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

New Jersey Health Services Program NEWSLETTER

Volume P-390

June 1, 1984

To: All Providers of Health Care in Counties of Atlantic, Gloucester, Salem, Burlington, Camden, Cumberland, Ocean, and Cape May

Subject: Medicaid Eligible Recipients Participating as Omnicare/the hmo Subscribers

Effective: Immediately

Background: Omnicare/the hmo (formerly the Cumberland Regional Health Plan), a Health Maintenance Organization (HMO) located in Vineland, Mays Landing and Marmora 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 the counties of Cape May, Cumberland or Atlantic, and who choose to be subscribers to Omnicare/the hmo.

The services provided by Omnicare/the hmo 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, and
17. Optical appliances.

*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 Omnicare/the hmo an authorized EXHAUSTION OF BENEFITS form, a copy of which must be submitted with all claims.

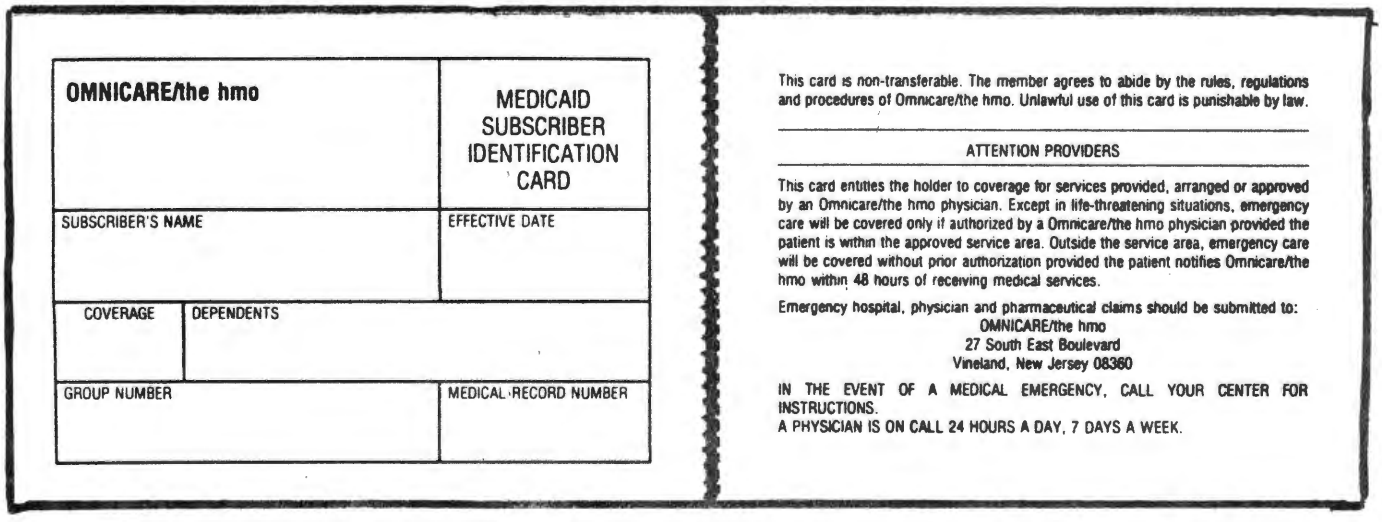
The following services or items are not provided by Omnicare/the hmo and Medicaid eligible subscribers of the Plan may secure these services for Medicaid providers who will be reimbursed under the existing rules and regulations of the New Jersey Medicaid Program:

1. Dental Services,
2. Prosthetic and Orthotic appliances,
3. Medical supplies and equipment,
4. Medical Day Care,
5. Invalid Coach, and
6. Hearing Aids.

Subscribers of Omnicare/the hmo 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 physician from Omnicare/the hmo, 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 Omnicare/the hmo within 48 hours of receiving medical services. Hospital and physician claims should be submitted to:

Omnicare/the hmo
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 Omnicare/the hmo Subscriber Identification Card. An example of the card is shown below:



OMNICARE/the hmo	MEDICAID SUBSCRIBER IDENTIFICATION CARD
SUBSCRIBER'S NAME	EFFECTIVE DATE
COVERAGE / DEPENDENTS	
GROUP NUMBER	MEDICAL RECORD NUMBER

This card is non-transferable. The member agrees to abide by the rules, regulations and procedures of Omnicare/the hmo. 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 an Omnicare/the hmo physician. Except in life-threatening situations, emergency care will be covered only if authorized by a Omnicare/the hmo physician provided the patient is within the approved service area. Outside the service area, emergency care will be covered without prior authorization provided the patient notifies Omnicare/the hmo within 48 hours of receiving medical services.

Emergency hospital, physician and pharmaceutical claims should be submitted to:
OMNICARE/the hmo
27 South East Boulevard
Vineland, New Jersey 08360

IN THE EVENT OF A MEDICAL EMERGENCY, CALL YOUR CENTER FOR INSTRUCTIONS.
A PHYSICIAN IS ON CALL 24 HOURS A DAY, 7 DAYS A WEEK.

The County Welfare Agencies will be issuing altered check stubs to Medicaid eligible individuals who choose to become subscribers. 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

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

NOTICE TO PROVIDER

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.

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Any questions regarding this Newsletter should be directed to Dennis Doderer, Project Coordinator, Prepaid Health Plans, Division of Medical Assistance and Health Services, telephone (609) 984-3347.

OMNICARE

the hmo

Dear Provider:

This is to inform you that _____ a member of OMNICARE/the hmo has exhausted the _____ days of coverage for your services. A Plan subscriber may continue to receive these services, however, and 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, 696-8009.

Sincerely,

The OMNICARE Claims Department

caf

☐ CUMBERLAND MEDICAL CENTER
27 S.E. BOULEVARD
VINELAND, N.J. 08360
609-696-2232

☐ MEMORIAL PARK FAMILY PRACTICE CENTER
ROUTE 50 SOUTH
MAYS LANDING, N.J. 08330
609-625-9146

☐
ADMINISTRATIVE OFFICES
27 S. E. BOULEVARD
VINELAND, NEW JERSEY 08360
609-696-2232

☐ MARMORA FAMILY PRACTICE CENTER
WAYSIDE VILLAGE SHOPPING CENTER
MARMORA, N.J. 08223
609-398-6610

☐ ATLANTIC CITY FAMILY MEDICAL CENTER
1616 PACIFIC AVENUE
ATLANTIC CITY, N.J. 08401
609-348-5859

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

REC'D MAY 29 1984

New Jersey Health Services Program NEWSLETTER

Volume P-391

May 29, 1984

TO: PROSTHETIC AND ORTHOTIC PROVIDERS

SUBJECT: REVISED PROSTHETIC AND ORTHOTIC CODES, DESCRIPTIONS AND FEES

EFFECTIVE: FOR CLAIMS PROCESSED ON OR AFTER JUNE 4, 1984

BACKGROUND: The Division of Medical Assistance and Health Services adopted a new rule in the New Jersey Administrative Code (N.J.A.C. 10:55-3.1) effective June 4, 1984. The rule revised the procedure codes and nomenclature for prosthetics and orthotics to make them consistent with Medicare. In addition, the fees were increased for many of the procedure codes.

PURPOSE: This newsletter and attachment replace the existing procedure codes, narrative descriptions and Medicaid fee schedule with the new listing of procedure codes, narrative descriptions, and corresponding Medicaid fee schedules for prosthetic and orthotic devices. The schedule of allowances for shoes and shoe appliances that begins on page 44 is included but not revised.

ACTION: 1. Providers are required to use the new procedure codes, and complete narrative descriptions corresponding thereto, for all claims submitted on or after June 4, 1984.

The correct procedure code must be entered in item 13B of the claim form (MC-15-C1). The corresponding narrative description must be entered in Item 13D. Providers should enter their customary charges in Item 13F.

The Prudential Insurance Company will process the claim and reimburse in accordance with the revised Medicaid fee schedule that corresponds to the procedure code(s).

Claims that do not contain the new procedure codes and corresponding narrative descriptions will be returned to the provider for completion.

2. If it is necessary to use more than one claim form to submit a claim, additional copies of the claim form (MC-15-C1) must be used. For example, there must be a notation in the upper right hand corner that reads page "1 of 3", page "2 of 3", page "3 of 3" so that the entire claim can be readily identified. All items must be completed on page 1, and the items listed below must be completed on each succeeding page:

a. Items 1 through 4 - (patient's name, address, HSP number, and person number);
b. Item 9 - Provider's Identifying Information;
c. Item 13 - Report of Services;
d. Item 18 - Provider Certification - The provider must sign and date each claim form that is submitted for payment.

INSTRUCTIONS: Providers are instructed to delete Chapter IV, pages 25 through 45, and replace them with the attached pages numbered 25 through 48 .

If there are any questions concerning the new procedure code listing, please contact the Prudential Insurance Company at their toll free number, 800-582-7052.

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

New Jersey Health Services Program NEWSLETTER

Volume P-392

June 11, 1984

TO: All Providers and
Those Interested in Provider Enrollment

SUBJECT: Community Care Program for the Elderly and Disabled (CCPED) - Phase II

EFFECTIVE: October 1, 1984

PURPOSE: This Newsletter is to inform you that the New Jersey Medicaid Program's Community Care Program for the Elderly and Disabled is being extended to the additional counties of Cape May, Hudson, Hunterdon, Mercer, Middlesex, Passaic, Salem, Sussex and Warren.

BACKGROUND: The CCPED currently offers seven home care services which require prior authorization by the Medicaid District Offices including Case Management, Home Health Services, Homemaker Services, Medical Day Care, non-emergency Medical Transportation, Respite Care, Social Adult Day Care and the one service which does not require prior authorization is Pharmacy services.

The program currently serves and continues to serve recipients residing in the seven counties of Atlantic, Bergen, Burlington, Gloucester, Morris, Ocean and Somerset.

The eligibility criteria remain the same. Recipients eligible for this Program must:

1. Be 65 or over, or determined disabled under the Social Security Act and receiving Social Security disability payments, and eligible for Medicare.

2. Be assessed in need of Skilled Nursing Facility/Intermediate Care Facility (SNF/ICF) Care; and

3. Have an income which exceeds the appropriate SSI community standard up to the standard for institutional care (currently $882.00 per month).

General information about CCPED was issued to all providers in volume-numbered Newsletter P-371 or BC-266 dated December 5, 1983.

However, for specific information regarding provider enrollment, prior authorization, billing procedures and procedure codes, providers who may participate in the program are referred to the January 9, 1984 Newsletters as follows:

Home Health Agency Providers to P-374
Homemaker Agencies to P-375
Medical Day Care Providers to P-376
Social Adult Day Care Centers to P-377

ACTION: Homemaker Agencies, Home Health Agencies, Social Adult Day Care Centers, and Medical Day Care Centers, wishing to serve clients residing in the Phase II counties, who are not already enrolled as CCPED providers should contact at this time:

Mrs. Frances Garrett, Chief
Provider Enrollment Unit
Division of Medical Assistance
and Health Services
CN-712
Trenton, New Jersey 08625
(609) 292-1921

As in Phase I, the new Case Management Sites will be located in a County Board of Social Services, a Home Health Agency or a Medicaid District Office. The actual sites have not yet been selected and will be announced in the near future.

Any questions regarding this Newsletter should be directed to Carol H. Kurland, Office of 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

REC'D JUN 29 1984

New Jersey Health Services Program NEWSLETTER

Volume P-393

June 18, 1984

TO: DENTISTS, HOSPITAL ADMINISTRATORS, INDEPENDENT CLINICS

SUBJECT: REVISION TO THE DENTAL SERVICES MANUAL

EFFECTIVE: JULY 1, 1984

PURPOSE: The New Jersey Medicaid Program is pleased to inform providers of dental care of the following important changes in the provision of dental services:

1. Selective Increase of the Medicaid Schedule of Maximum Allowances
2. Revision of Selected Procedure Codes
3. Extension of Time Frame for the Replacement of Dentures
4. Change in Definition of Consultation
5. Addition of Codes for Hospital Admission and Visits

BACKGROUND: The last increase in Medicaid dental fees took place in 1973. Since that time it has been impossible to make further increases due to a series of budgetary constraints. Now, a new increased schedule of maximum allowances has been adopted along with other specific changes outlined in this Newsletter. Chapter IV of the Dental Services Manual has been revised and is enclosed with this newsletter under the heading Subchapter 3 - Procedure Codes and Descriptions. Please note that all numerical designations in Subchapter 3 (Rev. 6/84) are changed to conform with submission requirements for the New Jersey Administrative Code (N.J.A.C.). As part of a long-range plan, other chapters will be revised in the near future.

ACTION: All changes take effect July 1, 1984. All claims processed for payment after June 30, 1984 will be reimbursed under the new schedule of maximum allowances. DENTAL TREATMENT PLANS AUTHORIZED ON A DENTAL SERVICES CLAIM FORM (MC-10) BEFORE JULY 1, 1984 SHOULD BE SUBMITTED AS AUTHORIZED. UNDER NO CIRCUMSTANCES SHOULD PROCEDURE CODES BE CHANGED.

SUMMARY OF CHANGES:

1. Dentures - Adjustment to or repair of dentures does not now require prior authorization when the Medicaid reimbursement rate does not exceed $53.00 - Specialist Fee or $48.00 - Non-Specialist fee.

2. Denture Authorizations: Dentures will not be authorized when the dental history reveals that a denture was provided through any New Jersey State, county, or municipal agency in the seven and one-half (7½) year period prior to the date of the current request. Previously this period was 5 years.

3. Consultation and Hospital Admission: Consultation has been redefined and subjected to conditions as specified on the page numbered 43a attached to this newsletter. New procedure codes are listed in Subchapter 3, 10:56 - 3.16 (d) through (f), pages 78 and 79.

4. Silicate Restorations will no longer be a reimbursable service under the New Jersey Medicaid Program.

5. Composite Restorations: The reimbursement for this service will be increased by two factors; one, an increase in keeping with that applied to other selected procedure codes, and two, an increase making acid etch an integral part of all composite procedures. Acid etch will no longer be reimbursable as a separate procedure.

6. Crowns: The entire procedure code system for crowns will be changed. There will be only one code for each type of crown. Use the type of metal most appropriate for the patient's needs -

1. High and medium noble
2. Low noble, or
3. Base metal content

7. Root Canal Therapy: The procedure codes for root canal therapy will be updated. Codes 3310, 3320, and 3330 will be retained under the heading "Conventional Type Root Canal Therapy", with an increase in the schedule of maximum allowance. A new heading "Paste-Fill Type Root Canal Therapy" will be added with new codes at the present maximum allowance level.

8. The procedure code changes are listed in the following summary as:

A. Codes Eliminated
B. New Codes
C. Codes With Increase in Maximum Allowance

A. CODES ELIMINATED:

1. Restorative				
Silicate:	2216	2217	2218	
Crowns:	2720	2722	2750	2752
	2790	2792	2810	
Others:	2960 (This code will not be reimbursable after June 30, 1984 even if previously authorized (see item "5." above).			
2. Prosthodontics (fixed):	6210	6212	6225	6226
	6240	6242	6250	6252
3. Anesthesia:	9222	9223		

B. NEW CODES

1. Diagnostic:	0999			
2. Preventive:	1999			
3. Restorative (crowns):	2721	2751	2791	
4. Endodontics:	3311	3321	3331	
5. Prosthodontics:	5995	6211	6241	6251
6. Visit:	9420	9421		

C. CODES WITH INCREASE IN MAXIMUM ALLOWANCE

1.	Diagnostic:	0470						
2.	Preventive:	1515	1522					
3.	Restorative:							
	Amalgam	2110	2120	2130	2131			
		2140	2150	2160	2161			
	Composite	2320	2321	2322	2323	2324		
		2325	2326	2351	2352	2353		
	Crowns	2710	2711	2721±	2751±			
		2791±	2830	2840	2896			
4.	Endodontics:	3310	3320	3330	3425	3426	3430	3431
5.	Prosthodontics:	5310	5312	5313				
6.	Repairs:	5611	5612	5616	5617	5621		
		5622	5623	5624	5641	5642		
		5643	5644	5651	5652	5654		
		5655	5661	5662	5671	5672		
		5681	5682	5683	5684	5685		
		5686	5687	5695				
7.	Rebase/Reline:	5711	5712	5721	5722			
		5751	5752	5761	5762			
8.	Prosthodontics:							
	Fixed	6211±	6241±	6251±	6640	6645		
9.	Exodontics:	7110	7115					
10.	Anesthesia:	9220	9221	9225				
11.	Visits:	9410	9411	9412				

± While these procedure codes are new codes, they represent fee increases for codes being replaced.

