the Director may suspend such organization and/or individual person within said organization who is responsible for such violation.

116.14 Scope of Exclusion from State Contracting

Exclusion from State contracting by virtue of debarment, suspension or disqualification shall extend to all state contracting and subcontracting within the control or jurisdiction of the Division. However, when it is determined essential to the public interest by the Director of the Division, and upon filing of a finding thereof with the Attorney General, an exception from total exclusion may be made with respect to a particular State contract.

116.15 Notification of the Attorney General and the Treasurer

Insofar as practicable, prior notice shall be given to the Attorney General and the Treasurer of any proposed debarment or suspension.

GENERAL INFORMATION ABOUT THE PROGRAM**116.16 Notice of Suspensions and Debarments**

The Division shall provide the State Treasurer with the names of all persons suspended or debarred and the effective date and term thereof, if any.

116.17 Applicability

The rules herein shall be applicable to all persons, providers, contractors and their affiliates who engage in State contracting with the Division as defined herein.

117. CIVIL RIGHTS

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

118. OBSERVANCE OF RELIGIOUS BELIEF

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

119. FREE CHOICE BY COVERED PERSON AND BY PROVIDER

The concept of freedom of choice applies to both provider and recipient. An eligible person is free to choose providers of service who meet Program standards and who elect to participate. It is understood that when a provider has accepted an individual for care he will accept the Program's policies and reimbursement for all covered services and/or items which he provides or delivers during that period when, by mutual agreement, the recipient is under the provider's care. In this provision of professional services, it is considered automatic that the provider will be bound by the code of ethics governing his profession. The Local Medical Assistance Unit will assist covered persons in obtaining services if the eligible person cannot locate a provider.

120. INTEGRITY OF THE MEDICAID PROGRAM

The New Jersey Medicaid Program, in order to continue to maintain the integrity of the Program, strictly prohibits its employees from accepting gifts or gratuities of any kind and of any value from individuals, representative Provider organizations or institutions who provide services and are reimbursed through the Program. This includes the prohibition of offers of special employment, consultation fees, and all other gratuities by a provider, individual or facility.

121. CONFIDENTIALITY OF RECORDS

All medical records, computer data, and other information of covered persons acquired under this Program shall be confidential and shall not be released by the Program without the written consent of the covered person or his authorized representative. This shall not preclude the release of statistical or summary data or information in which covered persons are not, and cannot be identified, nor shall it preclude exchange of information between individuals or institutions providing care, Contractors and State or local official agencies. Disclosure without consent of the covered person shall be limited to purposes directly connected with the administration of the Program pursuant to Federal and State law.

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122. RECORD KEEPING AND PROVIDER CERTIFICATION REQUIREMENT

Program providers are required to certify that the services billed on any claim were personally rendered by or under their direct personal supervision (as defined by Program regulations); that the furnished information is true, accurate and complete; and the provider agrees to keep such records as are necessary to disclose fully the extent of services provided, and to furnish information for such services as the Program may request, and agrees that where such records do not document the extent of services billed, payment adjustments will be necessary and that the services billed on any claim and the amount charged therefore are in accordance with the regulations of the New Jersey Medicaid Program; and that no part of the net amount payable under any claim has been paid; and that payment of such amount will be accepted as payment in full without additional charge to the patient or to others on his behalf. The Provider also certifies that the services have been furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act and that it is understood that payment and satisfaction of any claim will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

123. DIRECTORY OF LOCAL MEDICAL ASSISTANCE UNITS (LMAU)

<u>County</u>	<u>Street Address</u>	<u>Municipality</u>	<u>Zip Code</u>	<u>P.O. Box</u>	<u>Telephone</u>
Atlantic	1601 Atlantic Ave.	Atlantic City	08404	1709	609-344-2861
Cape May	" " "	" "	"	"	" " "
Bergen	50 Main Street	Hackensack	07601		201-488-5667
Burlington	Chesley & Alloway Bldg. Rt. 38 & Eayrestown Rd.	Mt. Holly	08060		609-261-0448
Camden	530 Cooper Street	Camden	08101	1089	609-757-2870
Cumberland	501 Landis Avenue	Vineland	08360		609-696-0521
Essex	155 Washington Street	Newark	07102		201-648-2470
Gloucester	Southwood Shopping Ctr.	Woodbury	08096		609-845-7185
Salem	" " "	"	"		" " "
Hudson	880 Bergen Avenue	Jersey City	07306		201-792-6390
Hunterdon	79 Main Street	Flemington	08822		201-782-1130
Somerset	" " "	"	"		" " "
Warren	" " "	"	"		" " "
Mercer	1424 So. Broad St.	Trenton	08610		609-292-7315
Middlesex	75 Paterson Street	New Brunswick	08903	1274	201-246-0653
Monmouth	1200 Memorial Drive	Asbury Park	07712		201-775-5700
Morris	4 Court Street	Morristown	07960		201-267-1700
Sussex	" " "	"	"		" " "
Ocean	1861 Hooper Ave.	Toms River	08753		201-255-6226
Passaic	100 Hamilton Plaza	Paterson	07505		201-523-2800
Union	333 N. Broad St.	Elizabeth	07208		201-355-8860

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DENTAL SERVICES

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CHAPTER II
DENTAL SERVICES

200. DENTAL SERVICES

201. DEFINITIONS

201.1 Dental Services

Dental Services are defined as any diagnostic, preventive, or corrective procedures administered by or under the direct personal supervision of a dentist in the practice of his profession. Such services include treatment of the teeth and associated structures of the oral cavity, and of disease, injury, or impairment which may affect the oral or general health of the individual. Such services shall maintain a high standard for quality and shall be within the reasonable limits of those services which are customarily available and provided to most persons in the community within the limitations and exclusions hereinafter specified. (For Place of Service, see Section 202.9)

NOTE: Direct personal supervision means the actual physical presence of the dentist on the premises.

201.2 Participating Dentists

Any dentist licensed to practice dentistry by the appropriate agency of the state where the dental services are rendered, accepts the policies, regulations, and procedures as promulgated by the New Jersey Division of Medical Assistance and Health Services, and signs a provider agreement, is eligible to participate in the Dental Care aspects of the New Jersey Medicaid Program.

201.3 Attending Dentist

The attending dentist is considered to be the one who assumes the primary and continuing dental care of the patient.

The services of only one attending dentist will be recognized at a given time (refer to Section 201.4).

201.4 Concurrent Care

Concurrent Care is that type of service rendered to patients by practitioners where the dictates of dental necessity requires the services of dentists of different specialties in addition to the attending dentist so that appropriate and needed care can be provided.

201.5 Transfer

Transfer is the relinquishing of responsibility for the continuing care of the patient by one dentist and the assumption of such responsibility by another dentist. Such transfers will require a new authorization where prior authorization is required. (See Section 202.2 (2))

201.6 Specialist

- A. A Specialist is one who is licensed to practice dentistry in the state where treatment is rendered, who limits his practice solely to his specialty, which is recognized by the American Dental Association, and who, in addition, meets one of the following conditions:
1. In New Jersey, and where required in other states, has obtained specialty certification from the appropriate agency of the state where dental services are to be rendered; or,
 2. In those states not requiring specialty certification:
 - a. Is a Diplomate of the appropriate American Dental Association recognized Board; or
 - b. Meets the minimum requirements for that specialty as stipulated by the American Dental Association.
- B. Any provider who meets the above-cited qualifications, who desires specialist reimbursement is required to submit written documentation to the Prudential Insurance Company, Medical Administration Division, P. O. Box 1900, Millville, N.J. 08332. This documentation must be as follows:
1. In New Jersey, and where required in other states - a copy of the specialty certificate/permit issued by the appropriate agency of the state where dental services are to be rendered; or,
 2. In those states not requiring specialty certification and when the practitioner is not listed in the Directory of the American Dental Association under "Character of Practice" as a specialist:
 - a. From his Specialty Board indicating his status as a Diplomate; or,
 - b. From the American Dental Association stipulating that he meets the minimum requirements for his specialty.
- C. Specialist reimbursement, where appropriate, will be limited to the following specialties:
1. Oral Surgery
 2. Endodontics
 3. Pedodontics
 4. Orthodontics
 5. Periodontics
 6. Prosthodontics

201.7 Consultation

A consultation is defined as that service rendered by a qualified dentist upon request of another practitioner in order to evaluate through history, appropriate physical findings and other ancillary means, the nature and progress of a dental or related disease, illness, or condition and/or to establish or confirm a diagnosis, and/or determine the prognosis, and/or suggest appropriate therapy.

A consultation requires a personal examination of the patient with a written report to include, as appropriate, the information described above, a copy of which must be retained with the patient's records and must be made available, upon request, to this Division or any of its authorized representatives. A copy of this report must be provided to the referring practitioner.

- A. When the practitioner rendering the consultation services assumes the continuing care of the patient, any subsequent services rendered by him will no longer be considered as consultation.
- B. When consultation services are requested, the referring practitioner must include in his clinical records and on the Dental Form MC-10 (Remarks) the name of the consulting practitioner to whom the patient is being referred. The consulting practitioner must note the name and the Individual Medicaid Practitioner Number (IMP Number) of the referring (attending) practitioner in his clinical records and on the Dental Form (MC-10) (Referring Practitioner)

NOTE: If there is no referring practitioner (i.e., the patient makes an appointment on his own), there will be no reimbursement for consultation.

201.8 Referral

Referral is the directing of the patient from one practitioner to another for diagnosis and/or treatment.

NOTE: If in the opinion of a dentist, the patient requires the services of a specialist, he must note the name of the practitioner to whom the patient is being referred (Remarks) and the specialist must note the name and Individual Medicaid Practitioner Number (IMP Number) of the referring dentist on the Dental Form (MC-10) (Referring Practitioner)

201.9 Emergency

An emergency is defined as a specific condition or conditions of the oral cavity and/or contiguous tissues which cause severe and/or intractable pain or could compromise the life, health, or safety of the patient unless treated immediately.

For example:

- A. Pain or acute infection from a restorable or a non-restorable tooth.
- B. Pain resulting from injuries to the oral cavity and related structures.
- C. Extensive, abnormal bleeding.
- D. Fractures of the maxilla or mandible or related structures or dislocation of the mandible.

NOTE: When a case of an emergency nature arises and consultation with the attending practitioner is impossible, due consideration must be given to the preservation of those teeth that could be involved in the overall treatment plan of the attending practitioner.

202. PROGRAM POLICIES

202.1 Dental Treatment Plan

- A. In accordance with good dental practice, a plan of treatment, as appropriate, shall be developed and described for all patients on the Dental Form (MC-10) following an examination. If no treatment is necessary, this fact must be entered on the Dental Form (Diagnosis).
- B. The dental treatment plan not requiring prior authorization may be reviewed by Dental Consultants of the New Jersey Medicaid Program to determine its appropriateness.
- C. In those instances where prior authorization is necessary, the Regional Dental Consultant may modify the providers treatment plan in accordance with the guidelines of the dental aspects of the New Jersey Medicaid Program. If in the professional judgment of the provider such modification is not appropriate, he may request another review by the Regional Dental Consultant. A further review at the Division's Central Office may be requested through the Regional Dental Consultant.
- D. In any dental treatment plan, the dentist must discuss the proposed treatment with the patient or responsible person.
- E. Consideration for development of a dental treatment plan shall be based upon the least costly treatment fulfilling the requirements of the specific situation.
- F. AUTHORIZATION FOR A DENTAL TREATMENT PLAN DOES NOT GUARANTEE ELIGIBILITY FOR PAYMENT UNDER THE NEW JERSEY MEDICAID PROGRAM. THE VALIDATION FORM SHOULD BE EXAMINED CAREFULLY ON EACH VISIT TO BE CERTAIN THE PATIENT IS CURRENTLY ELIGIBLE (Refer to Chapter I).

202.2 Prior Authorization

Prior authorization means approval by a Dental Consultant of the New Jersey Medicaid Program before a service is rendered. (See Chapter III for a listing of the appropriate Dental Field Offices with addresses and phone numbers).

202.2(1) Procedures which do not Require Prior Authorization

- A. Diagnostic examination with required radiography (limited to a maximum of twenty-five (\$25.00) dollars) necessary to develop a treatment plan (Refer to Section 203.1., A. and B.).
- B. Emergency treatment with required radiography. (Refer to Sections 201.9 and 203.1 B.)
- C. Adjustments to, or repair of dentures when the Medicaid reimbursement does not exceed thirty-four (\$34.00) dollars - non-specialist fee, or thirty-nine (\$39.00) dollars-specialist fee.
- D. "Routine Dental Services", as limited to those designated below, may be performed to the extent that they are dentally necessary.

1. Oral prophylaxis (Refer to Section 203.2 A.)

2. Topical fluoride application for persons twenty (20) years of age and under. (Refer to Section 203.2 B.)

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

3. Restoration of carious permanent and deciduous teeth with silver amalgam, silicate cement, composite, or other plastic materials. (Refer to Section 203.3 A.)

4. Pulp capping for permanent and deciduous teeth. (Refer to Section 203.4 D.)

5. Pulpotomy for permanent and deciduous teeth. (Refer to Section 203.4 B.) More than one (1) pulpotomy requires prior authorization.

6. Extractions of non-restorable teeth. (Refer to Section 203.7)

EXCEPTION: Extractions necessitating a dental prosthesis require prior authorization.

All dental services other than those listed in A. through D. above are defined as "non-routine dental services" and must be authorized.

NO REIMBURSEMENT WILL BE MADE FOR ANY DENTAL SERVICE PERFORMED BEYOND ONE (1) YEAR (365 DAYS) FROM THE DATE OF THE INITIAL EXAMINATION ON THAT TREATMENT PLAN (Refer to Section 203.1 A.1.)

202.2(2) Procedures which require Prior Authorization

- A. Treatment plans involving a combination of "routine" and "non-routine" dental services.
- B. All treatment plans involving "non-routine" dental services.
- C. Supplemental Authorization:

Additional and/or amended services found necessary after the dental treatment plan has been authorized may be requested by recording such need on the Dental Form (MC-10). This should then be submitted for supplemental authorization together with the original treatment plan. PAYMENT WILL NOT BE MADE FOR SUCH TREATMENT WITHOUT AUTHORIZATION FROM THE REGIONAL DENTAL CONSULTANT IN THE DENTAL FIELD OFFICE.

NO REIMBURSEMENT WILL BE MADE FOR ANY DENTAL SERVICES PERFORMED BEYOND ONE (1) YEAR (365 DAYS) FROM THE DATE OF THE INITIAL EXAMINATION ON THAT TREATMENT PLAN (See Section 203.2 A.1. and refer to Chapter III, Section 300.2 G.2.c.).

EXCEPTION: Orthodontic treatment

202.3 Non-Covered Services

A non-covered service is that procedure which is primarily for cosmetic purposes or for which dental necessity cannot be demonstrated.

202.4 Standards of Service

- A. The dental treatment plan provided shall be in accordance with the ethical and professional standards of the dental profession.
- B. All materials used must meet the specifications established by the American Dental Association.

202.5 Special Dental Services

Dental services for which no specific provisions are made, or are limited or prohibited in these policies and procedures may be considered on an individual basis. Such a request should be forwarded to the Regional Dental Consultant in the appropriate Dental Field Office (refer to Chapter III), and must be accompanied by all supporting evidence.

