

Amended by R.2001 d.51, effective February 5, 2001.
See: 32 N.J.R. 3929(a), 33 N.J.R. 555(a).

In (e), substituted "Utilization Management" for "Health Services Administration", substituted "Medical Assistance Customer Center" for "Medicaid District Office" and substituted "MACCs" for "MDOs".

10:54-5.34 Prosthetic and orthotic services (P & O)

(a) Custom-made prosthetic and orthotic appliances (required to replace, support or strengthen parts of the body) are allowable when prescribed by a licensed physician. For purpose of the New Jersey Medicaid program, "custom-made" means a device or appliance fabricated (constructed and/or assembled) in an approved facility under the specific direction of a prescribing physician and designed to fit and perform a useful function solely for that specific individual for whom it was ordered.

1. Custom-made appliances must be fabricated by a person certified as a prosthetist and/or orthotist by the American Board of Certification in Orthotics and Prosthetics, incorporated and fabricated in a facility accredited by the same certification board. The facility must be approved by the New Jersey Medicaid program to provide either prosthetic or orthotic (P & O) services or both to Medicaid beneficiaries. The physician may contact the Medical Assistance Customer Center to determine which P & O dealers are eligible under the program. The P & O provider must obtain prior authorization from the Medical Assistance Customer Center to provide these services. For a listing of Medical Assistance Customer Centers, see the end of N.J.A.C. 10:49, Administration Chapter.

i. In lieu of accreditation/certification by the American Board for Certification in Orthotics and Prosthetics, certification by the Board for Certification in Podorthotics may be accepted for providers limiting their scope of practice to shoe orthotics, custom molded shoes, and shoe modifications. (See also N.J.A.C. 10:55-1.3 incorporated herein by reference.)

(b) Prosthetic and orthotic appliances shall require a personally signed and dated order (prescription) by the prescribing physician, which includes the following:

1. Patient's name, age, address, H.S.P. (Medicaid) Case and Person Number; and
2. Relevant diagnosis(es) (including ICD-9 codes) supporting need for custom-made prosthetic and orthotic appliances; and
3. Detailed (meaningful) description of the prosthetic and orthotic appliance order. Terminology such as "leg brace", "artificial limbs", "orthopedic shoes", and so forth, on a prescription is unacceptable.

(c) The approved prosthetic and orthotic provider, upon receipt of an acceptable prescription, shall request prior authorization from the appropriate Medical Assistance Customer Center or the Podiatric Consultant, as appropriate,

on a "Prior Authorization Form for Prosthetic and Orthotic Services (FD-357)."

1. In the event that a physician's prescription does not contain the prosthetic and orthotic nomenclature accepted by this Division, the facility shall transform the original prescription to conform to the accepted nomenclature. This does not imply that the physician's prescription will in any way be altered.

Amended by R.2001 d.51, effective February 5, 2001.
See: 32 N.J.R. 3929(a), 33 N.J.R. 555(a).

In (a)1, substituted "beneficiaries" for "recipients" in the second sentence and substituted references to Medical Assistance Customer Centers for references to Medicaid District Offices throughout; in (c), substituted "Medical Assistance Customer Center" for "Medicaid District Office" preceding "or the Podiatric Consultant."

10:54-5.35 Rehabilitative services; general

(a) Rehabilitative services include physical therapy, occupational therapy, and speech-language pathology and audiology, including the use of such supplies and equipment as are necessary in the provision of such services. Rehabilitative services and other restorative services are provided for the purpose of attaining maximum reduction of physical or mental disability and restoration of a Medicaid beneficiary to his or her best functional level. Rehabilitative services shall be made available to Medicaid beneficiaries as an integral part of a comprehensive medical program.

(b) In a physician's office, rehabilitative services shall be provided by or under the direction of a physical therapist, occupational therapist, speech-language pathologist or audiologist employed by or under contract to the physician. Each of these therapy services are discussed at N.J.A.C. 10:54-5.36, 5.37, and 5.38, respectively.

1. Physical therapy, speech-language pathology and audiology services shall be reimbursed directly to the physician only when provided in the physician's office.

2. Physical therapy and speech-language therapy treatments shall be individual and shall consist of a minimum of 30 minutes.

3. Audiology services shall be reimbursed only when services are provided in an office of an Ear, Nose and Throat Specialist.

4. Occupational therapy services shall not be reimbursed, if provided in the physician's office.

(c) A plan of treatment shall be completed during the Medicaid beneficiary's initial evaluation visit and retained on file.

1. The plan of treatment shall be definitive as to the type, amount, frequency, and duration of the rehabilitative services that are to be furnished and shall include the beneficiary's diagnosis and the anticipated goal(s) of the treatment.

Amended by R.2001 d.51, effective February 5, 2001.

See: 32 N.J.R. 3929(a), 33 N.J.R. 555(a).

In (a) and (c), substituted references to beneficiaries for references to recipients throughout.

10:54-5.36 Rehabilitative services; physical therapy

(a) Physical therapy is a service prescribed by a physician and provided to a Medicaid beneficiary by or under the direction of a qualified physical therapist. Physical therapy does not include therapy which is purely palliative, such as the application of heat in any form; massage, routine calisthenics; group exercises; assistance in any activity; use of a simple mechanical device; or other services not requiring the special skill of a licensed physical therapist.

1. A qualified physical therapist is an individual who is:
 - i. Licensed by the State of New Jersey as a physical therapist in accordance with N.J.A.C. 13:39A; and
 - ii. A graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent.
2. If treatment or services are provided in a state other than New Jersey, the physical therapist shall meet the requirements of that state, including licensure if applicable, and all applicable Federal requirements.

Amended by R.2001 d.51, effective February 5, 2001.

See: 32 N.J.R. 3929(a), 33 N.J.R. 555(a).

In (a), substituted "beneficiary" for "recipient" preceding "by or under" in the introductory paragraph.

10:54-5.37 Rehabilitative services; occupational therapy

(a) Occupational therapy is a service prescribed by a physician and provided to a Medicaid beneficiary by or under the direction of a qualified occupational therapist and includes the necessary supplies and equipment.

1. A qualified occupational therapist is an individual who is:
 - i. Registered by the American Occupational Therapy Certification Board (AOTCB); or
 - ii. A graduate of a program in occupational therapy approved by the Committee on Allied Health Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association (AOTA).
2. If treatment or services are provided in a state other than New Jersey, the occupational therapist shall meet the requirements of that state, including licensure if applicable, and all applicable Federal requirements.

(b) Occupational therapy shall be reimbursed when provided in settings other than a physician's office.

Amended by R.2001 d.51, effective February 5, 2001.

See: 32 N.J.R. 3929(a), 33 N.J.R. 555(a).

In (a), substituted "beneficiary" for "recipient" following "provided to a Medicaid" in the introductory paragraph.

10:54-5.38 Rehabilitative services; speech-language pathology and audiology

(a) Speech-language pathology services and audiology services are diagnostic, screening, preventive, or corrective services prescribed by a physician and provided to a Medicaid beneficiary by or under the direction of a speech-language pathologist or audiologist. They include necessary supplies and equipment.