Any questions you may have concerning this Newsletter may be directed to:

Archie H. Bell, D.D.S., Chief
Bureau of Dental Services
Division of Medical Assistance
and Health Services
CN-713
Trenton, New Jersey 08625
Telephone (609) 984-7863

DENTAL SERVICES MANUAL MAINTENANCE:

1. Remove and discard Exhibit "B", page 55.
2. Remove and discard Chapter IV (3/78), pages 56 through 82, and replace with the attached Subchapter 3 (6/84), pages 55 through 81.
3. Insert page 43a (attached to Newsletter) after page 43 in Chapter II of the Dental Services Manual.
4. Make handwritten revisions to:
   (a) 202.2(1)C, Chapter II, page 16, as noted in Item 1 under Summary of Changes, on page 1 of this newsletter and
   (b) 203.6B. 8. b., Chapter II, page 31, as noted in Item 2. under Summary of Changes, on page 1 of this newsletter.

203.10 Consultations

(See Subchapter 3 for procedure codes - (10:56-3.16 (d))

(A consultation is defined as that service rendered by a qualified dentist upon request of another practitioner in order to evaluate through personal examination of the patient, history, appropriate physical findings and other ancillary means, the nature and progress of a dental or related disease, illness, or condition and/or to establish or confirm a diagnosis, and/or to determine the prognosis, and/or to suggest appropriate therapy. A consultation should not be confused with "referral for treatment" when one practitioner refers a patient to another practitioner for treatment, either specific or general, that is, endodontic treatment on teeth #s 3 and 5; or extract teeth #s 7, 8, 9, and 10; or extract tooth or teeth causing pain; etc.).

(a) Consultations are subject to the following conditions:

1. A written report must be provided to the referring practitioner which includes diagnosis and recommendations for future management. A copy must be retained with the patient's records and must be available, upon request, to the New Jersey Medicaid Program or any of its authorized representatives.

i. When the practitioner rendering the consultation services assumes the continuing care of the patient, any subsequent services rendered by him will no longer be considered as consultation.

ii. When consultation services are requested, the referring practitioner must include in his clinical records and on the Dental Services Claim Form MC-10 (remarks) the name of the consulting practitioner to whom the patient is being referred. The consulting practitioner must note the name and the individual Medicaid practitioner number (IMP number) of the referring (attending) practitioner in his clinical records and on the Dental Services Claim Form (MC-10) (referring practitioner).

iii. A consultation will be disallowed if there is no referring practitioner, i.e. the patient makes an appointment on his own.

iv. A consultation will be disallowed if performed on the same recipient by the same practitioner, members of the same group, members of a shared health care facility, or practitioners sharing a common record within a 12 month span of a prior claim for the same or related disease, illness or condition.

v. A consultation will be declined in any setting, if the consultation occurs between members of the same group, shared health care facility, or practitioners sharing common records.

vi. If a consultation is billed in an inpatient setting and the patient is then transferred to the service of the consultant, the consultant may not bill for a Hospital Day - Initial; however, Hospital Day - Subsequent - may be billed for visits on ensuing days.

vii. If a consultation is billed in an Emergency Room setting and the patient is then admitted to the consultant's service as a hospital inpatient, future visits of the consultant may be billed as a Hospital Day - Subsequent. If the patient is admitted to another practitioner's service, that practitioner may bill for Hospital Day - Initial. Future visits of the consultant for that inpatient hospitalization may be billed as a Hospital Day - Subsequent - and be considered as concurrent care IF concurrent care can be justified as dentally/medically necessary.

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

New Jersey Health Services Program NEWSLETTER

Volume P-394

June 18, 1984

To: All Participating Medical Day Care Providers

Subject: Medical Day Care Services Manual Revisions

Effective: Immediately

Action: Policy changes were recently proposed and adopted in the New Jersey Administrative Code (N.J.A.C. 10:65 1.2-2.7) which necessitated revisions to the Medical Day Care Services Manual. The revisions include:

1. Language changes permitting a hospital-affiliated medical day care facility, providing it complies with all program requirements, to provide the same basic services now provided by all nursing home-based and free-standing Medical Day Care Centers.

2. A policy change to the current practice of granting authorization or reauthorization of Medical Day Care services for a period up to 90 days. The 90 day (or less) limitation will be retained for the initial authorization period; however, reauthorization may be for a period up to six (6) months.

3. A policy change to allow for an initial evaluation visit for physical or speech-language services without prior authorization. This regulation is in addition to and does not change the existing Medical Day Care regulation that allows an initial evaluation visit for medical day care services without prior authorization.

   When completing the MC-14 claim form, Independent Outpatient Health Facility, indicate in Item 13, block B, Procedure Code, 0049 for an initial physical therapy evaluation visit or Procedure Code 0047 for an initial speech-language evualation visit. All therapy following the initial evaluation visit will continue to require prior authorization.

   The reimbursement fee for an initial evaluation visit for physical or speech-language therapy will be the same as that which the medical day care center is reimbursed for a subsequent treatment visit.

4. A clarification of the role of the Medical Director.

A copy of Subchapter 1 (rev. 5/84) and Subchapter 2 (rev. 5/84) are attached. The changes have been bracketed for your convenience.

Manual Maintenance:

Please discard your existing Subchapter 1 (2/80) and Subchapter 2 (2/80) and replace with the attached Subchapters 1 and 2 (rev. 5/84). All Newsletters should be discarded except for the following Prudential Newsletters: P-376, dated January 9, 1984; P-371, dated December 5, 1983; P-362, dated July 15, 1983; P-360, dated June 24, 1983; P-357, dated March 28, 1983; P-355, dated March 21, 1983; P-318, dated October 19, 1981; P-310, dated September 7, 1981; P-309, dated September 1, 1981; P-299, dated May 11, 1981; and P-269, dated May 12, 1980.

Your revised manual should consist of the following: Chapter I (Rev. 12/77); Subchapter 1 (Rev. 5/84); Subchapter 2 (Rev. 5/84); and all of the Newsletters listed above.

Any questions regarding this Newsletter should be directed to Carol Kurland, Medical Day Care Program Coordinator at (609) 292-1940.

MEDICAL DAY CARE SERVICES MANUAL

N.J.A.C. TITLE 10

CHAPTER 65

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MEDICAL DAY CARE SERVICES MANUAL

N.J.A.C. TITLE 10

CHAPTER 65

SUBCHAPTER 1

1.1 SCOPE

The Medical Day Care Program is concerned with the fulfillment of the health needs of eligible recipients of the New Jersey Medicaid Program who could benefit from a health services alternative to total institutionalization. Medical Day Care is a program of medically supervised, health related services provided in an ambulatory care setting to persons who are non-residents of the facility, who do not require 24 hour in-patient institutional care and yet, due to their physical and/or mental impairment, need health maintenance and restorative services supportive to their community living.

1.2 DEFINITIONS

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

"Administration-Medical Day Care Center" means the Medical Day Care Center shall provide an identifiable administrative unit, headed by a Director, responsible for the overall conduct of all day care program activities.

"Medicaid Eligibility" means in order to obtain Medical Day Care Services, the participant must be determined eligible to receive Medicaid services in the community under the existing programs of Aid to Families with Dependent Children, Supplemental Security Income, and/or Medicaid Only.

"Medical Day Care Center" means an identifiable part of a long-term care facility, or a hospital affiliated facility, or a freestanding ambulatory care facility, or such other facility which is licensed by the New Jersey State Department of Health to provide non-residential medical day care services, which possesses a valid and current provider agreement from the New Jersey Division of Medical Assistance and Health Services and which provides services as described in this manual under Section 1.4 (N.J.A.C. 10:65-1.4).

"Medical Day Care Participant" means a person who is medically eligible and whose assessed physical and psychosocial needs:

1. Do not require 24 hours a day on an in-patient basis in a hospital or long-term care facility.

2. Cannot be met totally in any other ambulatory care setting, such as a physician's office or hospital out-patient clinic.

3. Require and can be met satisfactorily by a seven hour, day long active medical program provided by licensed and non-licensed personnel, including portal to portal travel time.

"Volunteer" means a person who gives his/her time and services regularly without remuneration.

1.3 PROGRAM PARTICIPATION

(a) A Medical Day Care Center operated by a public or private agency or organization, either proprietary or non-profit, or a subdivision of such an agency or organization, must meet the following requirements in order to participate in the New Jersey Medicaid Program:

1. Licensure and approval by the New Jersey State Department of Health as a non-residential medical day care center;

2. Certification that the Medical Day Care Center meets the Federal and State requirements for participation in accordance with the Manual of Standards for Licensure of Non-Residential Medical Day Care Facilities of the New Jersey State Department of Health;

3. Approval for participation as a Medical Day Care Center provider by the New Jersey Medicaid Program. This includes, at a minimum, the completion of the New Jersey Medicaid Provider Application FD-20-C2 (Exhibit II), the Participation Agreement FD-218 (Exhibit III), and an Outline for Written Statement On Proposed Medical Day Care Center (Exhibit VI). Continued participation as a New Jersey Medicaid provider is contingent upon approval annually by the New Jersey Medicaid Program.

(b) A cost study, as defined by the Division, shall be prepared annually detailing expenditures of the Medical Day Care Program. Medical Day Care Program costs must be segregated from other operational costs. (Medicaid reimbursement rates may be based on cost study information or on a percentage of the ICF-B per diem rates.)

(c) The Division shall conduct an on-going evaluation of the Center's Medical Day Care Program by on-site visits to the Medical Day Care Center. A Medical Day Care On-Site Report MCNH-89 (Exhibit VII) shall be completed by Division staff and a copy shall be forwarded to the Center.

1.4 REQUIRED SERVICES

(a) As a minimum the following services shall be provided by the Center for participation in the Medical Day Care Program.

1. Medical Services

i. The Center Director, with the Medical Director of the

facility shall establish written medical and administrative policies governing the provision of medical services to the participants. The Medical Director shall be responsible for, but not be limited to, the following:

(1) Develop and amend these medical policies as needed.

(2) Supervise the provision of medical services.

(3) Advise the Center Director regarding medical and related problems.

(4) Establish procedures for medical matters, such as medical supervision, storage of medication, emergency coverage, emergency services, records, use of consultants, patient review, rehabilitation services, medication and discharge planning.

Procedures shall be located in the Center Director's office and at the Nurses' station, readily available to staff.

(5) Establish relationships with appropriate personnel in other institutions, such as general or special hospitals, rehabilitation centers, home health agencies, clinics, laboratories, and related community resources. This would include but not be limited to arrangements for emergency room services unavailable within the facility.

ii. The Medical Day Care Center shall provide:

(1) A medical evaluation of all participants, provided or arranged for by the Medical Director as needed, but at least every ninety days.

(A) This medical evaluation and any medical services required should be coordinated by the participant's attending physician.

(B) If the participant has no attending physician, the Medical Director shall assist the participant to secure one.

(C) In the event that an attending physician cannot be obtained to regularly care for the participant, the participant may choose the Medical Director as his/her attending physician, provided the Medical Director becomes the participant's attending physician with all the responsibilities attendant to such a role over a 24-hour period on a continuing basis.

(D) It is only in this new role as attending physician that the Medical Director can bill the New Jersey Medicaid Program on the Health Insurance Claim Form 1500-N.J. (Exhibit VIII) for services rendered this participant.

(2) The Medical Director may not bill the New Jersey Medicaid Program separately for any service performed for a Medicaid eligible while serving in his capacity as Medical Director.

(3) An individual medical record on each participant.

(4) Medical orders for treatment of participant(s) which shall include medication, diet, activities permitted, and therapies, such as physical therapy, occupational therapy, and speech-language therapy.

2. Nursing Services

i. A registered professional nurse shall be available on the premises of the Medical Day Care Center at all times when the facility is operating, to evaluate the need of each participant for nursing care, initially, and on a continuing basis, and to provide for such care. If there is ancillary nursing staff, the registered professional nurse provides supervision of this staff.

ii. The Nursing Staff shall provide but not be limited to the following:

(1) Administration and/or supervision of prescribed medications;

(2) Implementation of prescribed treatments;

(3) Dressing changes;

(4) Observation of and instruction in personal hygiene;

(5) Rehabilitative and restorative nursing;

(6) Taking vital signs as necessary in temporary illness;

(7) Assistance in activities of daily living;

(8) Necessary documentation of all nursing services;

(9) Discharge planning, coordinated with the health care team.

iii. The Center's Nursing Staff shall assure that nursing services provided to participants are coordinated with health services currently received at home, as well as with existing community health agencies and services available to participants in time of need.

3. Social Services

i. A social worker or designate with qualified social work consultation shall be responsible for the implementation of the social services component and, accordingly, work closely with

public and private community agencies in planning appropriately for the service needs of each participant.

ii. The social work staff shall provide but not be limited to the following social services:

(1) Continued identification of social and emotional needs of each individual in relation to the home situation and in the Center;

(2) Direct counseling and referral in social, financial, and legal matters;

(3) Assistance with housing and shopping;

(4) Counseling in the availability and utilization of community resources, and the coordination of these services;

(5) Discharge planning, coordinated with the health care team;

(6) Documentation of social service information.

4. Transportation Services

i. The Center shall provide transportation for participants to and from their homes as well as to and from services provided indirectly by the Center. No participant's total daily commutation time shall exceed two hours.

ii. Transportation provided by the Center shall be included in the per diem costs of the Medical Day Care Program.

5. Personal Care Services

i. To insure quality personal care, the Center staff shall make daily checks to assure that participants are maintaining personal hygiene, receiving medications as prescribed (which includes assuring the renewal of prescriptions as necessary and the disposition of outdated or discontinued drugs), and participating in appropriate social and recreational activities.

ii. Personal care service shall include education in and assistance with activities of daily living (i.e., walking, eating, toileting, grooming) and supervision of personal hygiene.

6. Dietary Services

i. The Center shall provide a minimum of one meal per day. The meal and snacks shall supply at least one-third of the daily nutritional requirements recommended by the National Research Council.

ii. Special diets and supplemental feeding shall be made available as ordered by the physician involved in the documentation of the individualized plan of care, and the plan supervised by the facility dietitian.

iii. Dietary counseling and education shall be provided to participants and their families.

7. Social Activities

The Center staff, under the direction of the Activities Coordinator, shall provide a planned program of recreational, social and leisure activities suited to the needs of the participants, and designed to encourage physical exercise, social interaction and to complement community resources.

i. The Center may involve volunteers in the implementation of the social activities program.

ii. The current monthly schedule of activities shall be posted at a location convenient to participants, staff and families.

iii. Social activities shall include, but not be limited to:

(1) Opportunities for arts and crafts;

(2) Development of hobbies;

(3) Discussion groups;

(4) Speakers and films;

(5) Periodic excursions or outings;

(6) Involvement of participants in community service projects which can be carried out at the Center.

iv. The activities program shall be coordinated with occupational and physical therapy programs so that a total plan of care is provided each participant.

v. The participants and their families when possible shall be involved in the planning and implementation of the activities program.

8. Rehabilitative Services

i. Rehabilitative Services, which include physical therapy, occupational therapy, and speech-language therapy shall be provided by the Center to those participants whose need for these services has been definitely described in the individualized plan of care.

ii. Physical and speech-language therapies provided by the Center shall not be included in the per diem costs for Medical Day Care. However, they are reimbursable and shall be billed separately. Prior authorization is not required for an initial visit to evaluate the need for physical or speech-language therapies. All subsequent therapy treatment visits following the initial visit will continue to require prior authorization. (See Section 1.6.)

iii. Occupational therapy shall be included in the per diem costs for Medical Day Care.

1.5 STAFF

(a) The Center shall have adequate staff capability to provide supervision to the participants at all times. The composition of the staff shall depend in part on the needs of the participants and on the number of participants the program is serving. As a minimum, the Center must have a Medical Day Care Center Director, a registered Professional Nurse, a Social Worker, an Activities Coordinator and a Medical Director. If the freestanding facility has no Medical Director, a licensed physician shall be appointed to serve in this capacity.

1. Medical Day Care Center Director

The Director of the Center is responsible for the overall conduct and management of all program activities on a full-time basis. The Director shall:

i. Be a qualified health professional, such as a Nursing Home Administrator, licensed nurse, physician, licensed physical therapist, certified eligible occupational or speech-language pathologist or social worker.

ii. Be experienced in the care of the elderly and disabled and knowledgeable regarding their physical, social and medical health needs.

