(f) All medical supplies and DME items purchased or rented for use by nursing facility residents require prior authorization Items included in the NF's per diem are not covered (see N.J.A.C. 10:59–1.4).

(g) Medicare/Medicaid claims do not require prior authorization (See N.J.A.C. 10:59–1.9).

Case Notes

Digital scale for applicant with morbid obesity was not an item for which Medicaid funds were available. R.S. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 65.

Medical necessity authorized purchase of thermal scan thermometer with Medicaid funds for severely retarded child. C.F. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 45.

10:59–1.7 Policy considerations for purchase, rental and repair of DME

(a) Medical suppliers may request payment for medical supply services only after the supply/equipment has been delivered to the recipient (see N.J.A.C. 10:49–9.5). All requests for payment shall be submitted timely, in accordance with N.J.A.C. 10:49–7.2.

(b) For durable medical equipment requiring prior authorization (PA), decisions regarding rental or purchase rest with the Division of Medical Assistance and Health Services.

i. Durable medical equipment may be rented when, in the judgment of the Medicaid program, the medical need for the equipment is of such a duration that rental of the equipment is more economically practical than authorizing its purchase.

(c) When durable medical equipment is authorized and purchased on behalf of a Medicaid recipient, ownership of such equipment will vest with the Division of Medical Assistance and Health Services. The recipient will be granted a possessory interest for as long as the recipient requires use of the equipment.

(d) Durable medical equipment items may be repaired and suppliers reimbursed for replacement parts and/or labor charges when, in the judgement of the Medicaid Program, the medical need for the item will continue to exist for a period of time and repair is more economical than purchase.

(e) Repair costs related to rented DME shall be the responsibility of the provider and shall be considered a component of the Medicaid rental payment.

(f) Reimbursement for repairs, including parts and labor charges, will not be authorized for durable medical equipment under warranty. For purchased DME, reimbursement for the cost of repairs shall be limited to repairs not covered by a manufacturer's warranty.

(g) Reimbursement by the Medicaid program shall be limited to services billed by HCPCS codes followed by the appropriate following modifier(s).

1. NU refers to the purchase of medical supplies, new DME and/or services;

2. UE refers to the purchase of used DME; and

3. RR refers to the daily or monthly rental of DME.

10:59–1.8 Basis of reimbursement for medical supplies and DME

(a) Payment for purchase of medical supplies or DME shall be based on the following methods:

1. If there is no Medicaid Fee schedule, reimbursement shall be based on the lesser of the provider's usual and customary charge to the general public or a calculated maximum fee allowance equal to 130 percent of a supplier's invoice cost or 80 percent of the manufacturer's price list for supplies and equipment priced by report.

i. The invoice shall include the supplier as the addressee, item description, quantity, and cost.

ii. The manufacturer's price list shall include a manufacturer's name, item description, and suggested retail price per unit or package, and a notation by a supplier indicating the number of units per package, if not described by a manufacturer.

2. If there is a Medicaid Fee schedule, reimbursement shall be based on the lesser of the provider's usual and customary charge to the general public; or the Medicaid maximum fee allowance assigned by the Division.

(b) Payment for rental of DME will be calculated as follows:

1. If a medical equipment item has a maximum fee allowance of $100.00 or less, the monthly rental payment will be the amount billed or 20 percent of the approved purchase price, whichever is less. Six such payments shall be deemed to be the full purchase price. No further payments shall be made and the equipment will be considered the property of the State.

2. If a medical equipment item has an approved maximum fee allowance of more than $100.00, the monthly rental payment will be the amount billed or 12 percent of the fee, whichever is less. Ten such payments shall be deemed to be the full purchase price and no further payments shall be made and the equipment will be considered the property of the State.

3. If the purchase of a rental item is authorized prior to the close of the maximum rental period (see N.J.A.C. 10:59–1.8(b)1 and 2), a final payment will be made which equals the difference between the sum of the prior rental payments and the maximum fee allowance.

