



STATE OF NEW JERSEY
 Department of Institutions and Agencies,
 Division of Medical Assistance and Health Services

DO NOT CIRCULATE

NEWSLETTER

New Jersey Health Services Program

Volume 1 - 2

March 4, 1970

In order to avoid delay in processing your claims, please pay particular attention to the following items on Form MC-10; REQUEST FOR AUTHORIZATION AND PAYMENT OF DENTAL SERVICES.

- Item #1 Patient's Name
 Copy patient's first name exactly as it appears on the Validation stub.
- Item #3 Health Services Program Case Number
 Copy this number exactly as it appears on the Validation stub or plastic I. D. Card.
- Item #4 Patient Person Number
 This number only appears on the Validation stub. Claim will be rejected if not recorded.
- Item #5 Age
 Obtain from the patient, or his authorized representative.
- Items #16 & 17 Services Rendered or Requested Procedure Number:
 Record procedure codes as they appear in Chapter IV of your manual. DO NOT COMBINE DIFFERENT PROCEDURES UNDER ONE PROCEDURE CODE. Where the same procedure is performed on different teeth, record the code number only once but identify the number of services and teeth involved under "DESCRIPTION OF TREATMENT", e.g., 0220 is limited to the first periapical or bitewing radiograph. All additional periapical or bitewing radiographs may be combined under the single procedure code #0230.
- Date Performed: Record date(s) of each service for which payment is requested.
- Fee Requested: DO NOT COMBINE FEES FOR DIFFERENT SERVICES, e.g., Extraction of a tooth and the X-ray involved are two separate services and each must be entered under its own procedure code, and a fee entered for each service.
- When identical services are entered under one procedure code, a combined fee may be entered under "FEE REQUESTED".

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Item #18 Place of Service

Dental Services may be performed in other than the doctor's office. Thus, it is necessary that this item be properly checked or recorded.

Item #19 Patient Certification

The patient or his authorized representative must sign the form at the completion of treatment. If this cannot be done, please explain in the remarks section.

Item #20 Provider Certification

The dentist must sign the form at the completion of treatment. This denotes that all services for which payment is requested have been rendered.

Please add the following procedure codes to page 46 of your manual. They were inadvertently omitted.

5640 Replacing broken tooth on denture (no other repairs) first tooth.

5645 Replacing additional teeth, each tooth.

All requests for authorization and payment must be submitted through the Local Medical Assistance Unit of the patient's county of residence. Do not send claims directly to the Prudential Insurance Company.



New Jersey Health Services Program

NEWSLETTER

Volume 1-3

April 17, 1970

ATTENTION: Participating Family Planning Clinics

The following are our policies regarding maximum allowances for family planning clinic services. This change from the previously allowed fee per visit became effective for claims submitted for services provided on and after April 1, 1970.

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

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

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

III. The following fee schedule represents maximum amounts allowable. Reimbursement will be made of customary charges when they are lower than these maximum amounts.

Initial Medical Visit - Family Planning

Includes:

- Medical, social, obstetrical history
- Complete pelvic examination - including visual inspection of cervix
- Breast examinations
- Papanicolaou smear (excludes cytology study)
- Contraceptive counseling
- Referral as indicated
- Includes costs of birth control drugs dispensed \$15.00

Insertion of Intrauterine Device

Includes cost of device and necessary post-procedural follow-up. \$ 7.50

Laboratory, Cytology Study (Papanicolaou Smear) \$ 3.50

Medical Revisit - Family Planning

May include pelvic examination, changes in method or physicians' instructions
 Includes costs of birth control drugs dispensed \$ 5.00



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

New Jersey Health Services Program NEWSLETTER

Volume1-4.....

June 8, 1970

SUBJECT: Relationship of Hospitals and Practitioners to Registered Hospital Outpatients Under the New Jersey Health Services Program (Medicaid)

It has been brought to our attention that there is considerable activity and some confusion on the part of hospitals and practitioners in their efforts to define their relationship to patients who seek "clinic" services and are covered by the Medicaid Program. The purpose of this Bulletin is to clarify this area by reviewing certain basic concepts of the Health Services Program, but it is in no way intended to cover all possible situations.

One of the major areas of concern is the definition of outpatient hospital services and clinic services. Although common usage of the term "clinic services" have connotated the hospital outpatient department, the requirements for Federal financial participation have called for consistency with terminology developed under Title XIX of the Social Security Act.

In developing the New Jersey State Plan for Medical Assistance the guidelines and definitions contained in Supplement D (Federal) Handbook of Public Assistance Administration, the Federal Social Security Act, and the New Jersey Medical Assistance and Health Services Act, were followed. The terms "outpatient hospital services" and "clinic services" are defined in Supplement D as follows:

"'Outpatient hospital services' are those preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to an outpatient by an institution licensed for formally approved as a hospital by an officially designated State standard-setting authority, and is qualified to participate under Title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation."

"'Clinic services' are those preventive, diagnostic, therapeutic rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician or dentist in a facility which is not part of a hospital but which is organized and operated to provide medical care to outpatients."

With these definitions as a background, the following are basic concepts under which the New Jersey Health Services Program operates in regard to Outpatient Hospital Services:

1. A Medicaid patient has a right to the same level of medical care as any private patient.
2. A Medicaid patient has a right to be a private patient and as such select his personal physician.

3. There must be a definite and identifiable distinction between a registered hospital outpatient and a private patient.
4. Medicaid will pay the hospital for its costs incurred in the treatment of a registered hospital outpatient.
5. Medicaid will reimburse a physician for treating a private patient.
6. Whatever arrangement is entered into between a hospital and physician(s), Medicaid will pay the hospital its costs, or a physician his charges, but not both, for a service rendered; and when this relates to registered hospital outpatients it must apply to all registered hospital outpatients.

Under the concepts outlined above, there are only two ways a physician may obtain remuneration for treating a "Medicaid" eligible person who applies for services as a registered hospital outpatient. The first would be for the physician to accept and treat a patient as a private patient in the exact manner as all other private patients of that physician are treated. To be considered a private patient, the circumstances would have to include:

1. Treatment of the patient in facilities maintained or arranged for by the physician for all of his patients;
2. The same 24-hour-a-day access to the physician as all other private patients of the physician have such access;
3. Maintenance of financial and medical records of the patient, with the physician accepting the complete responsibility for the continuity of care of the patient;
4. Elimination of registration as a hospital outpatient.

Under these circumstances, the physician would be reimbursed his allowable charges and there would be no payment to the hospital. If the physician treats his private patient in hospital facilities, and bills the patient for his services, any charges for the use of the hospital facilities will be the responsibility of the physician and the hospital cannot bill the Medicaid program for any reimbursement.

The second method by which a physician would obtain remuneration for rendering care to a "Medicaid" patient would be by entering into a financial arrangement with the hospital under which the hospital would pay the physician on some agreed-upon basis for services rendered to all registered hospital outpatients in the hospital's outpatient facilities. This expense to the hospital of payments to the physicians would be an allowable cost in determining outpatient costs, and, as such, Medicaid will pay its share of this cost.



New Jersey Health Services Program NEWSLETTER

Volume 1-5

July 1, 1970

SUBJECT: Manual Revision - Requirements for an Independent Clinic

Effective this date the following Sections of the Independent Clinic Manual are revised.

200.1 Clinic Services

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

200.2 Independent Clinic

For approval as a provider, each "clinic services" facility must individually meet the following requirements:

A. Organization

1. Be a voluntary, non-profit, organization; and,
2. Make a charge to all patients for services provided. The charge made to medical assistance patients must not be more than that made to any other patient.

B. Approval

1. Be approved to provide psychiatric services by the New Jersey Department of Institutions and Agencies, Division of Mental Health and Hospitals (applicable only to Mental Health Clinics); or,
2. Be approved to provide dental services by the State Board of Registration and Examination in Dentistry of New Jersey (applicable only to Dental Clinics); or,
3. Meet the minimum standards of the New Jersey State Department of Health to qualify as an "Independent Outpatient Health Facility" (applicable only to Family Planning Clinics and Neighborhood Health Centers); or,
4. Meet the approval of the Division of Medical Assistance and Health Services, if requirements B 1, 2, 3 are not applicable, by submitting to the Division information on:
 - a. Services provided.
 - b. Organizational structure.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-7

August 24, 1970

SUBJECT: PLASTIC IDENTIFICATION CARDS

Effective this date, the plastic identification card issued to Medicaid eligible recipients by the New Jersey Health Services Program is no longer required for verification of eligibility. The current monthly validation form (see Section 101.2 of your Provider Manual) is the sole indicator of eligibility. Services may be provided only upon presentation of this validation form.

SUBJECT: PROVIDER MANUAL REVISION AND NEW JERSEY HEALTH SERVICES PROGRAM POLICY ON METHADONE.

Please add methadone in any form, i.e., tablets, capsules, liquid or powder, to the list of Pharmaceutical Services Not Eligible for Payment in the following manuals:

Pharmacy — Section 206
Podiatry — Section 213.2H
Physician — Section 220.2H
Dental — Section 234.3H

Policy

As of August 1, 1970, the New Jersey Hospital Service Plan will not reimburse pharmacies for prescriptions for methadone. This policy applies to all uses of the drug and is not limited to its uses in persons who are addicts.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

NEW JERSEY HEALTH SERVICES PROGRAM

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

Volume 1-8

September 25, 1970

SUBJECT: PROVIDER IDENTIFICATION OF FAMILY PLANNING SERVICES
AND LISTING OF LOCAL MEDICAL ASSISTANCE UNITS

The following policy and procedures have been developed by the Division of Medical Assistance & Health Services in order to identify the rendering of family planning services by eligible providers.

POLICY

Services and supplies furnished in conjunction with family planning must be clearly identified by the provider on all claims submitted for payment.

Procedure

1. Physician's Service

- a. Physicians are requested to write "Family Planning" in section 10D of the form MC-8 (Physicians and Practitioner's Claim). This notation should be made following the insertion of the description of services and procedures in this section.
- b. When sending a laboratory a specimen as part of family planning routine, identify the specimen as "Family Planning" so that the laboratory may properly identify its services when submitting its claim.

2. Outpatient Hospital

- a. Family planning services should be identified by using Code-10 for all clinic visits rendered in conjunction with family planning.
- b. Code-10 should be inserted in item 18 (type of clinic) on form MC-4 (Outpatient Hospital Claim). Include on this claim form only those charges relating to Family Planning.

3. Independent Laboratories

- a. When a specimen is forwarded by a physician or a family planning clinic and is identified as "Family Planning" the laboratory should include, in addition to the description of the laboratory procedure, the words "Family Planning" on the laboratory claim form MC-13.

4. Independent Clinics

- a. Family Planning should be identified by writing the words "Family Planning" in section 10C on the claim form MC-14 (Clinic Services). This notation should be made following the insertion of the description of services and procedures in this section.
- b. Only procedures and services related to Family Planning should be claimed on one claim form. Unrelated procedures and services should be claimed on separate claim forms.

Effective October 1, 1970 local units in Cape May, Salem, Somerset, Sussex and Warren counties will be consolidated with other Local Medical Assistance Units.

All requests and correspondence previously sent to these offices must now be forwarded to a new address. Example: County 05, Cape May, must now be sent to County 01, Atlantic City address.

Please replace your existing list of the Local Medical Assistance Units with the attached.

DIRECTORY OF LOCAL MEDICAL ASSISTANCE UNITS

The first two digits of the recipient's Health Services Program Identification number indicate the Local Medical Assistance Unit having jurisdiction.

Inquiries concerning eligibility and applications for eligibility are to be sent to the County Welfare Board of patient's residence.

<u>County Code</u>	<u>Street Address</u>	<u>Municipality</u>	<u>P.O. Box</u>	<u>Zip Code</u>
01	1601 Atlantic Ave., 6th Floor	Atlantic City	1970	08404
02	90 Main Street, 2nd Floor	Hackensack	813	07601
03	50 Rancocas Rd., 2nd Floor	Mt. Holly	607	08060
04	709 Market Street, 2nd Floor	Camden	19	08101
05	1601 Atlantic Ave., 6th Floor	Atlantic City	1970	08404
06	27 Fayette Street, 2nd Floor	Bridgeton	440	08302
07	505 South 15th St., 2nd Floor	Newark	1576	07101
08	10 Harrison Street	Woodbury	1900	08096
09	100 Newkirk St., 2nd Floor	Jersey City	8216	07306
10	79 Main Street, 2nd Floor	Flemington	19	08822
11	205 East State St., Rear Plaza	Trenton	2465	08625
12	75 Paterson Street Basement	New Brunswick	1274	08903
13	(Address) Cottage K1 P. O. Box in Red Bank	Marlboro Red Bank	 778	07746 07701
14	6 Court Street	Morristown	425M	07960
15	952 President Ave., Apt. #1	Toms River	1005	08753
16	152 Market Street	Paterson	2863	07509
17	10 Harrison Street	Woodbury	1900	08096
18	79 Main Street, 2nd Floor	Flemington	19	08822
19	6 Court Street	Morristown	425M	07960
20	7 Bridge Street, 4th Floor	Elizabeth	776	07201
21	79 Main Street, 2nd Floor	Flemington	19	08822

I M P O R T A N T N O T I C E

TO INSURE PROMPT PAYMENT WHEN SUBMITTING MEDICAID CLAIMS BE SURE TO ENTER THE NAME, HEALTH SERVICES PROGRAM CASE NUMBER, PERSON NUMBER AND SEX EXACTLY AS THEY APPEAR ON THE VALIDATION FORM.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-9

November 16, 1970

NEW JERSEY HEALTH SERVICES PROGRAM BULLETIN NO. 9

SUBJECT: POLICY ON HOSPITAL OUTPATIENT DENTAL SERVICES

POLICY

Effective November 2, 1970, all aspects of dental care as detailed in the Dental Services Manual apply with the following exceptions:

- (1) Reimbursement for hospital outpatient dental services will be made on a per visit basis.
- (2) Routine dental services rendered in hospital outpatient departments do not require prior authorization. All other dental services require prior approval.
- (3) Post operative x-rays will be kept with the patient's records in the outpatient department for post audit review.

The following is the definition of routine dental services:

ROUTINE DENTISTRY

(Includes the following procedures, as defined in the Dental Services Manual)

1. Emergency Treatment
2. Examination with necessary radiography
3. Preventive Dentistry
 - a. Prophylaxis
 - b. Fluoride treatment
4. Restoration of carious permanent or deciduous teeth with:
 - a. Silver amalgam
 - b. Silicate, plastic, or composite filling material
5. Pulp Capping or pulpotomy for permanent and deciduous teeth, endodontic treatment (single rooted teeth)
Limitation: If more than one tooth requires endodontic treatment, prior approval is required.
6. Extraction of non-restorable teeth

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

NEW JERSEY HEALTH SERVICES PROGRAM

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

November 16, 1970

TO: Hospital Administrators

RE: New Jersey Health Services Bulletin -
Policy on Hospital Outpatient
Dental Services

New Jersey Health Services Program Bulletin Number 9 is attached explaining hospital outpatient dental services.

This bulletin supplements Section 205.10 on Dental Services in the Hospital Manual.

PROCEDURE FOR OBTAINING PRIOR AUTHORIZATION WHEN DENTAL SERVICES ARE OTHER THAN ROUTINE

If, in the course of the initial examination and development of a treatment plan, services requiring prior authorization are included, then all subsequent services including those defined as routine dentistry require prior approval. The hospital will submit the treatment plan on the Dental Form (MC-10) with x-rays to the appropriate Local Medical Assistance Unit for review.

If a treatment plan is developed which requires only routine dentistry, but a treatment change becomes necessary and services requiring prior authorization are indicated, then the routine services to that date may be submitted for payment and the request for additional services must be submitted for approval at the Local Medical Assistance Unit. A record of care already completed with appropriate x-rays must be included.

PROCEDURE FOR BILLING FOR DENTAL SERVICES

After completion of treatment either authorized or routine, the Dental Form (MC-10), with descriptions and dates of services rendered, utilizing proper procedure code numbers, is attached to the Hospital Outpatient Form (MC-4), which is used to make the charge for the dental clinic visit. These forms are then submitted to the appropriate fiscal agent for the hospital.

Mr. Orsini.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-16

April 2, 1971

TO: Hospital Administrators

SUBJECT: NEWBORN ELIGIBILITY

Physician Providers have been experiencing difficulties in obtaining timely reimbursement for services rendered to newborns under the Health Services Program.

The problem involves the time required for the determination of eligibility by the County Welfare Board and the subsequent placement of the newborn on the Medicaid eligibility file.

In an attempt to resolve this problem, a new procedure will be immediately implemented to expedite the processing of eligibility determination for newborns. The Local Medical Assistance Unit will isolate all Hospital Admission Notices (MC-1C) for pregnancy admissions and will notify the County Welfare Board to process these cases on a priority basis.

The role of the hospital in this matter is most important in that your cooperation will enable the physicians on your staff to be promptly paid for services rendered to newborn recipients.

Your attention is called to Section 301. of the Health Services Program Hospital Manual, which instructs Hospitals to submit the Hospital Admission Notice (MC-1C) to the appropriate Local Medical Assistance Unit within 48 hours of admission.

Your cooperation in this matter will be appreciated.

Mr. P. ...



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

New Jersey Health Services Program NEWSLETTER

Volume ...1-17.....

April 2, 1971

TO: Hospital Administrators

SUBJECT: NEW JERSEY HEALTH SERVICES PROGRAM AND OTHER INSURANCE

The policy of the New Jersey Health Services Program concerning "other insurance" is stated in Section 110.3 (page 9) of the Health Services Program Hospital Manual:

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

We have been advised that on occasions "medical assistance recipients" have requested statements of benefits paid in their behalf by the New Jersey Health Services Program (Medicaid). It is believed that some of these recipients might be covered either in part or in whole by some other type of health insurance. Therefore, if you have a record of having provided a duplicate statement of benefits to a recipient or receive such a request in the future, please notify the Bureau of Medical Care surveillance, P.O. Box 2486, Trenton, New Jersey, 08625 of the patient's full name, address and Health Services Program case number.

Such information will enable the Bureau to investigate such cases to determine possible fiscal responsibility of another carrier, and ultimately reduce unnecessary payments by the Health Services Program.



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

New Jersey Health Services Program NEWSLETTER

Volume1-19.....

June 1, 1971

TO: All Providers

SUBJECT: POLICY ON THE ELIMINATION OF PAYMENT OF THE MEDICARE B COINSURANCE FACTOR

This policy statement changes the basis of payment for services rendered to individuals who are covered under both Medicare part B and the New Jersey Health Services Program for all such services rendered on or after June 1, 1971.

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

Charges not paid by Medicare because of the coinsurance features will not be considered for supplementary payment by the New Jersey Health Services Program. However, this change does not preclude consideration of charges for services which are eligible under Medicaid even though they may be ineligible under Medicare.

SUBJECT: NON-INSTITUTIONAL PROVIDER CLAIM TIME LIMITATIONS

Policy

Claims for payments of non-institutional services must be received not later than the 90 days following the last date of service as indicated on the claim. For the purposes of this time limitation, a claim is a submission in writing, which indicates a request for reimbursement in connection with medical services of a specified nature furnished to an eligible recipient. If a claim, as defined above, is received by the Division of Medical Assistance and Health Services or Contractor within the time limit specified, the claim is considered to be filed timely, even though additional information is supplied after the time limitations.

Purpose

This policy establishes time limits for submittal of claims to the New Jersey Health Services Program by non-institutional providers. Non-institutional providers are defined as all eligible participating providers except hospitals, nursing homes, and home health agencies, which are reimbursed based on reasonable cost.

Services Provided January 1, 1970 - August 31, 1971

Claims must be submitted no later than December 1, 1971.

Services Provided September 1, 1971 and thereafter

Claims must be submitted within (90) days of the date of the last service on the claim.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-20

TO: Home Health Agencies

SUBJECT: POLICY ON NEED FOR URGENT ADDITIONAL HOME HEALTH SERVICES

When an authorization for Home Health Services is in effect and the condition of the patient changes, requiring prompt additional Home Health Services, the Home Health Agency may request the Local Medical Assistance Unit to authorize the additional service. When the need is urgent such request may be made by telephone and does not require the submission of a new plan of treatment. Authorization for such additional service may be issued but not exceed three additional treatments without the submission of a new plan of treatment.



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

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New Jersey Health Services Program

NEWSLETTER

Volume 1-21

June 28, 1971

TO: All Providers

SUBJECT: CHANGE IN RELEASE DATE OF MEDICAID IDENTIFICATION MATERIALS

As of July 1, 1971, Division of Public Welfare regulations do not permit the mailing of maintenance checks to clients by County Welfare Boards before the 1st calendar day of each month. The current monthly validation stub (normally a tear off from the check) is sent to the recipient at this time.

The Medicaid program reminds you that eligibility must be verified before services are provided.

[Faint, illegible stamps and markings]



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

New Jersey Health Services Program NEWSLETTER

Volume 1-22

July 10, 1971

TO: Suppliers

SUBJECT: POLICY ON ORTHOTIC APPLIANCES THAT MAY BE PROVIDED BY OTHER THAN A CERTIFIED PROSTHETIC AND/OR ORTHOTIC FACILITY

The following items, customarily listed as orthotic appliances, are reimbursable from facilities other than certified or provisionally certified Prosthetic and Orthotic facilities (i.e. pharmacies, non-approved prosthetic and orthotic facilities, medical-surgical suppliers, etc.) in addition to certified shops. Each of the fourteen (14) items listed requires prior authorization from the Local Medical Assistance Unit regardless of price or charge to the Program:

1. Cervical Collars
 - a. Soft
 - b. Hard
 - c. Malleable Frame
2. Abdominal Belts (fashioned elastic type - not used for incisional hernia)
3. Abdominal Corsets (non-elastic type)
4. Abdominal Supports (low back - non-elastic type - size to fit patient)
5. Sacro-iliac and lumbo-sacral corsets, supports or belts (male or female)
6. Special corset, boned and reinforced with steel stays
7. Combination corset with inside abdominal belt
8. Elastic support stockings, etc.
9. Surgical weight hose
10. Trusses
11. Knee Cage (standard)
12. Hand Orthosis
 - a. Short Opponents
 - (1) C-Bar
 - (2) Lumbrical Bar
13. Denis Browne Splints and Fillauer Bar

14. Shoes

BILLING INSTRUCTIONS

Non-certified providers must bill for these items on the Medical Supplies and Equipment Claim (Form MC-11) to which authorization (Form Medicaid 33030) signed by the Local Medical Consultant, must be attached.

Certified Prosthetic and Orthotic facilities must bill for these items on the Prosthetic and Orthotic Appliance Claim (Form MC-15), which must be signed by the Local Medical Consultant in the space provided.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-25

September 2, 1971

To: Hospital Administrators

Subject: Medicare Extended Care Benefits
(Revised, please destroy Newsletter dated September 1, 1971)

Please remind those persons involved in discharge planning to consider the possibility of dual coverage that may be available to a Medicare beneficiary who is also eligible for Medicaid benefits.

A hospital should make arrangements to transfer patients to a participating extended care facility if they require continuous skilled nursing care and are covered under the Hospital Insurance Program (Part A). The Hospital Insurance Program will reimburse a participating extended care facility if the beneficiary has been a hospital inpatient for at least three days and if the patient is transferred to an extended care facility within 14 days of the date of discharge from the hospital.

The New Jersey Health Services Program requires that when a covered person has other health insurance that such benefits be used before making application for payment under Title XIX Medicaid. The fact that an individual was previously ineligible for payment of extended care benefits under Medicare, Title XVIII, does not mean that following a new hospital confinement a recipient will not qualify for extended care benefits under Medicare. If a Medicare/Medicaid patient requires extended care, persons involved in discharge planning should explore the possibility of Medicare coverage and arrange to transfer the patient to a participating extended care facility.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-26

October 1, 1971

TO: All Providers

SUBJECT: RELATIONSHIP OF NEW JERSEY HEALTH SERVICES PROGRAM
TO OTHER HEALTH INSURANCE AND LIABILITY COVERAGE

In our continuing efforts to safeguard the expenditure of the taxpayers dollars and to uphold public confidence in the New Jersey Medicaid Program we are requesting your cooperation in notifying our Bureau of Medical Care Surveillance of any and all requests from attorneys, insurance companies and/or recipients to either furnish copies of medical bills or fill out insurance forms for services rendered to Medicaid patients.

If you have a record of having provided a duplicate statement of benefits to a recipient or receive such a request in the future, please notify the Bureau of Medical Care Surveillance, P.O. Box 2486, Trenton, New Jersey 08625. Please provide the patient's full name, Health Services Program Case Number, address, phone number, if available, and date(s) of treatment. Also, please include the name, address and phone number of the insurance company or legal firm involved in the case.

Information of this type, provided by you, will enable the Bureau of Surveillance to review such cases to determine possible fiscal responsibility of another carrier and ultimately reduce unnecessary payments by the Medicaid Program.



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

New Jersey Health Services Program NEWSLETTER

Volume1-27.....

October 4, 1971

TO: ALL PROVIDERS

SUBJECT: MEDICAID IDENTIFICATION FOR RESIDENTS OR PATIENTS OF STATE INSTITUTIONS RECEIVING HEALTH SERVICES IN THE COMMUNITY

Certain patients of State Psychiatric Hospitals, residents of State schools for the mentally retarded, and outpatients in Family Care Facilities have recently been declared eligible for health services provided in the community, i.e., physicians, dentists, general hospitals, etc.

The eligibles have ten-digit Health Services Program Case Numbers 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>
Greystone Park Psychiatric Hospital	31
Trenton Psychiatric Hospital	32
Marlboro Psychiatric Hospital	33
Ancora Psychiatric Hospital	34
N.J. Neuropsychiatric Institute	35
Arthur Brisbane Child Center	36

<u>The Schools for the Retarded:</u>	<u>2 Digit Code</u>
Vineland State School	41
North Jersey Training School Totowa	42
Woodbine State School	44
New Lisbon State School	45
E.R. Johnstone Training and Research Center	46
Woodbridge State School	47
Hunterdon State School	48
Family Care	90

In order to provide identification of these individuals for community services, the "Validation of Eligibility", form FD-34 (sample attached) was developed. This form is completed by an authorized representative of the State Institution and must be presented by the patient or his attendant when services are requested. The FD-34, is valid for a maximum of 30 days and must be returned with the patient.

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.

Because of the elimination of the two-digit County identification number and substitution of the two-digit institutional identification number, the Division has designated specific Local Medical Assistance Units 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.

IF PATIENT'S
IDENTIFICATION
NUMBER IS:

CONTACT:

31	Morris Local Medical Assistance Unit
32	Mercer Local Medical Assistance Unit
33	Monmouth Local Medical Assistance Unit
34	Camden Local Medical Assistance Unit
35	Hunterdon Local Medical Assistance Unit
36	Monmouth Local Medical Assistance Unit
41	Cumberland Local Medical Assistance Unit
42	Passaic Local Medical Assistance Unit
44	Atlantic Local Medical Assistance Unit
45	Burlington Local Medical Assistance Unit
46	Burlington Local Medical Assistance Unit
47	Middlesex Local Medical Assistance Unit
48	Hunterdon Local Medical Assistance Unit
90	Ocean Local Medical Assistance Unit

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

VALIDATION OF ELIGIBILITY

<u>DOE</u>	<u>JOHN</u>	<u>D.</u>	<u>3120 004212</u>	<u>01</u>
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 30 days from date of issue. All policies and procedures specified 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.

<u>John Smith Institutional Adjuster</u>	<u>9/1/71</u>
Signature and Title of State Institution Representative	Date of Issue
<u>Greystone Park Psychiatric Hospital</u>	
Name of State Institution	Telephone No.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-28

October 8, 1971

SUBJECT: REVISED DEFINITION OF QUALIFIED PHYSICAL THERAPIST -
PROVIDER MANUAL REVISIONS

Section 200.3	Home Health Manual
Section 209.1 (b)	Hospital Manual
Section 200.3	Independent Clinic Manual
Section 210.2	Physician's Manual
Section 209.1	Special Hospital Manual

The specified sections of the manuals listed above should be revised to define "Qualified Physical Therapist" as follows:

"A qualified physical therapist is one who:

1. Has graduated from a physical therapy curriculum approved by --
 - a. The American Physical Therapy Association; or
 - b. The Council on Medical Education and Hospitals of the American Medical Association; or
 - c. The Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association; or
2. Prior to January 1, 1966 --
 - a. Has been admitted to membership by the American Physical Therapy Association; or
 - b. Has been admitted to registration by the American Registry of Physical Therapist; or
 - c. Has graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education, is licensed or registered as a physical therapist, and where appro-

Definition of Qualified Physical Therapist (continued)

priate, has passed a State examination for licensure as a physical therapist; or

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

974.905
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STATE OF NEW JERSEY
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume1-29.....

October 8, 1971

ATTENTION: INDEPENDENT OUTPATIENT FACILITIES PROVIDING DENTAL SERVICES

- SUBJECTS:**
- (1) POLICY ON ALLOWANCES FOR DENTAL SERVICES PERFORMED IN APPROVED INDEPENDENT OUTPATIENT FACILITIES
 - (2) SUBMISSION OF DENTAL CLAIMS FROM INDEPENDENT OUTPATIENT FACILITIES DIRECTLY TO CENTRAL OFFICE
 - (3) ELIMINATION OF CLINIC SERVICES CLAIM (FORM MC-14) FOR DENTAL CLINICS

- (1) Effective November 1, 1971, all approved Independent Outpatient Health Facilities providing Dental Services will be reimbursed on a fee-for-service basis. The mechanism for reimbursement will be to pay billed charges up to 60% of the Health Services Program Schedule of Maximum Dental Allowances.

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

- (2) The Independent Outpatient Health Facility will perform the necessary diagnostic services and submit the treatment plan on the Request for Authorization and Payment of Dental Services Form (MC-10) to the Division of Medical Assistance and Health Services (Post Office Box 2706, Trenton, New Jersey 08625) for approval of the treatment plan (NOT FEES) by a Central Office Dental Consultant. NOTE: Effective November 1, 1971, Dental Clinics will submit all requests to Central Office ONLY.

After completion of authorized treatment, the MC-10 should be properly signed and returned to the Central Office with post treatment X-rays for approval and submission to the Prudential Insurance Company of America for payment.

- (3) The policy requiring Dental Clinics to utilize both the MC-10 and the Clinic Services form (MC-14) is rescinded effective November 1, 1971. Only the MC-10 is needed.



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

New Jersey Health Services Program NEWSLETTER

Volume1-33.....

March 1, 1972

ATTENTION: Providers of Family Planning Services

SUBJECT: REVISED PROVIDER IDENTIFICATION OF FAMILY PLANNING SERVICES

The material presented in this Newsletter restates and further clarifies the Division policy concerning family planning services as originally stated in Newsletter 8 dated September 25, 1970.

POLICY

Services and supplies furnished in conjunction with family planning must be clearly identified by the provider on all claims submitted for payment.

These services are specifically directed toward the elective determination of the size of the family by medical, surgical or other means, within the context of the law, which is deemed appropriate and effective by the physician and acceptable to the patient.

A "Family Planning Visit", therefore, is defined as that procedure, service or medication which is specifically provided to voluntarily determine the size of a family as related to fertility and infertility and shall include permanent sterilization (male or female) as well as contraceptive services or surgery performed for that stated purpose.

The following procedures have been developed by the Division of Medical Assistance and Health Services in order to identify the rendering of family planning services by eligible providers:

PROCEDURE

1. Physician's Service

- a. Physicians are requested to check off "Family Planning" in section 12E of the Form MC-8 (Physicians and Practitioners Claim). This notation should be made following the insertion of the descriptions of services and procedures in section 12D.

- b. When sending a specimen to a laboratory as part of family planning routine, identify the specimen as "Family Planning" so that the laboratory may properly identify its services when submitting its claim.

2. Out-Patient Hospital

- a. Family planning services should be identified by using Code 10 for all clinic visits rendered in conjunction with family planning.
- b. Code 10 should be inserted in item 18 (type of clinic) on Form MC-4 (Out-patient Hospital Claim). Include on this claim form only those charges relating to Family Planning.

3. Independent Laboratories

- a. When a specimen is forwarded by a physician or a family planning clinic and is identified as "Family Planning", the laboratory should include in addition to the description of the laboratory procedure, column 10D "Family Planning" on the revised Laboratory Claim Form MC-13-C1. However, if the Laboratory is utilizing the original Laboratory Claim Form MC-13(1-70) the words Family Planning should be written next to the procedure.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-34

December 30, 1971

TO: Hospitals

SUBJECT: Revised Procedure for the Submission of Claims
Insufficient A.I.D. Recertification

Participation in the New Jersey Health Services Program requires that approved general hospitals comply with the provisions of the Approval by Individual Diagnosis Program (A.I.D.) as stipulated in the A.I.D. Manual (Second Revision).

The procedure previously required that a letter of justification be submitted to a Local Medical Assistance Unit for the purpose of obtaining approval for the lack of a timely recertification (MC2). This procedure has now been modified.

The revised procedure entails a notification by the contractor to the hospital indicating the reason for the rejection, and outlining the option of billing for only A.I.D. days or submitting a letter of justification for the insufficient recertification.

The hospital letter of justification will be evaluated and if acceptable the claim will be processed accordingly. If the letter of justification is submitted to excuse the absence of two or more A.I.D. certifications for a particular hospitalization, medical information must accompany the letter and should include doctor's orders, progress notes and discharge summary, to substantiate the medical necessity for the extended hospital stay.

All letters of justification will be maintained in a central file by the contractor for the purpose of isolating providers who are consistent offenders. These hospitals will be contacted by a representative of the contractor and offered any assistance necessary to rectify the hospital's recertification problem.

After this assistance, the provider will be notified that future non-compliance with the A.I.D. Program may result in rejections of subsequent letters of justification.

Further submissions or resubmissions of claims requiring certifications which do not conform with instructions will be subject to declination. If all or any of a hospital stay is declined because of incorrect or untimely A.I.D. certification the provider's only recourse would be to request a Fair Hearing as outlined in the Newsletter #24.

The issuance of an A.I.D. decline to a hospital will generate a review of the Practitioner's claim, in order that an appropriate reduction in payment can be effected.



New Jersey Health Services Program NEWSLETTER

Volume 1-41.....

April 1, 1972

ATTENTION: Participating Family Planning Clinics

This Newsletter supercedes New Jersey Health Services Program Newsletter 1-3 dated April 17, 1970.

The following are our policies regarding maximum allowances for family planning clinic services. This change from the previously allowed fee per visit became effective for claims submitted for services provided on and after April 1, 1970.

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

 NOTE: A year shall be defined as twelve (12) months following the initial visit or annual revisit.
- II. All family planning procedures for which reimbursement is made in the Health Services Program must involve physicians' services.
- III. The following fee schedule represents maximum amounts allowable. Reimbursement will be made of customary charges when they are lower than these maximum amounts.

Initial Medical Visit - Family Planning

Includes:

Medical, social, obstetrical history
 Complete pelvic examination - including visual inspection of cervix
 Breast examinations
 Papanicolaou smear (excludes cytology study)
 Contraceptive counseling
 Referral as indicated
 Includes costs of birth control drugs dispensed \$15.00

Insertion of Intrauterine Device

Includes cost of device and necessary post-procedural follow-up. \$ 7.50

Laboratory, Cytology Study (Papanicolaou Smear) \$ 3.50

Medical Revisit - Family Planning

May include pelvic examination, changes in method or physicians' instructions
 Includes costs of birth control drugs dispensed \$ 5.00

Annual Medical Revisit - Family Planning

Includes:

Updating medical, social, obstetrical history

Complete pelvic examination including visual inspection of cervix

Breast examination

Papanicolaou smear (excludes cytology study)

Referral when indicated

Includes costs of birth control drugs dispensed

\$10.00

Vasectomy

\$75.00



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

New Jersey Health Services Program NEWSLETTER

Volume 1-42.....

TO: Hospital Administrators
Hospital Business Managers
Hospital Billing Personnel

DATE: April 1, 1972

SUBJECT: REQUESTS MADE FOR MEDICAID RECIPIENTS' HOSPITAL STATEMENT
(PAID OR UNPAID)

This Newsletter supplements the New Jersey Health Services Program Newsletter 1-17 and 1-26 (Prudential) and Medicaid Bulletin dated 4/16/71 and Newsletter 14 (Blue Cross) dealing with "other insurance."

As pointed out in the referenced Newsletters, recipients sometimes have other types of insurance which may cover the medical expenses which were paid by Medicaid. In some instances it may be determined that a third party has legal liability for the recipient's medical bills for which Medicaid reimbursed you. In either situation, whenever resources become available to a recipient to pay for medical expenses which were paid by Medicaid, the New Jersey Health Services Program seeks reimbursement in accordance with Chapter 413, P.L. 1968.

In order to preserve funds available for health care under the Medicaid Program, we have established the following procedures to assist our Bureau of Medical Care Surveillance in effecting recovery of expenditures. Your cooperation in implementing these procedures will be greatly appreciated.

1. Whenever a request is made on behalf of a Medicaid recipient for a duplicate hospital statement, please complete the attached form letter (Form LD-13) and forward same to the Bureau of Medical Care Surveillance.
2. Please release the requested information with the following notation: (Rubber stamp may be utilized).

If other insurance or legal liability exists please contact:

Division of Medical Assistance and Health Services
Bureau of Medical Care Surveillance
Post Office Box 2486
Trenton, New Jersey 08625
(609) 292-5935 or (609) 292-7155

All personnel who handle such requests should become familiar with these procedures. An initial supply of forms is provided herewith; additional LD-13's can be obtained from your contractor, i.e. Prudential or Blue Cross.

Thank you for your cooperation in this endeavor.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-43.....

TO: All Providers (Except Institutions)

DATE: April 1, 1972

SUBJECT: 90 DAY TIME LIMITATION FOR CLAIMS SUBMISSION

The following is a restatement of the Medicaid regulation and clarification of its application on the time limits for submission of your claims to the Contractors (Blue Cross or Prudential).

The regulation applies to ALL PROVIDERS except hospitals, skilled nursing homes and home health agencies.

REGULATION

All claims for payment of non-institutional goods or services must be submitted no later than 90 days after the last date the goods or services are furnished.

APPLICATION

This regulation does not apply to those situations where non-compliance with the regulation was due solely to situations beyond the control of the provider. A written statement explaining the reason(s) for non-compliance must be submitted with the claim(s) involved. Due to the liberalized patient certification and signature requirements as defined in Newsletter 23 (7/26/71), the failure of a provider to obtain a patient's signature is not a legitimate reason for non-compliance with the 90-day time limit regulation.

PURPOSE

This regulation establishes time limits for submittal of claims to the New Jersey Health Services Program by non-institutional providers. Non-institutional providers are defined as all eligible participating providers except hospitals, nursing homes, and home health agencies, which are reimbursed based on reasonable cost. This regulation was promulgated because of administrative and fiscal scheduling required to effect efficient and timely controls of public funds.

CLAIM DEFINED

For this time limitation a medicaid claim is defined as a submission, in writing, which indicates a request for reimbursement in connections with medical or other services of a specified nature furnished to an eligible recipient. If a claim, as described above, is received by the Contractor or Medicaid (Central Office or Local Medical Assistance Unit) within the time limit specified, the claim is considered to be filed in time even though additional information may be required after the 90 day time limitation.



New Jersey Health Services Program NEWSLETTER

Volume 1-47

TO: Dentists, Independent Dental Clinics
SUBJECT: MODIFICATION OF MEDICAID DENTAL PROGRAM

June 16, 1972

IMPORTANT NOTICE!!

This Newsletter is of extreme importance to all dentists participating in the Medicaid Program. Please read it carefully and insert it in your Dental Manual.

Effective July 1, 1972, the New Jersey Medicaid Dental Program is being modified substantially to allow greater flexibility for participating dentists by expediting claims processing and reimbursement procedures. Below is a synopsis of the SIX MAJOR CHANGES with an explanation of procedures to be followed during the transition period from today through July 1, 1972.

Please be advised that these are procedural changes only, and the rules and regulations defined in the Dental Manual as to covered services, standards of treatment, prescription policies, recipient eligibility, etc. STILL APPLY. A completely new Dental Manual, reflecting these changes will be issued in the immediate future.

I CLAIM FORM REVISION

The Dental Claim form (MC-10) has been completely revised and is now a two part form. (Contractor and Provider) Please destroy your existing supply of MC-10's and utilize only the new MC-10 (Rev. 7/72). Instructions for completing the new claim are provided on pages 6 and 7 of this Newsletter.

II DENTAL SERVICES NOT REQUIRING PRIOR AUTHORIZATION INCLUDING "ROUTINE DENTISTRY"

A. As of July 1, 1972, the following "routine" dental services do not require prior authorization up to a maximum of \$75.00:

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

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

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

- a. Oral prophylaxis
- b. Topical flouride application for persons twenty (20) years of age and under
NOTE: This is not a covered service for persons 21 and over.
- c. Restoration of carious permanent and deciduous teeth with silver amalgam, silicate cement, composite and other plastic materials.
- d. Pulp capping for permanent and deciduous teeth.
- e. Pulpotomy for permanent and deciduous teeth. If more than one pulpotomy is necessary, prior authorization of the complete treatment plan is necessary.
- f. Extraction of non-restorable teeth. Where multiple extractions are recommended and a dental prosthesis will be needed, prior authorization will be necessary.

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

1. That all such "routine" services should be completed within 90 days of the date of the initial visit, and
2. That any such "routine" services may not be initiated again within six (6) months from the date of last service, and
3. All initial emergency, examination and routine dentistry services are to be included on one claim. Interim or split bills will be reviewed for compliance with limitations #1 and 2 above.

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

C. Procedure for "Routine" Dental Services

1. Following verification of recipient **validation** card, Dentist examines patient, takes necessary x-rays, performs emergency treatment if any, and develops a treatment plan on the revised Dental Claim (MC-10) using procedure codes supplied in Appendix A.
2. Treatment is completed by provider (should be within 90 days from initial visit).
 - a. Post-treatment x-rays as necessary are taken.

3. Dental Claim MC-10 (Contractor Copy) together with Pre-treatment and Post-treatment x-rays sent to Prudential within 90 days of last date of service. X-rays must be stapled to center rear of claim form. Dentist retains provider copy.

III DENTAL SERVICES REQUIRING PRIOR AUTHORIZATION

A. The following types of claims will require prior authorization from the Dental Field Office (See list of Dental Field Offices in Appendix B of this Newsletter):

1. Claims for "routine" services exceeding \$75.00.
2. Claims for additional "routine" services excluding emergencies rendered within six (6) months from the date of last service.
3. All claims involving a combination of "routine" and "non-routine" services (non-routine services are defined as all other allowable services that are not listed as "routine" in Appendix A).
4. All claims for "non-routine" services.

B. Procedures for Obtaining Prior Authorization and Billing

1. Following verification of recipient validation card, Dentist examines patient, takes necessary x-rays, and develops a treatment plan using procedure codes from Appendix A (Routine) and/or Chapter IV of the Dental Manual.
2. Revised Dental Claim (MC-10) (Both Copies) with pretreatment x-rays is submitted to the appropriate Dental Field Office. (See Appendix B for listing.)

NOTE: Independent Dental Clinics and all out-of-state providers are to continue to submit their claims to the Division Central Office.

3. The Dental Consultant reviews the Dental Claim (MC-10), authorizing or rejecting the services (not the fees) as may be appropriate and returns both copies of the MC-10 and x-rays to dentist.
4. Dentist completes authorized treatment and submits Contractor Copy of Dental Claim (MC-10) together with pre-treatment and post-treatment x-rays (stapled to center rear of claim) to Prudential for payment. Dentist retains Provider Copy. All claims must be submitted within 90 days of last date of service.
 - a. If during the course of treatment it is found that a change in authorized treatment is necessary, then the original Dental Claim (MC-10) (Contractor and Provider copies) with x-rays are returned by the provider to the specified Dental Field Office for appropriate authorization which is so noted on Dental Claim (MC-10).
 - (1) The Dental Claim (MC-10) (Contractor and Provider copies) and x-rays are returned to the provider for completion of authorized treatment.

- (2) Following completion of authorized treatment, claim is then submitted to Prudential in accordance with 4 above.

- C. Five Dental Field Offices have been established to handle all dental claims requiring prior authorization except for Independent Clinics and out-of-state providers who will submit their claims to the Division Central Office as in the past.

Dental claims requiring prior authorization are not to be sent to the Local Medical Assistance Units as has been the practice. All claims requiring authorization are to be submitted to the Dental Field Office corresponding to the County in which your office is located irrespective of the first two digits of the patient's Health Services Program Case Number. For example, a dentist located in Passaic County will submit all authorization requests to the Middlesex Medicaid Office regardless of whether the patient's Health Services Program Number indicates he resides in Passaic County or Camden County. Dental field offices are listed in Appendix B.

IV EMERGENCY SERVICES

Emergencies not defined as "initial routine" e.g. those emergencies which do not generate a treatment plan or emergencies occurring after treatment has been completed, but within six (6) months from date of last service may be billed directly to Prudential if the dentist describes and explains the nature and reason for the emergency in item 14 of the revised Dental Claim (MC-10).

V PUBLISHED FEE SCHEDULE FOR "ROUTINE" DENTAL SERVICES

Appendix A of this Newsletter is a comprehensive description of those procedures, together with procedure codes and fees which the New Jersey Medicaid Program defines as "routine". These codes are to be utilized when completing claim forms for all "routine" services. Procedure codes for "non-routine" services may be found in Chapter IV of the Dental Manual.

VI SPECIALIST REIMBURSEMENT

A Specialist is defined as a Dental Practitioner who meets the requirements of a Specialist as defined in Section 234.4A (page 27.1, Rev. 3/1/72) of the New Jersey Health Services Program Dental Manual.

Any Provider who meets the above-cited qualifications and who desires Specialist reimbursement is required to submit written documentation from Specialty Board indicating his status as a Diplomate, or, that he meets the minimum requirements of his respective Specialty Board as recognized by the American Dental Association.

TO: Provider Services Division
Prudential Insurance Company of America
Post Office Box 5000
Millville, New Jersey 08332

Reimbursement as a Specialist prior to July 1, 1972 does not guarantee such reimbursement subsequent to that date unless the above requirements are met.

At the present time, Specialist reimbursement where appropriate, will be limited to the following Specialities:

- A. Oral Surgery
- B. Endodontia
- C. Pedodontia
- D. Orthodontia

VII TRANSITIONAL PROCEDURES

Upon receipt of this Newsletter, all Dentists are to follow the following procedures until July 1, 1972.

There are four possibilities:

- A. Claims Ready to be Sent to Local Medical Assistance Unit for Prior Authorization.

If you have claims already filled out and ready to submit to the Local Medical Assistance Unit, follow the new procedures. It is not necessary to recopy this information onto a new claim form.

1. Submit claims for "routine" services under \$75.00 directly to Prudential with pre-treatment and post-treatment x-rays attached. Prior authorization is not necessary.
2. Submit claims requiring prior authorization e.g. "routine" over \$75.00, combination "routine" and "non-routine" claims, and "non-routine" to the appropriate Dental Field Office with pre-treatment x-rays attached. The Dental Field Office will process the claims in accordance with III B on pages 3 and 4 of this Newsletter.

- B. Claims Presently in Local Medical Assistance Unit:

1. Those claims presently in Local Medical Assistance Unit for authorization will be authorized or denied (as in the past) but will be returned to you with the pre-treatment x-rays attached. Upon completion of authorized services, you may submit the Contractor Copy of the claim directly to Prudential for payment with pre-treatment and post-treatment x-rays attached.
2. Those claims for completed services which you have sent to the Local Medical Assistance Unit for authorization for payment will be sent to Prudential, by the Unit, for payment as in the past.

- C. Claims You Have on Hand That Have Been Prior Authorized by Local Medical Assistance Unit:

1. Upon completion of authorized treatment submit the Contractor Copy of the MC-10 directly to Prudential with post-treatment x-rays.

NOTE: If during the course of treatment it is found that a change in the treatment plan is necessary, then submit the claim to the Dental Field Office for appropriate authorization of the change(s). Do not send claim back to the Local Medical Assistance Unit that originally authorized the treatment.

D. Claims for New Services Begun After Receipt of This Newsletter.

1. Claims for all patients for whom new treatment is begun after receipt of this Newsletter must conform to the new procedures. Utilize the new MC-10 claim form and submit only those claims requiring prior authorization to the Dental Field Office. Claims for "routine" services under \$75.00 are to be submitted directly to Prudential with pre-treatment and post-treatment x-rays attached.

VIII INSTRUCTIONS FOR COMPLETING REVISED MC-10 7/72 (EXHIBIT I)

Items 1 - 8

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

Obtain from patient, his present address and telephone number.

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

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

Item 9: Check off place where services are rendered.

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

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

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

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

Item 14:

- A. Dates of Service - Record date each service is performed.
- B. Procedure Code - Record procedure code as it appears in Appendix A (for routine dentistry) or in Chapter IV of your Dental Manual (for non-routine dentistry).
- C. Tooth Code - Record the code of the tooth the procedure is performed on.

D. Surface - Clearly indicate surface(s) involved using the following abbreviations:

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

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

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

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

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

Item 15: This section is to be completed in accordance with Newsletter 23 (7-26-71).

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

STATE OF NEW JERSEY
 DEPARTMENT OF INSTITUTIONS AND AGENCIES
 DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

APPENDIX A

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

<u>PROCEDURE NUMBER</u>	<u>DESCRIPTION</u>	<u>MAXIMUM FEES</u>	
		<u>GENERALIST</u>	<u>SPECIALIST</u>
	<u>DIAGNOSTIC</u>		
0110	EXAMINATION OF ORAL CAVITY AND COMPLETION OF TREATMENT PLANNING FORM	\$ 5.00	\$ 6.00
0130	EMERGENCY ORAL EXAMINATION - FOR TREATMENT AND OBSERVATION OF INJURIES TO TEETH AND SUPPORTING STRUCTURES, INCLUDING COMPLETE WRITTEN REPORT AND ONE X-RAY (Not applicable when performed as an adjunct to any reimbursable service)	5.00	6.00
	<u>RADIOGRAPHS</u>		
0210	COMPLETE INTRAORAL SERIES OF PERIAPICAL RADIOGRAPHS, INCLUDING 2 ADDITIONAL BITE-WING X-RAYS - 16 FILMS	17.00	17.00
0220	INTRAORAL PERIAPICAL OR BITE-WING RADIOGRAPH, SINGLE VIEW	2.00	2.00
0230	EACH ADDITIONAL SINGLE PERIAPICAL OR BITE-WING RADIOGRAPH	1.00	1.00
0240	INTRAORAL RADIOGRAPH, OCCLUSAL MAXILLARY OR MANDIBULAR, SINGLE VIEW	5.00	5.00

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

<u>PROCEDURE NUMBER</u>	<u>DESCRIPTION</u>	<u>MAXIMUM FEES</u>	
		<u>GENERALIST</u>	<u>SPECIALIST</u>
	<u>PREVENTIVE</u>		
	<u>DENTAL PROPHYLAXIS</u>		
1110	ADULTS - OVER 15 YEARS OF AGE, DEPENDING ON SEVERITY	10.00	11.00
1120	CHILDREN - UP TO AND INCLUDING 15 YEARS OF AGE	7.00	8.00
	<u>FLUORIDE TREATMENTS</u>		
1220	TOPICAL APPLICATION OF STANNOUS FLUORIDE, ONE TREATMENT (Excluding Prophylaxis)	5.00	6.00
1230	TOPICAL APPLICATION OF ACID FLUORIDE PHOSPHATE, ONE TREATMENT (Excluding Prophylaxis)	5.00	6.00
	<u>RESTORATIVE</u>		
	<u>AMALGAM RESTORATIONS</u>		
2110	AMALGAM - ONE SURFACE - DECIDUOUS	6.00	7.00
2120	AMALGAM - TWO SURFACE - DECIDUOUS	11.00	12.00
2130	AMALGAM - THREE SURFACE - DECIDUOUS	16.00	17.00
2131	AMALGAM - FOUR OR MORE SURFACES - DECIDUOUS	18.00	19.00
2140	AMALGAM - ONE SURFACE - PERMANENT	6.00	7.00

STATE OF NEW JERSEY
 DEPARTMENT OF INSTITUTIONS AND AGENCIES
 DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

<u>PROCEDURE NUMBER</u>	<u>DESCRIPTION</u>	<u>MAXIMUM FEES</u>	
		<u>GENERALIST</u>	<u>SPECIALIST</u>
	<u>OTHER RESTORATIVE SERVICES</u>		
2951	REINFORCEMENT PINS, PER PIN (Maximum reimbursable three (3) pins)	3.00	4.00
	<u>ENDODONTICS</u>		
	PULP CAPPING (Excluding final restoration)		
3110	PULP CAP DIRECT (Excluding final restoration)	5.00	6.00
	<u>PULPOTOMY</u>		
3220	VITAL PULPOTOMY (Limited to one)	10.00	11.00
	<u>ORAL SURGERY</u>		
	<u>ROUTINE EXTRACTIONS</u>		
7110	PERMANENT TOOTH OR TEETH	7.00	9.00
7115	DECIDUOUS TOOTH OR TEETH	7.00	9.00

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

<u>PROCEDURE NUMBER</u>	<u>DESCRIPTION</u>	<u>MAXIMUM FEES</u>	
		<u>GENERALIST</u>	<u>SPECIALIST</u>
2150	AMALGAM - TWO SURFACES, PERMANENT	11.00	12.00
2160	AMALGAM - THREE SURFACES, PERMANENT	16.00	17.00
2161	AMALGAM - FOUR OR MORE SURFACES, PERMANENT	18.00	19.00
	<u>SILICATE, ACRYLIC, PLASTIC, AND COMPOSITE RESTORATIONS</u>		
2211	SILICATE, ACRYLIC, OR PLASTIC RESTORATIONS (Class III or V)	7.00	8.00
	MAXIMUM PER TOOTH	18.00	19.00
2212	COMPOSITE RESTORATIONS (Class III or V)	8.00	9.00
	MAXIMUM PER TOOTH	20.00	21.00
2213	ACRYLIC, PLASTIC, OR COMPOSITE (INVOLVING INCISAL ANGLE CLASS IV)	12.00	13.00
	MAXIMUM PER TOOTH	20.00	21.00
2214	COMPOSITE RESTORATIONS (POST- ERIOR TOOTH), TWO SURFACES	13.00	14.00
2215	COMPOSITE RESTORATIONS (POSTERIOR TOOTH) THREE SURFACES	18.00	19.00

NOTE: Composite restorations may be provided on mesial, occlusal, and buccal surfaces of maxillary first bicuspids, however, the distal surface may also be provided but only in conjunction with the mesial and occlusal surfaces.

Appendix B

FOR DENTISTS LOCATED IN:

SUBMIT REQUEST FOR AUTHORIZATION TO:

1	Passaic Middlesex Morris Sussex Hunterdon Warren Somerset	Middlesex Medical Assistance Unit P. O. Box 1274 New Brunswick 08903 Telephone: 201-246-0653
2	Bergen Hudson Union	Hudson Medical Assistance Unit 100 Newkirk Street 5th Floor Jersey City 07306 Telephone: 201-792-6390
3	Essex	Essex Medical Assistance Unit P. O. Box 1576 Newark 07101 Telephone: 201-648-3700
4	Ocean Monmouth Mercer Atlantic Cape May	Mercer Medical Assistance Unit P. O. Box 2465 Trenton 08625 Telephone: 609-292-7315
5	Burlington Camden Cumberland Gloucester Salem	Camden Medical Assistance Unit P. O. Box 19 Camden 08101 Telephone: 609-365-3926

DENTAL CLINICS AND OUT-OF-STATE PROVIDERS
SUBMIT REQUESTS FOR AUTHORIZATION TO:

NEW JERSEY DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
POST OFFICE BOX 2706
TRENTON, NEW JERSEY 08625
TELEPHONE: 609-292-7420



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

New Jersey Health Services Program NEWSLETTER

Volume 149

August 1, 1972

ATTENTION: Hearing Aid Providers

SUBJECT: Revision to Hearing Aid Provider Manual

Please delete the phrase "in the State of New Jersey" from Section 202A of the Hearing Aid manual since qualified out of State hearing aid dispensers are eligible as providers for the New Jersey Health Services Program.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-50.....

TO: All Dentists

DATE: October 23, 1972

SUBJECT: REVISED PROCEDURES FOR ORTHODONTIC PROGRAM

Effective November 1, 1972 Section 233.7 (pages 23 and 24) of the New Health Services Program Dental Manual is rescinded and 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 as defined in Section 234.4A (page 27.1, revised 3/1/72) of the New Jersey Health Services Program Dental Manual. Orthodontic treatment will be authorized on a very selective basis.

Orthodontic treatment will not be authorized:

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

A. REFERRAL PROCEDURE

IT IS NO LONGER NECESSARY FOR THE ATTENDING DENTIST TO NOTIFY MEDICAID OF HIS INTENT TO REFER A PATIENT FOR ORTHODONTIC TREATMENT. However, 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 Orthodontia and requests for Orthodontic treatment should be delayed until the patient has all his 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 prospects of the patient remaining in the geographic area where treatment is to be rendered.
4. The time period that the patient will remain eligible for Medicaid benefits should be sufficient to complete the treatment.

Reminders

- a. Most children become ineligible for Medicaid at age 18.
- b. THE MEDICAID PROGRAM WILL NOT REIMBURSE A PROVIDER FOR ORTHODONTIC TREATMENT RENDERED DURING PERIODS OF INELIGIBILITY.

B. PROCEDURES TO BE FOLLOWED BY ORTHODONTISTS

The New Jersey Health Services Program Handicapping Malocclusion Assessment System * is to be utilized by Orthodontists to determine the need for Orthodontic treatment. (See Appendix A)

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 and a supply of FD 10's is enclosed for all Orthodontists known to the Program. An additional supply of forms can be ordered from:

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

C. EVALUATION OF THE REFERRED PATIENT

1. The Orthodontist, after considering the factors in A 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 (eighteen [18] 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 (18), do not proceed with the diagnostic workup. Submit a Dental Claim Form (MC-10) directly to Prudential, Box 5000, Millville, New Jersey 08332 with a copy of the FD-10 identifying, by procedure code 0120, the service that has been rendered. The maximum fee allowed for procedure 0120 is \$6.00.

NOTE 1: If the malocclusion does not meet the minimum number of assessment points (eighteen [18]), 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
- d. A deep overbite where incisor teeth contact palatal tissue.

NOTE 2: Repeated submission of requests for treatment below the Assessment Index Minimum (18) without sufficient substantiating information for such requests will necessitate denial of reimbursement for the diagnostic workups.

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

3. If the malocclusion meets or exceeds the minimum number of assessment points (18), the Orthodontist should proceed with the diagnostic workup without obtaining prior authorization.

D. PRIOR AUTHORIZATION FOR ORTHODONTIC TREATMENT

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

1. The Dental Claim (MC-10) utilizing the proper procedure code number with requested fees for:
 - a. Treatment necessary to carry the case to completion.
 - b. Assessment examination.
 - c. Diagnostic aids utilized.
2. A brief description of the proposed plan of treatment on his personal letter-head.
3. A copy of the Handicapping Malocclusion Assessment Form (FD-10).
4. Diagnostic aids which must include:
 - a. Diagnostic models with the correct inter-arch relationship indicated.
 - b. A cephalometric radiograph and a detailed tracing.
 - c. A complete series of intra oral radiographs consisting of 14 periapical and 2 bite-wing films (or a diagnostic panoramic radiograph).
 - d. One profile and one full face photograph (minimum size 3" X 3").

NOTE: ALL THE DIAGNOSTIC AIDS, EXCEPT THE MODELS, WILL BE RETURNED TO THE ORTHODONTIST, BUT MUST BE MADE AVAILABLE UPON THE REQUEST OF THE MEDICAID DENTAL DIRECTOR. IT IS SUGGESTED THAT MODELS BE DUPLICATED BEFORE SUBMISSION TO ENABLE YOU TO RETAIN A SET IN YOUR OFFICE.

The Medicaid Orthodontic Consultant will review the plan of requested treatment utilizing the diagnostic aids submitted and render a decision.

The Orthodontist and appropriate Social Agencies (County Welfare Board or Bureau of Children's Services) will be promptly notified by Medicaid of the action taken on the treatment request.

E. PROGRESS REPORTS

The Medicaid Dental Director will annually review the treatment by requesting progress models and any other appropriate records.

F. BILLING PROCEDURES

1. If Orthodontic Treatment is authorized

- a. The Contractor and Provider copies of the Dental Claim (MC-10) with X-rays and photos will be returned to the Orthodontist with the proper authorization.

- b. Orthodontist will retain the Provider copy and submit the Contractor copy immediately to Prudential for payment of the assessment examination and the diagnostic services previously performed. The Contractor copy will be Prudential's record of the total authorized Orthodontic treatment.
- c. The Orthodontist must complete a new MC-10 Dental Claim as he completes each stage of the authorized treatment. Insert the treatment dates, and and procedure code(s), complete items 15 and 16 and submit the Contractor's Copy for reimbursement directly to the Prudential Insurance Company. Claims for services completed should be submitted monthly or quarterly until the authorized treatment is completed.

NOTE: Claims for Orthodontic treatment already authorized and currently in progress are to be submitted directly to Prudential in accordance with item c above.

- d. Final records similar to diagnostic aides described in D 4 above taken at termination of treatment, must be submitted together with the last claim (MC-10) to: Dental Director, Division of Medical Assistance and Health Services, P.O. Box 2706, Trenton, New Jersey 08625.

2. If authorization for Orthodontic Treatment is denied

The Contractor and Provider copies of the Dental Claim (MC-10) will be returned to the Orthodontist with the X-rays and photos. The Orthodontist should then obtain the patient's signature on the MC-10, sign Item 16 and submit the Contractor copy to Prudential for payment of the assessment examination and those diagnostic services previously performed.

- 3. ALL REQUESTS FOR PAYMENT MUST BE RECEIVED WITHIN NINETY (90) DAYS OF THE DATE OF LAST SERVICE ON THAT CLAIM.

If there are any questions concerning this Newsletter, please call 609-292-7420.



1-50

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

Date _____

DEFINITION AND CRITERIA FOR ASSESSING HANDICAPPING MALOCCLUSION
PERMANENT DENTITION

Patient's Last Name	First Name	Health Services Program Case No.	Patient Person No.

DEFINITION: Handicapping malocclusion and handicapping dentofacial deformity are conditions that constitute a hazard to the maintenance of oral health, and interfere with the well-being of the child by adversely affecting dentofacial esthetics, mandibular function, or speech.

HANDICAPPING MALOCCLUSION ASSESSMENT RECORD
A. INTRA-ARCH DEVIATION

SCORE TEETH AFFECTED ONLY		MISSING	CROWDED	ROTATED	SPACING		NO.	POINT VALUE	SCORE
					OPEN	CLOSED			
MAXILLA	Ant.	17	18	19	20	21		X2	
	Post.	22	23	24	25	26		X1	
MANDIBLE	Ant.	27	28	29	30	31		X1	
	Post.	32	33	34	35	36		X1	
Total Score									

Ant. = anterior teeth (4 incisors); Post. = posterior teeth (include canine, premolars and first molar).

No. = number of teeth affected.

B. INTER-ARCH DEVIATION

1. Anterior Segment

SCORE MAXILLARY TEETH AFFECTED ONLY, EXCEPT OVERBITE*	OVERJET	OVERBITE	CROSSBITE	OPENBITE	NO.	P.V.	SCORE
37	38	39	40			X2	
Total score							

*Score maxillary or mandibular incisors.

No. = number of teeth affected; P.V. = point value.

2. Posterior Segment

SCORE TEETH AFFECTED ONLY	RELATE MANDIBULAR TO MAXILLARY TEETH				SCORE AFFECTED MAXILLARY TEETH ONLY				NO.	P.V.	SCORE
	DISTAL		MESIAL		CROSSBITE		OPENBITE				
	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT			
Canine	41	45	49	53	57	61	65	69		X1	
1st Premolar	42	46	50	54	58	62	66	70		X1	
2nd Premolar	43	47	51	55	59	63	67	71		X1	
1st Molar	44	48	52	56	60	64	68	72		X1	

No. = number; P.V. = point value;

Total Score

REMARKS:

GRAND TOTAL

PREPARED BY DR. J.A. SALZMANN, APPROVED BY THE BOARD OF DIRECTORS OF THE AMERICAN ASSOCIATION OF ORTHODONTISTS AND THE COUNCIL ON DENTAL HEALTH OF THE AMERICAN DENTAL ASSOCIATION.

THIS FORM HAS BEEN MODIFIED TO CONFORM WITH THE POLICIES OF THE NEW JERSEY HEALTH SERVICES PROGRAM WITH THE APPROVAL OF DR. SALZMANN.

NEW JERSEY HEALTH SERVICES PROGRAM

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

Volume 1-51

October 23, 1972

SUBJECT: Submission of Dental Claims

In July, 1972, the New Jersey Medicaid Dental Program was modified substantially to allow greater flexibility for participating dentists by expediting claims processing and reimbursement procedures. This change permitted providers to bill Prudential Insurance Company directly without securing prior authorization for routine dental services if the services were performed by the same provider for a recipient up to a maximum of seventy-five dollars (\$75.00). The \$75.00 maximum is based upon fee requested by the dentist, not on the scheduled allowances. Refer to The New Jersey Health Services Program Newsletter dated June 16, 1972, Volume 1-47, for complete details of this change.

We would like to review the most common type of errors and omissions which cause claim payments to be delayed. Proper completion of MC-10's will reduce phone calls and correspondence prior to payment. This will assist in shortening processing time and should improve the posture of your accounts receivable.

The following lists the most frequent omissions -- place it where you or your dental assistant can refer to it when billing.

- _____ Failure to indicate dates of service. If a particular procedure is not completed, line out the particular item.
- _____ Failure to forward required x-rays without a suitable explanation.
- _____ Lack of patient or provider signatures. When a patient's signature is unobtainable, refer to the procedures described in Newsletter 23 dated July 23, 1971.
- _____ Claims for routine services exceeding \$75.00 require prior authorization which has not been obtained.
- _____ Claims involving a combination of routine and nonroutine services require prior authorization which has not been obtained.
- _____ Claims reflecting changes in treatment plan after the claim was authorized require but lack authorization from the Dental Field Office.

The proper completion of the MC-10 will result in improved claim service. We trust this information will be helpful to you in reducing payment delays.



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

New Jersey Health Services Program NEWSLETTER

Volume1-52.....

October 16, 1972

TO: Hospital Administrators

SUBJECT: PROVIDER MANUAL REVISION
AMBULANCE SERVICES RENDERED BY HOSPITAL BASED AMBULANCE

The following section of the New Jersey Health Services Program Hospital and Special Hospital Manuals under the heading of "Covered Outpatient Hospital Services" is revised to read as follows:

205.2 Emergency Room Services, Including Ambulance

Hospital based ambulance services in "emergency conditions" when the outpatient is not subsequently admitted. "Emergency Condition" is defined as a critical illness or injury status for which prompt medical care may be crucial in saving life and limb.

Non-emergency ambulance service is a covered service only when it is ordered by a physician and is medically necessary. A physician's written order stating that any other method of transportation is medically contraindicated must accompany the claim.

The following section of the New Jersey Health Services Program Hospital and Special Hospital Manual under the heading of "Non-Covered Outpatient Hospital Services" is to be deleted in its entirety.

206.7 Transportation



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

New Jersey Health Services Program NEWSLETTER

Volume 1-54

TO: Hospitals

October 31, 1972

SUBJECT: Billing Procedures for Outpatient Services

It has come to our attention that some hospitals are submitting a separate MC-4 Outpatient Hospital Billing Form after each clinic visit.

The purpose of this newsletter is to remind our providers that The New Jersey Health Services Program requires a hospital to bill for outpatient services on a monthly billing cycle. Separate claim forms, however, will be required for services rendered in different calendar quarters.



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

New Jersey Health Services Program NEWSLETTER

Volume1-55.....

November 21, 1972

TO: Hospital Administrators
Special Hospital Administrators

SUBJECT: PATIENT ADDRESSES, TELEPHONE NUMBERS

Effective December 1, 1972, the New Jersey Health Services Program is requesting that the patient's address and telephone number (if any) be inserted on all Inpatient and Outpatient claim forms submitted for payment.

The existing claim form does not have a space allocated for address and telephone number, therefore, we are requesting that this information be included in the right hand corner of Item 17 ("Patient's Certification") however adequate space must be left in Item 17 for the patient's signature.

Your cooperation in providing this information will be appreciated. Revised claim forms, with proper space for this information and instructions will be available when the present supply of forms is depleted.



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

New Jersey Health Services Program NEWSLETTER

Volume1-57.....

February 2, 1973

TO: ALL DENTISTS, DENTAL CLINICS, OUT-PATIENT DEPARTMENTS RENDERING DENTAL SERVICES.

SUBJECT: RETENTION OF X-RAYS

Effective immediately, it will no longer be necessary to forward the pre and post-treatment X-rays with the Contractor's Copy of the Dental Form (MC-10) to the Prudential Insurance Company of America when claims are submitted for reimbursement.

It will still be necessary to submit the pre-treatment X-rays along with both copies of the Dental Form (MC-10) to the appropriate Dental Field Office for all dental services that require prior authorization. The pre-treatment X-rays will be returned to the Provider with the Dental Form (MC-10) following review of the claim. Pre-treatment and post-treatment X-rays must be retained by the Provider for a minimum of three years from the last date of service. These X-rays must be available upon request by the State or any of its agents.

The only effect of this change, is to eliminate the requirement that X-rays must be sent to the Contractor when submitting claims for reimbursement.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-58

March 14, 1973

TO: All Physician Providers

FROM: Division of Medical Assistance and Health Services

SUBJECT: Early and Periodic Screening, Diagnosis and Treatment
(Federal Mandate 40-11 [C-4]) for Medicaid Eligible
Children up to Twenty-one Years of Age

Since its inception, the New Jersey Division of Medical Assistance and Health Services has provided a full compliment of services to insure that all eligible individuals receive adequate medical care, early diagnosis and treatment, and referral when necessary. The intent of the Federal Mandate (EPSDT) in no way alters or extends our Program.

It is our contention that children under medical supervision by the capable and dedicated physicians within our State are receiving adequate care and should not be diverted from the mainstream of medicine to separate "screening facilities". Rather, we believe that eligible children not utilizing medical services should be identified and inducted into the mainstream of medicine.

Therefore, the Division is currently identifying these needy children for referral to physicians and existing medical facilities. Your dedication to the health needs of our people is recognized. We urge all physicians to accept the needy children referred, not only for initial complete physical examinations but for total medical supervision including vision, hearing, and dental evaluation, referring when necessary. Reimbursement, as is customary, is commensurate with the existing procedural code according to services rendered.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-60

May 1, 1973

TO: ALL PROVIDERS

SUBJECT: LISTING OF LOCAL MEDICAL ASSISTANCE UNITS

Please update your listing of local Medicaid offices (Local Medical Assistance Units) by comparing it with the directory shown below. The Camden and Gloucester Units have recently relocated:

<u>COUNTY CODE</u>	<u>COUNTY</u>	<u>STREET ADDRESS</u>	<u>MUNICIPALITY</u>	<u>ZIP CODE</u>	<u>P.O. BOX</u>	<u>TELEPHONE</u>
01	Atlantic	1601 Atlantic Ave.	Atlantic City	08404	1970	609-344-2861
05	Cape May	" " "	" "	"	"	" " "
02	Bergen	90 Main Street	Hackensack	07601		201-488-5667
03	Burlington	Chesley & Alloway Bldg. Rt. 38 & Eayrestown Rd.	Mt. Holly	08060		609-261-0448
04	Camden	530 Cooper Avenue	Camden	08101	19	609-365-3926
06	Cumberland	7 E. Broad Street	Bridgeton	08302	440	609-451-6550
07	Essex	796 Broad Street	Newark	07101	1576	201-648-3700
08	Gloucester	42 Delaware Ave.	Woodbury	08096	1900	609-845-7185
17	Salem	" " "	"	"	"	" " "
09	Hudson	100 Newkirk Street	Jersey City	07306		201-792-6390
10	Hunterdon	6 Court Street	Flemington	08822		201-782-1130
18	Somerset	" " "	"	"		" " "
21	Warren	" " "	"	"		" " "
11	Mercer	324 E. State Street	Trenton	08625	2465	609-292-7315
12	Middlesex	75 Paterson Street	New Brunswick	08903	1274	201-246-0653
13	Monmouth	320 Broad Street	Red Bank	07701		201-842-6440
14	Morris	4 Court Street	Morristown	07960		201-267-1700
19	Sussex	" " "	"	"		" " "
15	Ocean	1851 Hooper Avenue	Toms River	08753		201-255-6226
16	Passaic	152 Market Street	Paterson	07509	2863	201-523-2800
20	Union	7 Bridge Street	Elizabeth	07201		201-355-8860



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 61.....

May 29, 1973

ATTENTION: ALL PROVIDERS (EXCEPT HOSPITALS)

SUBJECT: DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

CLAIMS COLLECTIBLE UNDER THE NEW JERSEY "NO FAULT" LAW ARE NOT REIMBURSABLE UNDER THE MEDICAID PROGRAM

INTRODUCTION

Effective April, 1973, the provisions of Chapter I of the Medicaid Provider Manuals denying payment for that part of any benefits covered or payable under any insurance policy have been amended to include any benefits payable under an insurance policy covered by the New Jersey Automobile Reparation Reform Act, P.L. 1972, c.70. This will apply to all claims arising out of accidents occurring on or after January 1, 1973 which are covered by "No-Fault" insurance policies. The following is a brief explanation of some of the provisions of the "No-Fault" law as well as Medicaid's policy regarding claims submitted in "No-Fault" cases.

PROVISIONS OF THE "NO-FAULT" LAW

The New Jersey Automobile Reparation Reform Act, which is commonly referred to as the "No-Fault" Law, became effective January 1, 1973. The "No-Fault" Law requires that every liability insurance policy insuring an "automobile" as defined by the Act against loss resulting from liability imposed by law for bodily injury, death, and property damage arising out of ownership, operation, maintenance, or use of an automobile shall provide "Personal Injury Protection" (PIP) coverage, as set forth in the Act. The PIP benefits include the payment of all reasonable expenses for medical treatment, surgical treatment, dental treatment, professional nursing services, hospital services, rehabilitation services, X-ray and other diagnostic services, prosthetic devices, ambulance services, medication and other reasonable and necessary expenses resulting from the treatment prescribed by certain practitioners licensed by the State of New Jersey.

PIP benefits will be paid without regard to negligence, liability, or fault of any kind to the following classes of recipients:

1. the name insured under the "No-Fault" insurance policy;
2. the members of the insured's family residing in his household who sustained bodily injury as the result of a covered accident;
3. other persons sustaining bodily injury while occupying the automobile of the named insured;
4. other persons sustaining bodily injury while using the named insured's automobile with the permission of the named insured;
5. pedestrians sustaining bodily injury caused by the named insured's automobile or struck by an object propelled by or from such automobile.

Under Federal regulations, the Medicaid Program is mandated to treat third party liability as a current resource when such liability is found to exist and payment by the third party has been made or will be made within a reasonable time. In this regard it should be noted that a provision in the "No-Fault" Law states that a claim for a covered loss must be paid within 30 days after it is furnished to the "No-Fault" insurance carrier.

MEDICAID POLICY

Effective June 1, 1973 all claims for medical expenses covered or payable under an applicable "No-Fault" insurance policy will not be reimbursable by the Medicaid Program. This will apply to all claims submitted for payment to the appropriate Contractors on or after June 1, 1973, as well as all claims previously submitted but not yet paid as of that date, which arose out of covered accidents which occurred on or after January 1, 1973.

All providers affected by this policy are directed to determine whether the injuries involved were caused by an automobile accident for which there is "No-Fault" insurance coverage. If it is determined that "No-Fault" insurance coverage exists, providers are hereby directed to seek reimbursement from the recipient's "No-Fault" insurance carrier or from the recipient himself (if payment has been made to him), and not from the Medicaid Program.

Providers must indicate on their claim forms whether or not the injuries involved arose out of an automobile accident. On those claim forms for which there is no specific question regarding whether or not the injuries arose out of an automobile accident, e.g., Hospital Claims, this information must be provided in the "Remarks" box. The statement "Auto Accident - Yes" or "Auto Accident - No" will suffice. Providers must also indicate in the appropriate box on the claim forms marked "Other Insurance or Liability Coverage" whether or not there is "No-Fault" coverage in the particular case. Claim forms which fail to supply this information will be carefully reviewed by the Contractors and may be delayed or returned to the providers for additional information.

All claim forms which indicate that the injuries involved arose out of an automobile accident must contain certain additional information regarding the "No-Fault" status. Providers who receive "No-Fault" payments for care, services or supplies which are less than the provider would have obtained under the Medicaid Program may submit claims for the difference between the "No-Fault" payment and the Medicaid payment to the Contractor with an explanation from the "No-Fault" carrier of the amount of money obtained from the proceeds of the "No-Fault" insurance policy. Providers furnishing services or supplies to recipients injured in accidents which are not covered by an applicable "No-Fault" insurance policy, or for which payment has been denied by the "No-Fault" carrier may submit their claims to the Medicaid Contractor under existing procedures with an attached letter from the carrier denying payment.

All providers who already have been reimbursed by the Medicaid Program for claims arising out of covered automobile accidents occurring on or after January 1, 1973, should reimburse the Medicaid Program as soon as possible after "No-Fault" payments have been received.

Reimbursement to the Medicaid Program resulting from "No-Fault" payments is to be made payable to the "Treasurer, State of New Jersey" and mailed to:

State of New Jersey
Division of Medical Assistance and Health Services
Bureau of Medical Care Surveillance
Post Office Box 2486
Trenton, New Jersey 08625



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 62

June 1, 1973

ATTENTION: ALL HOSPITALS

SUBJECT: DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

CLAIMS COLLECTIBLE UNDER THE NEW JERSEY "NO FAULT" LAW ARE NOT REIMBURSABLE UNDER THE MEDICAID PROGRAM

INTRODUCTION

Effective April, 1973, the provisions of Chapter I of the Medicaid Provider Manuals denying payment for that part of any benefits covered or payable under any insurance policy have been amended to include any benefits payable under an insurance policy covered by the New Jersey Automobile Reparation Reform Act, P.L. 1972, c.70. This will apply to all claims arising out of accidents occurring on or after January 1, 1973 which are covered by "No-Fault" insurance policies. The following is a brief explanation of some of the provisions of the "No-Fault" law as well as Medicaid's policy regarding claims submitted in "No-Fault" cases.

PROVISIONS OF THE "NO-FAULT" LAW

The New Jersey Automobile Reparation Reform Act, which is commonly referred to as the "No-Fault" Law, became effective January 1, 1973. The "No-Fault" Law requires that every liability insurance policy insuring an "automobile" as defined by the Act against loss resulting from liability imposed by law for bodily injury, death, and property damage arising out of ownership, operation, maintenance, or use of an automobile shall provide "Personal Injury Protection" (PIP) coverage, as set forth in the Act. The PIP benefits include the payment of all reasonable expenses for medical treatment, surgical treatment, dental treatment, professional nursing services, hospital services, rehabilitation services, X-ray and other diagnostic services, prosthetic devices, ambulance services, medication and other reasonable and necessary expenses resulting from the treatment prescribed by certain practitioners licensed by the State of New Jersey.

PIP benefits will be paid without regard to negligence, liability, or fault of any kind of the following classes of recipients:

1. the name insured under the "No-Fault" insurance policy;
2. the members of the insured's family residing in his household who sustained bodily injury as the result of a covered accident;
3. other persons sustaining bodily injury while occupying the automobile of the named insured;
4. other persons sustaining bodily injury while using the named insured's automobile with the permission of the named insured;
5. pedestrians sustaining bodily injury caused by the named insured's automobile or struck by an object propelled by or from such automobile.

Under Federal regulations, the Medicaid Program is mandated to treat third party liability as a current resource when such liability is found to exist and payment by the third party has been made or will be made within a reasonable time. In this regard it should be noted that a provision in the "No-Fault" Law states that a claim for a covered loss must be paid within 30 days after it is furnished to the "No-Fault" insurance carrier.

MEDICAID POLICY

Effective June 1, 1973 all claims for medical expenses covered or payable under an applicable "No-Fault" insurance policy will not be reimbursable by the Medicaid Program. This will apply to all claims submitted for payment to the appropriate Contractors on or after June 1, 1973, as well as all claims previously submitted but not yet paid as of that date, which arose out of covered accidents which occurred on or after January 1, 1973.

All providers affected by this policy are directed to determine whether the injuries involved were caused by an automobile accident for which there is "No-Fault" insurance coverage. If it is determined that "No-Fault" insurance coverage exists, providers are hereby directed to seek reimbursement from the recipient's "No-Fault" insurance carrier or from the recipient himself (if payment has been made to him), and not from the Medicaid Program.

Providers must indicate on their claim forms whether or not the injuries involved arose out of an automobile accident. On those claim forms for which there is no specific question regarding whether or not the injuries arose out of an automobile accident, e.g., Hospital Claims, this information must be provided in the "Remarks" box. The statement "Auto Accident - Yes" or "Auto Accident - No" will suffice. Providers must also indicate in the appropriate box on the claim forms marked "Other Insurance or Liability Coverage" whether or not there is "No-Fault" coverage in the particular case. Claim forms which fail to supply this information will be carefully reviewed by the Contractors and may be delayed or returned to the providers for additional information.

All claim forms which indicate that the injuries involved arose out of an automobile accident must contain certain additional information regarding the "No-Fault" status. Providers who receive "No-Fault" payments for care, services or supplies which are less than the provider would have obtained under the Medicare Program may submit claims for the difference between the "No-Fault" payment and the Medicaid payment to the Contractor with an explanation from the "No-Fault" carrier of the amount of money obtained from the proceeds of the "No-Fault" insurance policy. Providers furnishing services or supplies to recipients injured in accidents which are not covered by an applicable "No-Fault" carrier may submit their claims to the Medicaid Contractor under existing procedures with an attached letter from the carrier denying payment.

All providers who already have been reimbursed by the Medicaid Program for claims arising out of covered automobile accidents occurring on or after January 1, 1973, should reimburse the Medicaid Program as soon as possible after "No-Fault" payments have been received.

Reimbursement to the Medicaid Program resulting from "No-Fault" payments is to be made payable to "Prudential" and mailed to:

Provider Services Division
Attention: J. Gamble, Manager
P. O. Box 5000
Millville, New Jersey 08332



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 63

July 23, 1973

TO: All Physician Providers

SUBJECT: Medicaid Reimbursement Rate Increase

We are pleased to announce that effective July 23, 1973 Medicaid reimbursement for office, home, hospital and ECF visits as well as medical, surgical and anesthesia services will be increased by 5%. In addition to the 5% basic increase, numerous surgical and anesthesia procedures have been re-evaluated and the allowances increased accordingly.

We wish to take this opportunity to thank you, who by your participation in the Medicaid Program have provided medical care to the Medicaid eligible recipients. Your dedication to the health needs of our people is recognized and appreciated.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-64

August 9, 1973

TO: All Family Planning Clinics

SUBJECT: Revised Reimbursement Policy - Family Planning Clinics

The reimbursement policy for approved family planning clinics as stated in New Jersey Health Services Program Newsletter Volume 1-41 (April 1, 1972) is changed as indicated below:

The following fee schedule represents maximum amount allowable for all claims submitted after August 6, 1973. Reimbursement will be made of customary charges when they are lower than these maximum amounts:

1. Initial Medical Visit - \$25.00
2. Annual Medical Re-Visit - \$25.00
3. Re-Visit - \$10.00
4. Insertion of IUD - \$10.00
5. Pap Smear - \$5.00

NOTE: All family planning clinic claims received by Prudential during the period of August 6, 1973 to August 20, 1973 for which the old maximum charges were billed by the providers will be paid at the new maximum rate. All claims received subsequent to August 20, 1973 will be paid at billed charges if they are lower than the new maximum rate.



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

New Jersey Health Services Program NEWSLETTER

Volume1-65.....

August 27, 1973

TO: ALL MEDICAL SUPPLIERS

SUBJECT: Reimbursement for Durable Medical Equipment Provided to Medicare/Medicaid Recipients

Effective September 3, 1973 the method of reimbursing medical suppliers for purchases and rentals of durable medical equipment, where both Medicare and Medicaid are involved, will be altered. Presently, the claim is processed and partially paid by Medicare. The deductible and coinsurance is then given further consideration by The New Jersey Health Services Program (Medicaid).

The following procedures have been adopted to alleviate confusion and simplify your accounting procedures. If you have any questions relative to this change please contact Mr. Dennis Pearce in the Medicaid Claim Division (609-825-8700 or 201-621-6960) extension 338.

Combination Medicare/Medicaid Claims

All services allowable under Medicare which are provided to an individual eligible for both Medicare and Medicaid benefits shall be billed on Form SSA-1490 REQUEST FOR MEDICARE PAYMENT, and the claims are to be sent directly to the Medicare Intermediary, Prudential (Medicare B Division) P.O. Box 6500, Millville, New Jersey, 08332. Providers should understand that they are agreeing to accept assignment when billing in this manner. In order to obtain Medicaid consideration, the provider MUST record the correct New Jersey Health Services Case and Person Number in item 5 in addition to the Health Insurance Claim Number in item 2 of Form SSA-1490.

The Medicaid Program alone will reimburse the provider of durable medical equipment (DME) for covered items provided to combination Medicare/Medicaid eligible persons. The provider will not receive partial payment from Medicare and partial payment from Medicaid for durable medical equipment.

Combination Claim For DME Not Requiring Prior Authorization

For covered items for a Medicare/Medicaid eligible person not requiring prior authorization under the Medicaid Program submit the original and one copy of the fully completed Form SSA-1490 "Request For Medicare Payment" directly to Prudential (Medicare B Division) P.O. Box 6500, Millville, New Jersey, 08332.

The prescribing physician's prescription, complete with patient's name, diagnosis and a specified period of necessity must be attached. The provider will receive direct reimbursement from Medicaid for the item, not separate payments from Medicare and Medicaid.

Combination Claims For DME Requiring Prior Authorization

For items requiring prior authorization under the Medicaid Program, the provider is to submit the physician's prescription complete with patient's name, diagnosis and a specified period of necessity and four (4) copies (use two claim forms with a carbon in between) of the completed form SSA-1490 to the appropriate Local Medical Assistance Unit. The item(s) must be fully described in item 7C on form SSA-1490.

The Local Medical Assistance Unit will review the prescription and item(s) requested and render a decision. If authorized, the Medicaid Medical Consultant will describe the terms of the authorization, insert the date of authorization and affix his signature in item 5 on the SSA-1490. The Local Unit will retain the one copy of form SSA-1490 and will return the original, and two copies together with the prescription, to the provider.

When billing, the provider is to submit two authorized copies of the 1490 and the prescription to Prudential (Medicare B Division) P.O. Box 6500, Millville, New Jersey, 08332.

All reimbursement to the provider will be made by the Medicaid Program. If a purchase has been authorized, the provider will receive a lump sum payment from Medicaid. If rental has been authorized, the monthly payments will be made by Medicaid only.

If the authorization is denied the Medicaid Medical Consultant will notify the provider of the reason(s), will write "Medicaid Authorization Denied" and sign his name in item 5, and return two copies of the claim and the prescription to the provider. If the provider renders the service when the authorization request has been denied, the claim may be submitted to Medicare for consideration, but there will not be any payment forthcoming from Medicaid.



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 66

September 17, 1973

TO: ALL DENTAL PROVIDERS

SUBJECT: New Policy - Patient Records

Effective October 1, 1973 the New Jersey Health Services Program policy on patient records will be changed. The previous policy as stated in Section 221.6D (page 15) of the Dental Manual is rescinded and a new Section, which will be 221.7 "Patient Records" is established.

New Manual pages will be issued in the near future.

The following is the new Medicaid policy regarding patient records and must be adhered to after October 1, 1973.

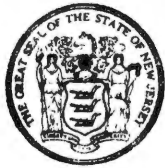
221.7 PATIENT RECORDS

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

THE RECORD SHALL CONSIST OF THE FOLLOWING:

- A. Pertinent dental and medical history
- B. Detailed clinical examination data to include where applicable:
 - 1. Patient's chief complaint
 - 2. Diagnosis
 - 3. Cavities
 - 4. Abnormalities
- C. Pre and post-operative radiographs (retained for a minimum of three years)
 - 1. Number and type of radiographs should be entered on patient's record

- D. Treatment plan with description of treatment rendered to include where appropriate:
 - 1. Tooth number
 - 2. Surfaces involved
 - 3. Site and size of treatment area (lesion, laceration, fracture, etc.)
 - 4. Materials used
 - 5. Date(s) of service(s)
- E. Medications
 - 1. Ordered by prescription or OTC
 - 2. Used in office treatment
- F. Diagnostic laboratory and/or radiographic procedure(s) ordered, including the result(s)
- G. Copy of the dental prosthetic work authorization(s), prescription(s) and dental prosthetic laboratory receipt(s)
- H. Explanation for any duplication of services within one year
- I. Reasons for discontinuation of services (including attempts to complete treatment)



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 67.....

September 17, 1973

TO: All Dentists, Independent Dental Clinics, Hospital Out-Patient Departments
Rendering Orthodontic Services

SUBJECT: ORTHODONTIC DIAGNOSTIC MODELS

Effective immediately, Orthodontic Diagnostic Models will be returned to the Provider following Orthodontic review. Models will no longer be retained by the Division of Medical Assistance and Health Services, but must be available upon request.

It is suggested that Orthodontic Diagnostic Models be duplicated before submission for review to enable you to retain a set in your office in the event of loss or breakage in transit.

Please make certain that the models are adequately packaged to prevent breakage, addressed and properly identified to help prevent loss.

This Newsletter revises Section 233.7 of the New Jersey Health Services Program Dental Manual which was previously amended by Newsletter Volume 1-50 dated 10/23/72 items D-4 (pg. 3) and F-1 and 2 (pgs. 3 and 4).



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 68

September 17, 1973

TO: ALL DENTAL PROVIDERS

SUBJECT: REIMBURSEMENT POLICY FOR RESTORATIONS IN POSTERIOR TEETH

This Newsletter will summarize and reaffirm the policy of the Dental Services Aspect of the New Jersey Health Services Program as described in Newsletter I-47 and Section 233.1 A.2. and 3. of the Dental Manual as they relate to the following:

Generally, only silver amalgam will be utilized for restoration of posterior teeth and only synthetic cement, composite, plastic, or acrylic filling material will be utilized in the anterior teeth.

EXCEPTIONS:

1. Composite restorations may be provided on the mesial, occlusal and buccal surfaces of the first bicuspid; 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.

Currently, a number of dental claims within the seventy-five dollar (\$75.00) limitation for routine dentistry are being submitted for payment indicating that posterior teeth other than the first bicuspid are being restored with synthetic cement, composite, plastic, or acrylic filling material. Those claims currently being processed for payment will be reimbursed at a fee comparable to silver amalgam restorations. Such fillings will be ineligible for payment if submitted for reimbursement after October 1, 1973.



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 69.....

September 25, 1973

TO: All Prosthetics and Orthotics Providers

SUBJECT: REVIEW OF P&O CERTIFICATIONS

In an effort to verify and update its records, the Division of Medical Assistance and Health Services will soon be surveying the American Board for Certification in Prosthetics and Orthotics, Inc. (ABCPO) to identify those persons and shops currently certified to provide prosthetics and/or orthotics.

Please be advised that this is merely advance notice to you that the survey will be conducted. You may be assured that the survey results will be used primarily to adjust Title XIX Medicaid records for future use and will not result in any retroactive judgments.



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

New Jersey Health Services Program NEWSLETTER

Volume1-70.....

September 25, 1973

TO: Chronic Renal Dialysis Centers, Hospitals, Special Hospitals, Physicians, Home Health Agencies, Medical Suppliers, Ambulance Providers, Independent Laboratories, Dentists

SUBJECT: MEDICARE NOW AVAILABLE FOR CERTAIN INDIVIDUALS UNDER AGE 65

IMPORTANT NOTICE !!!

As the result of the 1972 Social Security Amendments, better known as H.R. 1 or P.L. 92-603, there are two new groups of individuals UNDER AGE 65 who may be eligible for MEDICARE benefits subsequent to July 1, 1973. They are:

1. DISABLED people under 65 who are receiving social security or railroad retirement monthly benefits based on their disability, and who have been entitled to monthly disability benefits for at least 24 consecutive months.

The groups of beneficiaries are disabled workers, people 18 and over receiving benefits based upon a disability that began before age 22; disabled widows and disabled dependent widowers age 50-64; disabled qualified railroad retirement annuitants; and women age 50 or older entitled to mothers' benefits who, for 24 months prior to the first month they would have been entitled to Medicare, met all the requirements for disability benefits except for filing a claim for such benefits.

2. Persons under 65 who need hemodialysis treatment or a kidney transplant because of CHRONIC KIDNEY DISEASE. Medicare coverage can begin with the first day of the third month after the month in which a course of renal hemodialysis begins.

Under these provisions, such beneficiaries are eligible for both hospital insurance (Part A) and supplementary medical insurance (Part B).

ASK THE PATIENT !!

The New Jersey Health Services Program (Medicaid) requests that all providers of services ask their MEDICAID patients, regardless of age, if they are also Medicare beneficiaries. If the patient is Medicare eligible, obtain the Health Insurance Claim Number (Medicare) from the patient's Health Insurance ID card in addition to the New Jersey Health Services Program Case Number and follow the procedures described in your Medicaid Manual for submitting combination Medicare/Medicaid claims.

DIALYSIS PATIENTS

Medicaid eligible patients undergoing renal dialysis treatments are fully covered by Medicaid for all allowable Medicaid services for up to three months from the beginning of dialysis treatment. For example: A patient beginning dialysis on 8/20/73 would be eligible for Medicare on 11/1/73 (the third month after the month in which the course of renal dialysis was initiated). In this example MediCAID would pay for dialysis treatment and any other Medicaid allowable services from 8/20/73 until 10/31/73. As of 11/1/73 MediCARE would pay for the dialysis and would be the primary coverage for other Medicare allowable services e.g., Hospitalization, Physician services, Ambulance services, Medical Supplies etc. After 11/1/73, Medicaid would supplement the Medicare coverage, but the combined payment from both Programs shall not exceed the amount payable under Medicaid alone.

Patients who might be eligible for Medicare because of disability or chronic renal disease, but who are unaware of such benefits should be referred to their Social Security Administration office to apply for Medicare benefits. Your cooperation in making such referrals will be most appreciated.

If you have any questions regarding this matter you may contact any of the following: Your Medicare Fiscal Agent, representative, your Medicaid Contractor representative, or the Medicaid Local Medical Assistance Unit serving your area.

HOSPITALS AND DIALYSIS CENTERS

Effective immediately all hospitals and Renal Dialysis Centers are required to include in the remarks section of the inpatient Medicaid claim (MC-1) or the outpatient Medicaid claim (MC-4) the date of the first dialysis treatment rendered to the patient.

Please instruct your billing personnel that dialysis claims submitted after the receipt of this release will be required to have this information.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-72

September 21, 1973

TO: All Anesthesiologists

SUBJECT: Submission of Anesthesia Time on MC-8 Claim Forms

Effective with claims received on October 1, 1973, all claims for payment of anesthesia services will be processed using elapsed anesthesia time as an integral part of the reimbursement formula.

This change in procedure will require that each claim be submitted with total anesthesia (table) time indicated in block 12 D (Description of Service Furnished) of the MC-8 claim form.

Claims received after the above date that do not contain "time" data will be returned to the provider for completion.



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

New Jersey Health Services Program NEWSLETTER

Volume1-74.....

October 23, 1973

TO: ALL HOME HEALTH AGENCIES

Effective November 1, 1973, all Home Health Agencies requesting prior authorization for rehabilitation services (Physical, Occupational or Speech Therapy) for Medicaid eligible patients will utilize the new FD-06 form "REQUEST FOR AUTHORIZATION OR REAUTHORIZATION FOR PRESCRIBED REHABILITATION TREATMENT PROGRAM." As of November 1, 1973 form 33029 "HOME HEALTH AUTHORIZATION" is to be used solely for authorization requests for Skilled Nursing Care, Home Health Aides, and Medical/Surgical supplies.

PROCEDURES FOR USE OF FORM FD-06

The Home Health Agency will be responsible for the total completion of the "Patient Information" and "Medical Information and Therapy Requested" portions of the form, in triplicate. If the request is for initial authorization of rehabilitation services, it is not necessary to complete item 13 on the form.

NOTE: If the FD-06 is completed by the therapist, rather than the attending physician, the physician's prescription must be attached to the FD-06 when submitted for authorization to the Local Medical Assistance Unit (LMAU).

If authorized, the Billing copy and Provider copies of the FD-06 will be returned to the Home Health Agency by the LMAU. The Billing copy is to be submitted to the Contractor (Blue Cross or Prudential) together with the Home Health Claim (MC-3) for payment upon completion of authorized services.

A supply of FD-06 forms accompanies this Newsletter. Additional forms may be ordered from:

The Prudential Insurance Company
Provider Services Division
P. O. Box 5000
Millville, N.J. 08332
Telephone Numbers: 609-825-8700 - Ext. 482 or
201-621-6960 - Ext. 482

Questions regarding utilization of the FD-06 should be referred to the LMAU serving your area.



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

New Jersey Health Services Program NEWSLETTER

Volume1-75.....

November 14, 1973

TO: All Dental Providers
SUBJECT: MEDICAID REIMBURSEMENT RATE INCREASE

We are pleased to announce that effective November 12, 1973, Medicaid reimbursement for the majority of dental services were increased on a selective percentage basis. In addition to this increase, numerous surgical procedures were re-evaluated and allowances increased accordingly, effective July 23, 1973.

We wish to take this opportunity to thank you, who by your participation in the Medicaid Program have provided dental care to the Medicaid eligible recipients. Your dedication to the health needs of the people of the State of New Jersey is recognized and appreciated.