1. A speech-language pathologist or audiologist is an individual who is licensed by the State of New Jersey as a speech-language pathologist or audiologist, in accordance with N.J.A.C. 13:44C, and who meets all applicable Federal requirements including:
 - i. A certificate of clinical competence in Speech-Language Pathology or Audiology from the American Speech-Language-Hearing Association; or
 - ii. Completion of the equivalent educational requirements and work experience necessary for the certificate(s); or
 - iii. Completion of the academic program and is in the process of acquiring supervised work experience in order to qualify for the certificate(s).

2. If treatment or services are provided in a state other than New Jersey, the speech-language pathologist or audiologist shall meet the requirements of that state, including licensure if applicable, and all applicable Federal requirements.

Amended by R.2001 d.51, effective February 5, 2001.

See: 32 N.J.R. 3929(a), 33 N.J.R. 555(a).

In (a), substituted "beneficiary" for "recipient" following "provided to a Medicaid" in the introductory paragraph.

10:54-5.39 Rehabilitative services; separation of therapy and office visit reimbursement

(a) No portion of the time spent on therapy treatments may be considered as part of the time parameters of an office visit. Office visits billed during the same day shall clearly and separately meet the time and other parameters described in the applicable HCPCS procedure codes, N.J.A.C. 10:54-9.

(b) When the same type of rehabilitative service is performed on a Medicaid beneficiary more than once on the same day, for example, two physical therapy services, reimbursement shall be made for one service only. Likewise, when the treatment performed on a Medicaid beneficiary is merely a different modality within the same type of rehabilitative service, reimbursement shall be made for only one service per beneficiary per day.

Amended by R.2001 d.51, effective February 5, 2001.

See: 32 N.J.R. 3929(a), 33 N.J.R. 555(a).

In (b), substituted "beneficiary" for "recipient" throughout.

10:54-5.40 Second opinion program for elective surgical procedures—hospital inpatient and ambulatory surgical centers (ASC) services

(a) A second opinion shall be required for the elective surgical procedures listed under (b) below. The outcome of the second opinion will have no bearing on payment. Once the second opinion is rendered, the patient will retain the right to decide whether or not to proceed with the surgery; however, failure to obtain a second opinion for these procedures will result in a denial of the surgeon's claim. (See N.J.A.C. 10:54-9.11(c) and (d) for the list of HCPCS codes that require a second opinion.)

1. A second opinion shall be required for the surgery *indicated* below when the surgical procedure is elective. If the operating physician determines that the need for surgery is urgent or is an emergency, no opinion is required. Urgent or emergency (for second opinion purposes) 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.

i. If the patient is hospitalized or admitted to an ASC, a second opinion is not required if the procedure becomes urgent or an emergency during the course of the hospitalization or admission, regardless of the patient's admitting diagnosis.

ii. Reimbursement for urgent or emergency surgery shall be made only if a specific statement is attached to the claim form by the operating physician certifying that the second opinion requirement was not met and substantiating the urgent or emergency nature of the surgery.

2. A second opinion shall be required for any of the elective procedures whenever the New Jersey Medicaid program is to be billed for any portion of the 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 New Jersey Medicaid program shall not make supplementary payment unless the second opinion requirement has been met. However, the New Jersey Medicaid program shall make payment on the claim if the operating physician receives documentation that a second opinion was arranged and paid by another insurer. A copy of this documentation must be attached to the claim.

3. A second opinion shall be required for any of the four procedures to be done on an elective basis, even if the recommendation for surgery is made during the inpatient hospital stay or ASC admission. In this case, the patient should be discharged and the regular process for obtaining a second opinion should be followed. If the patient decides to have surgery, he or she can then be

scheduled for readmission since the case would have been elective in nature.

(b) The following elective surgical procedures require a second opinion by a physician under the Medicaid Second Opinion program:

1. Hernia Repair (common abdominal wall type);

i. A second opinion shall be required for any herniorrhaphy involving an adult (over 18 years of age).

ii. A second opinion shall not be required for herniorrhaphy involving a child or young adult 18 years of age or under.

2. Hysterectomy (see also N.J.A.C. 10:54-5.16(h) through (k));

3. Laminectomy;

4. Spinal fusion;

i. A second opinion shall not be required for spinal fusion for scoliosis in a child or young adult 18 years of age or under.

(c) The Medicaid Second Opinion program shall not require a second opinion for the following circumstances:

1. New Jersey Medicaid beneficiaries with HSP (Medicaid) Case Numbers with the first and second digits of 90 or the third and fourth digits of 60 who are residing out-of-State at the discretion of the New Jersey Department of Human Services.

2. Dually eligible Medicare/Medicaid beneficiaries, unless a second opinion is also mandatory under Medicare regulations.

(d) Medicare/Medicaid beneficiaries may optionally, (that is, on a voluntary basis) seek "second opinions" and the cost of the service shall be reimbursed by the New Jersey Medicaid program if not covered for reimbursement by Medicare.

(e) A second opinion shall be arranged through the fiscal agent's Medicaid Second Opinion Referral Center.

1. A consultation ordered by a physician shall not, by itself, meet the program's definition of a second opinion and no "Authorization for Payment" shall be granted based on such consultation. Second opinions arranged and paid for by other third party payers, in accordance with (a)2 above, will be considered second opinions by Medicaid.

2. All second opinion providers shall be Board Certified or Board Eligible by the appropriate American specialty board or osteopathic specialty board. The Referral Center shall ensure that the second opinion physician is a Board Certified or Board Eligible Specialist in the appropriate field (General Surgery, Pediatrics, Neurology, Neurosurgery, Obstetrics/Gynecology, or Orthopedics), and

has signed a Medicaid Second Opinion Provider Agreement.

i. To become approved as a Medicaid Second Opinion provider and receive a Second Opinion Provider Agreement application, contact the Medicaid Second Opinion Referral Center at the fiscal agent of the New Jersey Medicaid program.

3. The physician shall agree 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 has no financial involvement.

4. A second opinion shall be required, regardless of the setting in which the procedure is to be performed (inpatient hospital, outpatient hospital, independent clinic, Ambulatory Surgical Center, or physician's office).

5. In order to prevent claim denial as a result of a situation where one of the elective surgical procedures is scheduled and performed before the second opinion requirements are met, it is suggested that the elective surgery not be scheduled until after the second opinion has been rendered.

(f) At the time a recommendation for surgery is made, the first opinion physician or the patient's operating surgeon will give the patient a bilingual Medicaid Second Opinion program brochure which explains the program and the steps for obtaining a second opinion. The physician should check the appropriate box on the brochure to indicate the procedure being recommended. Copies of the brochure are available from the fiscal agent of the New Jersey Medicaid program.

1. The patient shall then follow the instructions outlined in the brochure to contact the Medicaid Second Opinion Referral Center and obtain a second opinion.

2. At the time the second opinion is rendered, the second opinion physician may contact the first opinion physician or the patient's operating surgeon to discuss the patient's medical history and the result of the previous diagnostic studies.

3. The second opinion physician will document the results of the second opinion on the Medicaid Second Opinion Referral Form. A copy of this report shall be forwarded by the Medicaid Second Opinion Referral Center to the referring physician.