4. If death, ineligibility, or other circumstances over which the New Jersey Medicaid Program has no control, should occur, rental fees for any medical equipment item shall terminate at the end of the month such circumstance(s) occur and no further payment will be made.

(c) Payment for replacement parts and repairs will be made as follows:

1. Reimbursement for replacement parts shall be based on the purchase policy described under N.J.A.C. 10:59–1.8(a); and

2. Reimbursement for labor charges will be the maximum fee allowance established by the Division per hour of labor provided.

10:59–1.9 Dual Medicare/Medicaid or NJ KidCare coverage

(a) When a Medicaid or NJ KidCare beneficiary also has Medicare coverage, the Medicaid and the NJ KidCare programs require that Medicare benefits be used first and to the fullest extent. Responsibility for payment by the New Jersey Medicaid or NJ KidCare program shall be limited to the unsatisfied deductible and/or coinsurance to the extent that the combined Medicare/Medicaid or Medicare/NJ KidCare payment does not exceed the Medicaid or NJ KidCare maximum allowable.

(b) In those instances where Medicare policy disallows reimbursement for an item/service under certain circumstances, for example, a special wheelchair for a NF resident, the provider shall obtain prior authorization from the Medicaid or NJ KidCare—Plan A program and submit a hard copy claim to Medicaid or NJ KidCare—Plan A with an Explanation of Benefits from Medicare attached.

(c) Medicare/Medicaid claims shall be filed timely, in accordance with N.J.A.C. 10:49–7.2.

(d) When a beneficiary is eligible for Medicare and Medicaid or Medicare and NJ KidCare coverage, a Medicare/Medicaid or Medicare/NJ KidCare claim will cross over from the Medicare DMERC Region A to the Medicaid or NJ KidCare fiscal agent. There are instances, however, where claims will not cross over from Medicare to Medicaid or NJ KidCare, for example, claims denied by Medicare or claims where the Medicaid or NJ KidCare fiscal agent is unable to match pertinent identifying data (see N.J.A.C. 10:49–7.2(d)3 for further instructions).

(e) There are situations in which Medicare coverage differs significantly from coverage considered medically necessary by the Medicaid or NJ KidCare program. In these situations, the provider may request PA from the Medicaid or NJ KidCare program prior to requesting Medicare payment.

1. The provider must request PA for the higher level of service under the procedure code assigned by the Division for "reconciliation of downgraded Medicare/Medicaid or Medicare/NJ KidCare claims."

(f) For dually eligible beneficiaries, Medicaid or NJ KidCare coverage shall be based on Medicare policy as it relates to rental and/or purchase of supplies and DME except as described in (e) above.

Amended by R.1998 d.382, effective July 20, 1998.
See: 30 N.J.R. 1255(b), 30 N.J.R. 2646(b).
In (a), inserted "to the extent that the combined Medicare/Medicaid or Medicare/NJ KidCare payment does not exceed the Medicaid or NJ KidCare maximum allowable" at the end, and inserted references to NJ KidCare and substituted beneficiary for recipient throughout the section.

10:59–1.10 Third party liability (TPL), excluding Medicare

(a) When a Medicaid recipient has other health insurance, the Medicaid program requires that such benefits be used first and to the fullest extent. Supplementation may be made for Medicaid covered services, but the combined total payment shall not exceed the amount payable under the Medicaid program in the absence of other coverage (see N.J.A.C. 49–7.3).

(b) Regardless of the status of a provider's claim with other third parties, all claims for Medicaid reimbursement shall be received by the Medicaid fiscal agent within the time frames specified in N.J.A.C.10:49–7.2, Timeliness of claim submission.

(c) The Medicaid program has not established any crossover arrangements with any third party insurer.

10:59–1.11 Recycling policy

(a) The New Jersey Medicaid Program shall recycle returned durable medical equipment items when the Program has determined that the cost of pickup, refurbishing and/or repair and delivery is more economical than purchase of a new item.