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

New Jersey Health Services Program

NEWSLETTER

Volume 1 - 78

December 17, 1973

TO: All Providers

SUBJECT: Retroactive Eligibility For Medicaid

Beginning January 1, 1974, persons applying for Medicaid benefits will be asked if they have outstanding medical bills incurred within a three month period, prior to the month of application for Medicaid. Persons indicating that they do have such bills will complete an application for retroactive Medicaid eligibility and will forward with the application, all outstanding bills to the Medicaid Central Office in Trenton.

If the New Jersey Health Services Program (Medicaid) determines that the person would have been eligible for Medicaid at the time the service/item was rendered, providers will be notified directly that such outstanding bills for any service/item covered by the New Jersey Health Services Program will be reimbursable in accordance with standard Medicaid rules, regulations and reimbursement procedures. The provider will then complete a regular Medicaid claim form for the services rendered that remain outstanding and submit to:

New Jersey Division of Medical Assistance
and Health Services
Retroactive Eligibility Unit
P. O. Box 2486
Trenton, New Jersey 08625

The Medicaid Retroactive Eligibility Unit will forward such claims to the appropriate Program Contractor for processing. Obviously, prior authorization procedures cannot be enforced since the service/item has already been provided prior to eligibility determination; however, all claims will be subjected to the Medicaid utilization review procedures and standards consistent with all Medicaid claims.

The Provider may not submit unpaid bills or claims directly to the Medicaid Retroactive Eligibility Unit. The patient must initiate the process by applying for retroactive eligibility in the prescribed manner. It should be noted that, for individuals who are either deceased or incapable of acting on their own behalf, an appointed guardian, relative or friend is authorized to make application for retroactive Medicaid eligibility when there are outstanding bills. Applications for retroactive Medicaid eligibility may be obtained from the Local Medicaid office or the Retroactive Eligibility Unit at the above address.

PREVIOUS PAYMENT

If any portion of the provider's total charge for the referenced patient has been paid by the patient, Medicare, or any other insurance carrier, the provider must indicate that fact and attach an explanation of payment from the patient, Medicare or the carrier.

The provider may not refund all or part of any previously made payment for services/items provided the patient based upon an expectation of reimbursement by Medicaid for the same services/items.

PATIENT SIGNATURE

For such retroactive claims it is not necessary for the provider to obtain the patient's signature on the claim, however the provider **MUST** indicate "Retroactive Claim" in the space allocated for the patient's certification.

The retroactive eligibility rule became effective in July, 1973.

Questions regarding this subject may be referred to the Local Medical Assistance Unit serving your area.



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

New Jersey Health Services Program

NEWSLETTER

Volume 1 - 79

December 17, 1973

TO: All Providers

SUBJECT: Medicaid Eligibility Card

IMPORTANT ! ! !

The message presented in this Newsletter is of extreme importance to all providers participating in the New Jersey Health Services Program (Medicaid). **KEEP THIS NEWSLETTER READILY AVAILABLE FOR EASY ACCESS.**

Beginning January 1, 1974 certain Medicaid eligible persons will receive a NEW type of validation form called a **MEDICAID ELIGIBILITY CARD**. The new type card will be different in appearance and content from the validation form you have been familiar with for the past four (4) years. The **MOST SIGNIFICANT** difference is that the **MEDICAID ELIGIBILITY CARD** (form FD-73) may be valid for up to **THREE MONTHS**. An illustration of the new form appears on the reverse side of this Newsletter. Other significant changes on the new form are:

1. The **MEDICAID ELIGIBILITY CARD** is good for **ONLY ONE PERSON**.
2. The **CARD** requires the eligible person's signature to be valid.
3. The **CARD** includes, in addition to the eligible cardholder's Address, his/her Date of Birth and Social Security Account Number. **NOTE: Providers are instructed to disregard the cardholder's Social Security Account Number.**
4. The **CARD** will include a period of validation.
5. Certain Medicaid eligible persons receiving the new **CARD** will not receive the **PLASTIC IDENTIFICATION CARD**. **NOTE: Pharmacy providers will be required to manually enter all patient information on the Pharmacy Claims for persons without the plastic card.**
6. There is a message on the card instructing the provider to ask the cardholder if he/she has other health insurance or Medicare coverage. **ASK THE QUESTION: if the patient indicates there is other health insurance or Medicare, YOU ARE TO BILL MEDICAID ONLY AFTER RECEIVING DENIAL OR PARTIAL PAYMENT FROM THE OTHER INSURANCE CARRIER. IF PATIENT HAS MEDICARE, FOLLOW THE INSTRUCTIONS IN YOUR PROVIDER MANUAL FOR SUBMISSION OF COMBINATION MEDICARE/MEDICAID CLAIMS. NOTE: MEDICARE COVERAGE OF COURSE, APPLIES ONLY TO THOSE SERVICES AND/OR ITEMS COVERED UNDER THE TITLE XVIII (MEDICARE) PROGRAM.**

WHO WILL RECEIVE THE NEW CARD?

The **MEDICAID ELIGIBILITY CARD** will be issued to those persons who are eligible for both Medicaid and Supplemental Security Income (SSI). SSI is a NEW federally administered program mandated by P.L. 92-603 (Social Security Amendments of 1972) which replaces the former adult Categorical Assistance programs of Blind Assistance, Disability Assistance, and Old Age Assistance which had been administered by the Federal

State and County governments through the County Welfare Boards. CERTAIN PERSONS WHOSE HEALTH SERVICES PROGRAM CASE NUMBER HAS THE THIRD AND FOURTH DIGITS OF "10" (OLD AGE), "20" (DISABLED) OR "50" (BLIND) WILL RECEIVE THE NEW CARD. E.G., 1210500012, 1220500034, or 1250500056. The Patient Person Number will also appear on the CARD and is to be utilized by all providers when completing Medicaid claims.

The more familiar type validation forms, valid for a maximum of one month, will continue to be issued by the County Welfare Boards for Medicaid eligibles who are not eligible for SSI benefits.

ELIGIBILITY QUESTIONS

Since Supplemental Security Income (SSI) has brought the Federal Social Security Administration into the Medicaid eligibility area, providers may encounter certain difficulties in the resolution of eligibility questions. Therefore, providers are encouraged to direct their eligibility questions to the Local Medical Assistance Unit (LMAU) serving their area. The LMAU will assist you in the resolution of your questions wherever possible, however in those instances where such questions cannot be resolved by the LMAU, the provider will be directed to the appropriate Agency.

(1) <u>1220500074</u> HSP CASE NO.	(2) <u>01</u> PER NO.	STATE OF NEW JERSEY DEPARTMENT OF INSTITUTIONS AND AGENCIES DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES MEDICAID ELIGIBILITY CARD
		State Seal
VALID: FROM: 01/01/74	(3)	PROVIDER: Ask cardholder if he or she has other health insurance or MEDICARE coverage.
TO: 03/31/74		(8)
John Smith 123 Any Street Anytown, N.J.	(4)	(Please see other side)
		<u>04/15/16</u> (6) DATE OF BIRTH
		<u>123 - 45 - 6789</u> (7) SOCIAL SECURITY ACCOUNT NO.
Sign Here <u>John Smith</u>	(5)	

- (1) Health Services Program Case No. - This is the identification number to be transferred to the appropriate Claim Forms.
- (2) Person Number - ALTHOUGH THIS FORM IS VALID FOR ONLY ONE PERSON, IT IS STILL MANDATORY TO INCLUDE THIS INFORMATION ON THE APPROPRIATE CLAIM FORMS.
- (3) Period of Coverage - Medicaid eligibility may be for up to THREE MONTHS.
- (4) Name and Address - Will identify the eligible individual.
- (5) Signature - The card is not valid unless the above identified person's signature appears here.
- (6) Date of Birth - Please enter the information in the applicable item of the appropriate claim form.
- (7) Social Security Number - Not required on Claim Form.
- (8) Provider Notice on Reverse Side - Please read the Notice on the reverse side of the card regarding the application of other insurance or Medicare.



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 81

January 9, 1974

TO: ALL DENTAL PROVIDERS

SUBJECT: PARTIAL PAYMENT FOR DENTAL SERVICE AND/OR APPLIANCES IN THE NEW JERSEY HEALTH SERVICES PROGRAM

Effective January 15, 1974 the New Jersey Health Services Program has established the following rule governing reimbursement for authorized dental service and/or appliances which are not completed or delivered due to circumstances beyond the control of the provider (e.g., death of patient, patient moving out-of-state etc.):

If these circumstances involving an eligible recipient, over which the provider has no control, preclude completion of a service and/or an authorized appliance, the New Jersey Health Services Program Contractor may reimburse the provider of services an amount consistent with the stage of completion of the authorized service and/or appliance, as determined by the Program's Consultant.

Reimbursement for an appliance completed but not delivered to the recipient because of circumstances beyond control of the provider may be authorized by the New Jersey Health Services Program. An amount equivalent to the professional component for inserting and adjusting the appliance will be deducted from the total reimbursement for such appliances.



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 82

January 14, 1974

TO: ALL PROVIDERS

SUBJECT: REVISION TO CHAPTER I OF THE MEDICAID MANUAL

On January 1, 1974 the New Jersey Health Services Program (Medicaid) will recognize Chiropractors and Psychologists, licensed by the State of New Jersey as eligible providers of services.

Accordingly you are instructed to make the following changes to Chapter I of your Medicaid Manual:

Page 5 Section 102 in H - Please add "Chiropractors and Psychologists"

Page 6 Section 103 - Please add Chiropractors and Psychologists

Page 8 Section 107 - Please add:

4. Services rendered by Chiropractors and Psychologists licensed by States other than New Jersey are not eligible for reimbursement under the New Jersey Health Services Program.

A new section entitled "Prohibition on Factoring - Uniform Claim Forms" to be identified as section 117 is stated below:

Section 117. Prohibition on Factoring - Uniform Claim Forms

No provider participating in the Health Services Program shall enter into any contract, agreement, or other understanding, whether oral or written, with any service bureau, management agency, or other organization, the purpose or effect of which is to cause a portion of any Medicaid claim payment to be diverted or made payable to any party other than the participating provider who rendered the services or supplies in question.

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 claims payment process, Medicaid claim forms, or exact replicas thereof, must be utilized. If standard Medicaid forms are not utilized, the service bureau or management agency 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 paragraphs one and two above, 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 paragraphs one and two 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 the Division.

It is suggested that this Newsletter be inserted in your Medicaid Manual following page 10.1 (Prudential edition), page 10.2 (Blue Cross edition) until new pages are issued.



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

New Jersey Health Services Program NEWSLETTER

Volume1-85.....

February 19, 1974

TO: ALL OPTICIANS

SUBJECT: APPLICATION FOR MULTI-LOCATION PROVIDER PARTICIPATION

Effective March 1, 1974 the New Jersey Health Services Program has adopted a rule which requires that all Opticians applying to participate in the Program or presently participating in the Program identify each and every branch or satellite location from which they will provide services to Medicaid eligible individuals.

Each separate location must meet all standards for Health Services Program participation and that location will receive a Health Services Program Provider number if approved for participation. Services rendered to Medicaid eligibles at an unapproved satellite may NOT be billed under the approved parent organization's provider number.

All approved providers who have, to date, been billing through the parent organization for their non-approved branch/satellite locations by utilizing the parent organization's provider number must make application for Medicaid approval for such facilities within sixty (60) days following adoption of this rule, without penalty.

Failure to make application within this 60 day period and continued billing on behalf of non-approved facilities will result in action by the New Jersey Health Services Program to recover funds paid as the result of improper billing and will subject the approved parent organization to suspension from the program. (See Chapter I, Section 116-A.7 of the New Jersey Health Services Program Provider Manual.)

The Provider Application (Form FD-20C1 Rev. 2/74) and Provider Agreement (Form FD-62) attached to this Newsletter must be completed by all opticians and returned to the following address by April 1, 1974:

The Prudential Insurance Company of America
Medical Administration Division
P. O. Box 1900
Millville, New Jersey 08332
ATTENTION: Barbara Wright

Billing through a central location for approved multi-location providers is allowable, however, the provider must utilize the pre-addressed claims for each office location as they reflect the proper address and provider number for that location. Selection of central or localized billing is left to the provider who must state his preference on the application.



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 86

February 19, 1974

TO: ALL INDEPENDENT CLINICS

SUBJECT: APPLICATION FOR MULTI-LOCATION PROVIDER PARTICIPATION

Effective March 1, 1974 the New Jersey Health Services Program has adopted a rule which requires that all Independent Clinics applying to participate in the Program or presently participating in the Program identify each and every branch or satellite location from which they will provide services to Medicaid eligible individuals.

Each separate location must meet all standards for Health Services Program participation and that location will receive a Health Services Program Provider number if approved for participation. Services rendered to Medicaid eligibles at an unapproved satellite may NOT be billed under the approved parent organization's provider number.

All approved providers who have, to date, been billing through the parent organization for their non-approved branch/satellite locations by utilizing the parent organization's provider number must make application for Medicaid approval for such facilities within sixty (60) days following adoption of this rule, without penalty.

Failure to make application within this 60 day period and continued billing on behalf of non-approved facilities will result in action by the New Jersey Health Services Program to recover funds paid as the result of improper billing and will subject the approved parent organization to suspension from the program. (See Chapter I, Section 116-A.7 of the New Jersey Health Services Provider Manual.)

The Provider Application (Form FD-20C1 Rev. 2/74) and Provider Agreement (Form FD-62) attached to this Newsletter must be completed by all clinics and returned to the following address by April 1, 1974:

The Prudential Insurance Company of America
Medical Administration Division
P. O. Box 1900
Millville, New Jersey 08332
ATTENTION: Barbara Wright

Billing through a central location for approved multi-location providers is allowable, however, the provider must utilize the pre-addressed claims for each office location as they reflect the proper address and provider number for that location. Selection of central or localized billing is left to the provider who must state his preference on the application.



**STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
POST OFFICE BOX 2486
TRENTON, NEW JERSEY 08625**

PROVIDER APPLICATION

1. _____ 2. _____
Legal Name of Organization **Type of Business or Facility**

3. _____
Address Street City County State Zip Code

4. _____ 5. _____ 6. _____
SSA and/or Employer Telephone Number Length of Time at Above Address
ID Number

7. _____ 8. _____
Billing Address, If Different Name of Administrator, Chief Executive Officer
or Other Official

9. List the specific service(s) for which you are requesting approval for reimbursement under the Medicaid Program _____

10. Do you operate from more than one location? Yes No If yes, list all other subsidiary or affiliated organization below: (Name and Address)

1. _____
 2. _____
 3. _____
 4. _____

Please attach additional sheet if necessary.

11. Do you or does your organization have any legal or professional relationships with any other health care organization(s) or facility(ies)? Yes No If yes, list all such relationships below:
12. Do you require a Certificate of Need under the Health Facilities Planning Act from the New Jersey Department of Health? Yes No If yes, have you applied for the Certificate? Attach copy of Certificate of Need, if available.
13. If your business or facility requires a license(s), list type of license(s), license number(s) and effective date of license(s).
14. **CERTIFICATION, ACCREDITATION OR APPROVAL** — Specify type, e.g., JCAH, New Jersey Department of Health, Community Mental Health Services, State Board of Dentistry, Title XVIII, American Board for Certification in Orthotics and Prosthetics, State Board of Pharmacy, etc., and attach copy.
15. Are you currently or have you ever been an approved provider of services under the New Jersey Health Services (Title XIX) Program? If yes, list type of service(s) provided.

16. Indicate legal status of your organization: Profit Corporation [], Non-Profit Corporation [], Partnership [], Sole Proprietor [], Government [], Other []. If other, please specify below:

17. Does any member of the organization have a ten percent or greater financial interest in any other organization providing services under the New Jersey Health Services Program? If yes, list name of individual and organization.

18. Do you charge for goods and/or services? TO ALL [], TO NONE [], TO CERTAIN GROUPS ONLY []. If you charge to all or only certain groups, please explain your arrangements below and attach copy of your fee schedule.

19. List below days and hours of operation.

20. Please indicate your preference to receive central or local reimbursement:

[] Reimbursement to each Satellite Location

[] Reimbursement to Central Location

Billing through a central location is allowable and left to the providers discretion. However, if the provider chooses to bill centrally pre addressed claims must be utilized since they reflect the proper address and provider number for that location.

21. FOR THE PURPOSE OF ESTABLISHING ELIGIBILITY TO RECEIVE DIRECT PAYMENT FOR SERVICES TO RECIPIENTS UNDER THE NEW JERSEY HEALTH SERVICES PROGRAM, I CERTIFY THAT THE INFORMATION FURNISHED ON THIS APPLICATION IS TRUE, ACCURATE AND COMPLETE.

22. _____
Signature of Provider or Authorized Agent Title Date

For Division Use Only

[] Approve

[] Approve

[] Approve

[] Disapprove

[] Disapprove

[] Disapprove

[] Other

[] Other

[] Other

Initial

Initial

Initial

Date

Date

Date



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

New Jersey Health Services Program NEWSLETTER

Volume1-87.....

March 15, 1974

TO: ALL DENTISTS, INDEPENDENT DENTAL CLINICS

SUBJECT: REVISED DENTAL FORM MC-10C4 Rev. 12/73

This Newsletter is extremely important and affects all Dental Providers who participate in the New Jersey Health Services Program. Please read it carefully and insert it in your Dental Manual.

In an attempt to respond to your suggestions, the MC-10 Dental Services form has been revised.

The newly revised form will assist the Dentist and his staff in reconciling patient accounts by aiding in identifying the amount paid for each individual line entry. Results from the improvement of the form will be reflected in the following areas:

- A. Promptness of payment
- B. Accuracy of claim processing
- C. Minimizing clerical errors at all levels.

With reference to the above please note the significant change to no. 14 and the addition of a new section no. 16 "Abbreviations". The above additions and changes will be of direct benefit to you in expediting your claim.

The revision of the MC-10 form in no way changes the rules and regulations as they apply to authorization, covered services, standards of treatment, prescription policies, recipient eligibility etc. Please destroy your existing supply of MC-10's and begin to utilize the new MC-10C4 (Rev. 12/73).

The following are instructions for completion of dental form MC-10C4 (Rev. 12/73):

INSTRUCTIONS FOR COMPLETING DENTAL FORM

NOTE: Only eleven (11) procedures may be entered on one form. Claims with twelve to twenty two (12 - 22) procedures require two forms, etc. Instructions for completing this form are as follows:

- Item 1. Patient's Name: Print patient's name, last name first, as it appears on patient's eligibility 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 no. exactly as it appears on the validation card.
- Item 4. Patient Person No.: Enter number as it appears on the validation card. Patient Person numbers 1 to 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 Insurance: Indicate other health insurance coverage by entering an X in the appropriate box. Auto Accident, indicate by placing an X in the appropriate box, if the treatment was necessary as a

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result of an auto accident. If answer is yes to either question, attach a copy of the explanation of payment from the appropriate insurance carrier. If no payment has been received, a complete report of the current status of the claim should be attached.

- Item 8. **Employment Related:** Indicate if patient's illness or injury is employment related by entering an X in the appropriate box. If yes, enter name and address of employer here.
- Item 9. **Provider Name, Address and Number:** This area is preprinted for your convenience. You need only enter your telephone number in the appropriate box.
- Item 10. **Place of Service:** Indicate the place of service by placing an X in the appropriate box.
- Item 11. **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.
- Item 12. **Number of X-Rays:** Indicate the number of pre-treatment and post-treatment X-rays on appropriate line.
- Item 13. **Date of Initial Impressions:** Insert date of initial impressions for maxillary and mandibular denture(s) on appropriate line, if applicable.
- Item 14. **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 performed. Year, month and day. Date 1-9 are to be shown as 01, 02, 03, etc. Example: May 9, 1973 should be entered as 73 05 09.

Procedure Code: Enter the appropriate procedure code for service proposed or performed. Refer to Dental Manual Chapter IV for proper code. Since amount of payment will be determined from procedure code, accuracy is most important.

No. of Teeth and Units of Service: Do not use. These spaces for contractor use only.

Fee Requested: Indicate your usual and customary charge for each procedure. Each charge must 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: Indicate number of tooth treated as indicated on completed Dental Chart. See Dental Chart Item 15.

Surface: Indicate each surface worked on for each procedure. Use abbreviations as shown in Item 16.

Description of Service: Briefly describe service rendered. Include materials used and all pertinent information using the abbreviations shown in Item 16 as appropriate.

Auth. Only: Do not use. This area for Dental Consultant use only.

- Item 15. **Dental Chart:** Indicate extractions missing teeth and restorations where treatment is proposed or has been completed.
- Item 16. **Abbreviations:** To be used when describing the service rendered.
- Item 17. This item 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 right. EG: Page 1 of 2. This area should reflect any attachments.

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- Item 18. **Name of Dental Prosthetic Laboratory:** This should be completed with the name and address of Dental Prosthetic Laboratory when prosthetic services are rendered.
- Item 19. **Remarks:** This space is for your use, should you feel a remark is necessary. Check box if additional information is attached.
- Item 20. **Patient Certification:** The patient must sign the claim only when services have been completed. The patient must not sign a blank claim form, nor must the patient sign as a condition to receiving services. When the patient's signature is unobtainable, the following procedure may 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 physically or mentally incapable of signing, a minor child, deceased, or for other reasons the patient's signature is not obtainable through reasonable effort, the form may be signed on his behalf by:
 - 1) A parent or
 - 2) A Legal Guardian or
 - 3) A Relative or
 - 4) A Friend or
 - 5) An Individual Provider or
 - 6) A Representative of an Institution Providing Care or Support or
 - 7) A Representative of Governmental Agency Providing Assistance.Be sure to indicate on the form why the patient was unable to sign.

Item 21. **Provider Certification:** The provider must sign and date the form before the claim may be processed.

A supply of the revised dental forms are enclosed with this Newsletter.



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

New Jersey Health Services Program NEWSLETTER

Volume1-88.....

March 15, 1974

TO: ALL DENTISTS, INDEPENDENT CLINICS

SUBJECT: REMOVAL OF THE DOLLAR LIMIT ON "ROUTINE DENTISTRY"
(THIS NEWSLETTER MODIFIES NEWSLETTER VOLUME 1-47 (6/16/72))

ATTENTION: IMPORTANT NEWSLETTER!!

This Newsletter is of extreme importance to all Dentists participating in the New Jersey Medicaid Program. Please read it carefully and insert it in your Dental Manual.

EFFECTIVE MARCH 15, 1974 IT WILL NO LONGER BE NECESSARY TO OBTAIN PRIOR AUTHORIZATION FOR "ROUTINE DENTAL SERVICES" WHEN FEES FOR SERVICES EXCEED SEVENTY-FIVE DOLLARS (\$75.00).

I. "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 232. of Dental Manual)
2. Topical fluoride application for persons twenty (20) years of age and under.

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 233.1 of Dental Manual; and Health Services Program Newsletters Volumes 1-47 and 1-68.)
4. Pulp capping for permanent and deciduous teeth.
5. Pulpotomy for one (1) tooth, permanent or deciduous.
6. Extraction of non-restorable teeth.

EXCEPTION: Multiple extractions necessitating a dental prosthesis.

All dental services other than those listed above are defined as "non-routine dental services".

"Routine dental services" may be performed without prior authorization from the Dental Field Office by the same provider (group) for an eligible recipient with the following limitations:

- a. That all such routine services should be completed within ninety (90) days of the date of the initial visit, and
- b. That any such dental services may not be initiated again within six (6) months from the date of last service.

(Vol. 1-88 con'd.)

NOTE: If you submit a claim for payment before completion of your established treatment plan because the recipient has not returned to complete that treatment, you must indicate this on that claim. In the event the same recipient returns to you at a later date to complete that "routine" treatment plan, you may submit the second claim to Prudential without prior authorization provided there is no change in the treatment plan and that the second claim is marked "continuation of previously established treatment plan".

II. In addition to "routine dental services" the following procedures also do not require prior authorization.

- a. Diagnostic examination with required radiography necessary to develop a treatment plan limited to a maximum of twenty-five (\$25.00) dollars. (Refer to Section 231.1, 231.2, and 233.7 of Dental Manual; and Health Services Program Newsletter Volume 1-50.)
- b. Emergency treatment with required radiography. (Refer to Section 230. and 231.2 of Dental Manual.)

III. Prior authorization will still be required for:

- a. Treatment plans for additional "routine dental services" rendered within six (6) months from the date of last service.
- b. Treatment plans which are a combination of "routine" and "non-routine dental services".
- c. Treatment plans for "non-routine dental services" only.

NOTE: If you submit a claim for payment before completion of your prior authorized treatment plan because the recipient has not returned to complete treatment, you should indicate this on that claim. In the event the same recipient returns to you at a later date to complete the prior authorized treatment you may submit the second claim to Prudential without prior authorization provided that there is no change in the treatment plan and the second claim is marked "continuation of previously authorized treatment plan". (Should not exceed one year from date of initial examination.)

A complete revision of the New Jersey Health Services Program Dental Manual will be issued to all participating Dentists in the near future.



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

New Jersey Health Services Program NEWSLETTER

Volume1-89.....

March 15, 1974

TO: ALL DENTAL PROVIDERS

SUBJECT: CHANGE IN ADDRESS

Effective immediately, the processing of Dental claims (MC-10) will be performed by the Medicaid Claim Division in the Prudential Insurance Company's Millville, New Jersey Office.

The telephone numbers will remain the same, i.e. 609-825-8700, 201-621-6960, extensions 493, 467 and 468.

All claims and correspondence will now be directed to: The Prudential Insurance Company of America, P. O. Box 1900, Millville, New Jersey 08332.

Pre-addressed envelopes designating P. O. Box 1900 will be supplied with future orders for claim forms.



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

New Jersey Health Services Program NEWSLETTER

Volume1 - 92.....

March 27, 1974

TO: APPROVED PROSTHETIC AND ORTHOTIC PROVIDERS

SUBJECT: FEE CHANGES FOR CERTAIN PROSTHETIC AND ORTHOTIC APPLIANCES

Effective April 1, 1974 the New Jersey Health Services (Medicaid) Program has increased the maximum allowable reimbursement for the forty-two (42) most frequently provided prosthetic and orthotic appliances. The list below identifies the procedure code, narrative description and maximum allowable payment under this Program for those forty-two items.

Additionally the maximum allowable labor charge has been increased to \$17.50 per hour; out-of-shop service will be \$17.50 per hour (representing portal to portal travel time); and in-shop services, where a consulting service is provided (without provision of an appliance or item), will be \$17.50 per hour.

These increases will be considered for all Medicaid P and O claims processed by Prudential after April 1, 1974.

PROSTHETICS & ORTHOTICS

Code #	Description	Max. Price Effective 4/1/74
3721	Spring Assist (Klenzak)	\$108
3732	Plastic hand orthosis	163
3800	Lumbral-sacral brace, A-P Control	90
3801	A-P and Lateral Control	119
3802	Posterior and Lateral Control, Dorso-Lumbar Brace	119
3805	A-P Control	113
3806	A-P and Lateral Control	148
3810	Scoliosis, Cervical, Collars, Anterior Control	659
3858	Full Corset	59
3923	Short Leg Brace (Includes solid stirrup, free motion ankle joint, calf band, calf cuff)	96
3925	Single Bar (round)	51
3940	Long Leg Brace (Includes solid stirrup, free motion ankle joint, free motion knee joint, calf band, calf cuff, 2 thigh bands, 2 thigh cuffs, knee pad optional)	237
3947	Double Bar	245
3955	Solid	14
3957	Caliper (round)	24
3965	Dorsi-and planter-flexion	13
3972	90° stop	13
3977	Lateral	42

Code #	Description	Max. Price Effective 4/1/74
3990	Adjustable Flexion Stainless Steel	69
4002	Calf	17
4003	Thigh-Mid	27
4011	Calf	12
4017	Lower Extension	27
4020	Both Knee Pad	19
4024	Standard	19
4050	Extra Padding Bilateral	49
4053	Metal	34
4058	Unilateral	63
4059	Bilateral	92
4073	Stirrup Transfer	14
4103	PTB (SACH foot, soft insert, cuff suspension)	562
4104	PTB (SACH foot, soft insert, knee joint, corset)	660
4106	PTS (SACH foot, soft insert, wedge)	660
4119	A/K (SACH foot, single axis friction knee, plastic quadrilateral socket open end, pelvic belt and hip joint)	800
4120	A/K (SACH foot, single axis friction knee, plastic total contact socket, pelvic belt and hip joint)	855
4121	A/K (SACH foot, single axis friction knee, plastic total contact socket and Silesian belt)	855
4131	Plastic B/K	315
4135	Plastic COMPONENT PARTS foot	341
4149	Bilateral Stainless Steel	49
4188	Standard	19
4241	Long B/E or Standard (Includes double wall socket, friction wrist, biceps cuff, elbow joint, harness and control assembly)	490
4242	Short B/E (Includes double wall socket, friction wrist, biceps cuff, elbow joint, harness and control assembly)	490



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

New Jersey Health Services Program NEWSLETTER

Volume 1-94

April 30, 1974

TO: ALL PROVIDERS

SUBJECT: INTEGRITY OF MEDICAID PROGRAM

This Newsletter is a reaffirmation of existing policy concerning the integrity of the New Jersey Health Services (Medicaid) Program and the personnel associated with administration of the program. It is restated at this time for the information of all Medicaid providers.

Statement of Objectives

The Division of Medical Assistance and Health Services, in order to continue to maintain the fiscal and moral integrity of the New Jersey Health Services Program, has adopted a strict policy prohibiting 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 policy includes the prohibition of offers of special employment, consultation fees, and all other gratuities by a provider, individual or facility.

A staff member who knowingly accepts gifts, gratuities or employment favors from a provider could be subject to immediate dismissal or other disciplinary action. In addition, any deliberate violation or effort to circumvent this policy by any provider could be considered cause for suspension or decertification from the New Jersey Health Services Program in accordance with Section 116 of the Medicaid program provider manuals. Section 116 lists various items which subject a provider of services to suspension or revocation from participation in the New Jersey Health Services Program.

Accordingly, your cooperation is therefore requested in refraining from offering or giving such gifts or gratuities to State Medicaid representatives and in helping to preserve the integrity of the Program.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-95

May 15, 1974

TO: ALL DENTISTS, DENTAL CLINICS, OUT-PATIENT DEPARTMENTS RENDERING DENTAL SERVICES

SUBJECT: X-RAYS

**DO NOT SEND X-RAYS TO PRUDENTIAL INSURANCE COMPANY OF AMERICA
WHEN SUBMITTING CLAIMS FOR REIMBURSEMENT.**

Some Providers are still submitting X-rays to Prudential Insurance Company of America when dental claims are submitted for reimbursement. This is no longer necessary as outlined in Volume 1-57 New Jersey Health Services Program Newsletter, February 2, 1973.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-96

May 15, 1974

TO: ALL DENTISTS, INDEPENDENT CLINICS

SUBJECT: PROVIDER MANUAL REVISION CHANGES FOR AUTHORIZATION OF DENTURES

Effective May 15, 1974 the New Jersey Health Services Program has adopted amendments to the rule on denture authorization affecting the following section of your Dental Manual.

Section 233.4 Prosthodontic Treatment, removable

G. Dentures will not be authorized when:

1. 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
2. Dental history reveals that a denture was provided by the Health Services Program in the three year period prior to the date of the current request. Lost, stolen or misplaced dentures or dentures mutilated in any way will not be routinely replaced.
3. Repair, relining or rebasing (jumping) of the patient's present denture will make it serviceable.

H. Denture repairs are allowable.

I. Before impressions are taken for authorized dentures all restorative, and preventive (oral hygiene) procedures must be completed. Reimbursement for the dentures will be denied if the provider fails to comply with this policy.

A complete revision of the New Jersey Health Services Program Dental Manual will be issued to all participating Dentists in the near future.



New Jersey Health Services Program NEWSLETTER

Volume 1 - 100

June 7, 1974

TO: ALL PHYSICIANS

SUBJECT: CYTOGENETIC ANALYSIS

Cytogenetic studies are reimbursable in the specific categories listed below. If the request for cytogenetic studies does not fit one of the categories listed below, prior authorization will be required. Prior authorization must be made on Medicaid form 33030 and must include proper recipient identification, the diagnoses and detailed reason why such services are being requested. The prior authorization form (33030) should be sent to the Bureau of Child Health Services, Division of Medical Assistance, P. O. Box 2486, Trenton, New Jersey 08608.

Cytogenetic Analysis:

A. Chromosomal studies are reimbursable when performed for acceptable clinical indications, among which are:

1. Findings suggesting a recognizable chromosomal abnormality:

- a) Trisomy (i.e., Down Syndrome, etc.)
- b) Sex chromosome abnormalities (i.e., Turner Syndrome, Klinefelter Syndrome, etc.)
- c) Deletion syndromes (i.e., Cri du chat, etc.)

2. When performed on at-risk parents or family of children with proven chromosomal abnormalities (i.e., translocation Down Syndrome, unique translocation, etc.)

3. When performed on a patient with multiple congenital anomalies associated with physical or mental retardation

(Exception: Recognizable syndromes known to have normal chromosomes, i.e.,

Cornelia de Lange
Hallermann Streiff
Rubinstein's Taybi, etc.)

4. Ambiguous genitalia.

5. Couples who are suspected of carrying a balanced translocation due to a history of repeated miscarriages and/or still births or perinatal deaths of infants with multiple congenital anomalies.

B. Chromosomal studies are not reimbursable for:

1. Syndromes associated with intrauterine infections (i.e., rubella, etc.).

2. Infants with congenital defects suspected to be due to agents (i.e., aminoplylline or thalidomide, etc.).

3. Recognizable syndromes known to have normal chromosomes (i.e., Cornelia de Lange, Hallermann Streiff, Rubinstein's Taybi, etc.).

4. No provision is made for reimbursement for individual band studies and 2 cell counts which are meaningless in therapy.

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Code No. 8914 Nuclear Chromatic Count
 (Buccal smear)

Code No. 8913 Chromosomal Analysis
 (a minimum of 15 cell count plus 1 karyotype)

NOTE: Payment will not be made for studies unless the nature of the condition is specified in item 12 column C of the MC-8 Physicians and Practitioners Claim form.

A physician may only claim reimbursement for these services performed for his own patients in his own office.

When requesting either of the above tests from an Independent Laboratory, it will be necessary to include the specific diagnosis as the Laboratory must include this information when submitting their claims for reimbursement.



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 101

June 7, 1974

TO: ALL INDEPENDENT LABORATORIES

SUBJECT: CYTOGENETIC ANALYSIS

Cytogenetic studies are reimbursable in the specific categories listed below. If the request for cytogenetic studies does not fit one of the categories listed below, prior authorization will be required. Prior authorization must be made on Medicaid form 33030 and must include proper recipient identification, the diagnoses and detailed reason why such services are being requested. The prior authorization form (33030) should be sent to the Bureau of Child Health Services, Division of Medical Assistance, P. O. Box 2486, Trenton, New Jersey 08608.

Cytogenetic Analysis:

A. Chromosomal studies are reimbursable when performed for acceptable clinical indications, among which are:

1. Findings suggesting a recognizable chromosomal abnormality:
 - a) Trisomy (i.e., Down Syndrome, etc.)
 - b) Sex chromosome abnormalities (i.e., Turner Syndrome, Klinefelter Syndrome, etc.)
 - c) Deletion syndromes (i.e., Cri du chat, etc.)
2. When performed on at-risk parents or family of children with proven chromosomal abnormalities (i.e., translocation Down Syndrome, unique translocation, etc.)
3. When performed on a patient with multiple congenital anomalies associated with physical or mental retardation
(Exception: Recognizable syndromes known to have normal chromosomes, i.e.,
Cornelia de Lange
Hallermann Streiff
Rubinstein's Taybi, etc.)
4. Ambiguous genitalia.
5. Couples who are suspected of carrying a balanced translocation due to a history of repeated miscarriages and/or still births or perinatal deaths of infants with multiple congenital anomalies.

B. Chromosomal studies are not reimbursable for:

1. Syndromes associated with intrauterine infections (i.e., rubella, etc.).
2. Infants with congenital defects suspected to be due to agents (i.e., aminopylline or thalidomide, etc.).
3. Recognizable syndromes known to have normal chromosomes (i.e., Cornelia de Lange, Hallermann Streiff, Rubinstein's Taybi, etc.).
4. No provision is made for reimbursement for individual band studies and 2 cell counts which are meaningless in therapy.

Reimbursement Schedule:

Code No. 8914 Nuclear Chromatic Count \$ 6.50
 (Buccal smear)

Code No. 8913 Chromosomal Analysis \$85.00
 (a minimum of 15 cell count plus 1 karyotype)

NOTE: Reimbursement will not be made unless the nature of the condition is specified in Item C of the Independent Laboratory Claim MC-13.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-102.....

June 14, 1974

TO: ALL MEDICAL SUPPLIERS

SUBJECT: BILLING PROCEDURES FOR MEDICAL SUPPLIES PROVIDED TO MEDICARE-MEDICAID RECIPIENTS

COMBINATION MEDICARE/MEDICAID CLAIMS

The following procedure has been adopted to help simplify your billing procedures. All Medicare eligible Medical supplies (exclusive of orthopedic shoes) provided to an individual eligible for both Medicare and Medicaid benefits must now be billed on form SSA-1490 REQUEST FOR MEDICARE PAYMENT, and the claims are to be sent directly to the Medicare Carrier, Prudential (Medicare Division II) P. O. Box 2000, Millville, New Jersey 08332. Providers should understand that they are agreeing to accept assignment when billing in this manner. In order to obtain Medicaid consideration, the provider MUST record the correct New Jersey Health Services case and person number in item 5 in addition to the Health Insurance Claim number in item 2 of form SSA-1490.

Please note that all providers should continue to refer to their Medical Supplier Manual, specifically to Section 205., regarding prior authorization procedures.



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 106

July 10, 1974

TO: ALL INDEPENDENT CLINICS

SUBJECT: CHANGES TO THE INDEPENDENT CLINIC MANUAL

Effective July 15, 1974, the New Jersey Health Services Program has adopted amendments affecting sections of your Independent Clinic Manual.

Accordingly, you are instructed to make the following changes to Chapter II of your Medicaid Manual:

I. Section 202.4 Podiatry Services

Necessary Podiatry service(s) may be provided by licensed Podiatrists in a clinic approved by the Division of Medical Assistance and Health Services in accordance with section 200.2 of this Manual. Upon completion of authorized services submit the Contractor's copy of the MC-14 C1 to Prudential Insurance Company.

II. Section 202.6 Dental Services - See Dental Manual for complete details. (The changes to this section affect paragraphs 1 and 2 only.)

Includes diagnostic, preventive and restorative dental treatments performed by a qualified dentist. All approved Clinics providing dental services will be reimbursed on the fee-for-service basis.

Clinics are instructed to charge their regular and customary fee for each service. Reimbursement will be on the basis of the billed charges not to exceed the Schedule of Maximum Dental Allowances of the Division.

If there are any questions concerning these adopted changes please contact us at:

The Prudential Insurance Company
Provider Services Division
P. O. Box 5000
Millville, New Jersey 08332
Telephone Numbers: 609-825-8700 Ext. 466 or
201-621-6960 Ext. 466



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

New Jersey Health Services Program

NEWSLETTER

Volume 1 - 108

August 12, 1974

TO: ALL HEARING AID DISPENSER PROVIDERS

SUBJECT: LICENSING REGULATIONS – HEARING AID DISPENSER

SECOND NOTICE !!!

On June 1, 1974 a Newsletter Volume 1 - 98 was sent to All Hearing Aid Dispenser Providers with information that as a result of NJSA45:9A-1 etseq. which became effective January 1, 1974, it is mandatory that all persons dispensing Hearing Aids hold a current valid license or temporary valid license.

We notified you that in accordance with revised Section 202 of the Hearing Aid Manual of the New Jersey Health Services (Medicaid) Program, we will only reimburse Hearing Aid Dispensers who hold a current valid license or temporary valid license from the New Jersey Board of Medical Examiners. We requested in our previous Newsletter that all Hearing Aid Dispensers forward a photostatic copy of their valid license or temporary valid license as a proof of possession in order that we may have these credentials in our provider files. We asked that you mail a photostat of your Hearing Aid Dispensers license to the following address:

The Prudential Insurance Company of America
Medical Administration Division
P.O. Box 1900
Millville, New Jersey 08332

This Newsletter is a second request for your compliance with the above requirements. Hearing Aid Dispensers who have not submitted proof of proper licensing credentials as of August 30, 1974 will no longer be reimbursed as providers of Hearing Aid Services by the Medicaid Program.



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

New Jersey Health Services Program

NEWSLETTER

Volume 1 - 109

August 12, 1974

TO: ALL DENTISTS, INDEPENDENT CLINICS

SUBJECT: PROVIDER MANUAL REVISION – PROVISION OF DENTURE(S) FOLLOWING TERMINATION OF ELIGIBILITY

Effective August 15, 1974, the New Jersey Health Services Program has adopted the following rule regarding termination of eligibility which augments Section 221.3 item D of the Dental Manual by adding a note.

Section 221.3 Basis of Payment

NOTE:

Notwithstanding anything in these regulations to the contrary, payment may be made for a complete denture furnished after termination of eligibility of an individual where the last tooth in a specific arch is extracted during the period of eligibility. In order to obtain reimbursement for this denture(s), the primary impression(s) must be initiated within 120 days and the denture inserted within 180 days after the extraction of the last tooth. Authorization procedures set forth in these regulations are applicable.

In addition to the above Manual revision, please be guided by the following instructions:

The dentist must indicate on the Dental Form (MC-10) submitted for authorization:

1. that the patient is now or will become ineligible.
2. the date of the last extraction in the specific arch involved.

In order to assure reimbursement, the dentist must make certain that the treatment is initiated and completed in accordance with the above time frame.

State of New Jersey

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION MEDICAL ASSISTANCE AND HEALTH SERVICES

ADMINISTRATIVE OFFICES
324 EAST STATE STREET
TRENTON, NEW JERSEY 08608



ADDRESS REPLY TO:
POST OFFICE BOX 2486
TRENTON, NEW JERSEY 08608

Volume I-121

August 1, 1975

**TO: PHYSICIANS, DENTISTS, OPTOMETRISTS, OPTICIANS, PODIATRISTS,
CHIROPRACTORS, PSYCHOLOGISTS, PROSTHETIC AND ORTHOTIC
SUPPLIERS, MEDICAL SUPPLIERS, HEARING AID DEALERS, TRANS-
PORTATION PROVIDERS**

SUBJECT: 10% REDUCTION IN REIMBURSEMENT

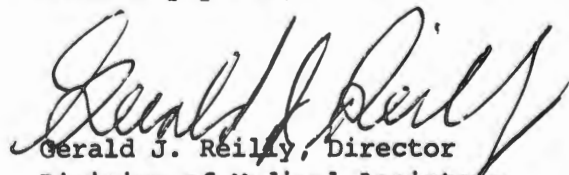
Because of the projected \$52 million budget deficit in the New Jersey Health Services (Medicaid) Program for the fiscal year beginning July 1, 1975, a reduction of 10% in provider reimbursement will become effective for all services performed on or after August 1, 1975.

This reduction will generate program savings of approximately \$10 million, and will assist us in our goal of balancing the budget. We intend to continue as comprehensive a program as we can under the circumstances.

In addition to the fee reduction, in certain program services a co-payment requirement is planned whereby the recipients will also share in this fiscal problem. Under the law, the co-payment maximum per service can be as high as \$3.00; however, for the most part co-payment will be in the \$.50 range and become effective September 1, 1975. A separate Newsletter will be forthcoming outlining the details of the co-pay implementation as they apply to your particular discipline. A pharmaceutical co-payment of \$.25 per prescription will go into effect on August 1, 1975.

Your cooperation and understanding during this difficult time, will be greatly appreciated.

Sincerely yours,


Gerald J. Reilly, Director
Division of Medical Assistance
and Health Services



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

New Jersey Health Services Program NEWSLETTER

Volume 1-122

August 1, 1975

TO: ALL PHYSICIANS AND INDEPENDENT LABORATORIES

SUBJECT: REDUCTION IN REIMBURSEMENT FOR LABORATORY SERVICES

The New Jersey Medicaid Program will reduce by 40% the present maximum allowable laboratory fees for all services performed on or after August 1, 1975.

This is consistent with the program's overall budgetary reductions in reimbursements for all services as well as the recent technological advancements in automated laboratory operations which have a direct affect on reimbursement equalization.

This decision is an interim measure until the Division of Medical Assistance and Health Services (Medicaid) undertakes a complete review of all laboratory Procedure Codes and their related fees.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-123

August 1, 1975

TO: ALL PHYSICIANS

SUBJECT: NEW JERSEY MEDICAID INJECTION POLICY

Effective August 1, 1975 the New Jersey Medicaid Program will make payment for injections (Intradermal, Subcutaneous, Intramuscular, Intravenous, or Intraarterial) - Office or Home Setting.

Reimbursement for the above injections are on a flat fee of \$2.50 each and are all-inclusive for the cost of the service and the drug or vaccine.

Reimbursement will be made in accordance with the New Jersey Medicaid Program's injection policy as outlined below.

Injectable prescription drugs are no longer a reimbursable item.

- EXCEPTION:
- A. In Long Term Care Facilities
 - B. Parenteral Anti-neoplastic Drugs
F.D.A. approved
 - C. Gammaglobulin when not available from the Department of Health or other agency and when used for medically acceptable purposes. Prior authorization required for obtaining the drug.
 - D. Measles, mumps, rubella as a combined vaccine when not available from the Department of Health or other agencies. Prior authorization required for obtaining the vaccine.
 - E. Drugs to be administered to a patient by other than the physician or his employee. Physician's prescription must carry the legend "For self-administration". Prior authorization is required.
 - F. Insulin

A visit for the sole purpose of an injection is reimbursable as an injection and not as an office visit plus injection. On the other hand, if the criteria of an office or home visit are met, an injection may, if medically indicated, be considered as an add-on to the visit. No reimbursement will be made for more than one injection per visit except in childhood immunizations (preventive care). 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.

Intravenous and Intraarterial injections are reimbursable only when performed by the physician.

(continued)

Vol. 1-123 cont.

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

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

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

No reimbursement will be made for estrogen injection given for the treatment of menopausal syndrome.

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 since this injection would normally be included in the prescribed fee for such a procedure.

BILLING PROCEDURES

Insert procedure code number 9072 (Injection) as a separate item and charge on Physician and Practitioner Claim Form MC-8 under Section 12B. This is to be followed by the name, dose of drug and route of administration. If childhood immunizations are administered indicate in Section 12C. The complete diagnosis for which the injection was given must be inserted on the same line in Section 12C.

PLEASE NOTE:

Prior authorization must be 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.



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 126

September 8, 1975

TO: ALL DENTISTS, INDEPENDENT CLINICS, AND HOSPITAL OUTPATIENT DEPARTMENTS

SUBJECT: CHANGES IN RADIOGRAPHY - SEC. 231.2 IN CHAPTER II OF DENTAL MANUAL

Effective September 1, 1975, the New Jersey Health Services Program has adopted the following changes to ALL ITEMS, paragraphs A through H, of Section 231.2 of the Dental Services Manual.

231.2 Radiography

- A. Radiological procedures are limited to those normally required to make a diagnosis. Radiographs must be taken to show all areas where treatment is anticipated including those of an emergency nature.
- B. 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 permitted as a single radiographic study every three (3) years without prior authorization for which reimbursement will be made is as follows:
1. Up to and including age six (6) - eight (8) films (six periapical plus two bite-wing films)
 2. 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.

- C. Posterior bite-wing and single anterior films may be taken as needed as part of an examination subject to limitations in Section 231.1 B. and 231.2 A., above.
- D. In order to establish a diagnosis, a single X-ray may be taken at any time.
- E. All X-ray films submitted to the Division of Medical Assistance & Health Services or its agents must be suitable for interpretation, 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 for replacement at no additional cost to the Division of Medical Assistance & Health Services, or where appropriate no reimbursement will be made.
- F. All X-ray films for which payment is requested must be available to the Dental Consultant for evaluation of the treatment or treatment request.

(continued)

- G. The X-ray films shall be forwarded to the Dental Consultant when procedures requiring prior authorization are requested. It is recommended that the two film packet be used by those dentists who desire to retain a set of films in their office at all times and for those instances where there is loss in transit.
- H. Post-operative X-rays, which are not reimbursable, must be taken of all areas where treatment has been completed and the dentist is requesting reimbursement for that treatment. Such X-rays must be available to representatives of the New Jersey Division of Medical Assistance & Health Services or its agents.

EXCEPTION:

1. Full dentures
2. Treatment of soft tissues
3. Simple extraction(s)



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 127.....

August 26, 1975

TO: ALL DENTISTS, INDEPENDENT CLINICS AND OUTPATIENT HOSPITAL DEPARTMENTS

SUBJECT: INCREASE FROM 18 TO 24 NUMBER OF REQUIRED POINTS UNDER MALOCCLUSION ASSESSMENT SYSTEM

(THIS NEWSLETTER MODIFIES NEWSLETTER VOLUME 1-50 (OCTOBER 23, 1972))

Effective September 1, 1975, the Assessment Index Minimum will be revised from eighteen (18) to twenty-four (24) points. The revised Section C. will read as follows:

C. EVALUATION OF THE REFERRED PATIENT

1. The Orthodontist, after considering the factors in A. 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 (24), do not proceed with the diagnostic workup. Submit a Dental Claim Form (MC-10) directly to Prudential, Box 1900, Millville, New Jersey 08332 with a copy of the FD-10 identifying, by procedure code 0120, the service that has been rendered. The maximum fee allowed for procedure code 0120 is \$6.00.*

NOTE 1: 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
- d. A deep overbite where incisor teeth contact palatal tissue.

NOTE 2: Repeated submission of requests for treatment below the Assessment Index Minimum (24) without sufficient substantiating information for such requests will necessitate denial of reimbursement for the diagnostic workups.

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

* Authorized fees are subject to a 10% reduction at this time.



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 128

August 26, 1975

TO: ALL DENTISTS, INDEPENDENT CLINICS AND OUTPATIENT HOSPITAL DEPARTMENTS

SUBJECT: CHANGES FOR AUTHORIZATION OF DENTURES FROM 3 TO 5 YEARS
(THIS NEWSLETTER MODIFIES NEWSLETTER VOLUME 1-96 (MAY 15, 1974))

Effective September 1, 1975 the New Jersey Health Services Program has adopted amendments to the rule on denture authorization affecting the following section of your Dental Manual.

Section 233.4 Prosthodontic Treatment, removable

G. Dentures will not be authorized when:

1. 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
2. Dental history reveals that a denture was provided by the Health Services Program in the five year period prior to the date of the current request. Lost, stolen or misplaced dentures or dentures mutilated in any way will not be routinely replaced.
3. Repair, relining or rebasing (jumping) of the patient's present denture will make it serviceable.

H. Denture repairs are allowable.

I. Before impressions are taken for authorized dentures all restorative, and preventive (oral hygiene) procedures must be completed. Reimbursement for the dentures will be denied if the provider fails to comply with this policy.



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 129

August 26, 1975

TO: ALL OPTICIANS, OPTOMETRISTS AND OPHTHALMOLOGISTS

SUBJECT: REPLACEMENT OF LOST, BROKEN, DAMAGED OR STOLEN GLASSES

EFFECTIVE SEPTEMBER 1, 1975 THE PROGRAM WILL NO LONGER PAY FOR REPLACEMENT OF OPTICAL APPLIANCES WHICH MAY HAVE BEEN LOST, BROKEN, DAMAGED OR STOLEN.

The Program will continue providing eye examinations and glasses within the guidelines of the New Jersey Health Services Program Vision Care Manual once every two years for persons 19 years of age or over and once a year for persons less than 19 years of age or 60 years of age or over. All subsequent prescriptions must have a change of at least .50 diopter in spherical or cylindrical power or a change in axis of 5 degrees or more. Frames are to be utilized for at least two years.



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

New Jersey Health Services Program

NEWSLETTER

Volume 1-131

September 8, 1975

TO: ALL PHYSICIANS

SUBJECT: INCLUSION OF STERILIZATION PROCEDURES INTO THE NEW JERSEY MEDICAID PROGRAM

Effective immediately the New Jersey Medicaid Program has adopted rules regarding sterilization procedures to be followed by physicians who perform services for eligible New Jersey Medicaid recipients.

The following are guidelines that must be followed prior to performing sterilization procedures:

A. Definitions

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

2. **Informed Consent (Requirements)**

Informed consent means the voluntary, knowing assent from the individual on whom any sterilization is to be performed after he has been given (as evidenced by a document executed by such individual):

- a. A fair explanation of the procedures to be followed;
- b. A description of the attendant discomforts and risks;
- c. A description of the benefits to be expected;
- d. An explanation concerning appropriate alternative methods of family planning and the effect and impact of the proposed sterilization including the fact that it must be considered to be an irreversible procedure;
- e. An offer to answer any inquiries concerning the procedures; and
- f. An instruction that the individual is free to withhold or withdraw his or her consent to the procedure at any time prior to the sterilization without prejudicing his or her future care and without loss of other project or program benefits to which the patient might otherwise be entitled.
- g. The documentation referred to in this section shall be provided by one of the following methods and should be bilingual as necessary:
 - Provision of a written consent document detailing all of the basic elements of informed consent as stated above.
 - Provision of a short form written consent document indicating that the basic elements of informed consent have been presented orally to the patient. The short form document must be supplemented by a written summary of the oral presentation. The short form document must be signed by the patient and by an auditor-witness to the oral presentation. The written summary shall be signed by the person obtaining the consent and by the auditor-witness. The auditor-witness shall be designated by the patient.
 - Each consent document shall display the following legend printed prominently at the top:

NOTICE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects.

(continued)

B. Scope of Services

Payment will be made for sterilization services subject to the following limitations:

1. No non-emergency sterilization may be performed unless:
 - a. Such sterilization is performed pursuant to a voluntary request for such services made by the person on whom the sterilization is to be performed; and,
 - b. Such person is advised at the outset and prior to the solicitation or receipt of his or her consent to such sterilization, that no benefits provided by programs or projects may be withdrawn or withheld by reason of his or her decision not to be sterilized; and,
 - c. A physician obtains legally effective informed consent from the individual on whom the sterilization is to be performed.
2. The physician shall not perform a non-therapeutic sterilization sooner than 72 hours following the giving of informed consent.
3. No sterilization procedures shall be performed on a person who has been judicially declared mentally incompetent under applicable State laws to give informed and binding consent to the performance of such an operation because of age or mental capacity.
4. No sterilization procedure may be performed with respect to sterilization of individuals under the age of 18 or legally incapable of consenting to the sterilization.

Manual page revisions will be forwarded to you in the near future.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

NEW JERSEY HEALTH SERVICES PROGRAM

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

Volume 1 - 133

September 18, 1975

TO: DENTISTS, MEDICAL SUPPLIERS, PROSTHETIC AND ORTHOTIC SUPPLIERS, HEARING AID DEALERS, TRANSPORTATION PROVIDERS, HOSPITAL AND SPECIAL HOSPITAL ADMINISTRATORS, INDEPENDENT CLINICS AND HOME HEALTH AGENCIES.

SUBJECT: UPDATE OF DIRECTORY OF LOCAL MEDICAL ASSISTANCE UNITS

Please be advised that effective September 3, 1975, both Medicaid Offices located in Newark (796 Broad Street and 505 South 15th Street) were moved and consolidated into one office at 155 Washington Street, Newark.

The correct mailing address is:

State of New Jersey Division of Medical
Assistance & Health Services
Essex County Local Medical Assistance Unit
155 Washington Street
Newark, N.J. 07102

The current telephone number will remain intact, i.e., (201) 648-2470 and 648-3700.



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

New Jersey Health Services Program NEWSLETTER

Volume ...1-136.....

September 25, 1975

TO: NEPHROLOGISTS AT NEW JERSEY MEDICAID APPROVED FACILITIES*

SUBJECT: OUTPATIENT AND HOME HEMODIALYSIS SERVICES RENDERED TO END-STAGE RENAL DISEASE PATIENTS.

This is to announce that the New Jersey Health Services Program (Medicaid) has approved a method of payment to physicians who render services for the maintenance of Medicaid patients with end-stage renal disease.

This method will become effective with services starting October 1, 1975. It will provide for:

1. Monthly payments to physicians for out-patient dialysis
2. Monthly payments for medical services rendered to patients on home dialysis and
3. For other services rendered to maintenance dialysis patients.

Attached is a Statement of Agreement for participation as well as guidelines to be followed. Please complete the agreement and mail it and all claims to Prudential Insurance Company, P.O. Box 1900, Millville, N.J., Attention: Supervisor, Unit V.

*New Jersey Centers

East Orange General
Helene Fuld
Holy Name
Jersey City Medical Center
Jersey Shore Medical Center
Monmouth Medical Center
Morristown Memorial
Muhlenberg
Newark Beth Israel Medical Center
Our Lady of Lourdes
Perth Amboy General
St. Barnabas Medical Center
St. Joseph's
Shore Memorial

*New York Centers

Grasslands
Lenox Hill
The New York Hospital

*Pennsylvania Centers

Albert Einstein Medical Center
Crozer-Chester Medical Center
Hahnemann Medical College and Hospital
St. Christopher's Hospital
Thomas Jefferson University



**STATEMENT OF AGREEMENT
MEDICAID CRD PROGRAM AND PHYSICIAN**

I, _____, Nephrologist, a staff physician at _____, a New Jersey Medicaid approved outpatient facility, agree to bill not more than \$160 per month (*less 10% reduction in reimbursement pursuant to Newsletter Volume 1-121, August 1, 1975) for medical services rendered to each patient with end-stage Renal Disease who is on dialytic therapy in an approved outpatient renal dialysis facility, or \$112 per month (*applicable as above) for medical services rendered to each patient on home dialysis. These services are described and covered by the monthly payment in accordance with Medicaid reimbursement and procedures. I further agree to accept the conditions indicated in the accompanying enclosure and agree to comply with the regulations and administrative instructions of the Division of Medical Assistance and Health Services.

This agreement shall remain in effect until the Division of Medical Assistance and Health Services is notified in writing of any intention to terminate direct billing for services each month, and this termination shall be effective no sooner than the 30th day following the day of its receipt by the Division of Medical Assistance and Health Services.

Date: _____

Signature

Renal Dialysis Program

The following guidelines and method of physician reimbursement are applicable for the HSP Hemodialysis Services.

I. Out-Patient Maintenance Service

The nephrologist will bill the program on a monthly basis for payment of services related to renal disease rendered to recipients on maintenance dialysis for that period.

The monthly allowable fee for this service shall be a maximum of \$160 per patient (see attached "Statement of Agreement").

A. Services Covered by the Agreement

1. Physician Services during dialysis (includes both supervisory and direct personal physician services to the patient) in connection with both complicated and uncomplicated sessions.

Note: Supervisory services do not include administrative services which the nephrologist may provide in a facility (i.e. staff training, facility management, procurement of permanent equipment and consummable supplies, etc.)

2. Office visits for the routine evaluation of patient progress or for treatment of renal disease complications, including the evaluation of diagnostic tests and procedures.
3. Office visits for services rendered by the nephrologist for conditions considered directly or indirectly related to renal disease (i.e. hypertension, renal complications, diabetes, ASCVD, etc. Not included would be those conditions requiring referral to another specialty discipline, i.e. orthopedist, surgeon, gynecologist, etc.)

B. Services Not Covered by the Agreement

1. Nephrologist's services to in-patients.

When patients for whom the nephrologist has agreed to bill on a monthly basis are hospitalized, the monthly fee shall be reduced by 1/30th for each day of hospitalization. The nephrologist may then bill on a fee for service basis for those in-patients. When in-patient services are rendered, the period between the date of admission to the hospital and the date of discharge from the hospital shall be used as the period of services to be subtracted from the monthly billing.

2. Out-patient dialysis in a facility other than usual treatment setting.

If the alternate facility (other than the usual facility) includes in its charge an amount for reimbursement of the "supervisory" services of the nephrologist (re: Section I, A, 1 above), the payment to the nephrologist from the "usual" facility, who is reimbursed by a monthly payment, shall be reduced by an amount appropriate to the number of days in the alternate facility.

3. **Declotting of shunts.**

Reimbursement to the nephrologist in accordance with the program's schedule of allowances.

4. **Services provided which are beyond that related to the patient's renal condition.**

Such services not covered under Section I, A, 1, 2 and 3 above may be billed to the program on a fee for service basis in accordance with the services rendered. The physician rendering such services shall provide documentation that the illness is not related to the renal condition and that additional visits are required.

5. **Concurrent care by physicians other than the nephrologist.**

Payment for such services shall be in accordance with Section 201.5, Physicians Manual (Concurrent Care).

II. Home (Self) Training of the Hemodialysis Patient.

It is generally recognized that about 25% of patients requiring dialysis could enter a program for training so that dialysis at home can be performed. It is also recognized that additional time and effort are required by the nephrologist in training the patient for home dialysis and that such expenditures could be more than offset by the use of this modality.

Therefore, the following parameters shall apply for this category of patient:

A. An additional fee of \$400 is reimbursable to the nephrologist under the following conditions:

1. The course of training shall cover approximately thirty (30) training episodes over a period of three (3) or more months.

Note: If training were initiated but required suspension for whatever reason, the nephrologist shall be reimbursed for those training episodes provided in the amount of \$10 per session, but not to exceed \$240.

2. The suitability of the patient for such training must be established prior to entry into the program;
3. Documentation of the reason(s) for cessation of training;
4. Elimination of the monthly reimbursement (\$160/patient) to the nephrologist once the patient is established on home hemodialysis treatments;
5. Reimbursement to the nephrologist of a monthly allowable fee of \$112 per patient.

B. Back-up Hemodialysis for the Home Dialysis Patient.

In the event a patient on home hemodialysis should, for legitimate reason, require facility out-patient maintenance as a single episode, no additional reimbursement will be allowed to the nephrologist. However, if the number of back-up treatments exceeds ten or extends over a period of 30 days or more, then reimbursement to the nephrologist shall be in accordance with Section I.

III. Inpatient Hemodialysis Services

Patients requiring hemodialysis on an in-patient basis (i.e. intercurrent illnesses requiring hospitalization) constitute a separate category of patient services. In such cases the following policies shall apply:

- A. Nephrologist reimbursement for other than supervisory dialysis shall be on a fee for service basis in accordance with the current procedure codes.
- B. Hemodialysis treatments required on an in-patient basis shall be reimbursable at \$30/dialysis episode. (The program recognizes the higher level of care and the greater nephrologist input and responsibility required for such treatment.)
 - 1. Patients covered under the monthly reimbursement rate (re: Section I) shall have that portion of the reimbursement deducted from the total nephrologist reimbursement (re: Section I, B, 1.)

Example: For 10 days of in-patient care, deduct 10/30 from the monthly rate of \$160 for the remaining out-patient care.

$$\frac{10 \times 160}{30} = \$53$$

IV. Peritoneal Dialysis

A. Out-Patient

- 1. If a patient is receiving treatments on a regular basis in an out-patient facility or at home, the nephrologist shall be entitled to the same monthly rate, and under the same conditions, as indicated in Sections I and II.

B. In-Patient

- 1. Reimbursement for in-patient peritoneal dialysis as an adjunct to hemodialysis or as a separate unconnected procedure shall be reimbursable in accordance with procedure codes 9408 - 9410.



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

New Jersey Health Services Program

NEWSLETTER

Volume 1 - 139

November 1, 1975

TO: ALL PHYSICIANS, DENTISTS, PODIATRISTS

SUBJECT: NEW JERSEY MEDICAID FORMULARY - EFFECTIVE NOVEMBER 10, 1975

The attached New Jersey Medicaid Formulary will become effective on November 10, 1975.

This Formulary is the result of considerable research by our staff and has been discussed at three meetings of the Medicaid Formulary Committee. The Committee includes representation from the New Jersey Medical Society, Board of Medical Examiners, New Jersey Pharmaceutical Association, Board of Pharmacy, New Jersey Society of Osteopaths, the Division of Consumer Affairs, and pharmacologists from the Philadelphia College of Pharmacy and Science and the New Jersey College of Medicine and Dentistry. The Committee has served, and will continue to serve, in an advisory capacity to the Medicaid Program.

Many changes have been made in the Formulary based on suggestions made by Committee members. Products listed have been limited to those for which accumulated data indicates there is no clinical significance when products of different manufacturers are interchanged. As additional information becomes available, it is anticipated more products will be added to the Formulary. Through this process we believe that Medicaid recipients will receive high quality medication while at the same time permitting the Program to save sorely needed dollars.

As of November 10, 1975, when prescribing a trade name multi-source drug product listed in Section I of the Formulary, for which a designated chemically equivalent product is listed in Section II of the Formulary, the prescriber must indicate either "Formulary Alternate Permitted" or "Dispense as Written" (may be abbreviated "FAP" or "DAW"), on each written or telephoned prescription.

For patients in long term care facilities, either statement or its abbreviation must appear on the patient's chart and be transposed onto the written prescription.

When the prescriber indicates "Formulary Alternate Permitted" or "FAP", the pharmacy provider shall dispense a designated chemically equivalent product, if such alternate is listed in Section II of the Formulary; when the prescriber indicates "Dispense as Written" or "DAW", the pharmacy provider shall follow those instructions.

Your cooperation in indicating "FAP" on all of your prescriptions will be appreciated and will enable this cost savings program to be effective.

Revised manual pages will be distributed shortly.

NEW JERSEY MEDICAID FORMULARY
NEW JERSEY HEALTH SERVICES (MEDICAID) PHARMACY PROGRAM

- SECTION I. Index of Trade-Name Products with their Designated Chemically Equivalent Names.**
- SECTION II. Acceptable Alternate Product Name and Company for the Designated Chemically Equivalent Name by Dosage Form and Strength.**

When prescriber indicates "Formulary Alternate Permitted" (FAP) and the trade name appears in Section I, the provider pharmacy must dispense a listed alternate product when the corresponding dosage form and strength is listed in Section II.

NEW JERSEY HEALTH
SERVICES PROGRAM

NEW JERSEY MEDICAID FORMULARY
SECTION I

11/10/75

<u>TRADE NAME AND COMPANY</u>	<u>DESIGNATED CHEMICALLY EQUIVALENT NAME</u>
<u>ACHROMYCIN-V (LEDERLE)</u>	<u>TETRACYCLINE</u>
<u>ALPEN (LEDERLE)</u>	<u>AMPICILLIN</u>
<u>AMCILL (PARKE-DAVIS)</u>	<u>AMPICILLIN</u>
<u>AMNESTROGEN (SQUIBB)</u>	<u>ESTROGENS, ESTERIFIED</u>
<u>BENADRYL (PARKE-DAVIS)</u>	<u>DIPHENHYDRAMINE</u>
<u>BETAPEN VK (BRISTOL)</u>	<u>PENICILLIN-V POT.</u>
<u>BRISTACYCLINE (BRISTOL)</u>	<u>TETRACYCLINE</u>
<u>BRISTAMYCIN (BRISTOL)</u>	<u>ERYTHROMYCIN</u>
<u>CHLOR-PZ (USV)</u>	<u>CHLORPROMAZINE</u>
<u>CHLOR-TRIMETON (SCHERING)</u>	<u>CHLORPHENIRAMINE</u>
<u>COMPOCILLIN-VK (ABBOTT-ROSS)</u>	<u>PENICILLIN-V POT.</u>
<u>CONESTRON (WYETH)</u>	<u>ESTROGENS, CONJUGATED</u>
<u>COSEA (ALCON)</u>	<u>CHLORPHENIRAMINE</u>
<u>CYCLOPAR (PARKE-DAVIS)</u>	<u>TETRACYCLINE</u>
<u>DARVON (LILLY)</u>	<u>PROPOXYPHENE</u>
<u>DARVON COMPOUND-65 (LILLY)</u>	<u>PROPOXYPHENE COMPOUND-65</u>
<u>DOLENE (LEDERLE)</u>	<u>PROPOXYPHENE</u>
<u>DOLENE COMPOUND-65 (LEDERLE)</u>	<u>PROPOXYPHENE COMPOUND-65</u>
<u>DOWMYCIN-E (DOW)</u>	<u>ERYTHROMYCIN</u>
<u>DOXY-II (USV)</u>	<u>DOXYCYCLINE</u>
<u>EQUANIL (WYETH)</u>	<u>MEPROBAMATE</u>
<u>ERYPAR (PARKE-DAVIS)</u>	<u>ERYTHROMYCIN</u>
<u>ERYTHROCIN (ABBOTT)</u>	<u>ERYTHROMYCIN</u>
<u>ESIDRIX (CIBA)</u>	<u>HYDROCHLOROTHIAZIDE</u>
<u>ETHRIL (SQUIBB)</u>	<u>ERYTHROMYCIN</u>
<u>EVEX (SYNTEX)</u>	<u>ESTROGENS, ESTERIFIED</u>
<u>GANTRISIN (ROCHE)</u>	<u>SULFISOXAZOLE</u>
<u>HISTASPAN (USV)</u>	<u>CHLORPHENIRAMINE</u>
<u>HYDRODIURIL (MS&D)</u>	<u>HYDROCHLOROTHIAZINE</u>
<u>ILOSONE (DISTA)</u>	<u>ERYTHROMYCIN</u>
<u>IMAVATE (ROBINS)</u>	<u>IMIPRAMINE</u>
<u>JANIMINE (ABBOTT)</u>	<u>IMIPRAMINE</u>
<u>LEDERCILLIN VK (LEDERLE)</u>	<u>PENICILLIN-V POT.</u>
<u>MENEST (BEECHAM)</u>	<u>ESTROGENS, ESTERIFIED</u>
<u>MILTOWN (WALLACE)</u>	<u>MEPROBAMATE</u>

NEW JERSEY HEALTH
SERVICES PROGRAM

NEW JERSEY MEDICAID FORMULARY
SECTION I

11/10/75

<u>TRADE NAME AND COMPANY</u>	<u>DESIGNATED CHEMICALLY EQUIVALENT NAME</u>
OMNIPEN (WYETH)	AMPICILLIN
ORETIC (ABBOTT)	HYDROCHLOROTHIAZINE
OXLOPAR (PARKE-DAVIS)	OXYTETRACYCLINE
PANMYCIN (UPIJOHN)	TETRACYCLINE
PEN-A (PFIZER)	AMPICILLIN
PENAPAR VK (PARKE-DAVIS)	PENICILLIN-V POT.
PENBRITIN (AYERST)	AMPICILLIN
PENSYN (UPJOHN)	AMPICILLIN
PENTIDS (SQUIBB)	PENICILLIN-G
PEN VEE K (WYETH)	PENICILLIN-V POT.
PFIZER-E (PFIZER)	ERYTHROMYCIN
PFIZERPEN (PFIZER)	PENICILLIN-G
PFIZERPEN VK (PFIZER)	PENICILLIN-V POT.
POLYCILLIN (BRISTOL)	AMPICILLIN
PREMARIN (AYERST)	ESTROGENS, CONJUGATED
PRESAMINE (USV)	IMPARMINE
PRINCIPEN (SQUIBB)	AMPICILLIN
PROMAPAR (PARKE-DAVIS)	CHLORPROMAZINE
QIDAMP (MALLINCRODT)	AMPICILLIN
QIDMYCIN (MALLINCRODT)	ERYTHROMYCIN
QIDPEN VK (MALLINCRODT)	PENICILLIN-V POT.
QIDTET (MALLINCRODT)	TETRACYCLINE
ROBICILLIN VK (ROBINS)	PENICILLIN-V POT.
ROBIMYCIN (ROBINS)	ERYTHROMYCIN
ROBITET (ROBINS)	TETRACYCLINE
SK-AMPICILLIN (SKF)	AMPICILLIN
SK-BAMATE (SKF)	MEPROBAMATE
SK-ERYTHROMYCIN (SKF)	ERYTHROMYCIN
SK-ESTROGENS (SKF)	ESTROGENS, ESTERIFIED
SK-PENICILLIN VK (SKF)	PENICILLIN-V POT.
SK-PRAMINE (SKF)	IMPAMINE
SK-SOXAZOLE (SKF)	SULFISOXAZOLE
SK-TETRACYCLINE (SKF)	TETRACYCLINE
SK-65 (SKF)	PROPOXYPHENE
SK-65 COMPOUND (SKF)	PROPOXYPHENE COMPOUND-65
SOXOMIDE (UPJOHN)	SULFISOXAZOLE
SULFALAR (PARKE-DAVIS)	SULFISOXAZOLE
SUMYCIN (SQUIBB)	TETRACYCLINE
TELDRIN (SKF)	CHLORPHENIRAMINE
TERRAMYCIN (PFIZER)	OXYTETRACYCLINE
TETRACYN (ROERIG)	TETRACYCLINE
TETREX (BRISTOL)	TETRACYCLINE

<u>TRADE NAME AND COMPANY</u>	<u>DESIGNATED CHEMICALLY EQUIVALENT NAME</u>
<u>TETREX BID (BRISTOL)</u>	<u>TETRACYCLINE</u>
<u>TETREX-S (BRISTOL)</u>	<u>TETRACYCLINE</u>
<u>THIURETIC (PARKE-DAVIS)</u>	<u>HYDROCHLOROTHIAZIDE</u>
<u>THORAZINE (SKF)</u>	<u>CHLORPROMAZINE</u>
<u>TOFRANIL (GEIGY)</u>	<u>IMIPRAMINE</u>
<u>TOTACILLIN (BEECHAM)</u>	<u>AMPICILLIN</u>
<u>UTICILLIN VK (UPJOHN)</u>	<u>PENICILLIN-V POT.</u>
<u>V CILLIN-K (LILLY)</u>	<u>PENICILLIN-V POT.</u>
<u>VEETIDS (SQUIBB)</u>	<u>PENICILLIN-V POT.</u>
<u>VIBRAMYCIN (PFIZER)</u>	<u>DOXYCYCLINE</u>

NEW JERSEY HEALTH
SERVICES PROGRAM

NEW JERSEY MEDICAID FORMULARY
SECTION II

11/10/75

<u>DESIGNATED CHEMICAL EQUIVALENT</u> <u>DOSAGE FORM AND STRENGTH</u>	<u>ACCEPTED ALTERNATE PRODUCT NAME</u> <u>AND COMPANY</u>
AMPICILLIN, CAPS 250MG	PEN-A (PFIZER)
AMPICILLIN, CAPS 500MG	PEN-A (PFIZER)
AMPICILLIN, SUSP 125 MG 100CC	PEN-A (PFIZER)
AMPICILLIN, SUSP 125 MG 200CC	PEN-A (PFIZER)
AMPICILLIN, SUSP 250 MG 100CC	PEN-A (PFIZER)
AMPICILLIN, SUSP 250 MG 200CC	PEN-A (PFIZER)
CHLORPHENIRAMINE SUST TABS/CAPS 8MG	CHLORPHENIRAMINE (LEDERLE)
CHLORPHENIRAMINE SUST TABS/CAPS 12MG	CHLORPHENIRAMINE (LEDERLE)
CHLORPROMAZINE TABS 10MG	CHLOR-PZ (USV) CHLORPROMAZINE (LEDERLE)
CHLORPROMAZINE TABS 25MG	CHLOR-PZ (USV) CHLORPROMAZINE (LEDERLE) CHLORPROMAZINE (ABBOTT)
CHLORPROMAZINE TABS 50MG	CHLOR-PZ (USV) CHLORPROMAZINE (LEDERLE) CHLORPROMAZINE (ABBOTT)
CHLORPROMAZINE TABS 100MG	CHLOR-PZ (USV) CHLORPROMAZINE (LEDERLE) CHLORPROMAZINE (ABBOTT)
CHLORPROMAZINE TABS 200MG	CHLOR-PZ (USV) CHLORPROMAZINE (LEDERLE) CHLORPROMAZINE (ABBOTT)
DIPHENHYDRAMINE CAPS 25MG	DIPHENHYDRAMINE (LEDERLE)
DIPHENHYDRAMINE CAPS 50MG	DIPHENHYDRAMINE (LEDERLE)
DOXYCYCLINE CAPS 50MG	DOXY-II (USV)
DOXYCYCLINE CAPS 100MG	DOXY-II (USV)
DOXYCYCLINE ORAL SUSP 25MG/5CC	DOXY-II (USV)
ERYTHROMYCIN TABS/CAPS 250MG	PFIZER-E (PFIZER)
ERYTHROMYCIN TABS/CAPS 500MG	PFIZER-E (PFIZER)
ESTROGENS, CONJ TABS 0.625MG	ESTROGENS, CONJUGATED (LEDERLE)
ESTROGENS, CONJ TABS 1.25MG	ESTROGENS, CONJUGATED (LEDERLE)
ESTROGENS, ESTERIFIED TABS 0.625MG	SK-ESTROGENS (SKF)
ESTROGENS, ESTERIFIED TABS 1.25MG	SK-ESTROGENS (SKF)
ESTROGENS, ESTERIFIED TABS 2.5MG	SK-ESTROGENS (SKF)
HYDROCHLOROTHIAZIDE TABS 50MG	ORETIC (ABBOTT) THIURETIC (PARKE-DAVIS)
IMIPRAMINE TABS 10MG	IMIPRAMINE (LEDERLE) SK-PRAMINE (SKF)
IMIPRAMINE TABS 25MG	IMIPRAMINE (LEDERLE) SK-PRAMINE (SKF)
IMIPRAMINE TABS 50MG	IMIPRAMINE (LEDERLE) JANIMINE (ABBOTT) SK-PRAMINE (SKF)
MEPROBAMATE TABS 200MG	SK-BAMATE (SKF)
MEPROBOMATE TABS 400MG	SK-BAMATE (SKF) MEPROBAMATE (LEDERLE)

NEW JERSEY HEALTH
SERVICES PROGRAM

NEW JERSEY MEDICAID FORMULARY
SECTION II

11/10/75

DESIGNATED CHEMICAL EQUIVALENT
DOSAGE FORM AND STRENGTH

ACCEPTED ALTERNATE PRODUCT NAME
AND COMPANY

OXYTETRACYCLINE CAPS 250MG

OXLOPAR (PARKE-DAVIS)

PENICILLIN-G TABS 200,000U

PFIZERPEN (PFIZER)

PENICILLIN-G (WYETH)

PENICILLIN-G TABS 250,000U

PFIZERPEN (PFIZER)

PENICILLIN-G (WYETH)

PENICILLIN-G TABS 400,000U

PFIZERPEN (PFIZER)

PENICILLIN-G (WYETH)

PENICILLIN-G LIQ. 250MG 100CC

PFIZERPEN (PFIZER)

PENICILLIN-G LIQ. 250MG 200CC

PFIZERPEN (PFIZER)

PENICILLIN-V POT. TABS 125MG

COMPOCILLIN VK (ABBOTT-ROSS)

V CILLIN-K (LILLY)

PENICILLIN-V POT. TABS 250MG

PFIZERPEN VK (PFIZER)

QIDPEN K (MALLINCRODT)

SK-PENICILLIN VK (SKF)

PENICILLIN-V POT. TABS 500MG

PFIZERPEN VK (PFIZER)

PENICILLIN-V POT. LIQ. 125MG 100CC

PFIZERPEN VK (PFIZER)

QIDPEN VK (MALLINCRODT)

PENICILLIN-V POT. LIQ. 125MG 200CC

PFIZERPEN VK (PFIZER)

QIDPEN VK (MALLINCRODT)

PENICILLIN-V POT. LIQ. 250MG 100CC

PFIZERPEN VK (PFIZER)

QIDPEN VK (MALLINCRODT)

PENICILLIN-V POT. LIQ. 250MG 200CC

PFIZERPEN VK (PFIZER)

PROPOXYPHENE CAPS 65MG

SK-65 (SKF)

PROPOXYPHENE COMPD-65 CAPS

SK-65 COMPOUND (SKF)

SULFISOXAZOLE TABS

SK-SOXAZOLE (SKF)

SULFISOXAZOLE (LEDERLE)

TETRACYCLINE CAPS/TABS 250MG

ROBITET (ROBINS)

SK-TETRACYCLINE (SKF)

TETRACYN (ROERIG)

TETRECYCLINE (WYETH)

TETRACYCLINE CAPS/TABS 500MG

ROBITET (ROBINS)

SK-TETRACYCLINE (SKF)

TETRACYN (ROERIG)

TETRACYCLINE (WYETH)

TETRACYCLINE SUSP 125MG/5CC

PANMYCIN (UPJOHN)

ROBITET (ROBINS)

SK-TETRACYCLINE (SKF)



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

New Jersey Health Services Program NEWSLETTER

Volume 1-141

January 5, 1976

TO: NEPHROLOGISTS AT NEW JERSEY MEDICAID APPROVED FACILITIES

SUBJECT: INTENT OF NEW JERSEY MEDICAID CRD PROGRAM – STATEMENT OF AGREEMENT

The recently distributed Statement of Agreement for the Medicaid Chronic Renal Dialysis Program (CRD) stipulated that the participating physician "agree to bill" not more than \$160.00 per month etc.

It is the intent of the New Jersey Medicaid Program that physicians agree to accept not more than the amounts stipulated in that agreement. Therefore, physicians should disregard the word "bill" and continue charging their usual and customary fees.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-142

January 5, 1976

TO: INDEPENDENT LABORATORIES

SUBJECT: REVISED CHAPTER II OF THE INDEPENDENT LABORATORY MANUAL

On September 26, 1975, revised Chapter II of the Independent Laboratory Manual was sent to your laboratory. The revised Chapter incorporated a number of major changes in the New Jersey Medicaid program for independent laboratories.

Among these changes was Section 203.1 of Chapter II, which requires each laboratory to provide the New Jersey Medicaid program with a listing of tests and profiles actually performed on its premises (addresses to be identified) and a current price list, including discounts, with an update of said list as capabilities change.

You were requested to comply with this requirement by forwarding the above information to Mr. Thomas M. Russo, Chief, Medical Care Administration, Division of Medical Assistance and Health Services, 324 E. State Street, Trenton, New Jersey 08625.

As of this date, no response has been received from your laboratory and it is again requested that the aforementioned information on tests and profiles be forwarded immediately to Mr. Russo. This new requirement is a condition for continued participation of your laboratory for reimbursement under the Medicaid program.

Please disregard this Newsletter if you have already complied with the requirement outlined above and forwarded the requested information to the Division of Medical Assistance and Health Services.



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

New Jersey Health Services Program

NEWSLETTER

Volume 1 - 144

January 9, 1976

TO: ALL PODIATRISTS, CHIROPRACTORS AND PSYCHOLOGISTS

Due to the severe shortage of State funds for operation of the New Jersey Medicaid Program, the Division of Medical Assistance and Health Services has found it necessary to discontinue direct reimbursement to providers of certain services that the Federal Department of Health, Education and Welfare defines as optional.

Accordingly, we must advise you that direct payments to Podiatrists, Chiropractors and Psychologists will be discontinued for all services rendered in all settings to Medicaid eligibles on and after January 16, 1976 unless prior authorized on or before January 15, 1976. All such prior authorized services must be rendered by March 15, 1976 and claims for them must be submitted in accordance with standard billing procedures. This means that all prior authorizations are no longer valid after March 15, 1976.

All requests for prior authorizations received after January 15, 1976 will be declined by the Program.

This action is being taken due to insufficient State funds. Should sufficient funds be provided by the New Jersey Legislature, these services will be restored.



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 145

January 9, 1976

TO: ALL PROSTHETIC AND ORTHOTIC PROVIDERS

Due to the severe shortage of State funds for operation of the New Jersey Medicaid Program, the Division of Medical Assistance and Health Services has found it necessary to discontinue direct reimbursement to providers of certain services that the federal Department of Health, Education and Welfare defines as optional.

Accordingly, we must advise you that direct provider payments for all Orthotic devices, Shoes and Shoe Appliances (as described on pp 26-34 and 41-45 in the Prosthetic & Orthotics Manual)/and repairs provided on and after January 16, 1976 will be disallowed unless prior authorized by the LMAU on or before January 15, 1976 as evidenced by the Medicaid, Medical Consultant's signature and date in item number 11 on claim form MC-15. All such prior authorized items must be dispensed by March 15, 1976 and claims must be submitted in accordance with standard billing procedures.

All requests received after January 15, 1976 for prior authorization for orthotics, shoes and shoe appliances will be declined by the LMAUs.

The Medicaid Program will continue to reimburse approved Prosthetic and Orthotic providers for Prosthetics (as described in pp 35-40 in the Prosthetic & Orthotics Manual) in accordance with the rules and regulations described in the Prosthetic & Orthotics Manual. Questions may be referred to your LMAU. Revised manual pages will be issued in the near future.

This action is being taken due to insufficient state funds. Should sufficient funds be provided by the New Jersey Legislature, these services will be restored.



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 146

January 9, 1976

TO: HEARING AID DISPENSERS

Due to the severe shortage of State funds for operation of the New Jersey Medicaid Program, the Division of Medical Assistance and Health Services has found it necessary to discontinue direct reimbursement to providers of certain services that the federal Department of Health, Education and Welfare defines as optional.

Accordingly, we must advise you that direct provider payments for hearing aids, hearing aid repairs, and hearing aid accessories (including batteries) provided to Medicaid eligibles 21 and over on and after January 16, 1976 will be disallowed unless prior authorized by the LMAU on or before January 15, 1976. All such prior authorized items must be completed and dispensed by March 15, 1976 and claims must be submitted in accordance with standard billing procedures.

All requests for prior authorizations for eligibles 21 and over, received after January 15, 1976 will be declined by the LMAUs.

The Medicaid Program will continue to pay for these services provided to Medicaid eligibles under age 21 in accordance with the rules and regulations described in the Hearing Aid Manual.

Providers are urged to obtain verification of age from patients as claims for eligibles 21 and over will be declined for payment.

Questions may be referred to your LMAU.

Revised manual pages will be issued in the near future.

This action is being taken due to insufficient State funds. Should sufficient funds be provided by the New Jersey Legislature, these services will be restored.



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 147

January 9, 1976

TO: ALL OPHTHALMOLOGISTS, OPTOMETRISTS, OPTICIANS

Due to the severe shortage of State funds for the operation of the New Jersey Medicaid Program, the Division of Medical Assistance and Health Services has found it necessary to discontinue direct reimbursement to providers of certain services that the federal Department of Health, Education and Welfare defines as optional.

Commencing January 16, 1976, eye examinations, glasses, contact lenses, vision training and sub-normal vision devices will no longer be reimbursable by the Medicaid Program for Medicaid recipients 21 years of age and older.

- Exceptions:
1. Medical treatment provided by a physician for eye injuries and pathological conditions.
 2. Services and/or appliances prior authorized on or before January 15, 1976 will be reimbursable if services are completed and appliances dispensed before March 15, 1976. If prior authorized services continue beyond March 15, 1976, the Program will not reimburse for any service rendered on March 16 or later.
 3. Any appliance prescribed on or before January 15, 1976 must be dispensed before March 15, 1976 to be considered for payment.

All requests for prior authorization received after January 15, 1976 will be declined by the Program.

Providers are urged to obtain verification of age from patients as claims for eligibles 21 and over will be declined for payment.

Revised Manual Pages will be issued in the near future. This action is being taken due to insufficient state funds. Should sufficient funds be provided by the New Jersey Legislature, these services will be restored.



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

New Jersey Health Services Program NEWSLETTER

Volume ...1...148.....

January 9, 1976

TO: MEDICAL SUPPLY AND EQUIPMENT DEALERS

Due to a severe shortage of State funds for operation of the New Jersey Medicaid Program, the Division of Medical Assistance and Health Services has found it necessary to discontinue direct reimbursement to providers of certain services that the Federal Department of Health, Education and Welfare defines as optional.

Accordingly, we must advise you that direct provider payments for all medical supplies, equipment/and repairs as described in the Medical Supplier Manual, provided to Medicaid eligibles on and after January 16, 1976, will be disallowed unless the item(s) has been prior authorized by the LMAU on or before January 15, 1976, as evidenced by the Medicaid Medical Consultant's signature and date in item 12 on the MC-11 claim form. All such prior authorized items and supplies must be dispensed by March 15, 1976 and claims must be submitted in accordance with standard billing procedures. Prior authorized rentals which extend beyond March 15, 1976 will be honored for payment only through March 15, 1976. No additional payments will be made beyond that date.

All requests for prior authorizations received after January 15, 1976 will be declined by the LMAUs.

Questions may be referred to your LMAU.

This action is being taken due to insufficient State funds. Should sufficient funds be provided by the New Jersey Legislature, these services will be restored.



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

New Jersey Health Services Program

NEWSLETTER

Volume 1 - 150

January 9, 1976

TO: ALL INDEPENDENT CLINICS

Due to the severe shortage of State funds for the operation of the New Jersey Medicaid Program, the Division of Medical Assistance and Health Services has found it necessary to discontinue direct reimbursement to providers of certain services that the federal Department of Health, Education and Welfare defines as optional. Accordingly, we must advise you that direct provider payments for the following services provided to Medicaid eligibles on and after January 16, 1976 will be disallowed unless such service(s) has been prior authorized on or before January 15, 1976. All such prior authorized services must be completed (and dispensed) by March 15, 1976 and claims must be submitted in accordance with standard billing procedures.

All requests for prior authorization for these services received after January 15, 1976 will be declined by the Program.

– PODIATRIST AND CHIROPRACTOR SERVICES to Medicaid eligibles of all ages rendered in the independent clinic

– VISION CARE SERVICES (e.g., eye examinations, glasses, contact lenses, vision training and subnormal vision devices) performed by Ophthalmologists, Optometrists and Opticians in the independent clinic for Medicaid eligibles 21 years of age and older.

Exceptions: 1. Medical treatment provided by a physician for eye injuries and pathological conditions.
2. Any appliance prescribed on or before January 15, 1976 must be dispensed on or before March 15, 1976 to be considered for payment.

– DENTAL SERVICES provided to Medicaid eligibles 21 years of age and over in the independent clinic.

– REHABILITATION SERVICES (e.g., physical, speech, and occupational therapy) to Medicaid eligibles of all ages in the independent clinic.

– PSYCHOLOGIST SERVICES to Medicaid eligibles of all ages in the independent clinic

PLEASE ADJUST YOUR BILLING RATES in accordance with the above deletions when submitting claims for services that continue to be reimbursable, a description of the services provided by the Clinic must be indicated under item 11 on claim form MC-14.

Where services as indicated above will continue to be available to Medicaid eligibles 21 and over we urge all providers to obtain verification of age from patients as claims for persons 21 and over will be declined for payment.

Revised Manual Pages will be issued in the near future.

These actions are being taken due to insufficient State funds. Should sufficient funds be provided by the New Jersey Legislature, these services will be restored.



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 151

January 9, 1976

TO: ALL DENTISTS

SUBJECT: TERMINATION OF DENTAL SERVICES FOR THOSE TWENTY-ONE (21) YEARS AND OLDER

Due to the severe shortage of State funds for operation of the New Jersey Medicaid Program, the Division of Medical Assistance and Health Services has found it necessary to discontinue direct reimbursement to providers of certain services that the Federal Department of Health, Education and Welfare defines as optional.

Accordingly, we must advise you that direct provider payments for dental services provided to Medicaid eligibles age twenty-one (21) and over on or after January 16, 1976, will be disallowed. Those dental services requiring and receiving prior authorization on or before January 15, 1976, may be continued, but must be completed by March 15, 1976, with claims submitted in accordance with standard billing procedures.

All requests for prior authorization for eligibles age twenty-one (21) and over, received after January 15, 1976 will be declined.

The Medicaid Program will continue to pay for those services provided to Medicaid eligibles under age twenty-one (21) in accordance with previously established rules and regulations.

Providers are urged to obtain verification of age from patients, as claims for reimbursement for eligibles age twenty-one (21) and over will be declined for payment.

Questions may be referred to your Regional Dental Consultant.

Revised Manual pages will be issued in the near future.

This action is being taken due to insufficient State funds. Should sufficient funds be provided by the New Jersey Legislature, these services will be restored.



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

New Jersey Health Services Program

NEWSLETTER

Volume 1 - 152

January 9, 1976

TO: GROUP PROVIDERS

SUBJECT: ELIMINATION OF PAYMENT FOR CERTAIN MEDICAID SERVICES

Due to the severe shortage of State Funds for operation of the New Jersey Medicaid Program, the Division of Medical Assistance and Health Services has found it necessary to discontinue direct reimbursement to providers of certain services.

Accordingly, Medicaid reimbursement for the services listed below rendered on or after January 16, 1976, will cease, unless the services were authorized on or before January 15, 1976. All such prior authorized services must be completed by March 15, 1976, and claims for them must be submitted in accordance with standard billing procedures. If any prior authorized services extend beyond March 15, 1976, the Medicaid Program will not reimburse for any service rendered on and after March 16, 1976. All requests for Prior Authorizations received after January 15, 1976, will be declined by the Program.

List of Ineligible Services:

1. All services rendered by Podiatrists, Chiropractors, and Psychologists in all settings.
2. All Orthotic devices, shoes and shoe appliances and repairs.
3. All medical supplies, equipment and repairs.
4. Rehabilitation services; e.g., physical, speech, and occupational therapy in Hospital and Special Hospital Outpatient Departments and in Independent Clinics for all ages.
5. All hearing aids, hearing aid repairs, and hearing aid accessories (including batteries) provided to Medicaid eligibles ages 21 and over.
6. Eye examinations, glasses, contact lenses, vision training, and subnormal vision devices provided to Medicaid eligibles ages 21 and over in all settings. (Exceptions: Medical treatment provided by a physician for eye injuries and pathological conditions is reimbursable. Any appliance prescribed on or before January 15, 1976, must be dispensed before March 15, 1976.)
7. All dental services provided to Medicaid eligibles ages 21 and over in all settings.

Providers of dentistry, vision care services, and hearing aids, as described above, are urged to obtain verification of age from patients as claims for eligibles age 21 and over will be declined for payment. Questions may be referred to your Local Medical Assistance Unit.

This action is being taken due to insufficient State Funds. Should sufficient funds be provided by the New Jersey Legislature, these services will be restored.



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

New Jersey Health Services Program

NEWSLETTER

Volume1-157.....

February 9, 1976

TO: ALL PROVIDERS (EXCEPT HOSPITALS)

SUBJECT: A REMINDER: MEDICAID AND THE NEW JERSEY "NO FAULT" LAW – UNSATISFIED CLAIM AND JUDGMENT FUND

It has come to our attention through submittal of claims to Medicaid that a reminder is needed regarding services rendered to victims of auto accidents involving uninsured or hit-run drivers. Please be advised that a Medicaid recipient who is:

- 1) THE VICTIM OF A HIT-RUN ACCIDENT
or
- 2) A PASSENGER IN AN UNINSURED VEHICLE
and
- 3) DOES NOT OWN OR BELONG TO A FAMILY
UNIT THAT OWNS A MOTOR VEHICLE

may be entitled to have payment made on his/her behalf from the Unsatisfied Claim and Judgment Fund (UCJF). The UCJF makes payment based on reasonable charges and within the same time frame as insurance companies making Personal Injury Protection (PIP) Payments. The injured party or his representative must file a "Notice of Intention to Make Claim" within ninety (90) days from the date of the accident. The appropriate forms as well as pamphlets explaining the "Fund" may be obtained by writing to:

Unsatisfied Claim & Judgment Fund
137 East State Street
Trenton, New Jersey 08666

Of course, the New Jersey Medicaid Program will consider payment of claims for injuries received from hit-run accidents or an accident with an uninsured motorist only when documentation regarding denial of benefits from the Unsatisfied Claim and Judgment Fund is attached to your Medicaid Claim Form. This procedure is identified in Chapter I of your Provider Manual, Sections 108, item 6, and 110, wherein, New Jersey Medicaid recipients are not entitled to have payment for health services made on their behalf unless all other sources of payment have been exhausted.

Should you or your staff have any questions regarding the above, please telephone your contractor at (201) 621-6960 or (609) 825-8700.



New Jersey Health Services Program NEWSLETTER

Volume 1 - 159

February 9, 1976

TO: INDEPENDENT CLINICS

SUBJECT: EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)
SUBSYSTEM REVISIONS – UPDATE AND CLARIFICATION OF VOL. 1 - 114

The Division of Medical Assistance and Health Services, in efforts to improve the EPSDT Subsystem, has modified the EPSDT Referral Report form (MC-19) from a two-part (Social Services and Provider Copies) to a three-part form, which includes one Social Services copy and two Contractor's copies. This revised form also contains some minor changes which include space in Section 4 for inclusion of a description of the Body System under "Other Problem (5)".

For those providers who have a supply on hand of the two-part form, continue using the form until your supply is depleted. In using the two-part form, you must attach both copies to your billing claim form MC-14 C1. The three-part forms may be ordered through Prudential Insurance Company when needed.

GENERAL INSTRUCTIONS

1. The MC-19 must accompany the MC-14 C1 claim form for the EPSDT examination only. It is not required for follow-up visits for further diagnosis or treatment. The MC-19 may not be submitted more than once per year per patient, as the EPSDT examination is not reimbursable more than one time each year.
2. If more than one clinic visit is needed to complete the EPSDT examination, list each date of service on the MC-14 C1 and attach to the MC-19 when billing. Only one payment will be made regardless of the number of visits.
3. Any subsequent or follow-up treatment provided to the EPSDT patient after the EPSDT examination has been provided and billed should be billed in the usual manner. Once an MC-19 is submitted, there is no need to use this form again for additional services. However, you should indicate "EPSDT Follow-up," and the appropriate diagnosis in Item 11 of the MC-14 C1 claim form.
4. The MC-19 may be generated either by the clinic or by a County Welfare Board or DYFS caseworker.
 - If the MC-19 is clinic-generated and screening is initiated by the clinic, only Sections 1 and 4 have to be completed.
 - If the MC-19 is brought to the clinic by the EPSDT patient on referral by a County Welfare Board or DYFS caseworker, Sections 1 and 3 will have already been completed; therefore, the clinic provider completes only Section 4.
5. When the EPSDT service is clinic-generated, the two Contractor's copies of the completed MC-19 must be attached to the MC-14 C1 when billing. The Social Service copy may be retained or destroyed at the option of the provider.

NOTE: Medicaid providers approved to offer EPSDT or capable of rendering the necessary services may initiate screening examinations without formal requirements involving verification that a child has not been previously screened, although this does not preclude inquiry of the County Welfare Board or the family regarding previous medical examinations or screening.

For further information, please call Prudential Insurance Company at (201) 621-6960 or (609) 825-8700.