202.6 Utilization Review, Quality Control and Peer Review

For the purposes of the New Jersey Medicaid Program, Utilization Review, Quality Control and Peer Review are considered to be ongoing components in regard to the dental services provided to eligible recipients.

Utilization refers to that service, procedure or item provided to a patient by a qualified provider in a setting at a time and in an amount which is appropriate and acceptable to the standards of the profession at an appropriate cost.

Utilization Review is the retrospective analysis of the performance of a dental provider with respect to the efficient provision for the use of services noted above from the viewpoint of fiscal accountability.

Quality is that standard of dental care or degree of excellence generally prevailing throughout the profession by those who provide similar service which is not related to any geographical area or population group as judged by competent practitioners who are qualified to perform those procedures.

Dental Review is the current ongoing review of the degree of quality in the delivery of continuing dental services and health care which is constantly monitored and maintained by the provision of appropriate direction, coordination and regulation through the cooperative efforts between representatives of the New Jersey Medicaid Program and a qualified body of peers.

Peer Review is the evaluation by practicing dentists as to the quality and efficiency of services ordered or performed by other practicing dentists and is considered to be the all-inclusive term for dental review efforts including dental practice analysis, inpatient hospital and extended care utilization review and dental claims audit and review.

In the accomplishment of the above, any or all reviews will include but not be limited to the following:

- A. A clinical examination made on a sampling of cases. Such examination may be made prior to, during, or upon completion of treatment.
- B. Additional diagnostic aids and data which may be requested to evaluate the case.
- C. Adequate records which must be maintained by the dentist providing treatment and shall be available for inspection. (See Section 202.7)

202.7 Patient Records

Dentists are required to maintain individual patient records which fully disclose the type and extent of services provided to a New Jersey Medicaid Program recipient. These records must be maintained for a minimum of seven (7) years following the last date of service rendered. Such information must be readily available to representatives of the New Jersey Medicaid Program or its agents as required.

- A. The record shall consist of the following:
 1. Pertinent dental/medical history

2. Detailed clinical examination data to include where applicable:
 - a. Patient's chief complaint
 - b. Diagnosis
 - c. Cavities
 - d. Missing teeth
 - e. Abnormalities
3. Pre-operative, progress, and post-operative radiographs (retained for a minimum of seven (7) years. (Check with your professional liability insurance company for possible retention for longer periods). The number and type of radiographs should be entered on the patient's record.
4. Treatment plan with description of treatment rendered to include where appropriate:
 - a. Tooth number
 - b. Surfaces involved
 - c. Site and size of treatment area (lesion, laceration, fracture, etc.)
 - d. Materials used
 - e. Date(s) of service(s)
5. Medications
 - a. Ordered by prescription or OTC
 - b. Used in office treatment
6. Diagnostic laboratory and/or radiographic procedure(s) ordered, including the result(s).
7. Copy of the dental prosthetic work authorization(s) (prescription(s)), and dental prosthetic laboratory receipt(s).
8. Explanation of any duplication of services within one (1) year (prosthetic services within five (5) years).
9. Reasons for discontinuation of services (including attempts to complete treatment).
10. Referral and consultation reports (see Section 201.7 and 201.8)

202.8 Basis of Payment

Reimbursement for covered services furnished under the New Jersey Medicaid Program shall be the customary and usual fee of the provider when it does not exceed Federal regulatory maximums and reasonable rates as determined by the Commissioner (Human Services). In no instance shall the charge to the Program exceed the usual and customary fee of the provider for identical services to other governmental

agencies or other groups or individuals in the community. If a patient receives care from more than one member of a partnership or corporation in the same discipline for the same service, the maximum payment allowance would be the same as that of a single attending dentist. The allowable fee for a given service shall constitute full payment. No private agreement, transaction or additional charge may be made by the dentist with, or on behalf of the covered person.

NOTE:

- A. A fee will be paid only for services rendered. If an eligible recipient does not return for completion of the treatment plan, only those services provided should be billed.
- B. If circumstances involving an eligible recipient, over which the provider has no control, preclude completion of a service and/or authorized appliance, the New Jersey Medicaid Program will reimburse the provider of services an amount consistent with the stage of completion of the authorized service and/or appliance.

NOTE: The stage of completion of the service should be detailed on the Dental Form (MC-10), or in the case of an appliance, denture or crown, etc., the case to the point of completion should be forwarded to the Regional Dental Consultant for pro-ration as determined by the Office of the Dental Director of the Program. The case will be returned to the provider and should be retained for at least one year.

- C. Partial reimbursement for an appliance completed but not delivered to the recipient because of circumstances beyond the control of the provider will be authorized by the New Jersey Medicaid Program. An amount equivalent to the professional component for inserting and adjusting the appliance will be deducted from the total reimbursement for such appliance. In the event the patient returns and the service is completed, the provider may request reimbursement for the deducted amount. Procedures as outlined in "Note:" under B. above, will apply.
- D. Reimbursement is not made for, and recipients may not be asked to pay for broken appointments. However, after repeated instances, the dentist should report these occurrences to the appropriate Dental Field Office (refer to Chapter III).
- E. Reimbursement for dental treatment can only be made during the period of patient eligibility.

EXCEPTION: 1.) The treatment listed below, authorized and actually in the process of being rendered during such period may be completed and payment allowed, provided the services are completed within sixty (60) calendar days following the termination of eligibility.

- a.) Prostheses (to include dentures, crowns, space maintainers, appliances, etc.) actually in process of fabrication.

- b.) Extractions in conjunction with the insertion of an immediate denture when initial impressions have been taken during the period of eligibility.
- c.) Endodontic treatment if pulp has been extirpated and treatment authorized.

EXCEPTION: 2.) Notwithstanding anything in these regulations to the contrary, payment may be made for a denture(s) furnished after termination of eligibility of an individual where the last tooth in a specific arch is extracted during the period of eligibility.

A denture, complete or partial may be furnished in the opposing arch, if appropriate within the guidelines of the Program, and authorized in conjunction with the above denture.

In order to obtain reimbursement for this denture(s), the primary impression(s) must be initiated within one hundred twenty (120) days and the denture(s) inserted within one hundred eighty (180) days after the extraction of the last tooth. Authorization procedures set forth in these regulations are applicable.

- 3.) Notwithstanding anything in these regulations to the contrary, payment may be made for an immediate complete denture (and the extractions of teeth incident to the insertion of that denture) initiated after termination of eligibility. However, prior authorization must have been obtained during an eligible period and all preliminary extractions (other than those extractions done in conjunction with procedure code 5135) completed during the period of eligibility.

A denture, complete or partial, may be furnished in the opposing arch, if appropriate within the guidelines of the Program, and authorized in conjunction with the above denture.

In order to receive reimbursement for this denture(s), primary impression(s) must be initiated within one hundred twenty (120) days and the denture inserted within one hundred eighty (180) days after the last preliminary extraction. Authorization procedures set forth in these regulations are applicable.

- F. When other health or liability insurance is available, the Medicaid Program requires that such benefits be utilized first. Supplementation may be made by the Medicaid Program up to the provider's customary and usual fee, but the combined total shall not exceed the amount payable under the Medicaid Program.

When other health insurance is involved, claims should not be filed with the Program unless accompanied by a statement of payment or denial from any other carriers.

No coinsurance will be payable by the New Jersey Medicaid Program in combination Medicare/Medicaid cases, however, payment toward the deductible will be made.

No payments will be made by the Program for any automobile accidents occurring on or after January 1, 1973 which are covered by "No Fault" insurance policies (New Jersey Automobile Reparation Reform Act PL1972, C70). For more detailed information, please refer to Chapter I, Section 104 and 106.

202.9 Place of Service

In addition to the private office, dental services may be provided in the home, a hospital, approved independent clinic, long term care facility, and elsewhere.

Services should be provided in any appropriate setting, governed by medical/dental necessity and not by the convenience or desires of the patient or the provider of services.

- A. Policies specific for dental services rendered in the outpatient departments of approved licensed hospitals and services rendered in approved independent clinics are described in their respective manuals.
 - 1. All services rendered to a patient in the hospital outpatient department as a registered clinic patient are considered hospital costs, including costs of dentists' services. Any arrangement, contractual or otherwise for payment of the dentist(s) providing a service(s) to such a clinic patient is therefore, between the hospital and the dentist(s).
- B. Dental services performed on an inpatient basis in approved licensed hospitals are reimbursable provided that they require that level of care which must be documented on the hospital records.

Dental services are also reimbursable if the patient is admitted for an eligible non-dental condition and dental services are rendered as part of the prescribed treatment for such condition, or to alleviate the patient's discomfort during the period of hospitalization.

PLEASE NOTE THAT:

- 1. Admission may be by the dentist or by a physician depending on the by-laws of the individual hospital.
- 2. When inpatient services are performed by a dentist(s), who is reimbursed by the hospital under contractual or other arrangements, the services are considered a hospital cost, and must be billed by the hospital and not by the dentist.

3. Authorization by a Dental Consultant of the Medicaid Program is for services only and does not authorize the place of service; thus such authorization does not guarantee payment.
 4. Whenever all or any portion of the hospital inpatient claim is denied for payment, the attending practitioner's claim for inpatient services rendered during the denial period will also be denied for payment.
- C. Dental services as performed by a licensed dentist in a long term care facility, or elsewhere outside the provider's office setting are reimbursable provided that:
1. The policies and procedures as detailed in this Manual are followed.
 2. In a long term care facility, the dentist rendering the dental services is not an owner, administrator, stockholder of the company or corporation or otherwise has a direct financial interest in the facility.

NOTE: Reimbursement of a supplemental fee for an out-of-office visit in addition to a fee for service is limited to once per trip per facility, regardless of the number of patients examined or treated during that visit.

203. SCOPE OF SERVICES

203.1 Diagnostic Services

A. Examination

1. A complete examination of the oral cavity must be a comprehensive and thorough inspection of the oral cavity to include diagnosis, charting, and recording of the recommended treatment. It should permit a Dental Consultant (with accompanying X-rays) to determine the appropriateness of the treatment plan.
 - a. This dental examination is reimbursable only when part of a total treatment plan, unless the examination discloses no need for treatment, in which case this must be INDICATED by placing the statement "No other treatment necessary" in the Diagnosis box on the Dental Form (MC-10).
 - b. For reimbursement purposes, a complete dental examination shall be limited to once every six (6) months unless prior authorized.
2. An emergency oral examination is distinguished from a complete examination of the oral cavity in that it is applicable only for diagnosis and/or observation of a specific complaint in an emergency situation. It is not reimbursable as an adjunct when other reimbursable services are performed (except diagnostic X-rays).

3. Handicapping Malocclusion Assessment examination (refer to Section 203.8.C.)

For reimbursement purposes, a Handicapping Malocclusion Assessment Examination is limited to the Orthodontist who is a qualified Specialist. (Refer to Section 201.6) This examination is limited to once every six (6) months unless prior authorized.

B. Radiography

Radiological procedures are limited to those normally required to make a diagnosis. Radiographs must be taken to show all areas where treatment is anticipated.

EXCEPTION: Soft tissue lesions.

All X-ray films must be available to the Dental Consultant for evaluation of the treatment or treatment request.

In accordance with good dental practice, the following guidelines must be adhered to:

1. A complete series radiographic study, at least fourteen (14) periapical plus two (2) posterior bite-wing films is limited to once every three (3) years without prior authorization for those patients fifteen (15) years of age or older.

For those under the age of fifteen (15) years, the maximum number of diagnostic X-rays reimbursable as a single radiographic study every three years without prior authorization is as follows:

- a. Up to and including age six (6) ---- eight (8) films (six periapical plus two bite-wing films)
- b. Age seven (7), up to and including age fourteen (14) ---- twelve (12) films (ten periapical films, plus two bite-wing films).

NOTE: The need for additional films in such a study must be substantiated and specific authorization obtained from the Dental Consultant before reimbursement will be considered.

2. Posterior bite-wing and single anterior films may be taken as needed as part of an examination subject to limitations in Section 203.1, A.1.b. and 2.
3. In order to establish a diagnosis, an X-ray(s) may be taken at any time, as appropriate.
4. All X-ray films must be suitable for interpretation and when submitted to the New Jersey Medicaid Program or its agents must be properly mounted, marked "Right" and "Left" and identified with the patient's name, the date, and the name of the dentist. Films that are technically unacceptable for

proper interpretation will be returned to the provider for replacement at no additional cost to the Medicaid Program, or where appropriate, no reimbursement will be made. When already reimbursed, recoupment will be made where indicated.

5. All X-ray films must be forwarded to the Dental Consultant when procedures requiring prior authorization are requested. It is recommended that the two film packet be used by all dentists so that they may retain a set of films in their offices at all times.
6. Post-operative X-rays normally taken at the conclusion of dental treatment by a dental provider shall be maintained as part of the patient's dental records (for example - final X-ray(s) at completion of endodontic treatment, certain surgical procedures, etc.).
7. All X-rays must be available to authorized representatives of the New Jersey Medicaid Program. They will be reviewed by Dental Consultants of the Medicaid Program and/or dentists representing organized dentistry.
8. It is most important, also, that all X-rays be examined carefully by the provider to assure quality care and to make certain that all necessary treatment has been diagnosed and completed.

C. Clinical Laboratory Services

"Clinical Laboratory Services" means professional and technical laboratory services ordered by a dentist within the scope of his practice as defined by the laws of the state in which he practices and provided by a laboratory that is qualified to participate under the Program. Such laboratories include:

1. Independent clinical laboratories, including physician operated, out of hospital laboratories which perform primarily diagnostic work referred by other practitioners.
2. Hospital laboratories and laboratories of educational institutions which provide laboratory services to ambulatory patients as requested by a licensed practitioner.

NOTE: Services provided by any of the above laboratories must be billed directly to the Program by the laboratory, and not by the dentist.

D. Diagnostic Radiological Services

Radiological (X-ray) services other than those ordinarily provided by a practitioner in his own office may be referred to a dental specialist who will provide radiological services limited to his own special field. Radiological services may also be requested from a physician who is a specialist in radiology or a qualified hospital facility.

NOTE: Services provided by another dentist, physician, or hospital facility must be billed directly to the Program by that provider and not by the referring dentist.

E. Additional Diagnostic Aids

Prior authorization is required for reimbursement for additional aids such as diagnostic models, photographs, etc. (Exception - See Section 203.8 D., Orthodontics)

203.2 Preventive Dental Care

In addition to a dental examination every six (6) months, preventive dental care encompasses the following recommended services:

A. Prophylaxis

1. Dental prophylaxis means the removal of calculus and stains from the exposed and unexposed surfaces of the teeth by scaling and polishing.
2. For reimbursement purposes, dental prophylaxis shall be limited to once every six (6) months unless prior authorized.

B. Fluoride Treatment

1. Topical fluoride treatment should be administered in accordance with appropriate standards. This consists of topical application of stannous fluoride or acid fluoride phosphate as a liquid or gel. The use of fluoride incorporated in the prophylaxis paste is not reimbursable as topical fluoride treatment.

NOTE: A complete prophylaxis must be performed prior to the topical fluoride treatment.

2. Reimbursement for topical fluoride treatment shall be limited to once every six (6) months without prior authorization for persons twenty (20) years of age and under.

NOTE: This is not a covered service for persons twenty-one (21) years of age and over.

3. Oral fluoride medication may be prescribed (see Section 203.9 D.6.c.).

C. Recall

Participating dentists are requested to extend the same type of recall procedure to eligible recipients as is used in good dental practice to encourage the maintenance of dental health.