(b) When the New Jersey Medicaid Program is advised that a durable medical equipment item is available for recycling, the Medicaid District Office shall contact an appropriate DME recycling provider who can service the item and who will recover, refurbish and store the item.

1. When the DME provider examines the item and finds that more than minimal repairs are needed, he must obtain prior authorization from the Medicaid District Office before undertaking any repairs. See: N.J.A.C. 10:59–1.11, Repair policy.

2. When, in the judgement of the New Jersey Medicaid Program, a durable medical equipment item cannot be repaired at reasonable cost, the item may be discarded after a representative of the Program has inspected the item.

(c) Reimbursement for repairs and recycling activities, that is, pickup, refurbishing and delivery, shall be made following delivery of the item to the next recipient.

(d) Reimbursement for recycling activities, that is, pick-up, refurbishing and delivery, shall be based on one of the following standards, whichever is greater:

1. The monthly rental fee for a new item of that type; or

2. $35.00.

(e) Reimbursement for recycling activities, that is pickup, refurbishing and delivery, equipment that is heavy and/or cumbersome and requires two or more persons shall be based on one of the following standards, whichever is greater.

1. Two months rental fee for a new item of that type; or

2. $70.00.

i. Prior authorization shall be obtained from the Medicaid District Office in order to claim reimbursement under this subsection (e).

(f) While the recycled equipment is in possession of the DME recycling provider, the DME recycling provider shall store, safeguard and maintain the equipment.

(g) State institutions will have first priority on recycled durable medical equipment, when specifically requested.

10:59–1.12 Parenteral therapy

(a) Parenteral therapy refers to the administration of a drug or specialized nutritional solution by a route other than the digestive system, commonly by peripheral vein.

(b) All parenteral therapy services, including total parenteral nutritional (TPN), require prior authorization (see N.J.A.C. 10:59–1.6).

(c) For parenteral therapy other than TPN, coverage through the medical supplier shall be limited to supplies and equipment. Coverage through the medical supplier for TPN therapy shall also include nutritional solutions.

1. Coverage for all disposable medical supplies related to TPN therapy shall be based on monthly rates as established by the Division (See N.J.A.C. 10:59–2.3 for monthly rates and unit descriptions).

(d) Service shall be limited to the maximum number of units covered during specified time periods, in accordance with N.J.A.C. 10:59–2.3.

10:59–1.13 Augmentative/alternative communication system (ACS)

(a) ACS requires prior authorization. Requests for prior authorization shall include the following:

1. A list of specialists involved in the multi-disciplinary team evaluation of the recipient, including, at a minimum, a speech-language pathologist, physical therapist, occupational therapist, and social worker;

2. An evaluation report by the speech-language pathologist, which shall include the following:

i. The communication status of the recipient, including relevant mental and physical disabilities;

ii. A list of augmentative/alternative communication devices/systems tried during the evaluation period;

iii. The rationale for the selection of the prescribed device/system and a description of how it will enhance functional communicative abilities;

iv. A certification that the recipient can mentally and physically benefit from the device/system and is willing to use it;

v. Recommendations for follow-up instruction so that maximum benefit may be obtained;

vi. A description of the recipient's gross and fine motor abilities, perceptual skills, reading skills, and cognitive abilities;

vii. Results of an audiometric screening and/or audiologic evaluation, as appropriate;

viii. A summary of past speech-language treatment;

ix. Results of the trial period with the device; and

x. A list of recommended augmentative communication devices, including all necessary accessories, prices and provider information.

(b) Follow up visits will be made by the appropriate MDO staff, at their discretion, to monitor appropriate ACS use.

(c) Reimbursement can be made for ACS rental during the trial period in accordance with the policy contained at N.J.A.C. 10:59–1.7 regarding rental of DME.