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

New Jersey Health Services Program NEWSLETTER

Volume1-161.....

February 17, 1976

TO: MEDICAL SUPPLY AND EQUIPMENT DEALERS

Until further notice, the life sustaining medical supply and equipment items listed below will continue to be reimbursable under the New Jersey Medicaid Program. Prior authorization requests for rental or purchase of these items will be approved based on the medical need of the individual patient, and authorized claims will be honored for payment if all other Program regulations, such as eligibility, have been complied with. This change applies to cases that had been authorized before January 16, 1976, and for new requests for authorization.

The January 16, 1976 cutoff as outlined in Newsletter No. 1 - 148, will not apply to:

Oxygen and other Compressed Gases

IPPB Machines

Oxygen Masks

Respirators

Oxygen Regulators

Suction Machines

Oxygen Cannulas

Catheters for Suction Machines

Questions may be referred to the Local Medical Assistance Unit.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-162

March 15, 1976

TO: ALL DENTISTS, OPHTHALMOLOGISTS, OPTOMETRISTS, OPTICIANS, PODIATRISTS, CHIROPRACTORS, PSYCHOLOGISTS, GROUP PROVIDERS, INDEPENDENT CLINICS, MEDICAL SUPPLY AND EQUIPMENT DEALERS, HEARING AID DISPENSERS, PROSTHETIC AND ORTHOTIC PROVIDERS

SUBJECT: RESTORATION OF PAYMENT FOR CERTAIN MEDICAID SERVICES

The New Jersey Legislature enacted, and Governor Byrne signed on March 8, 1976 an emergency supplemental appropriation enabling the Program to restore through June 30, 1976, certain reductions which Medicaid was forced to make.

Effective March 8, 1976, **MEDICAID SERVICES ARE REIMBURSABLE TO THE SAME EXTENT AS THEY WERE IMMEDIATELY PRIOR TO JANUARY 16, 1976.**

From January 16, 1976 through March 7, 1976, Medicaid services are reimbursable only if they required prior authorization and such authorization was granted on or before January 15, 1976, as stated in your respective Newsletters. This is because the restoration is not retroactive.

REFERENCE

Please refer to the following Newsletter dated January 9, 1976, which announced the Medicaid reductions to your speciality:

Dentists - Newsletter 1-151

Ophthalmologists, Optometrists, Opticians - Newsletter 1-147

Podiatrists, Chiropractors, Psychologists - Newsletter 1-144

Group Providers - Newsletter 1-152

Independent Clinics - Newsletter 1-150

Medical Supply and Equipment Dealers - Newsletters 1-148 and 1-161

Hearing Aid Dispensers - Newsletter 1-146

Prosthetic and Orthotic Providers - Newsletter 1-145



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 164

March 24, 1976

TO: ALL PHYSICIANS

SUBJECT: EMERGENCY MEDICAID REIMBURSEMENT FOR POLIO, MEASLES AND RUBELLA VACCINES.

PLEASE READ CAREFULLY!!

This is an important announcement regarding Medicaid reimbursement for Trivalent Oral Poliomyelitis Vaccine, Measles Vaccine, Rubella Vaccine, and combination Measles and Rubella Vaccine.

Since these vaccines are not currently available from the Department of Health, the New Jersey Medicaid Program, in the interest of providing quality health care has instituted the following program changes. For reference purposes, please see Newsletter Volume 1-123 which was issued on August 1, 1975 and Section 220 G 4 on page 25 of the Medicaid Physician's Manual:

1. **EFFECTIVE March 26, 1976 and until further notice (FOR REIMBURSEMENT PURPOSES ONLY)** Trivalent Oral Poliomyelitis Vaccine shall be considered to be an injectable (only when not available from the Department of Health or other agencies) reimbursable to the physician at a fee as for procedure code 9072 which covers both the service and the cost of the vaccine. Procedure code 9072 shall be used on the claim form when billing.
2. **EFFECTIVE March 26, 1976, and through June 30, 1976 only, Measles, Rubella, and combination Measles and Rubella Vaccine will be a recoverable pharmaceutical item to the physician if not available from the Department of Health or other agencies.**

Recovery will be made through a written prescription, with the recipient's name, address and HSP number, submitted to an approved provider pharmacy and which contains a prior authorization number obtained from the Local Medical Assistance Unit (LMAU).

Reimbursement to the physician will be a flat fee of \$2.50 subject to the 10 per cent reduction effective August 1, 1975.

Billing form MC-8 should show procedure code 9072 (injection) with the code, name, dose, and route of administration entered in Section 12.D and the term "immunization" inserted instead of "diagnosis" in Section 12.C.

Measles, Rubella, and combination Measles and Rubella Vaccine will not be a recoverable item after June 30, 1976 and regulations as noted under procedure code 9072 will then again prevail.

Please refer questions to the Medical Consultant in the Local Medicaid Office or to the Prudential Insurance Company.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-165

May 24, 1976

TO: HOSPITAL ADMINISTRATORS AND PRACTITIONERS

SUBJECT: HOSPITAL CLAIMS REVIEW - FAIR HEARING (THIS NEWSLETTER SUPERCEDES NEWSLETTER VOLUME 1-45 DATED MAY 1, 1972).

The time limit for requesting a Fair Hearing by a Hospital as the result of a claim denial has been reduced from 90 days to 20 days from the date of the letter of denial. The Hospital Claims Review and Fair Hearing procedures are:

HOSPITAL CLAIMS REVIEW

The Hospital Service Plan of New Jersey and the Prudential Insurance Company, Contractors for the New Jersey Health Services Program, are required to perform a detailed medical review of inpatient and outpatient hospital claims to assure reimbursement only for services and/or hospital stays judged to fall within the parameters of Sections 202 and 206 of the Hospital Manual. All hospitals should review both of these sections carefully.

If following an initial "medical review" of the Inpatient or Outpatient Claim, all or any portion of the services rendered appear to be non-covered as defined in Section 202 and/or 206 of the Hospital Manual, the Contractor will notify the hospital in writing of this fact and request that specific information to fully evaluate the claim be forwarded within 28 days * from the date of written notification. If the information is not received by the Contractor within the specified time, the case will be declined, in whole or in part, in accordance with the initial medical review.

*NOTE: The previous 21 day time requirement for submitting additional specific information on a declined claim has been extended from 21 days from the date of written notification to 28 days.

At this time, the hospital must provide all documentation necessary to support their claim. If after review of this additional information, the Contractor, with appropriate medical counsel, determines that all or any portion of the claim is not for covered services, payment will be reduced or denied.

Whenever all or any portion of the hospital claim is denied for payment, the attending physician's claim for services rendered during the corresponding period will also be denied for payment.

There will be no additional opportunity for the hospital to request a re-review after claim denial. (See Fair Hearing)

Program regulations prohibit the provider from billing the patient for any portion of the claim that has been denied.

(con'd)

FAIR HEARING

If a hospital or practitioner disagrees with the Contractor's determination to deny all or any portion of a claim, a Fair Hearing may be requested as outlined in Chapter I, Section 112.

In order to request a Fair Hearing as the result of a claim denial, the Hospital or Practitioner must indicate the reason for requesting the hearing in writing within 20 days from the date of the letter of denial, to:

**Division of Medical Assistance and Health Services
Fair Hearing Section
P.O. Box 2486
Trenton, New Jersey 08625**



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 167

June 28, 1976

TO: ALL PHYSICIANS

SUBJECT: A. MEDICAID TO PAY FOR CHILDHOOD IMMUNIZATIONS

B. IMMUNIZATIONS NOW SEGREGATED FROM NEW JERSEY MEDICAID POLICY ON INJECTIONS

To make certain that every Medicaid eligible child in the State of New Jersey receives his/her full complement of childhood immunizations without undue difficulty, the New Jersey Medicaid Program has altered its injection policy for physicians to expedite this goal. Under the new policy, Medicaid will pay the physician who will assume the cost of the vaccine.

Effective July 1, 1976 the following childhood immunizations will have individual procedure code numbers with individual fees which have been based on the cost of the vaccine plus a service charge. The fee is all inclusive for the cost of the vaccine and cost of its administration. NO PRIOR AUTHORIZATION IS REQUIRED.

The new procedure codes and fees effective July 1, 1976 are listed below:

<u>Procedure Codes</u>	<u>Maximum Fee</u>
9450 -- (Immunization - Measles)	\$4.50
9451 -- (Immunization - Rubella)	4.50
9452 -- (Immunization - Mumps)	5.20
9453 -- (Immunization - Measles and Rubella combined vaccine)	6.85
9454 -- (Immunization - Measles, Mumps, Rubella combined vaccine)	9.60
9455 -- (Immunization - Diptheria, Pertussis, Tetanus combined vaccine)	2.50
9456 -- (Immunization - Diptheria, Tetanus Toxoid combined vaccine)	2.50
9457 -- (Immunization - Diptheria Toxoid)	2.50
9458 -- (Immunization - Pertussis vaccine)	2.50
9459 -- (Immunization - Tetanus Toxoid)	2.50
9460 -- (Immunization - Oral polio vaccine)	2.50

Accordingly, the Medicaid Injection Policy (Procedure Code 9072) as published previously in Newsletter 1-123 to All Physicians is amended to exclude all references to immunization including Measles, Mumps, Rubella (combined vaccines MMR) which is now reimbursable under Code 9454 without a prior authorization. In addition, the restriction limiting one injection per visit (non-immunization) has been removed from Procedure Code 9072, although the other guidelines remain.

BILLING PROCEDURES

When billing for childhood immunizations insert the above appropriate procedure code in line 12D. of the Physicians' and Practitioners' Claim Form (MC-8) followed by the narrative "Childhood Immunization" and the generic name of the vaccine. Place your usual and customary fee for this service in box 12F. of the same form.

(continued)

FOR YOUR INFORMATION

Physicians should be advised that a totally revised up to date edition of Chapters II and IV of the Physicians Manual, with fee schedule for the non-surgical procedures, will be issued in August, 1976.

If you have any questions regarding this newsletter, your questions should be directed to the Local Medical Consultant located in the Local Medical Assistance Office in your area.



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 167

June 28, 1976

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Effective July 1, 1976 the following childhood immunizations will have individual procedure code numbers with individual fees which have been based on the cost of the vaccine plus a service charge. The fee is all inclusive for the cost of the vaccine and cost of its administration. NO PRIOR AUTHORIZATION IS REQUIRED.

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9456 -- (Immunization - Diptheria, Tetanus Toxoid combined vaccine)	2.50
9457 -- (Immunization - Diptheria Toxoid)	2.50
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9459 -- (Immunization - Tetanus Toxoid)	2.50
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BILLING PROCEDURES

When billing for childhood immunizations insert the above appropriate procedure code in line 12D. of the Physicians' and Practitioners' Claim Form (MC-8) followed by the narrative "Childhood Immunization" and the generic name of the vaccine. Place your usual and customary fee for this service in box 12F. of the same form.

(continued)

Vol. 1 - 167 (continued)

FOR YOUR INFORMATION

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If you have any questions regarding this newsletter, your questions should be directed to the Local Medical Consultant located in the Local Medical Assistance Office in your area.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-168

June 28, 1976

TO: MEDICAL SUPPLY & EQUIPMENT DEALERS

SUBJECT: CHANGE IN REIMBURSEMENT PROCEDURE FOR PAYMENT OF OXYGEN IN LONG TERM CARE FACILITIES

Effective July 1, 1976, Medical Supply and Equipment providers of oxygen supplied to Medicaid recipients in Long Term Care Facilities will be reimbursed directly by the Long Term Care Facility for oxygen supplies. The New Jersey Medicaid Program will no longer reimburse medical supply & equipment dealers for oxygen.

Please adjust your billing procedures accordingly.

You will continue to be reimbursed for oxygen supplied to patients in Long Term Care Facilities prior to July 1, 1976.



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 169

July 1, 1976

TO: ALL MEDICAID PROVIDERS

SUBJECT: MEDICAID SERVICES PROVIDED AFTER JUNE 30, 1976

The New Jersey Legislature enacted, and Governor Byrne signed on June 30, 1976 the Budget Appropriation Bill for the Fiscal Year beginning July 1, 1976.

The funds appropriated to the New Jersey Medicaid Program under the new budget should be sufficient to cover services to the same extent as they are covered on June 30, 1976. Accordingly, there will be no reduction in Medicaid covered services as of July 1, 1976.

NOTE To Hospitals and Special Hospitals

A special Newsletter will be sent to you under separate cover explaining the action to be taken as the result of the District Court decision (New Jersey Hospital Association et. al. Vs. Ann Klein and Richard Leone) on inpatient reimbursement rates.



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 172

October 21, 1976

TO: ALL PROVIDERS

SUBJECT: "SWINE FLU" IMMUNIZATION

As a national public health effort and in an endeavor to protect the population of the State of New Jersey against a potential flu epidemic, the Medical Society of New Jersey and the New Jersey Association of Osteopathic Physicians and Surgeons have endorsed the following position as it relates to swine flu immunization and the New Jersey Medicaid Program.

In view of the federal prohibition against Medicaid reimbursement for those resources available free of charge to the public, the New Jersey Medicaid Program will not reimburse any provider for services related to the administration of either mono or bivalent swine flu vaccine given under this national public health effort.

Your cooperation is appreciated.



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 173

January 19, 1977

TO: ALL PHYSICIANS AND INDEPENDENT CLINICS

SUBJECT: IMPROVED EARLY PERIODIC SCREENING DIAGNOSIS TREATMENT (EPSDT)
REFERRAL REPORT (MC-19) - ILLUSTRATED

The New Jersey Medicaid Program MC-19 EPSDT Referral Report Form (illustrated and attached) has been revised to simplify completion for you.

Effective January 17, 1977 supplies of the revised form will be available from The Prudential Insurance Company. Please destroy the old MC-19 Form (Rev. 4/75).

HIGHLIGHTS OF IMPROVED MC-19

- A. Note Section Four (4) "PROBLEM AREA", the chart includes a column for reporting NEWLY DETECTED OR SUSPECTED DEFECT. If there are no New problems, reporting is completed, simply by an "X" in the NO - space located above the detailed chart for PROBLEM AREA reporting.
- B. Again, under the PROBLEM AREA chart in the "REFERRED FOR TREATMENT AND/OR DIAGNOSIS-REFERRAL SOURCE, IF KNOWN"; please print or type name and address to whom patient was referred. Do not list laboratory as a referral.

A full definition of the EPSDT package is shown on the reverse side of the illustrated sample revised MC-19.

NOTE: Physicians must review laboratory results before billing.

(SEE REVERSE SIDE)

REMINDER

Basics of EPSDT Screening/Reporting and Billing

1. Completed MC-19 Form (two contactor copies) must accompany the MC-8 Physicians and Practitioners Billing Claim Form when billing for EPSDT Examination (9580).
2. Please submit EPSDT billing as soon as possible, preferably within 30 days. This will facilitate feedback to social service workers who assist the patient in getting needed diagnosis(es) and treatment services.
3. Please arrange, where necessary, for referrals to other providers for necessary further diagnosis and treatment within at least 60 days of your examination.
4. You may perform a screening examination and be reimbursed for your Medicaid patients who are not referred by case workers if the patient needs such an examination, but not more than once in any 12 month period. Eligible individuals between the age of 16 and 21 should receive the EPSDT package once a year during those years.



CWB _____

FIELD OFFICE # _____

SOCIAL WORKER # _____

EPSDT REFERRAL REPORT

1. PATIENT'S NAME AND ADDRESS (if known) _____ SEX _____ AGE _____ MEDICAID NUMBER AND PERSON NUMBER _____

FULL CASE NAME: Last First MI

2. TO BE COMPLETED BY SOCIAL WORKER

If, following contact, the client does not wish to be screened, or is ineligible, please check the appropriate block and return immediately to THE PRUDENTIAL INSURANCE COMPANY, P.O. BOX 1900, MILLVILLE, NEW JERSEY 08302.

DOES NOT CURRENTLY RECEIVING CARE FROM:

Not Medicaid Eligible (A) _____ Well Child Conference (G) _____

Not Able to be Contacted (B) _____ Neighborhood Health Center (H) _____

SCREENING Refused (C) _____ Head Start (I) _____

School (J) _____

(If available) Parent/Parent-Person Signature _____ Other _____ (L)

Social Worker Signature _____ Date _____ Physician _____ (M)

If physician, Print Name and Address _____

3. TO BE COMPLETED BY SOCIAL WORKER ONLY IF NUMBER 2 DOES NOT APPLY

The above-named parent (parent-person) has been interviewed and has agreed to obtain services for the listed patient. Medical screening of this recipient is approved provided that this form is presented to a Medicaid participating New Jersey Physician, Approved Independent Clinic, Approved Well Child Center, or participating Hospital Outpatient Department, along with a Medicaid identification card valid at time the service is to be rendered.

PHYSICIAN'S

Social Worker Signature and Title _____ Date Issued _____

County Welfare Board-Agency _____ Parent/Parent-Person Signature _____

NOTE: once every 12 mos

4. TO BE COMPLETED BY SCREENING PROVIDER AND FORWARDED WITH CLAIM FOR PAYMENT TO YOUR MEDICAID CONTRACTOR. Send two Contractor's Copies with your claim. You may not screen this patient more than once a year; follow-up services to this patient are billed according to established billing procedures. If the patient is referred to another provider, please print (or type) the provider's name and community, if known, in the last column below; otherwise indicate the referral with an "X."

Any New Problems Detected or Suspected? (0) [] YES NO [] If "NO," leave columns below blank. If "YES," place an "X" in appropriate column(s) below.

PROBLEM AREA	NEWLY DETECTED OR SUSPECTED DEFECT	TREATED BY ME (THIS FACILITY)	NO REFERRAL OR TREATMENT NEEDED	REFERRED FOR TREATMENT AND/OR DIAGNOSIS - REFERRAL SOURCE, IF KNOWN
Visual (1)				
Hearing (2)				
Dental (3)				
Lead Poisoning (4)				
Other Problem (5)				

CHECK ONLY IF CONDITION NOT PREVIOUSLY KNOWN

PRINT OR TYPE NAME AND ADDRESS TO WHOM PT. WAS REFERRED. DO NOT LIST LABORATORY REFERRALS.

I CERTIFY THAT THE ABOVE-NAMED PATIENT HAS BEEN EXAMINED IN ACCORDANCE WITH NEW JERSEY MEDICAID PROGRAM PROCEDURES AND STANDARDS FOR EARLY AND PERIODIC SCREENING. DIAGNOSIS AND TREATMENT, AND WHEN MEDICALLY INDICATED WAS TREATED BY ME (THIS FACILITY) OR REFERRED TO AN APPROPRIATE PRACTITIONER OR FACILITY FOR FURTHER DIAGNOSIS AND/OR TREATMENT, AS INDICATED ABOVE.

BEFORE SIGNING, SEE THE BACK OF THIS FORM FOR THE COLLECTIVE PROCEDURES THAT CONSTITUTE AN EPSDT SCREENING EXAMINATION.

PRINT OR TYPE: Provider Name and Address

Provider Signature

Date of Service

Social Security Number or Employer ID Number

CONTRACTOR'S COPY

DEFINITION OF EPSDT

Complete initial or interval history
Measurements (properly recorded), height and weight, head circumference to age 25 months
Physical and mental development assessment
Complete physical examination including dental, vision and hearing screening and blood pressure determination from age 5 up by physician or nurse practitioner under direct supervision of a physician.
Assessment of immunization status and initiation of steps to update immunizations.
Referral of all correctable abnormalities uncovered or suspected for further diagnosis and treatment.

The following laboratory procedures may be performed if medically indicated:

Hemaglobin or Hematocrit
Urinalysis (no less than four test dipstick)
Tuberculin
Sickle-cell Test
OVA and parasites
Lead Screening for specimen to be sent to State Department of Health Laboratory for lead screening
Other Laboratory tests as medically indicated.

Laboratory procedures performed by a physician for his patients in his office are reimbursable to the physician; if performed by outside independent laboratories, the laboratory must bill. The Medicaid Program does not reimburse for dipstick test; however, microscopic tests are reimbursable.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

NEW JERSEY HEALTH SERVICES PROGRAM

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

March 14, 1977

TO: ALL PHYSICIANS

SUBJECT: RESCISSION OF NEWSLETTER 1-173

Newsletter Volume 1-173 dated January 19, 1977 concerning the Improved Early Periodic Screening, Diagnosis and Treatment (EPSDT) Referral Report (MC-19) - Illustrated is hereby rescinded.

Attached Newsletter Volume 1-180 dated March 14, 1977 replaces Volume 1-173.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

NEW JERSEY HEALTH SERVICES PROGRAM

Governmental Health Programs Department, P.O. Box 5000, Millville, N. J. 08332

March 14, 1977

TO: INDEPENDENT CLINICS

SUBJECT: RESCISSION OF NEWSLETTER 1-173

Newsletter Volume 1-173 dated January 19, 1977 concerning the Improved Early Periodic Screening Diagnosis and Treatment (EPSDT) Referral Report (MC-19) - Illustrated is hereby rescinded.

Attached Newsletter Volume 1-181 dated March 14, 1977 replaces Volume 1-173.



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 174

January 19, 1977

TO: HOSPITAL ADMINISTRATORS
ATTENTION: DIRECTOR OF THE PEDIATRIC CLINIC

SUBJECT: IMPROVED EARLY PERIODIC SCREENING DIAGNOSIS TREATMENT (EPSDT)
REFERRAL REPORT (MC-19) - ILLUSTRATED

The New Jersey Medicaid Program MC-19 EPSDT Referral Report Form (illustrated and attached) has been revised to simplify completion for you.

Effective January 17, 1977 supplies of the revised form will be available from The Prudential Insurance Company. Please destroy the old MC-19 Form (Rev. 4/75).

HIGHLIGHTS OF IMPROVED MC-19

- A. Note Section Four (4) "PROBLEM AREA", the chart includes a column for reporting NEWLY DETECTED OR SUSPECTED DEFECT. If there are no New problems, reporting is completed, simply by an "X" in the NO - space located above the detailed chart for PROBLEM AREA reporting.
- B. Again, under the PROBLEM AREA chart in the "REFERRED FOR TREATMENT AND/OR DIAGNOSIS-REFERRAL SOURCE, IF KNOWN"; please print or type name and address to whom patient was referred. Do not list laboratory as a referral.

A full definition of the EPSDT package is shown on the reverse side of the illustrated sample revised MC-19.

NOTE: Physicians must review laboratory results before billing.

(SEE REVERSE SIDE)

REMINDER

Basics of EPSDT Screening/Reporting and Billing

1. Completed MC-19 Form (two contactor copies) must accompany the MC-8 Physicians and Practitioners Billing Claim Form when billing for EPSDT Examination (9580).
2. Please submit EPSDT billing as soon as possible, preferably within 30 days. This will facilitate feedback to social service workers who assist the patient in getting needed diagnosis(es) and treatment services.
3. Please arrange, where necessary, for referrals to other providers for necessary further diagnosis and treatment within at least 60 days of your examination.
4. You may perform a screening examination and be reimbursed for your Medicaid patients who are not referred by case workers if the patient needs such an examination, but not more than once in any 12 month period. Eligible individuals between the age of 16 and 21 should receive the EPSDT package once a year during those years.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

NEW JERSEY HEALTH SERVICES PROGRAM

Governmental Health Programs Department, P.O. Box 5000, Millville, N. J. 08332

March 14, 1977

TO: HOSPITAL ADMINISTRATORS
ATTENTION: DIRECTOR OF PEDIATRIC CLINIC

SUBJECT: RESCISSION OF NEWSLETTER 1-174

Newsletter Volume 1-174 dated January 19, 1977 concerning the IMPROVED EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) REFERRAL REPORT (MC-19) - ILLUSTRATED is hereby rescinded.

Attached Newsletter Volume 1-182 dated March 14, 1977 replaces Volume 1-174.



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

PREPARED BY PRUDENTIAL

New Jersey Health Services Program NEWSLETTER

Volume 1 - 176

January 31, 1977

TO: ALL PHYSICIANS, DENTISTS, PODIATRISTS

SUBJECT: CHANGES TO THE NEW JERSEY MEDICAID FORMULARY

Attached is a revision to Section II of the New Jersey Medicaid Formulary. Please remove and destroy Page II - 1 dated 11/10/75 and insert the new revision.

As you know, the New Jersey Medicaid Formulary became effective on November 10, 1975 and was the result of considerable research by our staff and the New Jersey Medicaid Formulary Committee.

As we indicated to you in the first edition of the New Jersey Medicaid Formulary, outlined in Volume 1-139 dated November 1, 1975, changes made in the Formulary based on suggestions made by the committee members would be updated from time to time. The attached is the first revision resulting from the work of the committee.

As a reminder when prescribing the trade name multi-source drug product listed in Section I of the Formulary, for which a designated chemically equivalent product is listed in Section II of the Formulary, the prescriber must indicate either "Formulary Alternate Permitted" or "Dispense as Written" (may be abbreviated "FAP" or "DAW"), on each written or telephoned prescription.

For patients in long term care facilities, either statement or its abbreviation must appear on the patient's chart and be transposed onto the written prescription.

When the prescriber indicates "Formulary Alternate Permitted" or "FAP", the pharmacy provider shall dispense a designated chemically equivalent product, if such alternate is listed in Section II of the Formulary; when the prescriber indicates "Dispense as Written" or "DAW", the pharmacy provider shall follow those instructions.

Your cooperation in indicating "FAP" on all of your prescriptions will be appreciated and will enable this cost savings program to be effective.

Effective February 1, 1977 Ampicillin products manufactured by Purepack Pharmaceutical Company, have been approved for inclusion in Section II of the New Jersey Medicaid Formulary. Pen-A-Products, manufactured by Pfizer Pharmaceuticals, will continue to be an accepted formulary alternate product until further notice.

Revised manual pages will continue to be distributed from time to time.

NEW JERSEY HEALTH
SERVICES PROGRAM

NEW JERSEY MEDICAID FORMULARY
SECTION II

2/1/77

<u>DESIGNATED CHEMICAL EQUIVALENT DOSAGE FORM AND STRENGTH</u>	<u>ACCEPTED ALTERNATE PRODUCT NAME AND COMPANY</u>
AMPICILLIN, CAPS 250MG	PEN-A (PFIZER) - (Purepac)
AMPICILLIN, CAPS 500MG	PEN-A (PFIZER) - (Purepac)
AMPICILLIN, SUSP 125MG 100CC	PEN-A (PFIZER) - (Purepac)
AMPICILLIN, SUSP 125MG 200CC	PEN-A (PFIZER) - (Purepac)
AMPICILLIN, SUSP 250MG 100CC	PEN-A (PFIZER) - (Purepac)
AMPICILLIN, SUSP 250MG 200CC	PEN-A (PFIZER) - (Purepac)
CHLORPHENIRAMINE SUST TABS/CAPS 8MG	CHLORPHENIRAMINE (LEDERLE)
CHLORPHENIRAMINE SUST TABS/CAPS 12MG	CHLORPHENIRMAINE (LEDERLE)
CHLORPROMAZINE TABS 10MG	CHLOR-PZ (USV) CHLORPROMAZINE (LEDERLE)
CHLORPROMAZINE TABS 25MG	CHLOR-PZ (USV) CHLORPROMAZINE (LEDERLE) CHLORPROMAZINE (ABBOTT)
CHLORPROMAZINE TABS 50MG	CHLOR-PZ (USV) CHLORPROMAZINE (LEDERLE) CHLORPROMAZINE (ABBOTT)
CHLORPROMAZINE TABS 100MG	CHLOR-PZ (USV) CHLORPROMAZINE (LEDERLE) CHLORPROMAZINE (ABBOTT)
CHLORPROMAZINE TABS 200MG	CHLOR-PZ (USV) CHLORPROMAZINE (LEDERLE) CHLORPROMAZINE (ABBOTT)
DIPHENHYDRAMINE CAPS 25MG	DIPHENHYDRAMINE (LEDERLE)
DIPHENHYDRAMINE CAPS 50MG	DIPHENHYDRAMINE (LEDERLE)
DOXYCYCLINE CAPS 50MG	DOXY-II (USV)
DOXYCYCLINE CAPS 100MG	DOXY-II (USV)
DOXYCYCLINE ORAL SUSP 25MG/5CC	DOXY-II (USV)
ERYTHROMYCIN TABS/CAPS 250MG	PFIZER-E (PFIZER)
ERYTHROMYCIN TABS/CAPS 500MG	PFIZER-E (PFIZER)
ESTROGENS, CONJ TABS 0.625MG	ESTROGENS, CONJUGATED (LEDERLE)
ESTROGENS, CONJ TABS 1.25MG	ESTROGENS, CONJUGATED (LEDERLE)
ESTROGENS, ESTERIFIED TABS 0.625MG	SK-ESTROGENS (SKF)
ESTROGENS, ESTERIFIED TABS 1.25MG	SK-ESTROGENS (SKF)
ESTROGENS, ESTERIFIED TABS 2.5MG	SK-ESTROGENS (SKF)
HYDROCHLOROTHIAZIDE TABS 50MG	ORETIC (ABBOTT) THIURETIC (PARKE-DAVIS)
IMIPRAMINE TABS 10MG	IMIPRAMINE (LEDERLE) SK-PRAMINE (SKF)
IMIPRAMINE TABS 25MG	IMIPRAMINE (LEDERLE) SK-PRAMINE (SKF)
IMIPRAMINE TABS 50MG	IMIPRAMINE (LEDERLE) JANIMINE (ABBOTT) SK-PRAMINE (SKF)
MEPROBAMATE TABS 200MG	SK-BAMATE (SKF)
MEPROBAMATE TABS 400MG	SK-BAMATE (SKF) MEPROBAMATE (LEDERLE)
OXYTETRACYCLINE CAPS 250MG	OXLOPAR (PARKE-DAVIS)



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

New Jersey Health Services Program NEWSLETTER

Volume 1-177

January 17, 1977

TO: ALL PHYSICIANS

SUBJECT: RESTORATION OF 10% REDUCTION IN REIMBURSEMENT

We are pleased to announce that effective January 17, 1977, the Medicaid Program will restore the 10% reduction in provider reimbursements, which has been in effect since August 1, 1975.

Therefore, the 10% restoration in provider reimbursement will become effective for all services performed on or after January 17, 1977, with the exception of laboratory services as outlined in Newsletter Volume 1-122 sent to "All Physicians and Independent Laboratories" dated August 1, 1975, announcing the reduction in reimbursement for laboratory services.

This Newsletter supersedes the letter issued to you on August 1, 1975, which announced the fee reductions due to budget deficits.

Thank you for your continued cooperation during this difficult fiscal period.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-178

January 17, 1977

TO: DENTISTS, OPTOMETRISTS, OPTICIANS, PODIATRISTS,
CHIROPRACTORS, PSYCHOLOGISTS, PROSTHETIC AND
ORTHOTIC SUPPLIERS, MEDICAL SUPPLIERS, HEARING
AID DEALERS

SUBJECT: RESTORATION OF 10% REDUCTION IN REIMBURSEMENT

We are pleased to announce that effective January 17, 1977 the Medicaid Program will restore the 10% reduction in provider reimbursements, which has been in effect since August 1, 1975.

Therefore, the 10% restoration in provider reimbursement will become effective for all services performed on or after January 17, 1977.

This Newsletter supersedes the letter issued to you on August 1, 1975, which announced the fee reductions due to budget deficit.

Thank you for your continued cooperation during this difficult fiscal period.



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 179

February 28, 1977

TO: PARTICIPATING MENTAL HEALTH CLINICS

SUBJECT: MENTAL HEALTH CLINIC RATES

The New Jersey Health Services (Medicaid) Program is pleased to advise all of the participating Mental Health Clinics of the new package of clinic services and reimbursements, which become effective for all services provided on and after March 3, 1977. Claims for services provided before March 3, 1977 but billed after March 3, 1977, will be paid at the \$10.00 rate.

This new approach recognizes five different modes of treatment in addition to psychological testing and was developed by the Division of Medical Assistance and Health Services with assistance from the Office of Community Services, Division of Mental Health and Hospitals and the New Jersey Association of Mental Health Agencies. Reimbursement differs according to mode of treatment provided.

It should be noted that Medicaid will reimburse an approved Mental Health Clinic for only one type of service on a given day. The \$300.00 per treatment year prior authorization policy remains in effect as described in Section 202.7 of the Medicaid Independent Clinic Manual.

The following fee schedule represents maximum amounts allowable. Reimbursement of customary charges will be made when they are lower than these maximum amounts. In no event should any charge for the procedures listed below exceed the customary charge to other individuals receiving the same service.

	<u>Procedure Code</u>	<u>Rate</u>
1. <u>Psychotherapy</u>		
Verbal, drug augmented, or other therapy methods provided by a psychiatrist, or a professional counsellor under the direction of a psychiatrist, in a person involvement with one patient to the exclusion of other patients and/or duties. A minimum of 50 minutes personal involvement with the patient is required. This includes a prescription visit when necessary.	0039	\$16.00
2. <u>Prescription Visit</u>		
A visit with a physician for review and evaluation of the medication history of the patient and the writing or renewal of prescriptions as necessary.	0038	\$ 4.50
3. <u>Family Therapy</u>		
Therapy with the patient and with one or more family members present. Verbal or other therapy methods are provided by a psychiatrist, or a professional counsellor under the direction of a psychiatrist, in personal involvement with the patient and the family to the exclusion of other patients and/or duties. A minimum session of	0036	\$22.50

(continued)

	<u>Procedure Code</u>	<u>Rate</u>
of 1½ hours is required with a minimum of 80 minutes personal involvement with the patient and the family and up to 10 minutes for the recording of data. The clinic may bill only for the patient and not for other family members.		
4. <u>Family Conference</u>		
Meeting with the family or other significant persons to interpret or explain medical, psychiatric or psychological examinations and procedures, other accumulated data and/or advice to the family or other significant persons on how to assist the patient. A minimum of 50 minutes of personal involvement with the family is required. The clinic may bill only for the patient and not for other family members.	0037	\$15.00
5. <u>Complete Psychological Testing</u>		
Five hours of psychometric and/or projective tests with a written report.	0021	\$75.00
6. <u>Group Therapy</u>		
Verbal or other therapy methods provided by one or more psychiatrists, or professional counsellors under the direction of a psychiatrist, in a personal involvement with two or more patients, with a maximum of 8 patients. A minimum session of 1½ hours is required. This includes preparation time in addition to the 1½ hours session time.	0035	\$ 8.00 per person
7. <u>Partial Hospitalization</u>		
A psychiatric service whose primary purpose is to provide a planned program of milieu therapy and other treatment modalities for non-residential patients. This includes a prescription visit when necessary.	Half Day - 0041 Full Day - 0042	\$ 8.00 \$15.50

Note: These rates reflect per diem payments with a prohibition against multiple billing for more than one service to a Medicaid patient in a given day.

BILLING INSTRUCTIONS

When billing the Medicaid Program in accordance with the new service package and fees, the Mental Health Clinic shall insert the following information in item 11 on the Independent Outpatient Health Facility Claim Form (MC-14):

- Item 11A - Enter the date of service for each service provided.
- Item 11B - Enter the appropriate procedure code listed above for each procedure or each date.
- Item 11C - Enter the short narrative description corresponding to the procedure code shown in Item 11B e.g., Psychotherapy, Individual, Family Therapy, etc.
- Item 11E - Enter your charge for each procedure billed.

When a Mental Health Clinic bills the Medicaid Program for any of the above procedures, it is certifying that it has, in fact, performed all of the components of that procedure code.

Any questions regarding this Newsletter should be directed to Edward M. Wallerstein, M.D., Chief Bureau of Mental Health (609-292-8199) or to the Provider Services Division, Prudential Insurance Company (609-825-8700 ext. 442 or 201-621-6960 ext. 442).



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 180

March 14, 1977

TO: ALL PHYSICIANS

SUBJECT: IMPROVED EARLY PERIODIC SCREENING DIAGNOSIS TREATMENT (EPSDT)
REFERRAL REPORT (MC-19) - ILLUSTRATED

The New Jersey Medicaid Program MC-19 EPSDT Referral Report Form (illustrated and attached) has been revised to simplify completion for you.

Effective immediately, supplies of the revised form will be available from The Prudential Insurance Company. Please destroy the old MC-19 Form (Rev. 4/75).

HIGHLIGHTS OF IMPROVED MC-19

- A. Note Section Four (4) "PROBLEM AREA", the chart includes a column for reporting NEWLY DETECTED OR SUSPECTED DEFECT. If there are no NEW problems, reporting is completed simply by an "X" in the NO - space located above the detailed chart for PROBLEM AREA reporting.
- B. Again, under the PROBLEM AREA chart in the "REFERRED FOR TREATMENT AND/OR DIAGNOSIS-REFERRAL SOURCE, IF KNOWN": please print or type name and address to whom patient was referred. Do not list laboratory as a referral.

A full definition of the EPSDT package is shown on the reverse side of the illustrated sample revised MC-19.

NOTE: Physicians must review laboratory results before billing.

(SEE REVERSE SIDE)

REMINDER

Basics of EPSDT Screening/Reporting and Billing

1. Completed MC-19 Form (two contractor copies) must accompany the MC-8 Physicians and Practitioners Billing Claim Form when billing for EPSDT Examination. (Code 9580)
2. Please submit EPSDT billing as soon as possible, preferably within 30 days. This will facilitate feedback to social service workers who assist the patient in getting needed diagnosis and treatment services.
3. Please arrange, where necessary, for referrals to other providers for necessary further diagnosis and treatment within at least 60 days of your examination.
4. EPSDT examination of Medicaid eligible children is reimbursable once every 12 months. One EPSDT examination between the ages of 16 and 21 is considered adequate.

For further detail, please refer to Newsletter Volume 1-115, dated January 29, 1975.



STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

EPSDT REFERRAL REPORT

FOR OFFICIAL USE ONLY
CWB _____
FIELD OFFICE # _____
SOCIAL WORKER # _____

PATIENT'S NAME AND ADDRESS (if known) _____ SEX _____ AGE _____ MEDICAID NUMBER AND PERSON NUMBER _____

FULL CASE NAME: Last First MI

2. TO BE COMPLETED BY SOCIAL WORKER

If, following contact, the client does not wish to be screened, or is ineligible, please check the appropriate block and return immediately to THE PRUDENTIAL INSURANCE COMPANY, P.O. BOX 1900, MILLVILLE, NEW JERSEY 08332.

DOES NOT

Not Medicaid Eligible (A) _____ CURRENTLY RECEIVING CARE FROM:
Well Child Conference (G) _____
Not Able to be Contacted (B) _____ Neighborhood Health Center (H) _____
SCREENING Refused (C) _____ Head Start (I) _____
School (J) _____
Other _____ (L)
Physician _____ (M)
If physician, Print Name and Address _____

(If available) Parent/Parent-Person Signature _____
Social Worker Signature _____ Date _____

3. TO BE COMPLETED BY SOCIAL WORKER ONLY IF NUMBER 2 DOES NOT APPLY

The above-named parent (parent-person) has been interviewed and has agreed to obtain services for the listed patient. Medical screening of this recipient is approved provided that this form is presented to a Medicaid participating New Jersey Physician, Approved Independent Clinic, Approved Well Child Center, or participating Hospital Outpatient Department, along with a Medicaid identification card valid at time the service is to be rendered.

PHYSICIAN'S

Social Worker Signature and Title _____ Date Issued _____
County Welfare Board Agency _____ Parent/Parent-Person Signature _____

NOTE: ONCE EVERY 12 MOS

4. TO BE COMPLETED BY SCREENING PROVIDER AND FORWARDED WITH CLAIM FOR PAYMENT TO YOUR MEDICAID CONTRACTOR. Send two Contractor's Copies with your claim. You may not screen this patient more than once a year; follow-up services to this patient are billed according to established billing procedures. If the patient is referred to another provider, please print (or type) the provider's name and community, if known, in the last column below; otherwise indicate the referral with an "X."

Any New Problems Detected or Suspected? (0) [] YES NO [] If "NO," leave columns below blank. If "YES," place an "X" in appropriate column(s) below.

PROBLEM AREA	NEWLY DETECTED OR SUSPECTED DEFECT	TREATED BY ME (THIS FACILITY)	NO REFERRAL OR TREATMENT NEEDED	REFERRED FOR TREATMENT AND/OR DIAGNOSIS - REFERRAL SOURCE, IF KNOWN
Visual (1)				
Hearing (2)				
Dental (3)				
Lead Poisoning (4)				
Other Problem - Indicate Appropriate Body System: (5)				

CHECK ONLY IF CONDITION NOT PREVIOUSLY KNOWN

PRINT OR TYPE NAME AND ADDRESS TO WHOM PT. WAS REFERRED. DO NOT LIST LABORATORY REFERRALS.

I CERTIFY THAT THE ABOVE-NAMED PATIENT HAS BEEN EXAMINED IN ACCORDANCE WITH NEW JERSEY MEDICAID PROGRAM PROCEDURES AND STANDARDS FOR EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT, AND WHEN MEDICALLY INDICATED WAS TREATED BY ME (THIS FACILITY) OR REFERRED TO AN APPROPRIATE PRACTITIONER OR FACILITY FOR FURTHER DIAGNOSIS AND/OR TREATMENT, AS INDICATED ABOVE.

BEFORE SIGNING, SEE THE BACK OF THIS FORM FOR THE COLLECTIVE PROCEDURES THAT CONSTITUTE AN EPSDT SCREENING EXAMINATION.

PRINT OR TYPE; Provider Name and Address

Provider Signature

Date of Service

Social Security Number or Employer ID Number

CONTRACTOR'S COPY

DEFINITION OF EPSDT

Complete initial or interval history.

Measurements (properly recorded), height and weight, head circumference to age 25 months.

Developmental assessment.

Complete physical examination including dental, vision and hearing screening and blood pressure determination from age 5 up by physician or nurse practitioner under direct supervision of a physician.

Assessment of immunization status and initiation of steps to update immunizations.

Referral of all correctable abnormalities uncovered or suspected for further diagnosis and treatment.

Medically necessary laboratory tests should be performed or referred to an approved laboratory.

NOTE: Lead Screening specimen must be sent to State Department of Health Laboratory.

Laboratory procedures performed by a physician for his patients in his office are reimbursable to the physician; if performed by outside independent laboratories, the laboratory must bill. The Medicaid Program does not reimburse for dipstick tests; however, urinalysis accompanied by microscopic is reimbursable.



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

New Jersey Health Services Program NEWSLETTER

Volume 1 - 181

March 14, 1977

TO: INDEPENDENT CLINICS

SUBJECT: IMPROVED EARLY PERIODIC SCREENING DIAGNOSIS TREATMENT (EPSDT)
REFERRAL REPORT (MC-19) - ILLUSTRATED

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A full definition of the EPSDT package is shown on the reverse side of the illustrated sample revised MC-19.

NOTE: Laboratory results must be reviewed by the physician before billing is submitted by the Clinic.

(SEE REVERSE SIDE)

REMINDER

Basics for EPSDT Screening/Reporting and Billing

1. Completed MC-19 Form (two contractor copies) must accompany the MC-14 Independent Outpatient Health Facility Form when billing for EPSDT Examination. (Code 9580)
2. Please submit EPSDT billing as soon as possible, preferably within 30 days. This will facilitate feedback to social service workers who assist the patient in getting needed diagnosis and treatment services.
3. Please arrange, where necessary, for referrals to other providers for necessary further diagnosis and treatment within 60 days of your examination.
4. EPSDT examination of Medicaid eligible children is reimbursable once every 12 months. One EPSDT examination between the ages 16 and 21 is considered adequate.

For further detail, please refer to Newsletter Volume 1-159, dated February 9, 1976.



STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

FOR OFFICIAL USE ONLY
CWB _____
FIELD OFFICE # _____
SOCIAL WORKER # _____

EPSDT REFERRAL REPORT

PATIENT'S NAME AND ADDRESS (if known) _____ SEX _____ AGE _____ MEDICAID NUMBER AND PERSON NUMBER _____

FULL CASE NAME: Last First MI

2. TO BE COMPLETED BY SOCIAL WORKER

If, following contact, the client does not wish to be screened, or is ineligible, please check the appropriate block and return immediately to THE PRUDENTIAL INSURANCE COMPANY, P.O. BOX 1900, MILLVILLE, NEW JERSEY 08332.

DOES NOT

Not Medicaid Eligible (A) _____ CURRENTLY RECEIVING CARE FROM:
Not Able to be Contacted (B) _____ Well Child Conference (G)
Neighborhood Health Center (H) _____
SCREENING Refused (C) _____ Head Start (I) _____
School (J) _____
Other _____ (L)
Physician _____ (M)
If physician, Print Name and Address _____

(If available) Parent/Parent Person Signature _____
Social Worker Signature _____ Date _____

3. TO BE COMPLETED BY SOCIAL WORKER ONLY IF NUMBER 2 DOES NOT APPLY

The above-named parent (parent-person) has been interviewed and has agreed to obtain services for the listed patient. Medical screening of this recipient is approved provided that this form is presented to a Medicaid participating New Jersey Physician, Approved Independent Clinic, Approved Well Child Center, or participating Hospital Outpatient Department, along with a Medicaid identification card valid at time the service is to be rendered.

DOES NOT

County Welfare Board Agency _____ Social Worker Signature and Title _____ Date Issued _____
Parent/Parent Person Signature _____

NOTE: once every 12 mos.

4. TO BE COMPLETED BY SCREENING PROVIDER AND FORWARDED WITH CLAIM FOR PAYMENT TO YOUR MEDICAID CONTRACTOR. Send two Contractor's Copies with your claim. You may not screen this patient more than once a year; follow-up services to this patient are billed according to established billing procedures. If the patient is referred to another provider, please print (or type) the provider's name and community, if known, in the last column below; otherwise indicate the referral with an "X."

Any New Problems Detected or Suspected? (0) [] YES NO [] If "NO," leave columns below blank. If "YES," place an "X" in appropriate column(s) below.

PROBLEM AREA	NEWLY DETECTED OR SUSPECTED DEFECT	TREATED BY ME (THIS FACILITY)	NO REFERRAL OR TREATMENT NEEDED	REFERRED FOR TREATMENT AND/OR DIAGNOSIS - REFERRAL SOURCE, IF KNOWN
Visual (1)	CHECK ONLY IF CONDITION NOT PREVIOUSLY KNOWN			PRINT OR TYPE NAME AND ADDRESS TO WHOM PT. WAS REFERRED. DO NOT LIST LABORATORY REFERRALS.
Hearing (2)				
Dental (3)				
Lead Poisoning (4)				
Other Problem - Indicate Appropriate Body System: (5)				

I CERTIFY THAT THE ABOVE-NAMED PATIENT HAS BEEN EXAMINED IN ACCORDANCE WITH NEW JERSEY MEDICAID PROGRAM PROCEDURES AND STANDARDS FOR EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT, AND WHEN MEDICALLY INDICATED WAS TREATED BY ME (THIS FACILITY) OR REFERRED TO AN APPROPRIATE PRACTITIONER OR FACILITY FOR FURTHER DIAGNOSIS AND/OR TREATMENT, AS INDICATED ABOVE.

BEFORE SIGNING, SEE THE BACK OF THIS FORM FOR THE COLLECTIVE PROCEDURES THAT CONSTITUTE AN EPSDT SCREENING EXAMINATION.

PRINT OR TYPE: Provider Name and Address

Provider Signature

Date of Service

Social Security Number or Employer ID Number

DEFINITION OF EPSDT

Complete initial or interval history.

Measurements (properly recorded), height and weight, head circumference to age 25 months.

Developmental assessment.

Complete physical examination including dental, vision and hearing screening and blood pressure determination from age 5 up by physician or nurse practitioner under direct supervision of a physician.

Assessment of immunization status and initiation of steps to update immunizations.

Referral of all correctable abnormalities uncovered or suspected for further diagnosis and treatment.

Medically necessary laboratory tests should be performed or referred to an approved laboratory.

NOTE: Lead Screening specimens must be sent to State Department of Health Laboratory.

The Medicaid Program does not reimburse for dipstick tests; however, urinalysis accompanied by microscopic is reimbursable.



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

New Jersey Health Services Program

NEWSLETTER

Volume 1-182

March 14, 1977

TO: HOSPITAL ADMINISTRATORS
ATTENTION: DIRECTOR OF THE PEDIATRIC CLINIC

SUBJECT: IMPROVED EARLY PERIODIC SCREENING DIAGNOSIS TREATMENT (EPSDT)
REFERRAL REPORT (MC-19) - ILLUSTRATED

The New Jersey Medicaid Program MC-19 EPSDT Referral Report Form (illustrated and attached) has been revised to simplify completion for you.

Effective immediately, supplies of the revised form will be available from The Prudential Insurance Company. Please destroy the old MC-19 Form (Rev. 4/75).

HIGHLIGHTS OF IMPROVED MC-19

- A. Note Section Four (4) "PROBLEM AREA", the chart includes a column for reporting NEWLY DETECTED OR SUSPECTED DEFECT. If there are no NEW problems, reporting is completed simply by an "X" in the NO - space located above the detailed chart for PROBLEM AREA reporting.
- B. Again, under the PROBLEM AREA chart in the "REFERRED FOR TREATMENT AND/OR DIAGNOSIS-REFERRAL SOURCE, IF KNOWN"; please print or type name and address to whom patient was referred. Do not list laboratory as a referral.

A full definition of the EPSDT package is shown on the ~~reverse~~ side of the illustrated sample revised MC-19.

NOTE: Laboratory results must be reviewed by the physician before billing is submitted by the hospital.

(SEE REVERSE SIDE)

REMINDER

BASICS FOR EPSDT SCREENING/REPORTING AND BILLING

When billing for EPSDT

- Completed MC-19 Form (two contractor copies) must accompany the MC-4 Outpatient Hospital Claim Form when billing for EPSDT Examination.
- Do not include other services on the same MC-4 Claim Form.
- Follow the New Jersey Medicaid Program procedures for outpatient hospital claims. See Hospital Manual Sections 310, 311, 312.
- Identify each visit covering the screening package by inserting the date and code "27" for clinic type in item 18 on the Outpatient Claim Form (MC-4).
- Insert letters EPSDT in item 22 on the MC-4 Claim Form.
- When referring for further diagnosis and/or treatment for other than visual, hearing, dental or lead poisoning, the diagnosis must be inserted in item 22 using the International Classification of Diseases Adapted (ICDA) nomenclature.
- Please submit EPSDT billing as soon as possible, preferably within 30 days. This will facilitate feedback to social service workers who assist the patient in getting needed diagnosis and treatment services.

Referrals

Please arrange, where necessary, for referrals to other providers for necessary further diagnosis and treatment within 60 days of your examination.

For further detail, please refer to Newsletter Volume 76, (Blue Cross), or Volume 1-158 (Prudential), both dated February 9, 1976.



STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

FOR OFFICIAL USE ONLY

CWB _____

FIELD OFFICE # _____

SOCIAL WORKER # _____

EPSDT REFERRAL REPORT

1. PATIENT'S NAME AND ADDRESS (if known) _____ SEX _____ AGE _____ MEDICAID NUMBER AND PERSON NUMBER _____

FULL CASE NAME: Last First MI

2. TO BE COMPLETED BY SOCIAL WORKER

If, following contact, the client does not wish to be screened, or is ineligible, please check the appropriate block and return immediately to THE PRUDENTIAL INSURANCE COMPANY, P.O. BOX 1900, MILLVILLE, NEW JERSEY 08332.

Not Medicaid Eligible (A)

CURRENTLY RECEIVING CARE FROM:

Not Able to be Contacted (B)

Well Child Conference (G)

Neighborhood Health Center (H)

SCREENING Refused (C)

Head Start (I)

School (J)

(If available) Parent/Parent Person Signature

Other _____ (L)

Physician _____ (M)

If physician, Print Name and Address

Social Worker Signature

Date

3. TO BE COMPLETED BY SOCIAL WORKER ONLY IF NUMBER 2 DOES NOT APPLY

The above-named parent (parent-person) has been interviewed and has agreed to obtain services for the listed patient. Medical screening of this recipient is approved provided that this form is presented to a Medicaid participating New Jersey Physician, Approved Independent Clinic, Approved Well Child Center, or participating Hospital Outpatient Department, along with a Medicaid identification card valid at time the service is to be rendered.

County Welfare Board Agency

Social Worker Signature and Title

Date Issued

Parent/Parent Person Signature

NOTE: once every 12 mos.

4. TO BE COMPLETED BY SCREENING PROVIDER AND FORWARDED WITH CLAIM FOR PAYMENT TO YOUR MEDICAID CONTRACTOR. Send two Contractor's Copies with your claim. You may not screen this patient more than once a year; follow-up services to this patient are billed according to established billing procedures. If the patient is referred to another provider, please print (or type) the provider's name and community, if known, in the last column below; otherwise indicate the referral with an "X."

Any New Problems Detected or Suspected? (0) [] YES NO [] If "NO," leave columns below blank. If "YES," place an "X" in appropriate column(s) below.

PROBLEM AREA	NEWLY DETECTED OR SUSPECTED DEFECT	TREATED BY ME (THIS FACILITY)	NO REFERRAL OR TREATMENT NEEDED	REFERRED FOR TREATMENT AND/OR DIAGNOSIS - REFERRAL SOURCE, IF KNOWN
Visual (1)	CHECK ONLY IF CONDITION NOT PREVIOUSLY KNOWN			PRINT OR TYPE NAME AND ADDRESS TO WHOM PT. WAS REFERRED. DO NOT LIST LABORATORY REFERRALS.
Hearing (2)				
Dental (3)				
Lead Poisoning (4)				
Other Problem - Indicate Appropriate Body System: (5)				

I CERTIFY THAT THE ABOVE-NAMED PATIENT HAS BEEN EXAMINED IN ACCORDANCE WITH NEW JERSEY MEDICAID PROGRAM PROCEDURES AND STANDARDS FOR EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT, AND WHEN MEDICALLY INDICATED WAS TREATED BY ME (THIS FACILITY) OR REFERRED TO AN APPROPRIATE PRACTITIONER OR FACILITY FOR FURTHER DIAGNOSIS AND/OR TREATMENT, AS INDICATED ABOVE.

BEFORE SIGNING, SEE THE BACK OF THIS FORM FOR THE COLLECTIVE PROCEDURES THAT CONSTITUTE AN EPSDT SCREENING EXAMINATION.

PRINT OR TYPE: Provider Name and Address

Provider Signature

Date of Service

Social Security Number or Employer ID Number

DEFINITION OF EPSDT

Complete initial or interval history.

Measurements (properly recorded), height and weight, head circumference to age 25 months.

Developmental assessment.

Complete physical examination including dental, vision and hearing screening and blood pressure determination from age 5 up by physician or nurse practitioner under direct supervision of a physician.

Assessment of immunization status and initiation of steps to update immunizations.

Referral of all correctable abnormalities uncovered or suspected for further diagnosis and treatment.

Medically necessary laboratory tests should be performed or referred to an approved laboratory.

NOTE: Lead Screening specimens must be sent to State Department of Health Laboratory.

The Medicaid Program does not reimburse for dipstick tests; however, urinalysis accompanied by microscopic is reimbursable.



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

New Jersey Health Services Program

NEWSLETTER

Volume 1 - 183

March 21, 1977

TO: ALL RADIOLOGISTS

SUBJECT: COMPUTERIZED TRANSAXIAL TOMOGRAPHY OF THE BRAIN – CHANGE IN REIMBURSEMENT

Effective for all services performed on or after March 28, 1977, the New Jersey Medicaid Program is reducing reimbursement for Computerized Transaxial Tomography (CAT) scans to an all inclusive fee of \$125. with or without contrast study.

This is in keeping with the New Jersey Medicaid Program reimbursement policy of not exceeding other major third party health insurers in certain procedure reimbursements.

This change affects Procedure Code 7854 - Computerized, Transaxial Tomography of the Brain, previously reimbursed at \$220. It further affects Procedure Code 7877 - Computerized, Transaxial Tomography of the Brain including contrast study, previously reimbursed at \$260.

When billing for CAT scans, please continue to use both Procedure Codes 7854 and 7877 where appropriate.



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

New Jersey Health Services Program NEWSLETTER

Volume 1-185

April 25, 1977

TO: ALL PROVIDERS

SUBJECT: INTRODUCTION OF THE NEW JERSEY MEDICAID PHARMACY PROGRAM PLASTIC CARD

This is to introduce the new Pharmacy Program Plastic Card which will replace the blue and white recipient Identification Card in existence since 1970. The new card (see below) as well as the old card is to be utilized exclusively by Pharmacy providers with imprinter machines for billing transactions. The replacement process will be done by attrition, this means, that the older card will still be in existence and can be used.

The new-look card is provided to the Medicaid recipient as a service to facilitate the billing of Pharmacy claims. You are reminded that this new plastic card as well as the old card is NOT to be used for identification purposes or proof that the recipient is eligible under the New Jersey Medicaid Program.

The validation form is the confirmation of an individual's eligibility under the New Jersey Medicaid Program. This must be checked monthly and will determine the following:

- a. current eligibility status
- b. proper case number (If it is not the same as the one on the plastic card, you must use the one on the validation form.)
- c. person number
- d. patient number

NEW JERSEY MEDICAID PHARMACY PROGRAM	
CASE NUMBER	
FOR BILLING PURPOSES ONLY	
AUTHORIZED SIGNATURE	VOID



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

New Jersey Health Services Program NEWSLETTER

Volume P - 187

June 27, 1977

TO: ALL MEDICAL SUPPLY AND EQUIPMENT DEALERS AND PRESCRIBING PRACTITIONERS
SUBJECT: CLARIFICATION OF MEDICAID POLICIES COVERING MEDICAL SUPPLIES AND EQUIPMENT

This Newsletter is being issued to both suppliers and prescribers in an effort to clarify certain Medicaid policies regarding covered medical supplies and equipment, non-covered services and those services which require prior authorization which have been causing a certain amount of confusion.

NON-COVERED SERVICES

Sections 201.1, 201.2 and 204. of the Medical Supplier Manual, describe non-covered services. The 13 items listed below are not reimbursable; neither are the items listed in Section 204. of the Medical Supplier Manual except as noted. The New Jersey Medicaid Program will not reimburse Suppliers for any of these services/items provided on or after July 1, 1977:

1. Oral Thermometers
2. Rectal Thermometers
3. Bathroom Scales
4. Feminine Syringes, Douche Bags
5. Ice Bags
6. Hot Water Bottles
7. Sterile Tongue Blades
8. Heating Pads
9. Hydrocollators
10. Infant Syringe, Family Syringe
11. Nasal Aspirators
12. Eye Patches
13. Plastic Gloves

FIRST AID SUPPLIES

Excessive amounts of first aid supplies (i.e., sterile gauze, adhesive tape, adhesive bandage, cotton, etc.), still require prior authorization from the Local Medical Assistance Unit. Do not submit these claims for payment without obtaining the authorization.

PRESCRIPTION POLICIES

As a reminder, Medical Supplies and Equipment require a personally signed, legible, dated order by the prescribing practitioner and must contain the following information: (See Section 203. of the Medical Supplier Manual.)

- 1) Patient's name, address, Health Services Program Number, and Person Number.
- 2) Description of supplies and/or equipment prescribed. Note: Phrase "wheelchair" or "patient needs wheelchair" is insufficient. Order must describe type and style of wheelchair.

(over)

- 3) Length of time medical equipment item is required.
- 4) Diagnosis and summary of patient's physical condition, to support need for item(s) prescribed.

(See your Supplier Manual, Section 203, Chapter II, for exception regarding Ostomy Supplies.)

Please check all claims and prescriptions thoroughly before submitting to avoid delay in payment.

UPDATE TO NEWSLETTER VOLUME 1-22, DATED 7/10/71

The following items, customarily listed as orthotic appliances, are reimbursable from facilities other than certified or provisionally certified Prosthetic and Orthotic facilities (i.e., pharmacies, non-approved prosthetic and orthotic facilities, medical-surgical suppliers, etc.) in addition to certified shops. However, each of the thirteen (13) items listed requires prior authorization from the Local Medical Assistance Unit Office regardless of price or charge to the Program:

- 1) Cervical Collars
 - a) Soft
 - b) Hard
 - c) Malleable Frame
- 2) Abdominal Belts (fashioned elastic type - not used for incisional hernia)
- 3) Abdominal Corsets (non-elastic type)
- 4) Abdominal Supports (low back - non-elastic type - size to fit patient)
- 5) Sacro-Iliac and Lumbo Sacral Corsets, supports or belts (male or female)
- 6) Special corset, boned and reinforced with steel stays
- 7) Combination corset with inside abdominal belt
- 8) Elastic Support Stockings, etc.
- 9) Surgical Weight Hose
- 10) Trusses
- 11) Knee Cage (standard)
- 12) Hand Orthosis
 - a) Short Opponents
 1. C-Bar
 2. Lumbrical Bar
- 13) Shoes

Prior authorization is not required for any other covered item not listed in the above for which the charge to the New Jersey Medicaid Program does not exceed \$30.00. However, a completed prescription must be attached. Suppliers refer to Section 203. and 205. of the Supplier Manual.



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

New Jersey Health Services Program NEWSLETTER

Volume P-188

July 11, 1977

TO: PARTICIPATING PHYSICIANS, DENTISTS AND PODIATRISTS

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

EFFECTIVE JULY 15, 1977

In order to comply with the cost limitation guidelines set forth by Department of Health, Education and Welfare (45CFR. 30(b) (2) (ii) August 15, 1975), the New Jersey Medicaid Program will reimburse participating pharmacies the newly established "MAC" prices for Ampicillin Capsules 250mg. @ \$0.0725 per capsule and Ampicillin Capsules 500mg. @ \$0.1390 per capsule REGARDLESS OF BRAND SPECIFIED with the following exception:

"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.

Since we recognize that the State of New Jersey has an anti-substitution law, it is requested that you help us by following these regulations so that the pharmacist is not needlessly penalized. Remember, the pharmacist has only two alternatives if you do not cooperate, for whatever reason: first, if the prescription is filled as written without certification, the pharmacist may suffer financial loss; and, second, the pharmacist may decide not to fill the prescription, causing hardship to the patient. Therefore, we urge you to cooperate in complying with the foregoing regulations in order to avoid needless phone calls and for the benefit of your patients.

While we in no way wish to infringe upon your professional judgment, we would encourage you to prescribe generically whenever it is possible to do so. Your assistance will be greatly appreciated.

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-189

July 25, 1977

TO: TRANSPORTATION PROVIDERS

SUBJECT: UPDATED TRANSPORTATION FEE SCHEDULE
CHANGE IN PRIOR AUTHORIZATION REQUIREMENTS

A complete revision to the New Jersey Medicaid Program's Transportation Manual will be published and disseminated late in the year 1977 or early in 1978 in conjunction with a revised Ambulance and Other Transportation Claim Form (MC-12). The revised Claim Form allows billing of multiple trips on a single claim, thereby saving time and paperwork for the Transportation Provider.

Effective August 1, 1977 the updated Transportation Fee Schedule printed below, as well as policy changes outlined in this Newsletter, will be implemented. The changes effect primarily the BASIS OF PAYMENTS Section 204.1 and 204.2 and PRIOR AUTHORIZATION, Section 203. of your current Transportation Manual.

<u>DESCRIPTION</u>	<u>MAXIMUM ALLOWANCE</u>
<u>Ambulance</u>	
Ambulance — One Way	\$24.00
Ambulance — Round Trip	48.00
Mileage	.80 per loaded mile
<u>Invalid Coach — Non Dialysis Patients</u>	
*Invalid Coach — One Way, First Patient	\$17.00
Invalid Coach — Round Trip, First Patient	34.00
Invalid Coach — One Way, each additional Patient	14.00 per patient
Invalid Coach — Round Trip, each additional Patient	28.00 per patient
Mileage	.80 per loaded mile
(If multiple load, mileage reimbursement will be made only for the one patient who travels the greatest distance.)	
<u>Invalid Coach — Dialysis Patients</u>	
First Patient, One Way	\$14.00
First Patient, Round Trip	28.00
Additional Patient, One Way	11.00
Additional Patient, Round Trip	22.00
Mileage	.80 per loaded mile
(If multiple load, mileage reimbursement will be made only for the one patient who travels the greatest distance.)	

No waiting time reimbursement will be made for dialysis patients.

*Maximum of three patients for Invalid Coach at one time, except for Dialysis Trips where a maximum of four patients is allowed.

(over)

Waiting Time

Waiting Time (Ambulance or Invalid Coach) is that period of actual time in increments of 15 minutes and beyond 30 minutes following delivery of the patient to his destination which may be considered as an added charge. It is limited to a maximum of one hour on one way trips. There will be no reimbursement for waiting time on round trips. An explanation of the need for waiting time must be attached to the MC-12 Claim Form.

Invalid Coach (Payable on one way trip only after a 30 minute wait)

1/4 hour	\$ 1.25
1/2 hour	2.50
3/4 hour	3.75
1 hour	5.00

Ambulance (Payable on one way trip only after a 30 minute wait)

1/4 hour	\$ 2.50
1/2 hour	5.00
3/4 hour	7.50
1 hour	10.00

Oxygen

1/2 hour minimum-Ambulance or Invalid Coach \$ 6.00 per 1/2 hour

Providers must submit all claims for multiple load patients batched together in one envelope. Medicaid mileage reimbursement is limited to the mileage which is incurred by the patient whose point of origin to point of destination (and back, if round trip) represents the greatest distance. No mileage charges are permitted for patients whose distance traveled lies in between these two points. In the batch the provider must certify as follows in item 10C on one of the MC-12 claim forms:

“This claim represents the mileage charge permitted for the one patient transported the farthest distance”, or a statement to this effect.

Prior Authorization Requirements will remain the same as outlined in your current New Jersey Medicaid Program Transportation Manual, Chapter II, Section 203., and Chapter III, Section 303. with the exception of Invalid Coach Services to patients receiving dialysis treatment; these services may be authorized for up to 90 days at a time. The provider should request authorization for dialysis trips on the claim for the first trip; subsequent claims covered by that authorization should be sent directly to Prudential.

Please contact your Medical Assistance Unit, if you have any questions.



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

New Jersey Health Services Program NEWSLETTER

Volume P-193

September 20, 1977

TO: ALL INDEPENDENT DENTAL CLINICS

SUBJECT: CHANGE IN ADDRESS

We are pleased to announce a revision in procedures for submission of Dental Claims.

Effective with all services rendered on or after October 1, 1977, the processing of Dental Clinic Claims (MC-10) will be performed by the Medicaid Claim Division in the Prudential Insurance Company, Millville, New Jersey.

It will no longer be necessary to complete the Clinic Claim (MC-14), eliminating the added paperwork involving clerical time.

All Dental Claims and Dental Correspondence will now be directed to: The Prudential Insurance Company of America, P. O. Box 1900, Millville, New Jersey, 08332. Telephone numbers: 609-293-2176 and 609-293-2177.

Pre-addressed envelopes, designating P. O. Box 1900, will be supplied with future orders for Dental Claim forms.

In addition, your current provider number will contain the following data:

1. Three zeros (0) preceding your provider number.
2. In place of the "E" suffix will be "CLN".

(Example: 000 123456 CLN)



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

New Jersey Health Services Program NEWSLETTER

Volume P - 194

September 5, 1977

TO: ALL OPHTHALMOLOGISTS

SUBJECT: REIMBURSEMENT FOR INTRAOCULAR LENS

Prostheses utilized in surgical procedures for inpatients are normally supplied by the hospital and reimbursement for the prosthesis is made to the hospital, and not to the attending surgeon. In the case of Intraocular Lens utilized in conjunction with cataract surgery, it has come to the attention of the New Jersey Health Services (Medicaid) Program that certain hospitals are not providing the intraocular lenses. Therefore, in those cases where the hospital does not supply the prosthesis and the surgeon provides his own, the surgeon is to utilize the following procedure for receiving reimbursement for the cost of the intraocular lens utilized:

1. Following surgery, form MC-9A-C2 (green) is to be completed indicating place of surgery, date of surgery, type and cost of the intraocular lens, using code no. 270.
2. Attach to the MC-9 the invoice which was supplied by the manufacturer and mail to the Vision Care Section, Division of Medical Assistance and Health Services, P. O. Box 2485, Trenton, New Jersey 08625. (Phone 609-292-7160)

The Vision Care Section will approve the MC-9 for reimbursement based on the actual cost to the surgeon.



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

New Jersey Health Services Program NEWSLETTER

Volume P - 195

September 12, 1977

TO: ALL PROVIDERS (EXCEPT HOSPITALS & SPECIAL HOSPITALS)

SUBJECT: MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

Effective January 1, 1978 the New Jersey Medicaid Program will be implementing a refined claims processing and utilization reporting system called the Medicaid Management Information System (MMIS). The Department of Health, Education and Welfare (HEW) has recommended MMIS as a method of developing a more efficient and cost effective Medicaid Program. States with a Federally approved MMIS qualify for additional Federal funding to develop and operate the system. In order to qualify for the additional Federal financing, the New Jersey Medicaid Program must redesign its provider claim forms to incorporate Federally required information.

As a result, provider claim forms will require additional information. One of the changes which will affect all provider claim forms is the requirement to identify on the claim the practitioner who rendered services or ordered health services, medical supplies or drugs. The Medicaid Program will soon be assigning each practitioner a unique Individual Medicaid Practitioner (IMP) Number for this purpose.

In the near future, we will be contacting you with more detailed information regarding the Individual Medicaid Practitioner (IMP) Number and other MMIS requirements.

Both the Program and your contractor will be assisting you in making the transition to the new claim forms.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

NEW JERSEY HEALTH SERVICES PROGRAM

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

Volume P - 197

September 26, 1977

TO: ALL PODIATRISTS

SUBJECT: NEW JERSEY MEDICAID INJECTION POLICY -- CHAPTER II

Enclosed are Manual page revisions to your Podiatry Manual which affects Chapter II. Please remove and destroy page 14 REV 6/15/74 from your existing Podiatry Manual and insert the attached new pages 14 and 14.1.

The changes become effective October 1, 1977 and affect the reimbursement policy on injections in that the New Jersey Medicaid Program will now make payment for injections (Intradermal, Subcutaneous, Intramuscular, Intravenous) in an office or home setting.

All changes are bracketed on the new manual pages.



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

New Jersey Health Services Program NEWSLETTER

Volume P-198.....

September 26, 1977

TO: ALL DENTISTS AND INDEPENDENT DENTAL CLINICS

SUBJECT: NEW JERSEY MEDICAID PROGRAM - INJECTION POLICY

Effective October 1, 1977, the New Jersey Medicaid Program will implement the following rule which reflects an important addition to section 234. (Other Services) of the Dental Manual and reimbursement will be made on or after this date for injection service provided to eligible Medicaid recipients:

234.8 - Injection Policy

Within the scope of accepted dental practice, the New Jersey Medicaid Program will make payment for injections (Intradermal, Subcutaneous, Intramuscular, or Intravenous) in the following setting: Office, home, and those independent clinics reimbursed for dental services provided on a fee for service basis.

- A. Reimbursement for the above injections are on a flat fee basis and are all inclusive for the cost of the service and the drug.
- B. A visit for the 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.
- C. Intravenous injections are reimbursable only when performed by the dentist.
- D. No reimbursement will be made for vitamins, liver or iron injections or combinations thereof except in laboratory proven deficiency states requiring parenteral therapy.
- E. No reimbursement will be made for placebos or any injections containing amphetamines or derivatives thereof.
- F. No reimbursement will be made for injection given as a preoperative medication or as a local anesthetic which is part of an operative or surgical procedure.
- G. Insert procedure code 9610, 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).



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

New Jersey Health Services Program NEWSLETTER

VolumeP-202.....

October 24, 1977

TO: CHRONIC RENAL DIALYSIS CENTERS, HOSPITALS, NEPHROLOGISTS

SUBJECT: MEDICARE ENTITLEMENT TO PATIENTS WHO NEED HEMODIALYSIS TREATMENT OR KIDNEY TRANSPLANT BECAUSE OF CHRONIC KIDNEY DISEASE.

This letter is being issued in order to clarify the procedures to be followed when applying for MediCARE coverage for MediCAID eligible Dialysis or Kidney transplant patients. There has been considerable confusion and delay in coordination of this process.

Previously, MediCAID had established procedures together with the Social Security Administration to coordinate the MediCARE eligibility determination for renal patients. These procedures stipulate that all Chronic Renal Disease Centers and Hospitals forward the applicable MediCARE applications (Statement of Claimant or other person, SSA 795, rev. 1-74 and Chronic Renal Disease Medical Evidence Report, SSA 2728) to the MediCAID Office in Trenton for coordination of benefits. However, most Chronic Renal Disease Centers and Hospitals are forwarding these documents instead to their local Social Security Office. This is causing difficulty in appropriate reimbursement to all medical providers, as well as confusion to both Intermediaries (Blue Cross and Prudential).

Since the patient is not MediCARE eligible during the first three months of renal dialysis, reimbursement for dialysis treatments and other MediCAID covered services provided to MediCAID eligible patients will be made by the New Jersey Medicaid Program. Once the patient is determined MediCARE eligible, however, the MediCAID Program will supplement the MediCARE payments in accordance with Section 110. of the Manual, i. e., supplementation to the extent that the payments do not exceed the maximum allowance under the MediCAID Program in the absence of other coverage. For example: a patient beginning dialysis treatment on January 16, 1977, would be eligible for MediCARE on April 1, 1977, (the third month after the month in which the course of renal dialysis was initiated, provided he/she met MediCARE eligibility criteria). In this example, MediCAID would pay for dialysis treatment and any other MediCAID allowable services from January 16, 1977, to March 31, 1977. As of April 1, 1977, MediCARE would be the primary coverage for dialysis and other MediCARE allowable services, e.g., hospital, physician services, ambulance services, medical services, etc. After April 1, 1977, MediCAID would supplement the MediCARE coverage as described above.

(over)

APPLICATION PROCEDURE

If you have any MediCAID eligible Chronic Renal Disease patients for whom you are filing MediCARE applications, please complete the forms SSA 795 and 2728 in accordance with revised Social Security guidelines, and mail both immediately to:

Division of Medical Assistance
and Health Services
c/o Retroactive Eligibility Unit
Post Office Box 2486
Trenton, New Jersey 08625

The MediCAID Office will then forward the completed forms SSA 795 and 2798 to the Trenton district Social Security Office. When the determination process is completed and a decision on MediCARE eligibility is made, the Trenton Social Security Office will notify the MediCAID Office. The MediCAID Office will then notify, in writing, the appropriate hospital or dialysis center of the approval and effective date, or the denial for MediCARE eligibility.

Please note that failure to follow this procedure will result in delayed or rejected MediCAID claims for all medical providers by the appropriate Contractors.

For all other Chronic Renal Disease patients who are not MediCAID eligible, continue to forward the forms SSA 795 and 2728 directly to your local Social Security District Office for MediCARE eligibility determinations.

If you have any questions regarding these procedures, please contact Mr. Richard J. Hickey at (609) 292-6867.



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

New Jersey Health Services Program NEWSLETTER

Volume P-203

November 1, 1977

TO: HEARING AID DISPENSERS

SUBJECT: REVISED MEDICAL SUPPLIES AND EQUIPMENT CLAIM FORM (MC-11-C3), EFFECTIVE NOVEMBER 1, 1977

Please refer to Newsletter Volume P-195 dated September 12, 1977 which announces a January 1, 1978 implementation date for the Medicaid Management Information System (MMIS). In order to incorporate federally required MMIS information, the MC-11 Claim Form has been redesigned.

Enclosed is a supply of the revised MC-11 Claim Form, which should be adequate for your current needs. For your convenience, and to expedite a reorder of claims, please use the attached reorder form.

In order that we may have operational data by the MMIS implementation date, the effective date for use of the revised claim form is November 1, 1977. If you receive your MC-11-C3 claim supply after November 1, begin using the new claim form immediately in accordance with the following instructions. Destroy all of your old claim forms.

The major changes to the form, (items 10, 12, 13 and 16), are highlighted below, followed by billing instructions and a sample claim form.

HIGHLIGHTS OF THE REVISIONS TO THE MC-11 CLAIM FORM

Item 10: Indicate whether injury resulted from an automobile accident by checking the appropriate block.

Item 12: Diagnosis

A diagnosis is required. Where possible, indicate both a primary and secondary diagnosis.

You may use the codes for diagnosis listed in the International Classification of Diseases (Adapted for use in the United States), published by the 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 13: EPSDT Program Referral - Complete this item for recipients under age 21.

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

(continued)

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

IMP Number: One of the most significant changes to the claim form is the requirement to identify practitioners by an Individual Medicaid Practitioner (IMP) Number. Item 16 on the revised claim refers to an IMP Number. Each Medicaid Practitioner has been assigned a unique IMP Number and has been advised of the requirement to make it available to other Medicaid providers.

Item 16: Prescribing Practitioner

Enter the name and Individual Medicaid Practitioner (IMP) Number of the practitioner who prescribed the hearing aid.

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

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

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

HEARING AID AND SUPPLIES BILLING INSTRUCTIONS

Instructions for Completion of Form MC-11

1. - 4. -Copy the Patient's Name, Health Services Program (HSP) Case Number, and Person Number EXACTLY as it appears on the Validation Form or Medicaid Eligibility Identification Card.
-For additional information, see Section 101. of your Medicaid Hearing Aid Manual.
5. -Indicate patient's age.
6. -Check appropriate block, to identify patient's sex.
7. -Check appropriate block to indicate whether the patient has other health insurance, liability coverage, or No Fault Auto Coverage.
-If yes, you must attach a copy of the decline notice or a copy of the explanation of payment from the carrier.
8. -Check as appropriate.
-If patient's illness or injury is work related, enter name and address of employer.
9. -This information is usually preprinted.
-If not preprinted, write in provider name, address, and provider number.
-Enter telephone number.
10. -Indicate whether injury resulted from an automobile accident.
11. -Indicate whether a prescription accompanies the claim when submitted for payment.
12. -Enter diagnosis.

13. -Complete this item for recipients under 21 years of age.
-Ask the patient and/or referring physician or clinic if this visit is a result of an EPSDT screening.
-Indicate if this patient is such a referral by checking the appropriate block.
- 14.A. -Enter date(s) item was provided.
- 14.B. -Enter item code as listed in Chapter IV of your Medicaid Hearing Aid Manual.
- 14.C. -Describe item(s) provided, including name of manufacturer and model number.
- 14.D. -Enter quantity of item provided.
- 14.E. -Not applicable; leave blank.
- 14.F. -Enter charges, indicating both list price and 20% discount off list price.
15. -Do not write in this space; for Division use only.
-When prior authorization is required, obtain authorizing signature from Local Medical Assistance Units.
16. -Enter the name and Individual Medicaid Practitioner (IMP) Number of the practitioner who prescribed the hearing aid.
17. -Indicate whether the patient is currently in a Long Term Care Facility.
-If yes, give name and address of Long Term Care Facility.
18. -Under ordinary circumstances, the patient must sign the claim form when services have been received.
-The claim form must indicate services rendered, prior to presenting it to the patient for signature.
-If the patient's signature is unobtainable, see the Billing Chapter in your Medicaid Hearing Aid Manual for procedures to follow.
19. -Read the Provider Certification carefully.
-The provider must sign item 17 before the claim can be considered for payment.
-Indicate the billing date which is the date the claim is mailed.

MEDICAL SUPPLIES AND EQUIPMENT CLAIM

1 Last Name First Name
 2 Patient's Street Address Telephone Number
 City State ZIP Code
 3 Health Services Program Case No. 4 Patient Person No. 5 Age 6 Sex Male Female
 7 Other Health Insurance or Liability Coverage? Yes No
 If Yes, attach a copy of Decline Notice or Explanation of Payment from Carrier.
 No Fault Auto coverage? (If Medicare — See Section 304 of Manual) Yes No
 8 Was Patient's Illness or Injury connected with employment? Yes No
 If Yes, give Name and Address of Employer here.
 10 Did injury result from automobile accident? Yes No
 11 Prescription Attached Yes No
 12 Primary Diagnosis Secondary Diagnosis
 13 Was this service performed as a result of an EPSDT Program Referral? Yes No
9 PROVIDER OF SERVICE INFORMATION
 Telephone Number Medicaid Provider Number (Enter only when not printed below)
 Name and Address
FOR CONTRACTOR'S USE ONLY

TOTAL AMOUNT A		TOTAL AMOUNT B		C O D E	P R E S C R I B I N G P R A C T I C I O N E R	A U T H	J A M	3rd P L C																
47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71

14 REPORT OF SERVICES

A	B	C		D	E	F
Date of Service	Item No.	Manufacturer's Name	Description of Item Provided	Model Number	Rental per Month	Sale Amount
						\$

15 AUTHORIZING SIGNATURE (Medical Consultant) (For Division Use Only) PERIOD OF RENTAL AUTHORIZATION
 Date to TOTAL CHARGES \$
 16 Name and Number of Prescribing Practitioner Name Individual Medicaid Practitioner No. 17 Patient in a Long Term Care Facility? Yes No
 If Yes, give the Name and Address of the Facility.

18 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) Date Signed

19 PROVIDER CERTIFICATION. I certify 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 therefore 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 Billing Date Mo./Day/Yr.

FOR PAYMENT MAIL TO: The Prudential Insurance Co. of America — P.O. Box 1900 — Millville, N.J. 08332

FOR CONTRACTOR'S USE ONLY

C A R D	DATES OF SERVICE								ITEM #	AMOUNT A	AMOUNT B	C O D E	R / P	J A M	DATES OF SERVICE								ITEM #	AMOUNT A	AMOUNT B	C O D E	R / P	J A M																															
	FROM				TO										FROM				TO																																								
	Mo.	Day	Mo.	Day	Mo.	Day	Mo.	Day							Mo.	Day	Mo.	Day	Mo.	Day	Mo.	Day																																					
3	11	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71
4	11	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71
5	11	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71



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

New Jersey Health Services Program NEWSLETTER

Volume ...P-204.....

November 1, 1977

TO: MEDICAL SUPPLY AND EQUIPMENT DEALERS

SUBJECT: REVISED MEDICAL SUPPLIES AND EQUIPMENT CLAIM FORM (MC-11-C3), EFFECTIVE NOVEMBER 1, 1977

Please refer to Newsletter Volume P-195 dated September 12, 1977 which announces a January 1, 1978 implementation date for the Medicaid Management Information System (MMIS). In order to incorporate federally required MMIS information, the MC-11 Claim Form has been redesigned.

Enclosed is a supply of the revised MC-11 Claim Form, which should be adequate for your current needs. For your convenience, and to expedite a reorder of claims, please use the attached reorder form.

In order that we may have operational data by the MMIS implementation date, the effective date for use of the revised claim form is November 1, 1977. If you receive your MC-11-C3 claim supply after November 1, begin using the new claim form immediately in accordance with the following instructions. Destroy all of your old claim forms.

The major changes to the form, (items 10, 12, 13 and 16), are highlighted below, followed by billing instructions and a sample claim form.

HIGHLIGHTS OF THE REVISIONS TO THE MC-11 CLAIM FORM

Item 10: Indicate whether injury resulted from an automobile accident by checking the appropriate block.

Item 12: Diagnosis

A diagnosis is required. Where possible, indicate both a primary and secondary diagnosis.

You may use the codes for diagnosis listed in the International Classification of Diseases (Adapted for use in the United States), published by the 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 13: EPSDT Program Referral - Complete this item for recipients under age 21.

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

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

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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-205

November 1, 1977

TO: PROSTHETIC AND ORTHOTIC APPLIANCE PROVIDERS

SUBJECT: REVISED PROSTHETIC AND ORTHOTIC APPLIANCE CLAIM FORM (MC-15-C1), EFFECTIVE NOVEMBER 1, 1977

Please refer to Newsletter Volume P-195 dated September 12, 1977 which announces a January 1, 1978 implementation date for the Medicaid Management Information System (MMIS). In order to incorporate federally required MMIS information, the MC-15 Claim Form has been redesigned.

Enclosed is a supply of the revised MC-15 Claim Form, which should be adequate for your current needs. For your convenience, and to expedite a reorder of claims, please use the attached reorder form.

In order that we may have operational data by the MMIS implementation date, the effective date for use of the revised claim form is November 1, 1977. If you receive your MC-15-C1 claim supply after November 1, begin using the new claim form immediately in accordance with the following instructions. Destroy all of your old claim forms.

The major changes to the form (items 10, 11, 12 and 15) are highlighted below, followed by billing instructions and a sample claim form.

HIGHLIGHTS OF THE REVISIONS TO THE MC-15 CLAIM FORM

Item 10: Indicate whether this claim is related to an injury which resulted from an automobile accident, by checking the appropriate block.

Item 11: Diagnosis

A diagnosis is required. Where possible, indicate both a primary and secondary diagnosis.

You may use the codes for diagnosis listed in 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 12: EPSDT Program Referral - Complete this item for recipients under age 21.

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

It is essential that the Medicaid Program be able to relate diagnostic and/or treatment services to the original screening. Therefore, when a patient under 21 visits your office, a reasonable effort should be

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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-206.....

November 1, 1977

TO: ALL PODIATRISTS, OPTOMETRISTS, PSYCHOLOGISTS, CHIROPRACTORS

SUBJECT: REVISED PHYSICIANS' AND PRACTITIONERS' CLAIM FORM (MC-8-C3), EFFECTIVE NOVEMBER 1, 1977

Please refer to Newsletter Volume P-195 dated September 12, 1977 which announces a January 1, 1978 implementation date for the Medicaid Management Information System (MMIS). In order to incorporate federally required MMIS information, the MC-8 Claim Form has been redesigned.

Enclosed is a supply of the revised MC-8 Claim Form, which should be adequate for your current needs. For your convenience, and to expedite a reoder of claims, please use the attached reorder form.

In order that we may have operational data by the MMIS implementation date, the effective date for use of the revised claim form is November 1, 1977. If you receive your MC-8-C3 claim supply after November 1, begin using the new claim form immediately in accordance with the following instructions. Destroy all of your old claim forms.

The major changes to the form, (items 12, 13, 14 and 17), are highlighted below, followed by billing instructions and a sample claim form.

HIGHLIGHTS OF THE REVISIONS TO THE MC-8 CLAIM FORM

IMP Number: One of the most significant changes to the claim form is the requirement to identify practitioners by an Individual Medicaid Practitioner (IMP) Number. Items 12 and 17 on the revised claim refer to an IMP Number. Each Medicaid Practitioner has been assigned a unique IMP Number and has been advised of the requirement to make it available to other Medicaid practitioners and providers (See Prudential Letter dated October 24, 1977).

Item 12: Referring Practitioner

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 12. If the patient is not a referral, leave item 12 blank.

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

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

(continued)

Item 17: Provider Certification

The IMP Number and signature of the practitioner actually performing the service(s) described on the claim is always required in item 17. If the IMP Number of the practitioner who performed the service is identical to the preprinted Medicaid Provider Number in item 9, you may check the block in lieu of writing out the IMP Number.

NOTE: The practitioner who signs and enters his IMP Number on the MC-8 is attesting to having personally rendered the services reported on the claim. If a claim covers services performed by more than one practitioner, the practitioner who performed the last procedure shall sign item 17 and include his/her IMP Number.

Item 13: EPSDT Program Referral - Complete this item for recipients under age 21.

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

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

Item 14: Prior Authorization

Certain podiatric, rehabilitation, mental health, and vision services require prior authorization by a Consultant with the New Jersey Medicaid Program. Chapter II of your Medicaid Provider Manual identifies services requiring prior authorization and procedures for requesting prior authorization.

If the request is approved, the Medicaid Consultant will assign a prior authorization number to the request form. The number received must be transcribed from the request form onto the MC-8 in item 14. This authorization number applies only to the service for which it was assigned and the date(s) for which it was approved.

The authorization form itself must accompany the MC-8 when submitting the claim in accordance with regulations in your Medicaid Provider Manual.

Continue to follow the procedures for submitting claims as outlined in the billing chapter of your Medicaid Provider Manual.

PHYSICIANS' AND PRACTITIONERS' BILLING PROCEDURES

Instructions for Completion of Form MC-8

1. 4. -Copy the Patient's Name, Health Services Program (HSP) Case Number, and Person Number **EXACTLY** as it appears on the Validation Form or Medicaid Eligibility Identification Card.
-For additional information, see Section 101 of your Medicaid Provider Manual.
5. -Indicate patient's age.
6. -Check appropriate block, to identify patient's sex.
7. -Check appropriate block to indicate whether the patient has other health insurance, liability coverage, or No Fault Auto Coverage.
-If yes, you must attach a copy of the decline notice or a copy of the explanation of payment from the carrier.
-When the recipient is covered by both Medicare and Medicaid, see Section 304. of your Provider Manual.
8. -Check as appropriate.
-If patient's illness or injury is work related, enter name and address of employer.
9. -This information is usually preprinted.
-If not preprinted, write in provider name, address, and provider number.
-Enter telephone number.
10. -Indicate whether injury resulted from an automobile accident.
11. -Write in the name of the institution, if place of service is other than doctor's office or patient's home.
-To be completed in addition to item 15B.
12. -If patient was referred to you, you must indicate the name and Individual Medicaid Practitioner (IMP) Number of the referring practitioner.
13. -Complete this item for recipients under 21 years of age.
-Ask the patient and/or referring physician or clinic if this visit is a result of an EPSDT screening.
-Indicate if this patient is such a referral by checking the appropriate block.
14. -For services which require prior authorization, copy the prior authroization number designated by the Medicaid office from the request for authorization form.
-Attach authorization approval form to claim when submitting for payment.
- 15.A. -Enter date(s) of each visit.
- 15.B. -Identify place of service, by selecting appropriate code as listed on the form under **REPORT OF SERVICES**.
- 15.C. -Enter diagnosis.
- 15.D. -Physicians and Psychologists:
 - Identify the procedure by code number as listed in Chapter IV of your Medicaid Provider Manual.
 - Insert procedure code in the column labelled "procedure code".
 - If a code to describe the service rendered is not provided in Chapter IV, enter a description of the service.

Optometrists, Podiatrists and Chiropractors:

-Enter description of services rendered.

- 15.E. -Check this column for each service ascribable to "Family Planning". These should include visits for infertility studies, oral, mechanical or chemical contraceptives and applicable surgical procedures.**
- 15.F. -Enter your usual and customary charge for each service or procedure.**
- 16. -Under ordinary circumstances, the patient must sign the claim form when services have been received.**
-The claim form must indicate services rendered, prior to presenting it to the patient for signature.
-If the patient's signature is unobtainable, see the Billing Chapter in your Medicaid Provider Manual for procedures to follow.
- 17. -Read the Provider Certification carefully.**
-The Individual Practitioner who personally performed or supervised the service(s) represented on the claim must put his/her signature and Individual Medicaid Practitioner (IMP) Number on each claim before submitting for payment.
-Indicate your degree by checking the appropriate block.
-If the IMP Number of the practitioner performing the service is identical to the preprinted Medicaid Provider Number in item 9, you may check the block in lieu of writing out the IMP Number.
-Indicate the billing date which is the date the claim is mailed.



STATE OF NEW JERSEY
 Department of Human Services
 Division of Medical Assistance and Health Services
PHYSICIANS AND PRACTITIONERS CLAIM

03

1 Patient's Last Name _____ First Name _____ 2 Patient's Street Address _____ Telephone Number _____

3 Health Services Program Case No. _____ 4 Patient Person No. _____ 5 Age _____ 6 Sex Male Female City _____ State _____ Zip Code _____

7 Other Health Insurance or Liability Coverage? Yes No
 If Yes, attach copy of Decline Notice or Explanation of Payment from carrier
 No Fault Auto Coverage? Yes No
 (If Medicare - See Section 304 of Manual)

8 Was Patient's Illness or Injury connected with employment? Yes No
 If Yes, give Name and Address of Employer here: _____

9 PROVIDER OF SERVICE INFORMATION

10 Did injury result from automobile accident? Yes No

Telephone Number _____ Medicaid Provider Number (Enter only when not printed below) _____
 Name and Address _____

11 Give Name of Institution if Place of Service is other than Doctor's Office or Patient's Home _____

12 Patient was a referral, Name and Individual Medicaid Practitioner Number of referring Practitioner _____

FOR CONTRACTOR'S USE ONLY

13 Was this service performed as a result of an PSDT Program Referral? Yes No

TOTAL AMOUNT A	TOTAL AMOUNT B	C O D E	J A M	HOSPITAL PROVIDER NUMBER	REFERRING PHYSICIAN	3rd P L C
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14 Prior Authorization Number _____

47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76
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15 REPORT OF SERVICES

1 - Doctor's Office 3 - Inpatient Hospital 5 - Long Term Care Facility 7 - Outpatient Hospital 9 - Other Locations 0 - Emergency Room
 2 - Patient's Home 4 - _____ 6 - Independent Laboratory 8 - Clinic (Other than Hospital based) (Specify in 15B)

A	B	C	D	E	F
DATE OF EACH VISIT	PLACE OF SERV	NATURE OF ILLNESS OR INJURY REQUIRING SERVICES (DIAGNOSIS)	FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE OF SERVICE	Procedure Code	CHECK (✓) IF FAMILY PLANNING CHARGE
					\$

16 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

Total Charge _____

SIGNATURE (Patient or authorized representative) _____ Date Signed _____

17 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 therefore 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 _____ MD DO DPM OD DC PhD
 Individual Medicaid Practitioner Number _____ Check if Same as Item 9 Billing Date MO/ DAY/YR _____

FOR PAYMENT MAIL TO: The Prudential Insurance Co of America - P.O. Box 1900 - Millville, N.J. 08332

FOR CONTRACTOR'S USE ONLY

DATES OF SERVICE					P L A C E	T Y P E	R / P	No. of Visits	V A L U E	AMOUNT A	AMOUNT B	C O D E	J A M	PROCEDURE CODE	PRIMARY DX	SECONDARY DX	F P C O D E																												
YR.	MO	DAY	MO	DAY																																									
14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59



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

New Jersey Health Services Program NEWSLETTER

Volume ...P-207.....

TO: ALL PHYSICIANS

SUBJECT: REVISED PHYSICIANS' AND PRACTITIONERS' CLAIM FORM (MC-8-C3), EFFECTIVE NOVEMBER 1, 1977

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HIGHLIGHTS OF THE REVISIONS TO THE MC-8 CLAIM FORM

IMP Number: One of the most significant changes to the claim form is the requirement to identify practitioners by an Individual Medicaid Practitioner (IMP) Number. Items 12 and 17 on the revised claim refer to an IMP Number. Each Medicaid Practitioner has been assigned a unique IMP Number and has been advised of the requirement to make it available to other Medicaid practitioners and providers (See Prudential Letter dated October 24, 1977).

Item 12: Referring Practitioner

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 12. If the patient is not a referral, leave item 12 blank.

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

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

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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-208

November 1, 1977

TO: INDEPENDENT LABORATORIES

SUBJECT: REVISED INDEPENDENT LABORATORY CLAIM FORM (MC-13-C2), EFFECTIVE
NOVEMBER 1, 1977

Please refer to Newsletter Volume P-195 dated September 12, 1977 which announces a January 1, 1978 implementation date for the Medicaid Management Information System (MMIS). In order to incorporate federally required MMIS information, the MC-13 Claim Form has been redesigned.

Enclosed is a supply of the revised MC-13 Claim Form, which should be adequate for your current needs. For your convenience, and to expedite a reorder of claims, please use the attached reorder form.

In order that we may have operational data by the MMIS implementation date, the effective date for use of the revised claim form is November 1, 1977. If you receive your MC-13-C2 claim supply after November 1, begin using the new claim form immediately in accordance with the following instructions. Destroy all of your old claim forms.

The major changes to the form (items 7, 8, 10 and 12), are highlighted below, followed by billing instructions and a sample claim form.

HIGHLIGHTS OF THE REVISIONS TO THE MC-13 CLAIM FORM

Items 7 and 8 must be completed.

Item 7: Other Insurance

Check the appropriate block to indicate whether the patient has other health insurance, liability coverage, or No Fault Auto Coverage. If yes, you must attach a copy of the decline notice or a copy of the explanation of payment from the carrier. When the recipient is covered by both Medicare and Medicaid, see Section 303. of your Medicaid Independent Laboratory Manual.

Item 8: Injury or illness related to employment or automobile accident.

Check the appropriate block to indicate whether illness or injury was connected with employment. If yes, enter the name and address of the employer.

Indicate whether injury resulted from an automobile accident.

Item 10: EPSDT Program Referral - Complete this item for recipients under age 21.

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

(continued)

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

IMP Number: One of the most significant changes to the claim form is the requirement to identify practitioners by an Individual Medicaid Practitioner (IMP) Number. Item 12 on the revised claim refers to an IMP Number. Each Medicaid Practitioner has been assigned a unique IMP Number and has been advised of the requirement to make it available to other Medicaid providers.

Item 12: Prescribing Practitioner

Enter the name and Individual Medicaid Practitioner (IMP) Number of the practitioner who prescribed the laboratory service(s).

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

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

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



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

New Jersey Health Services Program

NEWSLETTER

Volume P-209

November 1, 1977

TO: INDEPENDENT CLINICS

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

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

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

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

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

HIGHLIGHTS OF REVISIONS TO MC-14 CLAIM FORM

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

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

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

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

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

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

(continued)



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

New Jersey Health Services Program NEWSLETTER

Volume P-210.....

November 1, 1977

TO: ALL OPHTHALMOLOGISTS, OPTOMETRISTS, OPTICIANS

SUBJECT: REVISED OPTICAL APPLIANCES CLAIM FORM (MC-9-C3), EFFECTIVE NOVEMBER 1, 1977

Please refer to Newsletter Volume P-195 dated September 12, 1977 which announces a January 1, 1978 implementation date for the Medicaid Management Information System (MMIS). In order to incorporate federally required MMIS information, the MC-9 Claim Form has been redesigned.

Enclosed is a supply of the revised MC-9 Claim Form, which should be adequate for your current needs. For your convenience, and to expedite a reorder of claims, please use the attached reorder form.

In order that we may have operational data by the MMIS implementation date, the effective date for use of the revised claim form is November 1, 1977. If you receive your MC-9-C3 claim supply after November 1, begin using the new claim form immediately in accordance with the following instructions. Destroy all of your old claim forms.

The major changes to the form, (items 10, 11, 14, 18, 19 and 23), are highlighted below, followed by billing instructions and a sample claim form.