4. If the patient wishes to proceed with surgery after a second opinion is received, the operating physician shall contact the Referral Center to receive an "Authorization for Payment" prior to proceeding with the surgery.

i. A copy of the Second Opinion Report, as well as authorization for physician payment will then be sent to the operating physician. At the time the patient's hospital, independent clinic, or ambulatory surgical center (ASC) admission is arranged, the operating physician shall give the hospital or independent clinic or ASC its copy of the "Authorization for Payment". The second opinion is valid for one year from the date the second opinion is rendered.

(g) The physician claim associated with one of the second opinion procedures shall not be paid unless attached to the hard copy of the claim is:

1. An "Authorization for Payment", or

2. Documentation of a second opinion arranged through another insurer; or

3. 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.

(h) 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 eligibility must be verified by checking the patient's current New Jersey Medicaid Validation Form before rendering any service. (See N.J.A.C. 10:49-1.2, Administration on "How to identify a Medicaid beneficiary.")

(i) Third opinion: If as a result of the second opinion, the patient is given a conflicting opinion regarding the need for the elective surgery, the patient may contact the Medicaid Second Opinion Referral Center and arrange for a third opinion. (For third opinion billing, see N.J.A.C. 10:54-9.4 under procedure code 99274 ZZ.)

(j) For physician claim submission, the operating surgeon, upon receipt of the Second Opinion "Authorization of Payment" shall go through the normal process for arranging the surgery, ensuring the hospital, independent clinic, or ASC receives its copy of the authorization.

1. If the patient should change physicians after the authorization has been released, the newly designated operating physician may contact the Medicaid Referral Center for a copy.

2. Once the surgery is performed, the physician must attach to the Physician's claim form (HCFA 1500) either the operating physician's copy of the "Authorization of Payment" or a statement certifying as to the urgent or emergency nature of the procedure.

3. No Second Opinion authorization or certification shall be required for the anesthesiologist or assistant surgeon claims.

The code for manual differential WBC count (85007) will not be reimbursed in conjunction with codes 85021, 85022, 85023, 85024, 85025, and 85027.

Codes for platelet count (85590 and 85595) will not be reimbursed in conjunction with codes 85023-85027.

Code 85044 may be reimbursed in conjunction with codes 85023 and 85025, when a complete hemogram is ordered.

9. Codes 87040, 87045, 87060, 87070, 87184—Cultures

NOTE: These codes may only be billed when a pathogenic microorganism is reported. A culture that indicates no growth or normal flora must be billed as a presumptive culture, 87081 or 87082.

10. Code 88155—pap smear

NOTE: Obtaining specimen is not a separate eligible service.

11. Code 88348 and 89349—Electron microscopy; diagnostic and scanning are not reimbursable when used as a research tool.

NOTE: For reimbursement purposes, Medicaid will pay for the above diagnostic scanning procedure when it pertains to x-ray microanalysis for identification of asbestos particles and heavy metals, i.e.; gold, mercury, etc. and also when examining tissue specimens in occasional cases of malabsorption.

12. Code 89360—Sweat (without iontophoresis) test

NOTE: Reimbursement not eligible for qualitative tests. For reimbursement purposes, 84295 will not be reimbursed at any additional charge. Do not bill 84295 in conjunction 89360.

13. Code 36415—Utilize this code only for finger/heel/ear stick for collection of specimen(s). This service is reimbursable in the physician office laboratory (POL) when the specimen is not referred out to an independent clinical laboratory for testing. Finger/heel/ear stick is not reimbursable when billed by the independent clinical laboratory.

14. Code G0001—This service is reimbursable in the physician office laboratory (POL) when the specimen is not referred out to an independent clinical laboratory for testing. Venipuncture is not reimbursable when billed by the independent clinical laboratory. It is considered all inclusive as part of the laboratory test.

15. Code W8200—This code is reimbursable when submitted on same claim, and performed on same date as chemistry profiles.

16. Code W8900—This code may be used only once per trip regardless of the number of beneficiaries seen and requires a distance in excess of 20 miles per round trip.

10:54-9.10 Descriptions and Qualifiers for Level II and Level III Procedure Codes (except for Pathology/Laboratory)

(a) Introduction:

1. The following is a list of procedure codes with the "modifier L" in the IND column on the list of HCPCS Procedure Codes representing procedure codes specifically used by New Jersey Medicaid and not included in the CPT-4.

(b) Mental Health services:

- H5025 Psychotherapy Group (Maximum 8 persons per group: 90 minutes, per person, per session)
- W9106 Crisis Intervention—An emergency procedure provided in a nursing home by a psychiatric physician to a resident of that home to meet the immediate need of the resident in psychiatric crisis and the need of the facility. Request for this service shall be initiated by the attending physician, or by the nursing service director, supervisor or designee. Procedure includes written evaluation, drug prescription, conference with staff and recommendation of treatment plan. Use of procedure is limited to once in six months.

(c) Maternity Care:

- W9050 Attendance during and pediatric care to newborns at-risk vaginal deliveries.
QUALIFIER: Attendance by a physicians other than the physicians(s) rendering maternity care. Medically necessity for required attendance must be fully documented on the hospital record as well as a brief explanation written in ITEM 24 on the 1500 N.J. claim form. (Example: Fetal distress). If difficulties occur so that criteria of prolonged services (HCPCS 99150) or critical care (99160) can be met, the HCPCS 99150 or 99160 can be substituted in lieu of W9050. Payment may be in addition to eligible payment for normal newborn care through HCPCS 99431 or Hospital Inpatient (99221, 99222, 99223, 99231, 99232, 99233) or Critical Care (99291 or 99292) codes, as applicable.
- W9055 Attendance during and pediatric care to newborns at-risk caesarean section deliveries.
QUALIFIER: Attendance by a physicians other than the physician(s) rendering maternity care. Medically necessity for required attendance must be fully documented on the hospital record as well as a brief explanation written in ITEM 24 on the 1500 N.J. claim form. (Example: Fetal distress). If difficulties occur so that criteria of prolonged services (HCPCS 99150) or critical care (99160) can be met, then HCPCS 99150 or 99160 can be substituted in lieu of W9050. Payment may be in addition to eligible payment for normal newborn care through HCPCS 99431 or Hospital Inpatient (99221, 99222, 99223, 99231, 99232, 99233) or Critical Care (99291 or 99292) codes, as applicable.
- W9855 WM Initial Antepartum visit. (Separate procedure)
- W9855 Subsequent Antepartum visit. (Separate procedure).
- W9856 WM
- W9856 Indicate the specific dates of service on the HCFA 1500 claim form in Item 24

(d) Intrauterine devices:

- W0001 WF Supplying and inserting the intrauterine device "Paragard" by a physician including the post insertion visit.