D. Patient Education

Eligible recipients should receive dental health orientation identical to that given all patients.

203.3 Restorative Services

Restorative treatment is limited to those services necessary to adequately maintain and restore the integrity and contours of the natural tooth.

A. Filling Restorations

1. Reimbursement for restorations in deciduous teeth is limited to deciduous cuspids and molars of children up to and including age nine (9), or in deciduous incisors up to and including age five (5), but not where exfoliation is imminent.

EXCEPTION: Prior authorization by a Dental Consultant.

2. Reimbursement will only be made when silver amalgam is utilized for restoration of posterior teeth and silicate cement, composite, plastic, or acrylic filling material is utilized for the six (6) anterior teeth in each arch.

EXCEPTIONS:

- a. Composite restorations may be provided on the mesial, occlusal, and buccal surfaces of the first bicuspids; however, the distal surface may also be provided, but only in conjunction with the mesial and occlusal surfaces, or
- b. Prior authorization by the Dental Consultant.
3. Linings or bases will be provided under all fillings as required by good dental practice.
4. Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third (1/3) of the buccal or lingual surface(s) of the tooth.

B. Crown Restorations

1. Authorization for crowns may be granted only when there is substantial loss of tooth structure and the condition of the remaining teeth and supporting tissue justify this treatment. X-ray studies must be submitted.
2. Generally, temporary (quick cure) acrylic or plastic (pre-fabricated) crowns or acid etch type restorations only, may be authorized for badly broken down anterior teeth up to and including age fifteen (15). Likewise, preformed stainless steel crowns may only be authorized for deciduous teeth and permanent posterior teeth up to and including age seventeen (17).
3. Acrylic or porcelain veneer on metal may be authorized only when esthetically necessary.
4. Porcelain jackets will not be authorized.

203.4 Endodontia

When requesting endodontic treatment, consideration should be given to the age and general health of the patient, the status of the tooth in the arch, and the condition of the remaining dentition and supporting structures.

- A. Reimbursement for root canal therapy for all teeth shall include extirpation, treatment, complete filling of the root canal(s) with permanent material, all necessary X-rays during treatment and post-operatively, and follow-up care.

NOTE: Prior authorization is necessary. When the patient is in pain, the dentist should institute appropriate emergency measures to extirpate the pulp and/or relieve the pain only until authorization is requested and received.

- B. Pulpotomy

A pulpotomy will be limited to a deciduous tooth or a permanent tooth with incompletely formed roots. A post-operative X-ray must be available.

- C. Pulpectomy

Root canal therapy for deciduous teeth (with permanent successors only) will include extirpation, treatment, and filling of the root canal(s) with resorbable filling material. A post-operative X-ray must be available.

- D. Pulp capping (direct) is defined as an obtundent or regenerative dressing over the directly exposed vital pulp. This is differentiated from the routine placement of a medicated base or lining under a filling, which is not reimbursable.

- E. Apicoectomy

1. Apicoectomy will be considered for authorization and reimbursement only if one or more of the following conditions exist:

- a. Overfilled canal (previously treated tooth);
- b. Canal cannot be filled properly because of excessive root curvature or calcification;
- c. Fractured root tip that cannot be reached endodontically;
- d. Broken instrument in canal;
- e. Perforation of apical third of canal;
- f. Broken root canal filling lying free in periapical tissues and acting as an irritant;
- g. Periapical pathology not resolved by previous endodontic therapy;

- h. Periapical pathology which will not be resolved by endodontic therapy alone;
- i. A post, post and core, or post-crown which cannot be removed.

NOTE: Apicoectomy should not be performed for convenience. If endodontic treatment is necessary, but none of the above conditions exist, reimbursement for the apicoectomy will not be made.

- 2. Retrograde filling(s) will be inserted when necessary in conjunction with appropriate endodontic treatment, but not in lieu of a properly filled canal.
- 3. Post-treatment X-rays are required.

203.5 Periodontal Treatment

- A. Periodontal treatment may be authorized on a very selective basis. A detailed description of the condition, including radiographs must be submitted to the Dental Consultant.
- B. When requesting periodontal treatment, consideration should be given to the age and health of the patient, the amount of bone loss, the condition of the remaining dentition, the desire, ability and motivation of the patient to follow through with necessary home and follow-up care, and the prognosis, i.e., will the requested treatment preserve the remaining teeth for an appreciable length of time.

203.6 Prosthodontic Treatment

A. Fixed

Fixed bridges will not be authorized.

B. Removable

- 1. Dentures, both partial and complete, may be authorized when submitted evidence indicates masticatory deficiencies likely to impair the general health of the patient. Prefabricated dentures or dentures that are temporary in nature are not reimbursable.
- 2. The following factors should also be considered when requesting authorization for dentures (including immediate dentures):
 - a. Age, school status, employment status and rehabilitative potential of the patient (e.g., provision of dentures will enhance vocational placement);
 - b. Medical status of patient (nature and severity of disease or impairment) and psychological predisposition;

- c. Condition of the oral cavity, including abnormal soft tissue or osseous conditions;
 - d. Condition of present denture, if applicable.
3. Generally, authorization for partial dentures to replace posterior teeth will not be permitted if there are at least eight (8) posterior teeth periodontally sound in good occlusion and position, or where prosthesis in one (1) arch will produce equivalent dentition.
 4. Normally, there must be a three (3) month wait (for healing) between the date of last extraction and initiation of the denture(s) (partial or complete) (except immediate denture(s)).

NOTE: a. Should the provider initiate the denture treatment (i.e., take final impressions) prior to the expiration of the three (3) month healing period, he will be responsible for all subsequent relines, rebases, and/or remaking of the denture(s) if necessary for a six (6) month period following insertion.

b. When all services are to be performed by the same practitioner, the total treatment plan for the extractions and denture(s) will be authorized in toto. As soon as the extractions are completed the claim should be submitted for payment for the diagnostic and/or extraction(s) service. After the required period of time for healing has taken place and the denture provided, a second claim should be completed (for the denture(s) only) and submitted to the Contractor marked "continuation of previously authorized treatment plan". (Refer to Chapter III, Section 300.2 G.2.c.)

5. The fee for complete maxillary and/or mandibular denture(s) will include necessary adjustments for a six (6) month period following insertion.

NOTE: The fee for immediate dentures will include the necessary adjustments and relines for a six (6) month period following insertion.

6. Partial dentures must be described on the Dental Form (MC-10), indicating material used, position of clasps and teeth to be replaced. Fee includes necessary adjustments for a six (6) month period following insertion.
7. Payment for dentures will be denied unless ALL dental procedures, in BOTH arches are completed before impressions are taken for authorized dentures.
8. Dentures will not be authorized when:
 - a. Dental history reveals that any or all dentures made in recent years have been unsatisfactory for reasons that are not remedial because of physiological or psychological reasons, or

- b. Dental history reveals that a denture was provided through any New Jersey State, County, or Municipal Agency in the five (5) year period prior to the date of the current request, or
 - c. Repair, relining, or rebasing (jumping) of the patient's present denture will make it serviceable.
9. Denture relining, rebasing (jumping) or repairing (other than as noted in Section 203.6 B.4. and 5.) are reimbursable.
- NOTE: The fee will include all necessary adjustments for a six (6) month period following insertion for relining and rebasing and three (3) months for repairs.
10. The patient's name (first and last names or where space is a factor, first initial and last name) must be processed into all dentures during the original fabrication or where possible during any subsequent processing procedure (repair, reline, rebase, etc.). The Social Security number should also be included if space permits.

203.7 Exodontia and Oral Surgery

A. Exodontia

- 1. Extraction of teeth other than those classified as non-restorable requires prior authorization (see Section 202.2 (1))

NOTE:

- a. Where any extraction is being considered which will necessitate the insertion of a dental prosthesis, prior authorization is mandatory. Reimbursement for such an extraction(s) rendered without appropriate authorization will be denied, or if already paid, reimbursement will be recovered.

Due to the rule limiting the authorization of denture(s) (refer to Section 203.6 B.8.b.) it may be impossible to replace a denture(s) following such extraction(s). Therefore, careful consideration should be given to the condition of teeth,

- 1.) Prior to a request for dentures initially, and,
 - 2.) Prior to any extraction which would jeopardize an existing denture.
- b. When any extraction is to be performed in conjunction with or during orthodontic treatment, the dentist must determine:
 - 1.) That such orthodontic treatment has been authorized through the Office of the Dental Director, Division of Medical Assistance & Health Services. (The Regional Dental Consultant or the Office of the Dental Director may be contacted for this information.)

2.) That such extraction(s) has the express consent of the treating Orthodontist. Reimbursement will be denied (or if already paid, reimbursement will be recovered) for any extraction(s) performed:

- (a) In conjunction with orthodontic care if such orthodontic treatment has not had authorization from the Office of the Dental Director, or
- (b) On an appropriately authorized orthodontic case without the consent of the treating Orthodontist, or the approval of the Office of the Dental Director.

- 2. Reimbursement for dental extraction(s) will include indicated alveoplasty.
- 3. Alveoplasty, not related to current dental extraction(s), is reimbursable based on demonstrated dental necessity.
- 4. Reimbursement will not be made for the extraction of impacted teeth which have not been prior authorized. Extraction of impacted teeth will be authorized only when conditions arising from such impactions warrant their removal. Thus, the extraction of asymptomatic impacted teeth or those teeth where dental/medical necessity cannot be demonstrated will not be accepted for reimbursement.
- 5. Extractions in more than one sextant of the mouth must be justified as an emergency procedure.

B. Oral Surgery

- 1. Requests for reimbursement or authorization of oral surgical procedures must include a detailed description giving dates, diagnosis, site, and size of the operative area (number of lesions, number and size of lacerations, etc.). For authorization, pre and post-operative X-rays, radiological, operative, and laboratory reports should be submitted directly to the Dental Consultant with the Dental Form (MC-10). The dentist will also be responsible for making available all other reports, including hospital X-rays, upon request.
- 2. In the event that the oral surgery service to be performed is of an emergency nature and prior authorization is normally required but not feasible, then the Dental Form (MC-10) with all necessary information as mentioned in the above paragraph should be forwarded to the Dental Consultant for authorization prior to submission for payment.
- 3. The dentist performing a biopsy will receive reimbursement for the surgical portion only.
 - a. The laboratory performing the diagnostic service (and not the dentist) must bill the Program directly.

- b. There will be reimbursement to the dentist when the biopsy is performed as an independent procedure separate and apart, and on a different date from the excision of the total lesion.

203.8 Orthodontic Treatment

The following procedures are to be followed for orthodontic referral, evaluation, and treatment.

Orthodontic evaluation and treatment may be performed only by an Orthodontist who is a qualified specialist (see Section 201.6). Orthodontic treatment will be authorized on a very selective basis.

A. Orthodontic treatment will not be authorized:

1. For cosmetic purposes only
2. For individuals age twenty (20) or older

B. Referral procedure

The following factors should be considered by the referring dentist before making the referral and also by the Orthodontist before assessing the patient and performing the diagnostic workup:

1. All referrals for orthodontics and requests for orthodontic treatment should be delayed until the patient has all succedaneous teeth.
2. The patient, together with the parent or guardian, should have the desire and ability to complete an extended treatment plan.
3. The rehabilitative potential of the patient should be considered.

REMINDERS:

- a. Many children become ineligible for Medicaid at age 18.
- b. The prospects of the patient remaining in the geographic area where treatment is to be rendered should be considered.
- c. The time period that the patient will remain eligible for Medicaid benefits should be sufficient to complete the treatment.
- d. THE NEW JERSEY MEDICAID PROGRAM WILL NOT REIMBURSE A PROVIDER FOR ORTHODONTIC TREATMENT RENDERED DURING PERIODS OF INELIGIBILITY.

C. Handicapping Malocclusion Assessment System

THE NEW JERSEY MEDICAID PROGRAM HANDICAPPING MALOCCLUSION ASSESSMENT SYSTEM* IS TO BE UTILIZED BY ORTHODONTISTS TO DETERMINE THE NEED FOR ORTHODONTIC TREATMENT.

A reprint from the American Journal of Orthodontics (10/68) entitled "Handicapping Malocclusion Assessment to Establish Treatment Priority" provides comprehensive instructions for completion of the Assessment Record. A copy of the reprint can be ordered from:

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

D. Procedures to be followed by Orthodontist

1. The Orthodontist, after considering the factors in paragraphs B., 1., 2., 3., and C. above, performs a visual/oral examination of the patient, and completes the Assessment Record Form (FD-10) to determine if the severity of the malocclusion will qualify (twenty-four (24) points) for further diagnostic workup and submission of a proposed treatment plan.
2. If the malocclusion does not meet the minimum number of assessment points (twenty-four (24)), do not proceed with the diagnostic workup since reimbursement will be denied.

EXCEPTION:

If the malocclusion does not meet the minimum number of assessment points (twenty-four (24)), but there are other extenuating circumstances that should be considered, you may proceed with the diagnostic workup; however, these factors must be noted and substantiated when submitting the diagnostic workup and treatment plan for prior authorization.

EXAMPLES:

- a. Facial or oral clefts
- b. Extreme antero-posterior relationships
- c. Extreme mandibular prognathism

* The Assessment System is a modification of the work of Dr. J. A. Salzmann who has consented to allow the Medicaid Program to modify and utilize it. The major difference from Dr. Salzmann's original work is that the Medicaid Program does not allow the eight (8) additional points to denote aesthetic handicap for the anterior segment.

- d. A deep overbite where incisor teeth contact palatal tissue.
- e. Extreme bi-maxillary protrusion.

For reimbursement of the Assessment Examination only, submit a Dental Claim Form (MC-10) directly to:

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

with a copy of the Assessment Record Form (FD-10) identifying by procedure code 0140, the service that has been rendered.
(Limitation - See Section 203.1 A.3.)

- 3. If the malocclusion meets or exceeds the minimum number of assessment points (twenty-four (24)), the Orthodontist should proceed with the diagnostic workup without obtaining prior authorization.

E. Prior Authorization for Orthodontic Treatment

Upon completion of the diagnostic workup, submit the following to the Dental Section, Division of Medical Assistance & Health Services, P. O. Box 2706, Trenton, New Jersey 08625.

- 1. The Dental Form (MC-10) utilizing the proper procedure code number with requested fees for:
 - a. Assessment examination
 - b. Diagnostic aids utilized
 - c. Treatment necessary to carry the case to completion
- 2. A brief description of the proposed plan of treatment on provider's personal letterhead.
- 3. A copy of the Handicapping Malocclusion Assessment Form (FD-10).
- 4. Diagnostic aids must include and reimbursement will be limited to:
 - a. Diagnostic models with the correct inter-arch relationship indicated.
 - b. A cephalometric radiograph with a detailed tracing.
 - c. A series of intra-oral radiographs consistent with policy as stated in Section 203.1 B.1. (or a diagnostic panoramic radiograph).
 - d. Extra-oral lateral plate radiographs (but not if a diagnostic panoramic radiograph has been submitted).
 - e. Photographs (minimum size 2" x 2") or slides - maximum reimbursable - six (6).

NOTE: ALL THE DIAGNOSTIC AIDS WILL BE RETURNED TO THE ORTHODONTIST, BUT MUST BE MADE AVAILABLE UPON THE REQUEST OF THE OFFICE OF THE DENTAL DIRECTOR, DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES. IT IS SUGGESTED THAT MODELS BE DUPLICATED BEFORE SUBMISSION TO ENABLE YOU TO RETAIN A SET IN YOUR OFFICE SHOULD THERE BE BREAKAGE OR LOSS IN MAILING.