HIGHLIGHTS OF THE REVISIONS TO THE MC-9 CLAIM FORM

Item 10: EPSDT Program Referral - Complete this item for recipients under age 21.

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

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

Item 11: Diagnosis

A diagnosis is required. Where possible, indicate both a primary and secondary diagnosis. (Opticians: Obtain diagnosis from the prescribing practitioner.)

You may use the codes for diagnosis listed in the International Classification of Diseases (Adapted for use in the United States), as published by the Department of Health, Education and Welfare. (Do not confuse the diagnosis with the patient's complaint or symptoms.)

Item 14: Treated Glass

For glass lenses, indicate the process used, chemical or heat, by placing an X in the appropriate block.

(Continued)



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

New Jersey Health Services Program NEWSLETTER

Volume P-211

November 1, 1977

TO: All Dentists, Independent Dental Clinics

SUBJECT: Regulations Pertaining to a Special Area of Dentistry - General Anesthesia

IMPORTANT NOTICE

This newsletter is of extreme importance to all Dentists participating in the Medicaid Program. Please read it carefully and insert it in your Dental Manual.

Pursuant to the revisions to the Dental Practice Act promulgated by the New Jersey Board of Dentistry concerning General Anesthesia, the following changes must be implemented effective November 1, 1977, and will remain in effect until further notification.

The first claim submitted to Prudential on an MC-10 Dental Services Claim Form which includes General Anesthesia (Procedure Numbers 9220, 9221, 9222, 9223, 9224, or 9225) with a date of service of November 1, 1977, or later, must be accompanied by a copy of the Permit issued by the New Jersey Board of Dentistry in order to be processed for payment. Any claim submitted without the Permit will be returned to the provider.

After you have once submitted a copy of your Permit, any subsequent claims submitted must indicate your Permit number on the MC-10 in item 14 in the two line Description of Services Area whenever you indicate Procedure Numbers 9220, 9221, 9222, 9223, 9224, or 9225.

If you have not yet received your Permit, we are requesting that you hold all claims until you receive your Permit.

For those providers who are in a group practice, it will also be necessary to identify in item 14 the name as well as the permit number of the individual who actually administers the General Anesthesia.

Please note that any temporary Permit is only valid for a 30-day period. Effective December 1, 1977, it will be necessary for any provider who has now been issued a regular permit to follow all of the procedures outlined above in order for his claims to be processed for payment.



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

New Jersey Health Services Program NEWSLETTER

Volume P-213

November 21, 1977

TO: HOSPITAL AND SPECIAL HOSPITAL ADMINISTRATORS

SUBJECT: REVISED INPATIENT AND OUTPATIENT HOSPITAL CLAIM FORMS (MC-1-C4 AND MC-4-C4),
EFFECTIVE DECEMBER 1, 1977

As you know, the New Jersey Medicaid Program will be implementing a refined claims processing and utilization reporting system called the Medicaid Management Information System (MMIS), effective January 1, 1978. (See New Jersey Health Services Program Newsletter P-196, Oct. 3, 1977). In order to incorporate Federally required MMIS information, the MC-1 and MC-4 Claim Forms have been redesigned.

Enclosed is a supply of the revised MC-1 and MC-4 Claim Forms, which should be adequate for your current needs. For your convenience, and to expedite a reorder of claims, please use the attached reorder form.

In order that we may have operational data by the MMIS implementation date, the effective date for use of the revised claim forms is December 1, 1977. Therefore, effective December 1, destroy all of your old claim forms and use the new claim forms exclusively.

The major changes to the claim forms concern the requirement to:

- 1) Identify practitioners with an Individual Medicaid Practitioner (IMP) Number,
- 2) Relate claims payment to EPSDT screening,
- 3) Relate claims payment to Family Planning,
- 4) Identify the Prior Authorization Number as applicable.

These revisions to the forms are highlighted below.

More detailed billing instructions, specific to the respective claim form, follow. Items on the claim form which are new or revised are asterisked (*) in the billing instructions for easy reference.

HIGHLIGHTS OF THE MMIS REVISIONS TO THE MC-1 AND MC-4 CLAIM FORM

IMP Number: One of the most significant changes to the claim forms is the requirement to identify practitioners by an Individual Medicaid Practitioner (IMP) Number. Items 17 and 20 on the MC-1 and items 16, 19 and 21 on the MC-4 refer to an IMP Number.

Each Medicaid Practitioner has been assigned a unique IMP Number and has been advised of the requirement to make it available to other Medicaid providers. Hospital providers have been advised to compile a list of hospital affiliated Medicaid practitioners and their IMP Numbers to facilitate claims completion. In the event that you are unable to obtain the IMP Number directly from the practitioner, you may call (800) 322-8051 or (800) 322-8052 toll-free for the information. You will need the name and address of the practitioner in order to obtain the IMP Number.

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

(continued)

MC-1: Item 23:

MC-4: Item 24: **Prior Authorization Number.** This item applies to prior authorized Rehabilitation and Psychiatric Services.

Follow the prior authorization procedures as described in Chapter II of your Medicaid Hospital Manual.

Certain Rehabilitation and Psychiatric Services require that a request for prior authorization be made. If the request is approved, the Medicaid Consultant will assign a prior authorization number to the form or letter used to request authorization. The prior authorization number must be transcribed from the Request For Authorization onto the hospital claim in the block labelled "Prior Authorization Number". This authorization number applies only to the service(s) for which it was assigned and the date(s) for which it was approved.

The Request For Authorization itself must accompany the Hospital Claim when submitting the claim in accordance with regulations in your Medicaid Hospital Manual.

MC-1 and MC-4

Item 26: **EPSDT Program Referral - Complete this item for recipients under age 21.**

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

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

MC-1 and MC-4

Item 27: **Check if Family Planning**

Check the block, if services billed on the claim are ascribable to "Family Planning". These should include visits for infertility studies, oral, mechanical or chemical contraceptives and applicable surgical procedures.

Use the attached billing instructions to complete the revised MC-1 and MC-4 Claim Forms.

General Medicaid Policies and Procedures are unchanged. Continue to follow current procedures for submitting claims and refer to your Medicaid Hospital Manual for additional information.



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

New Jersey Health Services Program NEWSLETTER

Volume P-214

November 21, 1977

TO: HOME HEALTH AGENCY DIRECTORS

SUBJECT: REVISED HOME HEALTH CLAIM FORM (MC-3-C2), EFFECTIVE DECEMBER 1, 1977

Please refer to Newsletter Volume P-195 dated September 12, 1977 which announces a January 1, 1978 implementation date for the Medicaid Management Information System (MMIS). In order to incorporate federally required MMIS information, the MC-3 Claim Form has been redesigned.

Enclosed is a supply of the revised MC-3 Claim Form, which should be adequate for your current needs. For your convenience, and to expedite a reorder of claims, please use the attached reorder form.

In order that we may have operational data by the MMIS implementation date, the effective date for use of the revised claim forms is December 1, 1977. Therefore, effective December 1, destroy all of your old claim forms and use the new claim forms exclusively.

The major changes to the form, (items 14, 15, 16, 17, 19, 21, 23, 24 and 25), are highlighted below, followed by billing instructions and a sample claim form.

HIGHLIGHTS OF THE REVISIONS TO THE MC-3 CLAIM FORM

Items 14 and 15: Enter the patient's address and telephone number. Complete these items as fully as possible.

IMP Number: One of the most significant changes to the claim form is the requirement to identify physicians with an Individual Medicaid Practitioner (IMP) Number. Each Medicaid Physician has been assigned a unique IMP Number and has been advised of the requirement to make it available to other Medicaid providers.

You must always supply the IMP Number of the physician who ordered the Home Health Care. In the event that you are unable to obtain the IMP Number directly from the physician, you may call (800) 322-8051 or (800) 322-8052 toll-free for the information. You will need the name and address of the physician in order to obtain the IMP Number.

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

Items 16 and 17: Referring Physician

If the physician who referred the patient to your agency is other than the patient's attending physician in the community, you must write the IMP Number and name of the referring physician in items 16 and 17 respectively. Leave items 16 and 17 blank if the attending physician in the community ordered Home Health Care.

(continued)

Items 19 and 20: Attending Physician

Enter the IMP Number and Name of the patient's attending physician. This item must be completed on all claim forms.

Item 21: Prior Authorization Number

Continue to follow current procedures regarding prior authorization as outlined in Chapters II and III of your Medicaid Home Health Agency Manual.

Effective December 1, if a "Request for Home Health Care Authorization" (FD-139) is approved, the Medicaid Consultant will assign a prior authorization number to the FD-139. The prior authorization number must be transcribed from the FD-139 onto the MC-3 in item 21. This authorization number applies only to the service(s) for which it was assigned and the date(s) for which it was approved.

The contractor copy of the FD-139 must accompany the MC-3 when submitting the claim in accordance with regulations in your Medicaid Home Health Agency Manual.

Item 23: EPSDT Program Referral - Complete this item for recipients under age 21.

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

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

Item 24: Check if Family Planning.

Check the block, if services billed on the claim are ascribable to "Family Planning". These should include home health visits related to contraception or subsequent to Family Planning related surgical procedures.

Item 25: Third Party Liability Action

Indicate the source of third party payment, by entering the appropriate digit in the block. Do not leave this item blank; if there is no third party liability action, enter "0".

Continue to follow procedures for submitting claims as outlined in Chapter III of your Medicaid Home Health Agency Manual.

BILLING PROCEDURES FOR HOME HEALTH CLAIM

Instructions for Completion of the MC-3-C2

- Item 1. -Copy the patient's last name and first name, EXACTLY as it appears on the Validation Form or Medicaid Eligibility Identification Card.
2. -Copy the Case last name and first name, EXACTLY as it appears on the Validation Form or Medicaid Eligibility Identification Card.
3. -Indicate patient's sex, by entering "X" in the appropriate block.
4. -Use six (6) digits to enter the patient's birthdate, (e.g., May 6, 1977 is written 05/06/77).
-If only the year is known, enter the year.
-If birthdate is unavailable, submit claim without birthdate.
5. -Use six (6) digits to indicate the date when approved Home Health Care was initiated.
6. -Use six (6) digits to indicate the date of the first service for which you are billing on this claim.
7. -Use six (6) digits to indicate the date of the last service for which you are billing on this claim.
8. -Enter the number of visits being billed.
9. -This information is usually preprinted.
-If not preprinted write in provider name and address.
10. -Enter the patient's Medical Record Number.
- 11-12. -Copy the patient's HSP Case Number and person number EXACTLY as it appears on the Validation Form or Medicaid Eligibility Identification Card.
-For additional information, see Section 101. of your Medicaid Home Health Agency Manual.
13. -This information is usually preprinted.
-If not preprinted, enter six digit provider number.
- 14-15. -Enter patient's address and telephone number.
-Complete as fully as possible.
- 16-17. -If the patient was referred by a physician from another setting, you must indicate the 9 digit Individual Medicaid Practitioner (IMP) Number and name of the referring practitioner.
18. -Under ordinary circumstances, the patient must sign the claim form when services have been received.
-The claim form must indicate services rendered, prior to presenting it to the patient for signature.
-If the patient's signature is unobtainable, see the Chapter III in your Medicaid Home Health Agency Manual for procedures to follow.
- 19-20. -Enter the 9 digit Individual Medicaid Practitioner (IMP) Number and name of the attending physician.
-This item must be completed on all claim forms.

21. -Prior authorization is required for services following the initial visit.
-Copy the prior authorization number designated by the Medicaid Consultant on the Request for Home Health Care Authorization Form (FD-139).
-Attach FD-139 to claim when submitting for payment.
22. -Enter date of each service opposite the code which appropriately describes the service.
EXAMPLE: Skilled Nursing Care. 02 10/7; 10/8
Home Health Aid 03
Physical Therapy 10
Speech Therapy. 11 10/7
Occupational Therapy. 12
23. -Complete this item for recipients under 21 years of age.
-Ask the patient and/or referring physician or clinic whether the illness requiring services was detected during an EPSDT screening.
-Indicate if this patient is such a referral by checking the appropriate block.
24. -Check the block, if services billed on the claim are ascribable to "Family Planning". These should include home health visits related to contraception or subsequent to family planning related surgical procedures.
25. -Indicate the source of Third Party Payment, by entering the appropriate digit in the block.
-Do not leave blank; if none, enter "0".
26. -Indicate the patient's status, by entering the appropriate digit in the block.
-If plans for home health care extend beyond this billing period, enter "1", still patient.
27. -Using six digits, enter the date of the last visit under the plan of treatment, or the date of admission to the hospital, skilled nursing facility or intermediate care facility.
28. -Using standard medical terminology, enter all the diagnoses which relate to the condition requiring the current services. The primary diagnosis is the illness or condition which was the primary reason for the service. Other diagnoses should be shown under secondary.
-Where possible, enter the primary and secondary diagnosis codes as obtained from the International Classification of Diseases, Adapted (ICDA).
-Use the basic three (3) digit code, placing a zero before and after the appropriate code.
EXAMPLE: Meningitis 320 is written 03200.
29. -Enter the number of visits and charges for the period covered by the claim in the appropriate column.
-Use lines 27 and 28 to list additional services.
-Enter total charges on line 98.
30. -Item 30 is reserved solely for other insurance coverage.
-Item 29 and 30 cannot be completed on the same claim form.
-If patient is covered under Medicare see Section 301.2 of your Medicaid Home Health Agency Manual.
-If patient does not have Medicare coverage, enter charges not covered by Other Insurance on line 32 of item 30.
-The amount received from the Other Insurer must be entered on the bottom line, "Third Party Payment Amount".
31. -Check as appropriate.
-If patient's illness or injury is work related, enter name and address of employer.
-Indicate whether injury resulted from an automobile accident.
-If the injury or illness is related to an auto accident, please provide the auto insurance carrier and policy number in item 32 below.

- 32. -Check appropriate block to indicate whether the patient has other health insurance, liability coverage, or No Fault Auto Coverage.
 - If yes, you must attach a copy of the decline notice or a copy of the explanation of payment from the carrier.
 - Enter the name of the carrier and policy number under which other health insurance benefits are available.

- 33. -Read the Provider Certification carefully.
 - An authorized representative of the Home Health Agency must sign the MC-3 before the claim can be considered for payment. A stamped signature is acceptable.
 - Indicate the billing date which is the date the claim is mailed.
 - The billing date cannot be earlier than the "Claim Thru Date", item 7.

REMARKS: Use this space to enter additional information.

- 34-39. -Leave blank; for contractor use only.



HOME HEALTH CLAIM

1 Patient's Last Name		First Name		2 Case Last Name		First Name		3 Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		4 Birthdate Mo. / Day / Yr.	
5 Start Care Date Mo. / Day / Yr.		6 Claim From Date Mo. / Day / Yr.		7 Claim Thru Date Mo. / Day / Yr.		8 Visits		9 Provider Name and Address		10 Medical Record No.	
11 Health Services Program Case No.				12 Patient Person No.				13 Provider Number			
14 Patient's Address				15 Telephone Number							
16 Referring Physician's Individual Medicaid Practitioner Number				17 Referring Physician's Name Last First (Please Print) M.I.				18 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) _____ Date _____			
19 Attending Physician's Individual Medicaid Practitioner Number				20 Attending Physician's Name Last First (Please Print) M.I.							
21 Prior Authorization Number											
22 TYPE OF SERVICE (Indicate Dates Services Performed)						23 Was this service performed as a result of an EPSDT Program referral? Yes <input type="checkbox"/> No <input type="checkbox"/>					
02						24 Check (✓) if family planning <input type="checkbox"/>					
03											
10											
11											
12											
25 THIRD PARTY LIABILITY ACTION						26 Patient Status		27 Discharge Date			
0 - NONE 1 - MEDICARE A 2 - MEDICARE B 3 - OTHER INSURANCE 4 - LIABILITY 5 - WORKERS' COMPENSATION						1 - STILL PATIENT 2 - DISCHARGED		3 - DECEASED 4 - DISCHARGED TO OTHER FACILITY		Mo. / Day / Yr.	
6 - FAMILY OR FRIENDS PAID 7 - LITIGATION PENDING 8 - THIRD PARTY RESOURCE WON'T COVER CLAIM 9 - OTHER											
29 STATEMENT OF CHARGES						28 Charge or Current Diagnosis					
						Primary		Primary Diagnosis Code			
						Secondary		Secondary Diagnosis Code			
						31 Claim Related to Employment? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Name Of Employer					
						Auto Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No					
						32 Other Insurance or Liability Coverage? Yes <input type="checkbox"/> No <input type="checkbox"/> No Fault Auto Coverage? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Attach Copy of Decline Notice or Explanation of Payment from Carrier.					
								Name of Carrier _____ Policy Number _____			
						33 PROVIDER CERTIFICATION. I certify 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 therefore 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 REPRESENTATIVE SIGNATURE _____				BILLING DATE MO/DAY/YR	
30 OTHER COVERAGE — REMAINING CHARGES						Remarks:					
MEDICARE — DEDUCTIBLE						29					
OTHER (DESCRIBE)						32					
TOTAL						98					
34 Adjudicator Code						35 Payment		36 Process Code		37 Decline Code	
38 Organ Code											

FOR CONTRACTOR'S USE ONLY

34 Adjudicator Code		35 Payment		36 Process Code		37 Decline Code		38 Organ Code	



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

New Jersey Health Services Program NEWSLETTER

Volume P-215

November 7, 1977

TO: HOSPITAL AND SPECIAL HOSPITAL ADMINISTRATORS

SUBJECT: REQUIREMENT TO IDENTIFY PRACTITIONERS WITH AN INDIVIDUAL MEDICAID PRACTITIONER (IMP) NUMBER, EFFECTIVE DECEMBER 1, 1977

Please refer to Newsletter Volume P-196 dated October 3, 1977 which announces a January 1, 1978 implementation date for the Medicaid Management Information System (MMIS). As stated in the previous Newsletter, all provider claim forms are being redesigned in order to incorporate federally required MMIS information.

One of the most significant changes to the hospital claim forms is the requirement to identify practitioners with an Individual Medicaid Practitioner (IMP) Number. Each Medicaid practitioner has been assigned a unique IMP Number and has been advised of the requirement to make it available to other Medicaid providers when prescribing services and/or supplies for a Medicaid patient.

In order to have operational data by the MMIS implementation date, hospital providers will be required to include the IMP Number of the referring, attending and operating physicians on Hospital Claims, as applicable, effective December 1, 1977. You will be receiving a supply of revised claim forms and billing instructions in the near future.

In order to facilitate the billing process, it is suggested that you compile a list of names and IMP Numbers of those licensed practitioners who are affiliated with your hospital. In the event that you are unable to obtain the IMP Number directly from a practitioner, you may call (800) 322-8051 or (800) 322-8052 toll-free for the information. You will need the name and address of the practitioner in order to obtain the IMP Number.

If a practitioner does not have an IMP Number, (i.e., it is not available through the toll-free numbers mentioned above), you will be instructed to write "NON-PAR" in lieu of the IMP Number in the appropriate area on the revised claim.

Interns, residents and other house staff members have not been assigned IMP Numbers, since the licensed practitioner who provides the direct personal supervision of the intern, resident or house staff member is considered to be the referring or attending practitioner or operating surgeon.



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

SUPERSEDED

New Jersey Health Services Program

NEWSLETTER

Volume *P*

SUPERSEDED

December 1, 1977

TO: HOSPITAL ADMINISTRATORS, PHYSICIANS AND INDEPENDENT CLINICS

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

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

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

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

SECURING OF CONSENT OF STERILIZATION

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

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

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

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

SUPERSEDED

(Continued)



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

New Jersey Health Services Program NEWSLETTER

Volume

December 9, 1977

TO: HOSPITAL ADMINISTRATORS

SUBJECT: MEDICAID ELIGIBILITY INQUIRIES

In conjunction with the expanded capabilities of the M.M.I.S. Program, a new Medicaid Eligibility inquiry procedure will, for the first time, be available to all hospitals with teleprocessing equipment.

Effective December 19, 1977 hospitals will be able to utilize a new Medicaid inquiry format to obtain information regarding the eligibility and other insurance status of the patient prior to the submission of claims. As you are aware, benefits available under other health insurance coverage must be fully utilized before the Medicaid program will consider claims on the patient's behalf. Since other insurance carriers and the applicable policy numbers will be identified, your hospital will be able to immediately bill the primary carrier. Use of the Medicaid Eligibility format will enable your personnel to verify current Medicaid eligibility and to avoid declines for "other insurance" under the Medicaid Program by advising you immediately upon admission of the presence of other insurance. Balance bills may then be submitted, with the appropriate documentation attached, to the applicable Medicaid contractor for processing.

The new inquiry format will be available for use by ALL hospitals with teleprocessing equipment. Please emphasize to your business office personnel that claims must continue to be submitted to the applicable contractor as in the past.

Detailed instructions pertaining to the use of the inquiry format are enclosed. Please request that the appropriate personnel familiarize themselves with the procedures involved in utilizing and interpreting the responses to the Medicaid Eligibility inquiry.

Should you or your staff have any questions regarding the new format please contact us at (201) 456-2570.

MEDICAID ELIGIBILITY FORMAT

To obtain the Medicaid Eligibility Format the Teleprocessing operator will:

- 1) Ascertain that the terminal is in operation
- 2) Depress the ERASE SCREEN key to clear any prior formats
- 3) Request the Eligibility Format by:
 - a) Depressing the SOM key (P).
 - b) Entering the code MEIQ.
 - c) Pushing the Transmit Key.

The Medicaid Eligibility Format will then appear on the Screen.

***** MEDICAID ELIGIBILITY *****

TRAN CODE :... HSP CASE NO :..... PERSON NO :..

LAST NAME :..... FIRST NAME :..... INITIAL :

SEX : BIRTH DATE :. : . :

CURRENT MONTH ELIGIBLE : EFFECTIVE DATE :. : . :

NEXT MONTH ELIGIBLE : TERMINATION DATE :. : . :

OTHER INSURANCE CARRIER :..... POLICY NO :.....

MEDICARE COVERAGE :..... HIC NO :.....

ELIGIBILITY RECORD LAST CHANGED ON :. : . :

COMPLETION OF FORMAT

The operator will complete the following information, being certain that the first character of the variable information always replaces the colon (:).

TRANCODE : _ _ _ _

When the format appears the TranCode MEIQ will be automatically filled in. The cursor will appear at the HSP Case No field.

HSP CASE NO : _ _ _ _ _ _ _ _ _ _

Enter the ten (10) digit case number exactly as it appears on the patient's monthly validation stub or Medicaid eligibility card.

PERSON NO. : _

Enter the patient's two (2) digit person number.

The hospital portion of the Medicaid Eligibility format is now complete. Depress the Transmit key. If the information transmitted matches the information on the eligibility file the following items will be completed:

Last Name: The first twelve letters of the patient's last name will appear.

First Name: The first seven (7) letters of the patient's first name will be shown.

Initial: If applicable, the patient's middle initial will be shown.

Sex: M for Male; F for Female will be shown.

Birthdate: The patient's birthdate will appear.

Current Month Eligible: "Y" will indicate that the patient is currently eligible for Medicaid benefits.
"N" will indicate that your patient is not eligible for Medicaid benefits during the current month.

Effective Date: If available, six digits will be used to indicate the date the patient became eligible for Medicaid.

Next Month Eligible: "Y" will be entered if records indicate that the patient will be eligible for Medicaid benefits the following month;
"N" will reflect that the patient will not be eligible for Medicaid the following month.

Termination Date: If available, the date the patient's benefits terminate will be entered.

Other Insurance Carrier: If the patient has other health insurance the name of the carrier will be indicated. If no other insurance is available "NONE" will be entered.

Policy No: The number of the other health insurance policy will be entered. If there is no other insurance coverage, "NONE" will be entered.

Medicare Coverage: This area will be completed with one of the following:

Part A Only
Part B Only
Part A and B
NONE

HIC NO: The Medicare Health Insurance claim number will be indicate if the patient is entitled to Medicare coverage. If the patient does not have Medicare "NONE" will be entered.

Eligibility Record Last Changed On: If available, the date the patient's eligibility records were last changed will be indicated.

A copy of the format may be made by moving the cursor to the end of the format and depressing the copy button.

ERRORS

If the information entered on the format does not agree with the information contained in the eligibility records one of the following messages will appear:

Identification Number Invalid

or

No Match

In the event you receive one of the above error messages please contact either your local county welfare office or, in the case of an SSI recipient, your local Social Security office for assistance.



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

New Jersey Health Services Program NEWSLETTER

Volume P. 218

February, 1978

TO: ALL PHYSICIANS

SUBJECT: PNEUMOCOCCAL VACCINE POLYVALENT

Medicaid has added Pneumococcal Vaccine Polyvalent to its reimbursement schedule for immunizations consistent with the following conditions:

1. Procedure code 9461 has been established for this immunization;
2. The maximum allowable reimbursement of \$7.00 includes the cost of the vaccine and the cost of its administration;
3. No prior authorization is required. Indications for its use are based on the principles of good medical practice;
4. If there is a significant price reduction in the cost of the vaccine, reimbursement to the physician will be adjusted accordingly;
5. If the vaccine becomes available free of charge from any source, the Medicaid allowance to the physician for procedure code 9461 will then become \$2.50 (similar to the allowance for an injection);
6. **REIMBURSEMENT TO THE PHYSICIAN IS LIMITED TO THE OFFICE AND HOME SETTING;**
7. The vaccine will be available to patients in any approved health care facility upon the written order of the attending physician, who customarily does not receive direct reimbursement for the immunization.

Revised manual pages incorporating this new policy will be issued shortly.



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

New Jersey Health Services Program NEWSLETTER

Volume P-219

February 17, 1978

TO: ALL DENTISTS AND INDEPENDENT DENTAL CLINICS
SUBJECT: REGULATIONS PERTAINING TO REIMBURSEMENT AS A DENTAL SPECIALIST

This letter is of extreme importance to all dentists who wish to be reimbursed as specialists. Please read it carefully and insert it in your Dental Manual.

In order for the New Jersey Medicaid Program to reimburse a dentist as a specialist, a copy of the certificate issued by the New Jersey Board of Dentistry permitting him/her to announce practice in a special area of dentistry must be forwarded to the Prudential Insurance Company, Provider Maintenance Unit, Medical Administration, P.O. Box 1900, Millville, N.J. 08332. All permits must be received by March 10, 1978, in order to receive specialty reimbursement on or after April 1, 1978. The specialties reimbursable by the New Jersey Medicaid Program are:

- | | |
|-----------------|-------------------|
| 1. Endodontics | 4. Pedodontics |
| 2. Oral Surgery | 5. Periodontics |
| 3. Orthodontics | 6. Prosthodontics |

Those dentists who submit a copy of the specialty permit will receive an acknowledgement from Prudential Insurance Company. If you do not receive an acknowledgement by March 27, 1978, contact the Provider Maintenance Unit, Prudential Insurance Company, telephone number 609-293-2158.

If you have already forwarded a copy of your specialty permit, it is not necessary to repeat this procedure, unless you do not receive an acknowledgement.

If a copy of the specialty permit is not received for a dentist who is currently identified as a specialist, effective April 1, 1978, he/she will be reclassified as a general practitioner for the purpose of Medicaid reimbursement.

Reimbursement by specialty based upon a permit received after March 10, 1978 cannot be implemented until the specialty permit is processed at Prudential.



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

New Jersey Health Services Program NEWSLETTER

Volume P-221

April 24, 1978

TO: PARTICIPATING FAMILY PLANNING CLINICS

SUBJECT: 1) REVISED REIMBURSEMENT FOR INSERTION OF IUDS
 2) NEW PROCEDURES WHICH QUALIFY FOR MEDICAID REIMBURSEMENT

This Newsletter supersedes New Jersey Health Services Program Newsletter 1-64 dated August 9, 1973. ALL CHANGES ARE IDENTIFIED BY BRACKETS.

The following policies remain in effect for family planning clinic services.

- I. All family planning procedures for which reimbursement is made by the Medicaid Program must involve physicians' services.
- II. The following fee schedule represents maximum amounts allowable on and after May 1, 1978. Providers will be paid their customary charges when they are lower than these maximum amounts.

<u>DESCRIPTION OF SERVICE</u>	<u>PROCEDURE CODE</u>	<u>MAXIMUM ALLOWANCE</u>
<u>Initial Medical Visit - Family Planning</u>	0001	
Includes:		
Medical, social, obstetrical history		
Complete pelvic examination - including visual inspection of cervix		
Breast examinations		
Papanicolaou smear (excludes cytology study)		
Contraceptive counseling		
Referral as indicated		
Includes costs of birth control drugs dispenses		\$25.00
<u>Insertion of Intrauterine Device</u>	4591	
[Includes cost of device and necessary post-procedural follow-up		\$30.00
<u>Laboratory, Cytology Study (Papanicolaou Smear)</u>	8917	\$ 5.00
[<u>Pregnancy Test</u>	8961	\$ 4.00

(cont'd.)

<u>DESCRIPTION OF SERVICE</u>	<u>PROCEDURE CODE</u>	<u>MAXIMUM ALLOWANCE</u>
<p><u>Medical Revisit - Family Planning</u></p> <p>May include pelvic examination, changes in method or physicians' instructions. Includes costs of birth control drugs dispensed</p>	0002	\$10.00
<p><u>Routine or Follow-up Visit, Brief</u></p> <p>May include pelvic examination, changes in method or physicians' instructions. Minimum average time is five (5) minutes.</p>	0005	\$ 4.20
<p><u>Routine or Follow-up Visit, Prolonged</u></p> <p>May include pelvic examination, changes in method or physicians' instructions. Involves <u>20 or more</u> minutes of personal time in patient contact including documentation of time on the record as well as adequate significant progress notes on the chart. Includes cost of birth control drugs dispensed.</p>	9007	\$13.00
<p><u>Annual Medical Revisit - Family Planning</u></p> <p>Includes:</p> <p>Updating medical, social, obstetrical history Complete pelvic examination including visual inspection of cervix Breast examination Papanicolaou smear (excludes cytology study) Referral when indicated Includes cost of birth control drugs dispensed</p>	0006	\$25.00
<p><u>Vasectomy</u></p>	4241	\$75.00

IMPORTANT!

All family planning clinic claims received by Prudential during the period of May 1, 1978 to May 12, 1978 for which the old maximum charge for inserting of IUD (Procedure Code 4591) was billed by the provider will be paid at the new maximum rate. All claims received subsequent to May 12, 1978 will be paid at billed charges if they are lower than the new maximum rate.



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.

(Over)

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	New Jersey Blue Cross Plan
Provider Reorder Unit	Mail & Supply Section
P. O. Box 471	P. O. Box 420
Millville, N. J. 08332	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

VolumeP-227.....

July 17, 1978

TO: ALL DENTISTS, INDEPENDENT DENTAL CLINICS
AND DENTAL CLINICS IN HOSPITAL OUTPATIENT
DEPARTMENTS.

SUBJECT: EXCEPTION TO POLICY REGARDING REIMBURSE-
MENT FOR DENTAL SERVICE PERFORMED BEYOND
365 DAYS FROM DATE OF INITIAL EXAMINATION.

CURRENT POLICY

The Dental Services Manual, Section 202.2(1), page 16, which became effective May 15, 1978, states:

"NO REIMBURSEMENT WILL BE MADE FOR ANY DENTAL SERVICES PERFORMED BEYOND (1) YEAR (365 DAYS) FROM THE DATE OF THE INITIAL EXAMINATION ON THE TREATMENT PLAN."

EXCEPTION TO CURRENT POLICY

As a response to problems encountered by the provider community, the Medicaid Program has established a temporary exception to the policy stated above. All dental services on treatment plans initiated 365 days or more prior to May 15, 1978 must be completed on or before August 15, 1978. Claims for these services must be received by the Prudential Insurance Company within ninety (90) days of the last date of service on that claim.

If you wish to continue treatment, it will be necessary to reexamine the patient, to take X-rays as indicated by the Program, and to develop a new treatment plan. Where appropriate, prior authorization must be obtained from your Medicaid Dental Consultant. Please use the revised Dental Claim Form MC-10-C5 (7/77) for this purpose.



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

New Jersey Health Services Program

NEWSLETTER

Volume P-228

August 14, 1978

TO: Hospital and Special Hospital Administrators, Physicians, and Independent Clinics

SUBJECT: Policy Regarding Medicaid Reimbursement For Abortions
(Applies to Abortions Performed on New Jersey Medicaid Eligible Recipients In New Jersey and/or Other States)

This Newsletter supercedes Newsletters P-190, P-191 issued August 1, 1977.

On July 7, 1978, The Superior Court of New Jersey, Chancery Division - Middlesex County ordered the Division of Medical Assistance and Health Services (Medicaid) to reimburse providers for the costs of all medically necessary abortions where:

1. "the medical indications as to the necessity of an abortion for a particular woman are not insignificant and
2. relate to the physical and/or psychological condition of the woman in question, and
3. are not based solely on considerations of family planning or emotional or social convenience."

The determinations of medical necessity are subject to review by Medicaid in accordance with existing rules and regulations of the Medicaid program. Reimbursement will be made to Medicaid participating providers for medically necessary abortions performed on or after July 7, 1978 in accordance with the following guidelines:

- (1.) Medically necessary abortions may be performed up to and during the 12th week of pregnancy in a licensed hospital, licensed physician's office or licensed independent abortion clinic.
- (2.) Medically necessary abortions performed after the 12th week of pregnancy must be performed in a licensed hospital.
- (3.) A Physician Certification, (Form FD-179), copy attached, must be attached to the physician's Medicaid Claim form.

A copy of the completed FD-179 must also be attached to: a. the hospital's or independent clinic's Medicaid Claim form as appropriate; b. the anesthesiologist's Medicaid Claim form.

Those New Jersey Hospitals with tape-to-tape or teleprocessing billing capabilities will be required to submit hard-copy Inpatient (MC-1) or Outpatient (MC-4) claim forms for all abortion claims.

This Order is a Temporary Order, subject to being changed, dissolved or overturned at any time, and, if so dissolved, or overturned, the prior Medicaid policy, not to pay for abortions, except where the mother's life is in jeopardy by virtue of the pregnancy, may be reinstated, applied retroactively, and the Medicaid recipient may be responsible for re-payment of all State-reimbursed costs related to the abortion following recoupment from the provider. However, if the above is required to save the life of the mother, reimbursement will not be effected by reversal of this order.

If you have questions concerning the temporary abortion policy, please contact J. C. Breme, M.D., Medical Director, New Jersey Medicaid Program at 609-292-7673.

Ordering of Forms

Providers can obtain additional copies of the FD-179 form from their respective contractors by writing to the Prudential Insurance Company (P.O. Box 1900, Millville, New Jersey 08332) or Blue Cross (33 Washington Street, Newark, New Jersey 07102) as appropriate. It is acceptable for providers to photocopy the FD-179 Certification Form for their own use if there is not sufficient time to order an additional supply from the contractor.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
MEDICAID
NEW JERSEY HEALTH SERVICES PROGRAM

PHYSICIAN CERTIFICATION

I certify that it was Medically Necessary to perform an abortion on

Name and Address of Medicaid Recipient

Recipient's HSP
Case Number

for the following reason (Check One):

1. To preserve the woman's life.

2. The patient was a victim of rape or incest.

If this is checked, signed documentation from a law enforcement agency or public health service stating that:

(a) the person upon whom the medical procedure (abortion) was performed was reported, within 60 days of the incident, to have been the victim of an incident of rape or incest; and

(b) the documentation contains the name and address of the victim and the person making the report (if different), and the specific dates of the incident and report, as well as attesting to the fact that the incident was reported and that the report included the signature of the person reporting.

must be attached to all Medicaid Claim forms in addition to the Physician Certification (FD-179). If the victim meets a condition described in 1 or 3 these reports are not necessary and 1 or 3 should be checked.

3. Medically Necessary---

Severe and long-lasting physical health damage to the mother would have resulted if the pregnancy had been carried to term or the medical indications as to the necessity of the abortion for the woman are not insignificant and relate to her physical and/or psychological condition. If this is checked, two physicians, must certify that in their professional judgement this procedure was medically necessary.

NOTE: At least one of the two physicians who gives an opinion must also certify that he/she is not an "interested physician"

"(a) whose income is directly or indirectly affected by the fee which is paid for the performance of the abortion; or (b) the spouse of, or another relative who lives with, a physician whose income is directly or indirectly affected by the fee paid for the performance of the abortion. Copies of this form signed by two different physicians will be acceptable for this purpose and must be attached to all Medicaid Claim forms for the abortion." (Source 42 CFR 449.104)

I further certify that this abortion was not performed solely on consideration of family planning or emotional or social convenience of the patient.

Signature of Physician Who Performed the Abortion M.D., D.O. Physician's I.M.P. # Date

Signature of (Non Interested) Physician M.D., D.O. Physician's I.M.P. # Date



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

New Jersey Health Services Program NEWSLETTER

Volume P-230

September 25, 1978

TO: ALL PHYSICIANS AND INDEPENDENT LABORATORIES

SUBJECT: CHEMISTRY PROFILES

This is to announce the establishment of the following new laboratory profiles and procedure codes to be utilized when billing Medicaid:

Code

- 8302 Basic Chemistry Profile
- 8306 Expanded Chemistry Profile

Profile Components

The following list contains those tests which can be and are frequently done as groups and combinations on automated multichannel equipment. The profiles designated by the new codes may include any combination of those tests listed below. However, when billing, you must enter one of the Codes, 8302 or 8306, and indicate the total number of tests performed.

- | | |
|--------------------------------------|----------------------------|
| Albumin | Iron |
| Alkaline Phosphatase | Lactic Dehydrogenase (LDH) |
| Bilirubin, Total | Phosphorus |
| Bilirubin, Direct | Potassium (K) |
| Blood Urea Nitrogen (BUN) | Protein, Total |
| Calcium | SGOT |
| Chlorides (CL) | SGPT |
| Cholesterol | Sodium (Na) |
| Carbon Dioxide (CO ₂) | Triglycerides |
| Creatinine | Total Lipids |
| Gamma Glutamyl Transpeptidase (GGTP) | Uric Acid |
| Glucose | T4 by Immune Assay (EMIT) |

NOTE: Payment for the chemistry profile(s) includes the following calculations and ratios. These items are not eligible for separate or additional reimbursement.

- | | |
|----------------------|----------------|
| A/G Ratio | Globulin |
| BUN/Creatinine Ratio | FTI (T7) |
| Free Calcium | Free Thyroxine |

(over)

Billing Instructions

<u>Code</u>		<u>Maximum Dollar Value</u>
8302	Basic Chemistry Profile (NOTE: Code 8719 - SMA-12, will be replaced by Code 8302.) Use this code to bill when 3 to 16 of the above tests have been performed.	\$ 7.50
8306	Expanded Chemistry Profile Use this code to bill when 17 to 24 of the above tests have been performed.	\$11.00

Enter Code 8302 or 8306, whichever is applicable, in Item 11-B and identify the profile, indicating the total number of tests performed, in Item 11-C on the Independent Laboratory Claim MC-13A-C2 (7/77).

8607 Glucose (separate tube, gray top) performed on the same date as a Basic or Expanded Chemistry Profile will be paid an additional \$2.00.

Enter Code 8607 in Item 11-B and identify the test as "Glucose, separate tube, gray top" in Item 11-C on the Independent Laboratory Claim MC-13A-C2 (7/77).

Additional Tests

Other than those mentioned previously, reimbursement for additional tests performed on the same date as Basic or Expanded Chemistry Profile (Code 8302 or 8306), will be the current allowable fee for each such additional test.

Enter each procedure code number and/or each procedure code and narrative in Item 11-B and/or Item 11-C of claim form. Separate these tests from the profile identification. Indicate the individual charges for each additional test.

Billing Instructions - Claim Completion Example

11. Report of Services

A	B	C	E
<u>Date of Service</u>	<u>Proc Code</u>	<u>Identify Tests or Procedures And Attach Abnormal Findings</u>	<u>Charge</u>
8/15/78	8302	Basic Chemistry Profile (14 tests)	\$ #.##
8/15/78	8607	Glucose (separate tube, gray top)	#.##
	Additional Tests		
8/15/78	8936	Urinalysis	#.##
8/15/78	8628	CBC	#.##
		Total Charges	\$ #.##

The following new profiles are added:

8328	Electrolytes Sodium (Na) Potassium (K) Chlorides (CL) Carbon Dioxide (CO2)	\$ 6.00
------	--	---------

NOTE: Any three of the components on same date will be paid as Code 8328.

8310	Lipid Screen Cholesterol and Triglycerides	7.00
------	---	------

8322	Basic Lipid Profile (Phenotype) Cholesterol Triglycerides Lipoprotein Electrophoresis Lipoprotein Phenotyping (Frederickson Classification)	15.00
------	--	-------

8316	Expanded Lipid Profile (Phenotype) Cholesterol Triglycerides Lipoprotein Electrophoresis Lipoprotein Phenotyping (Frederickson Classification) High Density Lipoprotein (HDL)	23.00
------	---	-------

8321	Rheumatoid Profile Includes as a minimum four of the following tests: ASO Titer C-Reactive Protein (CRP) RA Latex (Rheumatoid Arthritis Factor) Uric Acid Alkaline Phosphatase Calcium	12.00
------	---	-------

8331	Rheumatoid Profile plus ANA (Antinuclear Antibody) (FANA)	18.00
------	--	-------

8317	Thyroid Profile T4 by RIA, plus T3 uptake, resin (T3 RU) (RT3U)	12.00
------	---	-------

Fee includes "T7", Free Thyroxine Index (FTI),
Calculated Free Thyroxine Index (CFT4) or
Calculated Thyroxine Iodine (T4I)

NOTE: T3 by uptake, resin (T3RU) is eligible for reimbursement only when done in conjunction with T4 by RIA as part of Thyroid Profile.

(over)

8332	Basic Prenatal (Obstetric) Profile (at least four of the following): Blood Group (ABO) Rh Factor Antibody Screen (Atypical Antibody Identification) Complete Blood Count (CBC c or s) (with or without differential) Serology (STS, VDRL, RPR)	10.00
8333	Basic Prenatal (Obstetric) Profile with Rubella HI Antibody Titer	15.00
8334	Expanded Prenatal (Obstetric) Profile Blood Group (ABO) Rh Factor Antibody Screen (Atypical Antibody Identification) Complete Blood Count (CBC c or s) (with or without differential) Serology (STS, VDRL, RPR) Cytology (Pap Smear) Urinalysis Urea Nitrogen (BUN) Glucose Sickle Cell	14.00
8335	Expanded Prenatal (Obstetric) Profile with Rubella HI Antibody Titer	19.00



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

New Jersey Health Services Program NEWSLETTER

Volume P-231

November 13, 1978

TO: ALL PROVIDERS OF OBSTETRICAL AND GYNECOLOGICAL SERVICES

SUBJECT: OBSTETRICAL AND GYNECOLOGICAL CODES - NEW CODES, MODIFICATION OF EXISTING CODES, RE-EMPHASIS OF EXISTING CODE NARRATIVE, INITIAL VISITS AND CONSULTATIONS

NEW CODES

The following four procedure codes 4579, 4580, 4799, and 4826 are reimbursable only to Program recognized specialists in obstetrics and gynecology.

<u>Procedure Code</u>	<u>Description</u>	<u>Specialist Only</u>
4579	Colposcopic examination without biopsy	\$21
4580	Colposcopic examination with biopsy	\$34
NOTE:		
(1) Codes 4579 and 4580 are reimbursable <u>only</u> if one or more of the following guidelines are met. If met, enter the indicated guideline in Section 15 C of the MC-8 Claim Form.		
(a) Patients who have a current pap smear reported as Class 2 or higher, or;		
(b) Patients who have had surgery for uterine cancer, or;		
(c) Patients who were exposed in utero to Diethylstilbestrol.		
4799	Amniocentesis - Note indication in Section 15 C of the MC-8 Claim Form. (Independent Procedure)	\$37
4826	Fetal Oxytocin Stress Test for Placental insufficiency. (This study is reimbursable <u>only</u> to the physician who is in direct physical attendance to the patient during the <u>complete</u> procedure in a hospital inpatient or outpatient setting) (Not reimbursable if patient goes into labor.)	\$30

(over)

MODIFICATION OF EXISTING CODES

- 4821 Total obstetrical care
- 4823 Subsequent ante partum visit
- 4825 Initial ante partum visit

Maternity related laboratory studies, previously included in the reimbursement for procedure codes 4821, 4823, and 4825, have been deleted from the associated narratives. Program regulations, as for any other laboratory studies, now apply.

RE-EMPHASIS OF EXISTING CODE NARRATIVE

- 4591 Insertion of intracervical or intrauterine device for contraception. (Includes cost of device and post-insertion visit.) Insert trade name of IUD in Section 15 D of the MC-8 Claim Form.

INITIAL VISITS AND CONSULTATIONS

Reimbursement will be made for the Initial Visit or for a Consultation performed on the same day as a colposcopic examination, IUD insertion, or amniocentesis provided that the Program criteria for an initial visit or consultation are completely fulfilled and documented on the record,



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

New Jersey Health Services Program NEWSLETTER

Volume P-232

November 15, 1978

TO: Hospital and Special Hospital Administrators, Physicians,
and Independent Clinics

SUBJECT: Modification of Medicaid Reimbursement for Abortions Performed
in Licensed Ambulatory Facilities. (Applies to Abortions
Performed on New Jersey Medicaid Eligible Recipients in
New Jersey and/or Other States)

The New Jersey State Department of Health has adopted an emergency amendment to the rules concerning the standards for licensure of ambulatory facilities regarding abortions in the second trimester. The full text of the adoption reads as follows:

"8:43 A-1.48(b) 1. Abortion. Beyond the first trimester and within a period of gestation not exceeding 16 menstrual weeks and/or 14 gestational weeks size as determined by a physician, termination of pregnancy using the dilation and evacuation procedure may be performed in a licensed ambulatory care facility." This emergency regulation became effective on August 9, 1978.

In Newsletter (P-228) dated August 14, 1978 the guidelines for reimbursement to be made to Medicaid participating providers for medically necessary abortions performed on or after July 7, 1978 were outlined.

Reimbursement will be made to Medicaid participating providers for medically necessary abortions performed in accordance with the following guidelines which have been revised to read as follows:

- (1) Medically necessary abortions may be performed up to and during the 12th week of pregnancy in a licensed hospital, licensed physician's office or licensed independent abortion clinic.
- (2) Medically necessary abortions performed after the 12th week of pregnancy must be performed in a licensed hospital.

EXCEPTION: On or after August 9, 1978, termination of pregnancy using the dilation and evacuation procedure, within a period of gestation not exceeding 16 menstrual weeks and/or 14 gestational weeks size as determined by a physician, may be performed in a licensed independent abortion clinic approved for participation in the Medicaid Program.

- (3) A Physician Certification, (Form FD-179), must be attached to the physician's, clinic's, or hospital's Medicaid 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-233

December 11, 1978

TO: ALL OPHTHALMOLOGISTS, OPTOMETRISTS AND OPTICIANS

SUBJECT: MEDICAID'S POSITION RELATIVE TO THE FEDERAL TRADE COMMISSION'S RULING CONCERNING PRESCRIPTION RELEASE REQUIREMENTS (EFFECTIVE JULY 2, 1978)

In response to inquiries from the provider community, the Medicaid Program would like to clarify its position with reference to the F.T.C. Ruling 16 CFR, Section 456.7 Separation of Examination and Dispensing which reads as follows:

"In connection with the performance of eye examinations, it is an unfair act or practice for a refractionist to:

- (a) fail to give to the buyer a copy of the buyer's prescription immediately after the eye examination is completed."

To prevent possible recipient overutilization which could result by your complying with the ruling as stated above, you are requested to adhere to the following.

If the recipient requests an additional copy of the original prescription, please proceed as follows:

NON-DISPENSING PROVIDERS - Ophthalmologists and Optometrists

- Note the date of the original prescription
- Indicate clearly that this prescription is a duplicate

DISPENSING PROVIDERS - Ophthalmologists, Optometrists, & Opticians

- Retain the original prescription
- Specify on the duplicate prescription that the original prescription was filled
- Indicate the date that the glasses were dispensed

By supplying this additional information, you will alert potential dispensers to check for possible duplication. We would appreciate your cooperation in prompt implementation of these measures.

Remember, the Program reimburses for eye examination, if necessary, and glasses, if there is sufficient change, within the guidelines of the New Jersey Health Services Program Vision Care Manual, once every two years for persons 19 years of age or over and once a year for persons less than 19 years of age or 60 years of age or over. Overutilization of this standard is a violation of Program Policy.

If we can be of further service in this matter, please contact the Vision Care Section (609) 292-7160.



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

New Jersey Health Services Program

NEWSLETTER

Volume P

December 26, 1978

TO: HOSPITAL ADMINISTRATORS, PHYSICIANS, AND INDEPENDENT CLINICS

SUBJECT: FEDERALLY MANDATED CHANGES FOR STERILIZATION AND
HYSTERECTOMY PROCEDURES.
NEW STERILIZATION AND HYSTERECTOMY FORMS
DESTRUCTION OF CURRENT STERILIZATION FORMS, FD-163, FD-164,
AND FD-165

(THIS NEWSLETTER SUPERCEDES THE UNNUMBERED NEWSLETTER DATED
DECEMBER 1, 1977)

Claims for any service involved in a sterilization or hysterectomy procedure, performed on or after February 6, 1979 will be rejected unless a new federally approved Sterilization Consent Form or Hysterectomy Receipt of Information Form (FD-189) has been completed and attached to each claim.

FEDERAL REQUIREMENTS

The Department of Health, Education, and Welfare has just issued new regulations, effective February 6, 1979, which amend the existing requirements for sterilizations that are reimbursed under the Medicaid Program. The new rules mandate that, before making payment for any sterilization or hysterectomy procedures, the Medicaid Agency must obtain the new consent form or acknowledgement of receipt of hysterectomy information and must document that the following requirements for sterilization were met:

1. The individual is at least 21 years old at the time consent is obtained;
2. The individual is not mentally incompetent or institutionalized.
3. The individual has voluntarily given informed consent.
4. At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

Hysterectomy

Prior to making payment for a hysterectomy, the completed Receipt of Hysterectomy Information Form must be received by the Medicaid Contractor and the following requirements must have been met:

1. A hysterectomy may not be performed solely for the purpose of rendering an individual permanently incapable of reproducing; or if there was more than one purpose to the procedure, would not be performed but for the purpose of rendering the individual permanently incapable of reproducing.
2. A hysterectomy on a female of any age may be performed when medically necessary, provided that the person who secured authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will render the individual permanently incapable of reproducing; and the individual or a representative must have signed a written acknowledgement of receipt of that information.

NOTE: There is no 30 day waiting period required before a medically necessary hysterectomy may be performed.

Informed Consent

Under the new regulations, an individual is considered to have given informed consent only if:

1. The person who obtained consent for the sterilization procedure offered to answer any questions the individual may have concerning the procedure, provided a copy of the Consent Form, and provided orally all of the following information or advice to the individual to be sterilized:
 - (a) Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled;
 - (b) A description of available alternative methods of family planning and birth control;
 - (c) Advice that the sterilization procedure is considered to be irreversible;
 - (d) A thorough explanation of the specific sterilization procedure to be performed;
 - (e) A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
 - (f) A full description of the benefits or advantages that may be expected as a result of the sterilization;
 - (g) Advice that the sterilization will not be performed for at least 30 days;
2. Suitable arrangements were made to insure that the information specified in paragraph 1 above was effectively communicated to any individual who is blind, deaf, or otherwise handicapped;

3. An interpreter was provided if the individual to be sterilized did not understand the language used on the approved Consent Form or the language used by the person obtaining consent;
4. The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained;
5. The Consent Form requirements were met.
 - (a) Content of the Consent Form. The Consent Form must be an exact replica of the federal form.
 - (b) Required signatures. The Consent Form must be signed and dated by:
 - (1) The individual to be sterilized;
 - (2) The interpreter, if one was provided;
 - (3) The person who obtained the consent; and
 - (4) The physician who performed the sterilization procedure.

NOTE: A copy of the Consent Form must be given to the individual.

6. Any additional requirement of State or local law for obtaining consent, except a requirement for spousal consent, was followed.
 - (a) Informed consent may not be obtained while the individual to be sterilized is:
 - (1) In labor or childbirth;
 - (2) Seeking to obtain or obtaining an abortion; or
 - (3) Under the influence of alcohol or other substances that affect the individual's state of awareness.

BILLING PROCEDURES

Unilateral procedures performed on the male or female genital system are considered sterilization procedures if available documentation will support the conclusion that the procedure results in sterilization. The provider, when performing a sterilization procedure must utilize the codes listed below. In order to receive reimbursement, it is necessary to check "Family Planning", item 12E of the MC-8 Physician and Practitioners Claim Form, or item 11D of the MC-14 Independent Outpatient Health Facility Claim Form. For hospitals to receive reimbursement, the MC-1 Inpatient Hospital Claim Form and the MC-4 Outpatient Hospital Claim Form must clearly indicate that the procedure is for sterilization; and item 27, "Check if Family Planning" must be checked. The completed new Consent Form or Hysterectomy Receipt of Information Form must be attached to all claims.

SURGICAL PROCEDURES

PROCEDURE CODE

A. Female

Transection of Fallopian Tube, unilateral or bilateral, abdominal or vaginal approach	4531
Transection of Fallopian Tube, unilateral or bilateral, abdominal or vaginal approach post-partum, during same hospitalization by physician effecting delivery	4532
Salpingectomy, complete or partial, unilateral or bilateral (independent procedure)	4541

SURGICAL PROCEDURES

PROCEDURE CODE

Salpingo-oophorectomy, complete or partial, unilateral or bilateral (independent procedure) 4545

Complete oophorectomy, unilateral or bilateral (independent procedure) 4569

Transection-Fulgeration of Fallopian Tubes by laparoscopy or culdoscopy; with or without dilation and curettage (independent procedure) 4549

B. Male

Vasectomy, unilateral or bilateral (independent procedure) 4241

Ligation (percutaneous) of vas deferens (independent procedure) 4261

FORMS

Begin using the new forms on January 6, 1979 for sterilization procedures which are scheduled to be done on or after February 6, 1979. After February 6, 1979 the sterilization forms FD-163, FD-164, and FD-165 should be destroyed.

The new sterilization and hysterectomy forms including; the new Consent Form, the Male/Female Sterilization Operation Pamphlet; and the Hysterectomy Receipt of Information Form - FD-189 are currently being printed. A limited number are now available from the Local Medical Assistance Units listed below. We request that only providers who contemplate performing sterilization or hysterectomy procedures in February or early March of 1979 obtain the forms in this manner.

All providers can expect to receive an initial supply by late February, 1979. After that mailing, additional copies can be obtained by writing to your respective contractors, Prudential Insurance Company, P.O. Box 1900, Millville, N.J. 08332 or Blue Cross, 33 Washington Street, Newark, N.J. 07102.

<u>LOCAL OFFICE</u>	<u>ADDRESS</u>	<u>TELEPHONE NUMBER</u>
Atlantic (Cape May)	22 South North Carolina Ave. Atlantic City, N.J. 08404	609-344-2861
Bergen	50 Main Street Hackensack, N.J. 07601	201-488-5667
Burlington	Chesley & Alloway Bldg., 2nd Flr. Rt. 38 & Eayrestown Road Mt. Holly, N.J. 08060	609-261-0448
Camden	530 Cooper Street, 3rd Flr. P.O. Box 1089 Camden, N.J. 08101	609-757-2870

<u>LOCAL OFFICE</u>	<u>ADDRESS</u>	<u>TELEPHONE NUMBER</u>
Cumberland	501 Landis Avenue (basement) Vineland, N.J. 08360	609-696-0521
Essex	155 Washington Street Newark, N.J. 07102	201-648-2470
Gloucester (Salem)	Southwood Shopping Center Woodbury, N.J. 08096	609-845-7185
Hudson	880 Bergen Avenue Jersey City, N.J. 07306	201-792-6390
Hunterdon (Somerset & Warren)	79 Main Street, 2nd Flr. Flemington, N.J. 08822	201-782-1130
Mercer	1424 S. Broad Street Trenton, N.J. 08610	609-292-7315
Middlesex	75 Paterson Street (basement) New Brunswick, N.J. 08903	201-246-0653
Monmouth	1200 Memorial Drive Asbury Park, N.J. 07712	201-775-5700
Morris (Sussex)	10 Park Place, 4th Flr. Morristown, N.J. 07960	201-267-1700
Ocean	1861 Hooper Avenue Toms River, N.J. 08753	201-255-6226
Passaic	100 Hamilton Plaza (Market St.) (9th Flr.) Paterson, N.J. 07505	201-523-2800
Union	333 North Broad St., 2nd Flr. Elizabeth, N.J. 07208	201-355-8860



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

New Jersey Health Services Program NEWSLETTER

Volume P-237

March 2, 1979

TO: Providers of Transportation Services

SUBJECT: On-site Medicaid Visitations

As an ongoing responsibility of the Division of Medical Assistance and Health Services for the monitoring and auditing of providers of transportation services under the Medicaid program, this is to inform you that, effective this date, Medicaid representatives from the Central Office and/or the Local Medical Assistance Unit may, at times, make on-site visits of transportation providers. Such visits may include a review of Medicaid transportation records and trips on vehicles providing transportation for Medicaid recipients. It is anticipated that you will provide any Medicaid representative who makes a monitoring/audit visit your full cooperation.

Sincerely yours,

A handwritten signature in cursive script, reading "Thomas M. Russo".

Thomas M. Russo, Director
Division of Medical Assistance
and Health Services

TMR:am



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

New Jersey Health Services Program NEWSLETTER

Volume P - 239

March 8, 1979

TO: HOSPITAL ADMINISTRATORS

SUBJECT: Transmission of Medicaid Claims via the Teleprocessing Terminal

Under the guidance and approval of the Division of Medical Assistance and Health Services (Medicaid), Prudential has worked out an arrangement with Blue Cross of New Jersey whereby the teleprocessing terminal (CRT) now used by your facility for transmission of Blue Cross claim data can also be used for your inpatient and outpatient Medicaid claims. The Medicaid data will be transmitted to Prudential's Millville office for processing and your checks and Statements of Claim Payment will be sent in the usual manner. The obvious benefits of this innovative cooperative endeavor are faster turnaround time, reduced paper work and mailing costs for your facility, as well as improved efficiency, and cost savings for the Medicaid Program.

Very shortly a Professional Relations Representative will be contacting you with more details and to make arrangements for implementation. It is anticipated that this new system will be operational approximately April 1, 1979.



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

New Jersey Health Services Program NEWSLETTER

Volume P-240

March 15, 1979

TO: ALL TRANSPORTATION PROVIDERS

SUBJECT: Revised Transportation Claim Form - MC-12-C-5 (10/78)

Attached is a copy of the newly revised Transportation Claim Form. You will begin to receive these new forms as you reorder claim forms. Continue to use the old forms, MC-12-C-4, until your supply is depleted.

CHANGES TO THE CLAIM FORM

1. Patient Certification - The patient signature item has been deleted on the new claim form. The new patient signature policy, implemented on October 15, 1978, requires transportation providers to obtain the patient's signature on a separate Medicaid Patient Certification Form for each service rendered. See Newsletter P-229 for additional information regarding the Patient Certification Form.

Note that in signing the Provider Certification (item 15), the provider certifies that "an individual Medicaid Patient Certification Form is on file for each service billed."
2. Practitioner Ordering Transportation - Enter the name and Individual Medicaid Practitioner (IMP) Number of the practitioner who ordered the transportation in item 11. This information was entered under item 13 on the old claim form.
3. EPSDT Indicator - The EPSDT indicator has been deleted from the new form, (formerly item 10 on the old claim form). Provider will not be required to enter this information.
4. Report of Services - Item 12 - Additional space has been provided in item 12 to make it easier to complete.



1. Patient's Last Name				First Name				2. Patient's Street Address				Telephone Number												
3. Health Services Program Case No.				4. Patient Person No.		5. Age		6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		City				State		Zip Code								
7. Other Health Insurance or Liability Coverage? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, attach copy of Decline Notice or Explanation of Payment from Carrier. No Fault Auto Coverage? Yes <input type="checkbox"/> No <input type="checkbox"/> (If Medicare - See Section 304 of the Transportation Manual)								8. Was Patient's Illness or Injury connected with employment? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, give Name and Address of Employer here.																
9. PROVIDER OF SERVICE INFORMATION												10. Did injury result from automobile accident? Yes <input type="checkbox"/> No <input type="checkbox"/>												
Telephone Number				Medicaid Provider Number (Enter only when not printed below)				11. Practioner ordering transportation Name				Individual Medicaid Practitioner (IMP) Number												
Name and Address																								
FOR CONTRACTOR'S USE ONLY																								
TOTAL AMOUNT A				TOTAL AMOUNT B				CODE	PRESCRIBING PRACTITIONER'S NUMBER				AUTH	JAM	3rd P.C.									
47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71

12. REPORT OF SERVICES												5-Long Term Care Facility				7-Outpatient Hospital				9-Other Locations (Specify in 12C)			
Place of Origin		1-Doctor's Office		3-Inpatient Hospital		6-Independent Laboratory		8-Clinic (Other than Hospital based)		0-Emergency Room		FOR CONTRACTOR'S USE ONLY											
A. Date of Service		B. Procedure Code		C. Place of Origin		D. Origin and Destination Points, Mileage, Waiting Time, (If indicated, Attach Detailed Explanation)						E. Fee Requested		Amount B		No. of Units		CODE	JAM				

13. REQUIRED INFORMATION												Total Charge			
A. Primary Diagnosis												14. AUTHORIZATION REQUEST INFORMATION (PRACTITIONER PRESCRIPTION MUST BE ATTACHED) WRITTEN REQUEST: mandatory for multiple trips (Invalid Coach only) and for individual trips known in advance. Number of trips requested _____ for calendar month and year _____ Number of dialysis trips requested _____ for three calendar months of _____ TELEPHONE REQUEST MADE? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, include LMAU authorization number _____ OCCUPANCY AND MILEAGE INFORMATION: How many patients in vehicle 1, 2, 3, 4, (Circle one). (NOTE: The maximum patient occupancy for Invalid Coach: 4 when transported for dialysis; 3 in all other instances.)			
B. Reason for Transportation															
C. If Emergency, briefly describe circumstance															
D. Was Patient admitted to Hospital? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, give Name and Address of Hospital															

15. PROVIDER CERTIFICATION. I certify 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 therefore 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. An individual Medicaid Patient Certification Form is on file for each service billed. I further certify that I am charging mileage only for one patient on any trip which includes more than one patient.

Provider Signature _____ Billing Date MO./DAY/YR. _____

16. FOR DIVISION USE ONLY															
Authorization or Denial (Medical Consultant)												LMAU Authorization No. _____			
<input type="checkbox"/> Authorization granted				<input type="checkbox"/> Authorization denied, letter attached				<input type="checkbox"/> Authorization granted as amended above							
FOR: <input type="checkbox"/> Ambulance				<input type="checkbox"/> Invalid Coach				<input type="checkbox"/> Air				<input type="checkbox"/> Other _____			
Authorized: (Date) FROM _____ TO _____								FOR A TOTAL OF _____ TRIPS				APPROVAL DATE _____			
AUTHORIZED BY: _____				SIGNATURE _____				TITLE _____				DATE _____			



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

New Jersey Health Services Program **NEWSLETTER**

Volume P-241

April 9, 1979

TO: ALL PHYSICIANS, DENTISTS, INDEPENDENT CLINICS, HOSPITAL OUTPATIENT DEPARTMENTS

SUBJECT: DENTAL REFERRAL OF MEDICAID CHILDREN FOLLOWING ROUTINE MEDICAL EXAMINATIONS OR E.P.S.D.T. SCREENINGS

Dental disease is the most prevalent health problem in children age 3 and over. Please review the criteria below and refer those children (age 20 and younger) who need dental care to their family dentist when appropriate.

1. Poor oral hygiene
 - a. heavy food debris
 - b. odor
 - c. bleeding gums
2. Caries
3. Oral pain, discomfort or sensitivity
4. Oral infection, bleeding, swelling or growth
5. Fractured teeth
6. Discolored teeth
 - a. isolated single tooth
 - b. generalized (Tetracycline stain, enamel hypoplasia, etc.)
7. Rotated, misaligned and abnormally missing teeth
8. Malocclusion (need for orthodontic care)
9. Dentally related facial deformities, acquired and congenital
10. Any additional problem warranting dental attention

Children require periodic examination and supervision to assure maintenance of good oral health.



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

New Jersey Health Services Program NEWSLETTER

Volume P-242

April 30, 1979

TO: ALL PROVIDERS

SUBJECT: HELPFUL HINTS IN PREPARING MEDICAID CLAIM FORMS AND KEEPING RECORDS

As you know a properly completed claim form showing all the necessary information usually results in prompt payment of your Medicaid claim. In our continuing effort to provide timely and efficient claim processing, we recently did a survey to determine the reasons some claims were either delayed or not paid at all.

The results of the survey show that omitting or not completing the following items accounts for the majority of the problems.

1. Provider Certification - Claim form not signed by the provider. A provider must sign, date and, where applicable, enter the Individual Medicaid Practitioner (IMP) Number of the practitioner rendering the service on each claim form.
2. Health Service Program Number (HSP) and Patient Person Number missing or inaccurate. This number should be shown exactly as it appears on the recipient's validation form.
3. Diagnosis not shown - A diagnosis must be indicated for each date of service on forms requiring this information.
4. Description of Service/Procedure Code - For fastest service, procedure codes should be utilized, if applicable. If codes are not available, narrative descriptions in sufficient detail to describe the services should be used. On dental claims, make sure the description is accurate and agrees with the procedure code.
5. Referring Practitioner not identified - If patient was referred, the name and Individual Medicaid Practitioner Number (IMP) of the referring practitioner must be shown on the claim form.
6. Date of service missing - A date of service must be shown for each treatment or service billed to the Program.
7. Individual charges not identified - Do not lump services under one charge. An individual fee must be shown for each treatment or service.

(con't)

8. Prior Authorization - In cases requiring Prior Authorization (see manual for details), authorization from the Division's Central Office, the Local Medical Assistance Unit in your area, or the Medicaid Dental Field Office, whichever is applicable, must be obtained prior to submitting a claim. See Chapter II for those services requiring prior authorization.
9. Dental claims submitted more than 90 days from the last date of service - excuses, such as missed appointments, will not be accepted as justification of over aged claims.

Chapter III of the Medicaid Provider Manual contains general billing procedures. Detailed instructions for proper completion of the revised claim forms is contained in the following volumes of the New Jersey Health Services Newsletter: P-203 Hearing Aid Dispensers; P-204 Medical Supplies and Equipment; P-205 Prosthetic and Orthotic; P-206 Podiatrists, Optometrists, Psychologists, Chiropractors; P-207 All Physician's; P-208 Independent Laboratories; P-209 Independent Clinics; P-210 Ophthalmologists, Optometrists, Opticians; P-215 Hospital and Special Hospital Administrators; Letter dated November 21, 1977 to Transportation providers; and Letter with accompanying revised Dental Manual dated May 1, 1978 to All Dentists and Independent Dental Clinics. This information should prove helpful to you and your office staff in preparing all Medicaid claim forms.

Record Keeping

As a reminder, we would also like to bring to your attention Medicaid requirements pertaining to individual provider records as indicated in the Provider Certification and Medicaid Provider Manuals. Your individual records must fully describe and support the kind and extent of services billed to the Program.

Please help us to help you by reviewing these items with your office staff. Complete and accurate claim information will ensure timely payments to you and save the additional expense incurred in resubmitting claims.



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-255

TO: HOSPITAL ADMINISTRATORS

December 28, 1979

SUBJECT: REVISED MEDICAID TELEPROCESSING FORMATS/BILLING INSTRUCTIONS FOR
 NON DIAGNOSIS RELATED GROUP (DRG) HOSPITALS

On January 7, 1980 the Medicaid Teleprocessing formats will be modified to facilitate the collection of limited DRG data from participating DRG hospitals.

The following new fields will appear at the bottom of the respective formats:

INPATIENT FORMAT

PAT CNTR #
 DRG #
 DRG AMT
 DRG PROC 1
 DRG PROC 2
 OUTL IND

OUTPATIENT FORMAT

PAT CNTR #
 DRG PROC 1
 DRG PROC 2

THESE FIELDS SHOULD NOT BE COMPLETED BY A NON-DRG PARTICIPATING HOSPITAL.

This is to remind you that numeric ICD-9-CM diagnosis codes should be entered on the format. If appropriate, you may also enter valid "V" codes. If a code contains less than five digits, add trailing zeros to make the numbers five digits; for example:

ICD-9-CM CODE

ENTER

413.0	Angina Pectoris - Angina Decubitus	41300
769	Respiratory Distress Syndrome	76900
V54.0	Other Orthopedic Aftercare-Aftercare involving removal of fracture plate or other internal fixation device.	V5400

EXCEPTIONS: DO NOT ENTER:

1. "E" Codes,
2. Manifestation Codes, or
3. The following "V" codes:

V01.0 - V02.9
 V10.0 - V19.8
 V22.2 - V23.8
 V27.0 - V27.9
 V42.0 - V46.9
 V60.0 - V61.49
 V61.8 - V64.3

All remaining items should be completed as usual.
 Should you or your staff have any questions please contact us at (609)293-2254.

DRG SUMMARY FORM

BLUE CROSS

MEDICARE

MEDICAID

OTHER _____

PATIENT NAME _____

PROVIDER NO. _____

HIC/CASE-I.D. # _____

PERSON # _____

ADMISSION DATE _____

DISCHARGE DATE _____

DRG INFORMATION

PATIENT CONTROL NUMBER _____

DRG NUMBER _____

DRG AMOUNT _____

DRG PROC 1 _____

DRG PROC 2 _____

OUTLIER

1980



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

New Jersey Health Services Program NEWSLETTER

Volume P-256

TO: DRG HOSPITAL ADMINISTRATORS

December 28, 1979

SUBJECT: INITIAL MEDICAID INSTRUCTIONS FOR DIAGNOSIS RELATED GROUP (DRG) IMPLEMENTATION

Effective January 7, 1980 revised Medicaid billing procedures will be implemented to accommodate the basic information needed for the DRG Project which is being implemented by the N.J. State Department of Health.

All Medicaid patients admitted during 1979 who are not discharged as of December 31, 1979 must be interim billed; that is, no inpatient claim for a Medicaid patient may span the calendar years 1979 and 1980.

To facilitate the collection of data required for the DRG Program, the Medicaid teleprocessing formats have been modified and an additional form prepared to be included when submitting hard copy claims. Also it is important that specific fields/items on the current billing formats/forms are properly completed. Please review the following instructions with your billing office personnel.

HIGHLIGHTS OF CURRENT INFORMATION

INPATIENT FORMAT/HARD COPY CLAIM FORM (TELEPROCESSING AND MC-1)

- a. BD (1st Line Teleprocessing and Item #4 MC-1)
 Enter the patient's date of birth using six digits. This field must contain the patient's exact date of birth. For example: June 5, 1930 should be entered as 060530.
- b. MED REC NO. (1st Line Teleprocessing and Item #10 MC-1)
 Insert the number used by your facility to identify the patient's records. You may enter up to eight characters or leave blank.
- c. PRIM DIAG (5th Line Teleprocessing and Item #31 MC-1)
 SEC DIAG

Enter the five digit primary or secondary diagnosis code using the International Classification of Diseases, Ninth Revision (ICD-9-CM). You may enter valid 'V' codes when appropriate. If the code contains less than five digits, add trailing zeros to make the number five digits. For example:

<u>ICD-9-CM CODE</u>	<u>ENTER</u>
413.0 Angina Pectoris - Angina Decubitus	41300
769 Respiratory Distress Syndrome	76900

V54.0 Other Orthopedic Aftercare - Aftercare
involving removal of fracture plate or other
internal fixation device.

V5400

EXCEPTIONS: Do not enter:

1. 'E' Codes,
2. Manifestation Codes, or
3. The following 'V' codes:

V01.0 - V02.9
V10.0 - V19.8
V22.2 - V23.8
V27.0 - V27.9
V42.0 - V46.9
V60.0 - V61.49
V61.8 - V64.3

- d. PRIM SURG (5th Line Teleprocessing
SEC SURG and Item #32 MC-1)

Using five digits indicate the primary and secondary surgical procedures (if any). Please refer to your Medicaid Surgical Procedure Codes Manual for the appropriate four digit code. Enter a leading zero before the four digit code. For example: 03261 is an appendectomy.

All other existing items should be completed in accordance with prior instructions.

MODIFIED/ADDITIONAL INFORMATION

The following new fields have been added to the bottom of the teleprocessing formats and an additional form is included to be submitted with hard copy claim forms (MC-1 and MC-4).

1. Inpatient Format (Teleprocessing)

- a. PAT CNTR # ... Enter the patient's unique number assigned by your hospital to facilitate retrieval of individual case records at your facility. Begin the PAT CNTR # in the first (left) position and leave any remaining positions blank. This should be the same number as that reported to the New Jersey State Department of Health.
- b. DRG # ... Leave blank at this time.
- c. DRG AMT ... Leave blank at this time.
- d. DRG PROC 1 ... The DRG Procedure Code #1 field should be completed using only the ICD-9-CM Surgical Procedure Codes found in ICD-9-CM, Volume III. You should enter the code which indicates the major surgical procedure. For example: Code #73.01, Induction of labor by artificial rupture of membranes, should be entered as 7301. If the code is not four digits, add trailing zeros to make it four digits. For example: Code #74.0, Classical Cesarean Section, should be entered as 7400.

NOTE: Do Not Enter The Medicaid Surgical Procedure code in this field.
The Medicaid Surgical Procedure code must be entered only in the PRIM SURG and SEC SURG fields on this format (or in Item #32 of the MC-1 claim form).

If no surgical procedure was performed, leave this field and the next field (DRG PROC 2) blank.

- e. DRG PROC 2 ... The DRG Procedure Code #2 field reflects the secondary surgical procedure, if any. To complete this field follow instructions for the DRG PROC 1 field above.
- f. OUTL IND Leave blank at this time.

2. Outpatient Format (Teleprocessing)

NOTE: This information must be completed only when billing for same day surgery (SDS) services.

- a. PAT CNTR # ... See instructions for PAT CNTR #, inpatient format, paragraph 1 a above.
- b. DRG PROC 1 ... See instructions for DRG PROC 1, inpatient format, paragraph 1 d above.
- c. DRG PROC 2 ... See instructions for DRG PROC 2, inpatient format, paragraph 1 e above.

3. Hard Copy Claims

The same additional DRG information required on the teleprocessing formats must also be submitted with hard copy claims billed on the MC-1 (Inpatient) or MC-4 (Outpatient) claim forms. To facilitate the submission of this additional information, form 1980, DRG Summary Form, has been developed. This form contains the same fields found on the last two lines of the revised teleprocessing formats and should be completed according to the instructions detailed in paragraphs 1 and 2, modified/additional information section, of this newsletter.

All claims, MC-1 or MC-4, for services rendered on and/or after January 1, 1980 should have a form 1980 attached to the upper right hand corner. Failure to submit the attachment will result in rejection of claims.

Enclosed is an initial supply of the form, DRG Summary Form, for your immediate needs. You should requisition additional supplies of this form from your Contractor in the usual manner.

Additional billing instructions will be released prior to the acceptance of your final DRG rates.

Should you have any questions, please contact us at (609) 293-2254.



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-258

January 28, 1980

TO: ALL PHYSICIANS, INDEPENDENT CLINICS AND HOSPITAL OUTPATIENT DEPARTMENTS

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

NEW EPSDT PACKAGE

As a result of new Federal and State regulations, effective October 1, 1979, the New Jersey Medicaid Program's Procedure Code for EPSDT is modified as follows: (Bold print indicates the changes from the previous code 9580 description.)

Code 9580 **EARLY PERIODIC SCREENING DIAGNOSIS TREATMENT (EPSDT)**
Birth through 20 years of age

As a minimum, the following must be included in the screening package:

1. Complete initial or interval history including recording of significant negative findings.
2. Measurements, height and weight; head circumference to age 25 months.
3. Physical development assessment.
4. Complete physical examination (**UNCLOTHED**) by a physician or nurse practitioner under the direct supervision of a physician to include:
 - a. **NUTRITIONAL ASSESSMENT**
 - b. Vision and hearing screening
 - c. Blood pressure determination for children age 5 and older.
5. Assessment and **ADMINISTRATION OF IMMUNIZATION(S)** appropriate for age and need. (See appropriate Procedure Code(s) 9450-9462 for immunization reimbursement).
6. Referral or follow-up of all correctable abnormalities uncovered or suspected for further diagnosis and treatment.
7. **REFERRAL TO A DENTIST FOR DIAGNOSIS AND TREATMENT FOR CHILDREN AGE 3 AND OLDER.**
8. Appropriate laboratory procedures, if medically indicated.

NOTE: Laboratory procedures performed by a physician, for his patients, in his office are reimbursable to the physician; if performed by outside independent laboratories, the laboratory must submit the claim. Lead screening test should be sent to the State Department of Health.

Medical records should substantiate the above services.

Discussion and consultation regarding findings should be an integral part of every EPSDT examination.

NOTE: This procedure code can be used one time during a 12 month period. For other evaluations and treatments, use other appropriate procedure codes. The EPSDT Referral Report form (MC-19) must accompany the claim form in order to receive reimbursement for Procedure Code 9580.

(Continued)

Please review this EPSDT description carefully. Pay particular note to Item No. 7 "Referral to a dentist for diagnosis and treatment". In most cases, direct dental referral will be initiated by a County Welfare or DYFS social services worker, at the time that EPSDT screening is accepted. However, if the EPSDT screening originates with a practitioner or clinic, the dental referral must be offered, and if accepted, must be arranged at the time of screening. The MC-19 will be revised to include a check box for documenting, "referral, accepted/refused". The amount of reimbursement will remain the same.

PROMPT BILLING AND REFERRAL

The Medicaid Program has developed a computer tracking system to insure that children receive follow-up treatment after the screening. Feedback from this program will be utilized by social services workers to provide assistance to families as needed.

The key to effective functioning of this system is the accurate completion and prompt return of the EPSDT Referral Report (MC-19). As before, the MC-19 must accompany your claim when billing for an EPSDT examination. Therefore, you can expedite the process by:

1. Billing promptly for EPSDT examinations;
2. Arranging for necessary referrals, when a child requires further diagnosis and/or treatment, within 30 days of your examination; and
3. Checking the appropriate block on the claim form when your service was performed as a result of an EPSDT referral. (Item No. 26, MC-4 Outpatient Hospital; Item No. 13, MC-8 Physicians and Practitioners Claim; and Item No. 8, MC-14 Independent Outpatient Health Facility).



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

New Jersey Health Services Program NEWSLETTER

Volume P-265

April 1, 1980

TO: PSYCHIATRISTS AND PSYCHOLOGISTS

SUBJECT: PSYCHOLOGICAL TESTING

Effective April 15, 1980, the New Jersey Medicaid Program will reimburse for psychological testing on the basis of a procedure code specific to each test, instead of reimbursement on the basis of a time factor. For all psychological testing performed on or after April 15, 1980, reimbursement for procedure codes 9468 through 9499 "Psychological Testing" will be made on the basis of the Specialist or Non-specialist provider classification, as indicated by the following fee schedule.

All psychological testing performed before April 15, 1980, will be reimbursed based on existing procedure codes, 9060 and 9066.

NOTE: Procedure Code 9499, "Other (By Report)" requires that a written report be submitted with "Physicians and Practitioners Claim Form", MC-8, for reimbursement.

<u>Procedure Code</u>	<u>Test</u>	<u>Medicaid Dollar Value</u>	
		<u>S</u>	<u>NS</u>
9468	Bayley Scale of Infant Development	\$48.	\$34.
9469	Bender Visual-Motor Gestalt Test	15.	10.
9470	Benton Visual Retention Test	15.	10.
9471	Blacky Pictures	30.	21.
9472	Cattel Infant Intelligence Scale	48.	34.
9473	Children's Apperception Test	30.	21.
9474	House-Tree-Person	22.	15.
9475	Human Figure Drawing (Draw-A-Person)	15.	10.
9476	Kinetic Drawings	15.	10.
9477	Merrill-Palmer Scale	37.	26.
9478	Michigan Picture Test	30.	21.
9479	Minnesota Developmental	48.	34.
9480	MMPI (machine scored)	22.	15.

(Continued)

<u>Procedure Code</u>	<u>Test</u>	<u>Medicaid</u> <u>S</u>	<u>Dollar</u> <u>\$</u>	<u>Value</u> <u>NS</u>
9481	Peabody Picture Vocabulary Test	18.		13.
9482	Projective Drawings	15.		10.
9483	Raven's Progressive Matrices (1938)	30.		21.
9484	Raven's Progressive Matrices (1947)	18.		13.
9485	Rorschach (or Holtzman) Inkblots	55.		39.
9486	Sentence Completion (any form)	15.		10.
9487	School Apperception Method	30.		21.
9488	Slosson Intelligence Scale	18.		13.
9489	Stanford-Binet	55.		39.
9490	Symonds Picture Story Test	30.		21.
9491	Thematic Apperception Test	30.		21.
9492	Vineland Social Maturity Scale	37.		26.
9493	Wechsler Adult Intelligence Scale	55.		39.
9494	Wechsler Intelligence Scale for Children	55.		39.
9495	Wechsler Intelligence Scale for Children-Revised	55.		39.
9496	Wechsler Primary & Preschool Intelligence Scale (WPPSI)	55.		39.
9497	Wechsler Memory Scale	26.		18.
9498	Wide Range Achievement Test	18.		13.
9499	Other (By Report)			

If you have any questions about this newsletter, please contact Edward M. Wallerstein, M.D., Chief, Bureau of Mental Health Services, New Jersey Medicaid Program at 609-292-8198.



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

New Jersey Health Services Program NEWSLETTER

Volume P-278

August 18, 1980

TO: All Psychiatrists
 SUBJECT: Addition of a New Code for Drug Management Visits
 EFFECTIVE DATE: Immediately

A patient visit or revisit for the sole purpose of evaluation of drug therapy and writing of a prescription should be coded on the Medicaid claim form as follows:

Procedure Code	Description	Medicaid Dollar Value	
		S	NS
9559	Drug Management Visit - review and evaluation of the medication history of a psychiatric patient with the writing or renewal of a prescription if indicated. <u>Office</u> or <u>Hospital</u> .	8.40	6.30

Note: Use of this code precludes the use on the same day of Procedure Codes 0005, 0001, 9007, 0003, 9022, 9050, 9051, 9056, or 9062.

Since the writing of a prescription and evaluation of specific drug therapy would be a normal component of any physician encounter, code 9559 should be used only if the drug evaluation is the sole purpose of the visit.



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

New Jersey Health Services Program NEWSLETTER

Volume P-279.....

October 20, 1980

TO: DENTISTS AND INDEPENDENT DENTAL CLINICS

SUBJECT: EPSDT - DENTAL EXAMINATIONS
 (EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT)

EFFECTIVE: IMMEDIATELY

Direct dental referral for diagnosis and treatment is Federally mandated for all children from age 3 (three) through age 20 (twenty) who request EPSDT screening.

The referral, in all cases, will be initiated by a Social Service Worker by means of an EPSDT Dental Referral Form (MC-19D, 10/80). A Social Worker will fill in Item 1 and sign Item 2 of the MC-19 Form. When a recipient presents a signed MC-19D Form to the dentist, it is an official notification that the recipient is requesting an EPSDT dental examination.

NEW PROCEDURE CODE 0119 - EPSDT Dental Examination

Code 0119 can be used only for an EPSDT dental examination. PROCEDURE CODE 0119 is the equivalent of Procedure Code 0110 (Clinical Oral Examination - Comprehensive).

	<u>S</u>	<u>NS</u>
REIMBURSEMENT FOR PROCEDURE CODE 0119.....	\$8.00	\$7.00

NOTE: Reimbursement is contingent upon:

- A. The completed MC-19D Form (Contractor's Copy) must accompany the Dental Claim Form (MC-10) when submitted to the Contractor for reimbursement.
- B. The Dental Claim Form for reimbursement must be received by the Contractor no later than 30 days from the date of service.
- C. Failure to attach the MC-19D Form to the Dental Claim Form (MC-10) or to meet the timely billing requirement will result in reduction of the reimbursement by \$1.00.

Any questions regarding this Newsletter should be referred to Archie H. Bell, D.D.S. or Gilbert S. Gold, D.D.S., P. O. Box 2706, Trenton, New Jersey, 08625. (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-280.....

November 3, 1980

TO: ALL PHYSICIANS AND INDEPENDENT CLINICS

SUBJECT: REVISED REIMBURSEMENT POLICY FOR SPECIALISTS

EFFECTIVE: Immediately

BACKGROUND: The purpose of this newsletter is to clarify the New Jersey Medicaid reimbursement policy for specialists. The professional criteria that a provider must satisfy for Program recognition as a specialist remains unchanged.

ACTION: Qualified physicians will be reimbursed as specialists only when it is demonstrated that at least 90% of their Medicaid practice is being limited to their area of specialization.

Therefore, if it is determined on review that a provider who has been reimbursed as a specialist has not been limiting 90% of his Medicaid practice to his area of specialization, the New Jersey Medicaid Program may seek recovery of the difference between the specialist and non-specialist rates together with appropriate penalties if warranted.

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

If you or your staff have any questions, contact Michael Spirito, M.D., Acting Medical Director, Division of Medical Assistance and Health Services, telephone (609) 292-7673.



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

New Jersey Health Services Program NEWSLETTER

Volume P-281.....

November 17, 1980

TO: All Medical Suppliers

SUBJECT: I. New Repair Policy - Effective December 1, 1980

II. Policy Clarification-Purchase of a Rental Item

Enclosed are revised pages dated 12/80 for your Medical Supplier Manual. Please review carefully the replacement pages as they incorporate recent changes to the Program. These changes, indicated by brackets placed in the margin of the revised pages and highlighted below, include both the implementation of a new repair policy which will reimburse medical suppliers for labor charges and clarification of the policies regarding purchase of rental items.

I. NEW REPAIR POLICY

The New Jersey Medicaid Program is implementing a new repair policy which will reimburse medical suppliers for labor charges. Medical suppliers will be eligible for reimbursement of labor charges for all repairs performed on or after December 1, 1980.

All requests for labor charges must be prior authorized by the Local Medical Assistance Unit. If authorized, labor charges will be reimbursed at \$10.00 per hour, divided into quarter-hour increments of \$2.50.

Excluded from a labor charge reimbursement are:

- (1) Repairs to durable medical equipment under warranty;
- (2) Repairs when combined cost of parts and labor charges exceed 50% of the item's replacement value;
- (3) Travel time.

When an emergency situation occurs and repairs are made without prior authorization, the supplier must obtain post authorization from the Local Medical Assistance Unit within two (2) LMAU working days of such repairs.

Submit your prior authorization request for labor charges on the Medical Supplies and Equipment Claim form (MC-11). Please note that the labor charge has been assigned a new Procedure Code - 6996.

II. POLICY CLARIFICATION - PURCHASE OF A RENTAL ITEM

When a medical equipment item with an approved purchase price under the Program of \$100.00 or more is authorized for rental, the monthly rental payment will be the amount billed or 12% of the approved purchase price, whichever is less. Ten such payments shall be deemed to be the full purchase price and no further payments shall be made. If the purchase of the rental item is authorized before the maximum rental to purchase conversion period (10 months), a final payment will be made equal to the remaining months of a ten-month rental period times either the amount billed or 1/10 of the approved purchase price, whichever is less.

Example 1:

Allowable Purchase Price		\$200.00
Allowable Monthly Rental Fee		\$ 24.00 (12% of \$200)
Rented for 6 months at \$24 per month =		\$144.00
Purchased in 7th month of rental		
4 remaining months at \$20 per month		
(10% of \$200)	=	\$ 80.00
Total Allowable \$144.00 + \$80.00	=	\$224.00

When a medical equipment item with an approved purchase price under the Program of less than \$100.00 is authorized for rental, the monthly rental payment will be the amount billed or 20% of the approved purchase price, whichever is less. Six such payments shall be deemed to be the full purchase price and no further payments shall be made. If the purchase of the rental item is authorized before the maximum rental to purchase conversion period (6 months), a final payment will be made equal to the remaining months of a six-month rental period times either the amount billed or 1/6 of the approved purchase price, whichever is less.

Example 2:

Allowable Purchase Price		\$ 72.00
Allowable Monthly Rental Fee		\$ 14.40 (20% of \$72)
Rented for 3 months at \$14.40 per month =		\$43.20
Purchased in 4th month of rental		
3 remaining months at \$12 per month		
(16.6% or 1/6 of \$72)	=	\$36.00
Total Allowable \$43.20 + \$36.00	=	\$79.20

III. MANUAL MAINTENANCE

Please discard the outdated material and replace with the attached revised pages:

- Subchapter 1 - Index - Revised 12/80
Pages 5,6,7,8, & 9. Revised 12/80
- Subchapter 2 - Pages 5,6,7, & 8. Revised 12/80
- Subchapter 3 - Page 4. Revised 12/80



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

New Jersey Health Services Program NEWSLETTER

Volume P-288.....

DATE: January 12, 1981

TO: OBSTETRICIANS AND GYNECOLOGISTS

SUBJECT: ANNUAL HEALTH MAINTENANCE EXAMINATION (CODE 9008)

The American College of Obstetricians and Gynecologists (ACOG) has determined that it is within the scope of obstetricians and gynecologists to be primary care physicians for women. This concept is encouraged by the ACOG.

In the past, physicians who have done Annual Health Maintenance Examinations have been internists, family practitioners and pediatricians. Obstetricians and gynecologists are now being added to the list. Therefore, if the criteria of code 9008 are met, reimbursement by the contractors will be made.

The criteria for Annual Health Maintenance Examinations, Code 9008, are as follows:

1. A complete history of the present illness or interval history
2. Updating the past medical, family and social/personal history
3. A complete systemic review and complete total system physical examination permitting deferment or omission of one system and including
4. A working diagnosis and treatment plan.

It is to be emphasized, however, that this code (9008) be utilized only if a complete examination and not just a gynecological examination is done.

If you have any questions regarding this Newsletter, please contact Joseph R. Fiorello, M.D., at (609) 292-8123.



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

New Jersey Health Services Program NEWSLETTER

Volume P-291.....

DATE: February 23, 1981

TO: OBSTRETRICIANS AND GYNECOLOGISTS

SUBJECT: ANNUAL HEALTH MAINTENANCE EXAMINATION (CODE 9008)
(THIS NEWSLETTER REPLACES P-288, DATED JANUARY 12, 1981)

Newsletter P-288 failed to enumerate all the criteria for Code 9008 and is being replaced by this letter.

The American College of Obstetricians and Gynecologists (ACOG) has determined that it is within the scope of obstetricians and gynecologists to be primary care physicians for women. This concept is encouraged by the ACOG.

In the past, physicians who have done Annual Health Maintenance Examinations have been internists, family practitioners and pediatricians. Obstetricians and gynecologists are now being added to the list. Therefore, if the criteria of Code 9008 are met, reimbursement by the Contractor (Prudential) will be granted.

The criteria for Annual Health Maintenance Examinations, Code 9008, is listed in the Procedure Code Manual, page 223.

It is to be emphasized, however, that code (9008) is to be utilized only if a complete examination (not just a gynecological examination) is performed.

If you have any questions regarding this Newsletter, please contact Joseph R. Fiorello, M.D., at (609) 292-8123.

MEDICARE/MEDICAID BULLETIN

81-2
Volume P-293

April, 1981

Medicare/Medicaid Common Claim Form

We are pleased to announce the adoption of a common claim form for your use when billing for medical services rendered to individuals with Medicare, Medicaid, or CHAMPUS coverage. In response to requests for simplification of the billing process and in an effort to reduce the number of forms currently required, the Medicare Program and the New Jersey Medicaid Program have authorized the implementation of the Health Insurance Claim Form (HCFA-1500). This form, a facsimile of which is attached, is a modified version of the American Medical Association's Health Insurance Claim Form.

When billing for services rendered to Medicare beneficiaries and to individuals with both Medicare and Medicaid coverage, providers who now use the HCFA-1490 will use the HCFA-1500. When billing for services rendered to individuals with Medicaid coverage only, providers who now use the MC-8 will use the HCFA-1500.

All other providers when billing for services rendered to individuals with Medicaid coverage only are to continue to bill on the claim forms currently in use.

Effective July 1, 1981, the HCFA-1500 common claim form will be distributed to providers now using the HCFA-1490 and the MC-8 on claim form orders filled after this date. However, you are asked to continue using your supply of HCFA-1490's and MC-8's until your stock is depleted. Instructions for ordering and completing the HCFA-1500 will be sent to you prior to July 1, 1981.



HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING THIS FORM

MEDICARE

MEDICAID

CHAMPUS

OTHER

OMB No. 0938-0008

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (First name, middle initial, last name)	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, city, state, ZIP code)	5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	6. PATIENT'S MEDICARE/CHAMPUS NO. (Include any letters)
	7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. PATIENT'S MEDICAID I. D. NO.
Telephone No.	10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. ACCIDENTAL INJURY AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>	8a. INSURED'S GROUP NO. (Or Group Name)
9. OTHER HEALTH INSURANCE COVERAGE- YES <input type="checkbox"/> NO <input type="checkbox"/> Enter Name of Policyholder and Plan Name and Address and Policy Number		11. INSURED'S ADDRESS (Street, city, state, ZIP code)
13. I Authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of Benefits in Accordance with Program Policy. For Federal Benefits I Request Payment Either to Myself or to the Person who Accepts Assignment Below.		
SIGNED _____ DATE _____		SIGNED (Insured or Authorized Person) _____

PHYSICIAN OR SUPPLIER INFORMATION

4. DATE OF	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION.	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>	16a. IF AN EMERGENCY CHECK HERE <input type="checkbox"/>	
DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____		DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____		
9. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. public health agency)		19a. I.D. NUMBER	20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____		
1. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)		21a. I.D. NUMBER	22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES		

3. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN E BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE.	23b. WAS THIS SERVICE PERFORMED AS A RESULT OF AN EPSDT PROGRAM REFERRAL? YES <input type="checkbox"/> NO <input type="checkbox"/> PRIOR AUTHORIZATION NO. _____
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24. A. DATE OF SERVICE	B. *PLACE OF SERVICE	C. * T.O.S.	D. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	E. DIAGNOSIS CODE	F. DAYS OR UNITS	G. CHARGES	H. CHECK IF FAMILY PLANNING	I. LEAVE BLANK
FROM	TO		PROCEDURE CODE (IDENTIFY) (Explain Unusual Services Or Circumstances)					

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part hereof.)	26. ACCEPT ASSIGNMENT (Medicare and CHAMPUS Only - See Back) YES <input type="checkbox"/> NO <input type="checkbox"/>	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
SIGNED _____ DATE _____	30. PROVIDER SOCIAL SECURITY/ I.D. NO.	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS & ZIP CODE		
2. PATIENT'S ACCOUNT NO.	33. EMPLOYER I.D. NO.			

4. REMARKS:

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program and renders payment for health benefits

provided through membership and affiliation with the Uniformed Services. Information on the patient's sponsor should be provided in items 3, 6, 7, 8, 9, and 11.

MEDICAID PAYMENTS: Authorization to Release Information, and Payment Request. I certify that the service(s) covered by this claim has been received, and 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 State Agency or its authorized Agents any information needed for this or a related claim.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE AND CHAMPUS)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

supervision by his/her employee, 2) they must be integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in the physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For services to be considered as 'incident' to a physician's professional service, 1) they must be rendered under the physician's immediate personal

For CHAMPUS claims, I further certify that neither I nor any employee who rendered the services are employees or members of the Uniformed Services (refer to 5 USC 5536).

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422 510).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE AND CHAMPUS INFORMATION

We are authorized by HCFA and CHAMPUS to ask you for information needed in the administration of the Medicare and CHAMPUS programs. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act as amended and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086.

For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor.

The information we obtain to complete Medicare and CHAMPUS claims is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare or CHAMPUS and to insure that proper payment is made.

With the one exception discussed below, there are no penalties under Social Security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of Medicare or CHAMPUS claims. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations or federal agencies as necessary to administer the Medicare and CHAMPUS programs.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether worker's compensation will pay for treatment. Section 1877(a) (3) of the Social Security Act provides criminal penalties for withholding this information.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency may request.

information is true, accurate and complete; and that the services covered by this claim and the amount charged therefore are in accordance with the regulations of the Medicaid 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, with the exception of authorized deductibles and coinsurance. I also certify that services have been furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act and Section 504 of the Rehabilitation Act of 1973.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): 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

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.

PLACE OF SERVICE CODES:

(IH) - Inpatient Hospital
 (OH) - Outpatient Hospital
 (O) - Doctor's Office
 (H) - Patient's Home
 (DCF) - Day Care Facility (PSY)
 (NCF) - Night Care Facility (PSY)
 (NH) - Nursing Home
 (SNF) - Skilled Nursing Facility
 (A) - Ambulance
 (OL) - Other Locations
 (IL) - Independent Laboratory
 (OMS) - Other Medical/Surgical Facility
 (RTC) - Residential Treatment Center
 (STF) - Specialized Treatment Facility
 (KC) - Independent Kidney Care Treatment Center
 (CL) - Clinic
 (ER) - Emergency Room

TYPE OF SERVICE CODES:

1 - Medical Care
 2 - Surgery
 3 - Consultation
 4 - Diagnostic X-Ray
 5 - Diagnostic Laboratory
 6 - Radiation Therapy
 7 - Anesthesia
 8 - Assistance at Surgery
 9 - Other Medical Service
 0 - Blood or Packed Red Cells
 A - Used DME
 M - Alternate Payment for Maintenance Dialysis
 Y - Second Opinion on Elective Surgery
 Z - Third Opinion on Elective Surgery



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

New Jersey Health Services Program

NEWSLETTER

Volume P-294

April 13, 1981

TO: PRACTITIONERS USING PIN FEED MEDICAID CLAIMS
SUBJECT: ADVANCE NOTICE OF HEALTH INSURANCE CLAIM FORM (HCFA-1500)
EFFECTIVE: July 1, 1981

BACKGROUND

The Health Care Financing Administration of the United States Department of Health and Human Services has adopted the Health Insurance Claim Form (HCFA-1500) as the common claim form to be used by practitioners when billing the Medicare, Medicaid, or CHAMPUS Programs for services rendered.