2. Registered Professional Nurse

The Registered Professional Nurse is a person who is licensed by the New Jersey Board of Nursing pursuant to N.J.S.A. 45:11-26 et seq. and has at least one year full-time or full-time equivalent experience in a health care setting.

3. Social Worker

The Social Worker shall possess a Master's degree in Social Work from an accredited graduate school of Social Work plus one year of full-time or full-time equivalent social work experience in a health care setting. If a designate is utilized, the designate shall possess a Bachelor's degree in the social sciences plus one year of social work experience in a health care setting. A designate must have available on-site consultation from a qualified social worker, a person with a Master's degree in Social Work from an accredited School of Social Work in accordance with the Department of Health's standards. (See N.J.A.C. 8:39-1.20(d).)

4. Activities Coordinator

An Activities Coordinator is a person who has:

i. A bachelor's degree from an accredited college with a major in recreation, occupational therapy, or a field related to

recreation, such as art, music, physical education, group work, or sociology; or

ii. An Associate degree in recreation and two years of full-time, or full-time equivalent, experience in recreation for the aged, handicapped, or retarded; or

iii. A high school diploma or equivalency certificate, two years of full-time, or full-time equivalent experience in a social or recreational program within the last five years, one year of which was full-time in a patient activities program in a health care facility, and has completed at least 36 hours of classroom training, approved by the Department, in activities programming; or

iv. Is certified by the New Jersey Board of Recreation Examiners as a recreation administrator or recreation supervisor, pursuant to Chapter 291, P.L. 1966; or

v. Is an occupational therapy assistant.

5. Medical Director

The Medical Director shall provide the medical consultation and supervision of the total health care program provided to the participants. (See Section 1.4(a)1.ii.) The Medical Director must be licensed to practice medicine in the State of New Jersey.

6. Staff-Participant Ratio

Adequate staff is defined as a ratio of one (1) regular full-time staff person to nine (9) participants, calculated on the basis of the daily census. The ratio shall include the Center Director and all other personnel (except the Medical Director) who are involved in direct patient care, excluding volunteers.

i. Without compromising the above required staff-patient ratio of 1-9, various staff positions could conceivably combine functions within one person, i.e., the Center Director may be a social worker or nurse, performing dual functions of the Director/Social Worker or Director/Nurse. New programs for start-up purposes, or programs with less than ten participants, may have no fewer than two full-time staff persons. The registered nurse must occupy one of the two positions. In programs of 60 or more participants, the Director may not serve a dual function.

1.6 PRIOR AUTHORIZATION

(a) Whenever the term "prior authorization", or "reauthorization", is used in this manual it shall mean approval granted by the Division of Medical Assistance and Health Services through the appropriate Medicaid District Office for payment for Medical Day Care services rendered to an eligible participant for a specific time period. Current Medicaid eligibility is a prerequisite for payment. Prior authorization must be obtained from the Medicaid District Office of the Division of Medical

Assistance and Health Services before an applicant for Medical Day Care can be considered medically eligible for the service within the New Jersey Medicaid Program.

(b) A Request for Medical Day Care Authorization or Reauthorization Form FD-140, (Exhibit IV) must be submitted by the Medical Day Care Center for each potential participant as a basis for determining a prior authorization or reauthorization for Medical Day Care Services. In order to avoid delay in approval, all information must be individualized, complete and comprehensive. The FD-140 will be reviewed by the Medical Evaluation Team, consisting of the Medical Consultant, Regional Staff Nurse, and Medicaid Social Worker and a determination will be made as to the person's eligibility for the Medical Day Care. The maximum duration for an initial authorization is 90 days (or less); reauthorization may be for a period up to six (6) months.

(c) While an authorization/reauthorization for Medical Day Care services is in effect and the condition of the patient changes, indicating the need for additional or decreased services, the Medical Day Care Center after consultation with the attending physician may submit a revised FD-140.

(d) The Medical Day Care Center may bill the Medicaid Fiscal Agent, Prudential Insurance Company, for one initial visit evaluation for eligible recipients without prior authorization.

1.7 PARTICIPANT REVIEW AND EVALUATION

(a) Each participant in the Medical Day Care Program shall be seen by his/her attending physician, as needed but at least every ninety (90) days. A record of the physician's visit, findings, and recommendations shall be documented on the participant's chart.

(b) Every ninety (90) days the participant's individualized plan of care shall be updated by the Medical Day Care Center staff to reflect the needs of the participant for Medical Day Care. This plan shall become part of the patient's permanent record at the center.

1.8 RECORDS

(a) As a minimum, the participant's chart shall contain the following information:

1. Application for admission form;

2. Individualized plan of care; performed initially and updated every ninety (90) days;

3. Medical history, record of physical examination, medication record, and laboratory reports, performed by the attending physician initially and updated every ninety days thereafter, citing general medical condition, disabilities and limitations. Also included shall be any consultations performed;

4. Daily nursing observations for the first five days of attendance and nursing progress notes at least every thirty days thereafter or more often as needed;

5. Social history initially, and social service progress notes every ninety days;

6. Activity progress notes every ninety days;

7. Physical, Speech-language, and Occupational Therapy and dietary progress notes as indicated;

8. Discharge Plan.

(b) Individualized Plan of Care

An Individualized Plan of Care shall be written for each participant prior to admission to the Program, with input from the participant, family, and interested community agencies. The plan shall state medical needs of the participant as evaluated by the attending physician, and nursing, social service and other service needs as determined by the Center Staff, with in-put from community agencies. Overall goals and services to be provided by the Center to fulfill the needs expressed should be indicated.

1. The Individualized Plan of Care shall be signed by the physician and by all Center Staff preparing the report.

2. Up-date of this plan shall be made at least every ninety days.

3. This Individualized Plan of Care is not part of the authorization/reauthorization process. Therefore, it should not be sent to the Medicaid District Office with the FD-140 form, which is to be used for the authorization/reauthorization only.

1.9 DISASTER PLAN

The Facility Disaster Plan shall be posted at the Nurses' station and other conspicuous locations throughout the Medical Day Care Center.

MEDICAL DAY CARE SERVICES MANUAL

N.J.A.C. TITLE 10

CHAPTER 65

SUBCHAPTER 2

INTERIM BILLING PROCEDURES

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Exhibit I — MC-14C2 Independent Outpatient Health Facility Claim Form

Exhibit II — FD-20C2 Medicaid Provider Application

Exhibit III — FD-218 Participation Agreement

Exhibit IV — FD-140 Request for Medical Day Care Authorization or Reauthorization

Exhibit V	HCFA-1483 Provider Billing for Medical and Other Health Services
Exhibit VI	Outline for Written Narrative Statement on Proposed Medical Care Center
Exhibit VII	MCNH-89 Medical Day Care On-Site Report
Exhibit VIII	1500 NJ Health Insurance Claim Form

N.J.A.C. TITLE 10

CHAPTER 65

SUBCHAPTER 2

INTERIM BILLING PROCEDURES

2.1 BILLING PROCEDURES

(a) This subchapter contains basic information and instructions necessary for the proper completion and submission of a claim. Included are exhibits to be utilized by Medical Day Care Centers for use in submitting claims for covered items or services. All forms to be completed by the facility are available from Prudential Insurance Company.

1. Payment: Payment will be based only on the number of days spent by the participant at the Medical Day Care Center. Billing will be performed by using the MC-14C2 claim form, Independent Outpatient Health Facility (Exhibit 1) which must indicate days of participant attendance during the period of authorization or reauthorization.

2. Reimbursement: The center participating in the Medical Day Care Program must agree to accept the reimbursement rate established by the New Jersey Medicaid Program. In a long-term care facility, the Medical Day Care per diem rate is 55 percent of the Intermedicate Care Facility-Level B rate for that facility. In freestanding facilites, the medical day care per diem rate is based on an average of the rate paid to long-term care facility medical day care providers in effect as of July 1 and January 1 of each year. The reimbursement rates set for a Medicaid participant in Medical Day Care centers may not exceed charges for non-Medicaid patients. The per diem reimbursement shall cover cost of all services listed in N.J.A.C. 10:65-1.4 with the following exceptions:

   i. physical and speech-language therapy services are not included in the per diem rate and these services must be billed separately on the MC-14C2 form.

   ii. The reimbursement fee for an initial visit for physical or speech-language therapy will be the same as that for which the Medical Day Care Center is reimbursed for a subsequent treatment visit.

3. Submission of Independent Outpatient Health Facility Claim Form (MC-14C2): A fully completed MC-14C2, Independent Outpatient Health Facility Claim Form must be submitted to Prudential Insurance Company with a copy of the FD-140 Form, Request for Medical Day Care Authorization or Reauthorization (Exhibit IV) issued by the Medicaid District Office.

4. Medicare/Medicaid coverage: The only possible services that can be considered for payment under Medicare/Medicaid are physical and

speech-language therapy. When the medical day care participant is covered under both programs only the Medicare Form HCFA-1483 (Exhibit V) must be completed with the appropriate section (Item 11) completed showing the Health Services Case and Person Number (HSP(Medicaid)Case Number).

2.2 GENERAL POLICY

Billing should be done on a monthly basis. In all cases, claims must be submitted no later than ninety days after the last date services are furnished, and no later than twelve (12) months from the earliest date of service as indicated on the claim form.

2.3 PARTICIPANT IDENTIFICATION

Verify that the participant is a covered person on the first visit and at least monthly thereafter. This is done by viewing the patient's validation form. It is especially important to review a participant's validation form when extended plans of treatment have been authorized or reauthorized. Prior authorization is no guarantee that an individual is an eligible participant.

2.4 PRIOR AUTHORIZATION

(a) Prior authorization means approval by the Medicaid District Office for medical day care services.

(b) Following the initial evaluation visit for medical day care, prior authorization is required. A claim for the initial visit must be submitted on the Independent Outpatient Health Facility Claim Form (MC-14C2) with the comment "Initial Visit Only" in item 13 (Report of services), Section D. This should only be done when the authorization has been declined.

(c) Prior authorization is required for all persons participating under the Medical Day Care Program. The maximum duration for an initial authorization is 90 days (or less); reauthorization may be for a period up to six (6) months. Reauthorization can be obtained by the submission of the FD-140 form, Request for Medical Day Care Authorization or Reauthorization, which must include in item 19 recommendations for extension of such continued participation in medical day care. Allow at least two weeks prior to termination date of previous authorization for processing of a reauthorization of this request.

1. How to obtain prior authorization:

   i. The form, FD-140, Request for Medical Day Care Authorization or Reauthorization, should be promptly completed by the attending physician with the involvement of the nursing and social work staff and submitted to the appropriate Medicaid District Office.

2. Completing the FD-140, Request for Medical Day Care Authorization or Reauthorization form (see Exhibit IV):

   All items, 1 through 21 inclusive must be completed on all FD-140 forms. All items should be typed or printed clearly.

i. Distribution of form FD-140 (four part snap-out form):

(1) Fiscal Agent's copy and provider copy and the Medicaid District Office copy are submitted to the Medicaid District Office, with the center retaining the second provider copy;

(2) Upon the Medicaid District Office approval or decline of the request, the Fiscal Agent copy and the provider copy will be returned to the Medical Day Care Center. The Medicaid District Office will retain their copy;

(3) If physical or speech-language therapy services are to be provided and are not allowed under Medicare or if Medicare benefits have been exhausted where a Medicare/Medicaid beneficiary is involved, item 14 on form FD-140 must be signed by the Medical Day Care Center, certifying that the services requested are not allowable or have been exhausted under the Medicare Program and that Medicare has not or will not be billed by the center for the same services.

3. Submission of authorization to the Fiscal Agent: When the request for authorization has been approved, it must be submitted together with the MC-14C2, Independent Outpatient Health Facility Claim form (Exhibit I) to Prudential Insurance Company for reimbursement for services provided.

4. Period covered by authorization: An approved request for an initial authorization will only be valid for a period of 90 days (or less); reauthorization may be for a period up to six (6) months as indicated in item 21 on form FD-140 - Request for Medical Day Care Authorization or Reauthorization.

2.5 MEDICAID DISTRICT OFFICES

(a) A list of Medicaid District Offices with addresses and telephone numbers can be found in Chapter I of this manual, see 10:49-1.24(a).

1. Eligibility questions: Provider inquiries concerning patient eligibility and/or applications for eligibility may be directed to the appropriate eligibility determination agency (if known by the provider) or to the Medicaid District Office serving the provider area. The Medicaid District Office will assist the provider to the appropriate eligibility determination agency.

2.6 INSTRUCTIONS; FORM MC-14

(a) Instructions for completion of the MC-14C2 - Independent Outpatient Health Facility Claim Form (see Exhibit 1):

1. Items 1-4 Name, address, case number and person number: Copy patient's name, HSP (Medicaid) Case Number, and patient person number exactly as it appears on the Medicaid Validation Form;

2. Items 5-6 — Self-explanatory;

3. Items 7-8 — Self-explanatory;

4. Item 9 — Name, address, and telephone number of provider: This information may be preprinted;

5. Item 10 — Not applicable;

6. Item 11 — Authorization: Insert in this space "authorization (or reauthorization) form FD-140 is attached";

7. Item 12 — Not to be completed;

8. Item 13 — Report of services:

   i. Item A — Enter each date on which service has been provided. Use a separate line for medical day care visit, for physical therapy treatment, for speech-language therapy treatment;

   NOTE: A visit means attendance at the medical day care center by the participant which consists of seven hours portal to portal.

   ii. Item B — Enter separately the procedure code for medical day care visit (0001) or for physical therapy treatment (0030) or for speech-language therapy treatment (0032);
   for an initial evaluation visit for rehabilitative therapy only, enter separately the procedure code for physical therapy (0049) or for speech-language therapy (0047);

   iii. Item C — Specify primary diagnosis;

   iv. Item D — Corresponding with the procedure code as outlined above enter the following wording: Medical day care visits or physical therapy treatment(s) or speech-language therapy treatment(s) including only the number of visits (or treatments) and the appropriate rate for each visit or treatment(s);

   v. Item E — Not applicable;

vi. Item F — Enter the total charges represented by the number of visits or treatments times the approved rate for same. The sum of the charges entered in column F should be shown at the bottom under "total charges $";

9. Items 14-16 — Self-explanatory;

10. Item 16a — Physician Case Manager: If the recipient is enrolled in the Medicaid Personal Physician Plan (MP Plan), enter the Physician Case Manager's name and IMP number. If not, leave blank.

11. Item 17 — Patient's certification: See Chapter I, N.J.A.C. 10:49-1.26.

12. Item 18 — Provider's certification: The provider must sign and date the form before the claim may be considered.

2.7 MAILING INSTRUCTIONS

Mail the original copy (Fiscal Agent's (contractor) copy) of the MC-14C2 Outpatient Claim Form together with the FD-140 form to:

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

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

EXHIBIT I

08

INDEPENDENT OUTPATIENT HEALTH FACILITY

Please Print

1 Patient's Last Name	First Name	2 Patient's Street Address	Telephone Number
DOE	John	123 Third Street	(609)292-1234

3 (Medicaid) Case No.	4 Patient Person No	5 Age	6 Sex	City	State	Zip Code
1 1 1 0 7 0 0 0 7 7	0 1	76	☒ Male ☐ Female	Trenton	New Jersey	08625

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

8 Was this service performed as a result of an EPSDT Program Referral?
Yes ☐ No ☒

10 Was Patient's Illness or Injury connected with employment?
If Yes give Name and Address of Employer here
☐ Yes ☐ No
Did injury result from automobile accident? ☐ Yes ☐ No

9 PROVIDER OF SERVICE INFORMATION

11 Prior Authorization Number: Authorization-FD-140 attached

Telephone Number	Medicaid Provider Number (enter only when not printed below)
(609)292-5678	123456

12 PRIOR AUTHORIZATION - FOR DIVISION USE ONLY

Name and Address

Mount Crest Nursing Home
423 Eleven Street
Trenton, New Jersey 08625

AUTHORIZING SIGNATURE Date

13 REPORT OF SERVICES

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
4-1-82	0001	CVA Diabetes	Medical Day Care Visit=x$	-	x000
4-2-82	0001	" "	" " " "	-	x000
4-3-82	0001	" "	" " " "	-	x000
4-1-82	0030	" "	Physical Therapy Treatment=x$	-	x000
4-3-82	0030	" "	" " "	-	x000
4-2-82	0032	" "	Speech-Language Treatment=x$	-	x000

14 Referring Practitioner's Name

Individual Medicaid Practitioner Number

Total Charges $ x0000

16 Operating Practitioner's Name

Individual Medicaid Practitioner Number

15 Attending Practitioner's Name

James Brown, M D

Individual Medicaid Practitioner Number 98765

16a. Physician Case Manager

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 4-5-82

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 William Smith

April 30, 1982
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

Patient's Name	HSP No. PP

Physician or Supplier

☐ Non-Spec.
☐ Spec._____ area

Referred to:	Date:

PLEASE VERIFY:

- ☐ Diagnosis
- ☐ PRV-Anesthesia-Asst. Surgeon
- ☐ Referring Physician
- ☐ Need Prior Auth.
- ☐ 65 or Over
- ☐ Date(s) of Service
  - ☐ Breakdown
- ☐ Service Rendered
- ☐ Charge(s)
  - ☐ Breakdown of
- ☐ If Doctor did Laboratory work
- ☐ HSP #
  - ☐ P.P. #
- ☐ Place of Service
- ☐ Other
  - ☐ See memo
- ☐ Need Signature
  - ☐ Provider
  - ☐ Patient
- ☐ Provider #
- ☐ Over 90 Days
- ☐ Prescription
- ☐ Approve Jam Code
- ☐ Time
  - ☐ Anes.
  - ☐ Psych.

charge for: _____

☐ Eligible? ☐ Reasonable?