A Consultant of the N. J. Medicaid Program will review the plan of requested treatment utilizing the diagnostic aids submitted and render a decision.

The Orthodontist will be notified by the Medicaid Program of the action taken on the treatment request following review by the Dental Consultant(s).

F. Progress Reports

Periodically, the Office of the Dental Director, Division of Medical Assistance & Health Services, will request a progress report from the provider, and if necessary progress models and any other appropriate records to determine whether authorization should be continued.

G. Final Records

Final records similar to diagnostic aids described in paragraph E.4., above, taken at termination of treatment must be submitted together with the last Dental Claim Form (MC-10) to:

Office of the Dental Director
Division of Medical Assistance & Health Services
P. O. Box 2706
Trenton, New Jersey 08625

203.9 Adjunctive General Services

A. Anesthesia, Analgesia, and Intravenous Sedation

1. Local Anesthesia: The administration of local anesthesia is considered part of the operative or surgical procedure and no additional fee will be paid.
2. Analgesia: an inhalation anesthetic for the purposes of analgesia is considered as part of an operative or surgical procedure, and no additional fee will be allowed.
3. General Anesthesia: In any setting, exclusive of a hospital, when general anesthesia is provided by the dentist, such may be authorized subject to the following:
 - a. Necessity for same is demonstrated.
 - b. Reimbursement can only be made to a dentist who satisfies all the established rules and regulations and has such written certification (permit) as may be required by the State of N.J. or the State in which the service is being rendered.

- c. When the dentist performing the dental service (attending dentist) also administers the general anesthesia, then procedure code 9220 (see Section 401.10) only is used and reimbursement will be limited to one (1) general anesthesia charge per visit.
- d. When general anesthesia is administered by a dentist whose sole function is to administer general anesthesia, such service is reimbursable provided:
 - 1.) Anesthetic management is necessary to perform restorative dentistry alone or restorative dentistry in conjunction with other dental services.
 - 2.) Special general anesthesia codes are utilized (see Section 401.10),
 - 3.) An anesthesia record is maintained and submitted along with both the Dental Forms (MC-10) for anesthesia and treatment.

NOTE: 1. The anesthesia record submitted must show elapsed anesthesia time, pinpoint the time and amounts of drugs administered, pulse rate and character, blood pressure, respiration, etc.

2. Elapsed anesthesia time means the time from induction of the general anesthesia to the completion of the operation, or in other words, table (chair) time only.

- e. Authorization of general anesthesia is not required in conjunction with an emergency procedure.
4. Intravenous Sedation: The administration of intravenous sedation may be authorized for reimbursement subject to the following conditions:
- a. Such sedation is administered continuously during the operative or surgical procedure.
- NOTE: No reimbursement will be made for injections given as pre-operative medication.
- b. Necessity for same is demonstrated.
 - c. Person administering the intravenous sedation is a dentist satisfying all rules and regulations as established and has such written certification (permit) as may be required by the State of New Jersey or the State in which the procedure is being performed.
 - d. There can be only one charge for intravenous sedation per visit.

- e. Prior authorization of intravenous sedation is not required in conjunction with an emergency procedure.

B. Injection

Within the scope of accepted dental practice, intradermal, subcutaneous, intramuscular, and intravenous injections are reimbursable in the following setting: office, home, and those independent clinics reimbursed for dental services on a fee for service basis.

1. Reimbursement for the above injections are on flat fee basis and are all inclusive for the cost of the service and the drug.
2. A visit for sole purpose of an injection is reimbursable for the injection only. If other dental procedures are performed that are reimbursable, an injection may, if medically indicated, be considered in addition to the other procedures. The drug administered must be consistent with the diagnosis and conform to accepted medical and pharmacological principles in respect to dosage, frequency, and route of administration.
3. Intravenous injections are reimbursable only when performed by the dentist.
4. No reimbursement will be made for vitamins, liver or iron injections or combinations thereof except in laboratory proven deficiency states requiring parenteral therapy.
5. No reimbursement will be made for placebos or any injections containing amphetamines or derivatives thereof.
6. No reimbursement will be made for an injection given as a pre-operative medication or as a local anesthetic which is part of an operative or surgical procedure.
7. The appropriate procedure code, name of the drug injected, dosage and route of administration, along with the complete diagnosis for which the injection was given must be inserted on the Dental Claim Form (MC-10).

C. Drugs and Supplies

Drugs, biologicals, or supplies used, administered or provided by the dentist are considered part of the professional service and no additional fee will be authorized.

D. Prescription Policies

1. This section is intended to describe the practitioner's responsibility in the writing of prescriptions in order to maintain the traditional patient-prescriber-provider relationship, and to ensure the recipient free choice of provider. Practitioners are urged to familiarize themselves with all aspects of this section in order to effect economies consistent with good medical/dental practices and to facilitate prompt payment to the provider.

All practitioners licensed or authorized to prescribe by the State of New Jersey, and who comply with all rules and regulations of the New Jersey Health Services (Medicaid) Program are eligible to prescribe for eligible Medicaid recipients. Out-of-State practitioners may prescribe under this Program, as herein outlined, if they meet the same requirements in their state.

The New Jersey Medicaid Program has an approved Generic Formulary. The prescriber should give preference to non-proprietary or generic named drugs of equal therapeutic effectiveness if available at a lower cost than proprietary or brandnamed drugs.

When prescribing a brandnamed drug, the prescriber must indicate either "Formulary Alternate Permitted" or "Dispense as Written" (may be abbreviated "FAP" or "DAW") on each written or telephoned prescription.

2. The practitioner's Individual Medicaid Practitioner Number (IMP Number) must appear on all prescriptions, and must be given to the pharmacist with all telephone orders. The appearance of this number in addition to the practitioner's name serves to expedite the mechanical aspects of processing the prescription claim. This requirement is a necessary and efficient step in computing each claim.
3. Patient's full name, address, and age must appear on prescription.
4. Dosage and directions.

The practitioner must include specific directions on all drug prescriptions or the prescription will not be eligible for payment. Examples of non-acceptable directions are "prn", "as directed", "ad lib", etc.

Exception:

- a. Topical application
 - b. Aerosol inhalers
 - c. Nitroglycerin, or
 - d. Pharmacy items for which specific directions for use are seldom possible.
5. The choice of prescription drugs remains at the discretion of the prescribing practitioner. However, the practitioner should be aware that pharmacies will not receive payment for certain prescription drugs. (See paragraph 8. of this section)

When prescribing a trade name multi-source drug product for which a Maximum Allowable Cost (MAC) limitation has been established by the Pharmaceutical Reimbursement Board, Department of Health, Education and Welfare, "limitation shall not apply in any case where a physician certifies in his own handwriting that in his judgment a specific brand is medically necessary for a particular

patient." In this instance, the dentist must write "Brand Necessary" or "Dispense as Written" in his own handwriting on each written or telephone prescription. (See Section 203.9 D.9.b.)

The practitioner should give preference to:

- a. Drugs listed in the latest edition of the U.S. Pharmacopoeia (U.S.P.), National Formulary (N.F.), A.M.A. Drug Evaluation, and Accepted Dental Therapeutics.
- b. Oral medication when as effective as injectable preparations.

6. Quantity of Medication

The quantity prescribed should provide a sufficient amount of medication necessary for the duration of the illness or an amount sufficient to cover the interval between visits, but may not exceed a sixty (60) day supply.

Any drug used continuously (i.e., daily, three times daily, every other day, etc.) for fourteen (14) days or more is considered to be a sustaining drug or maintenance medication and should be prescribed in sufficient quantities to treat the patient for up to sixty (60) days.

In Long Term Medical Care Facilities (i.e., Skilled Nursing Home, Infirmary Section of Home for the Aged, or Public Medical Institution), if the quantity of sustaining drug or maintenance medication is not indicated in writing by the prescriber, the pharmacy provider must dispense an appropriate quantity of medication not to exceed a one month supply.

EXCEPTION:

- a. Vitamins and vitamin-mineral combinations may be prescribed and dispensed in quantities up to a one hundred (100) day supply.
- b. Hypodermic syringes and/or needles may be prescribed and dispensed in quantities up to a one hundred (100) day supply (drugs to be administered to a patient by other than the prescriber or an employee of the prescriber). Written prescription must include this statement, "Medicaid authorized".
- c. Sodium fluoride drops, tablets, or oral rinse/supplement may be prescribed and dispensed in quantities up to a one hundred (100) day supply.

7. Services Requiring Prior Authorization

The following therapeutic classes and dosage forms require Prior Authorization obtained by the prescribing practitioner from the Local Medical Assistance Unit. If the request is approved, an authorization number will be provided and must appear on the prescriber's original prescription. The pharmacist must check

the box in the space provided on the Prescription Claim Form (MC-6) identifying a prior authorized item and enter the authorization number in the proper space in this area.

- a. Antiobesics and Anorexics
- b. Protein Replacement Products, such as (but not limited to) Prohana, Portagen, Nutramigen, and Neo-Mullsoy.
- c. Preventive drugs when not available through the Department of Health or provided without charge by public or voluntary agencies.
- d. Injectable drugs

Drugs to be administered to a patient by other than the prescriber or an employee of the prescriber. Written prescription must include the statement, "Medicaid authorized".

- e. Methadone

Exception:

Not reimbursable for use in drug detoxification or for addiction.

8. Pharmaceutical Services not Eligible for Payment

- a. Drugs for which adequate literature, i.e., package inserts, etc. and price catalogues are not readily available.
- b. Experimental drugs.
- c. Drugs administered or directly furnished by the practitioner. (Payment for drugs will be made only when dispensed by a registered pharmacist in a licensed pharmacy.)
- d. Preventive drugs and biologicals provided without charge through programs of other public or voluntary agencies (i.e., New Jersey State Department of Health, etc.)
- e. Medications prescribed for use by hospital inpatients.
- f. Prescribed non-legend (OTC) drugs for patients in long term medical care facilities (i.e., skilled nursing homes, infirmary sections of a home for the aged or public medical institutions).
- g. Prescriptions written and dispensed with non-specific directions.
- h. Telephoned "refill" prescriptions.
- i. Medication prescribed for a Title XIX (Medicaid) covered person who is receiving benefits under Part A of Title XVIII (Medicare) as a patient in a long term care facility.

- j. Prescribed non-legend drugs unless specifically listed in Appendix B (Allowable Non-Legend Drugs). (Appendix B is furnished separately as a loose-leaf section of the New Jersey Blue Cross Drug Code Register) The Register is available from Blue Cross.
- k. Food supplements, milk modifiers, infant formula, and therapeutic diets.

EXCEPTION:

Protein replacements, See Section G. (Services Requiring Prior Authorization)

- l. Methadone when used for drug detoxification or addiction.
- m. Drugs for which final orders have been published by the Food and Drug Administration, withdrawing the approval of their New Drug Application (NDA).

9. Telephoned Original Prescriptions

- a. Prescriptions may be telephoned to the pharmacist when in accordance with all applicable Federal and State laws and regulations, and must include prescriber's Individual Medicaid Practitioner Number (IMP Number) (See Section 203.9 D.2.)
- b. When a physician chooses to certify "Brand Necessary" or "Dispense as Written" or a MAC listed drug product, he must submit a written prescription order to the pharmacist, containing the certification within seven (7) days of the date of the telephone order. The prescription must be retained by the pharmacist as the original prescription. Failure to comply will result in the claim for that prescription to be reduced to the MAC reimbursement level.

NOTE:

For drugs listed in the New Jersey Medicaid Formulary, the prescriber must indicate either "Formulary Alternate Permitted" (FAP) or "Dispense as Written" (DAW) for each prescription transmitted. Then, the pharmacist shall transpose this information onto the written prescription.

10. Prescription Refill

- a. Refill instructions must be indicated by the practitioner on his original prescription.

NOTE:

Telephone orders for refills are not permitted.

- b. Prescriptions are limited to a maximum of two refills within a six month period. If additional quantities of the same medications are required, a new prescription must be written by the practitioner.

EXCEPTION:

Vitamins and vitamin/mineral combinations originally prescribed for a one hundred (100) days supply may be refilled two (2) times within one year.

- c. Refill instructions indicating "refill PRN" or indicating more than two refills will be honored for payment only up to the limits imposed in paragraph b. above.

11. Medical/Dental Supplies

Medical/Dental supplies and equipment and other devices that are essential for the patient's medical/dental condition are allowable unless otherwise available at no charge from community resources (i.e., The American Cancer Society, service organizations, etc.). A personally signed legible and dated order by the practitioner is required.

Following receipt of a prescription from the dentist, prior authorization from the Local Medical Assistance Unit must be obtained by the provider (pharmacist or medical supply dealer) for certain medical/dental supplies. Therefore, the practitioner must be prepared to certify and document medical/dental necessity to the Dental Consultant.

Normally, claims for items under \$30.00 require no prior authorization (unless specifically required in the Provider Manual and/or HSP Newsletters).

EXCEPTION:

Oral Hygiene Devices require prior authorization regardless of cost.

NOTE:

- a. Consideration for authorization shall be based on the least costly appliance fulfilling the requirements of the specific situation.
- b. Standard tooth brushes, dental floss, etc. are personal hygiene items and therefore not reimbursable.

CHAPTER III

300. PROVIDER INSTRUCTIONS FOR REQUESTING AUTHORIZATION AND
PAYMENT FOR DENTAL SERVICES

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CHAPTER III

AUTHORIZATION AND BILLING PROCEDURES

300. PROVIDER INSTRUCTIONS FOR REQUESTING AUTHORIZATION AND PAYMENT FOR DENTAL SERVICES

300.1 Patient Eligibility

- A. Patient eligibility should be verified by examining the validation form each time patient is treated.
- B. Since eligibility is usually on a monthly basis (SSI eligibility is on a three month basis) and most dental treatment other than diagnostic and/or emergency procedures will usually extend for a longer period, it is possible that a patient could become ineligible during the course of treatment.
- C. Payment will be made only for dental treatment completed to the date the patient is no longer eligible for services.

EXCEPTIONS: See Chapter II, Section 202.8.E.

300.2 Dental Services Form (MC-10) (Refer to Exhibit A. at end of Chapter III)

- A. This form is to be used for recording proposed treatment and also for billing of treatment rendered.
- B. Procedure code numbers and descriptions as they appear in Chapter IV must be used on this form. A fee must be requested for each procedure and MUST be the usual and customary fee of the provider.
- C. When prior approval is necessary (refer to Chapter II, Section 202.2 (2) for those treatment plans requiring prior authorization), the Dental Form (MC-10) (both copies) should be sent to the Dental Consultant in the Dental Field Office serving the County in which the provider practices (Refer to Exhibit B. at end of Chapter III).

NOTE: Out-of-State providers must submit their Dental Form (MC-10) to the Division Central Office for prior approval (refer to Exhibit B. at end of Chapter III).

- D. Pre-operative X-ray films must accompany the Dental Form (MC-10) when requesting authorization. (Refer to Chapter II, Section 203.1 B.)
- E. Instructions for completing the Dental Form (MC-10).

Item 1 - Patient's Name: Print patient's name, last name first, as it appears on the patient's Validation Form or Medicaid Eligibility Identification Card.

Item 2 - Patient's Address: Print complete address, include zip code. Enter patient's telephone number in appropriate space.