- W0001 WM WF Supplying and inserting the intrauterine device "Paragard" by a certified nurse-midwife including the post-insertion visit.
- W0002 WF Supplying and inserting the intrauterine device "Progestasert" by a physician including the post-insertion visit.
- W0002 WM WF Supplying and inserting the intrauterine device "Progestasert" by a certified nurse-midwife including the post-insertion visit.
- W0004 WF Removal of an IUD by a physician followed at the same visit by the insertion of the intrauterine device "Paragard" by a physician including the post-insertion visit.
- W0004 WM WF Removal of an IUD by a certified nurse-midwife (CNM) followed at the same visit by the insertion of the intrauterine device "Paragard" by a CNM including the post-insertion visit.
- W0008 WF Removal of an IUD by a physician followed at the same visit by the insertion of the intrauterine device "Progestasert" by a physician including the post-insertion visit.
- W0008 WM WF Removal of an IUD by a certified nurse-midwife (CNM) followed at the same visit by the insertion of the intrauterine device "Progestasert" by a CNM including the post-insertion visit.

(e) Pulmonary function tests:

- W9450 Combined pulmonary function testing (for basic evaluation of pulmonary physiology includes complete spirometry and any 6 or more pulmonary function studies)

(f) Hepatitis B Vaccine Immunization:

1. Coverage is available for post exposure prophylaxis and for vaccination of individuals in selected high risk groups, regardless of age, in accordance with the criteria defined by the CDC. In all such cases, the need for this vaccination must be fully documented in the recipient's medical record. In order to facilitate reimbursement for Hepatitis B immunoprophylaxis for high risk individuals, manufacturer, age, and dose specific procedure codes have been developed for use by physicians and independent clinics providing this service.

2. EXCEPTION: The New Jersey Medicaid program will reimburse for the universal vaccination of infants born on and after January 1, 1992, whose immunization was delayed beyond the newborn period because this policy was not yet in effect. However, the immunization schedule must be completed before the infant's second birthday.

- W9096 Hepatitis B immunoprophylaxis with Recombivax HB, 0.25 ml dose. This code applies only to newborns of HBsAg negative mothers.
- W9096 22 Hepatitis B immunoprophylaxis with Recombivax HB, 0.5 ml dose. This code applies only to newborns of HBsAg positive mothers.
- W9097 Hepatitis B immunoprophylaxis with Recombivax HB, 0.25 ml dose. This code applies only to high risk recipients under 11 years of age (exclusive of newborns).
- W9098 Hepatitis B immunoprophylaxis with Recombivax HB, 0.5 ml dose. This code applies only to high risk recipients 11-19 years of age.
- W9099 Hepatitis B immunoprophylaxis with Recombivax HB, 1.0 ml dose. This code applies only to high risk recipients over 19 years of age.

- W9333 Hepatitis B immunoprophylaxis with Engerix-B, 0.5 ml dose. This code applies only when immunizing newborns.
- W9334 Hepatitis B immunoprophylaxis with Engerix-B, 0.5 ml dose. This code applies only to high risk recipients under 11 years of age (exclusive of newborns).
- W9335 Hepatitis B immunoprophylaxis with Engerix-B, 1.0 ml dose. This code applies only to high risk recipients over 11 years of age.

(g) Certified Nurse Midwife code for Home Delivery:

- Z0250 WM Home Delivery Pack
QUALIFIER: All drugs and supplies, etc. necessary for the delivery in this setting.

(h) Speech-language pathology:

- Z0300 Speech/Language Pathology—Initial Visit Screening Examination
QUALIFIER: Screening examination only, per individual, per provider.
NOTE: It is the intent of the program to reimburse for either a screening examination or a comprehensive speech/ evaluation rendered to the 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 patient and the provider. The screening examination, in this instance becomes an integral part of the comprehensive speech/language evaluation and the claim submitted to the Program shall be for a comprehensive evaluation. If, however, the documentation reveals that the screening examination did not support the need for a comprehensive evaluation, the code that must be billed is Z0300 Speech/Language Pathology—Initial Visit Screening Examination.
- Z0310 Initial Comprehensive Speech/Language Pathology Evaluation by a Certified Speech/Language Pathologist.
QUALIFIER: This procedure code is used to bill for assessment and diagnosis(es) a problem, or problems, in any of the following areas: language competence and performance, phonological development or articulation skills, and/or physical integrity and performance of the speech mechanism including the respiratory, phonatory and articulation systems. Such evaluation requires 3 hours on the average. Discussion and consultation with the patient and/or family regarding findings and a written report are considered an integral part of the evaluation.
NOTE: It is the intent of the program to reimburse for either a screening examination or a comprehensive speech/ evaluation rendered to the 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 patient and the provider. The screening examination, in this instance, becomes an integral part of the comprehensive evaluation and the claim submitted to the Program shall be for a comprehensive speech/language evaluation. If, however, the documentation reveals that the screening examination did not support the need for a comprehensive evaluation, the code that must be billed is Z0300 Speech/Language Pathology—Initial Visit Screening Examination.

(i) PreAdmission Screening and Annual Resident Review (PASARR)

There are two sets of HCPCS procedure codes used for PreAdmission Screening (PAS) of PASARR Level II Screening as follows:

1. The reimbursement for both HCPCS procedure codes 90801 and W9847 with a Medicaid maximum fee allowance of \$100.00 is used by a psychiatrist and can be used in any setting for hospital or community.

i. Psychiatric diagnostic interview examination including history, mental status, or disposition (may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances other informants will be seen in lieu of the patient)

NOTE: The HCPCS codes 99313, W9849, 99333 and W9848 cannot bill along with consultation codes when rendered by the same physicians. The provider must use HCPCS codes 90801 and W9847.

QUALIFIER: This procedure is used for Medicare/Medicaid applicants who require an initial PASARR Level II Screen PreAdmission Screening (PAS of PASARR) and are being examined by a psychiatrist to determine the need for specialized services for mental illness, prior to admission into a nursing facility (NF), as required by Federal law.

It must be performed only by a Board Certified or Board Eligible Psychiatrist who must personally examine the patient.

For hospital patients, the examining psychiatrist must attach a completed Division of Mental Health and Hospitals Psychiatric Evaluation form (DMH&H-1989) to the patient's clinical chart. The hospital Discharge Planning or Social Services unit will be responsible for the submission of the Psychiatric Evaluation form to the Division of Mental Health and Hospitals, CN-727, Trenton, New Jersey 08625-0727, Attention: PASARR Coordinator.

For community patients, the examining psychiatrist will be responsible for obtaining the Division of Mental Health and Hospitals Psychiatric Evaluation form (DMH&H-1989) from the Medicaid District Office and submitting the completed form to the Division of Mental Health & Hospitals, CN-727, Trenton, New Jersey 08625-0727, Attention: PASARR Coordinator.

NOTE: The evaluation form must be mailed no later than 48 hours following the consultation to prevent undue delay in patient placement.

2. The reimbursement for both HCPCS procedure codes 99333 and W9848 with a Medicaid maximum fee allowance of \$44.00 is used by an attending physician (non-psychiatrist) when a psychiatrist is not readily or immediately available in a community setting.

i. Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three components:

- (1) A detailed interval history;
- (2) A detailed examination;
- (3) Medical decision making of high complexity.

QUALIFIER: This procedure is used for Medicare/Medicaid persons residing in the community (currently at home or boarding home) who are applicants to Medicare/Medicaid nursing facilities and are being examined by an attending physician to determine the need for specialized services for mental illness.