The use of a common claim form simplifies billing procedures for practitioners and, by assuring compatibility, simplifies processing of cross-over claims (Medicare/Medicaid).

The New Jersey Medicaid Program, in accordance with the decision of the Health Care Financing Administration, has adopted a Federally approved version of the Health Insurance Claim Form (HCFA-1500). This form will replace the existing Medicaid "Physician and Practitioner Claim" (Form MC-8).

The HCFA-1500 Form also replaces the Medicare Form-1490. Practitioners will be required to submit this form for services covered under the Medicare Program and rendered to Medicare/Medicaid eligible recipients.

ACTION

Effective July 1, 1981, New Jersey Medicaid will introduce the Health Insurance Claim Form (HCFA-1500) for use by practitioners when billing Medicaid. The MC-8 Form now in use will be accepted for processing after July 1, 1981 and practitioners are requested to use the MC-8 Form until their existing supplies are depleted.

Since the general format of the HCFA-1500 is different from the Form MC-8, a draft copy of the HCFA-1500 is attached. When a Pin-feed printer's copy of the form is available, it will be forwarded to you, to allow you (or your Service Bureau) to make final system changes.

In order to assist practitioners to adapt computer billing systems to the new billing form, instructions specific to the New Jersey Medicaid Program, for

completing the HCFA-1500, are attached. The information required on the HCFA-1500 for Medicaid purposes is basically the same as that required on the current MC-8 form with some exceptions. The changes and/or additions to the required information are highlighted as follows:

- The patient's birthdate must be entered instead of the patient's age (item 2).
- The patient's Medicare I.D. Number must be entered when appropriate (item 6).
- The box in Item 22 must be checked if the Practitioner is billing for laboratory work performed in his/her office.
- The Place of Service Codes, as noted on the back of the claim form, have been changed from a one position numeric character to a multi-position alpha character and must be entered in item 24B.
- Codes have been developed to correspond to the Type of Service rendered. The appropriate code must be selected from the table on the back of the claim form and entered in Item 24C.
- The appropriate Medicaid procedure code and a brief narrative description must be entered in Item 24D.

Please note that the procedure for submitting claims, as well as general Medicaid policy and procedures, remain unchanged. All practitioners will be required to use reorder forms received from Prudential Insurance Company. Instructions for reordering forms will be issued at a later date.

This Newsletter should be reviewed carefully and filed in your Medicaid Manual.

Any questions regarding the use of the HCFA-1500 should be directed to the Prudential Insurance Company: (609) 293-2109.

HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING THIS FORM

MEDICARE
 MEDICAID
 CHAMPUS
 OTHER

OMB No. 0938-0008

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (First name, middle initial, last name)	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, city, state, ZIP code)	5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	6. PATIENT'S MEDICARE/CHAMPUS NO. (Include any letters)
	7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. PATIENT'S MEDICAID I. D. NO.
Telephone No.	10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. ACCIDENTAL INJURY AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>	8a. INSURED'S GROUP NO. (Or Group Name)
9. OTHER HEALTH INSURANCE COVERAGE- YES <input type="checkbox"/> NO <input type="checkbox"/> Enter Name of Policyholder and Plan Name and Address and Policy Number		11. INSURED'S ADDRESS (Street, city, state, ZIP code)
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE - MEDICARE, CHAMPUS & MEDICAID (Read back before signing) <small>I Authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of Benefits in Accordance with Program Policy. For Federal Benefits I Request Payment Either to Myself or to the Person who Accepts Assignment Below.</small>		13. I Authorize Payment of Medical Benefits to Undersigned Physician or Supplier for Service Described Below.
SIGNED _____ DATE _____		SIGNED (Insured or Authorized Person) _____

PHYSICIAN OR SUPPLIER INFORMATION

4. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION.	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOM? YES <input type="checkbox"/> NO <input type="checkbox"/>	16a. IF AN EMERGENCY CHECK HERE <input type="checkbox"/>
7. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____		20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____
9. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. public health agency)		19a. I.D. NUMBER	22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES
1. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)		21a. I.D. NUMBER	23b. WAS THIS SERVICE PERFORMED AS A RESULT OF AN EPSDT PROGRAM REFERRAL? YES <input type="checkbox"/> NO <input type="checkbox"/> PRIOR AUTHORIZATION NO. _____

3. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN E BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE. _____

24. A. DATE OF SERVICE	B. PLACE OF SERVICE	C. T.O.S.	D. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	E. DIAGNOSIS CODE	F. DAYS OR UNITS	G. CHARGES	H. CHECK IF FAMILY PLANNING	I. LEAVE BLANK
FROM	TO		PROCEDURE CODE (IDENTIFY) (Explain Unusual Services Or Circumstances)					

5. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part hereof.)	26. ACCEPT ASSIGNMENT (Medicare and CHAMPUS Only - See Back) YES <input type="checkbox"/> NO <input type="checkbox"/>	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
30. PROVIDER SOCIAL SECURITY/ I.D. NO.		31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS & ZIP CODE		
SIGNED _____ DATE _____		33. EMPLOYER I.D. NO.		
2. PATIENT'S ACCOUNT NO.				
4. REMARKS:				

REFERS TO GOVERNMENT PROGRAMS ONLY

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It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether worker's compensation will pay for treatment. Section 1377(a) (3) of the Social Security Act provides criminal penalties for withholding this information.

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information is true, accurate and complete; and that the services covered by this claim and the amount charged therefore are in accordance with the regulations of the Medicaid 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, with the exception of authorized deductibles and coinsurance. I also certify that services have been furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act and Section 504 of the Rehabilitation Act of 1973.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): 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

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.

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 (NCF) - Night Care Facility (PSY)
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TYPE OF SERVICE CODES:

1 - Medical Care
 2 - Surgery
 3 - Consultation
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 5 - Diagnostic Laboratory
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 7 - Anesthesia
 8 - Assistance at Surgery
 9 - Other Medical Service
 0 - Blood or Packed Red Cells
 A - Used DME
 M - Alternate Payment for Maintenance Dialysis
 Y - Second Opinion on Elective Surgery
 Z - Third Opinion on Elective Surgery

INSTRUCTIONS FOR COMPLETION OF
HEALTH INSURANCE CLAIM FORM (HCFA-1500)
FOR MEDICAID BILLING

NOTE: CHECK MEDICAID BLOCK AT TOP OF FORM

- ITEM 1. Copy the patient's name EXACTLY as it appears on the Validation Form or Medicaid Eligibility Identification Card. For additional information, see Section 101 of your Medicaid Provider Manual.
- ITEM 2. Indicate patient's date of birth. Use six (6) digits (e.g., Sept. 10, 1980 is written 09/10/80). If only the year is known, enter the year.
If birthdate is unavailable, submit claims without birthdate.
- ITEM 3. Not applicable to Medicaid.
- ITEM 4. Indicate patient's address and telephone number.
- ITEM 5. Check appropriate block to identify patient's sex.
- ITEM 6. Copy the patient's Medicare I.D. Number as it appears on the Medicare Health Insurance card when the patient is covered by both Medicare and Medicaid.
- ITEM 7. Not applicable to Medicaid.
- ITEM 8. Copy the patient's Health Services Program (HSP) Case Number and Person Number EXACTLY as it appears on the validation form or Medicaid Eligibility Identification Card. For additional information, see Section 101 of your Medicaid Provider Manual.
- ITEM 9. Check appropriate block to indicate whether the patient has other health insurance coverage. If yes, you must attach a copy of the decline notice or a copy of the explanation of payment.
- ITEM 10. Check as appropriate.
If patient's illness or injury is work related.
If patient's injury resulted from an automobile accident or other.
- ITEM 11. Not applicable to Medicaid.
- ITEM 12. Under ordinary circumstances, the patient must sign the claim form when services have been received.
The claim form must indicate services rendered prior to presenting it to the patient for signature.
If the patient's signature is unobtainable, refer to the Billing Chapter in your Medicaid Provider Manual for procedures to follow.

- Item 13. Not applicable to Medicaid.
- ITEM 14. Not applicable to Medicaid.
- ITEM 15. Not applicable to Medicaid.
- ITEM 16. Not applicable to Medicaid.
- ITEM 16a. Not applicable to Medicaid.
- ITEM 17. Not applicable to Medicaid.
- ITEM 18. Not applicable to Medicaid.
- ITEM 19. If patient was referred to you, you must indicate the name of the referring practitioner.
- ITEM 19a. Enter the Individual Medicaid Practitioner (IMP) Number of the referring practitioner you entered in Item 19.
- ITEM 20. Not applicable to Medicaid.
- ITEM 21. Write in the name of the institution if place of service is other than doctor's office or patient's home.
To be completed in addition to Item 24b.
- ITEM 21a. Not applicable to Medicaid.
- ITEM 22. Check appropriate block to indicate whether Laboratory work was analyzed by you or outside your office.
- ITEM 23a. Enter diagnoses for all services identified in Item 24d.
- ITEM 23b. EPSDT Program Referral:
Complete this item for recipients under 21 years of age. Ask the patient and/or referring physician or clinic if this visit is a result of an EPSDT screening. Indicate if this patient is such a referral by checking the appropriate block.
For services which require prior authorization, copy the prior authorization number designated by the Medicaid office from the Request for Authorization form. Attach authorization approval form to claim when submitting for payment.
- ITEM 24a. Enter date(s) of each visit.
- ITEM 24b. Identify place of service by selecting appropriate alpha code as listed on the reverse side of form under "Place of Service" Codes.
- ITEM 24c. Identify type of service by selecting appropriate code as listed on the reverse side of form under Type of Service Codes.

ITEM 24d. Physicians, Psychologists, Podiatrists, and Optometrists:
Identify the procedure by code number, as listed in either the Procedure Code Manual or your respective Medicaid Provider Manual, and by a brief corroborative narrative description. Insert procedure code and the narrative description in the two columns provided under 24D.

If a code to describe the service rendered is not provided in the manual, enter an adequate description of the service.

Chiropractors

Enter code and description of services rendered as follows:
Code 9080 - Manual manipulation of the spine in the Office, Home, or SNF (Chiropractors only).

ITEM 24e. Enter reference numbers in (23a) related to applicable diagnosis for that visit.

ITEM 24f. Not applicable to Medicaid.

ITEM 24g. Enter your usual and customary charge for each service or procedure.

ITEM 24h. Check this column for each service ascribable to "Family Planning". These should include visits for infertility studies, oral, mechanical or chemical contraceptives and applicable surgical procedures.

ITEM 24i. Leave blank.

ITEM 25. Read the Medicaid Provider Certification on the reverse side of the form carefully.

The Individual Practitioner who personally performed or supervised the service(s) represented on the claim must put his/her signature on each claim before submitting for payment.

ITEM 26. Not applicable to Medicaid.

ITEM 27. Enter the sum total of the individual charges.

ITEM 28. Not applicable to Medicaid.

ITEM 29. Not applicable to Medicaid.

ITEM 30. Enter the Individual Medicaid Practitioner (IMP) Number of the practitioner actually performing the service described on the claim.

NOTE: If a claim covers services performed by more than one practitioner, the practitioner who performed the last procedure should enter his/her IMP number.

ITEM 31. If not preprinted, write provider name, address and provider number.

Enter telephone number.

ITEM 32. Not applicable to Medicaid.

ITEM 33. Not applicable to Medicaid.



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

New Jersey Health Services Program NEWSLETTER

Volume P-296

April 27, 1981

TO: INDEPENDENT LABORATORIES

SUBJECT: AMENDMENT OF RECORD RETENTION PERIOD

Effective: Immediately

Background: The record retention period has been seven (7) years for Independent Laboratories.

Action: The record retention period is being amended from seven (7) years to five (5) years. The New Jersey Administrative Code will read as follows:

10:61-1.4 Scope of Services

(c) All files of service and reference laboratories shall be maintained for a period of five (5) years.

If you have any questions about this Newsletter, please contact Ms. Phyllis Valeri at 609-292-3925.



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

New Jersey Health Services Program

NEWSLETTER

Volume P-299

May 11, 1981

TO: ALL PRACTITIONERS USING THE MC-8, PHYSICIANS AND PRACTITIONERS
CLAIM FORM

SUBJECT: HEALTH INSURANCE CLAIM FORM (HCFA-1500)

EFFECTIVE July 1, 1981

BACKGROUND

The Health Care Financing Administration of the United States Department of Health and Human Services has adopted the Health Insurance Claim Form (HCFA-1500) as the common claim form to be used by practitioners when billing the Medicare, Medicaid, or CHAMPUS Programs for services rendered.

The use of a common claim form simplifies billing procedures for practitioners and, by assuring compatibility, simplifies processing of cross-over claims (Medicare/Medicaid).

The New Jersey Medicaid Program, in accordance with the decision of the Health Care Financing Administration, has adopted a Federally approved version of the Health Insurance Claim Form (HCFA-1500). This form will replace the existing Medicaid "Physician and Practitioner Claim" (Form MC-8).

The HCFA-1500 Form also replaces the Medicare Form-1490. Practitioners will be required to submit this form for services covered under the Medicare Program and rendered to Medicare/Medicaid eligible recipients.

ACTION

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Since the general format of the HCFA-1500 is different from the Form MC-8, a draft copy is attached as well as instructions specific to the New Jersey Medicaid Program for completing the HCFA-1500. The information required on the HCFA-1500 for Medicaid purposes is basically the same as that required on the current MC-8 form with some exceptions. The changes and/or additions to the required information are highlighted as follows:

- The patient's birthdate must be entered instead of the patient's age (item 2).
- The patient's Medicare I.D. Number must be entered when appropriate (item 6).
- The box in Item 22 must be checked if the Practitioner is billing for laboratory work performed in his/her office.
- The Place of Service Codes, as noted on the back of the claim form, have been changed from a one position numeric character to a multi-position alpha character and must be entered in item 24B.
- Codes have been developed to correspond to the Type of Service rendered. The appropriate code must be selected from the table on the back of the claim form and entered in Item 24C.
- The appropriate Medicaid procedure code and a brief narrative description must be entered in Item 24D.

Please note that the procedure for submitting claims, as well as general Medicaid policy and procedures, remain unchanged. All practitioners will be required to use reorder forms received from Prudential Insurance Company. Instructions for reordering forms are given on the next page.

This Newsletter should be reviewed carefully and filed in your Medicaid Manual.

Any questions regarding the use of the HCFA-1500 should be directed to the Prudential Insurance Company: 800-582-7052.

HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING THIS FORM

MEDICARE

MEDICAID

CHAMPUS

OTHER

OMB No. 0938-0008

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (First name, middle initial, last name)		2. PATIENT'S DATE OF BIRTH		3. INSURED'S NAME (First name, middle initial, last name)	
4. PATIENT'S ADDRESS (Street, city, state, ZIP code)		5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		6. PATIENT'S MEDICARE/CHAMPUS NO. (Include any letters)	
Telephone No.		7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>		8. PATIENT'S MEDICAID I. D. NO.	
9. OTHER HEALTH INSURANCE COVERAGE- YES <input type="checkbox"/> NO <input type="checkbox"/> Enter Name of Policyholder and Plan Name and Address and Policy Number		10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. ACCIDENTAL INJURY AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>		8a. INSURED'S GROUP NO. (Or Group Name)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE - MEDICARE, CHAMPUS & MEDICAID (Read back before signing) <small>(Authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of Benefits in Accordance with Program Policy. For Federal Benefits I Request Payment Either to Myself or to the Person who Accepts Assignment Below.)</small>		13. I Authorize Payment of Medical Benefits to Undersigned Physician or Supplier for Service Described Below.		11. INSURED'S ADDRESS (Street, city, state, ZIP code)	
SIGNED _____ DATE _____		SIGNED (Insured or Authorized Person)			

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)		15. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION.		16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>		16a. IF AN EMERGENCY CHECK HERE <input type="checkbox"/>	
17. DATE PATIENT ABLE TO RETURN TO WORK		18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____		DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____			
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. public health agency)		19a. I.D. NUMBER		20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____		22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES	
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)		21a. I.D. NUMBER		23A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN E BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE.		23B. WAS THIS SERVICE PERFORMED AS A RESULT OF AN EPSDT PROGRAM REFERRAL? YES <input type="checkbox"/> NO <input type="checkbox"/>	

24. A. DATE OF SERVICE FROM _____ TO _____		B. PLACE OF SERVICE		C. T.O.S.		D. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (Explain Unusual Services Or Circumstances)		E. DIAGNOSIS CODE		F. DAYS OR UNITS		G. CHARGES		H. CHECK IF FAMILY PLANNING		I. LEAVE BLANK	
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24. A. DATE OF SERVICE		B. PLACE OF SERVICE		C. T.O.S.		D. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (Explain Unusual Services Or Circumstances)		E. DIAGNOSIS CODE		F. DAYS OR UNITS		G. CHARGES		H. CHECK IF FAMILY PLANNING		I. LEAVE BLANK	

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part hereof.)		26. ACCEPT ASSIGNMENT (Medicare and CHAMPUS Only - See Back) YES <input type="checkbox"/> NO <input type="checkbox"/>		27. TOTAL CHARGE		28. AMOUNT PAID		29. BALANCE DUE	
SIGNED _____ DATE _____		30. PROVIDER SOCIAL SECURITY/ I.D. NO.		31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS & ZIP CODE					
32. PATIENT'S ACCOUNT NO.		33. EMPLOYER I.D. NO.							
34. REMARKS:									

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program and renders payment for health benefits

provided through membership and affiliation with the Uniformed Services. Information on the patient's sponsor should be provided in items 3, 6, 7, 8, 9, and 11.

MEDICAID PAYMENTS: Authorization to Release Information, and Payment Request. I certify that the service(s) covered by this claim has been received, and 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 State Agency or its authorized Agents any information needed for this or a related claim.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE AND CHAMPUS)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in the physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For services to be considered as 'incident' to a physician's professional service, 1) they must be rendered under the physician's immediate personal

For CHAMPUS claims, I further certify that neither I nor any employee who rendered the services are employees or members of the Uniformed Services (refer to 5 USC 5536).

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422 510).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE AND CHAMPUS INFORMATION

We are authorized by HCFA and CHAMPUS to ask you for information needed in the administration of the Medicare and CHAMPUS programs. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act as amended and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086.

For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor.

The information we obtain to complete Medicare and CHAMPUS claims is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare or CHAMPUS and to insure that proper payment is made.

With the one exception discussed below, there are no penalties under Social Security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of Medicare or CHAMPUS claims. Failure to furnish any other information such as name or claim number, would delay payment of the claim.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations or federal agencies as necessary to administer the Medicare and CHAMPUS programs.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether worker's compensation will pay for treatment. Section 1877(a) (3) of the Social Security Act provides criminal penalties for withholding this information.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency may request.

information is true, accurate and complete; and that the services covered by this claim and the amount charged therefore are in accordance with the regulations of the Medicaid 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, with the exception of authorized deductibles and coinsurance. I also certify that services have been furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act and Section 504 of the Rehabilitation Act of 1973.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): 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

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.

PLACE OF SERVICE CODES:

(IH) - Inpatient Hospital
 (OH) - Outpatient Hospital
 (O) - Doctor's Office
 (H) - Patient's Home
 (DCF) - Day Care Facility (PSY)
 (NCF) - Night Care Facility (PSY)
 (NH) - Nursing Home
 (SNF) - Skilled Nursing Facility
 (A) - Ambulance
 (OL) - Other Locations
 (IL) - Independent Laboratory
 (OMS) - Other Medical, Surgical Facility
 (RTC) - Residential Treatment Center
 (STF) - Specialized Treatment Facility
 (KC) - Independent Kidney Care Treatment Center
 (CL) - Clinic
 (ER) - Emergency Room

TYPE OF SERVICE CODES:

1 - Medical Care
 2 - Surgery
 3 - Consultation
 4 - Diagnostic X-Ray
 5 - Diagnostic Laboratory
 6 - Radiation Therapy
 7 - Anesthesia
 8 - Assistance at Surgery
 9 - Other Medical Service
 0 - Blood or Packed Red Cells
 A - Used DME
 M - Alternate Payment for Maintenance Dialysis
 Y - Second Opinion on Elective Surgery
 Z - Third Opinion on Elective Surgery

MEDICAID CLAIM REORDER INSTRUCTIONS FOR THE HCFA-1500

When your current supply of MC8 claim forms reaches a point where a new supply must be ordered, use the Reorder Form attached below.

1. In Item A, put the number of claims requested in the "Amount Requested" block.

NOTE: If your office will be using the HCFA-1500 for Medicare billing, the amount requested may include the claims for this purpose.

2. If pre-addressed envelopes are needed, put the "Amount Requested" in Item L.

NOTE: If pre-addressed envelopes are needed for Medicare services, you may request them now by putting the number required in the "Amount Requested" block in Items C, D, E, F, G, H, I or J.

3. Print your name, address and Medicaid provider number as it appears now on your MC8 claim forms on the Reorder Form in the lower right hand corner.
4. A new Reorder Form will be sent to you with your requested supply of HCFA-1500 claim forms.

WHEN COMPLETED, REMOVE THIS SECTION AND MAIL TO:

Prudential Insurance Company
 Provider Reorder Unit
 P.O. Box 471
 Millville, New Jersey, 08332

N.J. MEDICARE/MEDICAID REORDER FORM

DATE REQUESTED _____

	DESCRIPTION	AMOUNT REQUESTED	PREVIOUS ORDER
A	REQUEST FOR PAYMENT - MEDICARE AND MEDICAID HCFA-1500		
B	REQUEST FOR PAYMENT - AMBULANCE MEDICARE ONLY HCFA-1491		
** ITEMS C-K FOR MEDICARE PRE-ADDRESSED ENVELOPES **			
C	P.O. BOX 1000 FOR: HUNTERDON, MERCER, MONMOUTH, OCEAN, SOMERSET COUNTIES. CHIROPRACTORS. RPT		
D	P.O. BOX 2000 FOR: ATLANTIC, CAMDEN, CAPE MAY, MIDDLESEX CUMBERLAND, GLOUCESTER, SALEM UNION COUNTIES. RENAL DIALYSIS		
E	P.O. BOX 3333 FOR: BURLINGTON, ESSEX, MORRIS SUSSEX, WARREN COUNTIES DURABLE MEDICAL EQUIPMENT		
F	P.O. BOX 4000 FOR: BERGEN, HUDSON, PASSAIC COUNTIES. PROSTHETICS AND ORTHOTICS		
G	P.O. BOX 2500 FOR: LABORATORIES		
H	P.O. BOX 3500 FOR: PODIATRY		
I	P.O. BOX 3700 FOR: AMBULANCE		
J	P.O. BOX 9000 FOR: RADIOLOGY, PATHOLOGY		
K	PHYSICIAN'S ORDER FOR D M E 7420M		
** ITEM L FOR MEDICAID PRE-ADDRESSED ENVELOPES **			
L	P.O. BOX 1900 FOR: ALL COUNTIES		

IF YOUR ADDRESS HAS CHANGED OR IS DIFFERENT THAN ADDRESS SHOWN, CHECK THIS BOX AND ENTER THE CORRECT INFORMATION BELOW:

OFFICE USE ONLY											
-----------------	--	--	--	--	--	--	--	--	--	--	--

NAME _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

COUNTY _____

SEND COMPLETED FORM TO: THE PRUDENTIAL INSURANCE CO PROVIDER REORDER UNIT P.O. BOX 471 MILLVILLE, NJ 08332 6.30.2022.22.17

PLEASE ORDER A THREE MONTH SUPPLY
 ALLOW FOUR WEEKS

A9854

B2523-B, Ed. 3-81

INSTRUCTIONS FOR COMPLETION OF
HEALTH INSURANCE CLAIM FORM (HCFA-1500)
FOR MEDICAID BILLING

NOTE: CHECK MEDICAID BLOCK AT TOP OF FORM

- ITEM 1. Copy the patient's name EXACTLY as it appears on the Validation Form or Medicaid Eligibility Identification Card. For additional information, see Section 101 of your Medicaid Provider Manual.
- ITEM 2. Indicate patient's date of birth. Use six (6) digits (e.g., Sept. 10, 1980 is written 09/10/80). If only the year is known, enter the year.
If actual birthdate is unavailable, enter the patient's age.
- ITEM 3. Not applicable to Medicaid.
- ITEM 4. Indicate patient's address and telephone number.
- ITEM 5. Check appropriate block to identify patient's sex.
- ITEM 6. Copy the patient's Medicare I.D. Number as it appears on the Medicare Health Insurance Card when the patient is covered by both Medicare and Medicaid.
- ITEM 7. Not applicable to Medicaid.
- ITEM 8. Copy the patient's Health Services Program (HSP) Case Number and Person Number EXACTLY as it appears on the validation form or Medicaid Eligibility Identification Card. For additional information, see Section 101 of your Medicaid Provider Manual.
- ITEM 9. Check appropriate block to indicate whether the patient has other health insurance coverage. If yes, you must attach a copy of the decline notice or a copy of the explanation of payment.
- ITEM 10. Check as appropriate.

If patient's illness or injury is work related.

If patient's injury resulted from an automobile accident or other.
- ITEM 11. Not applicable to Medicaid.
- ITEM 12. Under ordinary circumstances, the patient must sign the claim form when services have been received.

The claim form must indicate services rendered prior to presenting it to the patient for signature.

If the patient's signature is unobtainable, refer to the Billing Chapter in your Medicaid Provider Manual for procedures to follow.

- ITEM 13. Not applicable to Medicaid.
- ITEM 14. Not applicable to Medicaid.
- ITEM 15. Not applicable to Medicaid.
- ITEM 16. Not applicable to Medicaid.
- ITEM 16a. Not applicable to Medicaid.
- ITEM 17. Not applicable to Medicaid.
- ITEM 18. Not applicable to Medicaid.
- ITEM 19. If patient was referred to you, you must indicate the name of the referring practitioner.
- ITEM 19a. Enter the Individual Medicaid Practitioner (IMP) Number of the referring practitioner you entered in Item 19.
- ITEM 20. Not applicable to Medicaid.
- ITEM 21. Write in the name of the institution if place of service is other than doctor's office or patient's home.
To be completed in addition to Item 24b.
- ITEM 21a. Not applicable to Medicaid.
- ITEM 22. Check "No" block when laboratory work was analyzed by you. Do not bill Program if laboratory work was analyzed outside your office.
- ITEM 23a. Enter diagnoses for all services identified in Item 24d.
- ITEM 23b. EPSDT Program Referral:

Complete this item for recipients under 21 years of age. Ask the patient and/or referring physician or clinic if this visit is a result of an EPSDT screening. Indicate if this patient is such a referral by checking the appropriate block.

For services which require prior authorization, copy the prior authorization number designated by the Medicaid office from the Request for Authorization form.

Attach authorization approval form to claim when submitting for payment.
- ITEM 24a. Enter date(s) of each visit.
- ITEM 24b. Identify place of service by selecting appropriate alpha code as listed on the reverse side of form under "Place of Service" Codes.

ITEM 24c. Identify type of service by selecting appropriate code as listed on the reverse side of form under Type of Service Codes.

ITEM 24d. Physicians, Psychologists, Podiatrists, and Optometrists:

Identify the procedure by code number, as listed in either the Procedure Code Manual or your respective Medicaid Provider Manual, and by a brief corroborative narrative description. Insert procedure code and the narrative description in the two columns provided under 24D.

If a code to describe the service rendered is not provided in the manual, enter an adequate description of the service.

Chiropractors

Enter code and description of services rendered as follows: Code 9080 - Manual manipulation of the spine in the Office, Home, or SNF (Chiropractors only).

ITEM 24e. Enter reference numbers in (23a) related to applicable diagnosis for that visit.

ITEM 24f. Not applicable to Medicaid.

ITEM 24g. Enter your usual and customary charge for each service or procedure.

ITEM 24h. Check this column for each service ascribable to "Family Planning". These should include visits for infertility studies, oral, mechanical or chemical contraceptives and applicable surgical procedures.

ITEM 24i. Leave Blank.

ITEM 25. Read the Medicaid Provider Certification on the reverse side of the form carefully.

The Individual Practitioner who personally performed or supervised the service(s) represented on the claim must put his/her signature on each claim before submitting for payment.

If a claim covers services performed by more than one practitioner, the group member who performed the last procedure should sign the claim.

NOTE: Services rendered by non-specialist and specialist providers within a group practice must be submitted on separate claim forms.

- ITEM 26. Not applicable to Medicaid.
- ITEM 27. Enter the sum total of the individual charges.
- ITEM 28. Not applicable to Medicaid.
- ITEM 29. Not applicable to Medicaid.
- ITEM 30. Enter the Individual Medicaid Practitioner (IMP) Number of the practitioner actually performing the service described on the claim.

NOTE: If a claim covers services performed by more than one practitioner, the practitioner who performed the last procedure should enter his/her IMP number. Services rendered by non-specialist and specialist providers within a group practice must be submitted on separate claim forms.

- ITEM 31. If not preprinted, write provider name, address and provider number.

Enter telephone number

- ITEM 32. Not applicable to Medicaid.
- ITEM 33. Not applicable to Medicaid.



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

Volume P-304

TO: HOSPITALS AND PHYSICIANS
SUBJECT: FRIDAY/SATURDAY ADMISSION POLICY
Effective July 1, 1981

BACKGROUND

Section 202 of the Hospital Services Manual lists non-covered inpatient hospital services. Included in this list is Services Rendered Prior to Day Medically Necessary (Section 202.8). Medicaid does not pay for inpatient hospital services rendered prior to the day it is medically necessary for the diagnostic and/or surgical or medical treatment for which the patient is admitted.

Since this policy is particularly applicable to patients admitted to hospitals on Friday or Saturday, Medicaid has amended regulations to specifically address this issue.

ACTION

For patients admitted on a Friday or Saturday, inpatient services rendered on that Friday and/or Saturday will be considered a non-covered service and denied for payment. Admissions that fall within the following categories will be exempt from this policy.

1. Admissions for emergency care;
2. Admissions for obstetrical care;
3. Admissions for elective surgery to be performed the following day;
4. Admissions for which the attending physician has documented the medical necessity for the Friday or Saturday admission.

Please note that Medicaid Policy states whenever a hospital claim is denied for payment as a non-covered service, the attending physician's claim for services rendered during the corresponding period will also be denied for payment.

Any questions regarding this Newsletter should be referred to E. Yuliano, M.D. Medical Director, Division of Medical Assistance and Health Services, 324 East State Street, Trenton, N.J. 08625.



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 _____

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		

WORLD

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-307

August 1, 1981

TO: HOSPITAL ADMINISTRATORS

SUBJECT: Early Periodic Screening, Diagnosis and Treatment (EPSDT): Non-Covered Outpatient Hospital Service

EFFECTIVE: September 1, 1981

PURPOSE: The New Jersey Medicaid Program will no longer reimburse hospital outpatient departments for rendering EPSDT screening examinations.

BACKGROUND: Since September, 1973, the New Jersey Medicaid Program reimbursed hospitals for providing EPSDT screenings to Medicaid eligible children under 21 years of age in the outpatient department setting. At the time, EPSDT screening was a new program and New Jersey Medicaid utilized all available and qualified providers to accomplish the screening of eligible children. Currently, there no longer exists the need to reimburse for EPSDT screening in the hospital outpatient department setting since recent studies indicate the availability of alternate provider settings.

ACTION: No hospital outpatient department claim for EPSDT screenings rendered on or after September 1, 1981 will be reimbursed.

Your Contractor will no longer supply MC-19 (EPSDT Referral Report) forms.

Questions relative to this Newsletter should be directed to your Contractor.



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

New Jersey Health Services Program NEWSLETTER

Volume P-308.....

August 17, 1981

TO: Podiatrists

SUBJECT: Debridement of Hypertrophic Toenails

EFFECTIVE: September 10, 1981

BACKGROUND: Debridement of Hypertrophic Toenails is presently considered part of routine foot care and does not require prior authorization.

ACTION: Prior authorization must be obtained in order to receive Medicaid reimbursement for Debridement of Hypertrophic Toenail treatments performed more frequently than once every two months from prior treatment.

Requests to be referred to:

Chief, Podiatry Unit
CN 712
Trenton, New Jersey 08625

This Newsletter should be filed in your Medicaid Podiatry Manual. If there are any questions regarding this Newsletter, call Frederick Greenfield, D.P.M. at (609) 292-8159.



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

New Jersey Health Services Program NEWSLETTER

Volume P-311

September 1, 1981

TO: PHYSICIANS, PODIATRISTS
SUBJECT: PROCEDURE CODE MANUAL UPDATE
 WITH CERTAIN REVISIONS
EFFECTIVE: October 1, 1981

BACKGROUND: Enclosed is your new Procedure Code Manual which has been updated and revised.

In response to the request of the Medicaid Committee of the New Jersey Medical Society, the GEOGRAPHICAL factor has been eliminated as a parameter for reimbursement. In addition, the TIME factor has been deleted from the non-surgical codes except for vision training codes, the psychiatric and psychological codes, and Code 9071 (Prolonged detention with a patient) where time is the basis for the code, and Code 9030 (Comprehensive Consultation) where time is an optional alternative.

Please note any additions and/or deletions in the procedure codes or narrative descriptions relative to your practice.

SUMMARIZATION OF CHANGES:

- A. Revisions to certain non-surgical codes. The revisions represent the elimination of some codes, the consolidation of others, the alteration of certain fees both upward and downward, and the establishment of parity fee schedule for office, hospital, nursing home, sheltered boarding home and home visit services.

A list reflecting these changes is attached to this Newsletter.
- B. Radiology: The fee schedule is now divided into an office and a hospital setting in order to accommodate the hospital based radiologist whose contract is based on fee-for-service.

The procedure codes and their narratives are for the most part similar to Medicare codes.

NJ/KAS
 IS/Py
 C.2

W. J. ... LIBRARY
 SEP 1 1981
 185 W. State Street
 Trenton, N. J.

ACTION:

- A. Both a procedure code and brief corroborative narrative description of the services rendered must be used when submitting claims, for example,

Code 3261 - Appendectomy
Code 0001 - Office Visit

- B. On and after October 1, 1981, claims will be reimbursed based on the date of processing at Prudential, and not the date of service, except for the deleted non-surgical codes which will be paid based on date of service.
- C. PROMPTLY SUBMIT ALL CLAIMS IN SEPTEMBER. CLAIMS PROCESSED THROUGH SEPTEMBER 30, 1981, WILL BE REIMBURSED UNDER THE EXISTING CODE DESCRIPTIONS AND FEE SCHEDULE; CLAIMS PROCESSED ON AND AFTER OCTOBER 1, 1981, WILL BE REIMBURSED UNDER THE NEW DESCRIPTIONS AND FEE SCHEDULE.

Please discard your old Procedure Code Manual.

Questions concerning this Newsletter may be referred to S. Eugene Yuliano, M.D. Medical Director, at CN 712, Trenton, New Jersey 08625.

- Attachments: 1. "Non-Surgical Codes - Listing of Changes to Procedure Code Manual," dated September 1, 1981.
2. Procedure Code Manual, Ed. 9-81.

NON-SURGICAL CODES

LISTING OF CHANGES TO PROCEDURE CODE MANUAL

THE FOLLOWING LIST IS SEPARATED INTO FOUR CATEGORIES; I - GENERAL MEDICINE; II - CHILD HEALTH; III - EYE EXAMINATIONS; AND IV - PSYCHIATRIC SERVICES. UNDER EACH CATEGORY, "DELETED", "REVISED", AND "NEW" CODES ARE LISTED WHEN APPLICABLE.

PLEASE BE SURE TO READ THE FULL CODE DESCRIPTION IN THE PROCEDURE CODE MANUAL FOR EXCEPTIONS, LIMITATIONS, ETC., AS EACH CODE LISTED HAS BEEN CHANGED IN SOME FASHION.

I - GENERAL MEDICINE (SEE SECTION II FOR CHILD HEALTH CARE CODES)

A. DELETED CODES

- 1. OFFICE VISITS:
 - 9001 - INITIAL OFFICE VISIT, COMPREHENSIVE
 - 0005 - ROUTINE OR FOLLOW-UP OFFICE VISIT, BRIEF
 - 9007 - ROUTINE OR FOLLOW-UP OFFICE VISIT, PROLONGED

- 2. HOME/NURSING HOME) 9011 - INITIAL HOME VISIT, COMPREHENSIVE
 VISITS, INCLUDING) 9014 - FOLLOW-UP NURSING HOME VISIT, BRIEF
 SHELTERED BOARDING) 9016 - FOLLOW-UP NURSING HOME VISIT, PROLONGED
HOMES:)

- 3. HOSPITAL VISITS:
 - 9026 - INITIAL HOSPITAL DAY, COMPREHENSIVE
 - 9021 - 1ST DAY OF INTENSIVE CARE
 - 9022 - FOLLOW-UP HOSPITAL VISIT PROLONGED OR
2ND DAY OF INTENSIVE CARE

FEE SCHEDULE

B. REVISED CODES

		<u>SPECIALIST</u>	<u>NON-SPECIALIST</u>
1. <u>OFFICE VISITS:</u>	9000 - OFFICE VISIT, INITIAL	22	17
	0001 - OFFICE VISIT	9	7
	9008 - ANNUAL HEALTH MAINTENANCE RE-EXAMINATION	22	17
2. HOME-SHELTERED) BOARDING HOME OR) <u>NURSING HOME VISITS:</u>)	9010 - HOME - SHELTERED BOARDING HOME OR NURSING HOME VISIT - INITIAL	22	17
	0002 - HOME OR SHELTERED BOARDING HOME VISIT	9	7
	0004 - NURSING HOME VISIT	9	7

GENERAL MEDICINE CONT'D
 B. REVISED CODES CONT'D

FEE SCHEDULE

		<u>SPECIALIST</u>	<u>NON-SPECIALIST</u>
3. <u>HOSPITAL VISITS:</u>	9020 - HOSPITAL DAY, INITIAL	22	17
	0003 - HOSPITAL DAY	9	7
4. <u>CONSULTATIONS:</u>	9029 - CONSULTATIONS - LIMITED	22	N/A
	9030 - CONSULTATION - COMPREHENSIVE	37	N/A
5. <u>OTHER SERVICES:</u>	9071 - DETENTION - PROLONGED	37	32

II - CHILD HEALTH CARE

A. DELETED CODES

9001 - INITIAL OFFICE VISIT, COMPREHENSIVE
 0005 - ROUTINE OR FOLLOW-UP OFFICE VISIT, BRIEF
 9007 - ROUTINE OR FOLLOW-UP OFFICE VISIT, PROLONGED

B. REVISED CODES

9580 - EARLY PERIODIC SCREENING DIAGNOSIS & TREATMENT (EPSDT) 23 18
 (CLAIMS MUST BE SUBMITTED WITHIN 30 DAYS WITH MC-19 ATTACHED. FAILURE TO SUBMIT AN MC-19 WILL RESULT IN REIMBURSEMENT UNDER PREVENTIVE HEALTH CARE CODES; I.E. CODE 9006 OR CODE 0011.)
 0001 - OFFICE VISIT - (PROBLEM ORIENTED) 9 7
 9000 - OFFICE VISIT, INITIAL 22 17
 9035 - ROUTINE NEWBORN CARE - WELL BABY 22 17
 9037 - ATTENDANCE DURING AND PEDIATRIC CARE TO NEWBORN(S) AT CESAREAN SECTION 22 17

C. NEW CODES

9006 - ANNUAL HEALTH MAINTENANCE EXAMINATION AGES 3 YEARS THROUGH 20 YEARS 22 17
 0011 - OFFICE VISIT - PEDIATRIC PREVENTIVE HEALTH CARE 9 7

EYE EXAMINATION

FEE SCHEDULE

SPECIALIST NON-SPECIALIST

III - EYE EXAMINATION

A. DELETED CODES

5407 - EYE EXAM, PROLONGED

B. REVISED CODES

5400 - COMPREHENSIVE EYE EXAMINATION	22	N/A
5401 - COMPREHENSIVE EYE EXAMINATION	26	N/A
5406 - SCREENING EXAMINATIONS	9	N/A

IV - PSYCHIATRIC SERVICES

A. REVISED CODES

9050 - PSYCHOTHERAPY, INDIVIDUAL, ONE HOUR		NO CHANGE	
9051 - PSYCHOTHERAPY, INDIVIDUAL, ONE-HALF HOUR		NO CHANGE	
9053 - PSYCHOTHERAPY, GROUP		NO CHANGE	
9056 - INITIAL COMPREHENSIVE PSYCHIATRIC EVALUATION	NO CHANGE		26
9062 - FAMILY THERAPY - ONE AND ONE-HALF HOURS		NO CHANGE	
9064 - FAMILY THERAPY/FAMILY CONFERENCE, ONE HOUR		NO CHANGE	
9065 - FAMILY THERAPY/FAMILY CONFERENCE, ONE-HALF HOUR		NO CHANGE	



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

New Jersey Health Services Program NEWSLETTER

Volume P-317

October 12, 1981

TO: All Medical Suppliers

SUBJECT: I. Rental/Purchase of IPPB Machines
II. Policy Change for Vaporizers and Cool Mist Humidifiers

EFFECTIVE: November 1, 1981

Enclosed are revised pages dated 9/81 for your Medical Supplier Manual. Please review carefully the replacement pages as they incorporate recent changes to the Program. These changes, indicated by brackets placed in the margin of the revised pages and highlighted below, include both policy change on Rental/Purchase of IPPB Machines and policy changes on Vaporizers and Cool Mist Humidifiers.

I. RENTAL/PURCHASE OF IPPB MACHINES

IPPB machines may now be purchased at the discretion of the Local Medical Consultants or will be considered purchased when the rental payments exceed 120% of the approved purchase price.

Repairs for this item may be prior authorized when it is considered a purchase.

II. POLICY CHANGE FOR VAPORIZERS AND COOL MIST HUMIDIFIERS

The purchase of a vaporizer or cool mist humidifier will now be limited to one per household with a maximum charge to Medicaid of \$30.00.

The only exceptions to the above policy are:

- (1) Medical necessity warranting more than one, and;
- (2) Replacement of broken vaporizer or cool mist humidifier.

III. MANUAL MAINTENANCE

Please discard the outdated material and replace with the attached revised pages:

Subchapter 1 - Index - Revised 9/81
Pages 7, 8, 9 & 10 Revised 9/81



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

New Jersey Health Services Program NEWSLETTER

Volume P-324.....

DATE: January 18, 1982

TO: Independent Clinics and Hospital Administrators

SUBJECT: Revision of the FD-07 (Rev. 10/81) "Request For Authorization of Mental Health Services".

EFFECTIVE: February 1, 1982

Background

The recent adoption of a new policy requiring prior authorization for mental health services in Long-Term Care Facilities and all facilities covered under the Rooming and Boarding House Act of 1979 necessitated the revision of the FD-07 form, "Request For Authorization of Mental Health Services".

Action

This Newsletter will inform Independent Clinics and Hospital Outpatient Departments, as providers of mental health services, of the revision of the FD-07 form, "Request For Authorization of Mental Health Services".

On or after February 1, 1982, the newly revised form will replace the existing FD-07 (Rev. 9/77) and must be used when requesting authorization/reauthorization for those mental health services currently requiring prior authorization. When a request for authorization is approved, both the Contractor's Copy and the Provider's Copy will be returned to the Provider. When submitting a claim for reimbursement, the Provider must attach the Contractor's Copy of the authorization (FD-07 form) to the claim form, otherwise reimbursement will be denied. If the mental health services are not approved as requested, the provider will be notified, in writing, of the reason for denial or amendment. A copy of the new FD-07 (10/81) is attached and a supply of the new form is available upon request from your Contractor.

Any questions regarding this Newsletter should be directed to your Contractor. The telephone number for Prudential is (800) 582-7052 and for Blue Cross is (201) 456-2570.



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

**REQUEST FOR AUTHORIZATION
OF MENTAL HEALTH SERVICES**

PATIENT INFORMATION	1. PATIENT'S NAME	2. HEALTH SERVICE PROGRAM NO.	3. PATIENT PERSON NO.	4. AGE	5. SEX <input type="checkbox"/> M <input type="checkbox"/> F
	6. STREET ADDRESS	7. CITY, STATE, ZIP		8. TELEPHONE NUMBER	
	9. PLACE OF SERVICE - NAME AND ADDRESS			10. ATTENDING PHYSICIAN'S (SIGNATURE) IF ITEM 9 IS A LTCF	

CLINICAL INFORMATION	11. BRIEF CLINICAL HISTORY
	12. PRESENT CLINICAL STATUS (TO SUPPORT REQUEST)

13. DIAGNOSIS AND CODE (MUST CONFORM WITH DIAGNOSTIC AND STATISTICAL MANUAL III)
--

SERVICE REQUEST	14. TREATMENT REQUEST	FREQUENCY - INDICATE NUMBER			LENGTH OF SESSION - CHECK				
		PER WEEK	PER MONTH	PER YEAR	1 1/4 HR	1 HR	1/2 HR	1 DAY	1/2 DAY
	A. PSYCHOTHERAPY, INDIVIDUAL								
	B. PSYCHOTHERAPY, GROUP								
	C. FAMILY THERAPY								
	D. FAMILY THERAPY/CONFERENCE								
	E. PARTIAL HOSPITALIZATION								
	F. PARTIAL CARE								
	G. MEDICATION MANAGEMENT								
H. PSYCHOLOGICAL TESTING. BY CODE NUMBER: _____									

15. DURATION OF THIS SERVICE BLOCK:	STARTING DATE:	NUMBER OF MONTHS:
-------------------------------------	----------------	-------------------

PROVIDER	16. NAME AND ADDRESS OF PROVIDER	17. IMP NUMBER	18. TELEPHONE NUMBER
	PROVIDER NO.	19. PROVIDER SIGNATURE	20. DATE

FOR DIVISION USE ONLY - The following services are authorized not in excess of:

PSYCHOTHERAPY, INDIVIDUAL	1 HOUR	1/2 HOUR	PARTIAL HOSPITALIZATION	1 DAY	1/2 DAY
PSYCHOTHERAPY, GROUP	1 1/4 HOURS		PARTIAL CARE	1 DAY	1/2 DAY
FAMILY THERAPY	1 1/4 HOURS		MEDICATION MANAGEMENT		
FAMILY THERAPY/CONFERENCE	1 HOUR	1/2 HOUR	PSYCHOLOGICAL TESTING		

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

AUTHORIZATION	COMMENTS:
	THIS AUTHORIZATION PERIOD FROM: _____ THRU _____
	DATE _____
	AUTHORIZING SIGNATURE _____ TITLE _____



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

New Jersey Health Services Program NEWSLETTER

Volume P-325

(Revised)

Date: April 5, 1982

(Replaces Newsletter dated 1/4/82)

TO: Physicians and Psychologists

SUBJECT: New Policy on Prior Authorization for Mental Health Services in Long-Term Care Facilities and All Facilities Covered Under The Rooming and Boarding House Act of 1979, Chapter 496).

BACKGROUND: The new policy of prior authorization for mental health services in Long-Term Care Facilities and all facilities covered under the Rooming and Boarding House Act of 1979 (Residential Health Care Facilities, Boarding Houses and Rooming Houses) was proposed in the New Jersey Register and adopted as part of the New Jersey Administrative Code (N.J.A.C. 10:54-1.5b and 10:67-1.8b).

EFFECTIVE: February 1, 1982

ACTION: This Newsletter is to inform providers of mental health services that prior authorization will be required, following the initial consultation, for all mental health services rendered to eligible Medicaid residents of Long-Term Care Facilities and all facilities covered under the Rooming and Boarding House Act of 1979. The \$300.00 exemption will no longer apply to patients in these settings as of February 1, 1982.

In a Long-Term Care Facility (skilled nursing facility or intermediate care facility), the initial consultation shall be performed only upon a written order signed by the Attending Physician (on the order sheet) citing the reason(s) for the need for the consultation. If the Attending Physician telephones the order to an appropriate person designated by the Long-Term Care Facility, the physician, within forty-eight (48) hours, must countersign the order on the order sheet, citing the reason(s) for the consultation, or must personally have signed and forwarded to the Long-Term Care Facility an identical order on a prescription form, citing the reason(s) for the need for the consultation.

If mental health services are recommended by this consultation, the individual who will then provide the mental health services must submit a completed FD-07 form, "Request for Authorization of Mental Health Services", to the Local Medical Assistance Unit (LMAU) serving that particular Long-Term Care Facility. Items #10, #11, and #12 need not be filled in. However, a copy of the consultation report must be attached to the FD-07 form.

The medical consultant in the LMAU will discuss the request for services as identified on the FD-07 with the attending physician. Following such

discussion, the medical consultant will either authorize, modify, or deny the request for services and will return the FD-07 to the mental health provider. If the service is authorized, the medical consultant will forward a copy of the FD-07 to the Long-Term Care Facility. The FD-07 is to be made a part of the "order section" of the patient's chart.

If during a current period of authorization, the Mental Health provider believes that additional services will be required, or after a reasonable time interval a renewal of therapy for the same condition is deemed necessary, a formal consultation is not necessary. The Mental Health provider must fill out another FD-07 form completing all items except Item #10. Special attention is to be given to Items #11 and #12 on the form, supporting the need for additional therapy, and then complete the same procedure previously described.

In all facilities covered under the Rooming and Boarding House Act of 1979, (Residential Health Care Facilities, Boarding Houses and Rooming Houses), the Mental Health provider must submit the request for prior authorization and/or reauthorization on the FD-07, "Request for Authorization of Mental Health Services" to the Chief, Bureau of Mental Health Services, CN-712, Trenton, New Jersey 08625.

If the request for authorization is approved in either setting, both the Contractor's Copy and Provider's Copy will be returned to the Mental Health Provider. When submitting a claim for reimbursement, the Mental Health Provider must attach the Contractor's Copy of the authorization (FD-07 form) to the claim form or reimbursement will be denied.

Whenever services are not approved as requested, the Mental Health provider and patient will be notified, in writing, of the reason for denial or amendment.

The FD-07 form, "Request for Authorization of Mental Health Services" has been revised and must be used when requesting authorization after February 1, 1982. A supply of the new form is available from the Prudential Insurance Company upon request. Please destroy the existing FD-07 forms (Rev. 9/77).

When submitting claims for payment on the 1500-NJ form (Health Insurance Claim Form), Mental Health providers must complete Item #22 which identifies the address of the facility where services were rendered and Item #24B which identifies the place of service. If services were provided in a Long-Term Care Facility, the "NH" symbol must be utilized; if services were provided in any other facility covered under the Rooming and Boarding House Act of 1979, a "BH" symbol is to be utilized. Claims not following this policy will be rejected by the Contractor.

Claims submitted on or after February 1, 1982, will be processed based upon the date the service was rendered. However, any authorization already in effect prior to February 1, 1982 will remain in effect until the expiration of the authorization or until May 1, 1982, whichever comes first. No post facto requests for authorization will be accepted. If the patient is to continue therapy, a

consultation is not required, but the procedures for requesting additional services must be followed; for example:

<u>Authorization Period</u>	<u>Authorized Period Under Present Procedure</u>	<u>Authorization Required Under New Procedure</u>
12/1/81 thru 4/1/82	Authorization valid for entire period	
12/1/81 thru 6/1/82	Authorization valid thru 4/30/82	Prior authorization must be obtained for services on and after 5/1/82.

Any questions regarding this Newsletter relative to residential health care facilities, boarding homes and rooming houses should be directed to Raymond Reinhart, M.D., Chief, Bureau of Mental Health Services, CN-712, Trenton, New Jersey 08625, telephone (609) 292-8198.

Any questions regarding this Newsletter concerning skilled nursing and/or intermediate care facilities should be directed to the Medical Consultant in the appropriate Local Medical Assistance Unit of the Medicaid Program.



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

New Jersey Health Services Program NEWSLETTER

Volume P-326

January 18, 1982

TO: Independent Clinics

SUBJECT: Partial Care

EFFECTIVE DATE: Claims processed on or after February 1, 1982.

BACKGROUND: A new Independent Clinic Mental Health designation, Partial Care (PC), is being recognized by the Medicaid Program under N.J.A.C. 10:66-3.3. The current Partial Hospitalization Program will continue to be reimbursed.

ACTION: N.J. Medicaid program reimbursement will be made for Partial Care service claims processed on or after February 1, 1982 provided the Independent Clinic participates in the Medicaid Program and is approved to provide Partial Care by the Division of Mental Health and Hospitals of the Department of Human Services. Participating Clinics already approved by that Division to provide Partial Care need not apply. However, those clinics not approved for Partial Care must apply for approval to the Division of Mental Health and Hospitals. Those clinics whose programs are not yet approved for Partial Care will continue to be reimbursed at the Partial Hospitalization rate.

Procedure Code	Medicaid Dollar Value
Partial Care (half day, 3 hrs. min.)	0065 (new code) \$15.00
Partial Care (full day, 5 hrs. min.)	0066 (new code) \$30.00
Partial Hospitalization (half day, 3 hrs. min.)	0068 \$ 8.00
Partial Hospitalization (full day, 5 hrs. min.)	0069 \$15.50

Manual replacement pages will follow.

Any questions should be directed to Raymond B. Reinhart, Jr., M.D.,
 Chief, Bureau Mental Health Services, CN 712, Trenton, New Jersey 08625.



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

New Jersey Health Services Program NEWSLETTER

Volume P-331.....

April 26, 1982

TO: Independent Clinics

SUBJECT: Family Planning Services

The Division of Medical Assistance and Health Services has revised and adopted regulations in the New Jersey Administrative Code, 10:66-3.3, to clarify family planning procedure codes 0086, 0087, 0089 and 0090.

The revision concerns the dispensing of birth control drugs during family planning visits. The revised regulations state specifically that the costs of birth control drugs are included in the reimbursement fee for family planning codes 0086, 0087, 0089 and 0090. Therefore, at the time of a family planning visit, the birth control drugs should be dispensed. A prescription cannot be substituted.

Manual Maintenance:

Attached to this Newsletter for inclusion in your Independent Clinic Services Manual are replacement pages regarding revised family planning codes and replacement pages regarding partial care (N.J. Health Services Program Newsletter P-326, dated January 18, 1982, previously mailed to all Independent Clinics).

Please discard the outdated material and replace with the attached revised pages:

Subchapter 1 - Index revised 2/82
Page 7 revised 2/82
Page 8 revised 5/80
Pages 9 & 9.1 revised 2/82
Pages 10, 11, 12, 13 & 14, 14.1 revised
5/80

Subchapter 3 - Index revised 2/82
Pages 13 & 14 revised 4/82
Pages 25 & 26 revised 2/82
Pages 26.1 & 26.2 revised 9/81

MEDICARE / MEDICAID BULLETIN

82-2
VOLUME P-332

April, 1982

Health Insurance Claim Form
(1500 - N.J. Ed. 11/81)

We would like to take this opportunity to inform you that the Health Insurance Claim Form (1500-N.J.) will soon be supplied in single ply stock only. The change from a two-ply to a one-ply continuous pinfeed form results in significant savings in both the Medicare and Medicaid Programs.

This change will not affect the design of the form nor the method used to order the 1500-N.J. claim forms.





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

STATE LIBRARY
MAY 10 1982
185 W. State St.
Trenton, N. J.

New Jersey Health Services Program NEWSLETTER

Volume P-333

May 3, 1982

TO: Physicians, Podiatrists and Hospital Administrators

SUBJECT: Revised Replacement Pages to the Procedure Code Manual
Ed. 9-81.

BACKGROUND: In September 1981, the Division of Medical Assistance and Health Services distributed to all Providers a revised and updated Procedure Code Manual. The Division on a continuing basis adds new codes and revises or deletes existing codes as necessary. To ensure that your Procedure Code Manual remains an accurate and useful reference, the Division will issue replacement pages every six months to be incorporated into your Procedure Code Manual.

ACTION: Attached to this Newsletter are replacement pages incorporating additions, deletions and revisions made to the Procedure Code Manual, Ed. 9-81, from September, 1981 to March 1, 1982. The changes are outlined by brackets in the left margin.

Please discard the outdated pages in your Procedure Code Manual, Ed. 9-81 and replace with the attached revised pages.

Questions concerning this Newsletter may be referred to S. Eugene Yuliano, M.D., Medical Director, CN 712, Trenton, New Jersey 08625.

NJ/KAS
IS/P4



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

New Jersey Health Services Program NEWSLETTER

Volume P-335

June 1, 1982

TO: Independent Clinics

SUBJECT: Initial Visit for Rehabilitation Services
 (Physical, Speech, and Occupational Therapy)

EFFECTIVE: July 1, 1982

BACKGROUND: Independent Clinics must obtain prior authorization from the Medical Consultant of the Local Medical Assistance Unit before providing rehabilitation services. The policy is modified to the extent that an initial visit for physical, speech or occupational therapy will be permitted without prior authorization. The initial visit will be coded differently from subsequent visits for treatment. The new initial visit codes, existing therapy codes, and fees follow:

Physical Therapy

0047	Initial visit, physical therapy; per individual, per provider	\$7.00
9090	Treatment (no change)*	\$7.00

Speech Therapy

0049	Initial visit, speech therapy; per individual, per provider	\$7.00
0075	Treatment (no change)*	\$7.00

Occupational Therapy

0048	Initial visit, occupational therapy; per individual, per provider	\$7.00
0076	Treatment (no change)*	\$7.00

ACTION: For initial visits for physical therapy, speech therapy, or occupational therapy made on or after July 1, 1982, prior authorization from the Local Medical Assistance Unit is not required. All other visits require prior authorization and must be submitted under the existing codes. Claims submitted with both initial visit and follow-up treatment visits must clearly identify the respective services.

* For descriptions of codes 9090, 0075, 0076 see pages 37, 38 and 39 respectively in your Independent Clinic Services Manual.



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

New Jersey Health Services Program NEWSLETTER

Volume P-337

July 9, 1982

TO: All Providers

SUBJECT: MEDICAID ELIGIBILITY IDENTIFICATION CARD

EFFECTIVE: Immediately

BACKGROUND: The New Jersey Medicaid Program is issuing Medicaid Eligibility Identification cards monthly instead of quarterly for individuals eligible for the Supplemental Security Income Program. The card received in July is valid from July 1, 1982 to July 31, 1982 and each card issued thereafter will be valid for a period of one month only.

An individual eligible for Supplemental Security Income (Aged, Blind or Disabled) can be identified by the Health Services Program Case Number which has the third and fourth digits of the number as 10 (Aged), 20 (Disabled), or 50 (Blind).

Examples: 07-10-237845-01; 09-20-437090-01; 10-50-564374-01

ACTION: When providing Medicaid services for an individual eligible for Supplemental Security Income, the provider must check the Medicaid Eligibility Identification card to verify current eligibility each time a service is provided.

Any questions regarding this Newsletter should be directed to your Local Medical Assistance Unit.



STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program

NEWSLETTER

Volume P-338

August 1, 1982

TO: Participating Physicians, Dentists and Podiatrists

SUBJECT: Maximum Allowable Cost (MAC)

EFFECTIVE DATE: August 12, 1982

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

<u>Drug</u>	<u>MAC Limit</u>
Acetaminophen w/Codeine, 300 mg/60 mg oral tablets	\$0.1458
Ampicillin, 250 mg oral capsules	\$0.0422
Ampicillin oral suspension, 125 mg/5 ml	\$0.0114
Penicillin VK, 250 mg oral tablets	\$0.0417
Penicillin VK, 500 mg oral tablets	\$0.0649
Penicillin VK oral liquid, 125 mg/5 ml	\$0.0109
Tetracycline HCl, oral capsules, 500 mg	\$0.0394

Effective August 12, 1982, 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 (MAC) as indicated above.

MAC Drugs - Exception-Medical Certification-Medicaid-Pharmaceutical Services
Manual-10:51-1.6

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 of the Department of Health and Human Services limitations shall not apply in any case where a physician certifies in his/her own handwriting that in his/her medical judgement a specific brand is medically necessary for a particular patient. In this instance the physician must write "Brand Necessary" or "Brand Medically Necessary" in his/her own handwriting on each written prescription. In the case of a telephoned original prescription,

when a physician chooses to certify "Brand Necessary" or "Brand Medically Necessary" on a MAC listed drug product, he/she must submit a written prescription order to the pharmacist, containing the certification, within seven 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: Only the terms "Brand Necessary" or "Brand Medically Necessary" are valid for establishing Medical Certification. No other terminology is acceptable for reimbursement under the N.J. Medicaid Program.

Blanket authorizations denying substitutions are not permitted. Each prescription for a MAC drug must contain the statement, "Brand Necessary" or "Brand Medically Necessary" in the prescriber's own handwriting each time the prescriber chooses not to allow substitution on a MAC drug.

MAC Drugs - Exception - Medical Certification - Pharmaceutical Assistance to the Aged and Disabled (PAAD) Program Services Manual

The procedures outlined under the Prescription Drug Price and Quality Stabilization Act (N.J.S.A.-24:6E-1 et seq.) concerning prescriber's prerogative for substitution shall be the determinant for Medical Certification in the PAAD Program.

Only those prescription drugs with a MAC price which are also listed in the Drug Utilization Review Council (DURC) Formulary are subject to MAC requirements under PAAD. For purposes of reimbursement under the PAAD Program, the "Medical Certification" box on the Prescription Claim (form MC-6) must be checked for all MAC drugs listed in the (DURC) Formulary, when the prescriber has indicated that substitution is not permitted.

Any prescription drug product which is listed in the MAC price list but which is not listed in the DURC Formulary will be reimbursed at average wholesale price (AWP) less regression discount, if applicable. For purposes of reimbursement under the PAAD Program, the "Medical Certification" box on the Prescription Claim (form MC-6) must be checked for all MAC drugs not listed in the DURC Formulary in order to be paid at the AWP less regression, if applicable.

ACTION II: The Maximum Allowable Cost limit on Dicloxacillin Sodium 250 mg oral capsule has been suspended;

Attached is an updated MAC List. This material replaces P-282 - December 8, 1980.

Any questions regarding this newsletter should be directed to the Bureau of Pharmacy Services, Division of Medical Assistance and Health Services.
Telephone (609) 292-3156

LISTING OF MAC DRUGS

8/12/82

<u>DRUG ENTITY</u>	<u>MAC</u>	<u>EFFECTIVE DATE</u>
Acetaminophen w/Codeine, 300mg/30mg Tablets	\$0.0780 per Tablet	01/25/79
Acetaminophen w/Codeine, 300mg/60mg Tablets	\$0.1458 per Tablet	08/12/82
Amoxicillin, 250mg Capsules	\$0.2108 per Capsule	06/28/79
Amoxicillin, 500mg Capsules	\$0.3942 per Capsule	06/28/79
Ampicillin, 250mg Capsules	\$0.0422 per Capsule	08/12/82
Ampicillin, 500mg Capsules	\$0.1103 per Capsule	01/25/79
Ampicillin, Oral Suspension, 125mg/5ml	\$0.0114 per ml	08/12/82
Ampicillin Oral Suspension, 250mg/5ml	\$0.0205 per ml	11/07/77
Chlordiazepoxide HCl, 5 mg 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
Glutethimide, 500mg Tablets	\$0.0432 per Tablet	08/28/81
Hydralazine HCl, 25mg Tablets	\$0.0279 per Tablet	03/31/80
Hydralazine HCl, 50mg Tablets	\$0.0384 per Tablet	03/31/80
Hydrochlorothiazide, 25 mg 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

LISTING OF MAC DRUGS - CONTINUED

<u>DRUG</u>	<u>MAC</u>	<u>EFFECTIVE DATE</u>
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	\$0.0109 per ml	08/12/82
Penicillin VK Oral Susp., 250mg/5ml	\$0.0160 per ml	11/07/77
Penicillin VK, 250mg Tablets	\$0.0417 per Tablet	08/12/82
Penicillin VK, 500mg Tablets	\$0.0649 per Tablet	08/12/82
Potassium Chloride, Oral Liquid 10%	\$0.0030 per ml	12/15/80
Probenecid, 0.5gm Tablets	\$0.0644 per Tablet	01/25/79
Procainamide HCl, 250mg Capsules	\$0.0383 per Capsule	08/28/81
Procainamide HCl, 375mg Capsules	\$0.0505 per Capsule	08/28/81
Procainamide HCl, 500mg Capsules	\$0.0585 per Capsule	08/28/81
Propantheline Br, 15mg Tablets	\$0.0235 per Tablet	08/28/81
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	\$0.0394 per Capsule	08/12/82
Tetracycline HCl, 125mg/5ml Syrup	\$0.0104 per ml	10/15/79



STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program

NEWSLETTER

Volume P339.....

October 4, 1982

To: Physicians, Hospitals, Independent Clinics

Subject: Second Opinion Policy Changes

Effective: Immediately

Background: As described in the Health Services Program Newsletter (P-329 or BC-229; issued March 22, 1982), the New Jersey Medicaid Program has implemented a mandatory Second Opinion Program for the following elective surgical procedures: hysterectomy, cholecystectomy, tonsillectomy and/or adenoidectomy, hernia repair, laminectomy and spinal fusion.

The purpose of this Newsletter is to notify providers of the revised requirement for a second opinion for certain surgical procedures involving a child or young adult. In addition, provider reaction indicated the need to clarify certain pertinent Second Opinion requirements.

Revised Requirements: A second opinion will not be required for:

1. Herniorrhaphies involving a child or young adult 18 years of age or under. However, a second opinion is required for an umbilical herniorrhaphy in a child under the age of five (Procedure Code #3665) and for any herniorrhaphy involving an adult.

2. Spinal Fusion for scoliosis in a child or young adult; (Procedure Codes #0643, #0644, #0645).

Clarification of Existing Requirements:

1. A second opinion is required only for the surgical procedures listed under Background and only when they are considered to be elective. If the operating physician determines that the need for surgery is urgent or is an emergency, no second opinion is required. Urgent or emergency, as defined in the previous Newsletter, includes any situation in which a delay in performing surgery in order to meet the second opinion requirement could result in a significant threat to the patient's health or life. Reimbursement will be made only if a specific statement is attached to all claim forms by the operating physician certifying that the second opinion requirement was not met and substantiating the urgent or emergency nature of the surgery.

2. In order to meet Program requirements, a second opinion must be arranged through the Medicaid Second Opinion Referral Center at the Prudential Insurance Company. A physician-ordered consultation does not meet the Program's definition of a second opinion and no Authorization for Payment will be granted based on such

a consultation. The only exception to this policy involves second opinions arranged and paid for by other third party payors (see item 4).

3. In order to prevent claim denials as a result of situations where one of the elective surgical procedures is scheduled and performed before the second opinion requirement has been met, it is suggested that the elective surgery not be scheduled until after the second opinion has been rendered.

4. A second opinion is required for any of the six elective procedures whenever the New Jersey Medicaid Program is to be billed for any portion of the hospital or physician claim. Therefore, if a Medicaid patient is covered by other insurance (except when Medicare coverage is involved) which makes only partial payment on the claim, the Medicaid Program will not make supplementary payment unless the second opinion requirement has been met. However, the Medicaid Program will make payment on the claim if the operating physician and hospital receive documentation that a second opinion was arranged and paid by another insurer. A copy of this documentation must be attached to the Medicaid claim.

5. All Second Opinion Providers must be board certified by the American Specialty Boards in the appropriate specialty and have a signed Second Opinion Provider Agreement with the New Jersey Division of Medical Assistance and Health Services.

The physician agrees when completing the Second Opinion Provider Agreement not to perform surgery on the individual to whom he has given a second opinion, and not to make a referral unless requested by the patient and then only to a surgeon with whom the second opinion physician has no financial involvement. Eligible physicians who are interested and have not received a Second Opinion Provider Agreement application should contact the Medicaid Second Opinion Referral Center at (800) 582-5936.

6. Reimbursement will not be made for a second opinion rendered to a patient who is not Medicaid eligible. The issuance of a Medicaid Second Opinion Referral Form to the patient by the Medicaid Second Opinion Referral Center does not guarantee the patient's eligibility on the date of the second opinion or subsequent surgery. The patient's Medicaid eligibility must be verified by checking the patient's current New Jersey Medicaid Validation Form before rendering any service.

7. If the patient wishes to proceed with surgery after a second opinion is received, the operating physician must contact the Referral Center to receive an Authorization for Payment prior to proceeding with the surgery. Neither the physician nor hospital claim associated with one of the second opinion procedures will be paid unless attached to the hard-copy claim is an Authorization for Payment, or documentation of a second opinion arranged through another insurer, or a specific statement from the operating physician certifying that the second opinion requirement was not met and substantiating the urgent or emergency nature of the surgery.

If you have any questions regarding the Medicaid Second Opinion Program, you may contact the Medicaid Second Opinion Referral Center at the toll-free number (800) 582-5936.



STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program

NEWSLETTER

Volume P-340.....

November 1, 1982

TO: HOSPITAL ADMINISTRATORS, PHYSICIANS, AND INDEPENDENT CLINICS

SUBJECT: MEDICAID HYSTERECTOMY POLICIES AND CLAIM PROCESSING REQUIREMENTS

I. Purpose

To notify Medicaid Providers that Federal policy regarding documentation for hysterectomies has been revised effective August 4, 1982. The revisions change documentation requirements in cases where the patient was already sterile, or life-threatening emergency existed, or a hysterectomy was performed during the period of a patient's retroactive Medicaid coverage.

The Federal Government has allowed New Jersey to honor certain retroactive claims for hysterectomies performed on or after March 8, 1979 if the claims were rejected because of previous Federal policy on documentation.

Providers may resubmit, under the specific conditions described in c.i, ii, and iii on page 8 of this newsletter, claims for hysterectomies that were correctly denied for payment solely because of the lack of a Hysterectomy Receipt of Information Form (FD-189).

II. Supersedure

This Newsletter supersedes pages 7, 8 and 9 of Prudential Newsletter Volume P-334 and Blue Cross Newsletter Volume BC 232 both dated May 17, 1982. Both are titled "Medicaid Sterilization and Hysterectomy Policies and Claim Processing Requirements." The attached pages 7, 8 and 9 replace the May 17 Newsletter pages 7, 8 and 9.

Revisions are indicated by a line along the page margin.

III. Effective

- A. For hysterectomies performed on or after August 4, 1982.
- B. Retroactively, under specific conditions, for hysterectomies performed on or after March 8, 1979, where payment was denied.

IV. Scope

The policies and documentation requirements stated herein apply to hysterectomies performed on Medicaid eligible patients.

V. Resubmission of Claims

Resubmissions for hysterectomies performed on or after March 8, 1979 and before

(over)

August 4, 1982 must be sent, under separate cover, to the appropriate fiscal agent no later than February 1, 1983.

The resubmitted claim should have appropriate documentation, including the notice of rejection, attached.

Resubmit claims to Prudential through:

(Non-institutional claim): Prudential Insurance Company
John W. Kallop, Manager
Medicaid Claims Division II
P.O. Drawer 471
Millville, N.J. 08332

(Institutional claim): Prudential Insurance Company
Ann M. Johnson, Associate Manager
Provider Services Division
P.O. Box 5000
Millville, N.J. 08332

Resubmit claims to Blue Cross through:

Blue Cross of New Jersey
Joseph Rampone, Manager
Institutional Examination and Processing
33 Washington Street
Newark, N.J. 07102

The provider is responsible for identifying claims denied solely because of the lack of a Hysterectomy Receipt of Information Form (FD-189). The provider is also responsible for submitting a new claim which meets the requirements described on the attached pages.

Secondary providers, such as assisting surgeons or anesthesiologists, may resubmit claims that were denied solely because of the lack of an FD-189 Form if the other conditions for payment, as described in this newsletter, are met. The secondary provider is required to attach a copy of the physician certification to the resubmitted claim.

B. A hysterectomy may not be performed solely for the purpose of rendering an individual permanently incapable of reproducing. Hysterectomy is reimbursable as a surgical procedure if performed primarily for the purpose of removing a pathological organ.

C. Surgical hysterectomy procedures

The following 11 procedures codes are those considered valid for hysterectomy claim processing and reporting and require the completion of the Hysterectomy Receipt of Information Form (FD-189) or, under certain conditions (see 1.c. on page 8), a physician certification:

<u>Procedure Code</u>	<u>Description</u>
4614	Total hysterectomy (corpus and cervix) with or without tubes, and/or ovaries, one or both
4618	Supracervical hysterectomy: sub-total hysterectomy, with or without tubes, and/or ovaries, one or both
4620	Radical hysterectomy for cancer including regional lymph nodes
4626	Radical hysterectomy for cancer including regional lymph nodes plus removal of bladder and ureteral transplantations and/or abdomino - perineal resection of rectum and colon and colostomy or any combination thereof
4631	Vaginal hysterectomy
4632	Vaginal hysterectomy with plastic anterior and/or posterior colporrhaphy
4634	Vaginal hysterectomy with repair of enterocele
4803	Caesarean section and hysterectomy (Porro); includes prenatal and postpartum care
4804	Extraperitoneal caesarean section (Waters, Latzko); includes prenatal and postpartum care
4809	with supracervical hysterectomy
4810	with total hysterectomy

D. Specific requirements to be met and/or documented on the Hysterectomy

Receipt of Information Form (FD-189) or, under certain conditions, a physician certification:

1. A hysterectomy on a female of any age may be performed when medically necessary for a pathological indication provided the person who secured authorization to perform the hysterectomy has:
 - a. informed the individual and her representative (if any), both orally and in writing, that the hysterectomy will render the individual permanently incapable of reproducing, and
 - b. ensured that the form is completed and the individual or her representative has signed and dated a written acknowledgment of receipt of that information utilizing the Hysterectomy Receipt of Information Form (FD-189) prior to the hysterectomy, OR
 - c. the physician who performed the hysterectomy certifies, in writing, that the individual -
 - i. was sterile before the hysterectomy (include cause of sterility), or
 - ii. required a hysterectomy because of a life-threatening emergency in which the physician determined that prior acknowledgement was not possible (include nature of emergency), or
 - iii. was operated on during a period of the person's retroactive Medicaid coverage and the individual was informed, before the operation, that the hysterectomy would make her permanently incapable of reproducing or one of the conditions described in i or ii was applicable (include a statement that the individual was informed or describe which condition was applicable).

Retroactive Medicaid coverage is defined as the consideration of unpaid medical bills incurred during a three month period prior to the month the person applied for assistance.

Note 1: Although a physician certification is acceptable for situations described in c. above, the New Jersey Medicaid Program recommends that the Hysterectomy Receipt of Information Form (FD-189) be used whenever possible.

Note 2: There is no 30 day waiting period required before a medically necessary hysterectomy may be performed. The standard procedure for surgical consent forms will prevail.

VIII. Claim Processing Requirements

A. Sterilizations

1. Any claim (hospital, operating physician, anesthesiologist, clinic, etc.) involving one of the five sterilization procedures must have a properly completed Federal Sterilization Consent Form attached when it is submitted for reimbursement.
2. The practitioner Claim Form (1500 N.J.) must include the proper procedure code under 24D and a brief narrative (i.e., Code 4549 - Primary Sterilization-Fulguration of tubes - Laparoscopy).

3. Those New Jersey providers with tape-to-tape or teleprocessing billing capability are required to submit hard copy claim forms and a completed and signed Federal Sterilization Consent Form to their respective contractors for subsequent payment.
4. The "Family Planning" box on the claim form submitted for reimbursement must be checked.

B. Hysterectomies

1. Any claim (hospital, operating physician, anesthesiologist, clinic, etc.) involving one of the 11 hysterectomy procedures must have either a properly completed "Hysterectomy - Receipt of Information Form" (FD-189) or, under certain conditions, a physician certification attached when it is submitted for reimbursement.
2. Those New Jersey providers with tape-to-tape or teleprocessing billing capability are required to submit hard copy claim forms and a completed, signed FD-189 or, under certain conditions, a physician certification to their respective contractors for subsequent reimbursement.
3. The "Family Planning" box on the claim form submitted for reimbursement is not to be checked.

IX. Point of Contact

If you have any questions regarding the sterilization and/or hysterectomy policy, please contact S. Eugene Yuliano, M.D., Medical Director, New Jersey Division of Medical Assistance and Health Services at telephone number (609) 984-3341.

X. Supply/Ordering of Forms

Providers may photo copy the Federal Sterilization Consent Form and/or the Hysterectomy Receipt of Information Form (FD-189) or order a supply from their respective fiscal agent.

The Prudential Insurance Company
Provider Reorder Unit
P.O. Box 471
Millville, New Jersey 08332

or

Blue Cross of New Jersey
33 Washington Street
Newark, New Jersey 07102



STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-342

November 22, 1982

TO: PHYSICIANS, HOSPITAL ADMINISTRATORS AND INDEPENDENT LABORATORIES

SUBJECT: PROCEDURE CODE REVISIONS

EFFECTIVE: IMMEDIATELY

BACKGROUND: Upon reviewing claims submitted by Physicians and Independent Laboratories for cultures and sensitivity studies, the New Jersey Medicaid Program has found that incorrect procedure codes have been submitted for testing done on cultures that showed no pathogenic organism or only normal flora. Sensitivity tests performed on cultures reported as no growth or normal flora are not reimbursable by the New Jersey Medicaid Program.

ACTION: In order to clarify use of the procedure codes for cultures and sensitivities, the New Jersey Medicaid Program has revised the narrative description of procedure codes 8976 and 8459 as follows:

8976 Urine Culture, including identifications of organism(s), colony count and sensitivity studies \$6.00

NOTE: This code may only be billed when a pathogenic micro-organism is reported. A culture that indicates no growth or normal flora must be billed under code 8975.

8459 Culture \$9.00

All other sources (e.g. blood, stool, spinal fluid and tissue) including identification and isolation of one or more organisms together with sensitivity studies using up to 10 discs.

NOTE: This code may only be billed when a pathogenic micro-organism is reported. A culture that indicates no growth or normal flora must be billed under code 8996.

If you have any questions regarding this Newsletter, please contact Ms. Phyllis Valeri, Laboratory Consultant, Division of Medical Assistance and Health Services, at telephone 609 292-7673.



STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

VolumeP-343.....

December 6, 1982

TO: PHYSICIANS AND HOSPITAL ADMINISTRATORS
SUBJECT: NURSE-MIDWIFERY SERVICES/CERTIFIED NURSE-MIDWIVES
EFFECTIVE: JANUARY 1, 1983

BACKGROUND: Section 965 of Public Law 96-499, the Omnibus Reconciliation Act of 1980, mandates that payment be made for nurse-midwifery services provided to categorically needy recipients. Federal regulations, 42 CFR 440.1 et. seq., define nurse-midwifery services as those services provided by a certified nurse-midwife which are concerned with the management of the care of mothers and newborns throughout the maternity cycle.

ACTION: Effective January 1, 1983, the New Jersey Medicaid Program will implement nurse-midwifery services as a reimbursable Medicaid service available to all recipients. The New Jersey Medicaid Program will reimburse for nurse-midwifery services rendered on or after January 1, 1983. Reimbursement will be made to approved Medicaid providers such as the hospital, independent clinic, birthing center, physician or physician group who arrange for nurse-midwifery services. In addition, the New Jersey Medicaid Program will make direct reimbursement to the certified nurse-midwife who practices as and who is approved as an independent Medicaid provider. Highlights of Program requirements are:

Provider Participation:

In order to participate in the New Jersey Medicaid Program, a certified nurse-midwife must be licensed by and registered with the New Jersey Board of Medical Examiners as a certified nurse-midwife. The New Jersey Medicaid Program will only reimburse a certified nurse-midwife for nurse-midwifery services provided in New Jersey. Nurse-midwifery services can be provided in the hospital, both inpatient and outpatient, office, home, independent clinic or birthing center.

Provider Reimbursement:

Medicaid reimbursement will be made for nurse-midwifery services provided during the maternity cycle, which is defined by Federal regulation 42 CFR 440.165(c) as that time period corresponding to pregnancy, labor, birth and the immediate six-week postpartum period. Nurse-midwifery services will be kept identifiable and distinct from physician obstetrical services by the utilization of newly established nurse-midwifery procedure codes. When a certified nurse-midwife renders a service, the Medicaid provider will bill using the nurse-midwifery procedure codes. Hospitals will use their usual and customary billing procedures for nurse-midwifery services rendered by a salaried certified nurse-midwife.

The procedure codes, narrative descriptions and fees will be added to your Medicaid Procedure Code Manual as follows:

Procedure Code	Description	Medicaid Dollar Value
4841	<p><u>Total obstetrical care</u> when given by a certified nurse-midwife and includes:</p> <p>(1) Ante partum care consisting of initial ante partum visit and seven subsequent ante partum visits. <u>Specific dates of all visits are to be listed on the 1500-NJ claim form.</u></p> <p>NOTE: Reimbursement will be decreased by the fee for the initial ante partum visit (code 4845) if patient not seen for this visit. The total fee will also be decreased by the reimbursement sum for each subsequent ante partum visit (code 4843) which is less than seven.</p> <p>NOTE: If medical necessity dictates, corroborated by the record, additional visits above seven ante partum may be reimbursed under procedure code 0009 (routine or follow-up visit). The claim form should clearly indicate the reason for the medical necessity and date for each code 0009 listed.</p> <p>(2) Obstetrical delivery per vagina with or without episiotomy including postpartum care when provided by the certified nurse-midwife in the home, birthing center or in the hospital (inpatient setting). This applies to a vaginal delivery at full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours. This shall also include one visit between the 15th and 42nd postpartum day following delivery and out of the hospital. Include delivery date on the 1500-NJ claim form.</p>	\$165.20
4842	Obstetrical delivery per vagina with or without episiotomy including postpartum care when provided by the certified nurse-midwife in the home, birthing center or in the hospital (inpatient setting). This applies to a vaginal delivery at full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours. This shall also include one visit between the 15th and 42nd postpartum day following delivery and out of hospital. Include delivery date on the 1500-NJ claim form.	\$112.00
4845	Initial ante partum visit provided by a certified nurse-midwife (independent procedure).	\$15.40
4843	Subsequent ante partum visits provided by a certified nurse-midwife (independent procedure). Indicate specific dates of service.	\$5.60
4844	Postpartum care provided by a certified nurse-midwife who is other than the individual who performed the delivery and who is not related to this individual by any financial or contractual arrangement, e.g. group, clinic, employee, etc. One visit between the 15th and 42nd postpartum day following delivery. Include delivery date on the 1500-NJ claim form. (independent procedure).	\$9.10

<u>Procedure Code</u>	<u>Description</u>	<u>Medicaid Dollar Value</u>
4846	Insertion of intracervical or intrauterine device for contraception by certified nurse-midwife (includes cost of device and post insertion visit). Include delivery date on the 1500-NJ claim form. Note: Limited to within the 6 week postpartum period.	\$23.80
4847	Removal of an IUD by a certified nurse-midwife. Include delivery date on the 1500-NJ claim form. Note: Limited to within the 6 week postpartum period.	\$11.50
0009	Office or home visit by certified nurse-midwife applicable only when medical necessity warrants more than seven ante partum visits and is corroborated on the record.	\$6.30
4848	Home Delivery Pack. All drugs and supplies, etc., necessary for delivery in this setting.	\$40.00

If you have any questions regarding nurse-midwifery services, please contact S. Eugene Yuliano, M.D., Medical Director, Division of Medical Assistance and Health Services, at 609-292-7673.

A Nurse-Midwifery Services Manual is available upon request. Please contact The Prudential Insurance Company, your Medicaid fiscal agent, at 609-293-2164 to request that a manual be sent to you.



STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-344.....

December 6, 1982

TO: CERTIFIED NURSE-MIDWIVES

SUBJECT: NURSE-MIDWIFERY SERVICES

EFFECTIVE: JANUARY 1, 1983

BACKGROUND: Section 965 of Public Law 96-499, the Omnibus Reconciliation Act of 1980, mandates that payment be made for nurse-midwifery services provided to categorically needy recipients. Federal regulations, 42 CFR 440.1 et. seq., define nurse-midwifery services as those services provided by a certified nurse-midwife which are concerned with the management of the care of mothers and newborns throughout the maternity cycle.

ACTION: The New Jersey Medicaid Program is pleased to announce that effective January 1, 1983, nurse-midwifery services will be a reimbursable Medicaid service. The New Jersey Medicaid Program will make direct reimbursement to the certified nurse-midwife who is an approved Medicaid provider with independent provider status. The New Jersey Medicaid Program will also reimburse other approved Medicaid providers such as the hospital, independent clinic, birthing center, physician or physician group, who arrange for nurse-midwifery services. Highlights of Program requirements are:

Provider Participation:

In order to participate in the New Jersey Medicaid Program, a certified nurse-midwife must be licensed by and registered with the New Jersey Board of Medical Examiners as a certified nurse-midwife. The New Jersey Medicaid Program will only reimburse a certified nurse-midwife for nurse-midwifery services provided in New Jersey. Nurse-midwifery services can be provided in the hospital, both inpatient and outpatient, office, home, birthing center or independent clinic.

Provider Reimbursement:

Medicaid reimbursement will be made for nurse-midwifery services rendered on or after January 1, 1983, when provided during the maternity cycle which Federal regulation 42 CFR 440.165(c) defines as that time period corresponding to pregnancy, labor, birth and the immediate six-week postpartum period. Nurse-midwifery services will be kept identifiable and distinct from physician obstetrical services by the utilization of newly established nurse-midwifery procedure codes. When a certified nurse-midwife renders a service, the Medicaid provider will bill using the nurse-midwifery procedure codes.

The procedure codes, narrative descriptions and fees follow. The fees listed are those that are applicable when the certified nurse-midwife receives direct reimbursement.

Procedure Code	Description	Medicaid Dollar Value
4841	<p><u>Total obstetrical care</u> when given by a certified nurse-midwife and includes:</p> <p>(1) Ante partum care consisting of initial ante partum visit and seven subsequent ante partum visits. <u>Specific dates of all visits are to be listed on the 1500-NJ claim form.</u></p> <p>NOTE: Reimbursement will be decreased by the fee for the initial ante partum visit (code 4845) if patient not seen for this visit. The total fee will also be decreased by the reimbursement sum for each subsequent ante partum visit (code 4843) which is less than seven.</p> <p>NOTE: If medical necessity dictates, corroborated by the record, additional visits above seven ante partum may be reimbursed under procedure code 0009 (routine or follow-up visit). The claim form should clearly indicate the reason for the medical necessity and date for each code 0009 listed.</p> <p>(2) Obstetrical delivery per vagina with or without episiotomy including postpartum care when provided by the certified nurse-midwife in the home, birthing center or in the hospital (inpatient setting). This applies to a vaginal delivery at full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours. This shall also include one visit between the 15th and 42nd postpartum day following delivery and out of the hospital. Include delivery date on the 1500-NJ claim form.</p>	\$165.20
4842	Obstetrical delivery per vagina with or without episiotomy including postpartum care when provided by the certified nurse-midwife in the home, birthing center or in the hospital (inpatient setting). This applies to a vaginal delivery at full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours. This shall also include one visit between the 15th and 42nd postpartum day following delivery and out of hospital. Include delivery date on the 1500-NJ claim form.	\$112.00
4845	Initial ante partum visit provided by a certified nurse-midwife (independent procedure).	\$15.40
4843	Subsequent ante partum visits provided by a certified nurse-midwife (independent procedure). Indicate specific dates of service.	\$5.60
4844	Postpartum care provided by a certified nurse-midwife who is other than the individual who performed the delivery and who is not related to this individual by any financial or contractual arrangement, e.g. group, clinic, employee, etc. One visit between the 15th and 42nd postpartum day following delivery. Include delivery date on the 1500-NJ claim form. (independent procedure).	\$9.10

<u>Procedure Code</u>	<u>Description</u>	<u>Medicaid Dollar Value</u>
4846	Insertion of intracervical or intrauterine device for contraception by certified nurse-midwife (includes cost of device and post insertion visit). Include delivery date on the 1500-NJ claim form. Note: Limited to within the 6 week postpartum period.	\$23.80
4847	Removal of an IUD by a certified nurse-midwife. Include delivery date on the 1500-NJ claim form. Note: Limited to within the 6 week postpartum period.	\$11.50
0009	Office or home visit by certified nurse-midwife applicable only when medical necessity warrants more than seven ante partum visits and is corroborated on the record.	\$6.30
4848	Home Delivery Pack. All drugs and supplies, etc., necessary for delivery in this setting.	\$40.00

If you have any questions regarding nurse-midwifery services, please contact S. Eugene Yuliano, M.D., Medical Director, Division of Medical Assistance and Health Services, at 609-292-7673.

Please contact the New Jersey Medicaid Program's fiscal agent, The Prudential Insurance Company, at 609-293-2164 for enrollment information and applications.



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

New Jersey Health Services Program NEWSLETTER

Volume P-345

January 3, 1983

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 Updated Alpha Listing

EFFECTIVE: For Additional Drugs Listed As Less Than Effective Dispensed
On Or After February 1, 1983.

BACKGROUND: The Division of Medical Assistance and Health Services ceased
reimbursement December 3, 1981, for the Medicaid Program and
March 1, 1982, for the Pharmaceutical Assistance to the Aged and Disabled
(PAAD) Program, for all drugs that the Federal Food and Drug Administration
(FDA) has proposed to withdraw from the market.

A drug list was distributed to you for reference the week of November 23, 1981.
The list represented 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. In addition, Section 2103 of the Omnibus
Budget Reconciliation Act required this action for all identical, related, or
similar drugs.

ACTION: As of February 1, 1983, the Division of Medical Assistance and
Health Services will cease reimbursement for the following
nineteen drugs:

Actifed - C Expectorant	Omni - Tuss Suspension
Ambenyl Expectorant	Parafon forte Tablets
Clistin R-A Tablets	Phenergan Expectorant
Co - Pyronil Capsules,	Phenergan Expectorant W/Codeine
Pediatric Capsules, and Suspension	Phenergan Pediatric Expectorant
Dimetane Expectorant	Phenergan VC Expectorant
Dimetane Expectorant - DC	Phenergan VC W/Codeine Expectorant
Dipyridamole Tablets (Lemmon)	Pyribenzamine W/Ephedrine Tablets
Forhista Lenotabs	Tussionex Suspension, Tablets and Capsules
Hista Clopane Capsules	
Isosorbide dinitrate, Sublingual Tablets, Oral Tablets and Sustained Release Tablets and Capsules (Bolar, Zenith, and Chelsea)	

One exception exists to the general rule that all identical, related or similar
drugs are not reimbursable. Only certain manufacturers of dipyridamole and

isosorbide dinitrate are designated as less than effective. Dipyridamole products manufactured by Lemmon and isosorbide dinitrate products manufactured by Bolar, Zenith and or Chelsea are not reimbursable.

Any dipyridamole or isosorbide dinitrate product manufactured by the afore stated companies, regardless of the distributor, are not reimbursable.

All other manufacturers approved by the Federal Food and Drug Administration are eligible for reimbursement including the brand named products.

This action applies to both The New Jersey Medicaid and PAAD Programs.

Attached for your convenience is an updated brand named alphabetical listing of drug products that are considered less than effective under the Drug Efficacy Study Implementation (DESI) Program. You may discard the list distributed to you the week of November 23, 1981.

Attached for pharmacy providers only, are Pharmacy Manual replacement pages.

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



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

DRUG EFFICACY STUDY
IMPLEMENTATION (DESI)

DESI DRUG PRODUCTS
AND
KNOWN RELATED DRUG PRODUCTS THAT
LACK SUBSTANTIAL EVIDENCE OF EFFECTIVENESS
MEDICAID/PAAD PROGRAMS

(ADDITIONS OF FEBRUARY 1, 1983 HAVE BEEN UNDERLINED)

<u>Actacin - C Syr.</u>	Ambilog Oint.
<u>Actahist - C</u>	Ambilog Cream
<u>Actagen - C</u>	Aminobrain-Pt Elixir
<u>Actamine - C Syr.</u>	Aminophyllin and Amytal Tabs
<u>Actifed - C Exp</u>	Aminophyllin Comp Caps
Adrenosem Salicylate Inj.	Aminophyllin Comp Tabs
Adrenosem Syrup	Amo-Fed Caps
Adrenosem Tablets	Amophed Capsules
Albalon-A Oph Solution	Amphed Capsules
*Alevaire Liq.	*Amphocortin Cream
<u>Allerfrin W/Cod</u>	Ananase Tablets
<u>Allerphed C Expect</u>	Anisotropine Meth-Br W/PB Tabs
<u>Ambay Expt</u>	Antora-B Caps
<u>Ambecon</u>	Anugard-HC Supp
<u>Ambenyl Expect</u>	Anucon-HC Supp
<u>A-Nil Exp</u>	Anusol-HC Cream
Am-Ef-Sed Capsules	Anusol-HC Supp
Am-Ephen Capsules	Arlarex Tabs
Amesec Enseals	Arlidin Tablets
Amesec Pulvules	Asminorel Improved Tabs

*Discontinued by manufacturer or proposed for DESI list and discontinued by manufacturer before action could be taken.

Asthmacon Capsules
Avazyme Tablets
Azo-Gamazol Tablets
Azo-Gantanol Tablets
Azo-Sulfamethoxazole Tabs
Azolid-A Caps
Benomine W/PB Caps
Benomine W/PB Tabs
Bentyl Caps W/PB
Bentyl Tabs W/PB
Betadine Vaginal Gel
Biobid TD Caps
Biocort Ointment
Bio-Gan Supp
Biosynal-DC Caps
Bro-Phed Tabs
Bromanate Expect
Bromanate Expect DC
Bromanyl Expect
Bromatane Expect
Bromatane Expect DC
Bromenate Expect
Bromodiphen Comp Exp. W/Cod
Bromonate Expect
Bromonate Expect DC
Bromotuss Exp. W/Cod
Bromphen Comp W/Cod
Bromphen Expect

Bromphen Expect DC
Bromphen Expect DC W/Cod
Bromphenate Expect
Bromphenate Expect DC
Brompheniramine Comp Expect
Brompheniramine Expect
Brompheniramine Expect DC
Brompheniramine W/Cod Expect
Bromtane Expect
Bromtane Expect DC
Brophed Syrup
Brophed Tablets
Brophenyl Expect
Brotane Expect
Butagen Alka Caps
Butan-K Tabs
*Butazolidin Alka Capsules
C.D.P. Plus Caps
*Caldecort Ointment (Rx)
Cantil W/PB Tabs
Caquin Cream
Carbrital Elixir
Carbrital Kapseals
Cartrax Tablets
*Celestone W/Neomycin Cream
Cenalene Elixir
Cenalene Tablets S.C.
Cerebro-Nicin Caps

*Discontinued by manufacturer or proposed for DESI list and discontinued by manufacturer before action could be taken.

Cetacaine BT6 Spray	Com-Pro Caps
Cetacaine Kit	Com-Pro-Span TD Caps
Cetacaine Liquid	Combagen Caps
Cetacaine Spray	Combid Spansules
Chlordiazepoxide Plus Caps	Combined T.D. Caps
Chlordiazepoxide W/Clindinium Caps	<u>Cophed-C Expt</u>
Chlordinamide Caps	*Cor-Tar-Quin Cream
Chlordinium Capsules	Cor-Tar-Quin Forte Cream
Chlordinium Sealets	*Cor-Tar-Quin Lotion
Chlordinium Tablets	Cordran-N Cream
Chlorex Caps	Cordran-N Oint
<u>Chlorofon-F Tab</u>	Corovas Tymcaps
<u>Chlorzone Forte Tab</u>	Corque Cream
<u>Chlorzoxazone W/APAP Tab</u>	Cort-Quin Cream
<u>Chlorzoxazone W/Acetaminophen Tab</u>	Cortin Cream
Chymolase Tablets	Cortisporin Cream
Chymoral Tablets	*Cortomycin Oint
Clindex Caps	Cycladate
Clinoxide Capsules	Cyclandelate Caps
Clipoxide Caps	Cyclorex Caps
<u>Clistin R-A Tabs</u>	Cyclospasmol Capsules
*Clistin Expectorant	Cyclospasmol Tablets
*Coditrate Syrup	Cydel Capsules
Co-Perazine Caps TD	Cyvaso Caps
<u>Co-Pyronil Caps, Pediatric Caps & Susp</u>	D-Vaso Capsules
Com-Par Capsules	D-Vaso-S Liquid
*Discontinued by manufacturer or proposed for DESI list and discontinued by manufacturer before action could be taken.	

Dainite Tablets
Dainite-KI Tablets
Daricon W/PB Tabs
Deaner Tablets
Dek-Quin Cream
Dek-Quin Lotion
Deprol Tablets
Dibent-PB Tablets
Dibenzylamine Capsules (Exception:
Diagnosis of Pheochromocytoma)
Dicyclomine HCL W/PB Caps
Dicyclomine HCL W/PB Tabs
Dihydro Codeine Comp Caps
Dimetane Expect
Dimetane Expect DC
Dipyridamole Tab (Lemmon)
Diutensen Tablets
Domeform-HC Cream
Donnatal Extentabs
Dri-Phed W/Cod Expect
Durel-Cort V Cream
Durel-Cort V Oint
E.T.H. Syrup Comp
E.T.H. Tablets Comp
Elderton
Equagesic Tablets
Equanitate

Equazine Tabs
*Erythrocin Top Oint
*Erythromycin Top Oint
F.E.P. Cream
Federinal Susp
Fedrinal Susp
*Florinef Lotion
Forhista Lontabs
*Fluonid-N Cream
Geravite Elixir
Geravite Inj
Geroniazol Elixir
Geroniazol Tablets
Geroniazol-TT Tablets
Gevizol Liquid
Gevizol Tablets
H & I Cream
H.C.I. Cream & Oint
HCV Cream
H.V.B. Cream
Hemorrhoidal-HC Supp
Hemorrhoidal-HC Unisert
Hemorroid-HC Supp
Hemorroidal-HC Supp
Hemusol-HC Supp

*Discontinued by manufacturer or proposed for DESI list and discontinued by manufacturer before action could be taken.