- Item 3 - Health Services Program Case No.: Enter patient's Health Services Case Number exactly as it appears on the Validation Form or Medicaid Eligibility Identification Card.
- Item 4 - Patient Person No.: Enter number as it appears on the Validation Form or Medicaid Eligibility Identification Card. Patient Person numbers 1 through 9 must be shown as 01, 02, 03, etc.
- Item 5 - Age: Enter patient's age in full years as attained at last birthday.
- Item 6 - Sex: Indicate the patient's sex by placing an X in the appropriate box.
- Item 7 - Other Dental Insurance: Indicate other dental health insurance coverage by entering an X in the appropriate box.

No Fault Auto Coverage: Indicate by placing an X in the appropriate box if the treatment was necessary as a result of an auto accident.

If answer is yes to either question, attach a copy of the explanation of payment or the decline notice from the appropriate insurance carrier. If no payment has been received, a complete report of the current status of the claim should be attached.

NOTE: Claims collectible under the New Jersey "No Fault" Law are not reimbursable under the New Jersey Medicaid Program, however, supplemental payments can be made if the provider has received less than he would obtain from the Medicaid Program.

- Item 8 - Illness or injury - employment related or injury due to automobile accident: Indicate if patient's illness or injury is employment related or result of auto accident by entering an X in the appropriate box. If yes is indicated in employment related questions, enter the name and address of the employer.
- Item 9 - Place of Service: Indicate the place of service by placing an X in the appropriate box.
- Item 10 - EPSDT Program Referral

This question must be answered for recipients under twenty-one (21) years of age.

Early Periodic Screening, Diagnosis and Treatment (EPSDT), is an aspect of the Medicaid Program which ensures that

recipients under twenty-one (21) years of age receive early detection of disease and illness, as well as diagnostic and treatment services. If an EPSDT screening uncovers a health problem or defect, the patient may be referred to another practitioner for further diagnosis and/or treatment.

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

- Item 11 - Provider Name, Address and Number: This area is preprinted for the convenience of the provider who only need enter his telephone number in the appropriate box.

NOTE: Inform Prudential Insurance Company immediately of any errors in preprinting (refer to Exhibit B. at end of Chapter III).

- Item 12 - Existing or Previous Dentures: Indicate whether or not the patient has existing or previous dentures by placing an X in the appropriate box. If yes, indicate whether partial or complete dentures, date inserted, usable or repairable for both maxillary and mandibular.

NOTE: When prior authorization for dentures is requested, the claim will not be reviewed by the Dental Consultant if this Section is not completed.

- Item 13 - Number of X-rays: Indicate the number of pre-treatment and post-treatment X-rays on appropriate line.

- Item 14 - Date of Initial Impressions: Insert date of initial impressions for maxillary and mandibular denture(s) on appropriate line, if applicable.

- Item 15 - Record Recommended Treatment: Do not make any entries in the shaded area. Use one line for each procedure. Print clearly.

Date of Service: Date procedure was completed, - month, day and year. Numbers 1 through 9 are to be shown as 01, 02, 03, etc. Example: May 9, 1978 will be entered as 05 09 78.

Procedure Code: Enter the appropriate procedure code for service proposed or performed. Refer to Chapter IV of Dental Manual for proper code. Since amount of payment will be determined from procedure code, accuracy is most important.

Units of Service: DO NOT USE. These spaces for contractor use only.

Fee Requested: The provider MUST indicate his usual and customary charge for each procedure. Each charge should contain six numerals.

EXAMPLES: \$1.00 written as 0001.00
 \$20.00 written as 0020.00
 \$300.00 written as 0300.00

Amount B, Code and Jam: DO NOT USE. These spaces for contractor use only.

Tooth Code: Identify tooth treated by utilizing tooth numbers from Dental Chart (Item 15 G)

Surface: Indicate each surface treated for each procedure. Use abbreviations as shown in Item 19.

Description of Service: Briefly describe service rendered. Include materials used and all pertinent information using the abbreviations shown in Item 19 as appropriate.

Authorization for Services Only: DO NOT USE.

The Dental Consultant will indicate by initials, date and possibly by a line connecting initials those services which are authorized and, therefore, reimbursable under the New Jersey Medicaid Program. Refer to Exhibit A. at end of Chapter III.

Service Denied: The Dental Consultant will indicate by an X in this column those services which are denied. The service itself will not be lined out by the Dental Consultant. Refer to Exhibit A. at end of Chapter III.

Complete Dental Chart accurately and in detail: Indicate missing teeth, extractions, restorations to be placed indicating all areas where treatment is proposed or has been completed as noted above.

- Item 16 - Diagnosis(es): Enter a diagnosis for those procedure codes prefixed with a "d" in Chapter IV. Where possible, select the diagnosis from the International Classification of Diseases (Adapted for use in the United States), as published by the United States Department of Health, Education and Welfare. (Do not confuse the diagnosis with the patient's complaint or symptoms - pain, swelling, etc. is not acceptable as a diagnosis).
- Item 17 - Referral: Indicate in the appropriate box whether this patient was a referral from another practitioner. If yes, the name and Individual Medicaid Practitioner Number (IMP Number) of the referring practitioner must be provided.
- Item 18 - Remarks: This space is for provider use, should a remark be necessary. Place an X in this box if additional information is attached.

- Item 19 - Abbreviations: To be used when describing the service rendered.
- Item 20 - Charting Symbols: To be used when charting services on The Dental Chart portion of Item 15.
- Item 21 - This Section is to be completed on each claim. If one page is the complete claim, place an X in the top block. If there is more than one page to the complete claim, place an X in the second box and fill in blanks to the right, e.g.: Page 1 of 3, page 2 of 3, etc.
- Item 22 - Patient Certification: The patient must sign the claim only when services have been completed. The patient must not sign a blank form, nor must the patient sign as a condition to receiving services. When the patient's signature is unobtainable, the following procedure must be used:
- a. Illiterate Patient: The patient may sign by the mark X and the signature must be witnessed by another person including the provider of service who signs his name and address on the same line.
 - b. Other: If a patient is deceased, a minor child, physically or mentally incapable of signing, or the patient's signature is not obtainable through reasonable effort, the form may be signed on his behalf by:
 - 1) a parent, or
 - 2) a Legal Guardian, or
 - 3) a relative, or
 - 4) a friend, or
 - 5) an individual provider, or
 - 6) a representative of an institution providing care or support, or
 - 7) a representative of governmental agency providing assistance.

Be sure to indicate on the form why the patient was unable to sign, and the relationship of the signee to the patient-recipient.

- Item 23 - Provider Certification: The signature and IMP Number of the dentist actually performing or supervising the service(s) described on the claim is required in item 23.

EXCEPTION: DENTAL GROUPS - When practitioners in a group practice (whether sole ownership, association, partnership or corporation) submit claims for Medicaid reimbursement, the signature of any member of the group will be accepted on the claim form for billing purposes.

However, the group will be required to enter the IMP Number of the practitioner who personally performed the services represented on the claim. If a claim covers services performed by more than one practitioner, the IMP Number of any one of the performing practitioners will be accepted.

- F. The Dental Form (MC-10) is available from the Medicaid Claims Division, Prudential Insurance Company, P. O. Box 1900, Millville, New Jersey 08332.

300.3 Billing Instructions

A. Routine Dental Services

1. After the routine dental services are completed, have the patient (or his authorized representative) sign the Dental Form (MC-10), Item 22. The provider must also personally sign and date the Dental Form (MC-10), Item 23.
2. The top copy (Contractor's) of the Dental Form (MC-10) should be forwarded to:

Prudential Insurance Company of America
Medicaid Claims Division
P. O. Box 1900
Millville, New Jersey 08332

The second copy (Provider's) should be retained by the provider.

3. REQUEST FOR PAYMENT MUST BE RECEIVED WITHIN NINETY (90) DAYS OF THE LAST TREATMENT DATE.

B. Authorized Treatment Plans

1. After previously authorized treatment plans are completed, the patient (or his authorized representative) must sign the Dental Form (MC-10), Item 22. The provider must also personally sign and date the Dental Form (MC-10), Item 23.
2. The top copy (Contractor's) of the Dental Form (MC-10) should be forwarded to:

Prudential Insurance Company of America
Medicaid Claims Division
P. O. Box 1900
Millville, New Jersey 08332

The second copy (Provider's) should be retained by the provider.

3. REQUEST FOR PAYMENT MUST BE RECEIVED WITHIN NINETY (90) DAYS OF THE LAST TREATMENT DATE

NOTE: When the provider submits a Dental Form (MC-10) for payment before completion of the prior authorized treatment plan because the recipient has not returned

to complete the treatment plan as set forth on the Dental Form, it must be indicated on that Dental Form. In the event the same recipient returns at a later date to complete the prior authorized treatment (should not exceed one (1) year from date of initial examination), the provider may submit the second Dental Form to Prudential without prior authorization provided that there is no change in the treatment plan and the second Dental Form is marked "continuation of previously authorized treatment plan".

C. Orthodontic Treatment (refer to Chapter II, Section 203.8 of the Dental Manual).

1. Following utilization of the Handicapping Malocclusion Assessment System, when the malocclusion does not meet the minimum number of points, the Orthodontist should not proceed with the diagnostic work-up, but should bill for the Assessment Examination only by submitting the Contractor Copy of a Dental Claim Form (MC-10) directly to:

Prudential Insurance Company of America
Medicaid Claims Division
P. O. Box 1900
Millville, New Jersey 08332

with a copy of the FD-10 identifying by procedure code 0140 the service that has been rendered (limitation - See Chapter II, Section 203.1 A.3.)

2. If the malocclusion meets or exceeds the minimum number of assessment points but the case does not fall within the parameters that have been established for orthodontic treatment under the Medicaid Program, the Dental Form (MC-10) with authorization of the diagnostic services performed, will be returned to the Provider for completion of those sections requiring patient and provider signatures and dates. The Contractor's copy may then be submitted to Prudential at the address above for reimbursement.
3. If the orthodontic treatment is approved, proceed as follows:
Immediately, submit the Contractor Copy of the authorized Dental Form (MC-10) with dates of service for those diagnostic services performed to Prudential at the address above. This will be a request for payment for the diagnostic services and will also be Prudential's record of the total authorized orthodontic treatment plan. Retain the Provider copy for the office records.
4. As each stage of authorized orthodontic treatment is finished, complete a new Dental Form (MC-10), insert treatment dates, procedure codes and descriptions, complete sections requiring patient and provider signature and submit the Contractor Copy directly to the Prudential Insurance Company for reimbursement.

Claims may be submitted monthly or quarterly until the authorized treatment is completed.

5. REQUEST FOR PAYMENT MUST BE RECEIVED WITHIN NINETY (90) DAYS OF THE LAST TREATMENT DATE ON EACH CLAIM.



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

DENTAL SERVICES
(PLEASE PRINT)

04

1. Patient's Last Name RECIPIENT				First Name IMA				2. Patient's Street Address 50 MAIN Street				Telephone Number 201-555-2222											
3. Health Services Program Case No. 5530000444				4. Patient Person No. 01		5. Age 30		6. Sex <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female		City ANYTOWN				State NJ		ZIP Code 08999							
7. Other Dental Insurance or Liability Coverage? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, attach copy of Decline Notice or Explanation of Payment from Carrier.								8. Was Patient's illness or injury connected with employment? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, give Name and Address of Employer here.															
No Fault Auto Coverage? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								Did injury result from automobile accident? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
9. Place of Service - <input type="checkbox"/> Patient's Home <input checked="" type="checkbox"/> Doctor's Office <input type="checkbox"/> Indep. Clinic <input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> L.T.C.F. <input type="checkbox"/> Other								10. Was this service performed as a result of an EPSDT Program Referral? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
11. PROVIDER OF SERVICE INFORMATION																							
Telephone Number 201-555-1111				Medicaid Provider Number (Enter only when not printed below) 987654321				PARTIAL Mx. <input checked="" type="checkbox"/> Md. <input checked="" type="checkbox"/>				FULL DATE INSERTED 1-7-70 6-30-75				USABLE: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				REPAIRABLE: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Name and Address Richard Roe, DDS 20 Broadway Bigtown, NJ 07999								13. Number of X-rays Pretreatment 14 Post-treatment _____				14. Date of Initial Impressions Maxillary 4-26-78 Mandibular _____											
JULIAN DATE																							
FOR CONTRACTOR'S USE ONLY																							
TOTAL AMOUNT A																							
TOTAL AMOUNT B																							
47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63																							

15. RECORD RECOMMENDED TREATMENT (11 Services Only)										GRAY SHADED AREA FOR CONTRACTOR USE ONLY											
A. Dates of Service			B. PROCEDURE CODE	C. UNITS OF SERV.	D. FEE REQUESTED	E. AMOUNT B	F. TOOTH CODE	G. SUR. FACE	H. Description of Service (Including X-rays, prophylaxis, materials used, etc.) Use abbreviations from Item 19 Below	I. Division Use Only Authorization for Services only	J. Services Denied										
MO	DA	YR																			
01	12	07	18	011110	30	01010100			EXAMINATION												
01	12	07	78	012114	32	01020100			X-RAYS (PERI-APICAL)												
04	11	07	78	111110	62	010115010			PROPHYLAXIS												
01	12	05	78	711110	62	010201010			EXTRACTIONS		XYZ										
01	13	11	78	23212	30	010215010			C												
01	13	11	78	23213	62	010210010			C												
01	12	05	78	712110	30	010210010			SURGICAL EXTRACTION												
01	20	05	78	211150	62	010210010			Am												
01	05	23	78	51232	30	012150010			MAX CC BAR 2 CLASPS - RESIN BASE												
01	05	23	78	513110	62	010215010			1 Additional CC clasp												
01	12	11	78	313110	30	011010010			Root CANAL THERAPY		1-22-78 XYZ										

18. G		16. Diagnosis(es): PERIAPICAL ABSCESS				17. Is this a Referral? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Referring Practitioner:			
		18. REMARKS: <input type="checkbox"/> Additional information attached.				19. ABBREVIATIONS B - Buccal C - Composite D - Distal G - Gold F - Facial H - Incast S - Silver I - Incisal CC - Chrome Cobalt L - Lingual SS - Stainless Steel M - Mesial Md - Mandibular O - Occlusal Ma - Maxillary AM - Amalgam OR - Defective Restoration			
		20. CHARTING SYMBOLS Extraction Missing Surfaces to be restored B L MOD				21. CHECK ONE BELOW: <input type="checkbox"/> Complete Claim <input checked="" type="checkbox"/> Page 1 Of 2			
FOR RANGING		22. PATIENT'S CERTIFICATION. Authorization to Release Information, and Payment Request. I certify that the service(s) covered by this claim has been received, and I request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the Division of Medical Assistance and Health Services or its authorized Agents any information needed for this or a related claim. Signature (Patient or authorized representative): Ima Recipient Date Signed: 5-23-78				23. PROVIDER CERTIFICATION. I certify that the services covered by this claim were personally rendered by me or under my direct personal supervision (as defined by Program regulations), that the foregoing information is true, accurate and complete, and I agree to keep such records as are necessary to disclose fully the extent of services provided, and to furnish information for such services as the State Agency may request; and that the services covered by this claim and the amount charged therefor are in accordance with the regulations of the New Jersey Health Services Program; and that no part of the net amount payable under this claim has been paid, and that payment of such amount will be accepted as payment in full without additional charge to the patient or to others on his behalf. I also certify that the services have been furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act. I understand that payment and satisfaction of this claim will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both. Provider Signature: Richard Roe Billing Date: 5-23-78 Individual Medicaid Practitioner Number: 49999499A <input type="checkbox"/> Check if same as Item 11			