If this examination reveals the need for a more specialized examination, a psychiatric consultation may be requested by the attending physician. Existing consultation

codes for limited consultation and for comprehensive consultation may be used for this purpose by the consulting psychiatrist as appropriate.

If the individual has a diagnosis of Alzheimer's disease or related dementias, as described in the 1987 edition of the Diagnostic and Statistical Manual of Mental Disorders, documentation must be provided to the admitting Medicaid certified nursing facility, for the individual's clinical record, on the history, physical examination, and diagnostic workup, to support the diagnosis. (A new examination does not have to be completed.)

The examining attending physician will be responsible for obtaining the Division of Mental Health and Hospitals Psychiatric Evaluation form (DMH&H-1989) from the Medicaid District Office and submitting the completed form to the Division of Mental Health and Hospitals, CN-727, Trenton, New Jersey 08625-0727, Attention: PASARR Coordinator.

NOTE: The evaluation form must be mailed no later than 48 hours following the consultation to prevent undue delay in patient placement.

3. There is one set of HCPCS procedure codes used for Annual Resident Review (ARR) of PASARR as follows:

The reimbursement for both HCPCS procedure codes 99313 and W9849 with a Medicaid maximum fee allowance of \$44.00 are used for Medicare/Medicaid nursing facility patients who are being evaluated by an attending physician for the purposes of an annual resident review to determine the need for specialized services for mental illness.

i. Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three components:

- (1) A detailed interval history;
- (2) A detailed examination;
- (3) Medical decision making of moderate to high complexity.

QUALIFIER: If this examination reveals the need for a more specialized examination, a psychiatric consultation may be requested by the attending physician. Existing consultation codes for limited consultation and for comprehensive consultation may be used for this purpose by the consulting psychiatrist as appropriate.

If the individual has a diagnosis of Alzheimer's disease or related dementias, as described in the 1987 edition of the Diagnostic and Statistical Manual of Mental Disorders, documentation must be provided to the admitting Medicaid certified nursing facility, for the individual's clinical record, on the history, physical examination, and diagnostic workup, to support the diagnosis. (A new examination does not have to be completed.)

These codes can only be utilized on an annual basis by the same physician on the same patient.

The examining attending physician must attach a completed Division of Mental Health and Hospitals Psychiatric Evaluation form (DMH&H-1989) to the patient's clinical chart. The Nursing Facility administrator will be responsible for providing these forms to the attending physician as well as submitting the completed form to the Division of Mental Health and Hospitals, CN-727, Trenton, New Jersey 08625-0727, Attention: PASARR Coordinator.

NOTE: The evaluation form must be mailed no later than 48 hours following the consultation.

(j) HealthStart Maternity Medical Care Services and Health Support Services for Physicians

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

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

3. The enhanced reimbursement (i.e. HealthStart procedure codes) for delivery and postpartum care shall be claimed only for a patient who received at least one antepartum HealthStart maternity medical and Health Support Service.

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

i. Laboratory procedures performed by an outside laboratory shall be reimbursed to the laboratory.

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

W9025	HealthStart INITIAL ANTEPARTUM MATERNITY MEDICAL CARE VISIT, includes:	72.00	69.00
W9025 WM		67.00	

1. History, including system review;
2. Complete physical examination;
3. Risk assessment;
4. Initial plan of care;
5. Patient counseling and treatment;
6. Routine and special laboratory services on site or by referral, as appropriate;
7. Referrals for other medical consultations, as appropriate (including dental); and
8. Coordination with the HealthStart Health Support Services provider, as applicable.

W9026	HealthStart SUBSEQUENT ANTEPARTUM MATERNITY MEDICAL CARE VISIT, includes:	22.00	21.00
W9026 WM		19.00	

1. Interim history;
2. Physical examination;
3. Risk assessment;
4. Review of plan of care;
5. Patient counseling and treatment;

6. Laboratory services on site or by referral, as appropriate;

7. Referrals for other medical consultations, as appropriate (including dental);

8. Coordination with HealthStart case coordinator.

NOTE: This code may be billed only for the 2nd through 15th antepartum visit.

NOTE: If medical necessity dictates, corroborated by the record, additional visits above the fifteenth visit may be reimbursed under procedure code, i.e. 99211, 99212, 99213, 99214, and 99215. The date and place of service shall be included on each claim detail line on the 1500 N.J. claim form. The claim form should clearly indicate the reason for the medical necessity and date for each additional visit.

W9027	HealthStart REGULAR DELIVERY, includes:	465.00	418.00
W9027 WM		371.00	

1. Admission history;
2. Complete physical examination;
3. Vaginal delivery with or without episiotomy and/or forceps;
4. Inpatient postpartum care;
5. Referral to postpartum follow-up care provider including:

(a) Mother's hospital discharge summary; and the

(b) Infant's discharge summary, as appropriate.

NOTE: Obstetrical delivery applies to a full term or premature vaginal delivery and includes care in the home, birthing center or in the hospital (inpatient setting). Include the delivery date on the 1500 N.J. claim form in Item 24A.

W9028	HealthStart POSTPARTUM CARE VISIT	22.00	21.00
W9028 WM		19.00	

1. Outpatient postpartum care by the 60th day after the vaginal or caesarean section delivery includes:

- (a) Review of prenatal, labor and delivery course;
- (b) Interim history, including information on feeding and care of the newborn;
- (c) Physical examination;
- (d) Referral for laboratory services, as appropriate;
- (e) Referral for ongoing medical care, when appropriate; and
- (f) Patient counseling and treatment.

NOTE: The postpartum visit shall be made by the 60th postpartum day. Include the delivery date on the 1500 N.J. claim form in Item 24A.

W9029 HealthStart REGULAR DELIVERY 487.00 439.00
AND POSTPARTUM includes:
W9029 WM 390.00

1. Admission history;
2. Complete physical examination;
3. Vaginal delivery with or without episiotomy and/or forceps;
4. Inpatient postpartum care;
5. Referral to postpartum follow-up care provider including:
 - (a) Mother's hospital discharge summary; and
 - (b) Infant's discharge summary, as appropriate.
6. Outpatient postpartum care by the 60th day after the delivery;
 - (a) Review of prenatal, labor and delivery course;
 - (b) Interim history, including information on feeding and care of the newborn;
 - (c) Physical examination;
 - (d) Referral for laboratory services, as appropriate;
 - (e) Referral for ongoing medical care, when appropriate; and
 - (f) Patient counseling and treatment.

NOTE: This code applies to a full term or premature vaginal delivery and includes care in the home, birthing center or in the hospital (inpatient setting). Include delivery date on the 1500 N.J. claim form in Item 24A.

W9030 HealthStart TOTAL OBSTETRICAL 867.00 802.00
CARE
W9030 WM 723.00

Total obstetrical care consists of:

1. INITIAL ANTEPARTUM VISIT AND FOURTEEN SUBSEQUENT ANTEPARTUM VISITS. Specific dates are to be listed on the claim form.

NOTE: Reimbursement will be denied if the services delivered do not meet the criteria for the visits. The elements of the visits shall include the following:

- a. History (initial or review), including system review;
- b. Complete physical examination;
- c. Risk assessment;
- d. Initial and ongoing care plan;
- e. Patient counseling and treatment;

- f. Routine and special laboratory tests on site, or by referral, as appropriate;
- g. Referral for other medical consultations, as appropriate (including dental); and
- h. Coordination with the HealthStart Health Support Services provider, as applicable.