Hepto Tabs	Isobid Caps
Heptogesic Tablets	Isopropamide Caps
Hexabamate Tabs	Isopro TDC Caps
<u>Hista Clopane Caps</u>	Isopropazine Caps
Hydrocortisone W/Iodochlorhydroxyquin	Isordil W/Phenobarb Tablets
Hydrocortisone W/Neomycin	<u>Isosorbide Dinitrate Subl Tabs,</u> <u>Oral & Sust. Rel Tabs & Caps</u> (Bolar, Zenith & Chelsea only)
Hydromax Syrup	Isoxsuprine HCL Tabs
*Hydromet Lot	*Kenalog-S Cream
Hydrophed Syrup	*Kenalog-S Ointment
Hydrophed Tabs	*Kenalog-S Lotion
Hydroxy Compound Tabs	Lanabutazone Comp Caps
Hydroxy Ephed Syrup	Lanvisone Cream
Hydroxyephed Tabs	Librax Caps
Hydroxyzine Comp Syrup	Lidaform-HC Cream
Hydroxyzine Comp Tabs	Lidaform-HC Lotion
Hydroxyzine Plus Liquid	Lidinium Caps
Hydroxyzine Plus Tabs	Lidoxide Capsules
Hydroxyzine, Theoph & Ephed Tabs	Luftodil Tablets
Hysone Ointment	Lufyllin-EPG Tabs & Elixir
ICN-Isox Tabs	Lyrizine Tablets
Ilotycin Ointment	M-T Comp Tabs
Iodo-HC Cream	Mannitol Hexanitrate W/PB Tabs
Iodo-HC Mild Cream	Maracon Tabs
Iodo-HC Ointment	Marax Syrup
Iodochlor Cream W/HC	Marax Syrup DF
Iodochlor Ointment W/HC	
Iso-Perazine T.D. Caps	

*Discontinued by manufacturer or proposed for DESI list and discontinued by manufacturer before action could be taken.

Marax Tablets	Myco-Aricin Cream & Oint
Menic Tablets	Myco Cream & Oint
Mepergan Fortis Capsules	Myco-Triacet Cream & Oint
Mepro Comp Tabs	Myco-Tricolone Comp Cream
Mepro-Analgesic Tabs	Mycort Cream
Mepro-Hex TM Tablets	Mycogen Cream & Oint
Meprobamate-Comp Tabs W/Tridihex	Mycolog Cream & Oint
Meprobamate-Plus Tabs	*Myconef Ointment
Meprobamate, Ethoheptazin & Aspirin Tabs	Mytrex Cream & Oint
Meprobamate W/Tridihexethyl Tabs	N.N.G.T. Cream & Oint
Meprogese Tabs	Naphcon-A
Meprogenic Tabs	Naturetin-K Tablets
Meprohex Tabs	*Neo Aristocort Cream & Oint
Meproplus MLT Tabs	*Neo Aristocort Opth Oint.
Meprotrate-20 Tabs	*Neo Aristoderm Aerosol
*Meti-Derm W/Neomycin Aerosol & Oint.	Neo Cort-Dome Cream & Lotion
Metrazol Ampuls	Neo Decadron Top Cream
Metrazol Liquid	*Neo Decaspray
Metrazol Tablets	Neo Hytone Cream
Midrin Capsules	Neo Nysta-Cort Ointment 1%
Migral Tablets	Neo-Cortef Cream, Oint & Lot
Milpath Tablets	Neo-Delta-Cortef Ointment
Miltrate Tablets	*Neo-Diloderm Cream
Mity-Quin Cream	*Neo-Domeform HC Cream
Mivert Pellsules	*Neo-Hydeltrasol Oint
Murray-Gesic Tabs	*Neo-Hydeltrasol Lot
Mycocet Cream	*Neo-Hytone Cream

*Discontinued by manufacturer or proposed for DESI list and discontinued by manufacturer before action could be taken.

* Neo-Magnacort Oint	Nysolone Cream & Oint
Neo-Medrol Cream	Nyst-Olone Cream
*Neo-Nysta-Cort Ointment	*Nysta-Cort Lot
Neo-Oxylone Ointment	*Nystaform-HC Lotion & Oint
Neo-Parcort Ointment	Nystatin Cream W/Neomycin & Triamcin
Neo-Polycin-HC	Nystatin Oint W/Neomycin & Triamcin
*Neo-Resulin-F	<u>Omni-Tuss Susp</u>
Neo-Synalar Cream	*Onycho-Phytex Sol
*Neo-Tarcortin Ointment	Opcon-A Opth Sol
*Neomycin Sulf W/Hydrocortamate HCL Oint	Ophthel Liquid
*Neosporin Lotion	Orenzyme Bitabs & Tabs
Neosporin-G Cream	Oxaine-M Suspension
NGT Cream	P.E.T.N. Tabs W/PB
Niapent Elixir & Tabs	Pamate 200 Tabs
Nico-Metrazol Elixir & Tabs	Pamate 400 Tabs
Nico-Vert Capsules & Tabs	Panzol Liq
Nicotiacol Tabs	Papase Tablets
Nicotinyl Alcohol Tabs	<u>Parafon Forte Tabs</u>
Nicotinyl Tartrate Tabs	Par Pent Liq & Tabs
Nicozol Elixir & Tabs	Par-Eth Tablets
Nilspasm Tablets T.D.	Parlib-X
Nioric Elixir & Tabs	Parothyl Tablets
Nitranitol Tablets	Pathibamate Tablets
Nitranitol W/PB Tablets	Pathilon Sequels
*Nycin-HC Oint	Pathilon Sequels W/PB
Nylidrin HCL Tabs	
*Discontinued by manufacturer or proposed for DESI list and discontinued by manufacturer before action could be taken.	

Pathilon Tabs 25 MG (W/PB 15mg)
Pedi-Cort-V Cream
Penalate Elixir
Pentacort Cream
Peritrate W/PB Tabs
Peritrate-SA W/PB Tabs
Pharma-Gesic Tabs
Phenergan Expect
Phenergan Expect W/Cod
Phenergan Pediatric Expectorant
Phenergan VC Expect
Phenergan VC W/Cod Expect
Phenylbutazone Alka Caps
Phenylbutazone Plus Caps
Phenylbutone-A Caps
Phenylzone-A Capsules
Potaba Capsules
Potaba Envules
Potaba Powder
Potaba Tabs
Priscoline Injection 25mg
Priscoline Lontabs 80mg
Priscoline Tablets 25mg
Probanthine W/PB Tabs
Pro-Bid Caps
Pro-Iso Caps
Prochlor Iso-BID

Prochlor-Iso T.R. Caps
Prochlorbid Lanacaps
Prochlorperazine W/Isopropamide
Proclan Expect
Proclan Expect VC
Proclan Pediatric
Proclan V.C. W/Cod Expect
Proclan W/Cod Expect
Prometh Expect
Prometh Expect VC W/Cod
Prometh W/Cod
Prometh W/Dextrometh
Prometh Pediatric
Promethazine Comp W/Cod Expect
Promethazine Expect
Promethazine Expect DC
Promethazine Expect DC W/Cod
Promethazine Expect DM
Promethazine Expect Pediatric
Promethazine Expect V.C.
Promethazine Expect VC W/Cod
Promethazine Expect W/Cod
Promethazine Expect W/Cod & Decong
Promethazine Expect W/Decong
Promethazine Expect W/Phenyleph
Promethazine Expect W/Phenyleph
& Cod

*Discontinued by manufacturer or proposed for DESI list and discontinued by manufacturer before action could be taken.

Promethazine HCL VC Expect W/Cod

Promethazine HCL W/Cod

Promethazine W/Cod

Promex W/Cod

Promide W/PB Tabs

Propantheline BR W/PB Tabs

Propazine TD Caps

*Propion Gel

Protran Plus Tabs

Puretane Expect

Puretane Expect DC

Pyribenzamine W/Ephedrine Tabs

*Pyribenzamine Expectorant
With Ephedrine

Quadrinal Susp & Tabs

Quibron-Plus Caps & Elixir

Racet Cream

Racet Forte Cream

Racet LCD Cream

Rautrax Tablets

Rautrax-N Modified Tablets

Rautrax-N Tablets

Regal-Bid Caps

Regal-DC Caps

Regal Log Cream & Oint

Rofed C Syrup

Roniacol Elixir

Roniacol Tablets 50mg

Roniacol Timespan

Ronigen Timetabs

Rotane Expect DC

Ru-Vert Liquid & Tabs

Ruhexatel W/Reserpine Tabs

Rycotin Time-Tabs

Sedachol Caps

Senilex Tabs

Senilezol Elixir & Caps

Sinodeine Caps

Sorbitrate Tablets W/PB

Spasmate Tabs

Speniacol Tabs

Spenpath Tabs

Spentane Expect

Spentane Expect DC

Stera-Form Cream

Steraspasmol Caps

Sterazolidin Capsules

Steroform Cream & Oint

*Supertah-HC Oint

Su-Ton Liquid

Su-Zol Liquid

Synalgos Caps (new & old formula)

Synalgos-DC Caps (new & old formula)

Synlgen-DC Caps

*Discontinued by manufacturer or proposed for DESI list and discontinued by manufacturer before action could be taken.

T.C.M. Tabs	Tolazoline HCL-Tabs
T.E.H. Comp Tabs	Tranquigesic Tabs
T.E.H. Tablets	Tri-Bamate Tablets
T.T.H. Tabs	Tri-Hexabamate Tabs
T-Gen Supp	Tri-Statin Cream
Tega-Vert Capsules & Tabs	Tri-Statin Ointment
Tegagen Supp	<u>Triacin C Exp</u>
Tegamide Supp	<u>Triacin C Syrup</u>
*Terra-Cortril Aerosol & Ointment	<u>Triafed-C Syrup</u>
Theda CDP Plus Caps	Triamcinolone Cream & Oint W/Nystatin Plus
Theda MEP Plus Tabs	Triamcinolone NNG Cream
Theda Prochloramide	Triamcinolone Plus Cream
Theophedrine Tabs	Tribamate Tabs
Theophozine Liquid	Tridihexethyl CL W/Mepro Tabs
Theophozine Tabs	Trihexamate
Theophylline Plus Elixir	Trimate
Theophylline, Ephed & Hydroxyzine	Trimethobenzamide Supp
Theozine Syrup & Tabs	Triprobamate
*Thephorin Expectorant	Tritran-400
Therax Tabs	Trocinate Tablets
Tigan Caps	<u>Tussionex Susp, Tabs & Caps</u>
Tigan Pediatric Supp	<u>Tuzone Tab</u>
Tigan Supp	Uni-Com Cap
TMC-200 Tabs	Uni-Prob W/PB 15mg Tabs
TMC-400 Tabs	Valpin-50-PB Tablets

*Discontinued by manufacturer or proposed for DESI list and discontinued by Manufacturer before action could be taken.

Valpin W/PB Elixir & Tabs
Vasocen Tabs
Vasocon-A Drops
Vasodigen Tabs
Vasodilan INJ/Ampul
Vasodilan Tablets
Vasoprine Tablets
Vasorex Tabs
Vasostin Tabs
Vernacel Oph Sol
Vio-Hydrocort Cream
Vio-Pramasone Cream & Lot
Viodo Cream
Vioform-H.C. Cream
Vioform-H.C. Cream Mild
Vioform-H.C. Lotion & Oint
Vioform-H.C. Oint Mild
Viotag Cream
Vita-Metrazol Elixir & Tablets
Vytone Cream
Wyanoids-HC Suppositories
Zactane Tablets
Zactirin Tablets
Zactirin-Compound-100 Tablets
*Ze-Tar Quin Cream
*Zetone Cream
Zoxaphen Tab

*Discontinued by manufacturer or proposed for DESI list and discontinued by manufacturer before action could be taken.



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

New Jersey Health Services Program NEWSLETTER

Volume P-346

December 20, 1982

TO: INDEPENDENT CLINICS

SUBJECT: NURSE-MIDWIFERY SERVICES/CERTIFIED NURSE-MIDWIVES

EFFECTIVE: JANUARY 1, 1983

BACKGROUND: Section 965 of Public Law 96-499, the Omnibus Reconciliation Act of 1980, mandates that payment be made for nurse-midwifery services provided to categorically needy recipients. Federal regulations, 42 CFR 440.1 et. seq., define nurse-midwifery services as those services provided by a certified nurse-midwife which are concerned with the management of the care of mothers and newborns throughout the maternity cycle.

ACTION: Effective January 1, 1983, the New Jersey Medicaid Program will implement nurse-midwifery services as a reimbursable Medicaid service. Reimbursement will be made to approved Medicaid providers such as the hospital, independent clinic, physician or physician group who provide for nurse-midwifery services. In addition, the New Jersey Medicaid Program will make direct reimbursement to the certified nurse-midwife who is an approved Medicaid provider with independent provider status. Highlights of Program requirements are:

Provider Participation:

In order to participate in the New Jersey Medicaid Program, a certified nurse-midwife must be licensed by and registered with the New Jersey Board of Medical Examiners as a certified nurse-midwife. The New Jersey Medicaid Program will only reimburse a certified nurse-midwife for nurse-midwifery services provided in New Jersey. Nurse-midwifery services can be provided in the hospital, both inpatient and outpatient, office, home, independent clinic or birthing center.

Provider Reimbursement:

All independent clinics who utilize the services of a certified nurse-midwife for nurse-midwifery services will be reimbursed only when the independent clinic has enrolled and been approved by the New Jersey Medicaid Program to provide obstetrical services.

Medicaid reimbursement will be made for nurse-midwifery services rendered on or after January 1, 1983, when provided during the maternity cycle which Federal regulation 42 CFR 440.165(c) defines as that time period corresponding to pregnancy, labor, birth and the immediate six-week postpartum period. Nurse-midwifery services will be kept identifiable and distinct from physician obstetrical services by the utilization of newly established nurse-midwifery procedure codes. When a certified nurse-midwife renders a service, the Medicaid provider will bill using the nurse-midwifery procedure codes.

The procedure codes, narrative descriptions and fees will be added to your Independent Clinic Services Manual as follows:

<u>Procedure Code</u>	<u>Description</u>	<u>Medicaid Dollar Value</u>
4841	<p><u>Total obstetrical care</u> when given by a certified nurse-midwife and includes:</p> <p>(1) Ante partum care consisting of initial ante partum visit and seven subsequent ante partum visits. <u>Specific dates of all visits are to be listed on the Independent Outpatient Health Facility claim form(MC-14).</u></p> <p>NOTE: Reimbursement will be decreased by the fee for the initial ante partum visit (code 4845) if patient not seen for this visit. The total fee will also be decreased by the reimbursement sum for each subsequent ante partum visit (code 4843) which is less than seven.</p> <p>NOTE: If medical necessity dictates, corroborated by the record, additional visits above seven ante partum may be reimbursed under procedure code 0009 (routine or follow-up visit). The claim form should clearly indicate the reason for the medical necessity and date for each code 0009 listed.</p> <p>(2) Obstetrical delivery per vagina with or without episiotomy including postpartum care when provided by the certified nurse-midwife in the home, birthing center or in the hospital (inpatient setting). This applies to a vaginal delivery at full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours. This shall also include one visit between the 15th and 42nd postpartum day following delivery and out of the hospital. Include delivery date on the Independent Outpatient Health Facility claim form(MC-14).</p>	\$165.20
4842	Obstetrical delivery per vagina with or without episiotomy including postpartum care when provided by the certified nurse-midwife in the home, birthing center or in the hospital (inpatient setting). This applies to a vaginal delivery at full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours. This shall also include one visit between the 15th and 42nd postpartum day following delivery and out of hospital. Include delivery date on the Independent Outpatient Health Facility claim form(MC-14).	\$112.00
4845	Initial ante partum visit provided by a certified nurse-midwife (independent procedure).	\$15.40
4843	Subsequent ante partum visits provided by a certified nurse-midwife (independent procedure). Indicate specific dates of service.	\$5.60
4844	Postpartum care provided by a certified nurse-midwife who is other than the individual who performed the delivery and who is not related to this individual by any financial or contractual arrangement, e.g. group, clinic, employee, etc. One visit between the 15th and 42nd postpartum day following delivery. Include delivery date on the Independent Outpatient Health Facility claim form(MC-14). (independent procedure).	\$9.10

<u>Procedure Code</u>	<u>Description</u>	<u>Medicaid Dollar Value</u>
4846	Insertion of intracervical or intrauterine device for contraception by certified nurse-midwife (includes cost of device and post insertion visit). Include delivery date on the Independent Outpatient Health Facility claim form(MC-14). Note: Limited to within the 6 week postpartum period.	\$23.80
4847	Removal of an IUD by a certified nurse-midwife. Include delivery date on the Independent Outpatient Health Facility claim form(MC-14). Note: Limited to within the 6 week postpartum period.	\$11.50
0009	Clinic or home visit by certified nurse-midwife applicable only when medical necessity warrants more than seven ante partum visits and is corroborated on the record.	\$6.30
4848	Home Delivery Pack. All drugs and supplies, etc., necessary for delivery in this setting.	\$40.00

Family Planning Services:

All independent clinics who utilize the services of a certified nurse-midwife for the following family planning visit procedure code will be reimbursed only when the independent clinic has enrolled and been approved by the New Jersey Medicaid Program to provide family planning services. Please review the procedure code very carefully, as reimbursement for this visit will only be allowed in very specific instances. The procedure code, narrative description and fee follow:

0091	Routine or follow-up visit, prolonged - provided by a certified nurse-midwife and limited to within the 6 week postpartum period: may include pelvic examination, changes in method or instructions. Involves 20 or more minutes or personal time in patient contact, including documentation of item as well as adequate significant progress notes on the clinic record. This code includes cost of birth control drugs dispensed. A prescription cannot be substituted. Include delivery date on the Independent Outpatient Health Facility claim form(MC-14).	\$9.10
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If you have any questions regarding nurse-midwifery services, please contact S. Eugene Yuliano, M.D., Medical Director, Division of Medical Assistance and Health Services, at 609-292-7673.

A Nurse-Midwifery Services Manual is available upon request. Please contact The Prudential Insurance Company, your Medicaid fiscal agent, at 609-293-2164 to request that a manual be sent to you.



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

New Jersey Health Services Program NEWSLETTER

Volume P-347

January 10, 1983

TO: DENTISTS, HOSPITAL ADMINISTRATORS AND INDEPENDENT CLINICS

SUBJECT: DENTAL EXAMINATION, PROPHYLAXIS AND FLUORIDE TREATMENT

EFFECTIVE: FOR SERVICE RENDERED ON AND AFTER FEBRUARY 1, 1983

BACKGROUND: The New Jersey Medicaid Program proposed and adopted a change in guidelines for dental examination, prophylaxis and topical fluoride treatment. The changes as stated in this Newsletter supersede guidelines as noted in the Dental Manual:

- Section 203.1 Diagnostic Services
 - A. Examination
 - B. Radiography
- Section 203.2 Preventive Dental Care
 - A. Prophylaxis
 - B. Fluoride Treatment

Previously, reimbursement for dental examination and prophylaxis were limited to once every six months for persons of all ages, while fluoride treatment was to be provided once every six months for persons twenty years of age and under.

- ACTION: As of February 1, 1983 the New Jersey Medicaid Program will limit reimbursement for these dental procedures as follows:
1. Comprehensive Dental Examination - limited to once every six months for those patients through age seventeen and once every twelve months for those patients eighteen years of age and older.
 2. Dental Prophylaxis - limited to once every six months for those patients through age seventeen and once every twelve months for those patients eighteen years of age or older.
 3. Topical Fluoride Treatment - limited to once every six months for those patients through age seventeen and once every twelve months for those patients eighteen years of age up to and including twenty years of age.
 4. Handicapping Malocclusion Assessment Examination - limited to once every 12 months.

Note: In items 1. through 4. above, this service is available on a more frequent basis only if authorized by a Dental Consultant of the Medicaid Program.

The dentist who examines a long-term care facility patient must provide the treatment necessary unless the examination indicates that a specialist is needed.

The originals of all x-ray films must be available to the Medicaid Dental Consultant. For those dentists who wish to retain a set of x-ray films in their office at all times, it is recommended that the two film packet be used. The original films should be forwarded to the Division of Medical Assistance and Health Services as follows:

- a) when procedures requiring prior authorization are requested,
- b) upon request for post utilization, and
- c) upon request for adjudication of claim reimbursement problems.

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) 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-348

January 10, 1983

TO: The Directors of All Participating Treatment Facilities (PTF) in The New Jersey Health Care Financing Administration (HCFA) Alcoholism Project (New Jersey H.A.P.)

SUBJECT: Medicaid Reimbursement for Alcoholism Services in Free-Standing Alcoholism Treatment Facilities

EFFECTIVE DATE: For service rendered on and after October 1, 1982, Participating Treatment Facilities (PTFs) may bill from the date they have been approved to provide alcoholism service.

BACKGROUND: A four-year alcoholism services demonstration is being conducted under section 402 of the Social Security Amendments of 1967 as amended by section 222 (b) of Public Law 92-603.

The New Jersey Medicaid Program received the grant award from the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA). The New Jersey H.A.P. will be administered by the Department of Health, Division of Alcoholism (DOA). Participating Treatment Facilities (PTFs) in the following five counties will participate in the demonstration project: Essex, Middlesex, Monmouth, Morris and Union. The purpose of the project is to demonstrate the cost effectiveness and feasibility of providing alcoholism services to Medicare/Medicaid eligible recipients in free-standing alcoholism treatment facilities.

ACTION: New Jersey Medicaid Program reimbursement will be made to Alcoholism Participating Treatment Facilities for alcoholism service claims with a date of service on and after October 1, 1982. PTFs must be approved to provide alcoholism services by the Health Care Financing Administration, the New Jersey Medicaid Program and the Division of Alcoholism. When the Provider Agreement has been approved, The Prudential Insurance Company, the fiscal intermediary, will furnish you with a provider number and preprinted claim forms.

The PTF must keep such patient records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the New Jersey H.A.P. as described in the HCFA Alcoholism Services Demonstration Provider Manual.



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

PROVIDER BILLING INSTRUCTIONS

1. Verify that the client possess a current New Jersey Medicaid Eligibility Identification card (FD-73) as pictured below. Other valid Medicaid eligibility identification includes County Welfare Agency and Division of Youth and Family Services (DYFS) stubs. The Prudential Eligibility Hot Line Number is: 800 - 582-7052

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

RESTRICTED SERVICES WHEN INDICATED
 Pharmacy Physician Other
 THE SERVICES CHECKED CAN BE FURNISHED ONLY BY THE PROVIDER BELOW:

0430-123456 01
 HSP (Medicaid) Case No. Per No.

VALID: From: 11/1/82 To: 11/31/82

John Doe
 127 Main St.
 Anywhere, N.J.

COPY

123-45-6789
 Social Security Account Number
 2/47
 Date of Birth

Medicare Coverage _____
 HIC (Medicare) No. _____
 Other Insurance _____
 Policy Number _____
 Provider: Ask cardholder if he or she has Medicare or other health insurance not listed. * (Please see other side.)

John Doe
 Recipient's Signature

NOTICE TO CARDHOLDER: Your immediate attention is required:

FD-73
 12/82

COPY

1. Sign your name on the face of this card.
2. If there is Medicare coverage or other health insurance not listed or incorrectly listed, or if this card is lost, notify the Medicaid District Office. For telephone number, see Telephone Directory under New Jersey State of, Human Services Department, Medicaid, Local Administration Bureau. Unless the report of a card loss can be documented by the Medicaid District Office, you may be liable to repay Medicaid for any benefits obtained through its unauthorized use.
3. If you move, notify your Local Social Security Office immediately.

FEDERAL and STATE LAW make it a crime and set the punishment for persons who have been found guilty of making any false statement or representation of a material fact to receive any benefit or payment under the medical assistance program. This Department is required to make you aware of this law and to warn you against making any false statement in an application or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended.

NON-TRANSFERABLE UNDER PENALTY OF LAW

NOTICE TO PROVIDERS:

The name which appears 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 Medicare coverage or other health insurance not listed, please indicate information in appropriate area on claim form. You are to bill MEDICAID only *AFTER* receiving denial or partial payment from the other insurance company.

FRONT

BACK

2. Fill out the Independent Outpatient Health Facility Form (MC-14) (see copy attached) and mail the original to The Prudential Insurance Company, P.O. Box 5000, Millville, N.J. 08332.
3. The 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 Prudential Insurance Company.
4. In claim form Item 13 (Report of services) Section A (Dates of Service) - start with the date on which the participant was admitted to the PTF or the date the participant began receiving services under the New Jersey H.A.P. If the participant was a client of the PTF prior to the date he or she entered the demonstration, that date of admission to the PTF should not be entered on the claim form. In such cases, show the date on which the participant entered the demonstration.
5. A separate billing form (MC-14) must be submitted for each of the following types of services covered under the demonstration:
 - (a) Inpatient Alcoholism Detoxification Services
 - (b) Inpatient Alcoholism Treatment and Rehabilitation Services
 - (c) Outpatient Alcoholism Treatment Services

For example a Laboratory Test performed during Inpatient Alcoholism Detoxification should be billed on the same claim form with Inpatient Alcoholism Detoxification - Routine Care, not on a claim form for Outpatient Alcoholism Treatment Services, since it is not listed as an Outpatient Alcoholism Treatment Ancillary Service.

6. In claim form Item 13 (Report of services) Section A (Dates of Service) - you may use a monthly range of dates if the treatment has been continuous on a daily basis during these dates.

For example, Inpatient Rehabilitation Treatment for the month of November starting on the 1st through the 30th would be shown on one line in Item 13A as: 11/1/ - 11/30/82. However, be sure to specify in 13D (Code Description) that this is Inpatient Rehabilitation and also specify daily continuous treatment. (See Exhibit I)

If there is a break in treatment, up to six different periods in the month may be shown on one claim form. Use one line for each procedure code (routine or ancillary).

If more than six periods of treatment exist in a month, the additional periods of treatment should be listed on a separate claim form in the same manner as described above.

7. In claim form Items 13 B (Procedure Code) - Enter the appropriate 3 position numeric procedure codes, and in 13D (Code Description) - Enter descriptions for the specific type of services and ancillaries being filed on this form. Indicate patient status, that is, discharged, a current

patient, or benefits exhausted, by adding to the three position code a fourth position number as follows:

- 1 = Discharged
- 2 = Still Patient
- 3 = Benefits Exhausted

For example, to indicate the rendering of Inpatient Alcoholism Treatment and Rehabilitation - Routine Care - Code 201 - for a current patient, add the fourth position number 2 to the Procedure Code 201 resulting in: 2012. The codes and descriptions are attached.

8. In claim form item 13 E (Described as The Family Planning Column) - Enter the number of covered days for which you are billing (for the above example there would be 29 covered days.) The day of discharge or death are not covered days. The number of covered days allowed for each service is:

Inpatient Alcoholism Detoxification Services -
Routine Care = 5 days per episode
(for an unlimited number of episodes)

Inpatient Alcoholism Treatment and Rehabilitation
Routine Care = 30 days per calendar year

Outpatient Alcoholism Treatment Services -
Routine Care = 45 visits per calendar year

9. In claim form Item 15 (Attending Practitioner's Name; Individual Medicaid Practitioner (IMP) number) - Enter the practitioner's name and IMP number from the Directory of Individual Medicaid Practitioners IMP Numbers provided to you, or call Prudential at 800-582-7052. If the practitioner has no IMP number, enter his/her name and address; if the practitioner is not a Medicaid participant enter NON-PAR; if there is no attending practitioner enter NONE.
10. In claim form Item 16 (Operating Practitioner's name) - Enter the date care started for this service and the number of covered days used to date for this calendar year. (See Exhibit 1).

Any questions regarding this newsletter should be directed to:

Carl Skowronek, Program Development Specialist
Department of Human Services
Division of Medical Assistance and
Health Services (Medicaid)
Cn-712
Trenton, New Jersey 08625
Telephone (609) 984-5629

Edward F. Gilligan, New Jersey H.A.P. Project Officer,
Department of Health, Division of Alcoholism
129 East Hanover Street
Trenton, New Jersey 08608
Telephone (609) 292-8947

PROCEDURE CODES

INPATIENT ALCOHOLISM DETOXIFICATION CODES:

- Code: 101 Inpatient Alcoholism Detoxification Services - Routine Care may include:
- 1) room and board;
 - 2) nursing services and related care;
 - 3) individual/group/family counseling;
 - 4) general non-emergency transportation;
 - 5) physical examinations.

Services must be provided in a Participating Treatment Facility (PTF) approved for participation in New Jersey's Health Care Financing Alcoholism Project (New Jersey H.A.P.)

Services may be provided in a non-hospital setting. Length of stay is a maximum of five days unless special circumstances exist.

Note: If an inpatient detoxification episode exceeds five days, the PTF must submit with the claim supporting documentation, including progress notes and Individual Treatment and Diagnostic Plan, justifying coverage beyond five days for consideration for reimbursement for the additional days of services. There is no limit on the number of episodes per client.

- Code: 102 Laboratory test - inpatient alcoholism detoxification ancillary service.
- Code: 103 Pharmacy - inpatient alcoholism detoxification ancillary service.
- Code: 104 Medical supplies - inpatient alcoholism detoxification ancillary service.
- Code: 105 Psychiatric Evaluation - inpatient alcoholism detoxification ancillary service.

INPATIENT ALCOHOLISM TREATMENT AND REHABILITATION CODES:

- Code: 201 Inpatient Alcoholism Treatment and Rehabilitation Services - Routine Care may include:
- 1) room and board;
 - 2) nursing services and related care;
 - 3) individual/group/family counseling;
 - 4) general non-emergency transportation;
 - 5) physical examinations

Services must be provided in a Participating Treatment Facility (PTF) approved for participation in New Jersey's Health Care Financing Administration Alcoholism Project (New Jersey H.A.P.) A minimum of 20 hours of active treatment per week in a coordinated therapeutic program must be provided.

Note: Reimbursement is limited to 30 days of treatment per calendar year.

- Code: 202 Laboratory Test - inpatient alcoholism treatment and rehabilitation ancillary service
- Code: 203 Pharmacy - inpatient alcoholism treatment and rehabilitation ancillary service
- Code: 204 Medical Supplies - inpatient alcoholism treatment and rehabilitation ancillary service
- Code: 205 Psychiatric Evaluation - inpatient alcoholism treatment and rehabilitation ancillary service

OUTPATIENT ALCOHOLISM TREATMENT CODES:

- Code: 301 Outpatient Alcoholism Treatment Services-Routine Visits may include:
- 1) individual/group/family counseling;
 - 2) after-care/follow-up.

Services must be provided by a Participating Treatment Facility (PTF) approved for participation in New Jersey's Health Care Financing Administration Alcoholism Project (New Jersey H.A.P). The PTF must meet State and local licensure and certification requirements.

Note: Reimbursement will be limited to forty-five outpatient visits per calendar year. An outpatient visit is incurred when an outpatient service is rendered. If more than one routine service is rendered on the same day, only one visit will be counted.

- Code: 305 Psychiatric evaluation - outpatient alcoholism treatment ancillary service is reimbursable only if part of routine care or routine care is furnished subsequent to the psychiatric evaluation.
- Code: 306 Transportation - outpatient alcoholism treatment ancillary services



INDEPENDENT OUTPATIENT HEALTH FACILITY Please Print

1 Patient's Last Name Doe		First Name John		2 Patient's Street Address 127 Main St.		Telephone Number 555-1234		
Health Services Program Case No 0 4 3 0 1 1 2 3 4 5 6		4 Patient Person No 0 1	5 Age 35	6 Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		City Anywhere	State N.J.	Zip Code 00000

7 Other Health Insurance or Liability Coverage? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, attach copy of Decline Notice or Explanation of Payment from Carrier No Fault Auto Coverage? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10 Was Patient's Illness or Injury connected with employment? If Yes, give Name and Address of Employer here	
8 Was this service performed as a result of an EPSDT Program Referral? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Did injury result from automobile accident? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

9 PROVIDER OF SERVICE INFORMATION		11 Prior Authorization Number N/A	
Telephone Number 555-4321	Medicaid Provider Number (enter only when not printed below) 38000		
Name and Address Participating Treatment Facility	12 PRIOR AUTHORIZATION - FOR DIVISION USE ONLY N/A		
		AUTHORIZING SIGNATURE	Date:

A. Dates of Service	B. Procedure Code	C. Nature of Illness or Injury Requiring Services	D. Fully describe surgical or medical procedures and other services or supplies furnished for each date listed	E. Check if Family Planning	F. Charge
11/1 - 11/30/82	2011	Alcoholism	Inpatient-Rehab. Routine Care - Daily Cont. Treatment	29	1,500.00
11/2, 11/25	2021		Laboratory Test - Urine Test	2	2.00
11/5	2031		Pharmacy - Aspirin, 10 Tablets	1	1.00
11/5	2041		Medical Supplies - Bandages	1	2.00
11/2	2051		Psychiatric Evaluation - Dr. Smith	1	15.00

14 Referring Practitioner's Name		Total Charges \$	
Individual Medicaid Practitioner Number		16. Operating Practitioner's Name 11/1/82 29 Covered days	
15. Attending Practitioner's Name None		Individual Medicaid Practitioner Number	
Individual Medicaid Practitioner Number			

17. 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) John Doe Date Signed 11/30/82

18. PROVIDER CERTIFICATION. I certify 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 therefore 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 and Section 504 of the Rehabilitation Act of 1973. 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 Elizabeth Black Billing Date 11/30/82
Mo. / Day / Yr.



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

New Jersey Health Services Program NEWSLETTER

Volume P-349

January 10, 1983

TO: Physicians, Hospital Administrators and Independent Clinics
in Essex, Middlesex, Monmouth, Morris and Union Counties

SUBJECT: Expanded Medicare/Medicaid Benefits for Alcoholism Treatment
Services Resulting from The New Jersey Health Care Financing
Administration (HCFA) Alcoholism Project (New Jersey H.A.P.)

EFFECTIVE DATE: October 1, 1982

BACKGROUND: A four-year alcoholism services demonstration is being
conducted under section 402 of the Social Security Amendments
of 1967 as amended by section 222 (b) of Public Law 92-603.

The New Jersey Medicaid Program received the grant award for reimbursement to free-standing alcoholism facilities from the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA). The New Jersey H.A.P. will be administered by the Department of Health, Division of Alcoholism. Five counties will participate in the demonstration project: Essex, Middlesex, Monmouth, Morris, and Union. The purpose of the project is to demonstrate the cost effectiveness and feasibility of providing alcoholism services to Medicare/Medicaid eligible clients in free-standing alcoholism treatment centers.

ACTION: As of October 1, 1982, New Jersey H.A.P. participating
free-standing alcohol treatment centers will be reimbursed for
Inpatient and Outpatient Alcoholism Treatment Services.

Inpatient Detoxification and Inpatient Treatment and Rehabilitation Services may include routine care and ancillaries. Routine care consists of (1) room and board, 2) nursing services and related care, 3) individual, group and family counseling, 4) general transportation, and 5) physical examinations. Ancillary services consist of 1) laboratory test, 2) pharmacy, 3) medical supplies, and 4) psychiatric evaluation.

Outpatient Treatment Services may include routine care and ancillaries. Routine care for outpatient services consists of 1) individual, group, and family counseling and 2) after-care/follow-up. Ancillary services consist of 1) psychiatric evaluation and 2) transportation. Under certain circumstances meals will be served to the participant.

Medicaid reimbursement will be made for claims with a date of service on or after October 1, 1982. Medicare reimbursement, by HCFA, became available as of July 1, 1982. All other existing Medicare/Medicaid coverage for alcoholism will remain in effect.

If any of your clients are Medicare or Medicaid eligible and require these services, you are requested and encouraged to contact the Alcoholism Information and Referral Center in your area for further information. These agencies will assist you in the identification and referral to a participating treatment facility (PTF).

ESSEX COUNTY

National Council on Alcoholism
North Jersey Area, Inc.
Essex County Division
60 South Fullerton Avenue
Room 211
Montclair, N.J. 07042
(201) 783-9313
Nancy Branch, Director

*Newark Branch
699-711 Springfield Avenue
Newark, N.J. 07103
(201) 375-2106
Joyce Love, Coordinator

MIDDLESEX COUNTY

MIDDLESEX COUNCIL ON ALCOHOLISM Inc.
1369 Route 130 and Griggs Road.
Dayton, N.J. 00881
(201) 246-1450
Marcia Smith, Director

MONMOUTH COUNTY

National Council on Alcoholism
of Central Jersey, Inc.
Monmouth County Division
90 Monmouth Street
Red Bank, N.J. 07701
(201) 741-5200
Barry Johnson, Director

MORRIS COUNTY

National Council on Alcoholism of
Morris County Inc.
The Baud Building
95 Mt. Kemble Avenue
Morristown, N.J. 07960
(201) 267-8887
Frances Flynn, Director

UNION COUNTY

Union Council on Alcoholism
300 North Avenue East
Westfield, N.J. 07090
(201) 233-8810
Teresa McGeary, Director

Union Council on Alcoholism
Elizabeth (Alexian Brothers
Branch)
645 Livingston Avenue
Elizabeth, N.J. 07206
(201) 351-9000 Ext. 379
Trudi Baird, Coordinator

STATEWIDE

*ALACALL (24 hour hot line)
800 322-5525

*Indicates this organization has a Spanish interpreter available.

Any questions regarding this Newsletter should be directed to:
Carl Skowronek, Program Development Specialist, Department of Human Services,
Division of Medical Assistance and Health Services (Medicaid), CN-712, Trenton,
New Jersey. Telephone (609) 984-5629.

Edward F. Gilligan, New Jersey H.A.P. Project Officer, Department of Health,
Division of Alcoholism, 129 East Hanover Street, Trenton, New Jersey 08608.
Telephone (609) 292-8947.



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

New Jersey Health Services Program NEWSLETTER

Volume P-350

February 1, 1983

TO: Pharmacy Providers, Participating Physicians, Dentists and Podiatrists

SUBJECT: Maximum Allowable Cost (MAC)

EFFECTIVE DATE: Retroactive to January 1, 1983

ACTION I: On December 28, 1982, the Pharmaceutical Reimbursement Board (PRB) of The Department of Health and Human Services notified the Division of Medical Assistance and Health Services that the PRB established a new Maximum Allowable Cost (MAC), effective January 1, 1983, for the following drug entities:

<u>Drug</u>	<u>MAC Limit</u>
Doxepin HCL 10mg	\$0.1030
Doxepin HCL 25mg	\$0.1328
Doxepin HCL 50mg	\$0.1869
Doxepin HCL 100mg	\$0.3382

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 (MAC) as indicated above.

ACTION II: The Maximum Allowable Cost limit on Erythromycin 500mg tablet is suspended.

The instructions for billing "Medical Certification" in the New Jersey Medicaid and the Pharmaceutical Assistance to the Aged and Disabled (PAAD) Programs can be obtained from either Newsletter Volumes Blue Cross (B)-236 or Prudential (P)-338 (August 1, 1982). Attached is an updated MAC list to replace the list dated 8/12/82.

Any questions regarding this Newsletter should be directed to the Bureau of Pharmacy Services, Division of Medical Assistance and Health Services, CN-712, Trenton, New Jersey 08625. Telephone (609) 292-3756.

LISTING OF MAC DRUGS

January 1, 1983

<u>DRUG ENTITY</u>	<u>MAC</u>	<u>EFFECTIVE DATE</u>
Acetaminophen w/Codeine, 300mg/30mg Tablets	\$0.0780 per Tablet	01/25/79
Acetaminophen w/Codeine, 300mg/60mg Tablets	\$0.1458 per Tablet	08/12/82
Amoxicillin, 250mg Capsules	\$0.2108 per Capsule	06/28/79
Amoxicillin, 500mg Capsules	\$0.3942 per Capsule	06/28/79
Ampicillin, 250mg Capsules	\$0.0422 per Capsule	08/12/82
Ampicillin, 500mg Capsules	\$0.1103 per Capsule	01/25/79
Ampicillin, Oral Suspension, 125mg/5ml	\$0.0114 per ml	08/12/82
Ampicillin Oral Suspension, 250mg/5ml	\$0.0205 per ml	11/07/77
Chlordiazepoxide HCl, 5 mg 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	\$0.1030 per Capsule	01/1/83
Doxepin HCl, 25mg Capsules	\$0.1328 per Capsule	01/1/83
Doxepin HCl, 50mg Capsules	\$0.1869 per Capsule	01/1/83
Doxepin HCl, 100mg Capsules	\$0.3382 per Capsule	01/1/83
Erythromycin Stearate, 250mg Tablets	\$0.0697 per Tablet	01/25/79
Glutethimide, 500mg Tablets	\$0.0432 per Tablet	08/28/81
Hydralazine HCl, 25mg Tablets	\$0.0279 per Tablet	03/31/80
Hydralazine HCl, 50mg Tablets	\$0.0384 per Tablet	03/31/80
Hydrochlorothiazide, 25 mg 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

LISTING OF MAC DRUGS - CONTINUED

<u>DRUG</u>	<u>MAC</u>	<u>EFFECTIVE DATE</u>
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	\$0.0109 per ml	08/12/82
Penicillin VK Oral Susp., 250mg/5ml	\$0.0160 per ml	11/07/77
Penicillin VK, 250mg Tablets	\$0.0417 per Tablet	08/12/82
Penicillin VK, 500mg Tablets	\$0.0649 per Tablet	08/12/82
Potassium Chloride, Oral Liquid 10%	\$0.0030 per ml	12/15/80
Probenecid, 0.5gm Tablets	\$0.0644 per Tablet	01/25/79
Procainamide HCl, 250mg Capsules	\$0.0383 per Capsule	08/28/81
Procainamide HCl, 375mg Capsules	\$0.0505 per Capsule	08/28/81
Procainamide HCl, 500mg Capsules	\$0.0585 per Capsule	08/28/81
Propantheline Br, 15mg Tablets	\$0.0235 per Tablet	08/28/81
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	\$0.0394 per Capsule	08/12/82
Tetracycline HCl, 125mg/5ml Syrup	\$0.0104 per ml	10/15/79



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

New Jersey Health Services Program NEWSLETTER

Volume P-351

February 7, 1983

TO: ADMINISTRATORS - DIAGNOSIS RELATED GROUP (DRG) HOSPITALS

SUBJECT: CONVERSION OF MEDICAID CLAIM PAYMENT FROM PER DIEM TO DRG PRICE PER CASE METHODOLOGY

EFFECTIVE: For admissions on or after March 1, 1983, the New Jersey Medicaid Program will reimburse inpatient claims at DRG hospitals according to the DRG price per case criteria developed by the Department of Health.

The following information must be reflected on all Uniform Bill-Patient Summary (UB-PS) claims submitted via hard copy, tape-tie, or the Blue Cross teleprocessing network in order to implement the price per case payment methodology. Claims without this information will be rejected for payment.

A. All Claims -

1. Birth date (block 10)
2. Sex (block 9)
3. DRG code and outlier indicator (block 37) - The outlier indicator must be compatible (based on a comparison of the acute days to the trim points for the specific DRG) with the DRG code.
4. Diagnosis code (s) (blocks 88 through 94)
5. Procedure code (s) (blocks 95 through 102)
6. Discharge status code (block 66)

B. Special Notes -

1. Price per case payment will be calculated as follows:

$(\text{DRG Base Rate} \times \text{Markup}) \times \text{Payor Factor} = \text{Prediscounted DRG Amount}$

This amount as calculated by the contractor must agree with the DRG amount as calculated by the hospital. Data reflected on the claim form must agree with the contractor's pricing file data or the claim will reject from the processing system. Consequently, providers should ensure that the contractor is aware of any changes in base rates, markup factor, or payor factor before submitting claims with new rates or factors.

2. If the patient status code (block 66) is EX, EA, or LA, the outlier indicator should always be "Y".

3. If the admission date is the same as the discharge date, the outlier indicator must be "Y".

4. Payment for outlier claims will be calculated as follows:

Total Charges x Payor Factor = Prediscounted DRG Amount

(See comment in item B.1.)

C. Exceptions -

1. The internal pricing file will not be utilized for claims which reflect a change in the level of care; e.g., acute days and SNF days during one stay. These claims will continue to be billed hard copy and processed as before in accordance with the billing matrix.

2. The preceding price per case instructions do not apply to Same Day Surgery claims. These type claims will also continue to be billed hard copy and processed as before.

Should you have any questions regarding this Newsletter, please contact your contractor - Prudential - at 609-293-2045.



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

New Jersey Health Services Program NEWSLETTER

Volume P-353

March 14, 1983

TO: Administrators - Diagnosis Related Group (DRG)
Hospitals

SUBJECT: DRG Procedure Code Changes for Services
Rendered to Newborns

EFFECTIVE: Immediately

PURPOSE: To Update Procedure Codes and Billing Instructions
for DRG Hospitals

BACKGROUND: The DRG Program requires the use of separate claims when billing for services rendered to a mother and newborn. To avoid the time lag between the birth of an infant, the determination of the infant's eligibility, and the addition to the Medicaid Eligibility File, the New Jersey Medicaid Program has modified the billing system to process claims for newborn care under the DRG system. This modified billing system allows the use of the mother's Health Services Program (Medicaid) Case/Person number, in certain situations, for services rendered to a newborn.

ACTION: For services rendered to the mother and newborn, separate claim forms must be submitted. The mother's Health Services Program Case/Person number must be entered on both claim forms for cases involving one of the six DRG DELIVERY CODES: 370, 371, 372, 373, 374, 375 and one of the seven DRG related newborn codes: 385, 386, 387, 388, 389, 390, 391. These codes replace previous DRG delivery and newborn codes.

Any claim for newborn care that involves a DRG code other than those noted above may not be submitted for processing until the family's Health Services Program Case number and the newborn's individual Health Services Program Person number, obtained from the County Welfare Agency or Division of Youth and Family Services, are entered on the claim form.

Hospital administrators should encourage appropriate staff members to counsel prenatal patients concerning the eligibility process in order to expedite the determination of newborn eligibility.

Please file this newsletter with your Medicaid provider manual.

If you have any questions, please contact your appropriate Medicaid contractor: Blue Cross: (201) 456-2570; Prudential: (609) 293-2268.



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

New Jersey Health Services Program NEWSLETTER

Volume P-354

April 11, 1983

TO: Physicians, Podiatrists, Psychologists, Independent Laboratories
and Hospital Administrators

SUBJECT: Revised Replacement Pages to the Procedure Code Manual(Ed.9-81)

ACTION REQUIRED: Attached to this Newsletter are replacement pages incorporating additions, deletions and revisions made to the Procedure Code Manual, Ed. 9-81, from March 1, 1982 to September 1, 1982. Only those pages that are relevant to your section(s) of the Procedure Code Manual are included. The changes are outlined by brackets in the left margin.

PHYSICIANS AND HOSPITAL ADMINISTRATORS PLEASE NOTE:
Code 7390 - "Pelvimetry, with or without placental localization."

We wish to call your attention to the additional requirements accompanying procedure code 7390. The "Statement on Use of Pelvimetry X-Ray Examination" outlined in the FDA Drug Bulletin, Vol. 11, Number 3 dated November, 1981, stated that "Pelvimetry, used to evaluate the relative sizes of the fetal head and maternal pelvis and thus to help decide on the necessity for Cesarean section, can expose the fetus to a significant amount of x-radiation. Pelvimetry should be performed only when the physician caring for the patient feels that pelvimetry will contribute to the decisions concerning diagnosis or treatment. The reason for requesting pelvimetry should be written on the patient's chart."

In accordance with the FDA's recommendations, the New Jersey Medicaid Program has added procedure code 7390 to the group of procedure codes requiring evidence of Medical Necessity. (See HSP Newsletter P-217 dated December 26, 1977.) Effective immediately, before reimbursement will be made, the New Jersey Medicaid Program will require that written evidence of medical necessity for code 7390, "Pelvimetry, with or without placental localization," accompany the 1500-N.J. claim form. The medical necessity may be stated in "Remarks" box 34 of the 1500-N.J. claim form. If box 34 does not provide sufficient space, an addendum may be attached to the 1500-N.J. claim form.

Please discard the outdated pages in your Procedure Code Manual, Ed. 9-81, and replace with the attached revised pages.

Questions concerning this Newsletter may be referred to S. Eugene Yuliano, M.D., Medical Director, CN-712, Trenton, N.J. 08625.

Procedure Code Manual

<u>Section</u>	<u>Page</u>	<u>Revision/Description</u>	<u>Procedure Code</u>
Index	1	Change: Aneurysm: Aorta, other	2401-2411, 2460 2464
		Add: Angioplasty, transluminal	2514
		Add: Aorta, Arch	2406-2411, 2472
		Remove: Aorta, Thoracic	2400
		Remove: Aorta, Arch	2400, 2472
		Change: Aortography	2437, 2438, 7512-7523
		Change: Arteriotomy	2375
		Add: Artery, Resection Artery, Biopsy	2388 2389
	2	Change: Audiometry	9337, 9340-9342, 9345-9349
		Change: Biopsy, Bones Biopsy, Renal	7453, 0501, 0503 0510, 0549-0551 3819, 3820
	3	Remove: Chemotherapy	9412, 9413
	4	Change: Embolus, Thrombus	2375-2584
		Add: Femoral Artery Bypass	2412, 2414
	5	Add: Fetal Non Stress Test	4827, 4828
	7	Remove: Madden proc. (stasis)	2383
		Change: Mobin-Udin Umbrella Procedure	2525
8	Remove: Phlebotomy	2380, 2381, 9400	
9	Add: Primary Sterilization	4531, 4532, 4549	

<u>Section</u>	<u>Page</u>	<u>Revision/Description</u>	<u>Procedure Codes</u>
		Change: Hemodialysis Shunt	2427-2428
		Add: Somatosensory	9338
10		Add: Stereo Fundus Photography	5396
		Add: Thrombectomy	2380-2382, 2384
11		Add: Visual Brain-Stem- Evoked Response (VBR)	9339

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<u>Section</u>	<u>Page</u>	<u>Revision/Description</u>
Surgery	17	Change: 0262; Defect size changed to " ½ inch to 1 inch".
	20	Change: 0403; Procedure description changed.
	21	Change: 0408; Procedure description changed.
		Change: 0409; Procedure description changed.
		Change: 0410; Procedure description changed.
	22	Add: C0481, C0482; removed from page 21 to 22.
	25	Add: To 0634, 0635; Second opinion designation included.
	26	Add: To 0636 to 0642; Second opinion designation included.
	40	Add: To 1495, 1496; Second opinion designation included.
	57	Remove: 2373, 2374
		Change: 2375, 2388, 2389; Procedure descriptions changed.
		Change: 2380, 2381; Procedure descriptions changed.
		Add: 2382, 2384; Thrombectomies.
		Remove: 2383
		Change: 2390, 2392, 2394; Procedure descriptions changed.

<u>Section</u>	<u>Page</u>	<u>Revision/Description</u>
		Add: 2393; Subclavian thrombaendarterectomy
		Remove: 2400, 2403, 2404
		Change: 2402, 2405
	58	Remove: 2421
	59	Change: 2441; Procedure description changed.
		Change: 2464; Procedure description changed.
	60	Change: 2486; Procedure description changed.
		Change: 2511; Procedure description changed.
		Add: 2514; Percutaneous transluminal angioplasty.
		Change: 2520, 2525; Procedure description changed.
	67	Add: To 2992, 2993, 2994, 3000; Second opinion designation added.
	77	Add: To 3515, 3516, 3517; Second opinion designation added.
		Change: 3505; Procedure description changed.
	78	Add: To 3631 to 3635; Second opinion designation added.
	79	Add: To 3646, 3651, 3661 to 3664, 3666; Second opinion designation added.
	80	Add: 3819; Renal biopsy.
	92	Change: 4531; Procedure description changed.
		Change: 4532; Procedure description changed.

<u>Section</u>	<u>Page</u>	<u>Revision/Description</u>
		Change: 4549; Procedure description changed.
	94	Add: To 4614, 4618, 4631, 4632, 4634; Second opinion designation added.
	96	Change: 4821; Note I updated to show PRV4823 for each subsequent ante partum visit.
	97	Add: 4827; Fetal non stress test for high risk pregnancy (office).
		Add: 4828; Fetal non stress test for high risk pregnancy (hospital outpatient).
	98	Remove: 4830 to 4835; To page 98.
	98.1	Add: New procedure codes for Certified Nurse Midwife services.
	98.2	
	99	Change: 4904; Procedure description changed.
		Change: 4911; Procedure description changed.
	102	Add: To 5190, 5208 to 5211; Second opinion designation included.
		Change: 5194; Procedure description changed.
	103	Add: To 5225; Procedure description changed.
		Change: 5255; Procedure description changed.
	107	Add: 5396; Stereo fundus photography.
Radiology	124	Change: 7369; Hospital based dollar allowance increased to \$52.00.
	125	Add: 7453; Percutaneous bone biopsy under fluoroscopic guidance.
		Add: 7390; Designated as Medical necessity procedure.

<u>Section</u>	<u>Page</u>	<u>Revision/Description</u>
Laboratory (Alpha)	139	Add: To 8459; Note added concerning payment requirements for culture.
(Numeric)	150	
	158	Add: To 8976; Note added concerning payment requirements for culture.
Psychiatric Services	174	Add: Note concerning psychiatric services rendered to patients in long term care facilities.
	175	Change: 9559; Procedure description changed.
Psychological Services	176	Add: Note concerning psychological services rendered to patients in long term care facilities.
Other Services	185	Add: 9337; Auditory and visual brain-stem-evoked response (ABR) (VBR).
		Add: 9338; Somatosensory evoked response testing.
	186	Add: 9346; Auditory brain-stem-evoked response (ABR).
	187- 192	Expanded pages to accommodate new procedures.

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**SURGERY
INTEGUMENTARY**

SURGERY

	Follow- Up Days	Surg. Value		Anes. Basic Units
		S	NS	
0197 Lesions over ¼ inch, complicated or unusually located (1.9 - 2.5 cm)	90	175.	170.	4.
0198 Malignant lesions over ¼ inch, unusually located, requiring complicated repair (Z-Plasty, rotation flap, pedicle flap, etc.) (1.9 - 2.5 cm)	90	182.	158.	5.
0225 Avulsion, nail, partial, or complete	0	10.	10.	3.
0227 Excision of nail, partial or complete, including nail bed or nail fold, with or without excision of subungual exostosis, (e.g. for fungus infection or chronic paronychia.)	0	18.	16.	3.
0228 Radical excision of nail, complete, including destruction of nail matrix, with or without removal of subungual exostosis (permanent surgical removal of chronic ingrown or deformed nail.)	30	42.	37.	3.
0238 Excision of pilonidal cyst or sinus	30	151.	131.	4.
Miscellaneous lesions (use appropriate procedure number and state diagnosis.)				
<u>Hemangioma</u> (see 0175-0178, 0260-0324.)				
<u>Hidradenitis</u> (see 0108, 0175-0178, 0260-0324.)				
<u>Lipoma</u> (see 0175-0178, 0260-0324.)				
<u>Lymph node dissection</u> (see 2651-2672.)				
<u>Melanoma</u> (see 0188-0197, 0260-0324.)				
<u>Ulcer - vascular or inflammatory</u> (see 0175-0178, 0260-0324.)				

REPAIR - SIMPLE

0250 Wounds - suture of laceration up to and including 1 inch	0	18.	16.	3.
0251 Over 1 inch to and including 2 inches	0	24.	21.	3.
0252 Over 2 inches to and including 3 inches	0	30.	26.	3.
0255 for each additional inch over 3 inches add	0	6.	5.	4.

REPAIR-COMPLEX (e.g., reconstructive surgery, complicated wound closure, skin grafts, etc.)

The following values (0260-0324) are to be applied in situations requiring unusual and time-consuming techniques of repair to obtain the maximum functional and cosmetic result. Unless otherwise noted, the stated values include the creation of the defect and necessary preparation for repair, or the debridement and repair of complicated lacerations (excluding 0251, 0252.)

Excision and/or repair by direct closure of lesion or laceration resulting in a LINEAR REPAIR:

0260 up to ½ inch, forehead, cheeks, chin, mouth, neck, axilla, genitalia, hands and feet	30	30.	26.	3.
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**SURGERY
INTEGUMENTARY**

SURGERY

		Follow- Up Days	Surg. Value		Anes. Basic Units	
			S	NS		
<u>0261</u>	eyelids, nose, ears and lips (See also 0290-0294, 2737-2746.) (For other areas see 0175-0178, 0188-0197, 0251-0252.)	30	38.	33.	4.	
{	0262	½ inch to 1 inch, trunk	30	34.	29.	4.
	0263	scalp, arms and legs	30	48.	42.	4.
	0264	forehead, cheeks, chin, mouth, neck, axilla, genitalia, hands and feet	30	67.	59.	4.
	0265	eyelids, nose, ears and lips (See also 0290-0294, 2737-2746.)	30	82.	71.	4.
	0266	1 inch to 3 inches, trunk	30	68.	63.	4.
	0267	scalp, arms and legs	30	106.	92.	4.
	0268	forehead, cheeks, chin, mouth, neck, axilla, genitalia, hands and feet	30	145.	126.	4.
	0269	eyelids, nose, ears and lips (See also 0290-0294, 2737-2746.)	30	193.	168.	4.
	0270	Unusual, complicated or over 3 inch linear repair	30	242.	210.	4.
	<u>Excision and/or repair by adjacent tissue transfer or re- arrangement (e.g., Z-plasty, rotation flap, advanced flap, double pedicle flap, etc.):</u>					
	<u>0275</u>	for defect up to 1 square inch, trunk	60	97.	84.	4.
	<u>0276</u>	scalp, arms and legs	60	145.	126.	4.
	<u>0277</u>	forehead, cheeks, chin, mouth, neck, axilla, genitalia, hands and feet	60	193.	168.	4.
	0278	eyelids, nose, ears and lips	60	242.	210.	4.
	0279	defect size between 1 square inch and 3 square inches, trunk	60	145.	126.	3.
	0280	scalp, arms and legs	60	193.	168.	3.
	0281	forehead, cheeks, chin, mouth, neck, axilla, genitalia, hands and feet	60	242.	210.	4.
	0282	eyelids, nose, ears and lips	60	290.	252.	4.
	0283	more than 3 square inches, unusual or complicated	60	242.	210.	4.
	<u>Eyelid full thickness, excision and repair:</u>					
	<u>0290</u>	by advancement flaps, up to ¼ eyelid margin	60	227.	197.	4.
	0291	over ¼ of eyelid margin	60	242.	210.	4.
	0292	by transfer flaps of tarso-conjunctiva from opposing eyelid, up to 2/3 of eyelid	60	242.	210.	4.
	0293	total eyelid, one or more stages, lower lid	60	362.	315.	4.
	0294	upper lid	60	411.	357.	4.

**SURGERY
INTEGUMENTARY**

SURGERY

		Follow- Up Days	Surg. Value		Anes. Basic Units
			S	NS	
0354	without anesthesia, small, office or hospital	0	9.	8.	3.
0355	without anesthesia, medium (whole face or whole extremity, etc.)	0	14.	11.	3.
0356	without anesthesia, large (more than one extremity, etc.)	0	18.	16.	3.

MEDICAL NECESSITY PROGRAM CODES

*0367	Fabric wrapping of abdominal aneurysm		B.R.	B.R.	
*0368	Bronchoscopy with injection of Radioactive substance		B.R.	B.R.	
*0369	Extra-Intracranial arterial bypass for stroke		B.R.	B.R.	
*0370	Fascia Lata by stripper as treatment for lower back pain		B.R.	B.R.	
*0371	Fascia Lata by incision and area exposure with removal of Sheath as treatment for lower back pain		B.R.	B.R.	
*0372	Hysterotomy non-obstetrical, vaginal		B.R.	B.R.	
*0373	Kidney Decapsulation unilateral and bilateral		B.R.	B.R.	
*0374	Ligation internal mammary arteries unilateral and bilateral		B.R.	B.R.	
*0375	Omentopexy for establishing collateral circulation in portal obstruction		B.R.	B.R.	
*0376	Ligation of Thyroid arteries (independent procedure)		B.R.	B.R.	
*0377	Ballistocardiogram (BCG)		B.R.	B.R.	

DESTRUCTION

0401	Electro-surgical or any other technique for destruction including use of scalpel with or without surgical curettement of facial nevi, leukoplakia, actinic or senile keratoses, or keratoacanthomas, to include local anesthesia, one lesion (50% for each additional lesion up to a total of three; over three, for each additional lesion add 25% up to a maximum of 400% for a single clinical session). This code to be used for minor superficial or intradermal lesions.	0	8.	6.	3.
0402	complicated lesion(s)	0	11.	8.	3.
0403	Electro-surgical destruction (except 0401 and 0402) or chemocautery (Mono-, Bi-, Trichloroacetic acid, phenol, etc.) or cryocautery (liquid N ₂ , CO ₂ , etc.) of BENIGN or PRE-MALIGNANT lesions involving the full thickness of the skin or mucous membranes (except 0405 and 0406) with or without curettement, one lesion (50% for second lesion; over two, each additional lesion 25%.) . . . "do not exceed 200% in single clinical session".	0	18.	15.	3.
0404	complicated lesion(s)	0	27.	24.	3.

*See Medical Necessity Program NJHSP Newsletter, Volume No. P-217

**SURGERY
INTEGUMENTARY**

SURGERY

		Follow- Up Days	Surg. Value		Anes. Basic Units
			S	NS	
0405	Flat plane, juvenile, pedunculated seed, seborrheic, senile) warts up to fifteen, includes destruction by scalpel (Re-treatment same as routine office visit.)	0	8.	6.	3.
0406	Electro-surgical or scalpel destruction of multiple fibro-cutaneous tags, up to fifteen; for next fifteen lesions add 50%; for third and fourth series of fifteen lesions add 25% - do not exceed 200% in single clinical session.	0	8.	6.	3.
0408	Chemosurgery, Mohs type or technique only. For malignancies of skin; includes removal of growth and microscopic <u>examination</u> of margins and base of specimen (up to and including 5 sections); <u>includes incision</u> , fulguration, applications of chemicals, etc.	30	25.	21.	3.
0409	<u>subsequent extension or continuation of above procedure including examination of additional tissue specimens</u> (up to and including 5).	30	8.	6.	3.
0410	<u>necessary or required examination of each additional tissue specimen over 5; applies to PRV 0408 and 0409</u>	30	BR	BR	3.
0412	Electrolysis epilation, each 1/2 hour	0	8.	6.	3.
0413	Excision of plantar verruca, single site unilateral	0	24.	21.	3.
0414	multiple sites, unilateral	0	37.	32.	3.

Breast

INCISION

0430	Puncture aspiration of cyst	0	13.	11.	3.
0431	Mastotomy with exploration or drainage of abscess, deep	14	61.	53.	3.

EXCISION

0441	Biopsy of breast	0	61.	53.	3.
0444	Excision of cyst, fibro-adenoma or other benign tumor, aberrant breast tissue, duct lesion (including gynecomastia) of nipple lesion (including any other partial mastectomy)	30	103.	89.	3.
0445	bilateral	30	121.	105.	3.
0446	Excision of chest wall tumor involving ribs	60	332.	289.	10.
0447	Excision of chest wall tumor involving ribs plus plastic reconstruction	60	473.	413.	13.
0457	Complete (simple) mastectomy	45	163.	142.	3.
0458	Modified radical mastectomy (simple mastectomy with axillary dissection)	60	332.	289.	5.
0470	Radical mastectomy, including breast pectoral muscles and axillary lymph nodes	60	362.	315.	5.
C0480	Mammoplasty, plastic operation on single breast, reduction or repositioning, (unilateral), one stage with or without nipple preservation. Do not use for reconstruction procedure following mastectomy for cancer.	90	178.	142.	6.

**SURGERY
INTEGUMENTARY**

SURGERY

		Follow- Up Days	Surg. Value		Anes. Basic Units
			S	NS	
C0481	Mammoplasty, plastic operation on breasts, reduction or repositioning, bilateral, one stage with or without nipple preservation. Do not use for breast reconstruction procedure following mastectomy for cancer.	90	242.	210.	4.
C0482	two stage	90	BR	BR	4.
C0483	augmentation, prosthetic, unilateral Do not use for breast reconstruction procedure following mastectomy	90	121.	105.	4.
C0484	bilateral	90	163.	142.	4.
0485	Mammoplasty, or breast reconstruction, proximal derma-fat-fascia transfer or graft, unilateral; for prosthetic augmentation or for reconstruction following cancer therapy.	90	242.	210.	4.
0486	Mammoplasty or breast reconstruction, complex, unilateral -- for post cancer therapy reconstruction or rehabilitation -- includes latissimus dorsi muscle transfer, creation of graft, creation of site, all associated pedicle flaps and skin grafts to recipient or donor site.	90	452.	NA	6.
0487	Mammoplasty or breast reconstruction, immediate plastic surgery component; for use when a general or plastic surgeon inserts a permanent or temporary, unilateral breast prosthesis as a continuation of a simple or modified radical mastectomy for tumor.	60	91.	79.	3.
0488	Mammoplasty, or breast reconstruction, delayed unilateral independent procedure, for rehabilitation following breast surgery for cancer or tumor.	90	242.	210.	6.
0489	Nipple transplant or reconstruction, unilateral, independent procedure, (supplemental to mammoplasty or breast reconstruction following cancer surgery).	45	91.	79.	3.

**SURGERY
MUSCULOSKELETAL**

SURGERY

		Follow- Up Days	Surg. Value S \$ NS		Anes. Basic Units
0577	small bones	60	90.	79.	4.
0578	Excision of tumor of mandible without replacement (For replacement see 0619.)	90	316.	276.	5.
0579	Partial removal (ostectomy and/or saucerization of small bone rasping technique)	21	61.	53.	3.
0580	Radical resection of bones for tumor with bone graft; scapula, humerus, pelvis, femur, tibia	90	422.	394.	6.
0581	other bones	90	274.	256.	6.

INTRODUCTION

(For associated procedures, see Fractures.)
(For injection procedure for intraosseous venography, see 2433.)

<u>0591</u>	Insertion of wire, pin, caliper or tongs (independent procedure)	0	55.	47.	4.
<u>0598</u>	Removal buried wire or pin (independent procedure)	0	24.	21.	3.
<u>0599</u>	Removal of caliper or tongs (independent procedure)	0	18.	13.	3.

REPAIR

0611	Osteoplasty; shortening of bone, femur, tibia, humerus	90	332.	289.	5.
0612	radius, ulna	90	242.	210.	3.
0613	other bones	90	BR	BR	4.
0614	lengthening of bone	90	332.	289.	4.
0616	mandible for prognathism or micrognathism, one or two stages	90	332.	289.	7.

BONE OR CARTILAGE GRAFT -

Osteoperiosteal graft, periosteal graft, or cartilage graft. Includes
obtaining and placing of graft. Unless otherwise indicated, values
are for autogenous grafts.

0617	Bone graft; femur, tibia, humerus	90	332.	289.	4.
0618	radius, ulna	90	242.	210.	4.
0619	skull or significant portion of mandible	90	332.	289.	7.
0620	other bones, including chin, nose, malar prominences	90	149.	130.	7.
0621	Cartilage graft, autogenous, to face, nose, ear or skull	60	261.	226.	7.

Spinal Fusion (For fusion of childhood scoliosis, see 0643, 0644,
0645.)

(Items 0634-0642 refer to spinal procedures at one interspace;
for each additional interspace, add 10%.)

{	*0634	Spinal fusion, cervical region, posterior technique	90	573.	499.	8.
	*0635	anterior technique	90	573.	499.	8.

*See Medicaid Second Opinion Program NJHSP Newsletter, Vol. P-329.

**SURGERY
MUSCULOSKELETAL**

SURGERY

		Follow- Up Days	Surg. Value		Anes. Basic Units
			S	\$ NS	
*0636	thoracic region, posterior or posterior-lateral technique	90	573.	499.	8.
*0637	interbody technique, anterior, lateral or posterior	90	573.	499.	8.
*0638	lumbar region, posterior or posterior-lateral technique	90	483.	420.	8.
	(For interbody technique, anterior see 0642.)				
*0639	Spinal fusion with removal of intervertebral disc, cervical region, posterior technique	90	665.	578.	8.
*0640	anterior interbody technique	90	376.	327.	8.
*0641	lumbar or thoracic region, posterior, posterior-lateral, or posterior interbody technique	90	665.	578.	7.
*0642	anterior interbody technique	90	489.	408.	7.
0643	Spinal fusion for scoliosis, child or young adult (less than 18 years of age), up to and including five interspaces	90	936.	814.	13.
0644	Harrington rod technique	90	936.	814.	13.
0645	Halo technique	90	936.	814.	9.
	(For adult scoliotic fusion see 0634-0642.)				
0647	Scapulopexy	90	274.	260.	6.
0648	Patellapexy	90	211.	184.	4.
0649	Pectus excavatum, infants, plastic repair (Funnel Breast)	90	211.	184.	3.
0650	Pectus excavatum (major) plastic repair (Funnel Breast)	90	BR	BR	11.
0654	Epiphyseal - diaphyseal fusion; epiphyseal arrest; epiphysiodesis or stapling; femur	90	242.	210.	4.
0655	tibia and fibula, proximal or distal	90	242.	210.	4.
0656	combined distal femur and proximal tibia and fibula (knee)	90	302.	263.	4.
0657	combined proximal and distal, tibia and fibula	90	302.	263.	3.
0658	combined distal femur and proximal and distal tibia and fibula	90	439.	382.	3.
0660	Hemi-epiphyseal arrest (e.g. for genu varus or genu valgus) distal femur (For removal and re-insertion of staples at same operation, use values listed above.) (For removal of staples only, 50% of listed values.) (Freeing of bone adhesions, callus or synostosis, independent procedure, see Ostectomy.)	90	197.	172.	3.

Fractures

SKULL

0681	Skull, non-operative (Depressed with operation, see 5018, 5020.)	0	40.	35.	
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*See Medicaid Second Opinion Program NJHSP Newsletter, Volume P-339.

**SURGERY
MUSCULOSKELETAL**

SURGERY

	<u>Follow- Up Days</u>	<u>Surg. Value</u> S \$ NS		<u>Anes. Basic Units</u>	
1344	Knee (femoral-tibial joint), simple, closed reduction	45	90.	79.	3.
1345	compound with uncomplicated soft tissue closure	45	91.	79.	3.
1346	simple or compound, open reduction	90	218.	189.	4.
1350	Patella, simple, closed reduction	0	72.	63.	3.
1351	compound with uncomplicated soft tissue closure	45	55.	47.	3.
1352	simple or compound, open reduction (with or without partial or total patellectomy)	90	211.	184.	3.
	(See also 0561, 1206 and 1632.)				
1354	Distal tibial-fibular joint (ankle mortise), open reduction and fixation	90	164.	142.	3.
1355	Ankle, simple, closed reduction	45	61.	53.	3.
1356	compound, with uncomplicated soft tissue closure	45	152.	131.	3.
1357	simple or compound, open reduction	90	305.	263.	3.
1361	Tarsal, simple, closed reduction	45	61.	53.	3.
1362	compound, with uncomplicated soft tissue closure	45	107.	92.	3.
1363	simple or compound, open reduction	90	211.	184.	3.
1371	Astragalo-tarsal, simple, closed reduction	45	61.	53.	3.
1372	compound with uncomplicated soft tissue closure	45	107.	92.	3.
1373	simple or compound, open reduction	90	211.	184.	3.
1376	Metatarsal, one bone, simple, closed reduction	45	61.	53.	3.
1377	compound with uncomplicated soft tissue closure	45	104.	91.	3.
1378	simple or compound, open reduction	90	121.	105.	3.
1385	Toe, one, simple, closed reduction	0	13.	11.	3.
1386	compound with uncomplicated soft tissue closure	45	18.	16.	3.
1387	simple or compound, open reduction	60	47.	40.	3.
1391	multiple joints and/or toes, simple, closed reduction	30	18.	16.	3.
1392	compound with uncomplicated soft tissue closure	45	30.	27.	3.
1393	simple or compound, open reduction	30	51.	45.	3.
	Bursae				

INCISION

1401	Drainage of infected bursa (puncture for aspiration)	0	13.	11.	3.
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SURGERY

		Follow- Up Days	Surg. Value S \$ NS		Anes. Basic Units
1406	Removal of subdeltoid calcium deposits	60	151.	131.	4.
1410	Removal of subtrochanteric calcium deposits	60	121.	105.	3.
1413	Needle puncture of bursa, with or without aspiration, injection or irrigation, initial or subsequent	0	25.	15.	3.

(for calcification
excluding injection)

EXCISION

1430	Radical excision of bursa, hand, wrist or forearm, (i.e., tenosynovitis fungosa, Tbc., and other granulomas)	60	226.	197.	3.
1431	Excision of bursa, olecranon	60	90.	79.	3.
1433	prepatellar, or Achilles tendon	60	90.	79.	3.
1435	subacromial (subdeltoid)	60	113.	99.	3.
1436	peritrochanteric, femur (For popliteal see 1562.)	60	121.	105.	3.

Muscles

INCISION

1450	Removal of foreign body in muscle, with anesthesia, includes hematoma (other than by needle aspiration)	7	51.	45.	3.
1451	Incision and drainage of deep tissue abscess or hematoma, or complicated wound revision, with or without insertion of drains, packing, etc., with or without closure. (Please submit operative report with this claim.)	30	BR	BR	3.
1452	Myocutaneous flap procedure for plastic reconstruction of major defect; includes preparation of site and all associated procedures; (this code may be used for major post mastectomy breast reconstruction).	90	452.	NA	13.
	NOTE: If a free graft is required for a donor site, then a 20% increase in fee is allowed.				
1453	Myocutaneous flap procedure for plastic reconstruction of moderate defects (ischial ulcers, etc.); includes preparation of site and all associated procedures including care of donor site.	90	375.	NA	8.
1454	Division of scalenus anticus, without resection of cervical rib	60	211.	184.	5.
1456	with resection of cervical rib	60	272.	236.	6.
1458	Division of sternocleidomastoid for torticollis, open operation	60	151.	131.	5.
1460	Muscle biopsy, superficial	0	30.	26.	3.
1462	deep	0	61.	53.	3.

SUTURE

{	*1495	Suture of ruptured diaphragm chronic, transabdominal (hiatal hernia)	90	362.	315.	7.
	*1496	transthoracic or combined	90	423.	368.	13.
	1497	acute, traumatic	90	518.	449.	13.

(For other specific muscles, see 1633, 1640, 1654.)

Tendons, Tendon Sheaths and Fascia

INCISION

1511	Drainage of tendon sheath acute suppurative tenosynovitis, one digit	0	24.	21.	3.
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*See Medicaid Second Opinion Program NJHSP Newsletter, Volume P-329.

**SURGERY
CARDIOVASCULAR**

SURGERY

		Follow- Up Days	Surg. Value S \$ NS	Anes. Basic Units
2364	Pump team - open heart surgical procedure (physician only) verified by the record-by the hour	0	35. NA	0.
2365	Coronary artery end-arterectomy or by-pass graft, triple jump or three vessel repair or four vessel repair, or three vessel repair with associated cardiac surgery procedure	90	1560. NA	20.
2366	Pulmonic valvuloplasty or augmentation of outflow tract (gusset) with or without commissurectomy or infundibular resection	90	980. NA	20.
2367	Tricuspid valvuloplasty, open or replacement	90	1025. NA	20.
2368	Valvuloplasty, two valves	90	1440. NA	20.
2369	Valvuloplasty, three valves	90	1640. NA	20.

PACEMAKER PROCEDURES

TEMPORARY

2321	Pacemaker electrode insertion <u>Temporary Transvenous</u> . (External Cardiac Pacemaker) <u>MEDICAL COMPONENT ONLY</u> : includes placement or medical supervision of placement of electrodes, voltage regulation, monitoring and all other medical care if rendered by attending physician)	0	110. NA	6.
2338	Pacemaker electrode insertion, <u>Temporary, Transvenous</u> (external cardiac pacemaker) <u>SURGICAL COMPONENT ONLY</u>	7	123. NA	6.
2339	Insertion of temporary (transvenous) electrode and/or cardiac pacemaker-external pacemaker. <u>ONE PHYSICIAN PERFORMING ENTIRE PROCEDURE</u> . For adjustment or removal use PRV 0003, "follow-up hospital visit". Claims for Assistant Surgeon or stand-by internist will be disallowed.	0	246. NA	6.
2356	Pacemaker insertion, <u>internal, permanent</u> pacemaker with myocardial (epicardial) electrodes by " <u>transthoracic incision</u> " or " <u>thoracotomy</u> ", initial or subsequent total replacement (when total removal prior to subsequent insertion of a pacemaker at a new site, add 50% of value of Code. 2357 and combine surgeries.) One Surgical Assistant at 15% of the fee is allowed. Only the assistant internist or assistant cardiologist is eligible for follow-up care. For cardiologist monitoring, see Code 9071. <u>OPERATIVE REPORT IS REQUESTED.</u>	90	328. NA	20.
2357	Replacement or repair of battery generator, revision of battery pocket, etc. (Sub-total replacement or repair)	30	245. NA	6.
2358	Pacemaker insertion, Uni-Polar or Bi-Polar, <u>Transvenous Catheter</u> with permanent pacemaker insertion by surgery, <u>initial subsequent total replacement</u> (when total removal prior to subsequent insertion of pacemaker at a new site, add 50% of value of Code 2359 and combine surgeries). One Surgical Assistant at 15% of the fee is allowed. Only the assistant internist or assistant cardiologist is eligible for follow-up care.	90	328. NA	6.
2359	Replacement or repair of electrodes, battery generator, revision of battery pocket, etc. (Sub-total replacement or repair)	30	144. NA	6.

**SURGERY
CARDIOVASCULAR**

SURGERY

		<u>Follow- Up Days</u>	<u>Surg. Value S \$ NS</u>	<u>Anes. Basic Units</u>	
INCISION					
{	2375	Arteriotomy with removal of thrombus or embolus, one or more fragments, any site.	60	275. NA	6.
	2388	Temporal artery resection; (this code may be used for simple resection of other accessible peripheral arteries) for suture, ligation, etc., use PRV 2511.	30	205. NA	5.
	2389	Temporal artery biopsy; (applicable to simple biopsies of other accessible arteries and veins) independent procedure.	0	72. NA	3.
VENOUS THROMBECTOMY, DIRECT OR WITH CATHETER					
{	2380	Thrombectomy, direct or with catheter; vena cava, iliac vein, by abdominal incision. (For ligation and division of inferior vena or insertion of Mobin-Udin umbrella, use PRV 2525).	60	383. NA	6.
	2381	vena cava, iliac femoropopliteal vein, by leg incision. (For combined abdominal and leg approach use PRV 2380 at 100% and PRV 2381 at 50%.)	60	246. NA	5.
	2382	axillary and subclavian vein, by arm incision	60	234. NA	5.
	2384	subclavian vein by neck incision	30	168. NA	5.
THROMBOENDARTERECTOMY					
(For Coronary Artery, See PRV 2349, 2362-2365)					
{	2390	Abdominal aorta and iliac arteries and/or femoral arteries	90	677. NA	20.
	2392	femoral and/or popliteal arteries NOTE: For uncomplicated or localized incisional revision of peripheral artery; for arteriosclerotic plaque, use PRV 2375.	90	472. NA	10.
{	2393	Subclavian, innominate by <u>thoracic incision</u>	90	723. NA	10.
	2394	carotid artery, vertebral, subclavian, by neck incision	90	615. NA	10.
Explanation of additional arteries performed in conjunction with PRV 2390 (e.g. mesenteric, celiac and renal) or with PRV 2392 (distal popliteal or tubioperoneal) may require medical review for higher level of reimbursement.					
DIRECT REPAIR OF ANEURYSM					
(Partial or Total) and Graft Insertion or By-Pass Graft for Aneurysm, False Aneurysm, or Occlusive Disease					
{	2401	Direct repair of aneurysm or excision (partial or total) and graft insertion (with or without patch graft) for aneurysm or occlusive disease; carotid or subclavian artery, by neck incision	90	650. NA	6.
	2402	axillary - brachial artery, by arm incision	90	410. NA	6.
	2405	innominate, subclavian artery, by thoracic incision	90	820. NA	20.
	2406	Ascending aorta arch graft, with bypass, with or without valve suspension	90	1150. NA	20.
	2407	with valve replacement	90	1440. NA	20.

**SURGERY
CARDIOVASCULAR**

SURGERY

		Follow- Up Days	Surg. Value S \$ NS	Anes. Basic Units
2408	abdominal aorta, including iliac vessels	90	759. NA	15.
2409	Transverse aortic arch graft, with bypass	90	1530. NA	20.
2410	Descending aortic arch (thoracic graft without bypass)	90	620. NA	15.
2411	with bypass	90	620. NA	15.
2412	Femoral-popliteal bypass graft. (See PRV 2413 and 2414 for other major types of bypasses involving the femoral artery.)	90	554. NA	8.
	NOTE: There are many anatomical variations of this surgical procedure which are included in this code. Claims accompanied by documentation of highly complex procedures may require medical review for higher level reimbursement.			
2413	Axillary to femoral by-pass graft	90	555. NA	20.
2414	Femoral to femoral by-pass graft	90	555. NA	20.
2415	Splenic Artery	90	680. NA	13.
2416	Hepatic, celiac or Mesenteric Artery	90	840. NA	13.
2417	Renal Artery, unilateral	90	760. NA	13.
2418	Renal Artery, bilateral	90	905. NA	13.
2419	iliac artery	90	660. NA	13.
2420	common femoral; femoral and branches thereof; popliteal	90	555. NA	5.
2422	A-V Fistula, Neck	60	410. NA	6.
2423	chest	90	675. NA	11.
2424	abdomen	90	675. NA	13.
2425	extremity	60	410. NA	5.

INJECTION PROCEDURE

INTRAVENOUS

2440	Injection procedure for venography, etc. needle or intracatheter, unilateral	0	30. NA	3.
2426	bilateral	0	50. NA	3.
2427	Catheter, by placement in superior or inferior vena cava, right heart or pulmonary artery. (Use this code for insertion of Hickman Catheter or equivalent.)	0	85. NA	3.
2428	by selective catheterization of renal adrenal, hepatic etc., vein	0	127. NA	3.
2433	Injection procedure for intraosseous venography	0	36. NA	5.

INTRA-ARTERIAL -- INTRA-AORTIC

2435	Injection procedure, needle or intra-catheter technique carotid or vertebral, unilateral	0	103. NA	5.
2436	bilateral	0	154. NA	5.
2430	Retrograde brachial	0	110. NA	5.
2434	Injection procedure for angiography extremity (percutaneous needle)	0	62. NA	5.

**SURGERY
CARDIOVASCULAR**

SURGERY

		Follow- Up Days	Surg. Value S \$ NS		Anes. Basic Units
2437	Injection procedure for aortography, translumbar	0	70.	NA	5.
2438	Catheter technique aorta, (arch abdominal midstream renal, aortic-iliac run-off etc.)	0	95.	NA	5.
2447	Cerebral, selective, <u>single</u> artery	0	110.	NA	5.
2449	Multiple cerebral arteries with or without midstream arch injection	0	155.	NA	5.
2336	Injection procedure for coronary arteriography (Sonnes or comparable technique) (See Page 55)	90	153.	NA	7.
2439	Injection procedure-renal celiac, mesenteric, splanchnic arch, single artery, with or without midstream injection, with or without aortography	0	115.	NA	5.
2431	Renal Artery Embolization Selective Embolization for therapeutic purpose and including the following: 1. Contrast study before and after therapeutic injection. 2. Surgical procedure. 3. Radiologic procedure (S & I). 4. Pre and post-operative care.	0	257.	NA	5.
	NOTE: Excludes angiography of other vessels.				
2429	bilateral renal or other arteries	0	135.	NA	5.
2441	Venapuncture, withdrawal of venous blood, intravenous injection (femoral, internal or external jugular or sagittal sinus) for diagnostic study or introduction of intravenous therapy, up to three years of age	0	13.	11.	0.
2442	scalp vein, for fluid therapy or indirect transfusion, up to three years of age	0	18.	16.	0.
2443	Exposure of an incision into vein (" <u>cutdown</u> ") for fluid therapy or indirect transfusion, under one year of age	0	24.	21.	0.
2444	over one year of age	0	18.	16.	0.
2445	Blood transfusion, indirect method	0	13.	11.	0.
2446	replacement type, infant initial or subsequent	0	151.	NA	0.
2448	direct method (umbilical catheter)	0	30.	26.	0.
2450	"push" transfusion given under two years of age	0	30.	26.	0.
2451	Arterial cutdown by attending or consultant physician; for arterial puncture, see code 9150; for arterial catheterization percutaneous approach, use code 9158. (Independent procedure)	0	61.	52.	0.
2452	Central Venous Pressure Catheter per Operative Venotomy (C.V.P.)	0	45.	NA	5.
2454	Injection of sclerosing solution into vein of leg, one	0	10.	8.	0.
2455	two or more injections, same leg	0	18.	16.	0.
	REPAIR				
2460	Repair aneurysm of aorta, lateral repair (for repair by graft use PRV 2408)	90	1025.	NA	0.
2464	Creation of aorto-pulmonary window, with or without bypass.	90	1025.	NA	20.

**SURGERY
CARDIOVASCULAR**

SURGERY

	<u>Follow- Up Days</u>	<u>Surg. Value S \$ NS</u>	<u>Anes. Basic Units</u>
2466 Banding of pulmonary artery	90	410. NA	20.
2472 Repair of aortic arch anomalies (vascular ring)	90	615. NA	20.
2473 Repair of atrial septal defect	90	980. NA	20.
2475 Excision of coarctation of aorta with primary anastomosis (See also 2400-2408)	90	615. NA	20.
2478 Pulmonary-subclavian anastomosis, Potts	90	615. NA	20.
2482 Blalock-Taussig procedure subclavian to pulmonary artery shunt	90	615. NA	20.
2486 Pulmonary superior vena caval anastomosis, Glenn	90	615. NA	20.
2487 Baffes Procedure: inferior vena cava to left atrium-right pulmonary vein to right atrium	90	1148. NA	20.
2489 Leveen or peritoneal Superior vena caval shunt	60	410. NA	5.
2490 Portocaval anastomosis	90	677. NA	10.
2496 Splenorenal anastomosis	90	677. NA	10.

SUTURE

2511 Arteriorrhaphy: suture, ligation, exploration, minor plastic revision, or lysis of wound, injury or disease of major artery, chest or abdomen. For incisional arteriotomy with removal of local plaque, use PRV 2375.	60	410. NA	10.
2512 extremity	30	246. NA	10.
2513 neck	30	205. NA	8.
2514 Percutaneous transluminal angioplasty of peripheral arteries	30	302. NA	5.
2515 Phleborrhaphy; suture of wound or injury of vein (independent procedure), trunk	60	410. NA	10.
2516 extremity	30	123. NA	8.
2520 Ligation and division of ductus arteriosus	60	410. NA	15.
2522 Ligation of carotid artery	30	205. NA	6.
2525 Ligation and division of inferior vena cava (Mobin-Udin Procedure)	90	410. NA	10.
*2526 Ligation of femoral vein	30	103. NA	4.
2530 Ligation and division of common iliac vein	90	238. NA	8.
2558 Ligation and division of long saphenous vein at sapheno-femoral junction, with or without retrograde injection or distal interruptions	30	103. NA	3.
2561 Ligation and division and complete stripping of long or short saphenous veins, unilateral	30	144. NA	3.
2562 bilateral	30	222. NA	3.
2563 long and short saphenous veins, unilateral	30	205. NA	3.

*See Medical Necessity Program NJHSP Newsletter Volume No. P-217

**SURGERY
CARDIOVASCULAR**

SURGERY

		<u>Follow- Up Days</u>	<u>Surg. Value</u>		<u>Anes. Basic Units</u>
			<u>S</u>	<u>NS</u>	
2565	bilateral	30	308.	NA	3.
2576	Ligation and division of short saphenous vein at saphenopopliteal junction (independent procedure)	30	54.	NA	3.
2581	minor varicose vein of leg, initial	15	31.	NA	3.
2585	subsequent	15	29.	NA	3.

**SURGERY
DIGESTIVE**

SURGERY

		Follow- Up Days	Surg. Value		Anes. Basic Units
			S	NS	
2899	alveolar ridge, anterior palate defect	90	101.	88.	6.

(For secondary minor revision see 0260-0270, 0277-0283.)

SUTURE

(For suture of palate injury see 0260-0270, 0277-0283.)

Salivary Glands and Ducts

INCISION

2911	Drainage of parotid abscess	0	42.	37.	3.
2912	Drainage of submaxillary abscess	0	42.	37.	3.
2914	Sialolithotomy, submaxillary or parotid, uncomplicated	0	29.	26.	3.
2915	Sialolithotomy, submaxillary, complicated	30	60.	53.	4.
2916	Sialolithotomy, parotid, extraoral	30	121.	105.	4.

EXCISION

2921	Biopsy of salivary gland	30	29.	26.	3.
2927	Excision of parotid tumor or gland, superficial, without nerve dissection	60	182.	158.	5.
2928	with nerve dissection	60	242.	210.	5.
2934	Excision of parotid gland, total, with dissection of facial nerve	60	362.	315.	5.
2937	with sacrifice of facial nerve	60	242.	210.	5.
2938	Excision of submaxillary tumor and/or gland	60	182.	158.	5.

REPAIR (Sialodochoplasty)

2941	Plastic repair of salivary duct, simple	60	151.	131.	5.
2942	complicated	60	215.	187.	5.

INTRODUCTION

2945	Injection procedure for sialography	0	13.	11.	3.
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SUTURE

2951	Closure of salivary fistula	60	151.	131.	5.
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MANIPULATION

2961	Dilation of salivary duct; ptyalectasis	0	13.	11.	3.
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Pharynx, Adenoids and Tonsils

INCISION

2970	Drainage of peritonsillar abscess	0	37.	32.	5.
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**SURGERY
DIGESTIVE**

SURGERY

		Follow- Up Days	Surg. Value		Anes. Basic Units
			S	NS	
2971	Drainage of retropharyngeal or parapharyngeal abscess, intraoral	0	61.	53.	5.
2973	external approach	0	151.	131.	5.

EXCISION

2981	Biopsy of oropharynx	0	18.	16.	3.
2982	hypopharynx	0	29.	26.	3.
2983	nasopharynx	0	39.	26.	3.

(For larynx, see 2070 or 2073.)

2984	Excision of pharyngoesophageal diverticulum, single stage (Zenker's Diverticulectomy)	90	252.	218.	6.
2985	multiple stages	90	302.	263.	6.
2989	Excision branchial cleft cyst or vestige, confined to skin and subcutaneous tissues	30	90.	79.	5.
2990	extending beneath subcutaneous tissues	30	211.	184.	5.

*2992 Tonsillectomy with or without adenoidectomy, under age 12 years

*2993 12 years or over

*2994 Adenoidectomy (independent procedure), primary or secondary

*3000 Excision of tonsil tag(s), hospital

3002 office

3004 Excision of lingual tonsil (independent procedure)

3005 Excision of nasopharyngeal fibroma

SUTURE

3006 Suture of wound or injury of pharynx

3007 Control of secondary hemorrhage following tonsil surgery

REPAIR

3011 Pharyngoplasty: plastic or reconstructive operation on pharynx

(For pharyngeal flap, see 2898.)

Esophagus

INCISION

3031 Esophagotomy, cervical (Insertion of endo-esophageal tube by laparotomy).

*See Medicaid Second Opinion Program NJHSP Newsletter, Volume No. P-329.

**SURGERY
DIGESTIVE**

SURGERY

		<u>Follow- Up Days</u>	<u>Surg. Value</u> <u>S \$ NS</u>		<u>Anes. Basic Units</u>
REPAIR					
3420	Anoplasty: plastic operation for stricture	90	242.	210.	4.
3421	infant, minor thin septum	0	26.	22.	4.
3422	Construction of anus for congenital absence, perineal approach	90	264.	229.	6.
3423	combined abdominal and perineal approach	90	421.	366.	7.
3425	Sphincteroplasty, anal, for incontinence	90	242.	210.	4.
3426	muscle transplant	90	301.	263.	4.
3427	Thiersch procedure for incontinence and/or prolapse	30	150.	131.	4.
DESTRUCTION					
3433	Condyloma, single or multiple internal and external, in hospital	30	147.	126.	4.
3434	external, electrodesiccation, initial	0	37.	32.	3.
3435	subsequent	0	6.	5.	3.
Liver					
INCISION					
3456	Aspiration biopsy of liver	0	30.	26.	3.
3458	Wedge Biopsy of Liver by laparotomy (independent procedure)	45	211.	184.	3.
EXCISION					
3464	Hepatectomy, partial: resection of liver	45	393.	341.	13.
REPAIR					
3471	Marsupialization of cyst or abscess of liver	60	272.	236.	7.
SUTURE					
3481	Hepatorrhapy: suture of liver wound or injury	45	272.	236.	7.
Biliary Tract					
INCISION					
3491	Hepaticotomy or hepaticostomy with exploration, drainage or removal of calculus	45	393.	341.	7.
3496	Choledochotomy or choledochostomy with exploration, drainage or removal of calculus, with or without cholecystotomy	45	332.	289.	7.
3500	Duodenocholedochotomy: transduodenal choledocholithotomy	45	393.	341.	7.
3501	Transduodenal sphincterotomy	45	393.	341.	7.

**SURGERY
DIGESTIVE**

SURGERY

		Follow- Up Days	Surg. Value		Anes. Basic Units
			S	NS	
3504	Cholecystotomy or cholecystostomy with exploration, drainage or removal of calculus	45	242.	210.	7.
*3505	Biliary Duct Stone Extraction via T-Tube tract, basket, snare or other instrumentals removal. (Burhenne technique); complete procedure	0	75.	64.	3.

INTRODUCTION

3509	Injection procedure for percutaneous trans-hepatic cholangiography (independent procedure)	0	43.	37.	3.
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EXCISION

*3515	Cholecystectomy	45	302.	263.	7.
*3516	Cholecystectomy with operative cholangiogram	45	314.	273.	7.
*3517	with open exploration of common duct	45	362.	315.	7.

REPAIR

3518	Exploration for congenital atresia of bile ducts	45	252.	218.	7.
3519	Direct anastomosis of gallbladder and gastro-intestinal tract (i.e., cholecystojejunostomy)	60	302.	263.	7.
3520	Roux-en-y anastomosis of gallbladder and gastro-intestinal tract	60	328.	284.	7.
3521	Direct anastomosis of extrahepatic biliary ducts and gastro-intestinal tract (i.e., Choledochodudenostomy)	90	362.	315.	7.
3522	Roux-en-y anastomosis of extrahepatic biliary ducts and gastro-intestinal tract	90	428.	371.	7.
3523	Plastic reconstruction of extrahepatic biliary ducts with end-to-end anastomosis	90	453.	394.	7.

Pancreas

INCISION

3541	Abdominal drainage of pancreatitis	60	242.	210.	7.
3544	Removal of calculus	60	393.	341.	7.

EXCISION

3550	Pancreatectomy, subtotal	60	332.	289.	7.
3551	subtotal (Whipple type)	60	483.	420.	7.
3552	total	60	483.	420.	7.
3553	Pancreatico-jejunostomy	60	302.	263.	7.

REPAIR

3565	Marsupialization of cyst of pancreas	60	302.	263.	7.
3566	Internal direct anastomosis of cyst to gastro-intestinal tract	60	302.	263.	7.

*See Medicaid Second Opinion Program NJHSP Newsletter, Volume No. P-329.

**SURGERY
DIGESTIVE**

SURGERY

3567 Roux-en-y internal anastomosis, cyst to gastro-intestinal tract

Follow-
Up
Days

Surg. Value
S \$ NS

Anes.
Basic
Units

60

302. 263.

7.

Abdomen, Peritoneum and Omentum

INCISION

3571 Exploratory Laparotomy: Exploratory celiotomy (Do not use this PRV when any other definitive surgery is performed/nor any 50% allowance.)

45

211. 184.

6.

3573 Drainage of peritoneal abscess or localized peritonitis exclusive of appendicular abscess

45

217. 189.

6.

3575 Subdiaphragmatic or subphrenic abscess

45

272. 236.

7.

3578 Retroperitoneal abscess

45

217. 189.

6.

3588 Peritoneocentesis: abdominal paracentesis, initial

0

30. 26.

3.

3590 subsequent

0

18. 16.

3.

EXCISION

3591 Trans-peritoneal excision of intra-abdominal or retroperitoneal tumors or cysts

60

380. 331.

6.

ENDOSCOPY

3595 Peritoneoscopy

15

85. 74.

4.

3596 Laparoscopy, by fiberoptic instrument, diagnostic with or without associated minor surgical procedure

15

121. 105.

6.

INTRODUCTION

3611 Pneumoperitoneum: intraperitoneal injection of air, initial

0

30. 26.

3.

3612 subsequent

0

13. 11.

3.

*3614 Injection procedure for retroperitoneal pneumography, unilateral or bilateral (independent procedure)

0

30. 26.

3.

3615 Injection procedure for pelvic pneumography (independent procedure)

0

26. 22.

3.

(See also 4462.)

REPAIR

HERNIOPLASTY, HERNIORRHAPHY, HERNIOTOMY:

** 3631 Inguinal, unilateral

45

182. 158.

4.

** 3632 Inguinal, bilateral

45

272. 236.

4.

** 3633 " unilateral with orchiectomy

45

211. 184.

4.

** 3634 " unilateral with excision of hydrocele (scrotal)

45

193. 168.

4.

** 3635 " unilateral, recurrent

45

211. 184.

4.

*See Medical Necessity Program NJHSP Newsletter, Volume No. P-217

** See Medicaid Second Opinion Program NJHSP Newsletter, Volume No. P-339.

**SURGERY
DIGESTIVE**

SURGERY

		Follow- Up Days	Surg. Value		Anes. Basic Units	
			S	NS		
{	**3646	Femoral, unilateral	45	182.	158.	4.
	**3651	recurrent	45	211.	184.	4.
	**3661	Ventral, incisional	45	211.	184.	6.
	**3662	recurrent	45	234.	204.	6.
	**3663	Epigastric (Spigelian)	45	151.	131.	4.
	**3664	recurrent	45	193.	169.	4.
	3665	Umbilical, under age five years	45	155.	134.	4.
{	**3666	over age five years	45	182.	158.	4.
	3667	Omphalocele, in newborn, one stage	45	207.	180.	6.
	3668	Gross type procedure, first stage	60	259.	225.	7.
	3669	second stage	60	259.	225.	7.
		(For diaphragmatic hernia, see 1495, 1496.)				
	3730	Abdominal Panniculus, resection of	45	182.	158.	7.
SUTURE						
	3734	Secondary suture of abdominal wall for evisceration or disruption	30	121.	105.	7.
		(For suture of ruptured diaphragm, see 1495, 1496.)				