EXHIBIT "B"

FOR DENTISTS, HOSPITAL OUT-PATIENT
DEPARTMENTS, INDEPENDENT CLINCS
LOCATED IN:

1 Passaic
Middlesex
Morris
Sussex
Hunterdon
Warren
Somerset

2 Bergen
Hudson
Union

3 Essex

4 Ocean
Monmouth
Mercer
Atlantic
Cape May

5 Burlington
Camden
Cumberland
Gloucester
Salem

SUBMIT REQUEST FOR AUTHORIZATION TO:

Dental Section
Middlesex Medical Assistance Unit
75 Paterson Street (basement)
P. O. Box 1274
New Brunswick 08903
Telephone: 201-246-0653

Dental Section
Hudson Medical Assistance Unit
880 Bergen Avenue (3rd floor)
Jersey City 07306
Telephone: 201-792-6390

Dental Section
Essex Medical Assistance Unit
155 Washington Street
Newark, 07102
Telephone: 201-648-3700

Dental Section
Mercer Medical Assistance Unit
1424 South Broad Street
Trenton 08610
Telephone: 609-292-7315

Dental Section
Camden Medical Assistance Unit
530 Cooper Street (3rd floor)
P.O. Box 1089
Telephone: 609-757-2870

OUT-OF-STATE PROVIDERS
SUBMIT REQUESTS FOR AUTHORIZATION TO:

Dental Section
N.J. Division of Medical Assistance and
Health Services
324 East State Street
P.O. Box 2706
Trenton, New Jersey 08625
Telephone: 609-292-7420

REQUEST FOR PAYMENT, PROVIDER
MANUALS, NEWSLETTERS, ADDITIONAL
DENTAL FORMS (MC-10), AND ANY OTHER
PRINTED INFORMATION SHOULD BE
ADDRESSED TO:

Prudential Insurance Company of America
Medicaid Claims Division
P.O. Box 1900
Millville, New Jersey 08332
Telephone: 609-293-2176
201-877-3777

CHAPTER IV

PROCEDURE CODES AND DESCRIPTIONS

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CHAPTER IV

PROCEDURE CODES AND DESCRIPTIONS

400. GENERAL POLICY

The code on dental procedures and nomenclature was developed by the Council on Dental Care Programs of the American Dental Association in order to "identify and categorize dental procedures covered under all types of third party programs. It is intended to facilitate the filing and processing of claims, data tabulation, and the collection of statistics for third party program operation".¹

Codes and nomenclature set forth in this chapter generally conform with those published by the American Dental Association,² but where necessary have been expanded and revised to permit better description, allow for more detailed patient records, ease the recording procedure for the dentist and to speed the reimbursement process.

The fees listed with these procedure codes represent the maximum payment permitted under the Program for a given procedure. Federal and State laws mandate that you must always request your usual and customary fee regardless of the maximum payment allowed.

401. USE OF PROCEDURE CODES

When completing the Dental Form MC-10, the provider should select and enter the procedure code(s) with description(s) that correctly identifies the service(s) rendered or to be rendered. Since reimbursement will be made by the procedure code, make very certain that the procedure code which you enter on the claim form is correct. If the service rendered does not conform to any code in this chapter, the provider must furnish a complete description of the service.

An asterisk (*) denotes those procedures which normally require prior authorization in order to be eligible for reimbursement under the New Jersey Medicaid Program.

A double asterisk (**) denotes those procedures which may be treated in an emergency situation when prior authorization is not feasible. These procedures must receive authorization prior to payment.

1 Journal of the American Dental Association, Volume 85, October, 1972, page 789

2 Journal of the American Dental Association, Volume 92, March, 1976, page 647

The letter (d) denotes those procedures which require that a Diagnosis be entered in the appropriate item on the Dental Form (MC-10) in order to be eligible for reimbursement (See Section 300.2 E. - Item 16)

NOTE: S - Denotes Specialist Fee
 NS - Denotes Non-Specialist Fee
 IC - Denotes Individual Consideration of Fee

401.1 "DIAGNOSTIC"

CLINICAL ORAL EXAMINATION

0110 Comprehensive - (See Section 203.1 A.1) - a 7. 6.
 thorough observation of all conditions present
 in the oral cavity and contiguous structures
 to include:

1. Charting of all abnormalities
2. Diagnosis, and,
3. Development of a complete treatment plan to be recorded in its entirety on the Dental Form(s) (MC-10).

For reimbursement of the examination:

1. It must be limited to once every six (6) months unless prior authorized.
2. All items on the Dental Form (MC-10) must be completed.
3. If no treatment is indicated, this fact must be noted on the Dental Form (MC-10) in the diagnosis box.

d0130 Emergency; for diagnosis and/or observation of 4. 3.
 a specific complaint (make note of diagnosis
 and/or observations on Dental Form (MC-10)).
 Not reimbursable as an adjunct to any reimburs-
 able service (Exception: diagnostic X-rays).

0140 Orthodontic Assessment, using Handicapping 6. -
 Malocclusion Assessment System (Assessment
 Form (FD-10) must accompany Dental Form
 (MC-10) when requesting reimbursement)

1. Limited to the Orthodontist who is a qualified Specialist (See Section 201.6).
2. Reimbursement limited to once every six (6) months unless prior authorized.

RADIOGRAPHS

Radiographs should be limited to those normally required to make a diagnosis, but must show all areas where treatment is anticipated (Exception: soft tissue lesions). These X-rays must be available to the Dental Consultant for evaluation of the treatment or treatment request.

1. For limitations according to age and time, see Section 203.1 A. and B.
2. As part of an examination, posterior bite-wing and single anterior films may be taken as needed. These are limited to once every six calendar months unless prior authorized (see Section 203.1 A.1.b.).
3. In an emergency situation, an X-ray(s) may be taken at any time in order to establish a diagnosis.

INTRAORAL RADIOGRAPHS

Periapical/Bitewing/Occlusal

0201	One (1) film	2.	2.
0202	Two (2) films	3.	3.
0203	Three (3) films	4.	4.
0204	Four (4) films	5.	5.
0205	Five (5) films	6.	6.
0206	Six (6) films	7.	7.
0207	Seven (7) films	8.	8.
0208	Eight (8) films (Maximum number of films reimbursable - up to and including age six (6) without authorization)	9.	9.
0209	Nine (9) films	10.	10.
0210	Ten (10) films	11.	11.
0211	Eleven (11) films	12.	12.
0212	Twelve (12) films (Maximum number of films reimbursable - age seven (7) up to and including age fourteen (14) - without authorization)	13.	13.
0213	Thirteen (13) films	14.	14.
0214	Fourteen (14) films	15.	15.
0215	Fifteen (15) films	16.	16.
0216	Sixteen (16) films (Maximum number of films reimbursable - age fifteen (15) or older - without authorization)	17.	17.
0240	Occlusal, per film	5.	5.

EXTRAORAL RADIOGRAPHS

0251	Lateral, antero-posterior, temporo-mandibular radiographs, etc., one view	10.	10.
------	---	-----	-----

		MAXIMUM ALLOWANCE		
		S	\$	NS
0252	Two views	15.		15.
0253	Three or more views	20.		20.
0310	Sialography only	15.		15.
0311	Sialography - including injection of contrast material (filling and/or emptying phases)	30.		30.
*0330	Panoramic radiograph - maxillary and mandibular - single film	10.		10.
*0340	Cephalometric radiograph	10.		10.
*0341	Cephalometric radiograph, including tracing	15.		15.

MISCELLANEOUS DIAGNOSTIC PROCEDURES

Biopsy - See Codes number 7285 and 7286

*0470	Diagnostic casts, per cast. Casts must have bases and be trimmed to permit articulation	8.		7.
*0471	Diagnostic photographs or slides, per view	1.		1.

401.2 "PREVENTIVE"

DENTAL PROPHYLAXIS

Dental prophylaxis is the removal of calculus and stains from the exposed and unexposed surfaces of the teeth by scaling and polishing and is limited to once every six (6) calendar months unless prior authorized.

1110	Patients over fifteen (15) years of age, maxillary and mandibular arches.	11.		10.
1111	Patients over fifteen (15) years of age, maxillary or mandibular arch (code to be used if patient is edentulous in opposing arch)	5.50		5.
1120	Patients up to and including fifteen (15) years of age, maxillary and mandibular arches	8.		7.

ADDITIONAL SCALING

Scaling over and above that necessary under prophylaxis above. The calculus must be abnormal and visible to the Dental Consultant on X-ray(s). Such scaling must require an additional visit and MUST be prior authorized.

*1150	Patients over fifteen (15) years of age, maxillary and mandibular arches	11.		10.
*1151	Patients over fifteen (15) years of age, maxillary or mandibular arch (code to be used if patient is edentulous in opposing arch).	5.50		5.

FLUORIDE TREATMENT - INCLUDING PROPHYLAXIS

Topical application of stannous fluoride or acid fluoride phosphate - one treatment following a complete prophylaxis (Fee includes both services)

Limited to once every six (6) calendar months without prior authorization for persons twenty (20) years of age and under (Not a covered service for persons twenty-one (21) years of age and over). A complete prophylaxis must be performed prior to the topical fluoride treatment.

1235	Patients over fifteen (15), up to and including twenty (20) years of age, maxillary and mandibular arches.	17.	15.
1236	Patients over fifteen (15), up to and including twenty (20) years of age, maxillary or mandibular arch (Code to be used if patient is edentulous in opposing arch).	8.50	7.50
1245	Patients up to and including fifteen (15) years of age, maxillary and mandibular arches.	14.	12.

OTHER PREVENTIVE SERVICES

SPACE MAINTAINERS

*1510	Fixed, unilateral, band type	40.	35.
*1515	Fixed, unilateral, stainless steel crown type (one crown)	53.	46.
*1520	Fixed, lingual or palatal arch, band type	61.	53.
*1522	Fixed, lingual or palatal arch, stainless steel crown type	93.	81.
*1524	Tooth processed to arch bar (wire) each tooth	6.	5.
*1525	Removable, bilateral type	69.	60.
*1550	Recementation of space maintainer	7.	6.

401.3 "RESTORATIVE"

The fee will include lining or base, restoration, polishing of restoration and local anesthesia, or analgesia. Reimbursement for restorations in deciduous teeth is limited to deciduous cuspids and molars of children up to and including age nine (9) or in deciduous incisors up to and including age five (5) but not where exfoliation is imminent. (See Section 203.3).

Prior authorization by a Dental Consultant is required above age limits.

AMALGAM RESTORATIONS

1. Reimbursable only when silver amalgam is utilized for restoration of posterior teeth.

Exception: Prior authorization by a Dental Consultant.

2. Procedure code must be selected on the basis of the number of surfaces restored per individual tooth (not on the basis of individual fillings), therefore, the fee for any surface will include one or more restorations on that surface.
3. Only one code is reimburable per tooth.
4. Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal or lingual surface(s) of the tooth.

2110	One surface - deciduous	7.	6.
2120	Two surfaces - deciduous	13.	12.
2130	Three surfaces - deciduous	18.	17.
2131	Four (or more) surfaces - deciduous	21.	20.
2140	One surface - permanent	7.	6.
2150	Two surfaces - permanent	13.	12.
2160	Three surfaces - permanent	18.	17.
2161	Four (or more) surfaces - permanent	21.	20.

SILICATE, ACRYLIC, PLASTIC OR COMPOSITE RESTORATIONS

Reimbursement will only be made when silicate cement, composite, plastic, or acrylic filling material is utilized for the six (6) anterior teeth in each arch. (Teeth numbers 6 through 11 and 22 through 27 and/or C through H and M through R).

EXCEPTIONS:

1. Composite restorations may be provided on the mesial, occlusal and buccal surfaces of the first bicuspids; however, the distal surface may also be provided but only in conjunction with the mesial and occlusal surfaces, or

2. When so authorized by the Dental Consultant.

When access to an inter-proximal cavity is gained by involvement of a second surface, reimbursement will be permitted for only one restoration.

Only one code is reimbursable per tooth.

SILICATE RESTORATIONS

2216	One (1) restoration, per tooth (Class III or Class V)	8.	7.
2217	Two (2) restorations, per tooth (Class III and/or Class V)	14.	13.
2218	Three (3) or more restorations, per tooth (Class III and Class V)	19.	18.

ACRYLIC, PLASTIC OR COMPOSITE RESTORATIONS

Anterior Teeth

2330	One (1) restoration per tooth (Class III or Class V)	9.	8.
2321	Two (2) restorations per tooth (Class III and/or Class V)	15.	14.
2322	Three (3) or more restorations per tooth (Class III and/or Class V)	21.	20.
2323	One (1) restoration per tooth (Class IV)	15.	14.
2324	Two (2) restorations per tooth (Class IV)	25.	23.
2325	Two (2) restorations per tooth (One (1) Class IV plus one (1) Class III or Class V)	21.	20.
2326	Three (3) or more restorations per tooth (One (1) Class IV plus additional Class III, IV, or V(s))	25.	23.

COMPOSITE RESTORATIONS

Posterior Teeth - First bicuspid only

2351	One (1) surface	9.	8.
2352	Two (2) surfaces	15.	14.
2353	Three (3) or more surfaces	21.	20.

GOLD FOIL RESTORATIONS

Primarily for use in Dental Colleges

*2410	One (1) surface	9.	8.
*2420	Two (2) surfaces	18.	16.
*2430	Three (3) or more surfaces	27.	24.

GOLD INLAY RESTORATIONS

Primarily for use in Dental Colleges

*2510	One (1) surface	31.	27.
*2520	Two (2) surfaces	56.	49.
*2530	Three (3) or more surfaces	75.	65.
*2540	Onlay, per tooth (in addition to above)	23.	20.

CROWNS

Authorization will be granted only when substantial loss of tooth structure exists and condition of remaining teeth and supporting tissues justify this treatment.

Acrylic or porcelain veneer or metal will be authorized only when esthetically necessary.

*2710	Plastic (acrylic or vinyl) (Laboratory processed)	86.	75.
*2711	Polycarbonate - prefabricated - generally authorized only for deciduous and permanent anterior teeth up to and including 15 years of age.	35.	30.
*2720	Plastic processed to gold (acrylic or vinyl veneer)	144.	125.
*2722	Plastic processed to semi-precious metal	132.	115.
*2750	Porcelain fused to gold	161.	140.
*2752	Porcelain fused to semi-precious metal	150.	130.
*2790	Gold (full cast)	127.	110.
*2792	Semi-precious metal (full cast)	115.	100.
*2810	Gold (3/4 cast)	81.	70.
*2830	Stainless steel - generally authorized only for deciduous teeth and permanent posterior teeth up to and including 17 years of age.	35.	30.
*2840	Temporary acrylic (quick cure) for fractured tooth - not in conjunction with any other restorative procedure on same tooth	23.	20.
*2891	Cast post and core - independent of crown - in addition to crown	52.	45.
*2892	Preformed dowel or post and built up core of composite or amalgam - in addition to crown	34.	30.
*2893	Prefabricated post and core - in addition to crown	34.	30.
*2894	Preformed dowel or post	14.	14.
*2895	Preformed dowel or post including cementation	21.	20.
*2896	Built up core of composite or amalgam in conjunction with codes 2951, 2952, or 2953.	12.	10.