Referring Individual's Identification _____

Claim Examiner _____ Date _____

TRENTON, NEW JERSEY 08625

MEDICAID PROVIDER APPLICATION

1. _____ 2. _____
Legal and/or Trade Name of Organization — Type of Business or Facility

3. _____
Address — Street — City — County — State — Zip Code

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

7. _____ 8. _____
Billing Address, If Different — Name of Administrator, Chief Executive Officer, Director 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. _____ _____
Please attach additional sheet if necessary.

11. 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 provider's 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.

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 Certification of Need. If no, explain why you don't require a Certificate.

13. If your business or facility requires a license(s), list type of license(s), license number(s), effective date of license(s), and attach a non-returnable copy.

14. CERTIFICATION, ACCREDITATION OR APPROVAL - - Specify type and attach copy. For Example JCAH (Hospitals); New Jersey Department of Health (Clinics); Office of Community Services (Mental Health Clinics); State Board of Dentistry (Dental Clinics); State Board of Pharmacy (Providers offering Pharmaceutical Services); American Board for Certification in Orthotics and Prosthetics (Prosthetist and/or Orthotist) See also question 15.

15. Approved by Medicare? [ ] Yes [ ] No If yes, attach copy of your approval, if applicable. If no, have you applied for Medicare approval? [ ] Yes [ ] No attach documentation.

Program? If yes, list type of service(s) provided and current status. If you were approved at one time and no long participate, explain the reason(s).

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

Do you or does your organization have any legal or professional relationships with any other heatlh care organization(or facility(ies)? [ ] Yes [ ] No If yes, list all such relationships below:

Does any member of your organization have a ten percent or greater financial interest in any other organization practice of an individual providing services under the New Jersey Medicaid Program? If yes, list name of individu and/or organization.

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

List days and hours of operation.

List the Names, SSA Number, License Number and Degree(s) for all Professional Staff in the Organization. Inclu Physicians, Dentists, Psychologists, Registered Physical Therapists, Optometrists, etc. If more space is needed atta additional sheets.

Name	SSA NO.	License No.	Degree, e.g., MD, DO, DD RPT, PhD, CPO, OD, et

FOR THE PURPOSE OF ESTABLISHING ELIGIBILITY TO RECEIVE DIRECT PAYMENT FOR SERVICES T RECIPIENTS UNDER THE NEW JERSEY MEDICAID (TITLE XIX) PROGRAM: I CERTIFY THAT THE INFORM TION FURNISHED ON THIS APPLICATION IS TRUE, ACCURATE, AND COMPLETE.

Signature of Provider _____ Title _____ Date _____

FOR DIVISION USE ONLY

[ ] Approve [ ] Disapprove [ ] Other _____ Initial _____ Date

[ ] Approve [ ] Disapprove [ ] Other _____ Initial _____ Date

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

PARTICIPATION AGREEMENT
NEW JERSEY HEALTH SERVICES PROGRAM
MEDICAL DAY CARE PROGRAM

(NAME OF FACILITY)_____
(ADDRESS)_____
(STATE LICENSE NO.)_____ MEDICAID PROVIDER NO.: LTC_____
MDC_____
HMDC_____

This Contract, made and entered into by and between the Department of Human Services through the Division of Medical Assistance and Health Services, hereinafter designated as the Department, and the above-named facility, a provider of services, whose address is as stated above, hereinafter designated as the Facility, Witnesseth:

Whereas, various persons eligible for benefits under the New Jersey Health Services Program (Medicaid) are in need of medical day care, as more specifically set forth in Program regulations and guidelines; and,

Whereas, Section 1902(a) (27) of Title XIX of the Social Security Act requires states to enter into a written agreement with every person or institution providing services under the State Plan for Medical Assistance (Title XIX); and,

Whereas, pursuant to N.J.S.A. 30:4D-1 et seq., the Department is responsible for the administration of the Medicaid Program and is authorized thereunder to take all necessary steps for the proper and efficient administration of the New Jersey Medicaid Program; and,

Whereas, to participate in the New Jersey Medicaid Program, a Medical Day Care Facility must: (1) be licensed under the laws of New Jersey as a non-residential Medical Day Care Facility (MDC) by the Department of Health; (2) be currently meeting on a continuing basis standards for licensure; (3) be administered by a qualified health professional; (4) meet on a continuing basis Federal and State standards for participation and more specifically Medical Day Care standards in Title XIX; (5) accept the terms and conditions of participation set out herein.

A. FACILITY AGREES:

1. That it will render all services which are required for participation in the Medical Day Care Program, including as a minimum: medical services, nursing services, social services, transportation, personal care services, dietary services, social activities and rehabilitative services;

2. That it will accept the Medical Day Care rate approved under the Medicaid Program as payment in full and will not make any additional charges to the participant or others on his behalf for Medicaid covered services, except for authorized physical therapy and speech-language pathology which are not included in the per diem reimbursement and must be billed separately. Medical Day Care Centers will be reimbursed in accordance with methods and procedures set forth in State regulations either on the basis of cost study information or a percentage of the Intermediate Care Facility Level B per diem rate, except for the hospital affiliated Medical Day Care Center which will be reimbursed at a negotiated per diem rate not to exceed the maximum Medical Day Care rate paid to long-term care facility based providers;

3. That it will promptly initiate and terminate billing procedures, pursuant to applicable regulations, when individuals covered under this Program enter or leave the Facility or are assessed at a different level of care;

4. That it will limit billing procedures under this Program to those eligible and authorized participants and for those days on which Medical Day Care services have been received;

5. That it will make available to the appropriate State and/or Federal personnel or their agents, at all reasonable times and places in New Jersey, all necessary records, including but not limited to the following:

    a. Medical records as required by Section 1902(e) (28) of Title XIX of the Social Security Act, and any amendments thereto;

    b. Records of all treatment, drugs, and services for which vendor payments are to be made under the Title XIX Programs, including the authority for and the date of administration of such treatments, drugs, or services;

    c. Documentation in each participant's record which will enable the Department to verify that each charge is due and proper prior to payment;

    d. Financial records of the Facility, including data necessary to determine appropriate reimbursement rates;

    e. All other records as may be found necessary by the Department in compliance with any Federal or State law, rule or regulation promulgated by the United State Department of Health and Human Services or by the Department;

6. That it will accept a maximum of _____ daily participants in accordance with the Department's regulations and the licensure standards of the Department of Health;

7. That it will cooperate fully in permitting and assisting representatives of the Department to make assessments and evaluations of services needed by and provided to participants in general, and of individual participants who are recipients of Medical Day Care services;

8. That it will secure and arrange for other health services as may be available for Medicaid patients pursuant to Program regulations;

9. That it will comply with State and Federal Medicaid laws, rules and regulations promulgated pursuant thereto;

10. That it will cooperate fully in permitting and assisting representatives of the Department in determining continuing conformity with the Federal and State standards applicable to non-residential Medical Day Care Facilities;

11. That it will notify the Department, within five working days, of any change in the status of its license to operate as issued by the Department of Health;

12. That it will notify the Department, within five working days, of any professional staff changes;

13. That it will notify the Medical Day Care participants, in writing, thirty days prior to the Facility's termination as a Medicaid Provider;

14. That it will immediately provide the Medicaid Program with written notice of any change in ownership and/or operation of the Facility, including changes in leases, officers and directors, stock ownership or sale of the Facility when:

Corporation (Profits)

a. There is acquisition by or transfer of ownership through purchase, contract, donation, gift, stock option, etc., of 25% or more of a corporation's outstanding stock (preferred or common).

b. There is acquisition of the physical assets of the Facility by a newly formed or existing corporation.

Partnership

a. There is acquisition by or transfer of ownership of 10% or more of the existing partnership's total capital interest.

b. There is acquisition of the physical assets of the Facility by a newly formed or existing partnership.

Proprietorship

a. There is purchase of the physical assets of the Facility.

Corporation

a. There is a change in the officer, trustee, directors or board members of the Facility.

15. To comply with the requirements of Title VI of the Civil Rights Acts of 1964 and Section 504 of the Rehabilitation Act of 1973 and any amendments thereto; and Section 1909 of P.L. 92-603, Section 242 (c) which makes it a crime and sets the punishment for persons who have been found guilty of making any false statement or representation of a material fact in order to receive any benefit or payment under the Medical Assistance Program. (The Department of Human Services is required by Federal regulation to make this law known and to warn against false statements in an application/agreement 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.)

16. That breach or violation of any one of the above provisions shall make this entire agreement subject to immediate cancellation at the Department's discretion, in keeping with the procedures adopted by the Division in accordance with the New Jersey Administrative Procedures Act.

B. DEPARTMENT AGREES:

17. That it will pay for authorized services provided by the Facility in keeping with the availability of State appropriations, on the basis of care required by the eligible individual as determined by the Department acting under the applicable regulations, but in no event will payment be made for any individual determined not to require Medical Day Care services;

18. That it will reimburse the Medical Day Care Center through Prudential Insurance Company of America in accordance with methods and procedures set forth in State regulations, either on the basis of cost study information or a percentage of the Intermediate Care Facility Level B per diem rates; reimbursement for the hospital affiliated Medical Day Care Center will be at a negotiated per diem rate not to exceed the maximum Medical Day Care Center rate paid to long-term care facility based providers;

19. That it will make such payments in accordance with applicable laws and regulations as promptly as is feasible after a proper claim is submitted and approved;

20. That it will give, subject to paragraph 16, the Facility 30 days' notice of any impending changes in its status as participating Medical Day Care Facility;

21. That it will notify the Facility of any change in Title XIX rules and regulations as it relates to the Facility's program, and will work with the individual Facility with the view toward providing the best care available within the limitations of the law and available money;

22. That the Facility may terminate its participation in the Medicaid Program at the expiration of this agreement upon a minimum of 60 days' written notice to the Department.

C. DEPARTMENT AND FACILITY MUTUALLY AGREE:

23. That, in the event the Federal and/or State laws should be amended or judicially interpreted so as to render the fulfillment of this agreement on the part of either party infeasible or impossible, or if the parties to this agreement should be unable to agree upon modifying amendments which would be needed to enable substantial continuation of the Title XIX Program as a result of amendments or judicial interpretations, then, and in that event, both the Facility and the Department shall be discharged from further obligation created under the terms of this agreement, except for equitable settlement of the respective accrued interests up to the date of termination.

24. That this agreement shall not be transferable or assignable and the agreement shall be null and void upon a change in ownership and/or operation;

25. That, in the event the participating Facility is sold, the Department shall make no division of the reimbursable proceeds for services rendered to Medicaid recipients between buyer and seller, but rather will reimburse the provider of record as of the billing month for all services rendered. Said Provider shall make the necessary adjustments;

Note: Item 26 is to be completed by the Division.

26. This agreement shall be effective on _____ and terminated on _____ unless terminated or amended prior thereto (1) by mutual consent of the parties, (2) for cause under applicable clauses herein, or (3) because of Federal and/or State government withdrawal from Program participation.

27. To be completed by the Facility.

_____
(Facility)

_____
(Address)

_____
(Authorized Signature)

_____
(Title)

28. _____
Division of Medical Assistance and Health Services
Department of Human Services

Division of Medical Assistance and Health Services

REQUEST FOR MEDICAL DAY CARE AUTHORIZATION OR REAUTHORIZATION

PATIENT INFORMATION

1. Participant Information Last Name	First Name	2. Sex	3. Age	4. Address	5. Social Security Account No.
DOE	JOHN	M	79	123 Third Street Trenton, New Jersey 08625	520-34-6000

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)
1110700077	01	(609)292-1234	Brown	James	(609)292-0111

11. Provider Identification (Name and Address)
Mount Crest Nursing Home
423 Eleventh Street
Trenton, New Jersey 08625

12. Provider Telephone No. (area code): (609) 292-5678

13. Provider No.: 123456

14. Provider's Certification: In my judgement, physical or speech-language therapy reqested herein is not allowable under the Medicare (Title XVIII) Program; accordingly, that program has not or will not be otherwise billed.;
Signature: William Smith

MEDICAL, NURSING AND SOCIAL INFORMATION

15. Name of Last Hospital or Long Term Care Facility Admission:
XYX Nursing Home
Admitted: 12/30/81 Discharged: 3/30/82

16. Diagnosis (including surgery and date)
Primary CVA, Diabetes
Secondary Slight paralysis and aphasia
Diagnosis known by: [X] Patient [X] Family [ ] Neither

17. Functional Limitations
- [X] Partial Paralysis
- [ ] Amputation
- [ ] Colostomy
- [ ] Wheelchair bound
- [X] Speech
- [ ] Hearing
- [ ] Vision
- [ ] Language barriers

Mental Behavior
- [ ] Confused
- [ ] Underactive/Regressed
- [X] Anxious
- [ ] Behavior problem

Activities Permitted
- [X] Ambulation
- [ ] Stairs
- [ ] Full
- [X] Part
- [ ] None

Diet
- [ ] Regular
- [X] Special (specify) Diabetic Diet #1

Nursing Components
- [X] Administer medication
- [ ] Treatments
- [ ] Observation/ Supervision
- [X] Instruction
- [ ] Personal care
- [ ] Restorative care
- [X] ADL
- [ ] Follow-up of Special Therapy

[X] Assistive devices (explain): uses walker
[X] Other (specify): occupational therapy
[X] Current Medication(s): Aldomet 250 mg. p.o. t.i.d.
Lente insulin 40 units a.c. breakfast
[X] Special Therapies, if needed: paralysis, aphasic
[ ] Special Problems (describe):

18. Social Information (i.e., living arrangements, family & community supports, attitudes, etc.) Lives with adult employed daughter and family who transports Mr. Doe on a daily basis. Interested and supportive to MDC plan.

19. Goals: [X] Rehabilitation [ ] Maintenance [ ] Preventive
Time required: 6 months
Plan of treatment: progressive ambulation; improved speech and independent A.D.L.
Discharge plan 10/1/82 (tentative)

SERVICES REQUEST INFO

20. Services requested: Projected start date: 4/1/82 End date: 10/1/82
Specify services indicating frequency, amount totals:
Medical day care visits: (0001) 5 times per week
Physical therapy treatments: (0030) 3 times per week
Speech-Language therapy treatments: (0032) 5 times per week

For Division Use Only

AUTHORIZATION

21. Authorization Information: [X] Authorization granted [ ] Authorization denied, letter attached [ ] Authorization granted, as amended above
Authorized: From: 4/1/82 To: 10/1/82

James Brown 4/30/82
Signature of Attending Physician & Date

AUTHORIZED BY	Signature	Date
[X] Medical Consultant	Robert Johnson, M.D.	4/30/82
[X] RSN	Mary Reilly	4/30/82
[X] Social Worker II	Carol White	4/30/82

EXHIBIT V

PROVIDER BILLING FOR MEDICAL AND OTHER HEALTH SERVICES

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

Form Approved
OMB No.
066-R-0017

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal

1. Patient's last name: DOE | First name: JOHN | MI: J

2. Health insurance claim number: 123456789A

3. Patient's address (Street number, City, State, ZIP Code): 123 THIRD STREET TRENTON, NEW JERSEY 08625

4. Date of birth: 01 30 03

5. Sex: [X] M [ ]

6. Provider name and address (City and State):
MOUNT CREST NURSING HOME
423 ELEVENTH STREET
TRENTON, NEW JERSEY 08625

7. Provider number: 123456

8. Medical record number: 3456789

9. Type of service:
A. [ ] Inpatient C. [X] Other (Specify) PHYSICAL THE
B. [ ] Outpatient SPEECH-LANGUAGE THERA

If you have other health insurance or if your State Medical Assistance Agency will pay part of your medical expenses and you want inform tion about this claim released to them upon their request, complete items 10 and 11.