W9031 HealthStart CAESAREAN SEC- 595.00 531.00
TION DELIVERY, includes:

1. Admission history;
2. Complete physical examination;
3. Caesarean section delivery;
4. Inpatient postpartum care;
5. Referral to postpartum follow-up care provider, including:
 - a. Mother's hospital discharge summary;
 - b. Infant's discharge summary, as appropriate;

NOTE: Include the delivery date on the claim form.
W9040 HealthStart enrollment process 30.00

1. Assistance with the presumptive eligibility determination for Maternity Care recipients, when and if applicable;
2. Patient registration and scheduling of the initial appointments;
3. Counseling and referral for WIC, food stamps, and other community-based services;
4. Assignment of HealthStart case coordinator; and
5. Outreach and follow-up on missed appointments.

NOTE: This code may be billed only once during pregnancy by the same provider.

W9041 HealthStart Development of Materni- 120.00
ty Plan of Care, includes:

1. Case coordination services;
2. Initial assessments:
 - a. Nutrition;
 - b. Health education; and
 - c. Social/psychological.
3. Case conference with Maternity Medical Care provider;
4. Initial plan of care developed by the HealthStart case coordinator;
5. Basic guidance and health education services;
6. Referral for other services including follow-up with County Boards of Social Services; and

7. Outreach, referral and follow-up activities including phone calls and letters.

NOTE: This code may be billed only once during the pregnancy by the same provider.

W9042 HealthStart Subsequent Maternity 50.00
Health Support Services Visit, includes:

1. Case coordination;
2. Review and update of care plan;
3. Coordination with maternity medical care provider;
4. Health education instruction;
5. Social/psychological guidance;
6. Nutrition guidance;
7. Home visit for high risk clients; and
8. Outreach, referral and follow-up activities including phone calls and letters.

NOTE: This code may be billed only once per trimester and not more than twice per pregnancy.

W9043 HealthStart Postpartum Maternity 100.00
Health Support Services, includes:

1. Case coordination services;
2. Review of the plan of care;
3. Review of the summary of hospital stay records and current medical status;
4. Nutrition assessment and counseling;
5. Social/psychological assessment and counseling;
6. Health education assessment and instruction;
7. Home visit(s) as applicable;
8. Referral, outreach and follow-up services;
9. Referral for pediatric preventive care and follow-up;
10. Transfer of pertinent information to pediatric, future family planning and medical care providers; and
11. Completion of the plan of care.

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

1. HealthStart Pediatric Care Guidelines provide for up to nine preventive child health visits for a child under two years of age.
 - i. All preventive child health visits shall be billed using the HealthStart Preventive Child Health Visit codes appropriate to the child's age at the time of visit. Each preventive child health visit HCPCS procedure code may be claimed only once per child.

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

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

i. Laboratory procedures performed by an outside laboratory shall be reimbursed to the laboratory.

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

W9060	Under 6 weeks	31.00	26.00
W9061	Between 6 weeks and 3 months	31.00	26.00
W9062	Between 3 months and 5 months	31.00	26.00
W9063	Between 5 months and 8 months	31.00	26.00
W9064	Between 8 months and 11 months	31.00	26.00
W9065	Between 11 months and 14 months	31.00	26.00
W9066	Between 14 months and 17 months	31.00	26.00
W9067	Between 17 months and 20 months	31.00	26.00
W9068	Between 20 months and 24 months	31.00	26.00

4. Early and Periodic, Screening, Diagnosis and Testing (EPSDT)

W9060 WT	Under 6 weeks	23.00	18.00
W9061 WT	Between 6 weeks and 3 months	23.00	18.00
W9062 WT	Between 3 months and 5 months	23.00	18.00
W9063 WT	Between 5 months and 9 months	23.00	18.00
W9064 WT	Between 9 months and 11 months	23.00	18.00
W9065 WT	Between 11 months and 14 months	23.00	18.00
W9066 WT	Between 14 months and 17 months	23.00	18.00
W9067 WT	Between 17 months and 20 months	23.00	18.00
W9068 WT	Between 20 months and 24 months	23.00	18.00
W9820	Every 12 months thereafter	23.00	18.00

NOTE: See N.J.A.C. 10:54-5.5 for more information about EPSDT.

5. HealthStart Pediatric Preventive Care Visit includes the following elements:

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

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

- (1) Sickle cell, PKU screening, as appropriate;
- (2) Hemoglobin or hematocrit twice, at 6-9 months and 20-24 months of age;
- (3) Urinalysis, twice: at 6-9 months and 20-24 months of age;
- (4) Tuberculin test, annually; and
- (5) Lead screening using blood lead level determinations between 6 and 12 months, at 2 years of age, and annually up to 6 years of age. At all other visits, screening shall consist of verbal assessment and blood lead level testing, as indicated.

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

(l) Diagnostic Radiology Services:

R0070 Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen

(m) Level III descriptions:

W1000 Renal transplantation, implantation of graft, with immunosuppressant therapy, with recipient splenectomy and recipient nephrectomy, unilateral and bilateral

W1001 Resuturing of dislocated intraocular lens, requiring an incision

W1002 Myringotomy with insertion of collar button, unilateral

W1003 Myringotomy with insertion of collar button, bilateral

W1008 Discission of lens capsule; incisional technique (needling of lens), initial

W1009 Discission of lens capsule; incisional technique (needling of lens), subsequent

W2000 Dislocation, lumbar, simple, closed reduction with anesthesia

W3600 Injection procedure for intraosseous venography

W3650 Insertion of port-a-cath into subclavian for chemotherapy

W4850 Insertion of tenckhoff catheter with concurrent omentectomy, panniculectomy, lysis of adhesions, or other related surgical procedure. (See code 49420 and 49421 for insertion without omentectomy, panniculectomy, etc.)

W5650 Removal of a foreign body from the vagina of a child

W5750 VABRA aspiration biopsy

W5760 Insertion of fletcher applicator for cesium implant, initial

W5760 76 Insertion of fletcher applicator for cesium implant, subsequent

W5920 Caudal anesthesia (epidural block) limited to obstetrical cases only eligible for reimbursement only when given by other than the delivery physician

W5930 Manual removal of placenta by other than the physician effecting delivery

W6499 AA Anesthesia for ECT, cat scan or MRI

W9170 Peritoneal dialysis, 3rd to 14th day

W9200 Subnormal vision exam, a continuation eye exam with limited additional test to determine if subnormal vision on devices would benefit problems not normalized

W9205 Subnormal vision work-up with written report, prior authorization required this is a battery of extensive tests and independent procedures to determine

W9215 Screening examination

W9220 Split lamp examination

W9310 Patient activated ECG recorders office, or nursing home, with or without transtelephonic transmissions of the recording

W9378 Transtelephonic cardiac pacemaker monitoring with EKG once per week limitation

W9382 Transtelephonic pacemaker monitoring, lithium battery (single chamber) 37th month & beyond, allowed once per 4 weeks & if more frequent then only by documented medical necessity