OTHER RESTORATIVE SERVICES

2910	Recement inlay	7.	6.
2920	Recement crown	7.	6.
2951	Reinforcement pins, one pin	4.	3.
2952	Reinforcement pins, two pins	7.	6.
2953	Reinforcement pins, three or more pins	10.	9.
2954	Reinforcement band, including cementation, not reimbursable as an adjunct to any reimbursable filling procedure on that tooth	18.	16.
2960	Acid etch for restoration (Reimbursable in conjunction with codes 2323 through 2326 and 2353 only.)	11.	10.

401.4 "ENDODONTICS"

Authorization of endodontic treatment will be influenced by the:

1. Age and general health of the patient,
2. Status of the tooth in the arch, and
3. Condition of the remaining dentition and supporting structures.

PULP CAPPING - DIRECT

A direct pulp cap is defined as an obtundent or regenerative dressing over the directly exposed vital pulp. This is differentiated from the routine placement of a medicated base, indirect pulp cap, or lining which is not reimbursable.

3110 Pulp cap-direct (excludes final restoration)	6.	5.
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PULPOTOMY

A pulpotomy will be limited to a deciduous tooth or a permanent tooth with incompletely formed roots. Post-operative X-ray(s) must be available.

d*3220 Vital pulpotomy (excludes final restoration)	15.	13.
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ROOT CANAL THERAPY

The fee for root canal therapy includes the extirpation, treatment - complete filling of all the root canal(s) with permanent material, all necessary X-rays during treatment and post-operatively, and follow-up care (Excludes final restoration).

d*3310 Incisors and cuspids (permanent) and all deciduous teeth without permanent successors.	75.	65.
d*3320 Bicuspids (permanent)	109.	95.
d*3330 Molars (permanent)	144.	125.

PULPECTOMY - for deciduous teeth

A pulpectomy includes extirpation, treatment, and filling of all the root canal(s) with resorbable filling material. Post-operative X-ray(s) must be available.

d*3345 Pulpectomy (deciduous teeth with permanent successors only)	17.	15.
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PERIAPICAL SERVICES

For complete details, see Section 203.4 E.

Apicoectomy will be considered for authorization and reimbursement only if one or more of the following conditions exist:

1. Overfilled canal (previously treated tooth),
2. Canal cannot be filled properly because of excessive root curvature or calcification,
3. Fractured root tip that cannot be reached endodontically,
4. Broken instrument in canal,
5. Perforation of apical third of canal,
6. Broken root canal filling lying free in periapical tissues and acting as an irritant,
7. Periapical pathology not resolved by previous endodontic therapy,
8. Periapical pathology which will not be resolved by endodontic therapy alone,
9. A post, post and core, or post-crown which cannot be removed.

NOTE 1: Apicoectomy should not be performed for convenience. If endodontic treatment is necessary, but none of the above conditions exist, authorization for the apicoectomy will not be granted.

NOTE 2: When more than one apical curettage and/or apicoectomy is performed through the same operative incision, the maximum amount reimbursable by the New Jersey Medicaid Program shall be amount specified in this schedule with the greater allowance, plus one-half (1/2) of the amounts specified for each of the other procedures.

NOTE 3: Retrograde filling(s) will be inserted when necessary in conjunction with appropriate endodontic treatment, but not in lieu of a properly filled canal.

NOTE 4: Post-treatment X-rays are required.

APICOECTOMY

d*3411	Incisors and cuspids, per tooth	55.	48.
d*3412	Bicuspid and molars, per tooth	83.	72.

APICOECTOMY COMBINED WITH SINGLE STAGE NERVE EXTIR-
PATION AND CANAL FILLING

d*3425	Incisors and cuspids, per tooth	93.	81.
d*3426	Bicuspid and molars, per tooth	110.	96.

OTHER PERIAPICAL SERVICES

*3430	Retrograde filling - additional (one root), per tooth	6.	5.
*3431	Retrograde filling - additional (two or more roots), per tooth	12.	10.
d*3440	Apical curettage, per tooth	49.	42.
*3450	Surgical resection of entire tooth root(s), hemi-section (not apicoectomy)	55.	48.

OTHER ENDODONTIC PROCEDURES

*3960	Bleaching of nonvital discolored tooth - per visit (limit two visits)	11.	10.
*3965	Apexification - limit two (2) visits - Treatment may extend over a period of eighteen (18) months, first visit	31.	27.
*3966	Apexification - second visit	16.	13.
3990	Emergency procedures (palliative)	7.	6.
*3999	Any other uncoded Endodontic service, by report	IC	IC

401.5 "PERIODONTICS"

Treatment will be authorized only on a very
selective basis. Detailed description and
radiographs required (See Section 203.5)

SURGICAL SERVICES

*4210	Gingivectomy or gingivoplasty, per sextant	29.	25.
*4220	Gingival curettage, per sextant	15.	13.
*4240	Gingival flap procedure, per sextant	24.	21.
*4260	Osseous surgery (including flap entry and closure) - per sextant	50.	43.
*4270	Pedicle soft tissue grafts, per site	32.	28.
*4271	Free soft tissue grafts (including donor site), per site	49.	42.

Vestibuloplasty - see codes 7340, 7345, and 7350

ADJUNCTIVE PERIODONTAL SERVICES

*4320	Provisional splinting - intra coronal, per tooth	18.	16.
*4321	Provisional splinting - extra coronal, per tooth	11.	10.
*4329	Occlusal adjustment - minor - one (1) to three (3) teeth	6.	5.
*4330	Occlusal adjustment, per sextant (minimum 4 teeth)	11.50	10.
*4331	Occlusal adjustment, complete	69.	60.
*4340	Periodontal scaling and root planing, per sextant	17.	15.
*4360	Special appliances (including bite-guard, night-guard, etc.) (Laboratory procedure)	50.	43.
*4365	Special appliances (Office procedure)	35.	30.
*4999	Any other uncoded Periodontal service, by report	IC	IC

401.6 "PROSTHODONTICS - REMOVABLE"

1. Dentures, both partial and complete, may be authorized when submitted evidence indicates masticatory deficiencies likely to impair the general health of the patient.
2. Normally, there must be a three (3) month wait (for healing) between the date of last extraction and initiation of the denture(s), partial and/or complete, except immediate denture(s).
3. The fee for partial and complete dentures will include necessary adjustments for a six (6) month period following insertion.
4. The fee for immediate dentures will also include the necessary adjustments and re-lines for a six (6) month period following insertion.
5. Partial dentures must be described on the Dental Form (MC-10), indicating material to be used, position of clasps, and teeth to be replaced.
6. PAYMENT FOR DENTURES WILL BE DENIED UNLESS ALL DENTAL PROCEDURES, IN BOTH ARCHES ARE COMPLETED BEFORE IMPRESSIONS ARE TAKEN FOR AUTHORIZED DENTURES (COMPLETE OR PARTIAL).
7. Dentures will not be authorized under certain conditions (See Section 203.6 B.).

8. Denture relining, rebasing (jumping) or repairing are reimbursable. However, no additional reimbursement will be made for repair procedures in conjunction with a rebase or reline of a complete or partial denture except for the replacement of missing or fractured teeth, and then only code 5630 can be used.

The fee will include all necessary adjustments for a six (6) month period following insertion for relining and rebasing and three (3) months for repairs.

9. The patient's name must be processed into all dentures during the original fabrication or where possible during any subsequent processing procedure (repair, rebase, reline, etc.) (See Section 203.6 B.10).

COMPLETE DENTURES - Including six (6) months post delivery care: Immediate Dentures - Also includes chairside relines, etc.

*5110	Complete maxillary	197.	171.
*5120	Complete mandibular	202.	176.

IMMEDIATE COMPLETE DENTURES

*5135	Immediate replacement of anterior teeth (including first bicuspid) in conjunction with complete dentures (codes 5110 and 5120 only) in addition to denture, maximum eight (8) teeth, per tooth.	6.	5.
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PARTIAL DENTURES - Including six (6) months post delivery care: Immediate partial dentures also include chairside relines, etc. - see code 5315.

Maxillary or mandibular, without clasps, resin base, up to and including five (5) teeth

*5211	Maxillary	86.	75.
*5212	Mandibular	86.	75.

Maxillary or mandibular, without clasps, resin base, six teeth or more

*5213	Maxillary	109.	95.
*5214	Mandibular	109.	95.

MAXIMUM ALLOWANCE
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Maxillary or mandibular, with two cast chrome cobalt clasps with rests, resin base

*5216	Maxillary	161.	140.
*5218	Mandibular	161.	140.

Maxillary or mandibular with cast chrome cobalt alloy bar (palatal/horseshoe or lingual) and two cast clasps and rests, resin base

*5232	Maxillary	213.	185.
*5233	Mandibular	201.	175.

Maxillary or mandibular with cast chrome cobalt alloy bar (palatal/horseshoe or lingual) and two cast clasps and rests, cast base

*5252	Maxillary	230.	200.
*5253	Mandibular	219.	190.

Unilateral partial denture, cast chrome cobalt alloy with two cast clasps and rests, cast base

*5282	Maxillary	86.	75.
*5283	Mandibular	86.	75.

ADDITIONAL UNITS FOR PARTIAL DENTURES

*5310	Each additional cast chrome cobalt alloy clasp and rest	17.	15.
*5312	Each additional wrought gold clasp and rest	15.	13.
*5313	Each additional buccal or facial arm clasp	8.	7.
*5315	Immediate replacement of anterior teeth in conjunction with partial dentures (codes 5211 through 5283 only) in addition to denture, maximum six (6) teeth, per tooth.	6.	5.

ADJUSTMENTS TO DENTURE Other than dentist providing denture or after the required period of post delivery care (e.g., new dentures, relines, rebases - six (6) months; repairs - three (3) months, etc.)

Complete Dentures

5411	Maxillary	7.	6.
5412	Mandibular	7.	6.

Adjustments to Partial Denture

5421	Maxillary	7.	6.
5422	Mandibular	7.	6.

REPAIRS TO DENTURES

Repairs include adjustments for three (3) months. Prior authorization is not normally necessary when Medicaid reimbursement for a repair to a denture does not exceed thirty-four dollars (\$34) - non-specialist fee, or thirty-nine dollars (\$39) - specialist fee.

Repairing broken complete denture with no teeth damaged

	5611 Maxillary	18.	16.
	5612 Mandibular	18.	16.

Repairing broken partial denture with no teeth damaged

	5616 Maxillary	18.	16.
	5617 Mandibular	18.	16.

Repairing broken complete denture, and in additional, replacing one tooth

	5621 Maxillary	24.	21.
	5622 Mandibular	24.	21.
	5630 Replacing additional teeth, each tooth	5.	5.

Repairing broken partial denture, and in addition, replacing one tooth

	5623 Maxillary	24.	21.
	5624 Mandibular	24.	21.
	5630 Replacing additional teeth, each tooth	5.	5.

Replacing broken tooth on complete denture (no other repairs) first tooth

	5641 Maxillary	18.	16.
	5642 Mandibular	18.	16.
	5630 Replacing additional teeth, each tooth	5.	5.

Replacing broken tooth on partial denture (no other repairs) first tooth

	5643 Maxillary	18.	16.
	5644 Mandibular	18.	16.
	5630 Replacing additional teeth, each tooth	5.	5.

Adding tooth to partial denture (resin or cast) to replace extracted tooth not involving clasp

MAXIMUM ALLOWANCE
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	or abutment tooth - attachment with resin only, first tooth		
5651	Maxillary	29.	25.
5652	Mandibular	29.	25.
5630	Replacing additional teeth, each tooth	5.	5.
	Adding tooth to cast partial denture - additional casting welded to original case - resin attachment of teeth, first tooth		
*5654	Maxillary	46.	40.
*5655	Mandibular	46.	40.
*5630	Replacing additional teeth, each tooth	5.	5.
	Adding tooth and new cast chrome cobalt alloy clasp and rest to partial denture following extraction of abutment tooth		
*5661	Maxillary	40.	35.
*5662	Mandibular	40.	35.
*5630	Adding additional teeth, each tooth	5.	5.
	Reattaching undamaged clasp on denture		
5671	Maxillary	21.	18.
5672	Mandibular	21.	18.
	Replacing damaged clasp with new cast clasp on denture		
5681	Maxillary	32.	28.
5682	Mandibular	32.	28.
	Repairing broken clasp by adding buccal/facial or lingual clasp arm only		
5683	Maxillary	26.	23.
5684	Mandibular	26.	23.
	Adding Steele's facing and backing to cast partial denture - additional casting welded to original case; first tooth		
*5685	Maxillary	53.	46.
*5686	Mandibular	53.	46.
*5687	Each additional tooth (in conjunction with codes 5685 and 5686 only)	22.	19.
*5695	Welding in addition to repair procedure (Exception - codes 5654, 5655, 5685, and 5686 which include welding) limit two (2) per denture.	8.	7.

DENTURE REBASING AND RELINING - Including adjustments
 for six (6) months

REBASING

The process of refitting a denture by the com-
 plete replacement of the denture base material
 without changing the occlusal relationship of
 the teeth.

Rebasing complete denture

*5711	Maxillary	69.	60.
*5712	Mandibular	69.	60.

Rebasing partial denture

*5721	Maxillary	63.	55.
*5722	Mandibular	63.	55.

RELINING

The process of resurfacing the tissue side of a
 denture with new base material to make it fit
 more accurately.

Relining complete denture (Office procedure)

*5731	Maxillary	20.	17.
*5732	Mandibular	20.	17.

Relining partial denture (Office procedure)

*5741	Maxillary	20.	17.
*5742	Mandibular	20.	17.

Relining complete denture (laboratory proce-
 dure)

*5751	Maxillary	52.	45.
*5752	Mandibular	52.	45.

Relining partial denture (laboratory procedure)

*5761	Maxillary	46.	40.
*5762	Mandibular	46.	40.

OTHER PROSTHODONTIC SERVICES - REMOVABLE

*5999	Any other uncoded Prosthodontic removable ser- vice, by report	IC	IC
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MAXIMUM ALLOWANCE
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401.7 "PROSTHODONTICS - FIXED"

ABUTMENTS

See Codes 2710 through 2810.

PONTICS

*6210	Cast gold	76.	66.
*6212	Cast semi-precious	64.	56.
*6225	Cast gold pontic for Steele's facing, Tru- pontic pin facing, etc.	90.	78.
*6226	Cast semi-precious pontic, etc. (See code 6225)	78.	68.
*6240	Porcelain fused to gold	115.	100.
*6242	Porcelain fused to semi-precious metal	104.	90.
*6250	Plastic processed to gold	90.	80.
*6252	Plastic processed to semi-precious metal	81.	70.

REPAIRS

*6610	Replacing broken pin facing with slotted or other facing	23.	20.
*6620	Replacing broken facing where post is intact	20.	17.
*6630	Replacing broken facing where post backing is broken	31.	27.
*6640	Replacing broken facing with acrylic resin (office procedure - quick cure - filling material, etc.)	17.	15.
*6645	Replacing broken facing with acrylic resin (laboratory procedure)	35.	30.

OTHER PROSTHODONTIC SERVICES - FIXED

6930	Recement bridge - one abutment	8.	7.
6931	Recement bridge - two or more abutments	14.	12.
6970	Recement facing	8.	7.
*6999	Any other uncoded Prosthodontic - fixed service	IC	IC

401.8 "EXODONTIA AND ORAL SURGERY"

In the event that the oral surgery service to be performed is of an emergency nature and prior authorization is normally required but not feasible, then the Dental Form (MC-10) with all necessary information should be forwarded to the Dental Consultant for authorization prior to submission for reimbursement.