10. Insuring organization and/or State agency name and address: NEW JERSEY HEALTH SERVICES PROGRAM

11. Policy and/or medical assistance number: 11107000 77-01

12. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in apply for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare cla I request that payment of authorized benefits be made on my behalf.

[X] Contained in provider's record

Signature (Patient or authorized representative) (Signature by mark must be witnessed): John Doe

Date: 4/15/8

13. Nature of illness or injury: C. V. A. – CEREBRAL VASCULAR ACCIDENT
DIABETES

[ ] Check here if illness or injury was connected with employment

Do not use this space

14. Surgical procedures

15. Statement of services	Covered Charges
A. Clinic visit ( )	
B. Emergency room ( )	
C. Laboratory	
D. Radiology	
E. Pharmacy	
F. Blood	
G. Ambulance	
H. Physical therapy	$ X COST
I. Other (Specify) SPEECH-LANGUAGE THERAPY	$ X COST
J. TOTAL	$ X COST

16. Statement Covers Period: First service 04 01 82 | Last service 04 05 82

17. Blood Information

A. Pints furnished	B. Pints replaced	Not Replaced C. Pints	D. Charge per pint	E. Patie paid for deductib

18. Professional component (hospital inpatients)
A. Pathology | B. Radiology

19. Other professio component

20. Date benefits exhausted or HH plan terminated: __ __ | __ __ | __ __

21. Patient paid (Excluding 17

22. I certify that the required physician's certification is on file.
William Smith

23. Date received: __ __ | __ __ | __ __

FOR INTERMEDIARY USE ONLY

24. Verified Patient Liability

A. Blood deductible	B. Cash deductible	C. Coinsurance

25. Payment Distribution

Provider	Patient

26. Date approved: __ __ | __ __ | __ __

Remarks:

MEDICAL DAY CARE

Outline for Written Narrative Statement on Proposed Medical Day Care Center

1. Describe the philosophy, goals and objectives for providing medical and ancillary health services to a non-resident population on a day care basis.

2. Describe the physical facilities to be used for the proposed Medical Day Care Center (diagram acceptable).

3. Describe the proposed Medical Day Care Program, including hours of operation; services to be provided, in-house and/or arrangement and staff who will be implementing the program.

4. Provide staff position descriptions and state qualifications of personnel selected for each position.

5. State total number of participants who will be served by Medical Day Care and give anticipated daily population.

6. Submit a projection of costs to be incurred by the Medical Day Care program. State the period of projection and provide the basis of cost allocation if applicable.

7. Will the Medical Day Care Center be funded by other than Title XIX; i.e., Title XX and Title III?

8. Is the proposed Medical Day Care Program a new service of your facility or an expansion of an existing Day Care program?

9. Additional comments relevant to the application for Medical Day Care under the New Jersey Medicaid Program.

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

MEDICAL DAY CARE ON-SITE REPORT

Name of Program _____ Survey Date _____

Address _____ Telephone Number _____

Facility Administrator _____ Initial Approval Date _____

Medical Day Care Center Director _____ Latest Contract Renewal Date _____

Current Total Enrollment _____ Avg. Daily Attendence _____ Medicaid Census _____

Number of Paid Staff _____ Number of Volunteers _____
(full-time)

Registered Nurse: Yes ( ) No ( ) Social Worker: Yes ( ) No ( )

Activity Coordinator: Yes ( ) No ( ) Medical Director: Yes ( ) No ( )

Check Each Item if Applicable:

Service Provided	Yes	No		Yes	No
1. Medical	___	___	15. Current Lab. Reports	___	___
2. Nursing	___	___	16. Nurses Notes	___	___
3. Social	___	___	Daily 1st. 5 days	___	___
4. Transportation	___	___	Every 30 days	___	___
5. Personal Care	___	___	17. Social History	___	___
6. Dietary	___	___	18. Social Progress Notes	___	___
7. Social Activities	___	___	Every 90 days	___	___
8. Rehabilitatative Services	___	___	19. Initial Activity Plan	___	___
9. Dental	___	___	20. Activity Progress Notes	___	___
10. Podiatry	___	___	Every 90 days	___	___
Records			21. Therapy Progress Notes	___	___
11. Admission Form	___	___	22. Discharge Plan	___	___
12. Individualized Plan or Care	___	___	23. Emergency Provisions	___	___
Updated Every 90 Days	___	___	24. Disaster Plan	___	___
13. Initial Physicial Exams	___	___			
Every 90 Days	___	___			
14. Medical Orders	___	___			

Comments: Indicate deficient areas according to item number in preceding section.

Team Recommendations to Facility:

Projected Revisit: _____

Facility Staff Present:

_____

_____ _____
Medical Consultant

_____

_____ _____
RSN/RNS

_____

_____ _____
ASWS

_____

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) Telephone No.	5. PATIENT'S SEX MALE ☐ FEMALE ☐ 7. PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER	6. PATIENT'S MEDICARE/CHAMPUS NO. (Include any letters) 8. PATIENT'S MEDICAID I. D. NO.
9. OTHER HEALTH INSURANCE COVERAGE- YES ☐ NO ☐ Enter Name of Policyholder and Plan Name and Address and Policy Number	10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES ☐ NO ☐ B. ACCIDENTAL INJURY AUTO ☐ OTHER ☐	8a. INSURED'S GROUP NO. (Or Group Name) 11. INSURED'S ADDRESS (Street, city, state, ZIP code)

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE - MEDICARE, CHAMPUS & MEDICAID (Read back before signing)
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.
Relationship: Check if other than patient ☐ Authorized Rep. ☐ Relative ☐ Other
SIGNED DATE

13. I Authorize Payment of Medical Benefits to Undersigned Physician or Supplier for Service Described Below.
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 ☐ NO ☐	16a. IF AN EMERGENCY CHECK HERE ☐
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	
21. 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 ☐ NO ☐ CHARGES	

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.
1.
2.
3.
4.

23B. WAS THIS SERVICE PERFORMED AS A RESULT OF AN EPSDT PROGRAM REFERRAL? YES ☐ NO ☐
PRIOR AUTHORIZATION NO.

24. A. DATE OF SERVICE FROM TO	B. *PLACE OF SERVICE	C.* T.O.S.	D. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES PROCEDURE CODE (IDENTIFY) 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 ☐ NO ☐	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DU
SIGNED ☐ MD ☐ DO ☐ DPM ☐ OD ☐ DC ☐ PhD 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:		TELEPHONE NO.		

*PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK

00-N.J. ED. 2-82

APPROVED BY AMA COUNCIL ON MEDICAL SERVICES
APPROVED BY THE HEALTH CARE FINANCING ADMINISTRATION, N.J. MEDICAID, AND CHAMPUS.

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 rec[illegible] and request that payment for these services be made on my beh[illegible] authorize any holder of medical or other information about me to rele[illegible] 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.

For services to be considered as 'incident' to a physician's professional service, 1) they must be rendered under the physician's immediate personal 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 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.

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.

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.

For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor.

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.

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.

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 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.

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
- (BH) - Boarding Home

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-395

July 16, 1984

To: All Providers

Subject: Phase II - Medicaid Personal Physician Plan (MP Plan) Demonstration Project

Effective: Immediately

Background: On July 15, 1983, the New Jersey Medicaid Program implemented Phase I of a four year Demonstration Project called the Medicaid Personal Physician Plan (MP Plan). Phase I was implemented in the tri-county area of Morris, Sussex and Warren counties.

Action: The purpose of this Newsletter is to announce Phase II of this Demonstration Project. Implementation will be in the counties of Atlantic, Burlington, Camden, Mercer and Middlesex.

The Medicaid services under the MP Plan, and included in the capitation, remain the same as outlined in detail in Newsletters BC-260 and P-362, dated July 15, 1983, with the addition of risk-free, incentive only, inpatient hospitalization component which must now be part of the capitation system.

The Physician Case Manager continues to case manage the patient while hospitalized. Hospitals will observe all existing rules of the Medicaid Program and must determine the MP Plan status of each Medicaid patient, and provide care with the authorization of the Physician Case Manager and the cooperation of the MP Plan member.

All Medicaid services available in Phase I are available to the Medicaid enrollees in Phase II.

The billing procedures as outlined in Newsletters BC-260 and P-362 remain unchanged.

Please address any questions regarding this Newsletter as follows:

1. Physicians residing in the counties of Atlantic, Burlington or Camden should contact their MP Plan Office, Area VIII, Southern New Jersey PSRO; physicians residing in the counties of Mercer or Middlesex should contact their MP Plan Office, Area VII, PRO.

   A toll free number will be made available at a later date.

2. All other providers should contact the appropriate Fiscal Agent: Blue Cross at (201) 456-2570 or Prudential at (toll free number) 800-582-7052.

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

New Jersey Health Services Program NEWSLETTER

Volume P-396

July 9, 1984

TO: ADMINISTRATORS - DIAGNOSIS RELATED GROUP (DRG) HOSPITALS

SUBJECT: HOSPITAL BILLING POLICY - ANCILLARY SERVICES RENDERED DURING NON-ACUTE PORTION OF HOSPITAL STAY

EFFECTIVE: IMMEDIATELY

PURPOSE: TO CLARIFY BILLING POLICY

BACKGROUND: New Jersey Medicaid has noted several recurring errors in billing procedures for services rendered to Medicaid patients. This Newsletter is being distributed to increase awareness of the proper billing procedures.

BILLING POLICY: Do not bill the New Jersey Medicaid Program or Medicaid recipients for services rendered to patients determined by the Utilization Review Organization (U.R.O.) to be:

1. admission denials, or
2. "carve out days." (For exceptions, see ANCILLARY SERVICES below.)

For cases in which the Utilization Review Organization has issued a "continued stay denial", Medicaid is liable only for those days certified as appropriate.

ANCILLARY SERVICES: Eligible ancillary services are inpatient ancillary services that would be eligible for payment if the services had been provided in an outpatient setting. The following are the only three situations when Medicaid may pay for eligible ancillary services rendered during a non-covered period of an inpatient admission.

1. U.R.O. denies the entire admission for acute level of care (U.R. Matrix example II); or
2. U.R.O. certifies the admission as acute but "carves out" days from the approved continued stay (U.R. Matrix example XIII); or
3. U.R.O. certifies that only part of the stay is acute. (U.R. Matrix examples IV and VI).

Examples of common inpatient ancillary billing situations are attached to this Newsletter.

Inpatient ancillary services rendered during a non-covered period of an inpatient admission must be submitted on an Outpatient Claim Form (MC-4C). Bill only for ancillaries that were rendered on or after the date the U.R.O. cut-off letter was sent to the patient.

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

New Jersey Health Services Program NEWSLETTER

Volume P-397

July 9, 1984

TO: HOSPITAL ADMINISTRATORS

EFFECTIVE: AUGUST 1, 1984

SUBJECT: OUTPATIENT HOSPITAL CLAIM FORM (MC-4C)
ELIMINATION OF CLINIC TYPE CODE 29 - "PHYSICIAN REFERRED"

The New Jersey Medicaid Program is eliminating the use of Clinic Code 29 - "Physician Referred". This will ensure greater accuracy in the collection of data relevant to services rendered to Medicaid eligible individuals in the outpatient departments of hospitals.

For claims submitted with dates of service on or after August 1, 1984, hospitals must indicate the clinic type code appropriate to the clinic service provided. As an example, services rendered to an individual referred by a physician to the allergy clinic must be billed as Clinic Code 02 (Allergy) not Clinic Code 29 (Physician Referred).

Please direct any question you may have on this issue to your Medicaid Fiscal Agent.

Telephone Numbers: Blue Cross----------(201) 456-2570

The Prudential Insurance Co.--------(609) 293-2294

Examples of Common Inpatient Ancillary Billing Situations

Billing Inpatient Ancillaries for Non-Covered (Residential) Care

1A. URO denies admission for acute level of care and patient remains after notification.

Admission Date: 4/24 — Discharge Date: 5/2
Period of Acute Care: None — Period of Non-Covered Care: 4/24-5/2 (8 days)
Date of URO Cut-Off Letter: 4/24 — Total Days: 8

Action:
Submit Outpatient Claim Form for eligible inpatient ancillaries incurred during entire admission.

1B. Same as #1A. except date for URO Cut-Off letter is 4/27.
Action:
Submit Outpatient Claim Form for only those eligible inpatient ancillaries incurred on or after 4/27.

1C. Same as #1A. except date of URO Cut-Off letter is 5/2.
Action:
No claim for inpatient ancillaries should be submitted as neither the Medicaid Program nor the patient is liable for any services up through the date of URO notification.

NOTE: For complete information on examples 1A., 1B. and 1C., see U.R. Matrix example II.

2. URO "carves-out" days from continued stay causing total number of days to fall below low trim point or after high trim point.

Admission Date: 3/1 — Discharge Date: 3/25
Period of Acute Care: 3/1/-3/15 and 3/19-3/25 (21 days) — Total Days: 24
Period of Non-Covered Care: 3/16-3/18 (3 days) — High Trim: 15
Action:
Submit eligible acute care charges on UB-PS Form. Submit Outpatient Claim Form for eligible inpatient ancillaries incurred during non-covered period.

NOTE: For complete information on example 2., see U.R. Matrix example XIII.

3A. Acute continued stay denied prior to low trim point or after high trim point and patient remains after notification.

Admission Date: 3/1 Discharge Date: 3/25
Period of Acute Care: 3/1-3/20 (20 days) Period of Non-Covered Care: 3/21-3/25 (4 days)
Total Days: 24 High Trim: 15
Date of URO Cut-Off Letter: 3/21

Action:
Submit eligible acute care charges on UB-PS form. Submit Outpatient Claim form for eligible inpatient ancillaries incurred during the non-covered period.

3B. Same as #3A except date of URO cut-off letter is 3/22.
Action:
Submit eligible acute care charges on UB-PS Form. Submit Outpatient Claim Form for only those eligible inpatient ancillaries incurred on or after 3/22.

3C. Same as #3A except date of URO cut-off letter is 3/25.
Action:
Submit eligible acute care charges on UB-PS Form. No claim should be submitted for inpatient ancillaries incurred during the period of non-covered care.

3D. Acute continued stay denied within trim points and patient remains after notification.

Admission Date: 3/1 Discharge Date: 3/20
Period of Acute Care: 3/1-3/13 (13 Days) Period of Non-Covered Care: 3/14-3/20 (6 days)
Total Days: 19 High Trim: 15
Date of URO Cut-Off Letter: 3/14

Action:
Submit eligible acute care charges on UB-PS Form. Reimbursement will be the DRG Price Per Case. Submit Outpatient Claim Form for only those eligible inpatient ancillaries incurred beyond the high trim point.

3E. Same as #3D except date of URO cut-off letter is 3/16.
Action:
Submit eligible acute care charges on UB-PS Form. Reimbursement will be the DRG Price Per Case. Submit Outpatient Claim Form for only those eligible inpatient ancillaries incurred on and after 3/16.

3F. Same as #3D except date of URO cut-off letter is 3/20.
Action:
Submit eligible acute care charges on UB-PS Form. Reimbursement will be the DRG Price Per Case.

No claim should be submitted for inpatient ancillaries incurred during the period of non-covered care.

NOTE: For complete information on examples 3A. through 3F., see U.R. Matrix examples #IV and #VI.

The OUTPATIENT CLAIM FORM for these services MUST BE ATTACHED TO THE INPATIENT UB-PS Form. A copy of the U.R.O. level of care certification(s) and/or patient cut-off letter must also be attached.

When completing the UB-PS Form for any eligible acute stay, the instructions given in Newsletters BC-249 or P-351, issued in February of 1983, must be followed. Charges for the acute level of care and the non-covered (residential) level of care must be displayed separately.

Outpatient Claim Forms for inpatient ancillaries are completed in the usual manner except for:

1. Claim From-Date (Block 5) - Enter date of inpatient admission.

2. Claim Thru-Date (Block 6) - Enter date of discharge of inpatient admission or date of death.

3. Visits (Block 7) - Must equal the total number of non-covered days.

4. Type of Service (Block 8) - Use Code 1 (Outpatient).

5. Clinic Type (Block 25) - Use Code 26 (other).

6. Statement of Charges (Block 30) - Enter charges for inpatient ancillaries on the appropriate outpatient service code line. Enter only ancillaries rendered on or after date of U.R.O. cut-off letter.