10:59–1.14 Pressure reduction systems

(a) Pressure reduction systems include:

1. Air fluidized bed systems which employ the circulation of filtered air through silicone-coated ceramic beads creating the characteristics of fluid;

2. Powered low air loss bed systems which incorporate the use of an air-bladder system consisting of a series of interconnected adjustable air sacs designed to allow air

escape to reduce support surface pressure. Air to the sacs is supplied by a separate power supply unit; and

3. Low end products which include any powered or non-powered overlay or mattress.

(b) Policies for providing and authorizing DME as described in N.J.A.C. 10:59–1.5 and 1.6 apply.

(c) Reimbursement for low end products is included in the NF's per diem, and therefore shall not be covered.

(d) Periods of Prior Authorization (PA) for air-fluidized and powered low air loss bed systems shall be limited to 30 days.

(e) Requests for PA for air fluidized and low air loss bed systems shall include the following:

1. A medical history relating to the wound which includes previous therapy and pressure relief systems utilized and found unsuccessful;

2. Physician progress notes indicating medical necessity, plan of treatment, and evaluation of response to treatment specific to the care of the wound;

3. A wound care flow sheet documenting weekly the site, size, depth and stage of the wound, noting also the presence and description of drainage or odor;

4. Laboratory values including a complete blood count and blood chemistries initially and on request thereafter.

5. A nutritional assessment by a registered dietitian initially and on request thereafter; and

6. Photographs of the site, upon permission of the recipient/family, after full due consideration is afforded to the recipient's right to privacy, dignity and confidentiality.

(f) Coverage for air fluidized and low air loss bed systems shall be limited to the following conditions:

1. The recipient has two stage III (full–thickness tissue loss) pressure sores or a stage IV (deep tissue destruction) pressure sore which involves two of the following sites: hips, buttocks, or sacrum; and

2. The recipient is bedridden or chairbound as a result of severely limited mobility; and

3. The recipient is receiving maximal medical/nursing care, previously instituted conservative treatment has been unsuccessful and all other alternative equipment has been considered and ruled out.

4. If the recipient has coexisting risk factors (such as vascular irregularities, nutritional depletion, diabetes or immune suppression) they must present post-operatively with a posterior or lateral flap or graft site requiring short-term therapy until the operative site is viable.

(g) Coverage for conditions other than those described in (e) above may be considered on an individual basis by the MDO.

10:59–1.15 Apnea monitor

(a) Apnea monitors shall require prior authorization (PA) for initial certification and subsequent recertification.

1. To obtain authorization, providers shall complete the "Home Apnea Monitor Certification" form FD–287 which requires the prescriber's signature. The FD–287 may be used in lieu of a prescription by suppliers.

(b) Coverage of apnea monitors shall be limited to use by infants not otherwise monitored for the same purpose by another device.

(c) Reimbursement for apnea monitors is included in the NF's per diem, and shall not be covered separately.

(d) Suppliers shall provide a properly functioning monitor in an environment that assures its safe and effective use.

(e) Apnea monitors shall be reimbursed on a monthly rental basis. The rental payment shall include, but not be limited to, belt lead wires, electrodes, patient connecting cable, and battery, if appropriate.

SUBCHAPTER 2. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:59–2.1 Introduction

(a) The New Jersey Medicaid Program utilizes the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology—4th Edition (CPT–4) architecture, employing a five-position code and as many as two 2–position modifiers. Unlike the CPT–4 numeric design, the HCFA assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three-level coding system. Level I codes are not applicable to medical supplies and durable medical equipment. The level II and Level III codes are as follows:

1. LEVEL II CODES (Narratives found at N.J.A.C. 10:59–2.3) are assigned by Health Care Financing Administration (HCFA) for physician and non-physician services which are not in CPT–4.

2. LEVEL III CODES (Narratives found in N.J.A.C. 10:59–2.3) are assigned by the Division to be used for those services not identified by CPT–4 codes or HCFA-assigned codes. Level III codes identify services unique to New Jersey.