**See Medicaid Second Opinion Program NJHSP Newsletter, Volume No. P-339.

**SURGERY
URINARY**

SURGERY

URINARY SYSTEM

**Follow-
Up
Days**

**Surg. Value
S \$ NS**

**Anes.
Basic
Units**

Kidney

INCISION

3802	Drainage of perirenal abscess (independent procedure)	90	272.	236.	6.
3806	Nephrotomy with exploration	90	393.	341.	6.
3808	Nephrotomy with drainage; nephrostomy	90	393.	341.	6.
3811	Nephrolithotomy, removal of calculus	90	302.	263.	6.
3812	large (staghorn) calculus	90	340.	294.	6.
3813	Division or transection of aberrant renal vessels (independent procedure)	90	332.	289.	6.
3815	Pyelotomy with exploration	90	393.	341.	6.
3816	Pyelotomy with drainage, pyelostomy	90	393.	341.	6.
3817	Pyelotomy with removal of calculus; pyelolithotomy; pelviolithotomy	90	393.	341.	6.

EXCISION

3819	Renal biopsy, by surgical (incisional) exposure of the kidney, any surgical approach; independent procedure	30	155.	132.	4.
3820	Renal biopsy, trochar or needle	0	30.	26.	3.
<u>3821</u>	Nephrectomy, including partial ureterectomy	90	393.	341.	6.
3822	with total ureterectomy through same or separate incision	90	483.	420.	7.
3824	Heminephrectomy	90	332.	289.	6.
3827	Excision of cyst of kidney	90	362.	315.	6.
3829	Aspiration or injection of renal cyst or renal pelvis	0	30.	26.	3.

INTRODUCTION

(For perirenal insufflation, unilateral or bilateral, see 3614.)

REPAIR

3830	Nephrostomy Tube Replacement not performed with other surgery, with or without dilation (limited to office, home or sheltered boarding home visit setting and including physician's cost of catheter).	0	15.	13.	3.
3831	Pyeloplasty: Plastic operation on renal pelvis with or without plastic operation on ureter or nephropexy	90	423.	368.	6.
*3835	Nephropexy: fixation or suspension of kidney (independent procedure)	90	302.	263.	6.
3841	Nephrorrhaphy: suture of kidney wound or injury	90	393.	341.	6.

*See Medical Necessity Program NJHSP Newsletter, Volume No. P-217

**SURGERY
URINARY**

SURGERY

	Follow-Up Days	Surg. Value		Anes. Basic Units
		S	NS	
3845 Closure of nephrostomy, pyelostomy or other renal fistula (e.g., renocolic fistula)	90	272.	236.	6.
3846 Symphysiotomy for horseshoe kidney	90	339.	295.	6.
3848 Renal Homo-Transplantation, Implantation of Graft, Excluding Donor and Recipient Nephrectomy	60	720.		6.
3849 Renal Homo-Transplantation; with Unilateral or Bilateral Recipient Nephrectomy	60	1200.		6.

Ureter

INCISION

3851 Ureterotomy with exploration or drainage (independent procedure)	90	362.	315.	6.
3852 Renal Homo-Transplantation; with Splenectomy	60	960.		6.
3853 Renal Homo-Transplantation; with Unilateral or Bilateral Recipient Nephrectomy and Splenectomy	60	1440.		6.
3854 Renal Homo-Transplantation, Reimplantation of Kidney	60	720.		6.
<u>3857</u> Ureterolithotomy, upper three quarters of ureter	90	362.	315.	6.
3858 lower one quarter	90	380.	331.	6.

EXCISION

3861 Ureterectomy, with bladder cuff (independent procedure)	90	393.	341.	6.
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REPAIR

3871 Ureteroplasty: plastic operation on ureter (stricture)	90	393.	341.	6.
3872 Ureterolysis, with or without repositioning of ureter, unilateral	90	237.	206.	6.
3873 bilateral	90	305.	265.	6.
3874 Ureteropyelostomy: anastomosis of ureter and renal pelvis	90	423.	368.	6.
3875 Ureteroureterostomy	90	423.	368.	6.
3876 Ureterocystostomy: anastomosis of ureter to bladder, unilateral	90	423.	368.	6.
3877 bilateral	90	513.	446.	6.
3880 Ureteroenterostomy: anastomosis of ureter to intestine, unilateral	90	423.	368.	6.
3881 bilateral	90	513.	446.	6.
3884 Ureterostomy: transplantation of ureter to skin, unilateral	90	362.	315.	6.
3885 bilateral	90	453.	394.	6.

SURGERY
FEMALE GENITAL

SURGERY

Oviduct

INCISION

		Follow- Up Days	Surg. Value		Anes. Basic Units
			S	NS	
{	4531	45	211.	184.	6.
	Primary Sterilization (Family Planning) Procedure by abdominal or vaginal approach (independent procedure)				
{	4532	45	151.	131.	6.
	Primary Sterilization (Family Planning) Procedure; post-partum during the same hospitalization and performed by any surgical method or approach by the same physician or group effecting the vaginal delivery (or abortion)				

EXCISION

4541	Salpingectomy, complete or partial unilateral or bilateral (independent procedure)	45	211.	184.	6.
4545	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (independent procedure)	45	242.	210.	6.

ENDOSCOPY

{	4549	45	182.	158.	6.
	Primary Sterilization (Family Planning) Procedure by laparoscopy or culdoscopy; with or without dilation and curettage (independent procedure)				

NOTE: Tubal surgery for primary sterilization performed at time of Caesarean Section carries no additional reimbursement.

REPAIR

4551	Salpingoplasty, unilateral or bilateral (independent procedure)	45	272.	236.	6.
4552	Surgical removal of polyethylene tubing secondary to salpingoplasty procedure by abdominal incision through peritoneum	15	61.	53.	3.
4553	Surgical removal of polyethylene tubing secondary to salpingoplasty procedure by abdominal incision extra-peritoneal	15	30.	26.	3.

Ovary

INCISION

4561	Drainage of ovarian cyst, vaginal approach, unilateral or bilateral	15	132.	114.	4.
4562	abdominal approach, unilateral or bilateral	45	242.	210.	4.
4564	Drainage of ovarian abscess, vaginal	15	106.	91.	4.
4565	abdominal approach	45	211.	184.	6.

EXCISION

4566	Biopsy of ovary, unilateral or bilateral (independent procedure)	45	211.	184.	6.
4568	Partial oophorectomy, bilateral or unilateral	45	242.	210.	6.
4569	Complete oophorectomy, unilateral or bilateral (independent procedure)	45	242.	210.	6.

Cervix Uteri

EXCISION

(For radical surgical procedures, see 4620, 4626.)

**SURGERY
FEMALE GENITAL**

SURGERY

	Follow-Up Days	Surg. Value		Anes. Basic Units
		S	NS	
4571 Biopsy or local excision of lesion, with or without fulguration, quadrant biopsy (independent procedure)	0	18.	16.	3.
4572 Cauterization of cervix; electro or thermal	0	13.	11.	3.
4573 Biopsy of cervix, circumferential (cone) with or without dilation and curettage, with or without Sturmdorff type repair	45	85.	74.	3.
4575 Trachelectomy: cervicectomy: amputation of cervix (independent procedure)	45	90.	79.	4.
4576 Cauterization of cervix; cryocautery, initial or repeat	0	24.	21.	3.
4577 total excision of cervical stump, with or without pelvic floor repair, abdominal approach	45	242.	210.	6.
4578 vaginal approach	45	242.	210.	4.
4579 Colposcopic examination without biopsy (Reimbursable only if one or more of the following guidelines are present, in which case a statement is to be written in 24D/E of the HCFA-1500/NJ claim form. (1) Patient must have a current pap smear reported as class 2 or higher or; (2) Patients who have had surgery for uterine cancer or; (3) Patients who were exposed in utero to Diethylstilbestrol).	0	21.	NA	
4580 Colposcopic examination with biopsy (Reimbursable only if one or more of the following guidelines are present, in which case a statement is to be written in 24D/E of the HCFA-1500/NJ claim form. (1) Patient must have a current pap smear reported as class 2 or higher or; (2) Patients who have had surgery for uterine cancer or; (3) Patients who were exposed in utero to Diethylstilbestrol).	0	34.	NA	

INTRODUCTION

4581 Insertion of any hemostatic agent for control of hemorrhage (independent procedure) (For insertion of any radioactive material see 7615.)	0	30.	26.	3.
4583 Insertion or removal of pessary for uterine support or prolapse or malposition - removal of I.U.D. (Intra-Uterine Device)	0	15.	15.	3.
4591 Insertion of intra-cervical or intra-uterine device for contraception (Includes cost of device and post-insertion visit)	30	34.	30.	3.
4592 Insertion of fletcher applicator for cesium implant, initial	15	72.	63.	3.
4593 subsequent	15	48.	42.	3.

**SURGERY
FEMALE GENITAL**

SURGERY

		Follow- Up Days	Surg. Value S \$ NS		Anes. Basic Units	
REPAIR						
4585	Tracheloplasty: surgical repair of incompetent cervix, loop type	0	90.	79.	4.	
4586	Shirodkar type	45	90.	79.	4.	
4587	Trachelorrhaphy, plastic repair of uterine cervix, vaginal approach	45	90.	79.	4.	
MANIPULATION						
4588	Dilation of cervical canal, instrumental (independent procedure)	0	30.	26.	3.	
4589	Dilation and curettement of cervical canal	15	72.	63.	3.	
Corpus Uteri						
EXCISION						
4610	Endometrial biopsy (independent procedure)	0	18.	16.	3.	
4613	Myomectomy: excision of fibroid tumor of uterus (independent procedure, non-obstetrical)	45	272.	236.	6.	
{	†4614	Total hysterectomy (corpus and cervix with or without tubes, and/or ovaries, one or both)	45	332.	289.	6.
	4615	Vabra Aspiration Biopsy	0	30.	28.	0.
	4616	Vakutage Aspiration Biopsy	0	28.	26.	0.
	4617	Gravilee Endometrial Biopsy	0	30.	28.	0.
{	†*4618	Supracervical hysterectomy: sub-total hysterectomy, with or without tubes, and/or ovaries, one or both	45	272.	236.	6.
	4620	Radical hysterectomy for cancer including regional lymph nodes	90	604.	525.	8.
	4626	plus removal of bladder and ureteral transplantations and/or abdomino - perineal resection of rectum and colon and colostomy or any combination thereof	90	753.	655.	8.
{	†4631	Vaginal hysterectomy	45	332.	289.	6.
	†4632	with plastic repair of vagina anterior and/or posterior colporrhaphy	45	332.	289.	6.
	†4634	with repair of enterocele	45	332.	289.	6.
INTRODUCTION						
(For insertion of radioactive substance into corpus with or without dilation and curettage, see 7615.)						
4675	Insufflation of uterus and tubes with air or CO2	0	30.	26.	3.	
4676	Injection procedure for hystero-salpingography	0	30.	26.	3.	

*See Medical Necessity Program NJHSP Newsletter, Volume No. P-217

†See Medicaid Second Opinion Program NJHSP Newsletter, Volume No. P-329

**SURGERY
FEMALE GENITAL**

SURGERY

		<u>Follow- Up Days</u>	<u>Surg. Value</u> <u>S \$ NS</u>		<u>Anes. Basic Units</u>
REPAIR					
*4683	Uterine suspension with or without shortening of round ligaments (independent procedure)	45	242.	210.	6.
*4684	with presacral sympathectomy	45	242.	210.	6.
4685	with interposition operation, with or without pelvic floor repair	45	242.	210.	6.
4690	with shortening of endopelvic fascia: parametrial fixation with or without pelvic floor repair (Manchester type)	60	272.	236.	6.
4692	with shortening of sacrouterine ligaments	45	242.	210.	6.
4694	Hysterosalpingostomy: anastomosis of tubes of uterus	45	211.	184.	6.
4695	Hysterorrhaphy: repair of ruptured uterus (non-obstetrical)	45	211.	184.	6.
Perineum					
EXCISION					
4710	Biopsy of perineum (independent procedure) (For excision of local lesion see 0175-0178, 0260-0324.)	0	18.	16.	3.
INCISION					
4720	Incision and drainage of perineal abscess (non-obstetrical)	0	30.	26.	3.
REPAIR					
4731	Perineoplasty: repair of perineum (independent procedure)	45	90.	79.	3.
4735	third degree laceration, old (independent procedure) (Also see 4441, 4480.)	45	211.	184.	3.
4742	Perineorrhaphy, post-partum, by other than delivering physician	0	90.	79.	3.
4745	Repair of perineal fistula (For repair of recent injury of perineum, non-obstetrical, see 4480.)	0	113.	99.	3.
4799	Amniocentesis - note indication (independent procedure)	0	37.	NA	

*See Medical Necessity Program NJHSP Newsletter, Volume No. P-217

**SURGERY
MATERNITY**

SURGERY

OBSTETRICAL SERVICES (MATERNITY)

Procedure codes are to be used regardless whether it is a single or multiple birth. All codes include pre-natal and post-natal care unless otherwise indicated.

INCISION

		<u>Follow- Up Days</u>	<u>Surg. Value S \$ NS</u>		<u>Anes. Basic Units</u>
4800	Classic caesarean section with pre-natal and post-partum care	45	369.	326.	7.
4801	Classic caesarean section	45	290.	257.	7.
4802	Low cervical (lower uterine segment) caesarean section; includes pre-natal and post-partum care	45	369.	326.	7.
4803	Caesarean section and hysterectomy (Porro); includes pre-natal and post-partum care	45	446.	394.	7.
4804	Extraperitoneal caesarean section (Waters, Latzko) Caesarean section, followed by hemorrhage and necessitating hysterectomy	45	369.	326.	7.
4809	with supracervical hysterectomy	45	483.	420.	7.
4810	with total hysterectomy	45	544.	473.	7.

EXCISION

4811	Removal of extrauterine pregnancy (ectopic pregnancy)	60	272.	236.	6.
4815	Removal of hydatidiform mole by dilation and curettage	90	121.	105.	3.
4819	Hysterotomy, for evacuation of pregnant uterus, prior to twenty-eight weeks of gestation, abdominal	45	272.	236.	6.

MANIPULATION

4821	<u>Total obstetrical care</u> includes:	60	236.	210.	4.
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- (1) Ante partum care consisting of initial ante partum visit and seven subsequent ante partum visits. Specific dates of all visits are to be listed on the HCFA-1500/NJ claim form.

NOTE: Reimbursement will be decreased by the fee for the initial ante partum visit (4825) if patient not seen for this visit. The total fee will also be decreased by the reimbursement sum for each subsequent ante partum visit (4823) which is less than seven.

NOTE: If medical necessity dictates, corroborated by the record, then additional visits above seven ante partum may be reimbursed under procedure code 0001 (routine or follow-up office visit). The claim form should clearly indicate the reason for the medical necessity and date for each 0001 listed.

**SURGERY
MATERNITY**

SURGERY

	Follow-Up Days	Surg. Value		Anes. Value		Anes. Basic Units
		S	NS	S	NS	
(2) Obstetrical delivery with in-hospital post-partum care (with or without low forceps and/or episiotomy of a vaginal delivery full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours). This shall also include one visit between the 15th and 60th post-partum day following delivery and out of hospital. Include delivery date on the HCFA-1500/NJ claim form.						
4822 <u>Obstetrical Delivery</u> with in-hospital post-partum care (with or without low forceps and/or episiotomy of a vaginal delivery full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours). This shall also include one visit between the 15th and 60th post-partum day following delivery and out of hospital. Include delivery date on the HCFA-1500/NJ claim form.	60	160.	144.			4.
4899 Caudal anesthesia (epidural block) limited to obstetrical cases <u>only</u> ; eligible for reimbursement only when given by other than the delivering physician.	0			51.	44.	
4823 Subsequent ante partum visits (independent procedure) Indicate specific dates of service.	0	8.	7.			
4824 Post-partum care (other than delivering physician) one visit between 15th and 60th post-partum day following delivery, out of hospital (independent procedure)	0	13.	11.			
4825 Initial ante partum visit (independent procedure)	0	22.	17.			
4826 Fetal Oxytocin Stress Test for placental insufficiency (This study is reimbursable <u>only</u> to the physician who is in direct physical attendance to the patient during the <u>complete</u> procedure, in a hospital in-patient or out-patient setting.) (Not reimbursable if patient goes into labor.)	0	30.	NA			
{ 4827 Fetal non-stress test for high risk pregnancy, limited to third trimester, in office setting				15.	NA	
NOTE: Complete diagnosis in standard nomenclature, gestational age with etiology of high risk must be clearly stated on the claim form.						
Claims for code 4827 and/or 4828 are limited to twice per pregnancy.						
{ 4828 Fetal non-stress test for high risk pregnancy, limited to third trimester, hospital outpatient department setting.				9.	NA	
NOTE: Complete diagnosis in standard nomenclature, gestational age with etiology of high risk must be clearly stated on the claim form.						
Claims for code 4827 and/or 4828 are limited to twice per pregnancy.						
Reimbursable only to the physician who is physically present during the test.						

**SURGERY
MATERNITY**

SURGERY

		<u>Follow- Up Days</u>	<u>Surg. Value</u> <u>S \$ NS</u>		<u>Anes. Basic Units</u>
ABORTION					
4830	Abortion: D & C/D & E, (including suction curettage) <u>1st Trimester</u>	45	79.	68.	3.
4831	Abortion: D & C/D & E, (including suction curettage) <u>2nd Trimester</u>	45	79.	68.	3.
4832	Abortion: Saline infusion of intra-amniotic solution (includes subsequent delivery or D & C/D & E) <u>1st Trimester</u>	45	79.	68.	3.
4833	Abortion: Saline infusion of intra-amniotic solution (includes subsequent delivery or D & C/D & E) <u>2nd Trimester</u>	45	79.	68.	3.
4834	Abortion: Abdominal Hysterotomy (includes tubal ligation or bilateral salpingectomy) <u>1st Trimester</u>	45	272.	236.	6.
4835	Abortion: Abdominal Hysterotomy (includes tubal ligation or bilateral salpingectomy) <u>2nd Trimester</u>	45	272.	236.	6.
4849	Manual removal of placenta by other than the physician effecting delivery	45	30.	26.	3.
4850	Abortion, first trimester, completed medically	30	42.	37.	3.
4851	(incomplete) completed surgically, (dilatation and curettage)	45	79.	68.	3.
4853	second trimester, completed medically	45	37.	32.	3.
4854	(incomplete) completed surgically, (dilatation and curettage)	45	79.	68.	3.
4856	missed, first or second trimester, completed medically or surgically	45	105.	91.	3.
4858	incomplete, septic, requiring dilatation and curettage and additional care	45	121.	105.	3.
4860	therapeutic, by dilatation and curettage	45	79.	68.	3.
4870	Dilatation and curettage of uterus for post-partum bleeding	45	72.	63.	3.

**SURGERY
CERTIFIED NURSE - MIDWIFE**

SURGERY

OBSTETRICAL SERVICES (MATERNITY/MIDWIFE)

For services rendered by more than one practitioner (e.g. physician or a certified nurse midwife in the employ of a physician or physician group), separate claim forms must be submitted for payment.

Follow-Up Days	Surg. Value		Anes. Basic Units
	S	NS	

4841 Total obstetrical care when given by a certified nurse midwife includes:

- | | | | | |
|---|----|----|--------|----|
| 1) Ante partum care consisting of initial ante partum visit and seven subsequent ante partum visits. <u>Specific dates of all visits are to be listed on the HCFA-1500/NJ claim form.</u> | 60 | NA | 165.20 | 4. |
|---|----|----|--------|----|

NOTE: Reimbursement will be decreased by the fee for the initial ante partum visit (4845) if patient not seen for this visit. The total fee will also be decreased by the reimbursement sum for each subsequent ante partum visit (4843) which is less than seven.

NOTE: If medical necessity dictates, corroborated by the record, then additional visits above seven ante partum may be reimbursed under procedure code 0009 (routine or follow-up office visit by certified nurse midwife). The claim form should clearly indicate the reason for the medical necessity and date for each 0009 listed.

- 2) Obstetrical delivery per vagina when performed by a certified nurse midwife with inhospital, home, or birthing center post-partum care, whichever applies, and with or without episiotomy. This applies to a vaginal delivery at full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours. This shall also include one visit between the 15th and 42nd post-partum day following delivery and out of the hospital. Include delivery date on the HCFA-1500/NJ claim form.

4842 <u>Obstetrical Delivery</u> per vagina when performed by a certified nurse midwife with inhospital, home, or birthing center post-partum care, whichever applies, and with or without episiotomy. This applies to a vaginal delivery at full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours. This shall also include one visit between the 15th and 42nd post-partum day, following delivery and out of hospital. Include delivery date of the HCFA-1500/NJ claim form.	60	NA	112.00	4.
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4843 Subsequent ante partum visits provided by a certified nurse midwife (independent procedure). Indicate specific dates of service.	0	NA	5.60	
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4844 Post-partum care provided by a certified nurse midwife (other than the delivering physician or certified nurse midwife) one visit between the 15th and 42nd post-partum day following delivery, out of hospital (independent procedure)	0	NA	9.10	
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4845 Initial ante partum visit provided by a certified nurse midwife (independent procedure)	0	NA	15.40	
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**SURGERY
CERTIFIED NURSE - MIDWIFE**

SURGERY

Follow- Up Days	Surg. Value S \$ NS	Anes. Basic Units
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SUPPLIES

{	4848 Home Delivery Pack. All drugs and supplies, etc., necessary for delivery in this setting.	0	NA	40.00
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OFFICE VISIT

{	0009 Office or home visit by certified nurse midwife applicable only when medical necessity warrants more than seven ante partum visits and is corroborated on the record.	0	NA	6.30
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CONTRACEPTIVE DEVICES

{	4846 Insertion of intracervical or intrauterine device for contraception by a certified nurse midwife (includes cost of device and post insertion visit)	0	NA	23.80
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NOTE: Limited to within 6 week post-partum period

{	4847 Removal of an IUD by a certified nurse midwife	0	NA	11.50
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NOTE: Limited to within 6 week post-partum period

**SURGERY
ENDOCRINE**

SURGERY

ENDOCRINE SYSTEM

Follow-Up Days	Surg. Value		Anes. Basic Units
	S	NS	

Thyroid Gland

INCISION

4904	Incision and drainage or aspiration of thyroglossal or thyroid cyst (includes aspiration biopsy)	0	48.	42.	4.
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EXCISION

4911	Local excision of small cyst or adenoma of thyroid (includes aspiration biopsy)	45	182.	158.	6.
4912	Total thyroid lobectomy, unilateral	45	272.	236.	6.
4914	Thyroidectomy, total or complete	45	332.	289.	6.
4917	subtotal or partial	45	302.	263.	6.
4924	total or subtotal for malignancy with radical neck dissection	90	573.	499.	6.
4925	total or subtotal for malignancy with limited neck dissection	90	386.	336.	6.
4937	secondary, unilateral	45	290.	252.	6.
4938	bilateral	45	338.	294.	6.
4941	Excision of thyroglossal duct, cyst or sinus	45	211.	184.	6.

**Parathyroid, Thymus, Pituitary, Pineal, Adrenal
Glands and Carotid Body**

(For hypophysectomy, see 2019 and 5130.)

EXCISION

4971	Parathyroidectomy or exploration of parathyroid	45	362.	315.	6.
4972	with mediastinal exploration with or without splitting of sternum	60	350.	303.	13.
4985	Adrenalectomy, transabdominal, lumbar or dorsal, unilateral	90	393.	341.	10.
4986	bilateral, one stage	90	415.	360.	10.
4987	two stages	90	498.	432.	10.
4989	Biopsy adrenal, unilateral	90	249.	215.	6.
4990	bilateral	90	290.	252.	6.
*4993	Excision of carotid body tumor, with excision of carotid artery	60	415.	360.	10.
*4994	without excision of carotid artery	60	362.	316.	6.

*See Medical Necessity Program NJHSP Newsletter, Volume No. P-217

**SURGERY
NERVOUS**

SURGERY

REPAIR

		<u>Follow- Up Days</u>	<u>Surg. Value</u>		<u>Anes. Basic Units</u>
			<u>S</u>	<u>\$ NS</u>	
5160	Ventriculocisternostomy	90	634.	551.	11.
5162	Repair of encephalocele	90	362.	315.	11.
5166	Ventriculoauricular shunt	90	362.	315.	11.
5167	replacement or irrigation of obstructed valve	90	326.	284.	11.
5168	replacement or irrigation of ventricular catheter	90	108.	95.	11.
5169	removal of shunt in toto without replacement	90	108.	95.	11.
5170	Ventriculo-auricular-peritoneal-pleural-ureteral shunt, co-surgeon, neurosurgical component	90	362.	315.	11.
5171	co-surgeon, abdominal surgical component		290.	252.	
5174	Craniectomy for craniostenosis, single suture	90	271.	236.	11.
5175	multiple sutures	90	362.	315.	11.

SPINE AND SPINAL CORD

INCISION

{	*5190	Laminectomy for decompression of the spinal cord and nerve roots (See also 5208-5210, 5225.)	90	665.	578.	10.
	5192	Cordotomy, cervico-dorsal	90	665.	578.	8.
{	5194	Rhizotomy: Division or transaction of nerve roots (by laminectomy). For percutaneous rhizotomy, use PRV 5255.	90	573.	499.	8.
	5198	Spinal puncture (spinal tap) lumbar, simple (independent procedure)	0	13.	11.	3.
	5199	diagnostic, initial, with study of hydrodynamics	0	18.	16.	3.

EXCISION

	5206	Laminectomy for lesion of spinal cord or meninges	90	694.	604.	8.
{	*5208	Laminotomy for removal of intervertebral discs, cervical	90	362.	315.	10.
	*5209	thoracic	90	362.	315.	10.
	*5210	lumbar	90	362.	315.	8.
	*5211	Excision of intervertebral discs, anterior approach, cervical	90	362.	315.	10.

(Also see 0634-0642)

INTRODUCTION

	5214	Injection procedure for myelography	0	61.	53.	4.
	5216	for discography	0	61.	53.	4.

*See Medicaid Second Opinion Program NJHSP Newsletter, Volume No. P-329

**SURGERY
NERVOUS**

SURGERY

		Follow- Up Days	Surg. Value		Anes. Basic Units	
			S	NS		
}	REPAIR					
	†5225	Laminectomy for spondylolisthesis (See also 5190)	90	435.	394.	8.
	5227	Repair of meningocele	90	393.	341.	8.
	5229	Repair of meningomyelocele	90	483.	420.	8.
	5231	Lumbar subarachnoid-peritoneal-ureteral shunt	90	361.	315.	8.
	5232	co-surgeon	0	339.	295.	
5233	Application crutchfield tongs or other skeletal traction device	0	32.	27.	3.	

**PERIPHERAL NERVES, OTHER EXTRACRANIAL NERVES,
AND GANGLIA**

INCISION

(For transection of trigeminal or gloss-pharyngeal nerves, see 5112, 5114.)

}	5252	Phrenic nerve transection or avulsion	30	121.	105.	4.
	5255	Transection, spinal nerve; also for destruction of dorsal nerve roots by radiofrequency (with or without fluoroscopic, radiographic or ultrasonic control) (facet Rhizotomy).	30	211.	184.	5.
	5257	Transection, occipital nerve	30	121.	105.	5.

EXCISION

(For excision of tender scar, skin and subcutaneous tissues with or without tiny neuroma, see 0175, 0178, 0265, 0266.)

	5273	Excision of surgically identifiable neuroma of cutaneous nerve	30	42.	37.	3.
	5274	digital nerve, one or both, same digit	30	53.	45.	3.
	5275	hand or foot, one (add 10 percent each additional)	30	79.	68.	3.
	5276	arm or leg	30	131.	114.	4.
	5277	Avulsion infraorbital nerve	30	182.	158.	3.
	5280	Stoefel's neurectomy	45	182.	158.	3.
	5282	Obturator Neurectomy	45	121.	105.	4.
	5283	Excision of Peripheral Neuroma (Morton's Neuroma, Neurofibroma, Schwannoma, etc.)	30	121.	105.	3.

NERVE BLOCK

DIAGNOSTIC OR THERAPEUTIC BLOCK

	5285	Sub-Arachnoid, spinal, simple with injection of anesthesia substance	0	30.	26.	
	5303*	Epidural or caudal, simple, with injection of anesthesia substance (temporary block-diagnostic or pain)	0	30.	26.	

*Not to be confused with PRV 4899 which is for obstetrical cases only

†See Medicaid Second Opinion Program NJHSP Newsletter, Volume No. P-329

SURGERY

**SURGERY
EYE**

EYE

Follow-
Up
Days

Surg. Value
S \$ NS

Anes.
Basic
Units

DIAGNOSTIC AND MANIPULATIVE PROCEDURES

5396 Stereo Fundus Photography, independent procedure, includes dilation of pupils, exposure and development of film, interpretation and report. Unilateral or bilateral.

(Not reimbursable for routine screening purposes.)

5398 Initial Retinal Exam including tonometry, slit lamp, ocular mobility, indirect ophthalmoscopy with retinal drawings and/or photography. 0 25. NA

5399 As above, subsequent or repeat same eye. 0 21. NA

5400 COMPREHENSIVE EYE EXAMINATION - This shall include as a minimum with or without cycloplegics and with or without a post cycloplegic visit, the following which also includes recording of negatives: 0 22.

- 1) Detailed case history
- 2) External and internal (ophthalmoscopic examination) including slit lamp.
- 3) Refraction (objective and subjective)
- 4) Gross visual fields
- 5) Tonometry (when indicated for patients under 35; mandatory for all patients over 35) This specific method used should be identified (i.e., the finger palpation test is not acceptable)
- 6) Binocular coordination testing (distance and near)
- 7) The diagnosis (ocular deficiency or deformity, visual or muscular anomaly, etc.)
- 8) Recommendations

NOTE: Procedure Code 5400 will be disallowed and down-graded to Procedure Code 0001, provided 0001's criteria are met, if Procedure Code 5400 or 5401 has been performed during the prior 12 months by the same physician, group, shared health care facility, or practitioners sharing a common record.

5401 COMPREHENSIVE EYE EXAMINATION including all the criteria covered by Procedure Code 5400 substituting Complete Diagnostic Visual Fields for Gross Visual Fields. 0 26.

NOTE: Procedure Code 5401 will be disallowed and down-graded to Procedure Code 0001, provided 0001's criteria are met, if Procedure Code 5400 or 5401 has been performed during the prior 12 months by the same physician, group, shared health care facility, or practitioners sharing a common record.

*5402 Gonioscopy, Diagnostic 0 15. 15.

5403 Vision training (Prior authorization required) (one hour or on individual basis) 0 10. 10.

5404 Vision training (Prior authorization required) (one hour with two patients) 0 8. 8.

5405 Vision training (Prior authorization required) (one hour with three patients) 0 6. 6.

*NOTE: These are not reimbursable when performed on the same day as Procedure Codes 5400 or 5401. Codes 5400 through 5419 precludes any type of office visit on the same day.

**SURGERY
EYE**

SURGERY

	Follow-Up Days	Surg. Value		Anes. Basic Units
		S	\$ NS	
5406 Screening Examinations - This shall constitute procedures performed to determine whether a comprehensive examination is necessary. As a minimum, the screening examination shall consist of the following: 1. External examination 2. Visual acuity in each eye 3. Gross muscle balance	0		9.	
*NOTE: These are not reimbursable when performed on the same day as Procedure Codes 5400 or 5401. Codes 5400 through 5419 preclude any type of office visit on the same day.				
NOTE: It is the intent of the Program to reimburse the Ophthalmologist or Optometrist for either a screening examination or a comprehensive eye examination rendered a patient, not both. If, as a result of the screening examination, it is felt that a comprehensive examination is necessary, it should be completed at that time or at the earliest mutual convenience of the provider and patient. The screening examination, in this instance, becomes an integral part of the comprehensive examination and the claim submitted to the program should be for a comprehensive eye examination. If, however, the screening examination reveals that no further examination is necessary, a claim should be submitted for a visual screening examination.				
*5408 Visual fields, complete diagnostic	0	8.	8.	
5409 Tonography	0	15.	15.	
5410 Provocative test(s) for glaucoma including water drinking and/or mydriatic and/or dark room test	0	15.	15.	
*5411 Ophthalmoscopy (Fundoscopy) with Mydriasis, direct and/or indirect method - independent procedure	0	8.	8.	
5412 Fitting contact lenses (follow-up)	0	8.	8.	
*5413 Ophthalmoscopy (Fundoscopy) with mydriasis, direct and/or indirect method under anesthesia - independent procedure, or Ophthalmodynamometry	7	15.	15.	3.
*5414 Slit lamp examination	0	8.	8.	
5415 Subnormal vision examination	0	10.	10.	
5416 Vision training workup and written report (prior authorization required)	0	25.	25.	
*5417 Tonometry	0	8.	8.	
5419 Fluorescein Angiography (with or without color film)	0	53.	53.	

*NOTE: These are not reimbursable when performed on the same day as Procedure Codes 5400 or 5401. Codes 5400 through 5419 precludes any type of office visit on the same day.

RADIOLOGY

Medicaid Dollar Value
Office Hospital Based
\$ \$

7361	barium enema with air contrast (with fluoroscopy by the radiologist)	40.00	16.20
7362	air contrast only (with fluoroscopy by the radiologist)	30.00	14.40
7363	Cholecystography, oral contrast	35.00	9.00
7364	Cholangiography, operative	40.00	10.80
7365	post-operative (T-Tube)	25.00	10.80
7366	intravenous	40.00	16.20
7367	intravenous with tomography	50.00	20.25
7368	Cholangiography, percutaneous, transhepatic, S & I only	25.00	9.00
7369	complete procedure	70.00	52.00

UROLOGICAL

7370	Kidney, Ureter, and Bladder (K.U.B.)	10.00	5.40
7371	multiple views	15.00	7.20
7372	Urography, intravenous, including K.U.B.	35.00	12.60
7373	including special hypertensive dye concentration and clearance studies ("renal washout")	50.00	18.00
7374	retrograde, including K.U.B.	35.00	9.00
7387	Urography, antegrade, S & I only (pyelostogram, nephrostogram, loopogram)	20.00	9.00
7388	complete procedure	35.00	18.00
7384	Urography, infusion, drip technique	40.00	14.40
7379	with nephrotomography	75.00	18.00
7375	Cystography, minimum three views, S & I only	15.00	9.00
7376	complete procedure	25.00	18.00
7377	Urethrocystography, retrograde, S & I only	20.00	9.00
7389	complete procedure	40.00	18.00
7378	Urethrecystography, voiding, S & I only	20.00	16.20
7399	complete procedure	35.00	22.50
7380	Pneumography, retroperitoneal, S & I only	25.00	9.00
7381	complete procedure	45.00	16.20
7382	Renal cyst study, translumbar study, (contrast visualization) S & I only	20.00	9.00
7383	complete procedure	40.00	21.60
7385	Vasography, vesiculography, or epididymography, S & I only	20.00	9.00

RADIOLOGY

Medicaid Dollar Value
 Office Hospital Based
 \$ \$

7386	complete procedure	70.00	31.50
<i>GYNECOLOGICAL AND OBSTETRICAL</i>			
*7390	Pelvimetry, with or without placental localization	25.00	9.00
7391	Placental localization, one view	20.00	7.20
7392	Hysterosalpingography, S & I only	20.00	9.00
7393	complete procedure	40.00	18.00
7396	Pneumography, pelvic, S & I only	25.00	10.80
7397	complete procedure	40.00	18.00
<i>MISCELLANEOUS</i>			
7450	Fluoroscopy (independent procedure, other than 7103)	10.00	4.00
7451	Herniogram Study - unilateral or bilateral	15.00	6.00
7452	Herniogram Study - unilateral or bilateral, including injection procedure	20.00	8.00
7453	Percutaneous Bone Biopsy, under Fluoroscopic Guidance. (Procedure reimbursable to only one physician.)	—	24.00
7454	Bone age studies	15.00	5.40
7455	Bone length studies (orthorentgenogram)	20.00	9.00
7457	Bone survey (long bone or for metastasis)	35.00	18.00
7458	Skeletal survey, complete	90.00	36.00
7460	Arthrography, single joint, any extremity, S & I only	15.00	10.80
7461	complete procedure	45.00	36.00
7462	Kymography	25.00	10.00
7463	Fistula or sinus tract study, S & I only	15.00	9.00
7464	complete procedure	20.00	13.50
7465	Mammography, unilateral	20.00	9.00
7466	bilateral	30.00	13.50
7467	Body section radiography, one plane (tomography, planigraphy, etc.) other than 7379	35.00	14.00
7468	two or more planes	50.00	20.00
7480	Xeromammography, bilateral	40.00	16.00
7481	unilateral	30.00	12.00
7482	Procedures using Xeroradiography, Polaroid or similar media, additional	4.00	1.60
7489	Cineradiography except where specifically included	30.00	5.40
7490	Additional views any procedure	5.00	5.00
7477	Examination in Home (Portable x-ray) additional charge for first person only.	NA	NA

*See Medical Necessity Program NJHSP Newsletter Volume No. P-217 for instructions on medical necessity procedures.

**MEDICINE
PSYCHIATRIC SERVICES**

Medicaid
Dollar
Value

S \$ NS

NOTE: For psychiatric services rendered to patients in long term care facilities and all facilities covered under the Rooming and Boarding House Act of 1979, see NJHSP Newsletter, Volume No. P-325.

NOTE: Only under exceptional circumstances will more than one mental health procedure be reimbursable per day for the same recipient by the same provider, group, shared health care facility, or practitioners sharing a common record.

9050	<u>PSYCHOTHERAPY, INDIVIDUAL, BY A PHYSICIAN, ONE HOUR</u> - office, hospital home or nursing home - Verbal, drug augmented or other methods provided physician is in personal involvement with patient to the <u>exclusion</u> of other patients or duties.	37.	26.
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This code number refers to a session which is defined as one hour of time including up to 10 minutes for the recording of data and/or counseling a relative or guardian. Minimum of 50 minutes personal involvement with the patient.

9051	<u>PSYCHOTHERAPY, INDIVIDUAL, BY A PHYSICIAN, ONE-HALF HOUR</u> - office hospital, home or nursing home - Verbal, drug augmented or other methods provided physician is in personal involvement with patient to the <u>exclusion</u> of other patients or duties.	19.	13.
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This code number refers to a session which is defined as one-half hour of time including five minutes for the recording of data. Minimum of 25 minutes personal involvement with the patient.

9053	<u>PSYCHOTHERAPY, GROUP, BY A PHYSICIAN, ONE AND ONE-HALF HOUR</u> - Verbal or other methods performed in office, hospital, or other suitable settings, with physician in personal involvement with the patients.	8.	6.
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(per person)

To include a maximum of eight persons and a minimum duration of one and one-half hours.

9055	<u>CONVULSIVE THERAPY</u> - electro convulsive Inpatient or Outpatient	32.	26.
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No additional reimbursement for anesthesia administered by treating physician.

Anesthesia reimbursable only to anesthesiologist, when:

- 1) His specialty is medically necessary.
- 2) Hospital rules limits use of anesthesia to anesthesiologist.

NOTE: Payment for convulsive therapy includes payment for all eligible services rendered on that day for the psychiatric condition.

9056	<u>INITIAL COMPREHENSIVE PSYCHIATRIC EVALUATION</u> , to include each of the following:	37.	26.
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- 1) A comprehensive history of the present illness.
- 2) A complete past neurological and psychiatric history including recording of negative findings.
- 3) A complete family and social/personal history.
- 4) A detailed psychiatric examination and evaluation.
- 5) A statement as to the need for organic work-up, whether physical examination was performed or ordered.
- 6) A complete diagnosis and treatment plan including confirmatory and differential diagnostic procedures recommended.

NOTE: This examination/evaluation includes the initiation of diagnostic and treatment programs and is usually used for:

- 1) Initial emergency evaluation for psychiatric treatment.
- 2) Complete psychiatric examination for placement in an institution.
- 3) Pre-adoption psychiatric evaluation for child placement.

**MEDICINE
PSYCHIATRIC SERVICES**

Medicaid
Dollar
Value
S \$ NS

No more than one initial comprehensive psychiatric evaluation is reimbursable per year for the same recipient by the same physician. This code may not be used as a substitute for code 9000, 9010, 9020, 9029.

{	9559	<u>DRUG MANAGEMENT VISIT</u> - review and evaluation of the medication history of a psychiatric patient with the writing or renewal of a prescription if indicated.	9.	7.
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NOTE: Use of this code precludes the use on the same day of Procedure Codes 0001, 0002, 0003, 0004, 9050, 9051, 9056, 9062, 9064 (Therapy) or 9065 (Therapy).

	9062	<u>FAMILY THERAPY - BY A PHYSICIAN, ONE AND ONE-HALF HOURS.</u> The patient and one or more family members present - office, hospital, home, or nursing home - verbal or other methods, provided physician is in personal involvement with family and patient to the <u>exclusion</u> of other patients or duties.	46.	32.
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NOTE: This code number refers to a session which is defined as one and one-half hours including up to 10 minutes for the recording of data. Minimum of 80 minutes personal involvement with the family and patient.

	9064	<u>FAMILY THERAPY/FAMILY CONFERENCE - BY A PHYSICIAN, ONE HOUR</u> <u>FAMILY THERAPY</u> , the patient and one or more family members present - office, hospital, home, or nursing home - verbal or other methods provided physician is in personal involvement with family and patient to the <u>exclusion</u> of other patients or duties.	37.	26.
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FAMILY CONFERENCE - Interpretation or explanation of psychiatric/psychological and other medical examinations and procedures, to family or other responsible persons, or advising them how to assist the patient.

NOTE: When "Family Conferences" are required for patients who will be treated pursuant to prior authorization, conferences must be requested on the same form (FD-07) as the principal treatment. Use the space in Box No. 11 marked "Other Types of Therapy".

NOTE: This code refers to a session which is defined as one hour of time including up to 10 minutes for the recording of data. Minimum of 50 minutes of personal involvement with the family.

	9065	<u>FAMILY THERAPY/FAMILY CONFERENCE, BY A PHYSICIAN, ONE-HALF HOUR</u> <u>FAMILY THERAPY</u> , the patient and one or more family members present - office, hospital, home, or nursing home - verbal or other methods provided physician is in personal involvement with family and patient to the <u>exclusion</u> of other patients or duties.	19.	13.
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FAMILY CONFERENCE - Interpretation or explanation of results of psychiatric/psychological examinations and procedures, or other accumulated data, to family or other responsible persons, or advising them how to assist patient.

NOTE: When "Family Conferences" are required for patients who will be treated pursuant to prior authorization, conferences must be requested on the same form (FD-07) as the principal treatment. Use the space in Box No. 11 marked "Other Types of Therapy".

NOTE: This code number refers to a session which is defined as one-half hour of time including five minutes for the recording of data. Minimum of 25 minutes personal involvement with the family.

**MEDICINE
PSYCHOLOGICAL SERVICES**

Medicaid
Dollar
Value
S \$ NS

NOTE: For psychological services rendered to patients in long term care facilities and all facilities covered under the Rooming and Boarding Home Act of 1979, see NJHSP Newsletter, Volume No. P-325.

NOTE: Only under exceptional circumstances will more than one mental health procedure be reimbursable per day for the same recipient by the same provider, group, shared health care facility, or practitioners sharing a common record.

9449	<u>PSYCHOTHERAPY, INDIVIDUAL, BY A PSYCHOLOGIST, ONE HOUR - office, hospital, home or nursing home - Verbal or other methods provided psychologist is in personal involvement with patient to the <u>exclusion</u> of other patients or duties.</u>	37.	26.
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This code number refers to a session which is defined as one hour of time including up to 10 minutes for the recording of data and/or counseling a relative or guardian. Minimum of 50 minutes personal involvement with the patient.

9463	<u>PSYCHOTHERAPY, INDIVIDUAL, BY A PSYCHOLOGIST, ONE-HALF HOUR - office, hospital, home or nursing home - Verbal or other methods provided psychologist is in personal involvement with patient to the <u>exclusion</u> of other patients or duties.</u>	19.	13.
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This code number refers to a session which is defined as one-half hour of time including five minutes for the recording of data. Minimum of 25 minutes personal involvement with the patient.

9464	<u>PSYCHOTHERAPY, GROUP, BY A PSYCHOLOGIST, ONE AND ONE-HALF HOUR - Verbal or other methods performed in office, hospital, or other suitable settings, with psychologist in personal involvement with the patients.</u>	8.	6.
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(per person)

To include a maximum of eight persons and a minimum duration of one and one-half hours.

9061	<u>INITIAL COMPREHENSIVE PSYCHOLOGICAL EVALUATION, to include the following:</u>	37.	26.
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- 1) A comprehensive history of the present illness.
- 2) A complete past psychological history including recording of negative findings.
- 3) A complete family and social/personal history.
- 4) A detailed psychological examination and evaluation.
- 5) A complete diagnosis and treatment plan including confirmatory and differential diagnostic procedures recommended.

NOTE: This examination/evaluation includes the initiation of diagnostic and treatment programs and is usually used for:

- 1) Initial emergency evaluation for psychological treatment.
- 2) Complete psychological examination for placement in an institution.
- 3) Pre-adoption psychological evaluation for child placement.

No more than one initial comprehensive psychological evaluation is reimbursable per year for the same recipient by the same psychologist.

9465	<u>FAMILY THERAPY BY A PSYCHOLOGIST, ONE AND ONE-HALF HOURS. The patient and one or more family members present - office, hospital, home or nursing home - verbal or other methods, provided psychologist is in personal involvement with family and patient to the <u>exclusion</u> of other patients or duties.</u>	46.	32.
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NOTE: This code number refers to a session which is defined as one and one-half hours including up to 10 minutes for the recording of data. Minimum of 80 minutes personal involvement with the family and patient.

**MEDICINE
PSYCHOLOGICAL SERVICES**

Medicaid
Dollar
Value

S	\$	NS
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9466	<p><u>FAMILY THERAPY/FAMILY CONFERENCE BY A PSYCHOLOGIST, ONE HOUR</u></p> <p><u>FAMILY THERAPY</u>, the patient and one or more family members present - office, hospital, home, or nursing home - verbal or other methods provided psychologist is in personal involvement with family and patient to the <u>exclusion</u> of other patients or duties.</p> <p><u>FAMILY CONFERENCE</u>, Interpretation or explanation of psychological examinations and procedures, or other accumulated data, to family or other responsible persons, or advising them how to assist patient.</p> <p>NOTE: When "Family Conferences" are required for patients who will be treated pursuant to prior authorization, conferences <u>must</u> be requested on the same form (FD-07) as the principal treatment. Use the space in Box No. 11 marked "Other Types of Therapy".</p> <p>NOTE: This code number refers to a session which is defined as <u>one hour of time</u> including up to 10 minutes for the recording data. Minimum of 50 minutes of personal involvement with the family.</p>	37.	26.
9467	<p><u>FAMILY THERAPY/FAMILY CONFERENCE BY A PSYCHOLOGIST, ONE-HALF HOUR</u></p> <p><u>FAMILY THERAPY</u>, the patient and one or more family members present - office, hospital, home, or nursing home - verbal or other methods provided psychologist is in personal involvement with family and patient to the <u>exclusion</u> of other patients or duties.</p> <p><u>FAMILY CONFERENCE</u> - Interpretation or explanation of results of psychological examinations and procedures, or other accumulated data, to family or other responsible persons, or advising them how to assist patient.</p> <p>NOTE: When "Family Conferences" are required for patients who will be treated pursuant to prior authorization, conferences <u>must</u> be requested on the same form (FD-07) as the principal treatment. Use the space in Box No. 11 marked "Other Types of Therapy".</p> <p>NOTE: This code number refers to a session which is defined as <u>one-half hour of time</u> including five minutes for the recording of data. Minimum of 25 minutes personal involvement with the family.</p>	19.	13.
9468	Bayley Scale of Infant Development	48.	34.
9469	Bender Visual - Motor Gestalt Test	15.	10.
9470	Benton Visual Retention Test	15.	10.
9471	Blacky Pictures	30.	21.
9472	Cattel Infant Intelligence Scale	48.	34.
9473	Children's Apperception Test	30.	21.
9474	House - Tree - Person	22.	15.
9475	Human Figure Drawing (Draw-A-Person)	15.	10.
9476	Kinetic Drawings	15.	10.

**MEDICINE
OTHER SERVICES**

Medicaid
Dollar
Value

S	\$	NS
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9271	Flow-volume loop-room air, before and after bronchodilator	15.	
9273	Flow-volume loop-helium, before and after bronchodilator	15.	
9274	Flow-volume loop-room air and helium, before and after bronchodilator	21.	
9275	Closing volume test	9.	

ALLERGY TESTING

The following procedures on the type and number of tests performed, must include observation and interpretation of the tests by a physician.

9300X	Scratch or puncture test, up to 60 tests, per 10 tests	5.	
9301X	in excess of first 60 tests, per 20 tests	5.	
9302X	Intradermal tests up to total of 60 tests, per 10 tests	8.	
9303X	in excess of first 60 tests, per 20 tests	8.	
9304X	Patch tests, each	1.	
9305X	Direct ophthalmic tests	2.	
9306X	Direct nasal tests	2.	
9307X	Passive transfer tests (including cost of recipient) per 10 tests	16.	
9311	Emulsified allergy antigen therapy - 1st shot	105.	
9312	2nd shot	53.	
9313	3rd shot	37.	
9315X	Preparation of allergy extracts - each 5cc	8.	
9316	Insect Sting Allergy Testing (includes the test materials)	21.	NA
9317	Insect Venom Extract		NA
9318	Immunotherapy for Insect Venom		NA

MISCELLANEOUS

*9320	Skin test with bacterial, viral or fungal extracts (includes reading test), e.g. brucella, tuberculin, histoplasma, coccidioidin, Frei, etc., each	4.	
9323	Exclusion test for phochromocytoma, e.g., regitine, benzodioxane, histamine, each	11.	
9330	Electro-encephalogram, awake, asleep (natural or induced) and activation (EEG) (Also, Electro-Oculogram and Supra Orbital Orbiculis Ocali Tests)	32.	
9333	Ultrasonic (ECHO) Encephalogram (with report)	16.	
9337	Auditory brain-stem-evoked response (ABR) and Visual brain-stem-evoked response (VBR) same patient same session. See codes 9346 and 9339 for accepted criteria for testing.	67.	NA
9338	Somatosensory evoked response testing, one or more nerves with interpretation.	55.	NA

NOTE: Claims must include full diagnosis in standard nomenclature.

*See Medical Necessity Program NJHSP Newsletter, Volume No. P-298

**MEDICINE
OTHER SERVICES**

**Medicaid
Dollar
Value**

S \$ NS

NOTE: Reimbursement to a qualified provider only, trained and experienced in somatosensory evoked response testing and who personally performed the testing.

NOTE: A licensed physician must be present to administer and supervise administration of a sedative and monitor the patient when sedation is required.

NOTE: Not reimbursable for initial testing, general screening, research studies or any situation where usefulness has not been clearly established and, therefore, is without controversy.

9339	Visual brain-stem-evoked response (VBR) (Computer averaging of brain stem potentials created by visual stimuli), with interpretation.	45.	NA
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Criteria for testing:

1. Inconclusive test results by standard vision testing.
2. Neonates and infants at risk* for vision loss (see code 9346 for at risk factors).
3. Children and adults who cannot perform behavioral testing.
4. Suspected organic neurologic lesion within or proximal to the visual pathway.

At risk factors and conditions for reimbursement apply as in code 9346.

NOTE: Reimbursable to hospital outpatient departments as a hospital charge or to a qualified provider (in office setting including ophthalmologists, neurologists, neurosurgeons, psychiatrists, and optometrists) trained and experienced with VBR testing, who personally performed the testing.

NOTE: Claims must include full diagnosis in standard nomenclature. A licensed physician must be present to administer or supervise administration of a sedative and monitor the sedated patient.

NOTE: Not reimbursable for initial testing, general screening, research studies or any situation where usefulness has not been clearly established and, therefore, is without controversy.

9340	Audiometric hearing tests, pure tone (air only) (with interpretation)	11.	
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9341	air and bone, with or without masking (with interpretation)	14.	
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9342	speech (with interpretation)	19.	
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9345	Complete audiogram, Air-Bone-Speech-Discrimination Impedance Audiometry	29.	
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9346	Auditory brain-stem-evoked response (ABR) (Computer averaging of brain-stem potentials created by acoustic stimuli), with interpretation.	45.	NA
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Criteria for testing:

1. Inconclusive test results by standard audiometric testing for:
 - a. Neonates and infants at risk* for hearing loss (see below for at risk factors);
 - b. Children and adults who cannot perform behavioral testing.
2. Suspected organic neurologic lesion within or proximal to the auditory pathways beyond the peripheral organs. Includes unilateral sensorineural hearing loss with medical evidence of retrocochlear pathology.

**MEDICINE
OTHER SERVICES**

Medicaid Dollar Value		
S	\$	NS

***At Risk Factors include:**

1. Family history of childhood deafness (hereditary childhood hearing impairment).
2. Intra-uterine fetal infections.
3. Congenital maxillo-facial abnormalities.
4. Birth asphyxiation.
5. Exposure to oto-toxic drugs/poisonings.
6. Birth weight less than 1200 grams.
7. Bilirubin level exceeding the exchange transfusion level according to established parameters of age and weight.
8. Major infection beyond the neonatal period in infancy.
9. Recovery from head trauma when there exists a high index of suspicion of auditory damage.
10. Non-congenital disorders of the CNS that interrupt auditory pathways.

NOTE: Not reimbursable for initial testing, general screening, research studies or any situation where usefulness has not been clearly established and, therefore, is without controversy.

Preliminary standard audiological examination report must be available for review on request. Claims must include full diagnosis in standard nomenclature. Normative data studies (established on-site) should be made available for review on request.

NOTE: Reimbursable to hospital outpatient departments as a hospital charge or to a qualified provider (office setting) trained in acoustics, instrumentation and auditory evaluation, experienced with ABR testing, and who personally performed the testing. Qualified providers include otologists, otolaryngologists, neurologists, psychiatrists, and neurosurgeons. The tester may include a qualified provider as well as a certified audiologist employed by one of the above.

NOTE: A licensed physician must be present to administer or supervise administration of a sedative and monitor the patient when sedation is required.

9347	Impedance Audiometry Testing (acoustic bridge studies)	10.
9348	Alternate loudness balance testing, S.S. tone decay	10.
9349	Bekesey Audiometry	12.
9343	Vestibular function test	16.
9344	Electronystagmography	30.
9350	Muscle testing, manual, extremity (excluding hand) or trunk, with report by physician	10.
9351	Muscle testing, manual hand (with or without comparison with normal side)	13.
9352	Nerve conduction, velocity and/or latency study, sensory nerve, each nerve, includes "H" reflex.	16.
9354	Range of motion measurements and report each extremity (excluding hand)	10.

**MEDICINE
OTHER SERVICES**

		Medicaid Dollar Value		
		S	\$	NS
9355	Muscle testing, manual, total evaluation of body (excluding hands)		32.	
9356	Muscle testing, manual, total evaluation of body, including hands		37.	
9357	Muscle testing, electrical: Reaction of degeneration; chronaxy, galvanic/tetanus ratio; one or more extremities, one or more methods, per hour		25.	
9358	Electromyography, one extremity and related areas of the back		37.	
9359	Strength duration curve, per nerve		12.	
9361	Range of motion measurement and report, hand (with or without comparison of normal side)		10.	
9362	Nerve conduction, velocity and/or latency study, motor nerve, each nerve, including "H" reflex, each nerve		16.	
9363	Transcutaneous electrical nerve stimulation	BR		
9364	Tensilon test for myosthenia gravis including electromyographic recording	BR		
9365	Electromyography, two extremities and related areas of back		57.	
9366	Tensilon test for myosthenia gravis (includes injections)		16.	
9367	Electromyography, three extremities and related areas of back		70.	
9368	Electromyography, four extremities and related areas of back		83.	
9645	Muscle re-education therapy with biofeedback	BR		NA

(Limited to unusual neuromuscular disorders or disabilities where the retraining of specific muscle groups has a potential for success and the more conventional methods have been unsuccessful. Also limited to hospital inpatient and out-patient and to the private office under the direct supervision and personal treatment involvement of a physiatrist or similar related specialty.)

ULTRASONIC DIAGNOSTIC PROCEDURES

"The following procedure codes reflecting ultrasound diagnostic procedures are for reimbursement purposes limited to physician specialists in the specific specialty they reflect or to a radiologist expert in that field".

(These procedures must include the mounted tracings with interpretations.)

*9370	Echocardiography, M-Mode, complete including 9374 and 9376 combined, plus chamber dimensions, "for multi dimensional, real time echocardiography, (sector scan) allow 50% extra".		40.	
9371	hospital		20.70	
*9372	Echocardiography, limited, e.g., follow-up or limited study		20.	
9373	hospital		9.	
*9374	Echocardiography, cardiac valve(s), M-Mode; for Multi-Dimensional, Real Time Echocardiography, allow 50% extra.		30.	
9375	hospital		13.50	

*Office

**MEDICINE
OTHER SERVICES**

		Medicaid Dollar Value		
		S	\$	NS
*9376	Echocardiography, pericardial effusion, M-Mode	25.		
9377	hospital	10.80		
*9378	Ophthalmic Sonography (A-Mode)	40.		
9379	hospital	18.		
*9380	Ophthalmic Sonography (B-Mode)	60.		
9381	hospital	34.20		
*9391	Carotid Artery Sonography (B-Mode)	40.		
9411	hospital	20.		
*9382	Thyroid Sonography (A-Mode)	20.		
9383	hospital	9.		
*9384	Thyroid Sonography (B-Mode)	30.		
9385	hospital	13.50		
**9386	Ophthalmic Sonographic Foreign Body Localization	BR		
OBSTETRICS, GYNECOLOGY, PELVIS				
†*9387	Pregnancy diagnosis Sonogram (B Scan)	30.		
†9388	hospital	13.50		
†*9389	Fetal Age Determinations (B Scan)	40.		
†9390	hospital	18.		
†*9369	Fetal Growth Rate (B Scan)	25.		
†9392	hospital	10.80		
†*9393	Placental Localization (B Scan) Sonogram	40.		
†9394	hospital	18.		
†*9395	Pregnancy Sonogram (B Scan)	55.		
†9396	hospital	25.20		
†*9397	Molar Pregnancy Diagnosis Sonogram (B Mode)	40.		
†9398	hospital	18.		
†*9399	Ectopic Pregnancy Diagnosis Sonogram (B Mode)	60.		
†9500	hospital	27.		
†*9501	IUCD Localization Sonogram (B Mode)	40.		

*Office

†See Medical Necessity Program NJHSP Newsletter, Volume No. P-298

**MEDICINE
OTHER SERVICES**

**Medicaid
Dollar
Value**

S	\$	NS
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†9502	hospital	18.
†*9503	Pelvic Mass Sonogram (B Mode)	55.
†9504	hospital	25.20
†*9505	Amniocentesis by Ultrasonic Guidance	25.
†9542	hospital	12.50

THORAX

*9506	Pleural Effusion Sonogram (A Mode)	25.
9507	hospital	10.80
*9508	Breast Sonogram (A Mode)	25.
9509	hospital	10.80
*9510	Breast Sonogram (B Mode)	50.
9511	hospital	22.50

PERIPHERAL VASCULAR SYSTEM

NOTE: These codes 9512, 9514 and 9516 apply only to services rendered in a hospital or equivalent ultrasound or x-ray laboratory on fixed equipment under specialist supervision and includes detailed interpretation of the graphic record, plus reports. Do not use these codes for screening Doppler flow studies.

*9512	Doppler Venous Flow Study	45.
9513	hospital	21.60
*9514	Doppler Arterial Flow Study	45.
9515	hospital	21.60
*9516	Doppler Arterial and Venous Flow Study	55.
9517	hospital	25.20

ABDOMINAL AND RETROPERITONEUM

*9518	Abdominal Sonogram, Complete Survey (B Scan)	60.
9519	hospital	27.
*9520	Abdominal Sonogram, Limited Study (B Scan)	40.
9521	hospital	18.
*9522	Hepatic Sonogram (B Scan)	60.
9523	hospital	27.
*9524	Gallbladder Sonogram (B Scan)	60.
9525	hospital	27.

*Office

†See Medical Necessity Program NJHSP Newsletter, Volume No. P-298

**MEDICINE
OTHER SERVICES**

		Medicaid Dollar Value		
		S	\$	NS
*9526	Renal Sonogram (B Scan)	60.		
9527	hospital	27.		
*9528	Pancreas Sonogram (B Scan)	60.		
9529	hospital	27.		
*9530	Spleen Sonogram (B Scan)	60.		
9531	hospital	27.		
*9532	Abdominal Aorta Sonogram (A Scan)	25.		
9533	hospital	10.80		
*9534	Abdominal Aorta Sonogram (B Scan)	55.		
9535	hospital	25.20		
*9536	Retroperitoneal Sonogram (B Scan)	60.		
9537	hospital	27.		
*9538	Urinary Bladder Sonogram (B Scan)	40.		
9539	hospital	18.		
**9540	Ultrasonic Guidance for renal cyst aspiration	BR		
**9541	Ultrasonic Guidance for renal biopsy or Pancreatic Biopsy	BR		

SPECIFIC THERAPEUTIC PROCEDURES

(For other procedures see "Surgery" and "Radiology".)

SPECIAL REIMBURSEMENT PROCEDURES FOR CHRONIC RENAL DISEASES

9040	Monthly reimbursement for patients <u>not</u> on self-dialysis (outpatient) (Outpatient hemodialysis)	160.		
9041	Monthly reimbursement for patients on self-dialysis (home) (Home dialysis)	112.		
9042	Physician reimbursement for self-dialysis training (Minimum of 3 months, maximum of \$400)			
9403	Declotting of A-V Shunt	38.		26.
9407	Hemodialysis - inhospital	30.		

MISCELLANEOUS

9400	Phlebotomy, therapeutic (independent procedure)	11.		
9408	Peritoneal dialysis, 1st day	61.		
9409	Peritoneal dialysis, 2nd day	24.		
9410	Peritoneal dialysis 3rd to 14th day	13.		
9417	Gastric lavage, treatment, e.g., ingested poisons, etc. (Levine Tube)	18.		16.

*Office

**Office/Hospital

**MEDICINE
OTHER SERVICES**

		Medicaid Dollar Value		
		S	\$	NS
9420	Electrical conversion of arrhythmia, external	30.		26.
9421	Cardiac Resuscitation (Massage) PER HOUR	37.		32.

For Psychological Testing see 9468-9499



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

New Jersey Health Services Program NEWSLETTER

Volume P-355

March 21, 1983

TO: ALL PROVIDERS

SUBJECT: MEDICAID ID CARDS

EFFECTIVE: APRIL 1, 1983

BACKGROUND: Federal and New Jersey laws require that all other sources of payment for medical care be used before Medicaid is asked to pay for medical care.

PURPOSE: To inform providers that, in order to reduce the number of claims initially rejected for payment by Medicaid due to third party insurance benefits, certain Medicaid Validation Cards will now include additional information. The availability of this information to providers will reduce the number of claims initially rejected for payment by the Medicaid Program because of third party insurance and will facilitate billing the third party.

ACTION: One of the following four messages may be printed on the top line of the Medicaid Validation Stubs issued by County Welfare Agencies. Only one message will appear on the stub. If more than one applies, the message printed will be chosen in the order of priority listed below. We suggest that providers take the specific actions listed after each message.

1. "NOT VALID FOR MEDICAID" - Do not honor invalidated Medicaid ID Stubs. This recipient is enrolled in the Medicaid Special Status Program. The recipient and others on his/her grant must produce a valid Special Status Medicaid ID card. (See Newsletters P-285 or BC-184.)
2. "RESTRICTED USE HMO-CALL 609-696-8004." - This recipient (and any member of his/her family on the grant) is enrolled in the Cumberland Regional Health Plan (CRHP). Call the number listed to determine whether the service or item you are being asked to give is provided by the CRHP. If you provide a service available through the CRHP, you risk being denied reimbursement by the Medicaid Program except in medical emergencies.

A separate Newsletter will be issued in the near future to the providers in the Cumberland County area describing the services covered by the CRHP.

3. "HMO COVERAGE". - There will be an asterisk (*) before the name of the recipient(s) enrolled in an HMO other than the CRHP. Determine which HMO the recipient(s) is covered by and contact the HMO to determine what services are covered. If you provide a service available through the HMO, you risk being denied reimbursement by the Medicaid Program except in medical emergencies.

4. "OTHER COVERAGE". - There will be an asterisk(*) before the name of the recipient(s) covered by another health insurer. Determine the insurer and the policy number. Please bill the other health insurer, as appropriate, for covered services before submitting a claim to the Medicaid Program for payment.

The following information may appear in the lower right corner of Medicaid Eligibility Identification Cards (FD-73 or FD-178) issued to SSI recipients and certain children under Division of Youth and Family Services supervision:

Name of Other Insurer
Corresponding Policy Number
Type of Medicare Coverage (A, B or A & B)
HIC Medicare Number

Please bill any other health insurer (including Medicare), as appropriate, for covered services before submitting a claim to the Medicaid Program for payment.

Please refer any questions or comments to the New Jersey Division of Medical Assistance and Health Services, Procedures Development and Communications, CN 720 Trenton, N.J. 08625. Attention: Bruce Fritzges or telephone 609 984-7409.



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

New Jersey Health Services Program **NEWSLETTER**

Volume P-356

April 1, 1983

TO: ALL PHYSICIANS, INDEPENDENT CLINICS AND HOSPITAL ADMINISTRATORS

SUBJECT: REVISED FEES FOR THE LISTED IMMUNIZATION SERVICES

EFFECTIVE: FOR IMMUNIZATION SERVICES PERFORMED ON AND AFTER APRIL 1, 1983

BACKGROUND: Due to the increased cost of vaccines, the New Jersey Medicaid Program has changed the fee schedule for the immunizations listed in this Newsletter and has added two new immunization procedure codes.

ACTION: The following procedure codes and corresponding fees will be effective for all immunization services rendered by physicians on and after April 1, 1983:

<u>Procedure Code</u>	<u>Description</u>	<u>Medicaid Dollar Value</u> \$
9075	RHO(D) Immune Globulin (Human) (Microdose for Abortions and Miscarriages)	34.00
9450	Immunization - Measles	9.15
9451	Immunization - Rubella	9.50
9452	Immunization - Mumps	10.25
9453	Immunization - Measles & Rubella combined vaccine (M&R)	13.55
9454	Immunization - Measles, Mumps & Rubella combined vaccine (MMR)	17.50
9455	Immunization - Diphtheria, Pertussis & Tetanus combined vaccine (DPT)	3.50
9456	Immunization - Diphtheria & Tetanus Toxoid combined vaccine (DT)	4.25
9457	Immunization - Diphtheria Toxoid	5.00
9459	Immunization - Tetanus Toxoid	3.95
9460	Immunization - Oral polio vaccine	4.25
9461	Immunization - Pneumococcal vaccine polyvalent	9.75
9462	Immunization - Rubella & Mumps combined vaccine	14.60
9445	Immunization - Influenza	4.75
9446	Immunization - Tetanus Antitoxin	5.50

If you have any questions regarding this Newsletter, please contact I. Fulton Erlichman, M.D., Acting Medical Director, Division of Medical Assistance and Health Services, at (609) 292-8157.



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

New Jersey Health Services Program NEWSLETTER

Volume P-357

March 28, 1983

To: All Providers of Health Care in Counties of
Atlantic, Cumberland, Gloucester, and Salem

Subject: Medicaid Eligible Recipients Participating as
Subscribers to the CUMBERLAND REGIONAL HEALTH PLAN

Effective: Immediately

Background: The Cumberland Regional Health Plan (CRHP), a Health Maintenance Organization (HMO) in Vineland, New Jersey, provides services for a specific group of Medicaid eligible individuals. The Medicaid eligible group consists of families who receive financial assistance under the program of Aid to Families with Dependent Children (AFDC), who are residents of Cumberland County, and who choose to be subscribers to the Cumberland Regional Health Plan.

The services provided by the Cumberland Regional Health Plan are:

1. General and Special hospital services, inpatient and outpatient,
2. Laboratory and X-ray services,
3. Early Periodic Screening, Diagnosis and Treatment approved equivalent services for enrollees under twenty-one years of age,
4. Physician services,
5. Home Health Care services (60 visits per year)*,
6. Physical therapy, occupational therapy, audiology and speech-language therapy services,
7. Independent clinic services (for Mental Health services, see Item #14),
8. Ambulance service required for emergency medical care,
9. Family planning services and supplies,
10. Nursing Home Care, skilled nursing and intermediate care (up to 30 days per year, per enrollee)*,
11. Podiatric services,
12. Optometric services,
13. Chiropractic services,
14. Mental health services (twenty (20) outpatient and thirty (30) inpatient days/year/enrollee)*,
15. Diagnosis and required medical treatment, and referral services for the abuse or addiction to alcohol or drugs, including detoxification,

16. Pharmaceutical services,
17. Optical appliances and
18. Hearing Aids.

*When during a calendar year sixty (60) visits for home health care or thirty (30) days of skilled nursing facility care have been utilized, a Medicaid eligible Plan subscriber may continue to receive these services and providers will be reimbursed under the existing rules and regulations of the New Jersey Medicaid Program during the remainder of the calendar year. Providers will receive from the Cumberland Regional Health Plan an authorized Exhaustion of Benefits form, a copy of which must be submitted with all claims.

The following services or items are not provided by the Cumberland Regional Health Plan and Medicaid eligible subscribers of the Plan may secure these services from Medicaid providers who will be reimbursed under the existing rules and regulations of the New Jersey Medicaid Program:

1. Dental services,
2. Prosthetics and Orthotics appliances,
3. Medical supplies and equipment,
4. Medical Day Care and
5. Invalid Coach.

Cumberland Regional Health Plan subscribers are entitled to receive emergency care services from any provider. Except in life-threatening situations, emergency care will be covered only if authorized by a CRHP physician provided the patient is within a 12 mile radius of Vineland. Outside a 12 mile radius, emergency care will be covered without prior authorization provided the patient notifies CRHP within 48 hours of receiving medical services. Hospital and physician claims should be submitted to:

Cumberland Regional Health Plan
27 South East Boulevard
Vineland, New Jersey 08360

Instructions for submission of claims for providing emergency services are also printed on the back of the Cumberland Regional Health Plan Subscriber Identification Card. An example of the card is shown below:

Cumberland Regional Health Plan 27 S. E. Boulevard Vineland, N. J. 08360 (609) 696-2232		SUBSCRIBER IDENTIFICATION CARD	
SUBSCRIBER'S NAME		EFFECTIVE DATE	
COVERAGE	DEPENDENTS		
GROUP NUMBER	CO-PAYMENT	MEDICAL RECORD NUMBER	

This card is non-transferable. The member agrees to abide by the rules, regulations and procedures of the Cumberland Regional Health Plan. Unlawful use of this card is punishable by law.

ATTENTION PROVIDERS

This card entitles the holder to coverage for services provided, arranged or approved by a Cumberland Regional Health Plan physician. Except in life-threatening situations, emergency care will be covered only if authorized by a CRHP physician provided the patient is within a 12 mile radius of Vineland. Outside a 12 mile radius, emergency care will be covered without prior authorization provided the patient notifies CRHP within 48 hours of receiving medical services.

Hospital and physician claims should be submitted to:
 Cumberland Regional Health Plan
 27 South East Boulevard
 Vineland, New Jersey 08360

IN THE EVENT OF A MEDICAL EMERGENCY, CALL (609) 696-2232 FOR INSTRUCTIONS.
 A PHYSICIAN IS ON CALL 24 HOURS A DAY, 7 DAYS A WEEK.

The Cumberland County Welfare Agency will be issuing an altered check stub to Medicaid eligible individuals who choose to become HMO members. Following is an example of the altered check stub which states on top of the card:

"RESTRICTED USE-HMO, CALL (609) 696-8004".

RESTRICTED USE-HMO CALL 609-696-8004

STUB NO.

02201528

DEPARTMENT OF HUMAN SERVICES
MEDICAID-ID

VALID ONLY FOR THE MONTH OF JANUARY 1983
MEDICAID HSP # 0134567890

NOTICE TO PROVIDER

ELIGIBLE PERSONS	PER #	ELIGIBLE PERSONS	PER #
	11		
	12		
	13		
LAST PERSON PRINTED	14		
	15		
	16		
	17		
	18		
	19		
	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

Any questions regarding this Newsletter should be directed to Lawrence Strand, Financial Analyst, Prepaid Health Plans, Division of Medical Assistance and Health Services, telephone (609) 292-1877.



CUMBERLAND REGIONAL HEALTH PLAN

27 South East Boulevard • Vineland, New Jersey 08360 (609) 696-2232

Arthur P. Schalick, Jr.
President, Board of Directors

Dominic V. DeCencio, Ph.D.
Executive Vice President

March 23, 1983

Dear Provider:

This is to inform you that _____ a member of Cumberland Regional Health Plan has exhausted the _____ days of coverage for your services. A Plan subscriber may continue to receive these services, however you will be reimbursed under the existing rules and regulations of the New Jersey Medicaid Program during the remainder of the calendar year.

A copy of this form must be submitted with all claims. Should you have any questions, please contact claims department 696-8001.

Sincerely,

The C.R.H.P. Claims Department

LS/k1s



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

New Jersey Health Services Program **NEWSLETTER**

Volume P-358

April 18, 1983

TO: ADMINISTRATORS - DIAGNOSIS RELATED GROUP (DRG) HOSPITALS
SUBJECT: CALCULATIONS FOR MEDICAID DRG PRICE PER CASE
EFFECTIVE: IMMEDIATELY

As stated in NJHSP Newsletter P-351 dated February 7, 1983, Medicaid inpatient claims will be paid on the basis of Department of Health DRG price per case criteria effective with admissions on or after March 1, 1983.

In order for each claim to be priced correctly, it is necessary that the contractor's DRG pricing file be complete and accurate for each DRG provider at the time of implementation. A pricing file for each DRG provider has been created utilizing base rate data, mark-up factor, payor factor, and the trim points in effect as of March 1, 1983. Providers must notify the contractor 30 work days before any changes in these elements are used in submitting claims. DRG amounts as calculated by the provider will be screened for accuracy. Significant variances (see below) will cause the claim to reject from the system.

The DRG amount will be calculated by the pricing file as follows:

Inliers - Base Rate (from pricing file)
 xMark-Up (from pricing file)
 Base Rate Incl. Mark-Up (product will be rounded to nearest cent*)
 xPayor Factor (from pricing file)
 Pre-Discounted DRG Amount (product will be rounded to nearest cent*)

Outliers - Total Charges (per claim)
 xPayor Factor (from pricing file)
 Pre-Discounted DRG Amount (product will be rounded to nearest cent*)

*Examples: Round off to the next higher number if the fraction of a cent is 5 or greater.

Product = \$1,215.444, rounded amount will be \$1,215.44;
 Product = \$1,215.445, rounded amount will be \$1,215.45.

The pre-discounted DRG amount will be compared, by dollars only, to the DRG amount on the claim. If they are equal, the pre-discounted DRG amount, both dollars and cents, will be overlaid in the DRG amount field and carried through the Medicaid system.

As in the past, a 4% prompt payor discount will be applied to all inpatient claims. Should you have any questions regarding this Newsletter, please contact your contractor - Prudential - at (609) 293-2045.



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

New Jersey Health Services Program NEWSLETTER

VolumeP-360.....

June 24, 1983

TO: All Providers

SUBJECT: Medicaid Eligibility Identification Card Revision

EFFECTIVE: July 1, 1983

ACTION: Effective July 1, 1983, the Division of Medical Assistance and Health Services will issue a single Medicaid Eligibility Identification Card for SSI, DYFS and Special Status clients.

The new card (FD-73/178) which replaces the SSI card (FD-73), and the DYFS card (FD-178), and the red and yellow Special Status cards previously used, will be computer generated and will be distributed monthly (SSI and the Special Status) or quarterly (DYFS).

The Special Status Program restricts the Medicaid client to a single provider of pharmaceutical services. The name and address of the pharmacy to which the client is restricted will be printed on the top of the Medicaid Eligibility Identification Card. In some cases, in an effort to discourage misuse or card lending, a message will be printed on the card alerting the provider to ask the Medicaid client for additional identification. If this message appears, to prevent unauthorized use, be certain to carefully request some other proof of the client's identification. The use of these new cards for Special Status clients will obviate use of the red and yellow Medicaid ID Special Status Cards described in New Jersey Health Services Program Newsletter Volume Nos. P-285 and BC-184.

The new card provides ADDITIONAL HEALTH INSURANCE information. If the Medicaid client has health insurance, the name of the other insurer will be printed together with a corresponding policy number. Additionally, the type of Medicare coverage (Part A, Part B or A and B) and the HIC (Medicare) Number will be included for all Medicare/Medicaid eligibles.

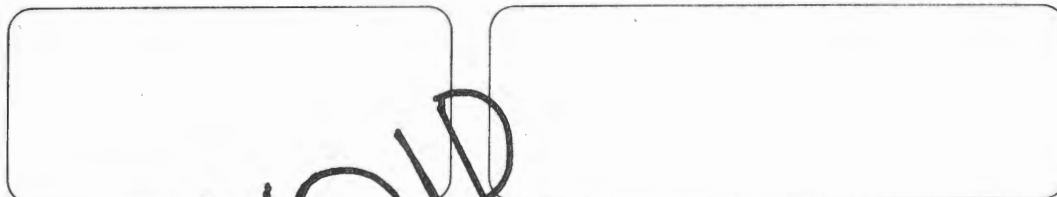
Federal and New Jersey laws require that all other sources of payment for medical care be used before Medicaid pays for medical care. With this in mind, it is requested that providers ask Medicaid clients if they have other insurance coverage even if it is not printed on the Medicaid Eligibility Identification Card. If the client indicates he/she has other insurance, but it is not identified on the card, the provider should bill the other insurance carrier and then submit, when appropriate, a claim to Medicaid for any unpaid balance identifying the other insurer.

Except for the changes noted above and changes in the format, the revised card contains the same basic information that appeared on the existing Medicaid Eligibility Identification Cards. There is no change in the way the card is used.

The New Jersey Medicaid Program will now issue two basic types of permanent Medicaid Eligibility Identification Cards, the new FD-73/178 for SSI, DYFS and Special Status clients (Exhibit I) and the Department of Human Services Medicaid ID Card, which is issued monthly for the AFDC and "Medicaid Only" clients (Exhibit II).

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

MEDICAID ELIGIBILITY IDENTIFICATION CARD (EXHIBIT I)



ADDITIONAL HEALTH INSURANCE *

HSP (MEDICAID) CASE NO. PERS NO.

0312064024 01

VALID FROM 07/01/83 TO 07/31/83

157-32-4872 04/03

MEDICARE PART A B
HIC NO 123456789A

SOC. SEC. ACCT. NO. DATE OF BIRTH

JOHN M. JONES
432 EAST STREET
SOMEWHERE, NEW JERSEY 08332

USE THIS CARD WHEN YOU NEED MEDICAL SERVICES
JOHN M. JONES

RECIPIENT'S SIGNATURE

FD-73/178 (REV. 7/83)

*OTHER INSURANCE COVERAGE

(EXHIBIT II)

DEPARTMENT OF HUMAN SERVICES
MEDICAID-ID

VALID ONLY FOR THE MONTH OF FEBRUARY 1983
MEDICAID HSP # 0930400130

NOTICE TO PROVIDER

ELIGIBLE PERSONS		PER #	ELIGIBLE PERSONS		PER #
*LINDA	DOE	01			11
*RON	DOE	02			12
*JUDY	DOE	20			13
LAST PERSON PRINTED					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.

VOID

For temporary proof of identification, the County Welfare Agencies will continue to issue the MAP-16 forms, the Division of Youth and Family Services will continue to issue the DYFS 16-36 cards, and the State Psychiatric Hospitals and Mental Retardation Institutions will continue to utilize the FD-34 as a validation of eligibility. These forms are shown in your Medicaid Provider Manual (Chapter I).

Any questions regarding this Newsletter should be directed to the Medicaid District Office serving your particular county.



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

New Jersey Health Services Program NEWSLETTER

Volume P-361

July 15, 1983

TO: ALL PHYSICIANS, INDEPENDENT CLINICS
AND HEALTH MAINTENANCE ORGANIZATIONS

SUBJECT: DEMONSTRATION PROJECT - MEDICAID PERSONAL PHYSICIAN PLAN (MP PLAN)

EFFECTIVE: IMMEDIATELY

INTRODUCTION: The New Jersey Medicaid Program is announcing a Demonstration Project, the Medicaid Personal Physician Plan, which will provide medical care in a manner different from the present Medicaid system. Participation in the MP Plan for physicians and recipients is voluntary. Either may choose the Plan or remain in the current Medicaid system. A physician may participate in both programs simultaneously.

A critical role in the Demonstration is assigned to the physician who undertakes patient case management and provides for primary care and referral care. The Plan is oriented toward coordinated personal health care as opposed to fragmented, episodic care. It is classified as a Primary Care Network or a health care delivery system whereby all of the Medicaid recipient's health care will be obtained through, but not necessarily from, a single primary care provider.

The MP Plan will be phased in throughout the State over a four-year period, or sooner if feasible. It will be implemented first in Morris, Warren, and Sussex counties. Participating providers may be in solo practice; group practice; professional corporation or association; health maintenance organization (HMO); independent, free-standing clinic; or in a hospital affiliated entity which allows for primary care services and is not subject to DRG reimbursement principles.

This four-year Statewide Demonstration Project was developed under a federal grant from the Health Care Financing Administration (HCFA) Grant Number 11-P-9822212, with the intention of improving provider reimbursement as part of the effort to improve the primary medical care of New Jersey Medicaid eligibles. The proposal was developed under guidelines established by HCFA for funding which led to inclusion of the following key elements:

- (a) a capitation system of reimbursement instead of fee-for-service;
- (b) the stimulation of competition among providers by providing strengthened alternatives to primary care in the hospital Emergency Room (ER) and Outpatient Department (OPD) setting;
- (c) a primary care physician who would be responsible for the provision of primary care delivery, referral, and ancillary services for non-institutional Medicaid recipients;
- (d) a broker concept for marketing, enrollment, grievance system and quality assurance monitoring.

The New Jersey Medicaid Program believes this Demonstration Project has benefits which will provide incentives for provider participation and has potential for success in containing or reducing the cost of medical care for Medicaid eligible persons while improving the overall quality and continuity of care.

The discussion which follows gives basic, but limited, information about the MP Plan and will cover:

- I. Role of participants in MP Plan
- II. Key Elements of MP Plan, including (1) Medicaid services under the MP Plan, (2) the Capitation System and (3) Claims payment.
- III. Summary

Discussion:

I. Role of Participants in MP Plan

1. Physician Case Manager (PCM)

The PCM is responsible for the provision of all primary care to Plan members, management of all referral services including ancillary services, follow-up care and higher level care.

The PCM may be a general practitioner or any specialist such as obstetrician-gynecologist, family practitioner, internist or pediatrician. A physician group, health maintenance organization (HMO), professional corporation or association also may participate in the Plan even though all physicians in such organizations are not participating as case managers.** Each Medicaid Plan member must be assigned to a specific PCM, including those instances where the PCM is a member of a group practice, HMO or similar type organization. The PCM in a provider organization establishes with the organization his/her own fiduciary arrangements for payment.

The PCM is to review and approve all medical services and expenditures on behalf of the patient and to provide or arrange for the provision of twenty-four hour, 7 day a week medical coverage. In addition to determining which medical services the patient receives, or in choosing the consultant who determines the services, the PCM is in the best position to evaluate the quality of care provided by a consultant, laboratory, pharmacy, hospital and other providers while still maintaining an awareness of the costs involved. The unique and critical features of case managing is the role of the PCM as both medical and financial manager for the patient's care.

The concept of the Physician Case Manager controlling costs has received wide support throughout the country since this role negates the need for increased government regulation and harsh budget caps.

** Due to the specific policies governing reimbursement under the New Jersey Diagnosis Related Group (DRG) Demonstration for hospital services, hospital outpatient departments will not be allowed to participate as PCM's. Outpatient clinics that are organizationally, financially and physically separate from the affiliated hospital will be allowed to participate.

The eligibility criteria for participation as a PCM are minimal:

- (1) must be a physician licensed to practice medicine or surgery;
- (2) must be an approved participating physician of the New Jersey Medicaid Program;
- (3) must enroll in the Plan through the designated Broker; and
- (4) must provide services through a free-standing, independent practice or hospital affiliated entity not subject to DRG reimbursement principles and which allows for provision of primary care services (solo practitioners, partnership, group practices, professional corporation or association, HMO, or independent clinic).

2. Broker Role

To ensure that the MP Plan is administered effectively, an agency at the local community level is selected for this role. The State contracts with a broker organization selected by bid process, with exception of Phase I. In Phase I, the Demonstration is confined to the northwestern part of the State (Warren, Sussex and Morris Counties) and the Professional Standards Review Organization (PSRO) in that area is utilized as the broker.

The broker is responsible for:

- (a) marketing to physicians and Medicaid eligibles;
- (b) enrolling physician case managers and Medicaid eligibles and maintaining a supply and demand equilibrium;
- (c) quality assurance of health care provided to Medicaid enrollees in the Demonstration;
- (d) implementing grievance procedures for enrollees and providers.

3. Medicaid Eligible Persons as Plan Members

Upon enrollment in the Plan, the Medicaid enrollee will select a PCM, for a minimum of six months, from a list provided by the broker or other enrolling agent (County Welfare Agency, Division of Youth and Family Services, Medicaid District Office). During the first 30 days of participation in the MP Plan, a member may return to the broker and request to change his/her physician selection. After this one allowable change of a PCM or after the expiration of the initial 30 days, a member may change case managers only (1) through the grievance procedure, or (2) on the six month anniversary of enrollment or (3) on re-enrollment. Each family member may select his/her own physician (e.g., mothers, an obstetrician/gynecologist; children, a pediatrician; fathers, a general practitioner). A Medicaid eligible family may enroll as Plan members only if all the Medicaid eligible family members join.

The enrolling agency issues an unique MP Plan Identification Card to the MP Plan member. The card contains the names of Plan members, and the name and telephone number of the PCM and the Broker. In addition there is a warning message to Medicaid providers with instructions not to provide services to Plan members, except for true emergency intervention, without authorization from the PCM. The current Medicaid Eligibility Identification Card will be stamped "Valid Only with MP Plan Card".

4. State Role

The State role in the Plan will include:

- (a) eligibility determination;
- (b) negotiating and signing contracts with brokers;
- (c) enrollment of Plan members;
- (d) maintaining and implementing the capitation accounting system;
- (e) fiduciary function in conjunction with the State's claims processing contractors, Prudential and Blue Cross;
- (f) providing PCM with (1) enrollment, (2) utilization and (3) accounting reports;
- (g) overseeing the Demonstration, monitoring its performance and carrying out mid-course corrections required to improve the effectiveness of the MP Plan program; and
- (h) development and overall monitoring of Quality Assurance System.

II. Key Elements of the MP Plan

1. Medicaid Services available under the MP Plan

A. Services Included in the Capitation: The following must be provided directly by the PCM or through authorized referral:

- (a) all physician services (including inpatient physician services);
- (b) certified nurse midwife services;
- (c) chiropractor services;
- (d) optometrist services;
- (e) podiatrist services;
- (f) psychologist services;
- (g) inpatient hospitalization (in Phases II through IV);
- (h) all hospital outpatient services;
- (i) ER services for emergencies;
- (j) prescription drugs;
- (k) clinic services at freestanding clinics;
- (l) home health services;
- (m) laboratory and radiology services;
- (n) durable medical equipment;
- (o) hearing aids;
- (p) optical appliances; and
- (q) medical supplies.

B. Services Excluded from Capitation

1. Require Authorization by PCM:

- (a) inpatient hospitalization (Phase I only);
- (b) long-term care;
- (c) medical day care;
- (d) prosthetics and orthotics; and
- (e) transportation.

2. Do Not Require Authorization by PCM:

- (a) dental services;
- (b) services unique to HUD Demonstration Provider services; and
- (c) services unique to Alcohol Demonstration Provider services.

Non-emergency services rendered in the emergency room are excluded as services available for MP Plan members unless authorized (and therefore paid for) by the PCM. In general, any provider rendering a service from list "A." will not receive a fee-for-service payment unless the service was authorized by the Physician Case Manager.

2. Capitation System:

A Physician Case Manager is reimbursed on a capitation basis for his/her services and for managing the care provided to enrolled patients. Differences in capitation rates reflect the fact that different people utilize a different mix of services with different cost structures. Thus the monthly capitation rates allocated to a PCM will depend upon the age, sex, category of eligibility (i.e. Aid to Family with Dependent Children Program, Old Age Assistance Program, etc.) and county of residence of the MP Plan members. The capitation payment is allocated to the PCM every month for each person enrolled in the PCM's panel.

In return for the capitation payments, the PCM must provide and/or manage and be responsible (within limits) for the services as listed previously.

3. Claims Payment:

The State will pay all referral providers directly through its existing claims processing system for services rendered to Plan members on the basis of a referral from the PCM. The only change from the current claim payment procedure is that all services, with the exception of Dentistry, must be approved by the PCM or the claim will be rejected. Blue Cross and Prudential have a tracking system for referral claims. All claim forms must carry the name and IMP number of the PCM even if there is Medicare or other insurance involvement.

III. Summary:

The MP Plan Demonstration Project will provide medical care in a new and innovative manner in the State of New Jersey. The participation of the physician as a case manager is crucial to the success of the Project. The New Jersey Medicaid Program believes that the Demonstration Project will improve the primary medical care of New Jersey Medicaid eligible persons participating in the MP Plan and that the Physician Case Manager practicing sound medicine stands to benefit from the capitation system as contrasted with the fee-for-service reimbursement.

Any physician or eligible provider wishing to obtain more information about the MP Plan and serves eligible recipients in Warren, Sussex or Morris counties may phone or write to: PSRO, Area 1, Region II, 2 Shunpike Road, Madison, N.J. 07940. Telephone 201-377-8100

All others wishing information may write to S. Eugene Yuliano, M.D., Medical Director, CN-712, Trenton, N.J. 08625.



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

New Jersey Health Services Program NEWSLETTER

Volume P-362

July 15, 1983

TO: ALL MEDICAID PROVIDERS

SUBJECT: Medicaid Personal Physician Plan (MP Plan)
Demonstration Project
PROCEDURES FOR SUBMITTING CLAIMS FOR MP-PLAN SERVICES

EFFECTIVE: Immediately

INTRODUCTION: The New Jersey Medicaid Program has implemented a four-year Statewide Competition Demonstration Project, called the Medicaid Personal Physician Plan (MP Plan), which will provide medical care in a manner different from the present Medicaid system. The Plan is classified as a Primary Care Network or a health care delivery system whereby all of the Medicaid eligible's health care is obtained through, but not necessarily from, a single primary care provider. It was developed under guidelines established by the Health Care Financing Administration for funding which led to the inclusion of the following key elements:

- (1) a primary care physician who would be responsible for the provision of all primary care delivery, referral, and ancillary services for non-institutional Medicaid eligibles;
- (2) a capitation system of reimbursement, instead of fee-for-service, for a physician participating in the Plan as a Physician Case Manager (PCM);
- (3) a broker concept for marketing, enrollment, grievance system and quality assurance monitoring and Plan reporting functions;
- (4) the stimulation of competition among certain types of Medicaid providers by providing strengthened alternatives to primary care in the hospital Emergency Room (ER) and Outpatient Department setting (OPD).

The role of Physician Case Manager has potential to (1) discourage doctor shopping, self-referral, and inappropriate and excessive utilization of Medicaid eligible services and (2) to effect better control over almost 500 million dollars of New Jersey Medicaid's total expenditures annually without reducing quality or scope of care provided. This concept of the Physician Case Manager controlling costs has received wide support throughout the country since this role negates the need for increased government regulation and harsh budget caps.

The MP Plan will be phased in throughout the State over a four-year period, or sooner if feasible. It will be implemented first in Morris, Sussex and Warren counties. Participating providers may be in solo practice; group practice; professional corporation or association; health maintenance organization (HMO); independent, free-standing clinic; or in a hospital affiliated entity which allows for primary care services and is not subject to DRG reimbursement principles .

PURPOSE: The purpose of this Newsletter is to inform Medicaid providers (1) about the MP Plan, (2) about the provider's role when a Physician Case Manager refers his/her patients for services or when a MP Plan member requests a service independently, and (3) to inform providers about the procedure which must be followed when submitting claims.

The role of Medicaid eligibles as MP Plan members, of physicians as Case Managers, and of the Contractors (Blue Cross and Prudential) as claims payor is outlined in this Newsletter under the section "Background". The procedures all providers must follow when submitting claims for services rendered MP Plan members are outlined under the section "Action".

BACKGROUND: The participation of physicians and Medicaid eligibles in the Demonstration Project is voluntary. A physician may participate in the MP Plan and continue to participate in the current Medicaid Program under the usual conditions.

1. Role of Medicaid Eligible:

A Medicaid eligible who enrolls in the Plan selects a Physician Case Manager, for a minimum of six months, from a list provided by the broker. Each Medicaid eligible will have his/her own PCM, including those instances where the case manager is a member of a group practice, a Health Maintenance Organization, or similar type organization. A Medicaid eligible family may enroll in the MP Plan only if all the Medicaid eligible family members join. It is not necessary, however, for each family member to choose the same PCM.

The Plan member allows his/her PCM to coordinate all medical care and agrees to seek care only from that chosen PCM except for specifically excluded services (such as dental) or in situations where a delay would cause lasting damage to the patient's health or loss of life.

2. Role of Physician Case Manager:

The PCM is responsible for the provision of all primary care to Plan members and for management of all referral services. The PCM must review and approve all medical services and expenditures on behalf of the patient (including referrals for ancillary services, specialty care, and hospitalization) and provide or arrange for the provision of twenty-four hour, 7 day a week medical coverage. A PCM is reimbursed on a capitation basis for his/her services and for managing the care provided to his/her patients. When the PCM refers a patient to a specialist, or writes a prescription to be filled at a pharmacy, or refers the patient to an independent laboratory, the costs of these referral services will be deducted from the PCM's Capitation Accounting Fund at the existing fee-for-service schedule. Thus, the PCM must be able to exercise judgment and control over services rendered to his/her patients. This is accomplished by the requirement that services must be authorized by the PCM before they are provided.

3. Role of Contractors:

The State will continue to pay all Medicaid providers directly through its existing claims processing system for authorized services rendered MP Plan members. The Contractors have a system for tracking claims submitted for these services. Providers will continue to submit claims for payment to

the appropriate contractor. Each claim will be matched against the Medicaid eligibility MP Plan file to determine (1) whether the Medicaid recipient is a MP Plan member, (2) whether the recipient was enrolled as such when the service was provided, and (3) whether the service was authorized by the PCM. If these conditions are met, the claim will be processed.

ACTION REQUIRED: All Medicaid providers are directly affected by the MP Plan if they provide services to MP Plan members. Specific procedures must be followed in order to receive reimbursement for these services.

PLEASE NOTE: WITH EXCEPTION OF SECOND OPINION, EXISTING NEW JERSEY MEDICAID PROGRAM REGULATIONS REMAIN IN EFFECT; FOR EXAMPLE, IF A SERVICE REQUIRES AUTHORIZATION FROM THE MEDICAID DISTRICT OFFICE (MDO) OR THE DIVISION'S CENTRAL OFFICE, THIS REQUIREMENT STILL APPLIES AS WELL AS THE REQUIREMENT THAT ALL SERVICES FOR MP PLAN MEMBERS BE APPROVED BY THE PCM BEFOREHAND.

A. ACTION REQUIRED BY PHYSICIAN CASE MANAGER:

1. SUBMIT 1500 N.J. FORM

The Physician Case Manager must submit a Health Insurance Claim Form (1500 N.J.) for each encounter with a patient who is included in his/her panel of MP Plan members. The form is required for encounter data, not for billing purposes. Information on the claim must include:

- (1) The same information which is required for the fee-for-service process, i.e., description of procedure, procedure code, etc.;
- (2) Code 9078 for office dispensed drugs; include name of drug in Item No.24D.

When a PCM participates in the MP Plan as a member of a group, the PCM's name and IMP number must be included in Item #30 (Provider Social Security, I.D. No.) on the 1500 N.J. form for services rendered the MP Plan member by the PCM, as well as the group's provider number in Item #31. In situations where a MP Plan patient is referred to other members of the group, the New Jersey Medicaid Program will not reimburse on a fee-for-service basis for these services.

A Physician Case Manager receives detailed instruction from his/her MP Plan broker about all aspects of the MP Plan and responsibilities as a PCM.

B. ACTION REQUIRED BY ALL PROVIDERS EXCEPT PCM's:

This section details the following four procedures which must be followed when providing services and requesting payment for services rendered MP Plan members:

1. Check eligibility validation card for MP Plan message
2. Ask to see MP Plan Card (contains name of PCM)
3. Receive authorization to provide service from PCM
4. Include PCM's name and IMP number on claim form even if there is Medicare or other insurance involvement.

1. CHECK ELIGIBILITY VALIDATION CARD FOR MP PLAN MESSAGE

Check the Medicaid eligibility validation form, as at present, but now providers also must look for one of the following two messages (depending upon which Medicaid eligibility validation form is presented):

(1) MEDICAID, PERSONAL PHYSICIAN PLAN
VALID ONLY WITH MP PLAN CARD

(This message will appear on the left side of the Medicaid Eligibility Identification Card (FD-73/178, Rev.7/83), in the "Additional Health Insurance" section, for cards issued to SSI and DYFS Medicaid eligibles who are enrolled as MP Plan Members.)


(2) VALID ONLY WITH MP PLAN CARD

(This message will appear on the Department of Human Services Medicaid ID card, in the upper left-hand corner, when issued to AFDC and "MEDICAID ONLY" eligibles who are enrolled as MP Plan members.)

Whichever Medicaid eligibility validation form is used, always check for the message: VALID ONLY WITH MP PLAN CARD.