7. Remarks: - Enter the statement "Billing for eligible ancillaries/non-covered inpatient."

Point of Contact

If you have questions regarding this Newsletter, please telephone the appropriate Medicaid Fiscal Agent:

Blue Cross	(201) 456-2570, 456-2534
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-398

August 6, 1984

TO: ALL PHYSICIANS AND INDEPENDENT CLINICS

SUBJECT: REIMBURSEMENT POLICY FOR SPECIALISTS

EFFECTIVE: IMMEDIATELY

BACKGROUND: In November 1980, the New Jersey Medicaid Program issued a New Jersey Health Services Program Newsletter to all physicians and independent clinics. The Newsletter stated that qualified physicians would be reimbursed as specialists only when at least 90% of their Medicaid practice was being limited to their area of specialization. The New Jersey Medicaid Program has repealed this policy.

ACTION: If a physician lost specialty status because of this rule, a physician may apply to the Prudential Insurance Company for a return to specialty status. The professional criteria requirements for specialists will remain the same and must be met in order for any provider to become a specialist under the Medicaid Program.

Please destroy your old Newsletter (P-280) dated November 3, 1980.

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, telephone (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-399

July 23, 1984

TO: SPECIALISTS IN OTOLOGY AND OTOLARYNGOLOGY

SUBJECT: NEW AUDIOLOGY PROCEDURE CODES

EFFECTIVE: Immediately

BACKGROUND: The New Jersey Medicaid Program has implemented several new audiology procedure codes which refer to the procedures being performed in a physician's office by a certified audiologist. The physician must bill for these codes since audiologists are not direct providers to the program.

ACTION: Attached are the new procedure codes and terminology that should be used when submitting claims to the Medicaid Program. These codes should be added to the MEDICINE - OTHER SERVICES section of your Procedure Code Manual.

If you have any questions regarding this Newsletter, please contact Emily White, Audiology Consultant, Division of Medical Assistance and Health Services, at (609) 292-3756.

		Medicaid Dollar Value S	Medicaid Dollar Value NS
9170	Evaluation of Central Auditory Function by the "Staggered Spondaic Word Test". Testing must be performed by an Audiologist in an environment that meets ANSI-1977 standards.	$ 20	NA
9171	Evaluation of Central Auditory Function by "Competing Sentences", "Filtered Speech", "Binaural Fusion", or "Rapidly Alternating Speech" (per test). Testing must be performed by an Audiologist in an environment that meets ANSI-1977 standards.	$ 10	NA
9172	Evaluation of Central Auditory Function by Synthetic Sentence Identification. Testing must be performed by an Audiologist in an environment that meets ANSI-1977 standards.	$ 30	NA
9173	Hearing Aid Examination - Otologists' office	$ 40	NA

1. Must be personally performed by a certified audiologist or an otologist with billing only by the otologist.

2. Includes an initial hearing aid testing visit plus follow-up visits of which there should be a minimum of one.

3. Initial hearing aid testing visit must be performed either:

   a) in the sound field both with and without amplification using a speaker system with a booster amplifier or

   b) with a Master Hearing Aid.

4. Follow-up visits shall consist of counselling and testing in the sound field within 21 days of the date the aid was provided. Aided and unaided sound field data must be obtained, using a speaker system with booster amplifier.

5. The test environment must meet the current national standards for background noise in audiometric test rooms and records maintained. Audiometers used must be capable of producing both warbled pure tones and speech. They must

be electronically calibrated to the current national standards on a quarterly basis with signed calibration records maintained.

9174	Hearing Aid Examination - Nursing Home Resident - Otologists' Office	$ 35	NA

1. Must be personally performed by a certified audiologist or an otologist with billing only by the otologist.

2. Includes initial hearing aid testing visit performed either:

   a) in the sound field both with and without amplification using a speaker system with a booster amplifier or

   b) with a Master Hearing Aid.

3. The test environment must meet the current national standards for background noise in audiometric test rooms and records maintained. Audiometers used must be capable of producing both warbled pure tones and speech. They must be electronically calibrated to the current national standards on a quarterly basis with signed calibration records maintained.

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

REC'D SEP 26 1983

New Jersey Health Services Program NEWSLETTER

Volume P-400

September 17, 1984

TO: HOSPITAL - BASED HOME HEALTH AGENCIES

SUBJECT: Community Care Program for the Elderly and Disabled (CCPED) - Procedures for Becoming Providers, Requesting Authorization and Submitting Claims for Home Health Services

EFFECTIVE: Immediately

PURPOSE: This Newsletter 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: The Community Care Program for the Elderly and Disabled currently serves and will continue to serve recipients residing in the seven counties of Atlantic, Bergen, Burlington, Gloucester, Morris, Ocean and Somerset.

As of October 1, 1984, the CCPED will enter Phase II and will be extended to the additional counties of Cape May, Hudson, Hunterdon, Mercer, Middlesex, Passaic, Salem, Sussex and Warren. The five remaining counties (Camden, Cumberland, Essex, Monmouth and Union) will be phased into the program October 1, 1985.

General information about CCPED was issued to all providers in Newsletter P-371 or BC-266 dated December 5, 1983.

The eligibility criteria remain the same. Recipients eligible for this Program must:

1. Be 65 or over, or determined disabled under the Social Security Act and receiving Social Security disability payments, and eligible for Medicare;

2. Be assessed in need of Skilled Nursing Facility/Intermediate Care Facility (SNF/ICF) Care; and

3. Have an income which exceeds the appropriate SSI community standard up to the standard for institutional care (currently $882.00 per month).

Individuals who are currently Medicaid eligible for community services are not covered under this program.

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.

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. A provider enrolled in the Community Care Program is issued a new provider number to be used when submitting claims under this program. If you have currently been submitting your claims to Blue Cross of New Jersey, you will now submit them to the Prudential Insurance Company for the Community Care Program for the Elderly and the Disabled.

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 6/84), 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.
   The services "Initial Evaluation, RN" and "Personal Care Asst." on the FD-139 form, item #22, are not to be used by the Home Health Agency for the Community Care Program.

   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, telephone approval may be obtained from the Community Care recipient's case manager. A list of the Case Management Sites are 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 for the regular Home Health Services program, 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 for the CCPED.

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.

In accordance with Diagnosis Related Group (DRG) regulations, at all times the provider must reflect its standard charge on the MC-14. The agency must bill the 100% charge but should expect to receive only 97% in return to reflect the 3% prompt payment discount.

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. Continue to send the claim form (MC-3C) to your regular Fiscal Agent.

THE HOSPITAL-BASED HOME HEALTH AGENCY MUST NOTIFY THE NEW JERSEY MEDICAID PROGRAM IF THEIR CHARGES CHANGE, 30 DAYS IN ADVANCE OF THE CHANGE. IF THE DIAGNOSIS RELATED GROUP (DRG) PROGRAM IS REVISED OR TERMINATES, THE NEW JERSEY MEDICAID PROGRAM RESERVES THE RIGHT TO RENEGOTIATE THE RATES OF THE HOSPITAL BASED HOME HEALTH AGENCY SERVICES REIMBURSED UNDER CCPED.

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 based upon charges will vary per agency as assigned in the approval letter from the Division of Medical Assistance & Health Services' Provider Enrollment Unit)

9431 - Hospital Based (H.B.) Home Health Aide (HHA), - 1 hour
9432 - H.B. HHA - 2 hours
9433 - H.B. HHA - 3 hours
9434 - H.B. HHA - 4 hours
9435 - H.B. HHA - 5 hours
9436 - H.B. HHA - 6 hours
9437 - H.B. HHA - 7 hours
9438 - H.B. HHA - 8 hours

0025 - Physical Therapy - Daily
0026 - Speech-Language Therapy - Daily
0027 - Occupational Therapy - Daily
0028 - Medical Social Services Visit - Daily
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. The Home Health Agency must furnish a list of supplies and costs used by that Agency to the case manager.

0093 - Respite Care - 8 hour day
0094 - Respite Care - 8 hour night
0095 - Respite Care - 12 hour day
0096 - Respite Care - 12 hour night
0097 - Respite Care - 24 hours

Only the above periods of time may be authorized as a respite care service. This service cannot be combined 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.

PROVIDER APPLICATIONS:
Agencies desiring to participate in this program should contact:

Provider Enrollment Unit
Division of Medical Assistance
and Health Services
CN-712
Trenton, New Jersey 08625
(609) 292-1921

for new provider applications.

Any questions regarding this newsletter should be directed to Carol H. 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

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 Physican'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:

( ) Home Health Care Services (attach to MC 3C claim form) ( ) Personal Care Assistant Services (attach to MC 14 claim form)
( ) Community Care Services (attach to MC 14 claim form)

MEDICAL, NURSING AND SOCIAL INFORMATION

16. Name of Last Hospitalization or Long Term Care Facility	Date Admitted	Date Discharged

17. Diagnosis (including surgery and date) Primary / Secondary	Diagnosis Known by: ( ) Patient ( ) Family ( ) Neither

18. Prognosis (check one): ( ) Good ( ) Fair ( ) Poor ( ) Guarded

19.

Functional Limitations		Continence	Mental Behavior	Activities Permitted		Special Problems
( ) Contractures	( ) Speech	( ) Bladder incontin.	( ) Disoriented	( ) O.O.B	( ) Full	( ) Decubitus ulcer
( ) Paralysis	( ) Hearing	( ) Bowel incontin.	1-2-3 Spheres	( ) B.R.P	( ) Part	( ) Skin Problem
( ) Amputation	( ) Vision	( ) Indwelling catheter	( ) Confused	( ) Ambulation	( ) None	( ) Allergy
( ) Wheelchair bound	( ) Other	( ) Colostomy	( ) Underactive/Regressed	( ) Stairs		( ) Other (specify)
( ) Assistive devices (explain):			( ) Anxious	Diet		
			( ) Behavior problem	( ) Regular	( ) Special (specify)	

20. Social Information:
Patient seems motivated to utilize Home Health ( ) Yes ( ) No Patient's home is equipped for his/her care ( ) Yes ( ) No
Family or friends available, willing and appropriate to assist ( ) Yes ( ) No If needed, community resources are available ( ) Yes ( ) No
Explanation of above and/or additional information

21. Goals: ( ) Rehabilitation ( ) Maintenance ( ) Preventive

Time Required: Discharge Plan:
Plan of Treatment (Medical Orders — Drugs, Treatment, Diet, etc.)

Nursing Components
( ) Administer medications ( ) Instruction ( ) ADL ( ) Follow-up of special therapy ( ) Other (specify)
( ) Treatments ( ) Personal Care ( ) ROM ( ) B and B Retraining
( ) Observation/Supervision ( ) Restorative care ( ) Ambulation ( ) 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/No. Hours	Charges/Fee; Per Visit/Per Hr.		No. Visits/Hrs.	Charges/Fee; Per Visit/Per Hr.
Skilled Nursing Care, RN			Initial Evaluation R.N. (CCPED)		
Home Health Aide			Personal Care Asst		
Homemaker			Supplies-Medical/Surgical		
Physical Therapy			Equipment		
Speech-Language Therapy			Other (identify)		
Occupational Therapy					
Respite (CCPED)					
Medical Social Service					

FOR DIVISON USE ONLY

SIGNATURE OF PHYSICIAN REQUESTING SERVICES DATE

SIGNATURE/AGENCY REQUESTING SERVICES DATE

AUTHORIZATION

FOR DIVISION USE ONLY

23. Authorization Information: ( ) Authorization granted ( ) Authorization denied, letter attached ( ) Authorization granted as amended above

Authorization From: To:
Home Health Care Services ( ) Acute ( ) Chronic
Personal Care Assistant Services
Community Care Program Services
Medical Consultant: RSN: SW II: DATE:

FD-139 (rev. 6/84)

Medicaid 81344 Ed. 6/84

FISCAL AGENT COPY

CASE MANAGEMENT SITES - COMMUNITY CARE PROGRAM FOR THE ELDERLY AND DISABLED

ATLANTIC COUNTY

Atlantic County Health Department
Division of Public Health Nursing
201 Shore Road
Northfield, New Jersey 08225

BERGEN COUNTY

Bergen County Welfare Agency
E. 221 Rte. 4 & Forest Avenue
Paramus, New Jersey 07652

BURLINGTON COUNTY

Burlington Medicaid District Office
50 Rancocas Road
Mt. Holly, New Jersey 08060

CAPE MAY COUNTY

Cape May County Welfare Board
Social Service Building
Routes 47 & 9, P.O. Box 222
Rio Grande, New Jersey 08242

GLOUCESTER COUNTY

Gloucester County Board
of Social Services
Human Services Building
Budd Blvd., P.O. Box 633
Woodbury, New Jersey 08096

HUDSON COUNTY

Bayonne Visiting Nurse Association
325 Broadway
Bayonne, New Jersey 07002

HUNTERDON COUNTY

Hunterdon County Board
of Social Services
Community Services Center
6 Gauntt Place
Flemington, New Jersey 08822

MERCER COUNTY

Visiting Nurse Association of Trenton
Christ Episcopal Church
301 Hamilton Ave., P.O. Box 7393
Trenton, New Jersey 08628

MIDDLESEX COUNTY

Visiting Nurse Association
1915 Old Georges Road
North Brunswick, New Jersey 08902

MORRIS COUNTY

Morris Medicaid District Office
10 Park Place, 4th Floor
Morristown, New Jersey 07960

OCEAN COUNTY

Ocean County Board of Social Services
1027 Hooper Avenue
Toms River, New Jersey 08753

PASSAIC COUNTY

Passaic County Board of Social Services
52 Church Street
Paterson, New Jersey 07505

SALEM COUNTY

Salem County Board of Social Services
98 Market Street, P.O. Box 218
Salem, New Jersey 08079

SOMERSET COUNTY

Somerset County Board of Social Services
73 E. High Street, P.O. Box 936
Somerville, New Jersey 08876

SUSSEX COUNTY

Sussex County Board of Social Services
18 Church Street, P.O. Box 218
Newton, New Jersey 07860

WARREN COUNTY

Visiting Homemakers of Warren County
5 West Washington Avenue, P.O. Box 450
Washington, New Jersey 07882

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

New Jersey Health Services Program NEWSLETTER

Volume P-401

August 1, 1984

To: All Providers

Subject: Medicaid Personal Physician Plan Out-of-Phase Projects in Essex, Passaic and Union Counties

Effective: Immediately

Background: As indicated in previous newsletters, the Medicaid Personal Physician Plan is a new voluntary program currently being offered with the existing New Jersey Medicaid Program. The MP Plan has been implemented in Morris, Sussex and Warren Counties (Phase I), and as of this date, in Atlantic, Burlington, Camden, Mercer and Middlesex Counties (Phase II).

Action: The purpose of this newsletter is to announce that because of the interest of community health centers and other providers, small out-of phase projects have been initiated in Essex, Passaic and Union Counties.

In addition to the existing rules of participation in the MP Plan as outlined in Newsletters B-260, P-362, and P-361, the following criteria must be met for MP Plan participation as a physician case manager in the out-of-phase counties of Essex, Passaic and Union:

1. Fifty per cent or more of the provider's clients must be Medicaid recipients and the provider must certify to this effect.

2. Participating providers must have offices in Essex, Union or Passaic Counties.

3. Enrolled Medicaid eligibles must reside in Essex, Union or Passaic Counties.

4. Providers who wish to participate must enroll prior to October 1, 1984. These providers will be eligible for the risk waiver.

If there are any questions concerning this newsletter, inquiries should be made as follows:

Physicians should contact the MP Plan Office at (toll free number) 1-800-624-0838

All other providers should contact their appropriate Fiscal Agent: Blue Cross at (201) 456-2570 or Prudential at (toll free number) 1-800-582-7052.