W9384 Transtelephonic pacemaker monitoring, lithium battery (dual chamber) 2nd to 6th month & 37th month & beyond allowed once per 4 weeks & if more frequent only by documented medical necessity

W9385 Transtelephonic pacemaker monitoring, lithium battery (single chamber) 1st month after implant allowed once per 2 weeks & if more frequent than only by documented medical necessity

W9386 Transtelephonic pacemaker monitoring, lithium battery (single chamber) 2nd month to 36th month allowed once per 8 weeks & if more frequent than only by documented medical necessity

W9387 Transtelephonic pacemaker monitoring, lithium battery (dual chamber) 1st month after implant allowed once per 2 weeks & if more frequent than only by documented medical necessity

W9388 Transtelephonic pacemaker monitoring, lithium battery (dual chamber) 7th to 36th month allowed once per 8 weeks & if more frequent than only by documented medical necessity

10:54-9.11 Supplemental Information Summarizing the Use of HCPCS

(a) Anesthesia: The following HCPCS procedure codes do not require the AA modifier when the professional services are rendered by an anesthesiologist:

20550	36489	62288	64421	64520
20600	36490	62289	64425	64530
20605	36491	64400	64430	93503
20610	62273	64402	64435	99291
31500	62274	64405	64440	99292
36400	62275	64408	64441	
36405	62276	64410	64442	
36406	62277	64412	64443	
36410	62278	64413	64445	
36415	62279	64415	64450	
36420	62280	64417	64505	
36425	62281	64418	64508	
36488	62282	64420	64510	

(b) Incidental Surgery: Certain surgical procedures when performed incidental to other surgical procedures by the operating surgeon or assistant surgeon are covered in the reimbursement allowance for the primary procedure. Such incidental procedures are as follows:

- 1. Breast biopsy (HCPCS 19100, 19101, 76095)—with other breast surgery (HCPCS 19110-19240);
- 2. Tracheostomy (HCPCS 31600-31610) with procedures such as the following:

- Laryngotomy (HCPCS 3100-31320)
 - Laryngectomy (HCPCS 31360-31382)
 - Pharyngolaryngectomy (HCPCS 31390-31395)
 - Laryngoplasty (HCPCS 31580-31588)
 - Tracheoplasty (HCPCS 31750-31760)
 - Excision of tracheal stenosis and anastomosis (HCPCS 31780-31781)
 - Suture of external tracheal wound (HCPCS 31800-31805);
3. Exploratory Thoracotomy (HCPCS 32095-32160) with other major thoracic procedures;
 4. Splenectomy (HCPCS 38100-38101, 38115) with Gastrectomy procedures (HCPCS 43620-43638);
 5. Appendectomy (HCPCS 44950) performed on a non-diseased appendix with any major abdominal surgery;
 6. Gastrostomy (HCPCS 43830) following or preceding a subtotal or hemigastrectomy; gastrorrhaphy (HCPCS 43840); vagotomy and pyloroplasty (HCPCS 43640); gastroduodenostomy (HCPCS 43810; or other gastric procedures (HCPCS 43500-43885) or esophageal resections (HCPCS 43400-43499) or pancreatic surgery (48100-48180);
 7. Enterolysis (freeing of intestinal adhesions—HCPCS 44005) and Lysis of adhesions (salpingolysis, ovariolysis) with other major abdominal surgery or uterine, salpingeal, ovarian surgery or C-Section;
 8. Ileostomy (HCPCS 44310), colostomy or cecostomy (HCPCS 44320) procedures performed in conjunction with procedures such as the following small intestine, colon or rectal procedures (HCPCS 44140-44155, 45110-45135);
 9. Exploratory Laparotomy (HCPCS 49000) with other intra-abdominal surgical procedures;
 10. Retroperitoneal Exploration (HCPCS 49010) with other major procedures in the pelvic or abdominal area;
 11. Omentectomy (HCPCS 49255) with any total or partial gastrectomy for malignancy or other gastric, small bowel, colon, pancreatic surgery or combined abdominal-perineal resection;
 12. Exploratory Cystotomy (HCPCS 51020-51045) with other major urinary bladder procedures requiring an incision into the bladder;
 13. Biopsy of ovary (HCPCS 58900) and drainage of ovarian cyst (HCPCS 58800-58822) with any intra-abdominal surgery including ovarian, uterine or salpingeal surgery;
 14. Exploratory Craniotomy (HCPCS 61304, 61305) with any other brain surgery; (HCPCS 61312-61576; 61680-61711; 62000-62258);
 15. Biopsy of Testis, needle (HCPCS 54505)—with any inguinal hernia repairs, orchiectomy, exploration of undescended testis, reduction or fixation of testis, hydrocele and scrotal surgery;

16. Eye Surgery for Removal of Cataracts—(HCPCS 66920, 66930, 66940) with any other optical procedure.

(c) Second surgical opinion: A second surgical opinion is not required for the following procedures:

1. All surgical procedures related to cholecystectomy;
2. Hernia repairs for recipients under 19 years of age;
3. Primary adenoidectomy for children under 12 years of age; and
4. Spinal fusion and laminectomy for scoliosis for recipients under 19 years of age.

5. It should be emphasized that the requirement for Second Surgical Opinion is waived when the operating physician determines that the need for surgery is urgent or emergent. For Second Opinion purposes, “urgent or emergent” means that a delay in surgery to comply with the protocol of the Second Surgical Opinion Program would result in a significant threat to the patient’s health or life.

6. To facilitate reimbursement in instances where the surgery meets the “urgent/emergent” definition, the physician or independent clinic must attach to the claim form, a statement from the operating physician attesting to the urgent/emergent nature of the illness or situation. (See previous Newsletters, P-329 (3/22/82) and P-339 (10/4/82).

7. No Medicaid Second Surgical Opinion Referral Form (FD-263) (9/91) will be required for claims submitted by an anesthesiologist or an assistant surgeon.

(d) Second surgical opinion: The following HCPCS codes do require a Second Surgical Opinion:

1. Hysterectomy (Elective Procedures):

58150	58267
58152	58270
58180	58275
58260	58280

2. Spinal fusion:*

22548	22595	22650	22840*
22554	22600	22800*	22842*
22556*	22610	22802*	22845*
22558	22612	22810	22849
22585	22625	22812	
22590	22630	22830*	

NOTE: HCPCS codes identified with an asterisk () do not require Second Surgical Opinion if the recipient is under 19 years of age with a diagnosis of scoliosis.

3. Laminectomy:*

63001	63045	63086	63196
63003	63046	63087	63197
63005	63047	63088	63198
63011	63048	63090	63199
63012	63055	63091	63200
63015	63056	63170	63250

63016	63057	63172	63251	36200	51725
63017	63064	63173	63252	36215	51726
63020	63066	63180	63265	36245	51736
63020 50	63075	63182	63266	36400	51741
63030	63076	63185	63267	36405	51772
63030 50	63077*	63190	63268	36406	51785
63035	63078*	63191	63270	36410	51592
63040	63081	63191 50	63271		
63042	63082	63194	63272		
	63085	63195	63273		

NOTE: HCPCS codes identified with an asterisk () do not require a Second Surgical Opinion if the recipient is under 19 years of age with a diagnosis of scoliosis.