EXODONTIA

Reimbursement for dental extraction(s) will include local anesthesia, indicated alveoplasty, and routine post-operative care.

Reimbursement will be denied for the following treatment rendered without prior authorization:

- A. Extraction of teeth other than those classified as non-restorable (See Section 203.7 A.),
- B. Extraction of one or more teeth which will necessitate a dental prosthesis,
- C. All extractions preparatory to or in conjunction with Orthodontic care.

Extractions in more than one sextant of the mouth must be justified as an emergency procedure.

UNCOMPLICATED EXTRACTIONS

7110	Permanent tooth, each tooth	9.	8.
7115	Deciduous tooth, each tooth	9.	8.

SURGICAL EXTRACTIONS

Reimbursement will not be made for extractions of impacted teeth which have not been prior authorized.

Authorization will be granted only when conditions arising from such impactions warrant their removal. Extraction of asymptomatic impacted teeth or those teeth where dental/medical necessity cannot be demonstrated will not be authorized or accepted for reimbursement.

**7210	Surgical removal of erupted tooth (requiring elevation of muco-periosteal flap, removal of bone and/or sectioning of tooth)	15.	13.
**7220	Surgical removal of tooth with soft tissue impaction requiring incision of overlying soft tissue.	21.	18.
**7235	Surgical removal of tooth with partial or complete bone impaction requiring incision of overlying soft tissue, removal of bone and/or sectioning of tooth.	61.	53.
**7250	Root recovery (surgical removal of residual root - <u>completely covered by bone</u>).	30.	26.
**7260	Oral antral fistula closure and/or antral root recovery.	72.	63.

OTHER SURGICAL PROCEDURES

**7270	Tooth replantation (including stabilization)	61.	53.
**7275	Tooth replantation (including stabilization) plus single stage nerve extirpation and canal filling.	86.	75.

		MAXIMUM ALLOWANCE	
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*7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including wire attachment.	54.	47.
*7281	Surgical exposure of impacted or unerupted tooth to aid eruption, etc.	30.	26.
d7285	Biopsy, oral tissue-hard; independent procedure (laboratory must bill separately.)	30.	26.
d7286	Biopsy, oral tissue - soft; independent procedure (laboratory must bill separately.)	18.	16.
<u>ALVEOPLASTY AND/OR ALVEOLECTOMY (SURGICAL PREPARATION OF RIDGE FOR DENTURES)</u>			
*7320	In edentulous areas only, per sextant	29.	25.
STOMATOPLASTY - Including revision of soft tissues on ridges, muscle reattachment, tongue, palate, and other oral soft tissues (complete description including size and position must be submitted).			
*7340	Stomatoplasty - uncomplicated, including management of hypertrophied and hyperplastic tissue, per sextant	30.	26.
*7345	Stomatoplasty - including ridge extension and management of hypertrophied and hyperplastic tissue, per sextant	61.	53.
*7350	Stomatoplasty - complicated - including ridge extension and management of hypertrophied and hyperplastic tissue and including soft tissue grafts, per sextant	79.	68.
<u>SURGICAL EXCISION</u>			
EXCISION OF CICATRICIAL, FIBROUS, INFLAMMATORY OR CONGENITAL CYSTIC LESION (to include lesions of skin, subcutaneous membrane or mucous membrane, including pyogenic granulomata and operculi).			
d*7410	Excision - lesion diameter up to and including 1.25 cm.	30.	26.
d*7420	Excision - lesion diameter over 1.25 cm. up to and including 3 cm.	42.	37.
d*7421	Excision - lesion diameter over 3 cm.	100.	86.
EXCISION OF BENIGN TUMORS			
d*7430	Lesion diameter up to and including 1.25 cm.	30.	26.
d*7431	Lesion diameter over 1.25 cm. up to and including 3 cm.	42.	37.
d*7432	Lesion diameter over 3 cm.	100.	86.

MAXIMUM ALLOWANCE
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EXCISION AND MANAGEMENT OF MALIGNANT LESION

(Biopsy report must be submitted with Dental Form (MC-10) for payment)

d**7440	Lesion diameter up to and including 1.25 cm.	100.	86.
d**7441	Lesion diameter over 1.25 cm. up to and including 3 cm.	274.	256.
d**7442	Lesion diameter over 3 cm.	473.	413

REMOVAL OF CYSTS AND NEOPLASMS

d*7450	Removal of odontogenic cyst or tumor, up to and including 1.25 cm. diameter	50.	43.
d*7451	Over 1.25 cm. diameter up to and including 3 cm.	100.	87.
d*7452	Over 3 cm.	150.	130.
d*7460	Removal of non-odontogenic cyst or tumor up to 1.25 cm. diameter	50.	43.
d*7461	Over 1.25 cm. diameter up to and including 3 cm.	100.	87.
d*7462	Over 3 cm.	150.	130.
d*7465	Destruction of lesions by physical methods - electro-surgery, chemotherapy, cryotherapy	18.	15.

EXCISION OF BONE TISSUE

*7470	Removal of exostosis, maxilla, per sextant	29.	25.
*7471	Removal of exostosis, mandible, per sextant	29.	25.
*7475	Removal of torus palatinus	90.	79.
d*7480	Partial ostectomy (guttering or saucerization)	211.	184.

SURGICAL INCISION

7510	Incision and drainage of abscess or cellulitis, intra-oral	18.	16.
7520	Incision and drainage of abscess, extra-oral	42.	37.
**7521	Incision and drainage of Ludwig's angina, extra-oral	84.	74.
**7530	Removal of foreign body, skin, subcutaneous or areolar tissue, uncomplicated	18.	16.
**7535	Removal of foreign body, skin, subcutaneous or areolar tissue, complicated	34.	29.
**7540	Removal of reaction producing foreign bodies, musculoskeletal system	51.	45.
*7550	Sequestrectomy for osteomyelitis, intra-oral	48.	42.
*7551	Sequestrectomy for osteomyelitis, extra-oral	90.	75.
d**7560	Sinusotomy, maxillary (antrotomy, Caldwell-Luc), unilateral	242.	210.
d**7561	Sinusotomy, maxillary (antrotomy, Caldwell-Luc), bilateral	320.	278.
d**7565	Lavage, maxillary sinus (independent procedure), unilateral	18.	10.
d**7566	Lavage, maxillary sinus (independent procedure), bilateral	24.	21.

TREATMENT OF FRACTURES

Open reduction involves the dissection of tissues and/or the visual inspection of the fracture site.

**7605	Maxilla, simple or compound, no reduction	30.	26.
**7606	Maxilla, closed reduction; teeth, if present, immobilized	121.	105.
**7607	Maxilla, open reduction; teeth, if present, immobilized	182.	158.
**7608	Maxilla, (complicated), open reduction; multiple surgical approaches (three (3) or more), fixation, traction, head-frame, multiple internal and/or external fixation, head cap, etc.	242.	210.
**7611	Maxilla, reduction and/or stabilization with circumferential wiring in one arch.	121.	105.
**7612	Maxilla, reduction and/or stabilization with circumferential wiring in two arches.	182.	158.
**7615	Maxilla, alveolar fracture; reduction with wiring, application of arch bar or splint, etc.	92.	80.
**7705	Mandible, simple or compound, no reduction	30.	26.
**7706	Mandible, closed reduction; teeth, if present, immobilized	121.	105.
**7707	Mandible, open reduction; teeth, if present, immobilized	242.	210.
**7708	Mandible, (complicated) open reduction; multiple surgical approaches (three (3) or more), including internal fixation, interdental fixation, skeletal pinning with extra-oral fixation, etc.	303.	263.
**7709	Mandible, reduction by skeletal pinning with external fixation	145.	126.
**7711	Mandible, reduction and/or stabilization with circumferential wiring in one arch	121.	105.
**7712	Mandible, reduction and/or stabilization with circumferential wiring in two arches	182.	158.
**7715	Mandible, alveolar fracture; reduction with wiring, application of arch bar or splint, etc.	92.	80.
**7777	Malar and/or zygomatic arch, simple or compound, no reduction	30.	26.
**7778	Malar and/or zygomatic arch, closed reduction (including towel clip technique)	42.	37.
**7779	Malar and/or zygomatic arch, depressed, open reduction	121.	105.
**7780	Malar and/or zygomatic arch, complicated, depressed, open reduction with internal skeletal fixation and multiple surgical approaches	236.	205.
**7785	Debridement of fractured alveolar process (per arch)	29.	25.
**7786	Surgical Stent	50.	43.

MAXIMUM ALLOWANCE
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REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER
TEMPORO-MANDIBULAR JOINT DYSFUNCTIONS

**7820	Dislocation, closed reduction	18.	16.
d**7830	Manipulation under anesthesia (anesthesia additional)	18.	16.
d*7840	Condylectomy	362.	315.
d*7850	Menisectomy	362.	315.
d*7860	Arthrotomy	362.	315.
d**7870	Arthrocentesis, injection or aspiration (give complete details)	18.	16.

OTHER ORAL SURGERY - REPAIR OF TRAUMATIC WOUNDS

(Describe completely, giving size and site, etc.)

**7907	Simple suture of recent wounds, up to and including 1.25 cm.	13.	11.
**7908	Over 1.25 cm. up to and including 2.5 cm.	18.	16.
**7909	Over 2.5 cm. up to and including 5 cm.	24.	21.
**7910	Over 5 cm. up to and including 7.25 cm.	30.	26.

For more than one of the above lacerations (maximum of three) full allowance will be paid for the longest laceration; each additional laceration will be paid according to size, at fifty percent (50%) of the allowable fee.

**7914	More than three lacerations and/or lacerations irregularly shaped and requiring extensive debridement or lacerations over 7.25 cm., by report	IC	IC
**7915	Removal of sutures and/or changes of dressings incident to lacerations, per visit (maximum three visits)	6.	5.

OTHER REPAIR PROCEDURES

d*7930	Injection of trigeminal nerve for destruction	48.	42.
d*7931	Avulsion of trigeminal nerve	91.	79.
*7960	Frenulectomy, independent procedure (frenectomy, frenotomy)	32.	28.
d**7980	Sialolithotomy (intra-oral)	48.	42.
d*7981	Excision of salivary gland	182.	158.
d*7982	Sialodochoplasty	151.	131.
d*7983	Closure of salivary fistula	151.	131.
d**7984	Dilation of salivary duct, ptyalectasis	13.	11.
**7990	Emergency tracheotomy	121.	105.
d**7995	Post-operative treatment beyond that normally provided as part of the basic procedure or when provided by practitioner other than one who provided the original service or in excess of "follow-up days" (California Relative Value Study - 1964) per visit	6.	5.

MAXIMUM ALLOWANCE
S \$ NS

d**7999 Any other uncoded oral surgery service (describe completely) IC IC

401.9 "ORTHODONTICS"

APPLIANCES FOR TOOTH GUIDANCE

*8110	Removable	69.	60.
*8120	Fixed or cemented	69.	60.
*8130	Adjustment - (maximum ten (10) visits), per visit	6.	5.

APPLIANCES TO CONTROL HARMFUL HABITS

*8210	Removable	69.	60.
*8220	Fixed or cemented	69.	60.
*8230	Adjustment - (maximum ten (10) visits), per visit	6.	5.

RETENTION APPLIANCES - ORTHODONTIC RETAINING APPLIANCES

(Following comprehensive treatment by a previous dentist)

*8310	Removable	69.	-
*8320	Fixed or cemented	69.	-
*8330	Adjustment - (maximum twelve (12) visits) per visit	6.	-

COMPREHENSIVE ORTHODONTIC TREATMENT

Case type - fixed or removable appliances - (Itemize fee for diagnostic procedures and formal treatment separately; also indicate anticipated time under treatment) - (Maximum treatment plus retention - three years)

*8410	Appliances	126.	-
*8420	1st through 12th month of treatment (to start on day insertion of appliance(s) is completed), per month	28.	-
*8430	13th through 24th month of treatment, per month	28.	-
*8440	25th through 30th month of treatment, per month	21.	-
*8450	31st through 36th month (maximum of treatment) per month	11.	-
*8999	Any other uncoded orthodontic service, by report	IC	IC

401.10 "OTHER SERVICES"

MAXIMUM ALLOWANCE
S \$ NS

UNCLASSIFIED TREATMENT

d9110	Emergency treatment of dental pain, or infection, palliative (flat fee for all services performed) when not covered by separately listed procedure	7.	6.
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ANESTHESIA

*9220	General	10.	10.
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1. The code above applies when the dentist performing the dental service (attending dentist) also administers the general anesthesia (see Section 203.9 A.3.c.)
2. Reimbursement will be made for the administration of only one general anesthesia per visit.

SPECIAL ANESTHESIA CODES

BASIC UNITS - See American College of Anesthesiologists
 Relative Value Guide - 1967

*9221	Maximum 4 units	20.	20.
*9222	Maximum 5 units	25.	25.
*9223	Maximum 6 units	30.	30.
*9225	TIME UNITS - each additional 15 minute period or major portion thereof. (Limited to "table" or "chair" time only) Maximum reimbursable two (2) hours.	5.	5.

1. The general anesthesia codes above are limited to use in restorative dentistry alone or restorative dentistry in conjunction with other dental services requiring anesthetic management, and must receive prior authorization from the Office of the Dental Director. These codes apply to those dentists appropriately qualified in general anesthesia (see Section 203.9 A.3.b.) and are reimbursable only to the dentist whose sole function is to administer general anesthesia. (See Section 203.9 A.3.d.)
2. An anesthesia record (see Section 203.9 A.3.d.3.) must be submitted which shows elapsed anesthesia time, and pinpoints time and amounts of drugs administered, pulse rate and character, blood pressure, respiration, etc. The dental forms (MC-10) for anesthesia

MAXIMUM ALLOWANCE
 S \$ NS

and treatment must accompany this record
 to permit authorization for reimbursement.

*9235 Intravenous Sedation (See Section 203.9 A.4.) 10. 9.

PROFESSIONAL CONSULTATION

(Diagnostic service provided by a dentist other
 than practitioner providing treatment) Complete
report must be available (See Section 201.7)

d9310 Consultation, per case 21. 18.

PROFESSIONAL VISITS

9410 House visits, in addition to fee for service
 provided 5. 5.

9411 Long term care facility visits, in addition to
 fee for service provided. This fee is reimbursed
 only once per trip per facility regardless of
 number of patients examined or treated. 5. 5.

9412 Hospital visits, in addition to fee for service
 provided. 5. 5.

INJECTIONS

d9610 Therapeutic drug injection (see Section 203.9 B.) 2.50 2.50

d**9611 Injection of one or more muscles of mastication 13. 11.
 in conjunction with treatment of T.M.J. dys-
 function

d**9612 Infiltration and/or nerve block for diagnostic 13. 11.
 purposes or purposes other than anesthesia in
 conjunction with operative or surgical procedure.

MISCELLANEOUS SERVICES

9910 Application of desensitizing medicaments 6. 5.

**9915 Stabilization of teeth (trauma), per tooth 11. 10.

d**9999 Other uncoded services (where no code number 1C 1C
 exists or existing code is not precisely
 applicable). Complete description of con-
 dition and proposed treatment must be submitted.
 By report.