2. ASK TO SEE MP PLAN CARD:

If the Eligibility Card carries the message "Valid Only With MP Plan Card", you must ask to see the MP Plan Card which is illustrated below. You will note that the member's name, physician's (case manager) name and telephone number and broker's name and telephone number are listed.

ATTENTION PROVIDERS		MP PLAN MEMBER IDENTIFICATION CARD	
<p>This card is non-transferable and is not proof of eligibility. The Medicaid Eligibility Identification Card is the member's proof of eligibility and must be presented with this card each time medical services are needed. The member agrees to abide by the rules, regulations and procedures of the Medicaid Personal Physician Plan. Unlawful use of this card is punishable by law. This card entitles the cardholder to coverage for services arranged for or approved by the Plan physician EXCEPT DENTAL SERVICES. Emergency Room services will be covered only if authorized by the physician identified on the front of this card. EXCEPTION: Life threatening situations DO NOT require authorization.</p>			
<p>RECIPIENT REMINDER To arrange for unscheduled care or to receive a consultation regarding any medical problem, please contact your physician for instructions. A physician is available hours a-day, 7 days a week. Any questions should be directed to your MP Plan office (listed on the front of this card).</p>		<p>NEW JERSEY DEPARTMENT OF HUMAN SERVICES MP-1 (6/83)</p>	
<p>New Jersey Medicaid Personal Physician Plan</p> <p><i>Plan Office:</i> PSRO, Area I, Region II 2 Shunpike Road Madison, N.J. 07940 Tel.: (201) 377-8100</p> <p>The MP Plan EXEMPTS you from any COPAY-MENT.</p>		<p><u>MEMBER'S NAME</u></p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<p><u>PHYSICIAN'S NAME</u> <u>TEL. NO.</u></p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

3. RECEIVE AUTHORIZATION TO PROVIDE SERVICE FROM PHYSICIAN CASE MANAGER
 Providers, with the exception of dentists, must have approval from the Physician Case Manager before providing any of the following services:

(a) The following services require authorization from the Physician Case Manager:

- (1) physician services, including inpatient physician services;
- (2) certified nurse midwife services;
- (3) chiropractor services;
- (4) optometrist services;
- (5) podiatrist services;
- (6) psychologist services;
- (7) hospital services, including
 - i. emergency room service (Note: true life or organ threatening conditions may be treated, with notification of the PCM as soon as possible)
 - ii. inpatient hospitalization; and
 - iii. outpatient clinic;
- (8) clinic services at free-standing clinics;
- (9) drugs (prescription);
- (10) home health services;
- (11) laboratory and radiology services;
- (12) long-term-care services;
- (13) medical day care;
- (14) medical equipment (durable);
- (15) hearing aids;
- (16) medical supplies;
- (17) optical appliances;
- (18) prosthetics and orthotics; and
- (19) transportation.

(b) The following services do not require authorization from the PCM:

- (1) dental services;
DENTIST PLEASE NOTE: A dentist who prescribes a drug for a MP Plan member must communicate this information to the PCM. The dentist must also write the PCM's name and IMP number on the prescription form as the pharmacist will need this information in order to submit a claim for payment.
- (2) services unique to Alcohol Demonstration Provider services;
- (3) services unique to HUD Demonstration Provider services.

(c) Two referral forms have been prepared for the PCM to use when requesting services. One referral form is for services and treatment and the second is for consultations. These two forms are listed below and a copy of each is attached to this Newsletter:

1. Form MP-6, 4/83, - MEDICAID PERSONAL PHYSICIAN PLAN (MP PLAN) ANCILLARY/TREATMENT SERVICES REFERRAL; and
2. Form MP-7, 4/83, - MEDICAID PERSONAL PHYSICIAN PLAN (MP PLAN) - REFERRAL SERVICES FORM.

The PCM will use these forms to indicate the service(s) requested. The PCM's IMP number is indicated for the provider's convenience.

If a MP Plan member requests a service and does not have a signed referral form, the provider must contact the PCM for authorization before rendering the service.

4. INCLUDE PCM'S NAME AND IMP NUMBER ON CLAIM FORM

ALL claims submitted for services rendered a MP Plan member must verify authorization from the Physician Case Manager by entering the the PCM's name and IMP number on the claim form even if there is Medicare or other insurance involvement.

Irrespective of the mode of claim submission (hard copy or electronic medium) all claims must include the PCM's name and IMP number. A claim submitted for a service which required authorization from the PCM will be rejected for payment if it does not include the PCM's name and IMP number.

You must enter the PCM's name and IMP number in the designated space on the appropriate claim form as follows:

a. HEALTH INSURANCE CLAIM FORM (1500 N.J.):

Item 19. (Name of referring physician...): Enter PCM's Name
Item 19a. (I.D. Number): Enter PCM's IMP Number

b. HOME HEALTH CLAIM (Mc-3C):

Item 16. (Referring Physician's Individual Medicaid Practitioner Number): Enter PCM's IMP Number
Item 17. (Referring Physician's Name): Enter PCM's Name

If the referring physician's name is different from the PCM, enter that information in "Remarks" section of Mc-3C form as follows:

Referring Physician: Name: _____ IMP Number: _____

PLEASE NOTE: This form has been revised to include a new space for the PCM. The revised form, Mc-3C (5-83), will be distributed by Prudential through the automated system for resupplying Medicaid claim forms. Blue Cross will distribute the revised form when their supply of the old form is depleted.

Enter the PCM information on the revised form, Mc-3C (5/83), as follows:

Item 20A. (Physician Case Manager Name): Enter PCM's name
(Individual Medicaid Practitioner Number): Enter PCM's IMP number

c. HOSPITAL CLAIM FORMS:

(1) Uniform Billing - Patient Summary (UB PS/80):

Item (11) (Attending Physician): Enter the PCM's IMP number

Item (105) (Remarks): Enter: PCM - _____ (PCM's Name)

(2) Inpatient Hospital Claim (MC-1C):

Item 17. (Attending Physician's Individual Medicaid Practitioner Number): Enter PCM IMP number

Item 18. (Attending Physician's Name): Enter PCM's name

PLEASE NOTE: For inpatient hospital billing, the Physician Case Manager will always be entered as the Attending Physician. If the Attending Physician's name is different from the Physician Case Manager's name, enter that information in the "Remarks" section of form as follows:

Attending Physician: Name _____ IMP Number _____

(3) Outpatient Hospital Claim (MC-4C):

Item 16. (Referring Physician's Individual Medicaid Practitioner Number): Enter PCM's IMP number

Item 17. (Referring Physician's Name): Enter PCM's name

Please Note: If the referring physician's name is different from the Physician Case Manager's name, enter that information in the "Remarks" section of the form as follows:

Referring Physician: (Name) _____ IMP Number _____

d. INDEPENDENT OUTPATIENT HEALTH FACILITY (MC-14):Item 14. (Referring Practitioner's Name): Enter PCM's Name
(Individual Medicaid Practitioner Number): Enter PCM's IMP numbere. INDEPENDENT LABORATORY CLAIM (MC-13A):Item 12. (Prescribing Practitioner Name): Enter PCM's Name
(Individual Medicaid Practitioner Number): Enter PCM's IMP number

PLEASE NOTE: This form is being revised to include a new space for the PCM. The revised form, MC-13A (4/83), will be distributed by Prudential in September through the automated system for resupplying Medicaid claim forms. Providers receiving the new form should enter information about the PCM as follows:

Item 12. (Physician Case Manager): Enter PCM's name
(Individual Medicaid Practitioner Number): Enter PCM's IMP numberf. MEDICAL SUPPLIES AND EQUIPMENT CLAIM (MC-11):

Item 16. (Name and number of Prescribing Practitioner): Enter PCM's name and IMP number

g. OPTICAL APPLIANCES (Request for Authorization and Payment)(MC-9A):Item 18. (Prescribing Practitioner Name): Enter PCM's Name
(Individual Medicaid Practitioner Number): Enter PCM's IMP number

PLEASE NOTE: This form is being revised to include a new space for the PCM. The revised form, MC-9A, will be distributed, when available, by Prudential through the automated system for

resupplying Medicaid claim forms. Enter the PCM information on the newly revised form as follows:

Item 18a. (Physician Case Manager): Enter PCM's Name
(Individual Medicaid Practitioner Number): Enter
PCM's IMP number

h. PRESCRIPTION CLAIM FORM (MC-6):

Item: (Prescriber's Individual Medicaid Practitioner's Number):
Enter PCM's IMP number

i. PROSTHETIC AND ORTHOTIC APPLIANCE CLAIM (MC-15):

Item 15. (Name and Number of Prescribing Practitioner): Enter
PCM's name and IMP number

j. TRANSPORTATION CLAIM (MC-12):

Item 11: (Name of Practitioner ordering transportation): Enter
PCM's name and IMP number

PLEASE NOTE: This form is being revised to include a new space for the PCM. The revised form MC-12 (5/83), will be distributed by Prudential in September through the automated system for resupplying Medicaid claim forms. Enter the PCM information on the revised form as follows:

Item 11a: (Physician Case Manager): Enter PCM's name
(Individual Medicaid Practitioner Number): Enter
PCM's IMP number.

In you have any questions concerning this newsletter, please inquire as follows:

1. Physicians Case Managers serving recipients in Morris, Sussex and Warren counties should contact their Broker: PSRO, Area 1, Region II, 2 Shunpike Road, Madison, N.J. 07940. Telephone 201-377-8100.
2. All other providers should contact the appropriate Contractor, Blue Cross at 201-456-2570 or Prudential at (Toll Free Number) 800-582-7052.

Attachments: Copy of Form MP-6, 4/83
Copy of Form MP-7, 4/83



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

**MEDICAID PERSONAL PHYSICIAN PLAN (MP PLAN)
 ANCILLARY/TREATMENT SERVICES REFERRAL FORM**

MP Plan Member's Name: _____ Referred To: _____
(Name of Service)

Date: _____

Member's HSP (Medicaid) Case No.: _____ Person No. _____

Physician Case Manager's Name: _____

Physician Case Manager's IMP No.: _____

Check appropriate box and specify/explain below:

CAPITATED SERVICES REQUIRING AUTHORIZATION

NON-CAPITATED SERVICES REQUIRING AUTHORIZATION

- | | | |
|--|---|--|
| <input type="checkbox"/> Laboratory services | <input type="checkbox"/> Optical Appliances | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Radiological services | <input type="checkbox"/> Home Health Care | <input type="checkbox"/> Long-Term Care |
| <input type="checkbox"/> Rehabilitation services | <input type="checkbox"/> Medical Supplies | <input type="checkbox"/> Medical Day Care |
| <input type="checkbox"/> Durable Medical Equipment | <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Prosthetics and Orthotics |

 SIGNATURE: *Physician Case Manager*

Specify ancillary services requested. Explain and certify medical necessity for medical equipment.



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

MEDICAID PERSONAL PHYSICIAN PLAN (MP PLAN)
REFERRAL SERVICES FORM

MP Plan Member Name: _____ Date: _____

Member HSP (Medicaid) Case No.: _____ Person No.: _____

Name of Consultant: _____

() Consultation only () Consultation with tests as needed () Consultation, assume management

Statement of the Problem:

Physician Case Manager IMP No.

SIGNATURE: Physician Case Manager

Date

SIGNATURE: Consulting Physician/Provider



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

New Jersey Health Services Program NEWSLETTER

Volume P-366

October 3, 1983

TO: ALL DENTISTS AND INDEPENDENT DENTAL CLINICS

SUBJECT: RENEWAL OF GENERAL ANESTHESIA PERMITS

EFFECTIVE: November 1, 1983

BACKGROUND: All dental general anesthesia permits issued by the New Jersey State Board of Dentistry will expire on October 31, 1983. In order for the New Jersey Medicaid Program to reimburse a dentist for administering general anesthesia after that date, a valid copy of the permit must be on file at the Prudential Insurance Company.

ACTION: Please forward a copy of your renewed permit by CERTIFIED MAIL-RETURN RECEIPT REQUESTED to the following address before October 15, 1983:

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

On or after November 1, 1983, reimbursement for claims submitted for general anesthesia will be limited to those dental providers having a currently valid general anesthesia permit on file with the Prudential Insurance Company. If you are unable to submit your permit by November 1, 1983, please hold any claims with dates of service on or after that date until your permit has been received at the Prudential Insurance Company. The date of receipt will appear on the green, Certified Mail - Return Receipt Card (PS Form 3811 - Dec. 1980), which will be returned to you by the United States Postal Service. Then you may submit your claims for payment.

Any questions regarding this Newsletter should be directed to Archie H. Bell, D.D.S., Chief, Bureau of Dental Services, Division of Medical Assistance and Health Services, Telephone (609) 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-367

October 17, 1983

TO: ALL OPHTHALMOLOGISTS, OPTOMETRISTS AND OPTICIANS

SUBJECT: ELIMINATION OF REQUIREMENT THAT LENS AND/OR FRAME
ENVELOPES BE SUBMITTED WITH THE OPTICAL APPLIANCE CLAIM
FORM (MC-9)

EFFECTIVE: FOR ALL OPTICAL APPLIANCE CLAIMS RECEIVED ON AND AFTER
NOVEMBER 1, 1983

ACTION: The New Jersey Medicaid Program is pleased to announce a revision in the New Jersey Administrative Code, "Vision Care Manual," that will lessen claims submission requirements for vision care providers. The revised regulation which is effective for all optical appliance claims received on and after November 1, 1983, eliminates the requirement that the lens and/or frame envelope(s) be submitted with the Optical Appliance claim form (MC-9). The revised regulation in no way affects the requirement that providers submit the fabricating laboratory invoice with the Optical Appliance claim form (MC-9).

Therefore, for all optical appliance claims received on and after November 1, 1983, providers will only be required to submit a fabricating laboratory invoice with the claim form (MC-9).

If you have any questions concerning this Newsletter, please contact A.F. Senaldi, O.D. at (609) - 984-3360.



New Jersey Health Services Program NEWSLETTER

Volume P-368.....

October 24, 1983

TO: SPECIALISTS IN RADIOLOGY AND
 NUCLEAR MEDICINE, HOSPITAL ADMINISTRATORS

SUBJECT: NEW RADIATION THERAPY AND TREATMENT PLANNING CODES

EFFECTIVE: IMMEDIATELY

BACKGROUND: As a result of recommendations from the Radiological Society of New Jersey, new procedure codes and descriptions are being implemented for radiotherapy services. The restructuring is based on the thinking that the complexity of treatment management depends not primarily on the energy of radiation used, but rather on the specifics of the individual case.

ACTION I: The following lists the procedure codes and text to be deleted from your Procedure Code Manual.

- Page 131 - Delete the RADIOTHERAPY section, which includes numbers 1 through 5 and procedure codes 7600, 7601, 7602, 7603, 7605, 7606, 7607, 7608 and 7609.
- Page 131 - Under the RADIUM AND RADIOISOTOPES section, delete the phrase "(For dosage calculation, preparation and planning of treatment see 9032)".
- Page 172 - Delete procedure code 9032.

ACTION II: The following new procedure codes and terminology should be used when submitting claims to the Medicaid Program. These codes should be added to the RADIOLOGY section of your Procedure Code Manual.

RADIATION THERAPY AND TREATMENT PLANNING

Treatment Planning

The treatment planning process includes interpretation of special testing, tumor localization, treatment volume determination, treatment time/dosage determination, choice of treatment ports, selection of appropriate treatment devices, and other procedures.

<u>Procedure Code</u>	<u>Description</u>	<u>Fee</u>	
		<u>Office</u>	<u>Hosp. Based</u>
7604	<u>Simple</u> - planning requiring single treatment area of interest encompassed in a single port or simple parallel opposed ports with minimal blocking.	\$22	\$22
7620	<u>Intermediate</u> - planning requiring three or more converging ports, two separate treatment areas, special blocking, standard wedges, or special time dose constraints.	\$34	\$34

Procedure Code	Description	Fee	
		Office	Hosp. Based
7621	<u>Complex</u> - planning requiring highly complex blocking, tangential ports, special wedges or compensators, three or more separate treatment areas, special beam considerations.	\$45	\$45
7622	Unlisted procedure	BR	BR

Teleradiotherapy Treatment

1. Includes use of x-ray and other high energy modalities (betatron, linear accelerator, etc.) radium, cobalt, and other radioactive substances unless otherwise specified.
2. Values for treatment of MALIGNANCIES include one year follow-up care unless otherwise specified.
3. Values for NONMALIGNANT conditions include 60 days follow-up care unless otherwise specified.
4. Values include concomitant office visit, but not concomitant surgical, diagnostic, radiological, or laboratory procedures.

Except where specified, assumes use of supervoltage/megavoltage or high energy particle sources. Per Treatment - Single or multiple portals, same area.

7623	<u>Simple</u> - benign lesions and most metastatic lesions of appendicular skeleton.	\$10	\$ 7.50
7624	<u>Intermediate</u> - the usual treatment for malignancy, including skin cancer and metastases to the trunk or spine.	\$20	\$15
7625	<u>Complex</u> - treatment of more complex problems such as Hodgkins disease, central nervous system or head and neck irradiation.	\$30	\$21
7626	Additional areas, each	\$10	\$ 7.50

Guidance for Radiation Therapy

7627	Ultrasonic guidance for placement of radiation therapy fields.	\$75	\$56
7628	Computerized tomography guidance for placement of radiation therapy fields.	\$75	\$56

The above codes include the concomitant office visit but not the concomitant surgical, diagnostic, radiological or laboratory services. Consultation services codes 9029 or 9030 billed in conjunction with treatment planning codes are NOT eligible. Payment can be made for one or the other.

Please update your Procedure Code Manual according to the above Actions. Replacement pages will be sent to you at a later date.

If you have any questions regarding this Newsletter, please contact I. Fulton Erlichman, M.D., Acting Medical Director, Division of Medical Assistance and Health Services, at (609) 292-8157.



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

New Jersey Health Services Program NEWSLETTER

Volume P-372

December 12, 1983

TO: HOME HEALTH AGENCIES

SUBJECT: INITIAL EVALUATION VISIT FOR REHABILITATION SERVICES

EFFECTIVE: FOR INITIAL EVALUATION VISITS FOR REHABILITATION SERVICES
MADE ON AND AFTER JANUARY 1, 1984

BACKGROUND: The New Jersey Medicaid Program has revised the "Home Health Services Manual," N.J.A.C. 10:60-1.4, to allow for an initial evaluation visit for rehabilitation services without prior authorization from the Medicaid District Office. All subsequent therapy treatment visits will require prior authorization.

ACTION: Effective January 1, 1984, an initial evaluation visit for rehabilitation services (physical, speech-language and occupational) made on and after January 1, 1984, will not require prior authorization from the Medicaid District Office. All subsequent therapy treatment visits following the initial evaluation visit will continue to require prior authorization from the Medicaid District Office. New Jersey Medicaid Program reimbursement for the initial evaluation visit will be the same as that which the agency is reimbursed for the subsequent treatment visits.

When completing the Home Health claim form, MC-3, please indicate in block 22, "Type of Service," when an initial evaluation visit for rehabilitation services has been made.

This regulation is in addition to and does not change the existing Home Health regulation that the home health agency may make one initial evaluation visit for home health services without prior authorization.



New Jersey Health Services Program NEWSLETTER

Volume P-373

December 26, 1983

TO: DENTISTS, HOSPITAL ADMINISTRATORS AND INDEPENDENT DENTAL CLINICS

SUBJECT: ORTHODONTIC TREATMENT

EFFECTIVE: For Services Rendered on and after January 1, 1984

BACKGROUND: The New Jersey Medicaid Program amended the New Jersey Administrative Code (N.J.A.C. 10:56-1.14, 1.21, 2.2, 3.7 and 3.15) to allow dentists who are not specialists in "Orthodontics" to be reimbursed when they provide orthodontic services to Medicaid recipients. These revisions relate to Sections 203.1 (Diagnostic Services), 203.8 (Orthodontic Treatment), 300.2 (Dental Claim Form MC-10, 401.1 (Diagnostic - Clinical Oral Examination) and 401.9 (Orthodontics) of the Dental Services Manual.

ACTION: The New Jersey Medicaid Program will allow all participating dentists to be reimbursed when they provide orthodontic services to Medicaid recipients on and after January 1, 1984 in accordance with the following policies and procedures.

Those orthodontic codes which previously did not have non-specialist fees have been assigned appropriate values.

A complete description and requirement of the Orthodontic Assessment Code (0140) follows. This replaces the information included on page 58 of the Dental Services Manual. Also, replace page 80, (3/78) in the manual with the attached updated page 80 (1/84).

Procedure Code	Description	Specialist Fee	Non-Specialist Fee
0140	Orthodontic Assessment, using Handicapping Malocclusion Assessment System (Assessment Form (FD-10) must accompany Dental Form (MC-10) when requesting reimbursement)	6.00	5.00

1. Reimbursement limited to once every twelve (12) months unless authorized.

When Orthodontic treatment is considered for a Medicaid recipient, the following points should be noted.

The New Jersey Medicaid Program Handicapping Malocclusion Assessment System is to be utilized to determine the need for a diagnostic workup.

For reimbursement purposes, a Handicapping Malocclusion Assessment Examination is limited to the provider or provider group who does such an examination with the intention of personally providing any Orthodontic treatment necessary.

Since Orthodontic treatment will not be authorized for individuals age 20 or older, the Handicapping Malocclusion Assessment Examination is not reimbursable for individuals age 20 or older.

Authorization for Orthodontic treatment shall be selective and limited to handicapping malocclusions as determined by the Medicaid Dental Consultant.

Submission of requests for treatment for patients with assessments below the minimum number of points required, without sufficient justification, or due to incorrect calculation, will necessitate denial of reimbursement for the diagnostic materials submitted.

When authorized, reimbursement for comprehensive Orthodontic treatment will include retention, as required, at no additional charge.

Reimbursement for the monthly fee is based on one or more visits to the practitioner during any calendar month. Reimbursement must not be requested for any month in which there is no patient visit.

Periodically, the Bureau of Dental Services will request a progress report from the provider, and if necessary, progress models and other appropriate records, to determine whether authorization should be continued. Failure to respond to this request in writing, personally signed by the provider, may result in suspension of authorization and reimbursement to the provider.

Final records, similar to diagnostic aids submitted as a diagnostic workup performed prior to treatment, must be submitted with the claim for the last six monthly visits to:

Division of Medical Assistance and Health Services
BUREAU OF DENTAL SERVICES
CN-713
Trenton, New Jersey 08625

In no instance will any of the last six monthly visits be payable until final records are received.

Failure to submit the final records may result in the recovery by the Division of Medical Assistance and Health services, of an amount not to exceed that paid for the previous 12 months of treatment actually reimbursed to the provider.

Any practitioner who wishes to provide Orthodontic Treatment under the Medicaid Program may request an "Orthodontic Packet" from Prudential which contains all necessary brochures and forms.

Order this packet from:

The Prudential Insurance Company
P.O. Box 1900
Millville, N.J. 08332

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) 984-7863.

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 (frenulectomy, 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.

APPLIANCE 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.	60.
*8320	Fixed or cemented	69.	60.
*8330	Adjustment - (maximum twelve (12) visits) per visit	6.	5.

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-three years)

*8410	Appliance	162.	140.
*8420	1st through 12 months of treatment (to start on day of insertion of appliance(s) is completed), per month	30.	26.
*8430	13th through 24th month of treatment, per	28.	24.
*8440	25th through 30th month of treatment, per	11.	9.
*8450	31st through 36th month (maximum of treatment	11.	9.
8999	Any other uncoded orthodontic service, by report.	IC	IC



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

New Jersey Health Services Program

NEWSLETTER

Volume P-374

January 9, 1984

TO: HOME HEALTH AGENCY PROVIDERS

SUBJECT: COMMUNITY CARE PROGRAM FOR THE ELDERLY AND DISABLED
PROCEDURES FOR REQUESTING AUTHORIZATION AND
SUBMITTING CLAIMS FOR HOME HEALTH SERVICES

EFFECTIVE: FOR SERVICES PROVIDED ON OR AFTER NOVEMBER 1, 1983

PURPOSE: General Information about the Community Care Waiver Program for the Elderly and Disabled was issued to all Providers in the Newsletter Volume P-371, dated December 5, 1983. This present Newsletter is specific to Home Health Agencies. It informs you how to become a provider under the Community Care Program, how to request authorization to provide home care services, and how to request reimbursement for providing those services.

BACKGROUND: Initially, all licensed home health agencies, except those which are hospital-based, are eligible to participate in this Community Care Program. All efforts are being made to include hospital-based agencies within the near future.

Home care services under the Community Care Program may be provided to individuals who are age 65 or over, or determined disabled under the Social Security Act and who are receiving Social Security disability payments, are eligible for Medicare, and who meet the nursing home level of care requirements. Also, their income must exceed the SSI community standard up to the institutional cap which is currently \$852.90. Individuals who are currently Medicaid eligible for community services are not covered under the Waiver.

Covered home care services which can be provided by the Home Health Agency under the Community Care Program include: skilled nursing, home health aide services, physical therapy, speech-language therapy, occupational therapy, medical social services, respite care and certain medical supplies. These services require prior authorization. Home Health agencies may provide case management services in selected counties.

Claims submitted for reimbursement of home care services under the Community Care Program will not be processed through the system used to process home health care claims under the regular New Jersey Medicaid Program. Instead, the Division of Medical Assistance and Health Services Independent Clinic Claims Processing System will be used to process the Community Care Program claims submitted by the Home Health Agency to The Prudential Insurance Company, the sole Contractor. Thus, a provider enrolled in the Community Care Program is issued a new provider number to be used when submitting claims under this Program.

ACTION:

A. PRIOR AUTHORIZATION:

1. Under the Community Care Program all home care services must be prior authorized by the Medical Evaluation Team in the Medicaid District Office.
2. A Home Health Agency requesting authorization to provide services under the Community Care Program must use the revised version of the FD-139 form which Home Health Agencies currently use to request home health services.

The form, Request for Home Care Authorization or Reauthorization (FD-139, Revised 12/83), copy attached, must be submitted to the Medicaid District Office serving the county where the Community Care recipient resides. Please note the changes in Items 15, 21, 22 and 23.

This form has been designed to service three programs: Home Health Services, Community Care for the Elderly and Disabled, and Personal Care Assistant Services (currently in the proposal stage).

The service codes "Initial Evaluation, RN" and "Personal Care Asst." on the FD-139 form, item #22, are not to be used by the Home Health Agency at this time.

PLEASE NOTE: An initial evaluation visit by a rehabilitation therapist or by a registered nurse requires prior authorization in the Community Care Program. In order to facilitate the process, approval may be obtained from the Community Care recipient's case manager (a list of the Case Management Sites is attached). However, to receive reimbursement for the initial evaluation visit, the Home Health Agency must include the initial evaluation visit on the FD-139. The form does not have to precede the visit. This is an exception from current Medicaid policy which does not require prior authorization for an initial evaluation visit.

B. BILLING PROCEDURES:

1. The Independent Outpatient Health Facility Claim Form, (MC-14), is to be used for billing.

A supply of the MC-14 forms with specific instructions will automatically be sent to you by Prudential when you are approved as a Community Care Provider. As in the present system, the FD-139 must be attached to the claim form when submitted to Prudential.

At all times the provider must reflect its standard charge on the MC-14 even though the actual payment will be different.

PLEASE NOTE: Home Health Agencies will continue to use the Home Health Claim Form (MC-3C) when billing for home health care services provided to regular Medicaid recipients not enrolled in the Community Care Program.

2. The following codes are to be used when submitting claims for the Community Care Program:

NEW PROCEDURE CODES FOR COMMUNITY CARE PROGRAM HOME CARE SERVICES ONLY
(Rates will vary per agency as assigned in the approval letter from the Division of Medical Assistance & Health Services' Provider Enrollment Unit unless indicated otherwise)

- 0023 - Home Health Aide Visit - up to 4 hours
- 0024 - Home Health Aide Visit - 5 to 8 hours
- 0025 - Physical Therapy - Daily
- 0026 - Speech-Language Therapy - Daily
- 0027 - Occupational Therapy - Daily
- 0028 - Medical Social Services Visit - Daily (\$25 maximum per visit)
- 0029 - Skilled Nursing Care Visit - Daily
- 0042 - Medical Supplies - \$50 Maximum per calendar month, per client, per agency.

Medical supplies under the Community Care Program are only available through Home Health Agencies and not directly through suppliers. Medical equipment is not reimbursed under this program. As in the regular Medicaid Home Health Program, medical supplies (other than drugs and biologicals) essential to enable the Home Health Agency to carry out the care plan, are normally supplied by the Home Health Agency, including, but not limited to gauze cotton bandages, surgical dressing, surgical gloves, and rubbing alcohol. When a patient requires an unusual or an excessive amount of first aid supplies, these must be requested on the FD-139, included in the care plan and prior authorized by the Medicaid Evaluation Team. Payment will be made to the Home Health Agency on the basis of the cost of the supply, plus 10% Home Health Agency administrative cost. Since each Home Health Agency deals with a different supplier, although costs may be similar, the Home Health Agency must furnish a list of supplies and costs used by that Agency to the case manager.

- 0077 - Homemaker - Hourly - \$8 maximum per hour
- 0078 - Case Management - Monthly \$45 per month, per client
- 0093 - Respite Care - 8 hour day - \$55 maximum per 8 hour day
- 0094 - Respite Care - 8 hour night - \$65 maximum per 8 hour night
- 0095 - Respite Care - 12 hour day - \$80 maximum per 12 hour day
- 0096 - Respite Care - 12 hour night - \$90 maximum per 12 hour night
- 0097 - Respite Care - 24 hours - \$100 maximum per 24 hours.

Only the above periods of time may be authorized as a respite care service. This service cannot be combined with the hourly homemaker service or with a visit by a Home Health Aide employed by a Home Health Agency. Respite Care has the above separate procedure codes and is to be handled as a separate service.

C. COST REPORTING INFORMATION:

A Home Health Agency participating in the Community Care Program will be reimbursed by the New Jersey Medicaid Program on a fee-for-service basis for services provided.

For the purposes of this special three year renewable program, cost finding techniques will be applied within Medicare's principles to both those persons receiving services covered by the waiver, as well as those persons not covered by the waiver. Agencies will be precluded from receiving additional reimbursement above the fee for the cost of the Community Care services established by the Division of Medical Assistance and Health Services.

D. COMPLETION OF THE HOME HEALTH AGENCY COST REPORT:

1. All costs associated with the provision of services to Community Care recipients are to be included in the routine Medicare/Medicaid cost-reporting mechanism. Non-reimbursable cost centers must be established for all services other than skilled nursing, physical speech-language and occupational therapies, medical social services, home health aide visits, respite care rendered by home health aides and certain medical supplies.
2. All visits provided to Community Care recipients are to be included in the total number of visits provided for each service respectively. This will establish a cost per visit as applied to the Medicare and Medicaid Programs.
3. When worksheet D4 (Computation of Medicaid Cost) is completed, only the data applicable to services rendered to regular Medicaid eligible recipients not enrolled in the Community Care Program will be reconciled.

This process allows the Home Health Agency 1) to be reimbursed on a fee-for-service basis for Community Care Program recipients, 2) to maintain compliance with Medicare reimbursement principles, and 3) to have all costs associated with these services allocated to respective payors.

E. PROVIDER APPLICATIONS:

Agencies desiring to participate in this program should contact:

Mrs. Frances Garrett, Chief
Provider Enrollment Unit
Division of Medical Assistance
and Health Services
CN-712
Trenton, New Jersey 08625
(609) 292-1921

for new provider application.

Any questions regarding this newsletter should be directed to Carol Kurland, Office of Home Care Programs, Division of Medical Assistance and Health Services at (609) 292-1940.

Any specific questions regarding completion of the cost report should be directed to Theodore C. Adams, Associate Manager, Provider Audit Division, The Prudential Insurance Company at (609) 293-2015.

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

REQUEST FOR HOME CARE AUTHORIZATION OR REAUTHORIZATION

PATIENT INFORMATION	1. Last Name		First Name	2. Sex	3. Age	4. Address	5. Social Security Account Number	
	6. HSP (Medicaid) Case Number		7. Person Number	8. Telephone Number () Area Code		9. Attending Physician's Name Last First		10. M.D.'s; DO's Telephone Number () Area Code
	11. Provider Identification (Name and address)					12. Provider Telephone Number		13. Provider Number

14. Provider Certification
 I certify this agency has determined the services described are not covered by the Medicare (Title XVIII) Program or I have verified that this patient's benefits for these services have been exhausted. I will not submit any additional billing to Medicare for this patient.
 Signature: _____

PROGRAM	15. Designate Type of Program:	
	<input type="checkbox"/> Home Health Care Services (attach to Mc3c claim form)	<input type="checkbox"/> Personal Care Assistant Services (attach to MC 14)
<input type="checkbox"/> Community Care Services (attach to MC 14 claim form)		

SOCIAL INFORMATION	16. Name of Last Hospitalization or Long Term Care Facility		Admitted	Discharged
	17. Diagnosis (including surgery and date) Primary Secondary		Diagnosis known by: <input type="checkbox"/> Patient <input type="checkbox"/> Family <input type="checkbox"/> Neither	

SOCIAL INFORMATION	18. Prognosis (check one): <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Guarded				
	19. Functional Limitations Contenance Mental Behavior Activities Permitted Special Problems				
<input type="checkbox"/> Contractures <input type="checkbox"/> Speech <input type="checkbox"/> Bladder incontin. <input type="checkbox"/> Disoriented <input type="checkbox"/> O.O.B. <input type="checkbox"/> Full <input type="checkbox"/> Decubitus ulcer <input type="checkbox"/> Paralysis <input type="checkbox"/> Hearing <input type="checkbox"/> Bowel incontin. 1-2-3 Spheres <input type="checkbox"/> B.R.P. <input type="checkbox"/> Part <input type="checkbox"/> Skin problem <input type="checkbox"/> Amputation <input type="checkbox"/> Vision <input type="checkbox"/> Indwelling catheter <input type="checkbox"/> Confused <input type="checkbox"/> Ambulation <input type="checkbox"/> None <input type="checkbox"/> Allergy <input type="checkbox"/> Wheelchair bound <input type="checkbox"/> Other <input type="checkbox"/> Colostomy <input type="checkbox"/> Underactive/Regressed <input type="checkbox"/> Stairs <input type="checkbox"/> Other (specify) <input type="checkbox"/> Assistive devices (explain): _____ <input type="checkbox"/> Anxious <input type="checkbox"/> Behavior problem <input type="checkbox"/> Regular <input type="checkbox"/> Special (specify)					

MEDICAL, NURSING	20. Social Information:			
	Patient seems motivated to utilize Home Health <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient's home is equipped for his/her care <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Family or friends available, willing and appropriate to assist <input type="checkbox"/> Yes <input type="checkbox"/> No		If needed, community resources are available <input type="checkbox"/> Yes <input type="checkbox"/> No	

Explanation of above and/or additional information _____

MEDICAL, NURSING	21. Goals: <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Maintenance <input type="checkbox"/> Preventive		
	Time Required: _____ Discharge Plan: _____		
	Plan of Treatment (Medical Orders — Drugs, Treatment, Diet, etc.) _____		
	Nursing Components:		

<input type="checkbox"/> Administer medications	<input type="checkbox"/> Instruction	<input type="checkbox"/> ADL	<input type="checkbox"/> Follow-up of special therapy	<input type="checkbox"/> Other (specify)
<input type="checkbox"/> Treatments	<input type="checkbox"/> Personal care	<input type="checkbox"/> ROM	<input type="checkbox"/> B and B Retraining	
<input type="checkbox"/> Observation/Supervision	<input type="checkbox"/> Restorative care	<input type="checkbox"/> Ambulation	<input type="checkbox"/> Transfer techniques	

Special Therapies (O.T., P.T., S.T.)—Attach goals and time period to achieve same/progress notes as necessary. _____

Social Service: _____

REQUEST INFORMATION	22. Request Information: Starting date: _____ Ending date: _____			
	Specify services/visits required:		No Visits	Charges/Fee Per Visit
	No Visits		No Visits	Charges/Fee Per Visit
	Skilled Nursing Care, RN	Initial Evaluation, RN (CCPED/PC)		
	Home Health Aide	Personal Care Asst.		
	Homemaker	Medical Supplies/Surgical		
	Physical Therapy	Equipment		
	Speech—Language Therapy	Other (Identify)		
	Occupational Therapy	FOR DIVISION USE ONLY		
	Respite (CCPED/PC)			
Medical Social Service				
SIGNATURE OF PHYSICIAN REQUESTING SERVICES		DATE	SIGNATURE/AGENCY REQUESTING SERVICES	
			DATE	

AUTHORIZATION	FOR DIVISION USE ONLY			
	Authorization Information: <input type="checkbox"/> Authorization granted <input type="checkbox"/> Authorization denied, letter attached <input type="checkbox"/> Authorization granted as amended above			
	Authorization From: _____ To: _____			
	Home Health Care Services <input type="checkbox"/> Acute <input type="checkbox"/> Chronic			
	Personal Care Assistant Services			
Community Care Program Services — Specify				
MD	RSN:	SW11:	DATE:	

CASE MANAGEMENT SITES - COMMUNITY CARE PROGRAM
FOR THE ELDERLY AND DISABLED

SEVEN COUNTIES DESIGNATED FOR THE
FIRST YEAR OF THE PROGRAM

Atlantic County Health Department
Division of Public Health Nursing
201 Shore Road
Northfield, N.J. 08225

Bergen County Welfare Agency
E. 221 Rte. 4 & Forest Avenue
Paramus, New Jersey 07652

Burlington Medicaid District Office
50 Rancocas Road
Mt. Holly, New Jersey 08060

Gloucester County Board of Social
Services
Human Services Building
Budd Blvd., P.O. Box 633
Woodbury, New Jersey 08096

Morris Medicaid District Office
10 Park Place, 4th Floor
Morristown, New Jersey 07960

Ocean County Board of Social Services
1027 Hooper Avenue
Toms River, New Jersey 08753

Somerset County Board of Social
Services
P.O. Box 936
73 E. High Street
Somerville, N.J. 08876



STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program

NEWSLETTER

Volume P-375

January 9, 1984

TO: HOMEMAKER AGENCIES

SUBJECT: COMMUNITY CARE PROGRAM FOR THE ELDERLY AND DISABLED PROCEDURES FOR REQUESTING AUTHORIZATION AND CLAIMS FOR HOMEMAKER AGENCY SERVICES

EFFECTIVE: FOR SERVICES PROVIDED ON OR AFTER NOVEMBER 1, 1983

PURPOSE: General Information about the Community Care Waiver Program for the Elderly and Disabled was issued to all Providers in Newsletter Volume P-371, dated December 5, 1983. This Newsletter is specific to Homemaker Agencies. It informs you how to become a provider under the Community Care Program, how to request authorization to provide homemaker services, and how to request reimbursement for providing those services.

BACKGROUND: Homemaker services under the Community Care Program may be provided to individuals who are age 65 or over, or determined disabled under the Social Security Act and who are receiving Social Security disability payments, are eligible for Medicare, and who meet the nursing home level of care requirements. Also, their income must exceed the SSI community standard up to the institutional cap which is currently \$852.90. Individuals who are currently Medicaid eligible for community services are not covered under the waiver. Covered homemaker services which can be provided by an approved Homemaker Agency under the Community Care Program include: Homemaker services; Initial Evaluation, R.N.; and Respite Care. These services require prior authorization.

ACTION:

A. PROVIDER APPLICATIONS:

Homemaker Agencies (profit or nonprofit) wishing to participate in this program should contact:

Mrs. Frances Garrett
Provider Enrollment Unit
Division of Medical Assistance and Health Services
CN-712, Trenton, New Jersey 08625
(609) 292-1921

for a provider application. After your application is reviewed and approved, the Division of Medical Assistance and Health Services will send you a provider approval letter. Our Contractor will send you your Medicaid provider number.

To participate in the Community Care Program, the Homemaker Agency must: 1) use aides who are certified by the New Jersey Department of Health; 2) meet standards and be accredited/approved by the National Home Caring Council or New Jersey Home Care Council or The Division of Medical Assistance and Health Services.

B. PRIOR AUTHORIZATION

1. Under the Community Care Program, all home care services must be prior authorized by the Medical Evaluation Team in the Medicaid District Office. Attached is a list of Medicaid District Offices.
2. A Homemaker Agency requesting authorization to provide services under the Community Care Program must use the Request for Home Care Authorization or Reauthorization (FD-139) form. A copy of the form (EXHIBIT I) and specific instructions are attached. This form must be submitted to the Medicaid District Office serving the County where the Community Care recipient resides.

PLEASE NOTE: 1) The Initial Evaluation, RN (code 0098) requires prior authorization. Authorization may be obtained by contacting the Community Care recipient's case manager (a list of the Case Management sites is attached). However, in order to receive reimbursement for the Initial Evaluation Visit, RN the Homemaker Agency must include the Initial Evaluation Visit, RN on the FD-139. The authorization request on the FD-139 form does not have to precede the visit.

2) On the FD-139 form, item #22, Personal Care Assistant Services (a new program currently in the proposal stage) cannot be billed in the Community Care Program.

C. BILLING:

1. The Independent Outpatient Health Facility Claim Form, (MC-14), is to be used for billing.

A supply of the MC-14 forms and instructions for completion will automatically be sent to you by Prudential (our Contractor) following your approval as a Community Care Provider. The FD-139 must be attached to the MC-14 Claim Form when submitted and is to be sent to the following address:

The Prudential Insurance Company
Medicaid Claim Division II
P. O. Box 1900
Millville, New Jersey 08332

2. The following codes are to be used when submitting claims for the Community Care Program:

NEW PROCEDURE CODES FOR COMMUNITY CARE PROGRAM - HOMEMAKER SERVICES

0077 - Homemaker - Hourly - \$8 maximum per hour
0098 - Initial Evaluation, RN - \$25 maximum per visit
0093 - Respite Care - 8 hour day - \$55 maximum per 8 hour day
0094 - Respite Care - 8 hour night - \$65 maximum per 8 hour night
0095 - Respite Care - 12 hour day - \$80 maximum per 12 hour day
0096 - Respite Care - 12 hour night - \$90 maximum per 12 hour night
0097 - Respite Care - 24 hours - \$100 maximum per 24 hours.

Only the above periods of time may be authorized as respite care services. This service cannot be combined with the hourly homemaker service. This is a separate procedure code and is to be handled as a separate service.

Any questions regarding this Newsletter should be directed to Carol Kurland, Home Care Programs, Division of Medical Assistance and Health Services at (609) 292-1940.



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

REQUEST FOR HOME CARE AUTHORIZATION OR REAUTHORIZATION

PATIENT INFORMATION: 1. Last Name, First Name, 2. Sex, 3. Age, 4. Address, 5. Social Security Account Number, 6. HSP (Medicaid) Case Number, 7. Person Number, 8. Telephone Number, 9. Attending Physician's Name, 10. M.D.'s DO's Telephone Number, 11. Provider Identification, 12. Provider Telephone Number, 13. Provider Number, 14. Provider Certification, 15. Designate Type of Program, 16. Name of Last Hospitalization or Long Term Care Facility, 17. Diagnosis, 18. Prognosis, 19. Functional Limitations, 20. Social Information, 21. Goals, 22. Request Information, 23. Authorization Information

Completion of the FD-139 (EXHIBIT I)
FOR USE BY HOMEMAKER AGENCIES ONLY

- Item 1 - 8 - Copy the Patient's Name, Health Services Program (HSP Medicaid) Case Number, and Person Number exactly as it appears on the Medicaid Validation Form.

Enter patient's sex, age, address, social security account number and telephone number.
- Items 9 - 10 - Enter attending physician's name and telephone number.
- Items 11- 13 - Enter provider information.
- Item 14 - Disregard.
- Item 15 - Designate type of Program.
- Items 16 - 21 - Enter information.
- Item 22 - Enter procedure code. Your procedure codes are listed in your provider approval letter and also on the attached Newsletter.

Enter starting and ending dates of service.
Enter No. of visits and fees per visit.
Enter signature of physician or your agency.

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

LOCAL OFFICE	LOCAL & REGIONAL ADMINISTRATOR	ADDRESS AND TELEPHONE NUMBER
Atlantic*	Mr. John Blake, L.A.	1 S. New York Avenue Atlantic City, NJ 08401 Tel. 609-441-3620 (SCAN) 541-3620)
Bergen	Mr. Alphonse Leone, L.A. Mr. Albert Bialogowicz, R.A.	50 Main Street Hackensack, N.J. 07601 Tel. 201-488-5667
Burlington	Ms. Helen Kern, L.A.	50 Rancocas Road Mt. Holly, N.J. 08060 Tel. 609-261-0448
Camden	Mr. Ronald Coppola, L.A.	Parkade Building, 519 Federal St., Rm. 207 Camden, N.J. 08101 Tel. 609-757-2870 (SCAN) 543-2870)
Cumberland (Cape May)	Mr. Thomas Daning, L.A.	501 Landis Avenue (basement) Vineland, N.J. 08360 Tel. 609-696-6560 (SCAN) 521-6560)
Essex*	Mr. John T. Russell, L.A. Mr. Albert Bialogowicz, R.A.	155 Washington Street Newark, N.J. 07102 Tel. 201-648-2470, 648-3700 (SCAN: 221-2470, 221-3700)
Gloucester (Salem)	Mrs. Eleanor Chatzinoff, L.A.	875 Mantua Ave. Suite B Woodbury, N.J. 08096 Tel. 609-845-7185
Hudson	Mrs. Alice Rooth, L.A. Mr. John Baxter, R.A.	880 Bergen Avenue Jersey City, N.J. 07306 Tel. 201-792-6390
Hunterdon (Somerset & Warren)	Mr. Richard Langbein, L.A. Mr. Albert Bialogowicz, R.A.	84 Park Avenue, 2nd Floor Flemington, N.J. 08822 Tel. 201-782-1130
Mercer*	Mr. Colin Bucher, L.A.	1424 S. Broad Street Trenton, N.J. 08610 Tel. 609-292-7315 (SCAN) 322-7315)
Middlesex	Mr. Harold Grim, L.A. Mr. John Baxter, R.A.	75 Paterson Street (basement) New Brunswick, N.J. 08903 Tel. 201-246-0653
Monmouth	Mr. William Bailey, L.A.	1200 Memorial Drive Asbury Park, N.J. 07712 Tel. 201-775-5700 (SCAN) 321-0155)
Morris (Sussex)	Mrs. Marie Reed, L.A. Mr. Albert Bialogowicz, R.A.	10 Park Place, 4th Floor Morristown, N.J. 07960 Tel. 201-267-1700
Ocean	Mr. Thomas Rafferty, L.A.	1861 Hooper Avenue Toms River, N.J. 08753 Tel. 201-255-6226
Passaic	Ms. Raphaelle Andriola, L.A. Mr. John Baxter, R.A.	100 Hamilton Plaza (Market Street) 9th Floor, Paterson, N.J. 07505 Tel. 201-523-2800 (SCAN) 243-2453
Union*	Mr. Dennis Doderer, L.A. Mr. John Baxter, R.A.	125 Broad St., 6th Floor, Hersh Towers Elizabeth, N.J. 07201 Tel. 201-648-4630 (SCAN) 221-4630

* Denotes office where Regional Administrator can be reached.

(Rev. 12/82)

CASE MANAGEMENT SITES - COMMUNITY CARE PROGRAM
FOR THE ELDERLY AND DISABLED

SEVEN COUNTIES DESIGNATED FOR THE
FIRST YEAR OF THE PROGRAM

Atlantic County Health Department
Division of Public Health Nursing
201 Shore Road
Northfield, N.J. 08225

Bergen County Welfare Agency
E. 221 Rte. 4 & Forest Avenue
Paramus, New Jersey 07652

Burlington Medicaid District Office
50 Rancocas Road
Mt. Holly, New Jersey 08060

Gloucester County Board of Social
Services
Human Services Building
Budd Blvd., P.O. Box 633
Woodbury, New Jersey 08096

Morris Medicaid District Office
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Ocean County Board of Social Services
1027 Hooper Avenue
Toms River, New Jersey 08753

Somerset County Board of Social
Services
P.O. Box 936
73 E. High Street
Somerville, N.J. 08876



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

New Jersey Health Services Program NEWSLETTER

Volume P-376.....

January 9, 1983

TO: MEDICAL DAY CARE PROVIDERS

SUBJECT: COMMUNITY CARE PROGRAM FOR THE ELDERLY AND DISABLED -
PROCEDURES FOR REQUESTING AUTHORIZATION AND SUBMITTING
CLAIMS FOR MEDICAL DAY CARE SERVICES

EFFECTIVE: FOR SERVICES PROVIDED ON OR AFTER NOVEMBER 1, 1983

PURPOSE: General Information about the Community Care Waiver Program for the Elderly and Disabled was issued to all Providers in the Newsletter Volume P-371, dated December 5, 1983. This Newsletter is specific to Medical Day Care Centers. It informs you how to request authorization to provide home care services, and how to request reimbursement for providing those services.

Home care services under the Community Care Program may be provided to individuals who are age 65 or over, or determined disabled under the Social Security Act and who are receiving Social Security disability payments, are eligible for Medicare, and who meet the nursing home level of care requirements. Also, their income must exceed the SSI community standard up to the institutional cap which is currently \$852.90. Individuals who are currently Medicaid eligible for community services are not covered under the waiver.

Covered services which can be provided by the Medical Day Care Center under the Community Care Program require prior authorization and will continue to be processed through the Division of Medical Assistance and Health Services Independent Clinic Claims Processing System with the Prudential Insurance Company. It is not necessary for the Medical Day Care Center who wishes to participate in this program to re-enroll. Only a Medicaid approved Medical Day Care Center may provide services to Community Care recipients.

ACTION:

A. Prior Authorization:

1. Under the Community Care Program, Medical Day Care services must be prior authorized by the Medical Evaluation Team in the Medicaid District Office.
2. A Medical Day Care Center requesting authorization to provide services under the Community Care Program must continue to use the Request for Medical Day Care Authorization or Reauthorization form (FD-140). This form must be submitted to the Medicaid District Office serving the county where the Community Care recipient resides.

3. The initial visit requires prior authorization for the Community Care Program. Approval may be obtained by contacting the Community Care recipient's case manager. Attached is a list of the Case Management Sites. However, in order to receive reimbursement for the initial visit, the center must include it on the FD-140 form. This authorization request form does not have to precede the visit. This is an exception to the current Medicaid policy of an initial evaluation not requiring prior authorization.

B. Billing Procedures:

1. The Independent Outpatient Health Facility Claim Form, (MC-14), is to be used for billing.
2. As in the present system, the FD-140 must be attached to the MC-14 claim form when submitted to Prudential.
3. Continue to use your current codes when submitting claims for the Community Care Program.
4. Reimbursement will equal what is currently being paid your center for Medical Day Care Services.

Any questions regarding this Newsletter should be directed to Carol Kurland, Office of Home Care Programs, Division of Medical Assistance and Health Services at (609) 292-1940.

CASE MANAGEMENT SITES - COMMUNITY CARE PROGRAM
FOR THE ELDERLY AND DISABLED

SEVEN COUNTIES DESIGNATED FOR THE
FIRST YEAR OF THE PROGRAM

Atlantic County Health Department
Division of Public Health Nursing
201 Shore Road
Northfield, N.J. 08225

Bergen County Welfare Agency
E. 221 Rte. 4 & Forest Avenue
Paramus, New Jersey 07652

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50 Rancocas Road
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Woodbury, New Jersey 08096

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Somerset County Board of Social
Services
P.O. Box 936
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Somerville, N.J. 08876



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

New Jersey Health Services Program NEWSLETTER

Volume P-377

January 9, 1984

TO: SOCIAL ADULT DAY CARE CENTERS

SUBJECT: COMMUNITY CARE PROGRAM FOR THE ELDERLY AND DISABLED
PROCEDURES FOR REQUESTING AUTHORIZATION AND SUBMITTING CLAIMS
FOR SOCIAL ADULT DAY CARE CENTERS

EFFECTIVE: FOR SERVICES PROVIDED ON OR AFTER NOVEMBER 1, 1983

PURPOSE: General Information about the Community Care Waiver Program for the Elderly and Disabled was issued to all Providers in the Newsletter Volume P-371, dated December 5, 1983. This Newsletter is specific to Social Adult Day Care Centers. It informs you how to become a provider under the Community Care Program, how to request authorization to provide home care services, and how to request reimbursement for providing those services.

BACKGROUND: Home care services under the Community Care Program may be provided to individuals who are age 65 or over, or determined disabled under the Social Security Act and who are receiving Social Security disability payments, are eligible for Medicare, and who meet the nursing home level of care requirements. Also, their income must exceed the SSI community standard up to the institutional cap which is currently \$852.90. Individuals who are currently Medicaid eligible for community services are not covered under the waiver.

ACTION:

A. PROVIDER APPLICATION:

1. Social Adult Day Care centers wishing to participate in the Community Care Program should contact:
Ms. Frances Garrett
Provider Enrollment Unit
Division of Medical Assistance
and Health services
CN-712
Trenton, New Jersey 08625
(609) 292-1921
for a provider application.
2. To participate, Social Adult Day Care centers must be under contract to the Division of Youth and Family Services. A copy of the approved Funding Request Form (DYFS 7-33c, rev. 2/82) and a copy of Annex A of the contract must be submitted when applying to be a provider in the Community Care Program.

A provider enrolled in the Community Care Program will be issued a Medicaid provider identification number to be used when submitting claims under this Program.

B. PRIOR AUTHORIZATION:

1. Under the Community Care Program, Social Adult Day Care services must be prior authorized by the Medical Evaluation Team in the Medicaid District Office. Attached is a list of District Medicaid Offices (Exhibit 1) and Case Management Sites (Exhibit 2).
2. A Social Adult Day Care Center requesting authorization to provide services under the Community Care Program must use the Request for Medical Day Care Authorization or Reauthorization Form (FD-140). A copy is attached (Exhibit 3). This form must be submitted to the Medicaid District Office serving the County where the Community Care recipient resides.
3. This form is currently under revision to accommodate the Social Adult Day Care Center. At present, please use the current FD-140 (Rev. 1-83) with modifications:
 - 1) Write CCPED across the top of form
 - 2) Item #14 - Disregard
 - 3) Item #20 - Cross out the word Medical and write in the word Social and the Service Code (0079)
 - 4) Item #20 - Physical Therapy Treatments and Speech-Language Therapy Treatments do not apply to you.
 - 5) Item #21 - Use Agency Representative signature instead of attending physician.

C. BILLING:

1. The Independent Outpatient Health Facility Claim form, (MC-14), is to be used for billing.

A supply of the MC-14 forms and instructions will automatically be sent to you by Prudential when you enroll as a Community Care Provider.

The FD-140 form must be attached to the MC-14 form and submitted to:

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

2. The following Procedure Code is to be used when submitting claims for the Community Care Program:

0079 Social Adult Day Care - Daily
(Rate will vary for each Agency as specified in the approval letter from the Division of Medical Assistance and Health Services' Provider Enrollment Unit).

Any questions regarding this Newsletter should be directed to Carol Kurland, Home Care Programs, Division of Medical Assistance and Health Services at (609) 292-1940.

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DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
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* Denotes office where Regional Administrator can be reached.

(Rev. 12/82)

CASE MANAGEMENT SITES - COMMUNITY CARE PROGRAM
FOR THE ELDERLY AND DISABLED

SEVEN COUNTIES DESIGNATED FOR THE
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Human Services Building
Budd Blvd., P.O. Box 633
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10 Park Place, 4th Floor
Morristown, New Jersey 07960

Ocean County Board of Social Services
1027 Hooper Avenue
Toms River, New Jersey 08753

Somerset County Board of Social
Services
P.O. Box 936
73 E. High Street
Somerville, N.J. 08876

PLEASE TYPE OR PRINT

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

EXHIBIT III

REQUEST FOR MEDICAL DAY CARE AUTHORIZATION OR REAUTHORIZATION

P A T I E N T I N F O R M A T I O N	1. Participant Information Last Name First Name		2 Sex	3 Age	4 Address	5 Social Security Account No	
	6. HSP (Medicaid) Case No.	7. Person No.	8. Telephone No. (include area code)		9. Attending Physician's Name Last First	10. Physician's Telephone No. (area code)	
	11. Provider Identification (Name and Address)				12. Provider Telephone No. (area code)	13. Provider No.	
M E D I C A L N U R S I N G A N D S O C I A L I N F O R M A T I O N	14. Physician's Certification: In my judgement, physical or speech-language therapy requested herein is not allowable under the Medicare (Title XVIII) Program; accordingly, that program has not or will not be otherwise billed. Signature: _____						
	15. Name of Last Hospital or Long Term Care Facility Admission:					Admitted: _____ Discharged: _____	
	16. Diagnosis (including surgery and date) Primary _____ Secondary _____					Diagnosis known by: <input type="checkbox"/> Patient <input type="checkbox"/> Family <input type="checkbox"/> Neither	
	17. Functional Limitations <input type="checkbox"/> Partial Paralysis <input type="checkbox"/> Amputation <input type="checkbox"/> Colostomy <input type="checkbox"/> Wheelchair bound		Mental Behavior <input type="checkbox"/> Speech <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Language barriers <input type="checkbox"/> Confused <input type="checkbox"/> Underactive/Regressed <input type="checkbox"/> Anxious <input type="checkbox"/> Behavior problem		Activities Permitted <input type="checkbox"/> Ambulation <input type="checkbox"/> Stairs <input type="checkbox"/> Diet <input type="checkbox"/> Regular <input type="checkbox"/> Special (specify) _____		Nursing Components <input type="checkbox"/> Full <input type="checkbox"/> Part <input type="checkbox"/> None <input type="checkbox"/> Administer medication <input type="checkbox"/> Treatments <input type="checkbox"/> Observation/Supervision <input type="checkbox"/> Instruction <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Personal care <input type="checkbox"/> Restorative care <input type="checkbox"/> ADL <input type="checkbox"/> Follow-up of Special Therapy
	<input type="checkbox"/> Assistive devices (explain): _____ _____ <input type="checkbox"/> Current Medication(s): _____ <input type="checkbox"/> Special Therapies, if needed: _____ _____ <input type="checkbox"/> Special Problems (describe): _____ _____ _____						
18. Social Information (i.e., living arrangements, family & community supports, attitudes, etc.) _____ _____ _____							
19. Goals: <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Maintenance <input type="checkbox"/> Preventive _____ Time required: _____ Discharge plan: _____ Plan of treatment: _____ _____ _____							
S E R V I C E S R E Q U E S T I N F O	20. Services requested: Projected start date: _____ End date: _____ Specify services indicating frequency, amount totals: Medical day care visits: _____ (0001) Physical therapy treatments: _____ (0030) Speech-Language therapy treatments: _____ (0032)					For Division Use Only _____ _____ _____	
	21. Authorization Information: <input type="checkbox"/> Authorization granted <input type="checkbox"/> Authorization denied, letter attached <input type="checkbox"/> Authorization granted, as amended above Authorized: From: _____ To: _____ Signature of Attending Physician & Date: _____ AUTHORIZED BY: <input type="checkbox"/> Medical Consultant <input type="checkbox"/> RSN <input type="checkbox"/> Social Worker II Signature _____ Date _____						



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

New Jersey Health Services Program NEWSLETTER

Volume P-378

January 16, 1984

TO: PROVIDERS OF PHARMACEUTICAL SERVICES, PHYSICIANS, AND DENTISTS

SUBJECT: EMERGENCY SERVICES TO RECIPIENTS RESTRICTED TO ONE SPECIFIC PHARMACY

EFFECTIVE: February 1, 1984

PURPOSE: To notify providers of procedures to be followed when serving any recipient restricted to one specific pharmacy.

BACKGROUND: Certain Medicaid recipients are restricted to one specific pharmacy for all pharmaceutical services. The message "RESTRICTED TO PHARMACY" and the name and address of the pharmacy appear in the upper left box of the recipient's Medicaid Eligibility Identification Card. These recipients are to obtain pharmaceutical services only at the indicated pharmacy except in an emergency.

An emergency, in this case, is defined as any situation where denying services would create a significant threat to the health or life of the recipient.

ACTION: Always carefully check every recipient's Medicaid eligibility before providing services. If a recipient cannot produce valid proof of eligibility, call 800-242-0861, 0862 to verify eligibility and/or restrictions.

Any restricted recipient requesting services at a pharmacy other than the one to which he/she is restricted is to be referred to the pharmacy to which he/she is restricted. However, the restricted recipient's prescription may be filled by another pharmacy if the prescription has the following notation in the PRESCRIBER'S HANDWRITING: "THIS IS AN EMERGENCY." TELEPHONE PRESCRIPTIONS MAY BE FILLED IN AN EMERGENCY BUT A WRITTEN PRESCRIPTION MUST BE SENT BY THE PRESCRIBER TO COVER THE TELEPHONE ORDER.

New Jersey Medicaid will reimburse the pharmacy for up to a 72-hour supply of the emergency medication. All claims must be submitted on a Pharmacy Claim Form (MC-6) with the pharmacy writing the word "EMERGENCY" in the AUTHORIZATION NUMBER BLOCK. Send this hard copy claim only to:

New Jersey Health Services Program
P.O. Box 549
Newark, New Jersey 07101

If a pharmacy other than the one to which the recipient is restricted fills a prescription in an emergency and does not comply with these billing instructions the claim will be declined.

CONTACT: Telephone Mabel Mendel, Bureau of Medical Care Surveillance, Division of Medical Assistance and Health Services, at (609) 984-7449 if you have any questions regarding this Newsletter.



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

New Jersey Health Services Program NEWSLETTER

Volume P-381

January 30, 1984

TO: ADMINISTRATORS-DIAGNOSIS RELATED GROUP
(DRG) HOSPITALS

SUBJECT: Payment for Hospital Patients Awaiting Placement In A Long-Term
Care Facility at the Skilled Nursing (SNF) or Intermediate Care
(ICF) Level

PURPOSE: To give instructions on billing for the above situation.

BACKGROUND: For admissions on or after March 1, 1983, the New Jersey Medicaid
Program will pay DRG Hospitals for SNF/ICF days based on the
provisions of the Utilization Review (U.R.) Matrix published by
the New Jersey State Department of Health.

ACTION: Follow directions in this Newsletter to receive SNF/ICF
payment.

I. Claim Preparation

- A. Submit all claims with SNF/ICF levels of care using a hard copy
UB-PS Form.
- B. Follow the information requirements given in Newsletter P-351,
dated February 7, 1983.
- C. Identify the revenue codes and charges associated with SNF/ICF
levels of care.
- D. Enter totals of 1) Medicaid eligible acute care charges, 2)
Medicaid eligible SNF/ICF charges and 3) the total of all
Medicaid eligible charges.
- E. Submit the claim with the following documentation:
 1. A copy of the letter(s) sent to the patient advising of the
change in the level(s) of care, and
 2. A Utilization Review Organization certification statement
which details the beginning and ending dates for each level
of care.

II. Payments

- A. There is no separate payment for eligible SNF/ICF days. Payment
for these days is added to the payment made for days at the acute

level of care. This combined amount is the payment amount shown on your payment voucher.

- B. The total number of covered days will appear on your payment voucher. This is the total of days certified at the acute, SNF and ICF levels of care.
- C. The eligible charges on your payment voucher is the total of the Medicaid eligible charges submitted on the UB-PS Form for the acute, SNF and ICF levels of care.
- D. Payments for claims with SNF/ICF days will be calculated as follows:

- 1. "Price Per Case" Calculation (For inliers, except "zero-base DRG's")

Direct Cost (Base Rate)
X Indirect Mark-Up factor

Price Per Case
X Payor factor

DRG Amount Due
- Prompt Payment Discount
Acute Care Payment Amount
+ Payment for Certified SNF/ICF Days Beyond High
Trim Point (days x rate)

Total Amount Paid

- 2. "Approved DRG Charges" Calculation (for outliers, and "zero-base DRG's")

Total Acute Care Charges
X Payor factor

DRG Amount Due
- Prompt Payment Discount
Acute Care Payment Amount
+ Payment for Certified SNF/ICF Days (days X rate)

Total Amount Paid

- E. When Medicare is the primary payor, the following additional rules apply:

- 1. Whenever the Medicare waiver or grace days provisions are applied to days at the SNF, ICF, or Residential level of care, any Part A deductible or co-insurance amounts for these days will not be eligible for reimbursement by Medicaid.
- 2. Maximum Medicaid reimbursement for any eligible SNF day for which Medicare applied Part A co-insurance will be the lesser of the applicable SNF rate or the Medicare co-insurance amount.

- F. If a previously submitted claim requested payment only for acute days and the admission date was on or after March 1, 1983, submit an Adjustment Notice requesting payment of the SNF/ICF days. A copy of the UB-PS Form showing all pertinent SNF/ICF data as well as copies of the patient notification letter and levels of care certifications should be attached to the adjustment notice.

III. Special Notes

A. Outlier Indicator

1. Enter "Y" (yes) if the case you are billing meets one of the following criteria:
 - a) The total number of acute days falls outside the DRG Trim Points (that is, less than the low trim point or more than the high trim point);
 - b) The patient discharges himself against medical advice;
 - c) The patient dies;
 - d) The patient is admitted and discharged on the same day;
 - e) The patient is assigned a DRG defined by the New Jersey State Department of Health as a "clinical outlier" DRG. In these situations, the "Approved DRG Charges" method is used to calculate payment.
2. Enter "N" (no) if the case you are billing does not meet any of the above criteria. In this situation, the "Price Per Case" method is used to calculate payment.

- B. Each SNF/ICF day eligible for reimbursement will be paid at the appropriate rate approved by the New Jersey State Department of Health.

Point of Contact

If you have questions regarding this Newsletter, please telephone your New Jersey Medicaid contractor: Prudential (609) 293-2294



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

New Jersey Health Services Program NEWSLETTER

Volume P-382

February 20, 1984

TO: PHYSICIANS

SUBJECT: APNEA MONITORS

EFFECTIVE: IMMEDIATELY

PURPOSE: Because of increased requests for apnea monitors, the New Jersey Medicaid Program has established guidelines for approving these monitors for home use. The approval process is outlined below.

ACTION:

I. Requirements

- A. All requests must be prior authorized through the Medicaid District Office of the patient's county of residence.
- B. All symptomatic patients for whom a home apnea monitor is requested must be evaluated (by a physician only) before approval of the monitor is given.
- C. Each request (by a physician only) must include: written medical data for the medical necessity of the monitor; completed form(s) certifying the family/caregivers meet all the requirements of item I.E.; physician responsible for follow up.
- D. PHYSICIAN RESPONSIBLE FOR FOLLOW UP MUST SEE THE PATIENT AT A MINIMUM OF ONCE EVERY 3 MONTHS AND DETERMINE THE NEED FOR CONTINUED HOME MONITORING. A Home Apnea Monitor Certification form, FD-287, must be completed by the attending physician for authorization by the Local Medical Consultant for continued Medicaid reimbursement. A copy of this form is attached and can be obtained through the Medicaid District Office in your area.
- E. Family/caregiver and relief personnel MUST be trained in the following:
 1. Infant cardio-pulmonary resuscitation (CPR) including periodic refresher courses for CPR for various age groups;
 2. The use and functioning of the monitor and all accessory equipment;
 3. Simple "repair" techniques and trouble-shooting for the monitor;
 4. Methods of observation and assessment - be able to differentiate between real and false alarms;

5. Intervention techniques;
 6. Keeping a daily log of observations and findings.
- F. Required Recertification:
1. Patient's physician must attest at least every three months to the continued medical necessity of the monitor for recertification authorized by the Medical Consultant. The authorized period will not exceed three months at a time.
 2. Required Information:
 - a. progress of patient/current status;
 - b. number of real alarms and treatment;
 - c. pneumogram results;
 - d. projected plans and date for discontinuing the monitor.
 3. Any additional information as requested by the Medical Consultant such as copy of daily logs, etc.

II. Criteria for Discontinuing the Monitor

- A. Infant has had a three month period with no necessity for vigorous stimulation or resuscitation, (two months if there were no major problems since initial event);
- B. Normal or resolved problem on follow up clinical assessment;
- C. Infant has had no real monitor alarms for at least two months (apnea setting of 20 seconds and heart rate setting of 60 beats/minute);
- D. Infant has not demonstrated any recorded persistent cardio-respiratory abnormalities;
- E. Infant tolerated a stressful event without symptoms - such as DPT immunization, URI;
- F. Infant has had two normal pneumograms and/or a normal sleep evaluation test series;
- G. Pneumograms:
 1. Usually run every two months, or more often (if appropriate) if there are changes or frequent alarms;
 2. Must be read and interpreted by a physician preferably the one responsible for the follow up of the baby.
- H. If patient is referred to a Medicaid participating Evaluation Center for case management of the apnea, the Evaluation Center must coordinate the follow up of the infant once discharged from the Center on a monitor.

III. Recommendations

A. Use of an Apnea Evaluation Center:

It is suggested that all patients, whose initial work up (below) is negative or inconclusive, be referred to a qualified apnea evaluation center for further and more sophisticated evaluation to determine:

1. If the patient is at risk for SIDS, and
2. If the patient is a candidate for home monitoring.

B. Recommended Support Services for Family/Caregiver:

1. Twenty-four hour access to the Apnea Evaluation Center or responsible physician for problems;
2. Twenty-four hour access to the monitor distributor for trouble shooting, emergency repairs, etc.;
3. Notification of family physician, police and local emergency squad that they have an infant on a monitor, in case of emergency;
4. Notification of case worker;
5. Notification of local power company to provide emergency power if necessary;
6. Referral to available community support groups;
7. Referral to public health agency for home visits, as necessary.

IV. Additional Information

A. The Evaluation:

1. Symptomatic Infants
 - a. Has had a life threatening episode with prolonged apnea with cyanosis, pallor, bradycardia, or change in consciousness;
 - b. Premature birth with periodic breathing pattern, feeding induced cyanosis or bradycardia, or apneic episodes.
2. Positive Family History - Symptomatic or Asymptomatic:
 - a. Sudden infant death of a full or half-sibling;
 - b. Siblings of patient with recurrent, unexplained apnea;
 - c. Mothers taking methodone or heroin during the pregnancy with the infant;

d. Multiple instances among cousins - evaluation recommended.

3. Asymptomatic Infants:

For the asymptomatic infant whose parents are anxious but there is a negative family and medical history, and negative physical exam of infant, research has not found monitoring to be beneficial (according to Dorothy Kelly, M.D., et al, a leading authority on monitoring).

4. Other includes physical conditions or diseases known to potentially cause intermittent, prolonged apnea; such as, Bronchopulmonary Dysplasia (BPD); anatomic abnormalities.

B. Components of the Evaluation:

1. Upon hospitalization of a symptomatic patient, the infant should be placed on continuous monitoring of cardio-respiratory status and studied to determine an etiology and a possible correctable underlying cause.

2. Complete history (including family history), physical exam and neuro-developmental assessment.

3. Combinations of the following basic tests are usually performed when indicated to determine a possible etiology:

a. complete blood count with differential;

b. urinalysis;

c. serum electrolytes (sodium, potassium, chloride, carbon dioxide) BUN, calcium, phosphate, glucose and magnesium;

d. blood gases;

e. chest x-ray;

f. electrocardiogram;

g. electroencephalogram - awake and asleep.

4. The following may also be included when indicated:

a. pulmonary function studies;

b. barium swallow and/or esophageal reflux scans;

c. amino acid screen;

d. fluoroscopy (airway);

- e. sepsis work up including lumbar puncture;
- f. transcutaneous oxygen monitoring while awake, asleep and feeding;
- g. computerized tomography scan - brain.

If you have any questions or need further assistance, contact the Medical Consultant of the Medicaid District Office in your area for assistance.



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

HGME APNEA MONITOR CERTIFICATION

Patient's Name _____ HSP(Medicaid) No./Per. No. _____

Address _____

Date of Birth _____ Telephone No. _____

Case Name _____

Pediatrician's Name _____ Telephone No. _____

Address _____

Physician (ordering monitor) _____ Telephone No. _____

Address _____

Diagnosis _____

History of Present Illness/Birth History: _____

Family History for Prolonged Apnea: Negative _____ Positive _____

Explain: _____

Evaluation Results: _____

Type of Monitor: _____ Provider of Monitor _____

The following have been done:

Instructions to Parents in CPR: _____

Instruction to Parents in Monitor Operation, General Care and Trouble Shooting: _____

Instruction to Parents regarding contact with Police, Fire/Rescue Electric Co.: _____

Referral to Support Groups: Public Health Nurse _____ SIDS Parent Group _____

RECERTIFICATION:

1. Progress of Patient and Current Status: _____

2. Documented Number of Real Alarms & Treatment: _____

3. Pneumogram Results: _____

4. Projected Plans and Date for Discontinuing Monitor: _____

I CERTIFY THAT THE ABOVE CONDITIONS EXIST, AND THE MEDICAL NECESSITY FOR AN APNEA MONITOR AND CONTINUED HOME MONITORING IS REQUIRED.

Attending Physician _____ Date _____

Medical Consultant _____ Date _____ Period of Authorization _____

(not to exceed 3 mos. at a time)



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

New Jersey Health Services Program NEWSLETTER

Volume P-383

March 1, 1984

TO: PHARMACY PROVIDERS, HOSPITAL ADMINISTRATORS, PHYSICIANS, DENTISTS,
PODIATRISTS AND INDEPENDENT CLINICS

SUBJECT: UPDATE OF DRUG PRODUCTS AND KNOWN RELATED DRUG PRODUCTS THAT LACK
SUBSTANTIAL EVIDENCE OF EFFECTIVENESS (DESI) FOR ADDITIONAL DRUGS
LISTED AS LESS THAN EFFECTIVE DISPENSED ON OR AFTER MARCH 1, 1984 FOR
THE N.J. MEDICAID PROGRAM, THE PHARMACEUTICAL ASSISTANCE TO THE AGED
AND DISABLED (PAAD) PROGRAM AND THE GENERAL ASSISTANCE PROGRAM

BACKGROUND: The Division of Medical Assistance and Health Services ceased
reimbursement December 3, 1981, for the New Jersey Medicaid Program
and March 1, 1982, for the Pharmaceutical Assistance to the Aged and Disabled (PAAD)
Program, for all drugs that the Federal Food and Drug Administration (FDA) has
proposed to withdraw from the market. In addition, Section 2103 of the Omnibus
Budget Reconciliation Act required this action for all identical, related, or
similar drugs.

ACTION I: As of March 1, 1984, The Division of Medical Assistance and Health
Services will CEASE reimbursement for the following drugs:

AVC Vaginal Cream
Bromalix - Elixir
Bromophen Elixir & TD Tablets
Bromphen Comp TD Tablets
Brompheniramine Comp Elixir
Brompheniramine, Phenylephrine and Phenylproanolamine
Cordamine P A Tablets
Dimalix Elixir
Dimetapp Elixir & Extentabs
Enarax 5 & 10
Gantrisin Vaginal Cream
Histatap Elixir & TD Tablets
Koro-Sulf Vaginal Cream
Midatap Elixir & Tabs
Normatane Elixir
Purebron Elixir & Comp TD Tablets
Rotapp Elixir
S-T Decongest Liquid
Tagatap Elixir & Tabs
Tamine Elixir & SR Tablets
Tuss-Ornade Liquid & Spansules
Tri Phen Elixir
Veltap Elixir
Vistrax 5 & 10
Westapp Elixir
Westiazole Vaginal Cream

ACTION II: The Division of Medical Assistance and Health Services will reimburse for the following drugs which were previously on the DESI list:

Azo - Gamazol Tablets
Azo - Gantanol Tablets
Azo - Sulfamethoxazole Tabs

Isosorbide Dinitrate Sublingual Tabs,
Oral & Sust. Release Tabs & Caps
(Bolar, Zenith & Chelsea only)

ACTION III: By virtue of reformulation, the following drugs have been reimbursed upon being marketed. Only the original products are on the DESI list.

Equagesic (new ethoheptazine free formula)

Synalgos D.C. - (latest revision of a promethazine free formula)

Please make these changes on the DESI list distributed to you the week of August 22, 1983. A complete updated list will be mailed to you later in the year.

Any questions regarding this Newsletter should be directed to the Bureau of Pharmacy, Division of Medical Assistance and Health Services, 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 -384

April 1, 1984

TO: ALL PROVIDERS LOCATED IN ESSEX COUNTY

SUBJECT: DISTRIBUTION OF MEDICAID-ID CARDS FOR AFDC CLIENTS

The New Jersey Medicaid Program has been advised by the Essex County Welfare Agency that effective April 1, 1984, their schedule is being updated for alternating delivery of checks for recipients of Assistance to Families with Dependent Children (AFDC) so that the checks will be received on the FIRST, THIRD, and FIFTH calendar days of each month.

As you know, the MEDICAID-ID is attached to the AFDC check, which means that some recipients will 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 HSP (MEDICAID) Case Numbers will receive their Medicaid Validations on the FIRST of the month:

Color of Medicaid-ID

0730000001 thru 0730011599	gray
0730028200 thru 0730050999	yellow
0730085500 thru 0730097299	green
0730115000 thru 0730121399	pink

Recipients with the following HSP (Medicaid) Case Numbers will receive their Medicaid Validations on the THIRD of the month:

0730011600 thru 0730021499	gray
0730051000 thru 0730070999	yellow
0730097300 thru 0730106699	green
0730121400 thru 0730127299	pink

Recipients with the following HSP (Medicaid) Case Number will receive their Medicaid Validations on the FIFTH of the month:

0730021500 thru 0730028199	gray
0730071000 thru 0730085499	yellow
0730106700 thru 0730114999	green
0730127300 thru 0730-UP	pink

For the time frame from the last day of the 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, (201) 733-4512, since the recipient will not have in his/her possession a Medicaid-ID.

PLEASE DO NOT CONTACT THE MEDICAID DISTRICT OFFICE FOR ELIGIBILITY VERIFICATION DURING THESE PERIODS, AS THEY DO NOT HAVE INFORMATION ON THESE CASES.

The New Jersey Medicaid Program appreciates your continued cooperation in the use of this system.

Please discard New Jersey Health Services Program Newsletters BC-213 or P-316 depending on which version you received, dated September 17, 1981.



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

New Jersey Health Services Program NEWSLETTER

Volume P-385.....

March 19, 1984

TO: INDEPENDENT MENTAL HEALTH CLINICS UNDER CONTRACT TO THE
DEPARTMENT OF HUMAN SERVICES, DIVISION OF MENTAL HEALTH AND
HOSPITALS

SUBJECT: PERSONAL CARE ASSISTANT SERVICE

EFFECTIVE DATE: FOR SERVICES PROVIDED ON OR AFTER FEBRUARY 6, 1984

PURPOSE: The purpose of this Newsletter is to introduce a new service,
Personal Care Assistant Services. This Newsletter informs you
how to become an approved provider, how to request authorization and how to request
reimbursement for providing these services.

BACKGROUND: "Personal Care Assistant Service" is a new statewide service
recognized by the New Jersey Medicaid Program under N.J.A.C.
10:66-3.3 (Independent Clinic Services Manual). This new service is intended for
individuals eligible in the community under the New Jersey Medicaid Program.

Personal Care Assistant Services accommodate long-term maintenance care as opposed
to acute or chronic levels of Home Health care.

Personal Care Assistant Services are comprised of health related tasks (see page
four for a complete definition) performed by a qualified individual in an eligible
recipient's home if the following are met:

- (1) performed under the supervision of a registered professional nurse,
- (2) certified by a physician in accordance with a written plan of care and
- (3) prior authorized by the Division of Mental Health and Hospitals.

Personal Care Assistant Services are reimbursable by the New Jersey Medicaid Program
when provided to Medicaid eligible recipients in their places of residence, such as:

- (a) private home
- (b) rooming house or
- (c) boarding house.

Medicaid reimbursement will not be made for Personal Care Assistant Services
provided to Medicaid eligible recipients in:

- (a) Residential Health Care Facility,
- (b) Class C Boarding Home,
- (c) Hospital,
- (d) Skilled Nursing Facility,
- (e) Intermediate Care Facilities,
- (f) Division of Mental Retardation Adult Foster Care Home and
- (g) Division of Youth and Family Services Foster Care Home.

Personal Care Assistant Services provided by a family member are not covered
services.

ACTION:

A. Provider Enrollment

Participating Mental Health Clinics must be approved to deliver Personal Care Assistant Services by the Provider Enrollment Unit of the Division of Medical Assistance and Health Services.

B. Prior Authorization

1. Personal Care Assistant Services must be prior authorized by the staff of the Division of Mental Health and Hospitals. However, prior authorization is not required for the initial nursing assessment visit. Send your request for authorization to:

Mr. Larry Stevens
Office of Fiscal Management Operations
Division of Mental Health and Hospitals
Capital Place One
Trenton, New Jersey 08625

2. An Independent Clinic requesting authorization to provide Personal Care Assistant Service must use the Request for Home Care Authorization or Reauthorization Form (FD-139). A sample copy of an FD-139 is attached with specific instructions for its completion on the back. The approved provider automatically receives a supply of these forms from The Prudential Insurance Company.
3. The maximum period for authorization is six months. For services extending beyond six months, reauthorization from the Division of Mental Health and Hospitals is required.

C. Billing Procedures

Please Note: The Independent Clinic Claims Processing System at Prudential (the sole fiscal agent for this system) will be used to process the personal care assistant claim.

1. The Independent Outpatient Health Facility Claim Form, (MC-14) must be used for billing.

The Prudential Insurance Company automatically sends you a supply of the forms with specific instructions when you are an approved provider.

2. The 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 Prudential Insurance Company.
3. The Request for Home Care Authorization or Reauthorization Form, (FD-139) which has been completed and signed by the Division of Mental Health and Hospitals must be attached to the MC-14 when submitting billing to:

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

4. Personal Care Assistant hourly service is limited to a maximum of 20 hours per week per client.
5. The following Procedure Codes are to be used when submitting claims for the Personal Care Assistant Service Program:

	<u>PROCEDURE CODE</u>	<u>MEDICAID DOLLAR VALUE</u>
<u>Personal Care Assistant Service (Individual)</u>	0056	up to \$7.40/hour
<u>Personal Care Assistant Service (Group) - Care provided involves two or more patients, with a maximum of eight patients in the same residen- tial setting at the same time</u>	0057	up to \$6.00/hour/ client
<u>Initial Nursing Assessment Visit</u>	0055	up to \$25.00/visit

D. NURSING SUPERVISION:

1. A registered professional nurse in cooperation with the physician's plan of care prepares written instructions for the personal care assistant to include the amount and kind of supervision needed, the specific needs of the patient and the resources of the patient, the family and other interested persons.
2. Supervision of the personal care assistant shall be provided by a registered professional nurse at a minimum of one visit every 60 days to assess the patient's health condition, as well as the quality of personal care assistant services received.
3. Reimbursement for nursing supervision is included in the hourly rate for the Personal Care Assistant Service (code 0056 or 0057).

DESCRIPTION OF PERSONAL CARE ASSISTANT AND DUTIES

Personal Care Assistant (PCA) means a person who has successfully completed a minimum 40 hour training program in personal care services approved by the New Jersey Medicaid Program. The PCA is primarily involved in the treatment and care of mentally handicapped and developmentally disabled patients in community settings, is employed by a State agency or by an independent clinic under contract with a State agency. The PCA performs duties as listed in the service definition that follows:

Household duties that are essential to the patient's health and comfort -

1. Care of the patient's room and areas used by the patient; Sweeping, vacuuming, dusting;
2. Care of kitchen; maintaining general cleanliness of refrigerator, stove, sink and floor, dishwashing;
3. Care of bathroom; maintaining cleanliness of toilet, tub, shower and floor;
4. Care of patient's personal laundry and bed linen (this may include necessary ironing and mending);
5. Necessary bed-making and changing of bed linens;
6. Re-arranging of furniture to enable the patient to move about more easily in his/her home;
7. Listing food and household supplies needed for the health and maintenance of the patient;
8. Shopping for above supplies, conveniently storing and arranging supplies, and doing other essential errands;
9. Planning, preparing and serving meals;

Activities of Daily Living -

1. Care of the teeth and mouth;
2. Grooming-Care of hair, including shampooing, shaving, and the ordinary care of nails;
3. Bathing in bed, in the tub or shower;
4. Using the toilet or bed pan;
5. Changing bed linens with patient in bed;
6. Ambulation indoors and outdoors, when appropriate;
7. Helping patients in moving - from bed to chair or wheelchair, in and out of tub and shower;
8. Eating-preparing meals, including special therapeutic diets for the patient;
9. Dressing;
10. Relearning household skills;
11. Accompanying the patient to clinics, physician office visits, or other trips which are made for the purpose of obtaining medical diagnosis, treatment or otherwise serve a therapeutic purpose.

Any question regarding this Newsletter should be directed to Carol Kurland, Office of Home Care Programs, Division of Medical Assistance and Health Services at (609) 292-1940.



PLEASE TYPE OR PRINT

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
REQUEST FOR HOME CARE AUTHORIZATION OR REAUTHORIZATION

Form with sections: PATIENT INFORMATION, PROGRAM, SOCIAL INFORMATION, MEDICAL, NURSING, REQUEST INFORMATION, AUTHORIZATION. Includes fields for patient details, diagnosis, prognosis, goals, and authorization status.

For the Personal Care Assistant Service Program

Completion of the FD-139

- Item 1 - 8 - Copy the Patient's Name, Health Services Program (HSP Medicaid) Case Number, and Person Number exactly as it appears on the Medicaid Validation Form.

Enter patient's sex, age, address, Social Security Account Number and telephone number.
- Items 9 - 10 - Enter attending physician's name and telephone number.
- Items 11- 13 - Enter provider information.
- Item 14 - Disregard.
- Item 15 - Designate Personal Care Assistant Services.
- Items 16 - 21 - Enter information.
- Item 22 - Use for Personal Care Assistant Service Only:

Enter starting and ending dates of service;

Enter No. of hours per week, total hours per period and fees per hour;

Enter signature of physician and your agency representative.



STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program

NEWSLETTER

Volume ...P-386....

March 19, 1984

TO: HOME HEALTH AGENCIES (CERTIFIED LICENSED)
HOMEMAKER AGENCIES (VOLUNTARY NON-PROFIT)
PHYSICIANS (SEPARATE MAILING - FOR INFORMATIONAL PURPOSES ONLY)

SUBJECT: PERSONAL CARE ASSISTANT SERVICES

EFFECTIVE DATE: FOR SERVICES PROVIDED ON OR AFTER FEBRUARY 6, 1984

PURPOSE: The purpose of this Newsletter is to introduce a new service, Personal Care Assistant Services. This Newsletter informs you how to become a provider, how to request authorization and how to request reimbursement for providing these services.

BACKGROUND: "Personal Care Assistant Service" is a new statewide service recognized by the New Jersey Medicaid Program under N.J.A.C. 10:60-1.5 (Home Health Services Manual). This new service is intended for individuals eligible in the community under the New Jersey Medicaid Program.

Personal Care Assistant Services accommodate long-term maintenance care as opposed to acute or chronic levels of Home Health care.

Personal Care Assistant Services are comprised of health related tasks (see page five for a complete definition) performed by a qualified individual in an eligible recipient's home if the following are met:

- (1) performed under the supervision of a registered professional nurse,
- (2) certified by a physician in accordance with a written plan of care and
- (3) prior authorized by the Division of Medical Assistance and Health Services.

Personal Care Assistant Services are reimbursable by the New Jersey Medicaid Program when provided to Medicaid eligible recipients in their places of residence, such as:

- (a) private home
- (b) rooming house or
- (c) boarding house.

Medicaid reimbursement will not be made for Personal Care Assistant Services provided to Medicaid eligible recipients in:

- (a) Residential Health Care Facility,
- (b) Class C Boarding Home,
- (c) Hospital (acute, special or psychiatric),
- (d) Skilled Nursing Facility,
- (e) Intermediate Care Facilities,
- (f) Division of Mental Retardation Adult Foster Care Home and
- (g) Division of Youth and Family Services Foster Care Home.

Personal Care Assistant Services provided by a family member are not covered services.

Medicaid recipients may not simultaneously receive both Home Health Care Services and Personal Care Assistant Services.

ACTION: A. Provider Enrollment

Certified licensed Home Health and voluntary non-profit Homemaker Agencies wishing to participate in this program should contact for appropriate instructions:

Mrs. Frances Garrett, Chief
Provider Enrollment Unit
Division of Medical Assistance
and Health Services
CN-712
Trenton, New Jersey 08625
(609) 292-1921

B. Prior Authorization:

1. Personal Care Assistant Services must be prior authorized by the Division of Medical Assistance and Health Services. However, prior authorization is not required for the initial nursing assessment visit.
2. The Request for Home Care Authorization or Reauthorization Form (FD-139) is to be used for authorization of this service and is to be sent to the Medicaid District Office (MDO) serving the county in which the client resides. A sample copy of an FD-139 is attached with specific instructions for its completion on the back. An approved provider automatically receives a supply of these forms from The Prudential Insurance Company. This form must be attached to the Independent Outpatient Health Facility Claim Form (MC-14) when it is submitted for payment.
3. The maximum period for authorization is 6 months. For services extending beyond 6 months, reauthorization by the Medicaid District Office is necessary.

C. Billing Procedures:

Please Note: Claims submitted for reimbursement of Personal Care Assistant Services will not be processed through the usual billing system for Home Health Agencies. The Independent Clinic Claims Processing System at Prudential (the sole fiscal agent for this system) will be used to process the personal care assistant claims.

1. The Independent Outpatient Health Facility Claim Form, (MC-14), must be used for billing. The Prudential Insurance Company automatically sends you a supply of the forms with specific instructions when you are an approved provider.
2. If you are a new provider, a Medicaid Provider ID Number will be issued to you by The Prudential Insurance Company. If you are

already enrolled in the Community Care Program for the Elderly and Disabled, the Provider Number issued to you for the Community Care Program is also to be used when completing the MC-14 claim form for Personal Care Assistant Services.

3. The Request for Home Care Authorization or Reauthorization Form (FD-139), which has been completed and signed by the Medicaid District Office, must be attached to the MC-14 when submitting billing to:

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

4. All claims must be received by Prudential 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 Prudential Insurance Company.
5. Personal Care Assistant hourly service is limited to a maximum of 20 hours per week per client.
6. The following Procedure Codes are to be used when submitting claims for the Personal Care Assistant Service Program:

	<u>PROCEDURE CODE</u>	<u>MEDICAID DOLLAR VALUE</u>
<u>Personal Care Assistant Service (Individual)</u>	0056	up to \$8.00/hour
<u>Personal Care Assistant Service (Group)</u> - Care provided involves two or more patients, with a maximum of eight patients in the same residential setting at the same time.	0057	up to \$6.00/hour/ client
<u>Initial Nursing Assessment Visit</u>	0055	up to \$25.00/ visit

D. NURSING SUPERVISION:

1. A registered professional nurse, in cooperation with the attending physician's plan of care, prepares written instructions for the personal care assistant to include the amount and kind of supervision needed, the specific needs of the patient and the resources of the patient, the family and other interested persons.
2. Supervision of the personal care assistant shall be provided by a registered professional nurse at a minimum of one visit every 60 days to assess the patient's health condition, as well as the quality of personal care assistant services received.
3. Reimbursement for nursing supervision is included in the hourly rate for the Personal Care Assistant Service (code 0056 or 0057).

C. The Certified Home Health Agency Cost Report:

1. All costs associated with the provision of Personal Care Assistant Services are to be included in the routine Medicare/Medicaid cost-reporting mechanism.
2. All visits provided under the PCA program to eligible Medicaid recipients are to be included in the total number of visits provided for each service respectively. This will establish a cost per visit as applied to the Medicare and Medicaid Programs.
3. When worksheet D4 (Computation of Medicaid Cost) is completed, the data applicable to services rendered to Medicaid eligible recipients not enrolled in the Personal Care Assistant Program will be reconciled.
4. At all times the provider must reflect its standard charge on the MC-14 even though the actual payment will be different.

This process allows the Home Health Agency to (1) be reimbursed on a fee-for-service basis for recipients of Personal Care Assistant Services, (2) maintain compliance with Medicare reimbursement principles and (3) have all costs associated with these services allocated to respective payors.

DESCRIPTION OF PERSONAL CARE ASSISTANT AND DUTIES

Personal Care Assistant (PCA) means a person who has successfully completed a 60 hour training program certified by the State Department of Health and is primarily involved in the treatment and care of elderly and disabled individuals living in their own homes in community settings. The PCA performs duties as listed in the service definition that follows:

Household duties that are essential to the patient's health and comfort -

1. Care of the patient's room and areas used by the patient; Sweeping, vacuuming, dusting;
2. Care of kitchen; maintaining general cleanliness of refrigerator, stove, sink and floor, dishwashing;
3. Care of bathroom; maintaining cleanliness of toilet, tub, shower and floor;
4. Care of patient's personal laundry and bed linen (this may include necessary ironing and mending);
5. Necessary bed-making and changing of bed linens;
6. Re-arranging of furniture to enable the patient to move about more easily in his/her home;
7. Listing food and household supplies needed for the health and maintenance of the patient;
8. Shopping for above supplies, conveniently storing and arranging supplies, and doing other essential errands;
9. Planning, preparing and serving meals;

Activities of Daily Living -

1. Care of the teeth and mouth;
2. Grooming-Care of hair, including shampooing, shaving, and the ordinary care of nails;
3. Bathing in bed, in the tub or shower;
4. Using the toilet or bed pan;
5. Changing bed linens with patient in bed;
6. Ambulation indoors and outdoors, when appropriate;
7. Helping patients in moving from bed to chair or wheelchair, in and out of tub and shower;
8. Eating-preparing meals, including special therapeutic diets for the patient;
9. Dressing;
10. Relearning household skills;
11. Accompanying the patient to clinics, physician office visits, or other trips which are made for the purpose of obtaining medical diagnosis, treatment or otherwise serve a therapeutic purpose;

Health Related Duties -

1. Helping and monitoring patient with prescribed exercises which the patient and personal care assistant have been taught by appropriate personnel;
2. Rubbing patient's back if not contra-indicated by physician;
3. Assisting with medications that can be self-administered;
4. Assisting patient with use of special equipment such as walker, braces, crutches, wheelchair, etc. after thorough demonstration by a registered professional nurse or physical therapist, with return demonstration until registered professional nurse or physical therapist is satisfied that patient can use equipment safely;

5. Assisting patient with simple procedures as an extension of physical, speech, or occupational therapy;
6. Taking oral and rectal temperature, radial pulse and respiration.

Any question regarding this Newsletter should be directed to Carol Kurland, Office of Home Care Programs, Division of Medical Assistance and Health Services at (609) 292-1940.

COPIES OF THIS NEWSLETTER WILL BE SUBMITTED TO ALL PARTICIPATING MEDICAID PHYSICIANS WITHIN THE NEXT TWO WEEKS FOR INFORMATIONAL PURPOSES.



PLEASE TYPE OR PRINT

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
REQUEST FOR HOME CARE AUTHORIZATION OR REAUTHORIZATION

Form with sections: PATIENT INFORMATION, PROGRAM, SOCIAL INFORMATION, MEDICAL, NURSING, REQUEST INFORMATION, AUTHORIZATION. Includes fields for patient details, diagnosis, prognosis, goals, and authorization status.

For the Personal Care Assistant Service Program

Completion of the FD-139

- Item 1 - 8 - Copy the Patient's Name, Health Services Program (HSP Medicaid) Case Number, and Person Number exactly as it appears on the Medicaid Validation Form.

Enter patient's sex, age, address, Social Security Account Number and telephone number.
- Items 9 - 10 - Enter attending physician's name and telephone number.
- Items 11- 13 - Enter provider information.
- Item 14 - Disregard.
- Item 15 - Designate Personal Care Assistant Services.
- Items 16 - 21 - Enter information.
- Item 22 - Use for Personal Care Assistant Service Only:

Enter starting and ending dates of service;

Enter No. of hours per week, total hours per period and fees per hour;
Enter signature of physician and your agency representative.



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

New Jersey Health Services Program

NEWSLETTER

Volume P-388

April 23, 1984

TO: HOSPITAL ADMINISTRATORS AND MEDICAL SUPPLIERS
SUBJECT: REQUEST FOR DURABLE MEDICAL EQUIPMENT (DME)
EFFECTIVE: Immediately

BACKGROUND: The New Jersey Health Services (Medicaid) Program regulations require prior authorization, from a Medicaid District Office, before durable medical equipment (DME) may be provided to a Medicaid recipient.

Problems develop when durable medical equipment providers are contacted by hospital personnel and told a patient is being discharged that day and needs a wheelchair. The provider cannot obtain the necessary prior authorization without complete information about the patient, including the discharge plan.

ACTION: The New Jersey Medicaid Program has made arrangements for DME providers to obtain verbal authorizations, subject to further review of written documentation and risk of rejection, but they must have full information available prior to getting verbal approval.

Therefore, when requesting any type of DME for patients to be discharged, please make sure the DME provider is given at least the following:

1. Patients' diagnosis and prognosis
2. Complete description of equipment needed, not just "needs wheelchair"
3. Justification for equipment
4. Whenever possible, the discharge planner should contact the DME provider at least 72 normal business hours prior to the patient leaving the hospital. This advance notice will give the DME provider reasonable opportunity to obtain the necessary prior authorization through the regular Medicaid process.

If you have any questions regarding this newsletter, please contact the Bureau of Pharmacy Services, Division of Medical Assistance and Health Services, 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-389

April 23, 1984

TO: ALL MEDICAL SUPPLIERS

SUBJECT: On-Site Reviews of Durable Medical Equipment
(DME) Requests

EFFECTIVE: Immediately

ACTION: Effective immediately, Medical Consultants/
Pharmaceutical Consultants from the Division of
Medical Assistance and Health Services may periodically visit
Medicaid recipients when equipment, such as wheelchairs,
hospital beds, or other DME items, is being requested. These
visits will enable our Medical Consultants to determine the
medical necessity for the requested item and if the equipment
is cost effective to the Medicaid Program.

All Medical Suppliers are requested to provide the consultants
whatever assistance is necessary to enable them to make the
appropriate determinations.

If you have any questions regarding this Newsletter, please
contact the Bureau of Pharmacy Services, Division of Medical
Assistance and Health Services, Telephone (609) 292-3756.