4. Hernia Repair (Unilateral or Bilateral including umbilical hernia—for recipients 19 years of age or older):

- 49505
- 49520
- 49525
- 49550
- 49555
- 49560
- 49565
- 49570
- 49585
- 49590
- 56316
- 56317

(e) Multiple surgical pricing: The following HCPCS procedure codes are excluded from multiple surgical pricing and as such shall be reimbursed like the primary procedure at 100 percent of the Medicaid Maximum Fee Allowance even when the procedure is done on the same patient, by the same surgeon, at the same operative session.

11700	36415	52000
11701	36430	53670
11710	35488	53675
11711	36489	54150
11901	36520	54160
19030	36522	54200
20500	36600	54220
20501	36620	54230
21079	38790	54235
21080	43200	54240
21081	43234	54250
21082	43235	56300
21083	43259	56350
21084	43260	57150
21085	44360	57170
21086	45300	57410
21087	45330	57450
21088	45335	57452
29000-29799	45378	58301
31520	46600	58340
31525	47500	58611
31575	47550	59020
31615	47552	59025
31622	50320	59030
31700	50394	59414
31708	50396	62270-62291
31710	50684	63690
31719	50686	63691
31720	50690	64400-64530
36010	50951	W2650
36100	50970	W2655
36120	51600	W3600
36140	51605	W5930
36160	51610	

(f) Surgery and office visit (New and Established Patient) Conflicts: The following procedure codes are excluded from the policy indicating that office visit codes are not reimbursed in addition to procedure codes for other conditions. Thus, the following Office Visit (New and Established Patient) procedure codes, listed below, may be billed with the procedure codes listed identified with the titles, Surgery Values and Excluded Codes. (If the surgical procedure code reimburses less than an Office Visit, reimbursement will be the higher of the office visit rate or the surgical procedure code rate, not both.)

1. The policy is applicable to these surgical procedure codes:

- 10000-69999
- T1000-T9999
- W0000-W6999
- W9027
- W9029
- W9030
- W9031

2. The policy is also applicable to office visit (new and established patient) procedure codes:

- 99211
- 99212
- 99213
- 99214
- 99215
- 99311
- 99312
- 99313
- 99331
- 99332
- 99333

3. The following procedure codes are excluded from this policy:

W2650	36010	38790	53670	59025
W2655	36100	47500	53675	59030
W3600	36120	50320	54150	59414
W3650	36140	50394	54160	59430
W5930	36160	50396	54200	62270
11900	36200	50684	54220	62272-62291
11901	36215	50686	54230	63690
19030	36245	50690	54235	63691
20500	36400	51600	54240	64400-64530
20501	36405	51605	54250	99381
20550	36406	51610	51725	
20600-20610		36410	51726	
21079-21088		36415	51736	
29000-29799		36430	57150	
31700	36488	51739	57170	
31708	36489	51741	57410	
31710	36520	51772	58301	
31719	36522	51785	58340	
31720	36600	51792	59020	

APPENDIX A

STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES			Form #17
Medicaid District Office	Director & Phone Number	Address	
(01) Atlantic Fax #1-609-344-2268	William Underland, Director Tel. 609-441-3620	1601 Atlantic Avenue, 7th Floor Atlantic City, NJ 08401	
(02) Bergen Fax #1-201-996-8084	Kate Buckley, Director Tel. 201-996-8060	171-173 Main Street Hackensack, NJ 07601	
(03) Burlington Fax #1-609-265-0095	Eileen Calabro, Acting Director Tel. 609-261-0448	50 Rancocas Road Mt. Holly, NJ 08060	
(04) Camden Fax #1-609-757-4626	Daniel Cooperson, Director Ronald Coppola, Regional Director Tel. 609-757-2870	101 Haddon Avenue, 5th Floor Camden, NJ 08103	
(05) Cape May (06) Cumberland Fax #1-609-794-2586	Barbara Dils, Director Tel. 609-696-6560	108 Landis Avenue Vineland, NJ 08360	
(07) Essex Fax #1-201-642-6468	Diane West, Director Tel. 201-648-2470; 201-648-3700	153 Halsey Street, 4th Floor Newark, NJ 07102	
(08) Gloucester (17) Salem Fax #1-609-845-0444	Joan Suleskey, Acting Director Tel. 609-853-4177	251 N. Delsea Drive Deptwood Center Deptford, NJ 08096-1930	
(09) Hudson Fax #1-201-433-7544	William Underland, Director Tel. 201-433-8011	2815 Kennedy Boulevard, 2nd Floor Jersey City, NJ 07306	
(10) Hunterdon (18) Somerset Fax #1-908-782-7899	Caroline Krajewski, Director Tel. 908-782-1130	84 Park Avenue, 2nd Floor Flemington, NJ 08822	
(11) Mercer Fax #1-609-599-4627	Eileen Calabro, Acting Director Tel. 609-292-7315	314-316 E. State Street Trenton, NJ 08608	
(12) Middlesex Fax #1-908-906-8275	Colleen DeMarks, Director John Russell, Regional Director Tel. 908-549-3541	Bldg. B, Suite 5 & 6 25 S. Main Street Edison, NJ 08837	
(13) Monmouth Fax #1-908-409-6446	Frances Garrett, Director Tel. 908-308-1159	1003 Route 9 North—Suite 200 Howell, NJ 07731-1113	
(14) Morris (19) Sussex (21) Warren Fax #1-201-631-6448	Marie Grubin, Director Tel. 201-631-6440	10 Park Place, 4th Floor Morristown, NJ 07960	
(15) Ocean Fax #1-908-255-0743	Gail Dempsey, Acting Director Tel. 908-255-0731	1510 Hooper Avenue Toms River, NJ 08753	
(16) Passaic Fax #1-201-684-8182	Kathleen Lohrey, Acting Director Tel. 201-977-4077	66 Hamilton Street Paterson, NJ 07505	
(20) Union Fax #1-908-353-5340	Director Tel. 908-820-3135	24-52 Rahway Avenue, 3rd Floor United Jersey Bank Bldg. Elizabeth, NJ 07201	
Northern Regional Medicaid Office Fax #1-201-684-7769	Thomas Rafferty Acting Regional Director Tel. 201-977-4541	100 Hamilton Plaza Room 601, Box 2 Paterson, NJ 07505	

Rev. 7/92

APPENDIX B

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is filed as an incorporated Appendix of this chapter/manual but is not reproduced in the New Jersey Administrative Code. When revisions are made to the fiscal agent billing supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agent Billing Supplement, write to:

Paramax/Unisys

CN 4801

Trenton, New Jersey 08650

or contact:

Office of Administrative
Quakerbridge Plaza, Build
CN 049

Trenton, New Jersey 08625

APPENDIX C

EMC MANUAL

AGENCY NOTE: The Electronic Media Claims (EMC) Manual is filed as an incorporated Appendix of this chapter/manual, but is not reproduced in the New Jersey Administrative Code. When revisions are made to the EMC

Manual, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the EMC Manual, write to:

Paramax/Unisys
CN 4801
Trenton, N.J. 08650