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

New Jersey Health Services Program NEWSLETTER

Volume P-402

August 6, 1984

TO: PHARMACY PROVIDERS, HOSPITAL ADMINISTRATORS, PHYSICIANS, DENTISTS, PODIATRISTS AND INDEPENDENT CLINICS

SUBJECT: DESI DRUGS -
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 SEPTEMBER 1, 1984 FOR THE NEW JERSEY MEDICAID PROGRAM, THE PHARMACEUTICAL ASSISTANCE TO THE AGED AND DISABLED (PAAD) PROGRAM AND THE GENERAL ASSISTANCE PROGRAM

EFFECTIVE: FOR ADDITIONAL DRUGS LISTED AS LESS THAN EFFECTIVE DISPENSED ON OR AFTER SEPTEMBER 1, 1984

BACKGROUND: The Division of Medical Assistance and Health Services ceased reimbursement on December 3, 1981 for the New Jersey Medicaid Program and on 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: As of September 1, 1984, the Division of Medical Assistance and Health Services will CEASE reimbursement for the following drugs:

AMODRINE TABLETS
ASMINYL TABLETS
WINSTROL TABLETS

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. The drugs that have been newly added to this updated list are underlined. The DESI list distributed to you on August 22, 1983 (BC-263 or P-363) may be discarded.

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 SEPTEMBER 1, 1984 HAVE BEEN UNDERLINED)

A.A.S. Vaginal Supp.
Actacin - C Syr.
Actahist - C
Actagen - C
Actamine - C Syr.
Actifed - C Exp
Adrenosem Salicylate Inj.
Adrenosem Syrup
Adrenosem Tablets
*Adroyd Tabs
Aid - Tuss Caps.
Albalon-A Oph Solution
*Alevaire Liq.
Allerfrin W/Cod
Allerphed C Expect
Ambay Expect
Ambecon
Ambenyl Expect
A-Nil Expect
*Anadrol 2.5 mg Tabs
Am-Ef-Sed Capsules
Am-Ephen Capsules
Amesec Enseals
Amesec Pulvules
Ambilog Oint.
Ambilog Cream
Aminobrain-Pt Elixir
Aminophyllin and Amytal Tabs
Aminophyllin Comp Caps
Aminophyllin Comp Tabs
Amo-Fed Caps
Amobell Caps
*Amodrine Tabs
Amophed Capsules
Amphed Capsules
*Amphocortin Cream
Ananase Tablets
Anaspaz-Pb Tabs
Anisotropine Meth-Br W/PB Tabs
Anti-Spas Caps, Elix. Liq., Tabs
Anti-Spasmodic Elix
Antispasmodic Caps Comp Tabs Elix Tabs
Antora-B Caps
Antrocol Caps, Elix, Tabs
Anugard-HC Supp
Anucon-HC Supp
Anusol-HC Cream
Anusol-HC Supp
Arlarex Tabs
Arlidin Tablets
Asminorel Improved Tabs
*Asminyl Tabs
Asthmacon Capsules
Atropine W/Phenobarbital Tabs
Avazyme Tablets
A.V.C. Vaginal Cream
A.V.C. Vaginal Supp
Azolid-A Caps
Bar-Don Elix, Tabs
Barbatose #2 Tabs
Barbeloid Tabs
Barbidonna C.R. Caps Elix Tabs #2 Tabs
Barophen Elixir
Bay-Ase Elixir
Belap Elixir, S.E. Tabs, Tabs
Belatol Elixir, Tabs
Bella-Phen Tabs
Bellabarb Tabs
Belladenal Elixir, Tabs
Belladenal-S Tabs
Belladonna W/PB Caps, Elix, Tabs
Belladonna Alk. W/Phenobarbital
Bellalphen Tabs
Bellastal Caps, Elix, Tabs
Bellemms #1 & 2 Tabs
Bello-Phen Tabs
Bellophene Tabs
Benomine W/PB Caps
Benomine W/PB Tabs
Bentyl Caps W/PB

*Discontinued by manufacturer or proposed for DESI list and discontinued by manufacturer before action could be taken.

Bentyl Syrup W/PB
Bentyl Tabs W/PB
Betadine Vaginal Gel
Biobid TD Caps
Biocort Ointment
Bio-Gan Supp
Biosynal-DC Caps
Bro-Phed Tabs
Bromalix Elixir
Bromanate Elixir
Bromanate Expect
Bromanate Expect DC
Bromanyl Expect
Bromatane Expect
Bromatane Expect DC
Bromenate Expect
Bromodiphen Comp Exp. W/Cod
Bromonate Expect
Bromonate Expect DC
Bromophen Elixir & TD Tabs
Bromotuss Exp. W/Cod
Bromphen Comp TD Tabs
Bromphen Comp W/Cod
Bromphen Expect
Bromphen Expect DC
Bromphen Expect DC W/Cod
Bromphenate Expect
Bromphenate Expect DC
Brompheniramine Comp Elixir
Brompheniramine Comp Expect
Brompheniramine Expect
Brompheniramine Expect DC
Brompheniramine, Phenylephrine & Phenylpropanolamine
Brompheniramine W/Cod Expect
Bromtane Expect
Bromtane Expect DC
Brophed Syrup
Brophed Tablets
Brophenyl Expect
Brotane Expect
Butabarb-Belladonna Elix, Tabs
Butabell HMB Elix, Tabs
Butagen Alka Caps
Butan-K Tabs
*Butazolidin Alka Capsules
Butibel Elix, R.A. Tabs, Tabs
C.D.P. Plus Caps
*Caldecort Ointment (Rx)
Caramiphen Edisylate & Phenylpropanolamine Caps
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
Cetacaine BT6 Spray
Cetacaine Kit
Cetacaine Liquid
*Chardonna Tabs
Chardonna-2 Tabs
Chlordiazepoxide Plus Caps
Chlordiazepoxide W/Clindinium Caps
Chlordinamide Caps
Chlordinium Capsules
Chlordinium Sealets
Chlordinium Tablets
Chlorex Caps
Chlorofon-F Tab
Chlorzone Forte Tab
Chlorzoxazone W/APAP Tab
Chlorzoxazone W/Acetaminophen Tab
Chymolase Tablets
Chymoral Tablets
Clindex Caps
Clinoxide Capsules
Clipoxide Caps
Clistin R-A Tabs
*Clistin Expectorant
*Coditrate Syrup
Co-Perazine Caps TD
Co-Pyronil Caps Pediatric Caps & Susp
Com-Par Capsules
Com-Pro Caps
Com-Pro-Span TD Caps
Combagen Caps
Combid Spansules
Combined T.D. Caps
Cophed-C Expt
*Cor-Tar-Quin Cream
Cor-Tar-Quin Forte Cream
*Cor-Tar-Quin Lotion
Cordamine P A Tabs
Cordran-N Cream
Cordran-N Oint
Corovas Tymcaps
Corque Cream
Cort-Quin Cream
Cortin Cream
Cortisporin Cream

*Discontinued by manufacturer or proposed for DESI list and discontinued by manufacturer before action could be taken.

*Cortomycin Oint
Cycladate
Cyclandelate Caps
Cyclorex Caps
Cyclospasmol Capsules
Cyclospasmol Tablets
Cydel Capsules
Cyvaso Caps
D-Vaso Capsules
D-Vaso-S Liquid
Dainite Tablets
Dainite-KI Tablets
Daricon W/PB
Deaner Tablets
Dek-Quin Cream
Dek-Quin Lotion
Deprol Tablets
*Dianabol Tabs
Dibent-PB Tablets
Dibenzyline Capsules (Exception: Diagnosis of Pheochromocytoma)
Dicyclomine HCL W/PB Caps
Dicyclomine HCL W/PB Tabs
Dihydro Codeine Comp Caps
Dimalix Elixir
Dimetane Expect
Dimetane Expect DC
Dimetapp Elixir & Extentabs
Dipyridamole Tab (Lemmon)
Diutensen Tablets
Dixatal Elixir
Dixotuss Liquid
Domeform-HC Cream
Donabarb Tabs
Donna-Phenal Elix
Donnamor Elix
Donnatal Caps, Elix, Tabs
Donnatal #2 Tabs
Donnatal Extentabs
Donnatal Plus Liq, Tabs
Donphen Tabs
Dri-Phed W/Cod Expect
Durel-Cort V Cream
Durel-Cort V Oint
E.T.H. Syrup Comp
E.T.H. Tablets Comp
Eldertonic
Enarax 5 & 10
+Equagesic Tablets
Equanitrate
Equazine Tabs
*Erythrocin Top Oint
*Erythromycin Top Oint
F.E.P. Cream
Federinal Susp
Fedrinal Susp
*Florinef Lotion
Forhistal Lontabs
*Fluonid-N Cream
Gantrisin Vaginal Cream
Gecil Expect
Geravite Elixir
Geravite Inj
Geroniazol Elixir
Geroniazol Tablets
Geroniazol-TT Tablets
Gevizol Liquid
Gevizol Tablets
Glycopyrrolate W/PB Tabs
H & I Cream
H.C.I. Cream & Oint
HCV Cream
H.V.B. Cream
Haponal Tabs
Hasp Elix, Tabs
Hemorrhoidal-HC Supp
Hemorrhoidal-HC Unisert
Hemorroid-HC Supp
Hemorroidal-HC Supp
Hemusol-HC Supp
Hepto Tabs
Heptogesic Tablets
Hexabamate Tabs
Hista Clopane Caps
Histatap Elixir & TD Tabs
Hybephen Elix, Tabs
*Hybephen LA Cap
Hydrocortisone W/Iodochlorhydroxyquin
Hydrocortisone W/Neomycin
Hydromax Syrup
*Hydromet Lot
Hydrophed Syrup
Hydrophed Tabs
Hydroxy Compound Tabs
Hydroxy Ephed Syrup
Hydroxyephed Tabs
Hydroxyzine Comp Syrup
Hydroxyzine Comp Tabs
Hydroxyzine Plus Liquid
Hydroxyzine Plus Tabs
Hydroxyzine, Theoph & Ephed Tabs
Hyonatol-B Elixir, Tabs
Hyophen Tabs

*Discountinued by manufacturer or proposed for DESI list and discontinued by manufacturer before action could be taken.
+New Ethoheptazine free formula is exempt.

Hyoscyamine CP Elixir
Hyosophen Caps, Elixir, Tabs
Hypnaldyne Tabs
Hysone Ointment
ICN-Isox Tabs
Ilotycin Ointment
Iodo-HC Cream
Iodo-HC Mild Cream
Iodo-HC Ointment
Iodochlor Cream W/HC
Iodochlor Ointment W/HC
Iso-Perazine T.D. Caps
Isobid Caps
Isopropamide Caps
Isopro TDC Caps
Isopropazine Caps
*Isordil W/Phenobarb Tablets
Isoxsuprine HCL Tabs
*Kenalog-S Cream
*Kenalog-S Ointment
*Kenalog-S Lotion
Kinesed Tabs
Koro-Sulf Vaginal Cream
Lanabutazone Comp Caps
Lanvisone Cream
Levsin W/PB Drops, Elix, Tabs, Time Caps
Librax Caps
Lidaform-HC Cream
Lidaform-HC Lotion
Lidinium Caps
Lidoxide Capsules
Luftodil Tablets
Lufyllin-EPG Tabs & Elixir
Lyrizine Tablets
M-T Comp Tabs
Mannitol Hexanitrate W/PB Tabs
Maracon Tabs
Marax Syrup
Marax Syrup DF
Marax Tablets
Menic Tablets
Mepergan Fortis Capsules
Mepro Comp Tabs
Mepro-Analgesic Tabs
Mepro-Hex TM Tablets
Meprobamate-Comp Tabs W/Tridihex
Meprobamate-Plus Tabs
Meprobamate, Ethoheptazin & Aspirin Tabs
Meprobamate W/Tridihexethyl Tabs
Meprogese Tabs
Meprogesic Tabs
Meprohex Tabs
Meproplus MLT Tabs
Meprotrate-20 Tabs
Methylandrostenediol Aq. Inj.
*Meti-Derm W/Neomycin Aerosol & Oint.
Metrazol Ampuls
Metrazol Liquid
Metrazol Tablets
Midatap Elixir & Tabs
Midrin Capsules
Migral Tablets
Milpath Tablets
Miltrate Tablets
Mity-Quin Cream
Mivert Pellsules
Murray-Gesic Tabs
Mycocet Cream
Myco-Aricin Cream & Oint
Myco Cream & Oint
Myco-Triacet Cream & Oint
Myco-Tricolone Comp Cream
Mycort Cream
Mycogen Cream & Oint
Mycolog Cream & Oint
*Myconef Ointment
Mytrex Cream & Oint
N.N.G.T. Cream & Oint
Naphcon-A
Naturetin-K Tablets
*Neo Aristocort Cream & Oint
*Neo Aristocort Opth Oint.
*Neo Aristoderm Aerosol
Neo Cort-Dome Cream & Lotion
Neo Decadron Top Cream
*Neo Decaspray
Neo Hytone Cream
Neo Nysta-Cort Ointment 1%
Neo-Cortef Cream, Oint & Lot
Neo-Delta-Cortef Ointment
*Neo-Diloderm Cream
*Neo-Domeform HC Cream
*Neo-Hydeltrasol Oint
*Neo-Hydeltrasol Lot
*Neo-Hytone Cream
*Neo-Magnacort Oint
Neo-Medrol Cream
*Neo-Nysta-Cort Ointment
Neo-Oxylone Ointment
Neo-Parcort Ointment
Neo-Polycin-HC
*Neo-Resulin-F

*Discontinued by manufacturer or proposed for DESI list and discontinued by manufacturer before action could be taken.

Neo-Synalar Cream
*Neo-Tarcortin Ointment
*Neomycin Sulf W/Hydrocortamate HCL Oint
Neoquess Inj., Tabs
*Neosporin Lotion
Neosporin-G Cream
NGT Cream
Niapent Elixir & Tabs
Nico-Metrazol Elixir & Tabs
Nico-Vert Capsules & Tabs
Nicotiacol Tabs
Nicotinyl Alcohol Tabs
Nicotinyl Tartrate Tabs
Nicozol Elixir & Tabs
Nilspasm Tablets T.D.
Nioric Elixir & Tabs
Nitranitol Tablets
Nitranitol W/PB Tablets
Normatane Elixir
*Nycin-HC Oint
Nylidrin HCL Tabs
Nysolone Cream & Oint
Nyst-Olone Cream
*Nysta-Cort Lot
*Nystaform-HC Lotion & Oint
Nystatin Cream W/Neomycin & Triamcin
Nystatin Oint W/Neomycin & Triamcin
Omni-Tuss Susp
*Onycho-Phytex Sol
Opcon-A Opth Sol
Ophthel Liquid
Orenzyme Bitabs & Tabs
Oxaine-M Suspension
P.E.T.N. Tabs W/PB
P.V. Tussin
Palbar Elix, Tabs
Palbar #2 Tabs
Pamate 200 Tabs
Pamate 400 Tabs
Pamine W/PB Drops, Elix, Tabs
Panzol Liq
Papase Tablets
Parafon Forte Tabs
Par Pent Liq & Tabs
Par-Eth Tablets
Par-Gream
Par Vag Supp
Parlib-X
Parothyl Tablets
Pathibamate Tablets
Pathilon Sequels
Pathilon Sequels W/PB
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
Pharmased Caps, Elix, Tabs
Phenergan Expect
Phenergan Expect W/Cod
Phenergan Pediatric Expectorant
Phenergan VC Expect
Phenergan VC W/Cod Expect
Phenobarbital W/Belladonna Elix, Tabs
Phenobella Tabs
Phenylbutazone Alka Caps
Phenybultazone Plus Caps
Phenylbutone-A Caps
Phenylzone-A Capsules
Potaba Capsules
Potaba Envules
Potaba Powder
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

*Discontinued by manufacturer or proposed for DESI list and discontinued by manufacturer before action could be taken.

Promethazine Expect W/Cod
Promethazine Expect W/Cod & Decong
Promethazine Expect W/Decong
Promethazine Expect W/Phenyleph
Promethazine Expect W/Phenyleph & Cod
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
Purebrom Elixir & Comp TD Tabs
Puretane Expect
Puretane Expect DC
Pylora Tabs
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
Relaxadon Tabs
Relaxadonna Tabs
*Robinul-PH Tabs
Rofed C Syrup
Roniacol Elixir
Roniacol Tablets 50mg
Roniacol Timespan
Ronigen Timetabs
Rotane Expect DC
Rotapp Elixir
Ru-Vert Liquid & Tabs
Ruhexatel W/Reserpine Tabs
Rycotin Time-Tabs
S-T Decongest Liquid
SBP Tabs
SBP Plus
Scodonnal Elix, Tabs
Scotatal Caps
Sedabel Elix, Tabs, Time Caps
Sedacord Tabs
*Sed-Tens Tymed
Sedachol Caps
Sedalix Elix
Sedapar Elix, Tabs
Senilex Tabs
Senilezol Elixir & Caps
Sinodeine Caps
Sorbitrate Tablets W/PB
Spabelin #1 and #2 Tabs
Spalix Elix, Tabs
Spasdel Caps, Elix
Spasloids Tabs
Spasmacaps Caps
Spasmate Tabs
Spasmolin Caps, Elixir Tabs
Spasmophen Elixir Tabs
Spasquid Elixir
Spastolate Elixir, Tabs, Time Caps
Speniacol Tabs
Spenpath Tabs
Spentane Expect
Spentane Expect DC
Stera-Form Cream
Steraspasmol Caps
Sterazolidin Capsules
Steroform Cream & Oint
*Supertah-HC Oint
Susano Elixir, Tabs
Su-Ton Liquid
Su-Zol Liquid
+Synalgos Caps (new & old formula)
+Synalgos-DC Caps (new and old formula)
Synalgen-DC Caps
T.C.M. Tabs
T.E.H. Comp Tabs
T.E.H. Tablets
T.T.H. Tabs
T-Gen Supp
Tagatap Elixir & Tabs
Tamine Elixir & SR Tabs
Tega-Vert Capsules & Tabs
Tegagen Supp
Tegamide Supp
*Terra-Cortril Aerosol & Ointment
Theda CDP Plus Caps
Theda MEP Plus Tabs
Theda Prochloramide
Theophedrizine Tabs
Theophozine Liquid
Theophozine Tabs

*Discontinued by manufacturer or proposed for DESI list and discontinued by manufacturer before action could be taken.
+Promethazine free formula is exempt (synalgos is an OTC).

Theophylline Plus Elixir
Theophylline, Ephed & Hydroxyzine
Theozine Syrup & Tabs
*Thephorin Expectorant
Therax Tabs
Tigan Caps
Tigan Pediatric Supp
Tigan Supp
TMC-200 Tabs
TMC-400 Tabs
Tolazoline HCL Tabs
Tranquigesic Tabs
Tri-Bamate Tablets
Tri-Hexabamate Tabs
Tri-Statin Cream
Tri-Statin Ointment
Tri Phen Elixir
Triacin C Exp
Triacin C Syrup
Triafed-C Syrup
Triamcinolone Cream & Oint W/Nystatin Plus
Triamcinolone NNG Cream
Triamcinolone Plus Cream
Tribamate Tabs
Tridihexethyl CL W/Mepro Tabs
Trihexamate
Trimate
Trimethobenzamide Supp
Triprobamate
Tritran-400
Trocinate Tablets
Tuss-Ade Caps
Tuss-Aid Caps
Tuss-Allernade Caps
Tuss-Coryztime
Tuss-Or Caps
Tuss-Ornade Liquid & Spansules
Tuss Allergine T.D. Caps
Tuss Danabe Caps
Tuss Danbade Caps
Tuss Genade Liquid & Caps
Tussadon Improved TD Caps
Tussadon Liquid
Tussanbade Caps
Tussionex Susp, Tabs & Caps
Tuzone Tab
Uni-Com Cap
Uni-Para Plus Tabs
Uni-Prob W/PB 15mg Tabs
Vagitrol Cream & Supp
Valpin-50-PB Tablets
Valpin W/PB Elixir & Tabs
Vasocen Tabs
Vasocon-A Drops
Vasodigen Tabs
Vasodilan INJ/Ampul
Vasodilan Tablets
Vasoprine Tablets
Vasorex Tabs
Vasostin Tabs
Veltap Elixir
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
Vistrax 5 & 10
Vita-Metrazol Elixir & Tablets
Vytone Cream
Westapp Elixir
*Westiazole Vaginal Cream
*Winstrol Tabs
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-403

August 27, 1984

TO: HOME HEALTH AGENCIES

SUBJECT: PERSONAL CARE ASSISTANT SERVICES (P-386)

EFFECTIVE: Immediately

PURPOSE: This Newsletter provides additional information relative to the inclusion of Personal Care Assistant Services into the Certified Home Health Agency Cost Report, HCFA-1728-81 (6-81). It amends Newsletter P-386, dated March 19, 1984, (pg. 4, section C, The Certified Home Health Agency Cost Report).

BACKGROUND: As a result of meetings with the certified home health agencies and the Home Health Agency Assembly of New Jersey, the amended information is being provided by the Medicaid Program for the participation of certified home health agencies in the new statewide Personal Care Assistant service program. Claims submitted for reimbursement are processed through the Prudential Insurance Company, a Medicaid Fiscal Agent.

ACTION: Please substitute the following for Section "C", entitled The Certified Home Health Agency Cost Report on page 4 of the volume numbered Newsletter P-386, dated March 19, 1984.

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. Costs associated with the initial nursing evaluation visit are to be included on line 8 (Skilled Nursing Care) of Form HCFA-1728-81 (6-81), Worksheet A.

3. The initial nursing evaluation visits are to be included in the total number of visits (Worksheet C, Part I, line 1, column 3 and page 1, Part II, line 1, column 5) and total Medicaid visits (Worksheet D-4, line 1, column 1 and page 1, Part II, line 1, column 3).

4. Costs associated with Personal Care Assistants are to be identified as such and included on line 27 of Form HCFA-1728-81 (6-81) Worksheet A. These costs are reflected as a non-reimbursable cost center and not part of the Home Health Aide category because the services being rendered are considered "homemaker" in nature.

5. Because Personal Care Assistant Services are being treated as a non-reimbursable cost, the visit count is not to be included on Worksheets C or D-4.

6. 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 skilled nursing services allocated to respective payors.

Any questions regarding this Newsletter should be directed to Carol H. Kurland, Administrator, Office of Home Care Programs at (609) 292-1940.

Any specific questions regarding completion of the cost report should be directed to Brenda Flanegan, Assistant Accounting Analyst, Provider Audit Division, The Prudential Insurance Company at (609) 293-2017.

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

RECD SEP 14 1983

New Jersey Health Services Program NEWSLETTER

Volume P-404

September 17, 1984

TO: HOSPITAL ADMINISTRATORS, PHYSICIANS AND INDEPENDENT CLINICS

SUBJECT: "HYSTERECTOMY RECEIPT OF INFORMATION FORM" - (FD-189 Rev.7/83)

EFFECTIVE: OCTOBER 1, 1984

BACKGROUND: Any claim involving a hysterectomy procedure must have a properly completed "Hysterectomy Receipt of Information Form" (FD-189 Rev. 7/83) attached to it when submitted to the New Jersey Medicaid Fiscal Agent for reimbursement. In the newsletter (P-364 or BC-264) dated August 29, 1983 on this matter, providers were instructed to use the newly revised one page version of the FD-189 (Rev. 7/83) form immediately for claims filed for hysterectomies performed on and after September 1, 1983 and to destroy the outdated forms. However, some providers continue to use the old three page FD-189 form.

ACTION: When submitting claims for hysterectomy services, providers must attach the current FD-189 (Rev. 7/83) Form. Failure to do so after September 30, 1984 will result in denial of these claims. For your convenience, a copy of the form is attached.

Supply/Ordering of Forms:

Providers may photocopy the "Hysterectomy Receipt of Information Form" (FD-189 Rev. 7/83) 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

Hospital Service Plan of New Jersey
(New Jersey Blue Cross)
33 Washington Street
Newark, New Jersey 07102

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

HYSTERECTOMY RECEIPT OF INFORMATION FORM

A woman who has a hysterectomy can never again get pregnant. When you have a hysterectomy, the doctor removes your uterus (womb). You can not have a baby after your uterus is removed and you will not have menstrual periods anymore.

I received the above information orally and in writing from _____ (name of clinic or physician) _____ before my operation was performed.

I talked to _____ (name of responsible person(s)) about a hysterectomy. _____ (She/He/They) discussed it with me and gave me a chance to ask questions and answered them for me before the operation.

I have read all of this notice. I agree that it is a true description of what was explained to me by _____ (name of staff member) of _____ (clinic/hospital/physician) and that all my questions were answered to my satisfaction.

I, _____, hereby consent (or did consent) of my own free will to have a hysterectomy done by _____ and/or associate(s) or assistant(s) of his or her choice.

I consent (or did consent) to any other medical treatment that the doctor thinks is (was) necessary to preserve my health.

I also consent to the release of this form and other medical records about the operation to representatives of the United States Department of Health and Human Services or employees of programs or projects funded by that Department <u>but only for</u> purposes of determining if Federal laws were observed.

_____ Patient's Signature

_____ Date Month/Day/Year

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

REC'D DEC 17 1984

New Jersey Health Services Program NEWSLETTER

Volume P-408

December 10, 1984

To: HOSPITAL ADMINISTRATORS

Subject: TELEPROCESSING MANUAL (Revised)

Effective: January 1, 1985

Purpose: This Newsletter provides hospital billing office personnel with revised instructions for billing the New Jersey Medicaid Program via the Teleprocessing System.

Background: Effective January 1, 1985, hospitals must utilize the National Uniform Bill, UB-82 - HCFA-1450, when billing hard copy for inpatient services. Consequently, it was necessary to revise the inpatient claim teleprocessing format and instructions in their entirety.

To maintain consistency with the coding for inpatient claims, it also was necessary to revise the coding requirements for selected fields on the outpatient format. These fields include those under the titles: Sex, Status, Primary and Secondary Surgery, DRG Proc 1 and DRG Proc 2.

In conjunction with the change to the use of the UB-82 claim form, the New Jersey Medicaid Program is converting from the current surgical procedure codes (PRV) to the use of ICD-9-CM surgical procedure codes.

Action Required: The new Teleprocessing Manual is attached for use by hospital billing staff as of January 1, 1985. The instructions should be reviewed carefully as the inpatient teleprocessing format was completely revised and necessary selected changes were also made to the outpatient format because of the revised coding requirements.

Please discard the present Chapter IV (TELEPROCESSING PROCEDURES) of the Hospital Services Manual and substitute the attached Chapter IV dated 12/10/84.

Please contact your New Jersey Medicaid Fiscal Agent if you have any questions concerning this Newsletter:

Blue Cross - (201) 456-2570
or
Prudential - (609) 293-2254

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

REC'D DEC 07 1984

New Jersey Health Services Program NEWSLETTER

Volume P-409

November 26, 1984

TO: PHARMACY PROVIDERS, HOSPITAL ADMINISTRATORS, PHYSICIANS, DENTISTS, PODIATRISTS AND INDEPENDENT CLINICS

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

EFFECTIVE: DECEMBER 1, 1984

BACKGROUND: The Division of Medical Assistance and Health Services ceased reimbursement 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: As of December 1, 1984, the Division of Medical Assistance and Health Services will cease reimbursement for the additional drugs added to the Drug Efficacy Study Implementation (DESI) list.

This action applies to the New Jersey Medicaid Program, the Pharmaceutical Assistance to the Aged and Disabled (PAAD) Program and the General Assistance Program.

Attached for your convenience is an updated brand named alphabetical listing of drug products that are considered less than effective under the DESI Program. The drugs that have been newly added to this updated list are underlined. The DESI list distributed to you on August 6, 1984 (BC-288 or P-402) may be discarded.

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.

DRUG EFFICACY STUDY IMPLEMENTATION (DESI)

DESI DRUG PRODUCTS AND KNOWN RELATED DRUG PRODUCTS THAT LACK SUBSTANTIAL EVIDENCE OF EFFECTIVENESS MEDICAID/PAAD PROGRAMS

(ADDITIONS OF DECEMBER 1, 1984 HAVE BEEN UNDERLINED)

A.A.S. Vaginal Supp.
Actacin - C Syr.
Actahist - C
Actagen - C
Actamine - C Syr.
Actifed - C Exp
Adrenosem Salicylate Inj.
Adrenosem Syrup
Adrenosem Tablets
*Adroyd Tabs
Aid - Tuss Caps.
Albalon-A Oph Solution
*Alevaire Liq.
Allerfrin W/Cod
Allerphed C Expect
Ambay Expect
Ambecon
Ambenyl Expect
A-Nil Expect
*Anadrol 2.5 mg Tabs
Am-Ef-Sed Capsules
Am-Ephen Capsules
Amesec Enseals
Amesec Pulvules
Ambilog Oint.
Ambilog Cream
Aminobrain-Pt Elixir
Aminophyllin and Amytal Tabs
Aminophyllin Comp Caps
Aminophyllin Comp Tabs
Amo-Fed Caps
Amobell Caps
*Amodrine Tabs
Amophed Capsules
Amphed Capsules
*Amphocortin Cream
Ananase Tablets
Anaspaz-Pb Tabs
Anisotropine Meth-Br W/PB Tabs
Anti-Spas Caps, Elix. Liq., Tabs
Anti-Spasmodic Elix
Antispasmodic Caps Comp Tabs Elix Tabs
Antora-B Caps
Antrocol Caps, Elix, Tabs
Anugard-HC Supp
Anucon-HC Supp
Anusol-HC Cream
Anusol-HC Supp
Arlarex Tabs
Arlidin Tablets
Asminorel Improved Tabs
*Asminyl Tabs
Asthmacon Capsules
Atropine W/Phenobarbital Tabs
Avazyme Tablets
A.V.C. Vaginal Cream
A.V.C. Vaginal Supp
Azolid-A Caps
Bar-Don Elix, Tabs
Barbatose #2 Tabs
Barbeloid Tabs
Barbidonna C.R. Caps Elix Tabs #2 Tabs
Barophen Elixir
Bay-Ase Elixir
Belap Elixir, S.E. Tabs, Tabs
Belatol Elixir, Tabs
Bella-Phen Tabs
Bellabarb Tabs
Belladenal Elixir, Tabs
Belladenal-S Tabs
Belladonna W/PB Caps, Elix, Tabs
Belladonna Alk. W/Phenobarbital
Bellalphen Tabs
Bellastal Caps, Elix, Tabs
Bellemms #1 & 2 Tabs
Bello-Phen Tabs
Bellophene Tabs
Benomine W/PB Caps
Benomine W/PB Tabs
Bentyl Caps W/PB

*Discontinued by manufacturer or proposed for DESI list and discontinued by manufacturer before action could be taken.

Bentyl Syrup W/PB
Bentyl Tabs W/PB
Betadine Vaginal Gel
Biobid TD Caps
Biocort Ointment
Bio-Gan Supp
Biosynal-DC Caps
Bro-Phed Tabs
Bromalix Elixir
Bromanate Elixir
Bromanate Expect
Bromanate Expect DC
Bromanyl Expect
Bromatane Expect
Bromatane Expect DC
Bromenate Expect
Bromodiphen Comp Exp. W/Cod
Bromonate Expect
Bromonate Expect DC
Bromophen Elixir & TD Tabs
Bromotuss Exp. W/Cod
Bromphen Comp TD Tabs
Bromphen Comp W/Cod
Bromphen Expect
Bromphen Expect DC
Bromphen Expect DC W/Cod
Bromphenate Expect
Bromphenate Expect DC
Brompheniramine Comp Elixir
Brompheniramine Comp Expect
Brompheniramine Expect
Brompheniramine Expect DC
Brompheniramine, Phenylephrine & Phenylpropanolamine
Brompheniramine W/Cod Expect
Bromtane Expect
Bromtane Expect DC
Brophed Syrup
Brophed Tablets
Brophenyl Expect
Brotane Expect
Butabarb-Belladonna Elix, Tabs
Butabell HMB Elix, Tabs
Butagen Alka Caps
Butan-K Tabs
*Butazolidin Alka Capsules
Butibel Elix, R.A. Tabs, Tabs
C.D.P. Plus Caps
*Caldecort Ointment (Rx)
Caramiphen Edisylate & Phenylpropanolamine Caps
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
Cetacaine BT6 Spray
Cetacaine Kit
Cetacaine Liquid
*Chardonna Tabs
Chardonna-2 Tabs
Chlordiazepoxide Plus Caps
Chlordiazepoxide W/Clindinium Caps
Chlordinamide Caps
Chlordinium Capsules
Chlordinium Sealets
Chlordinium Tablets
Chlorex Caps
Chlorofon-F Tab
Chlorzone Forte Tab
Chlorzoxazone W/APAP Tab
Chlorzoxazone W/Acetaminophen Tab
Chymolase Tablets
Chymoral Tablets
Clindex Caps
Clinoxide Capsules
Clipoxide Caps
Clistin R-A Tabs
*Clistin Expectorant
*Coditrate Syrup
Co-Perazine Caps TD
Co-Pyronil Caps Pediatric Caps & Susp
Com-Par Capsules
Com-Pro Caps
Com-Pro-Span TD Caps
Combagen Caps
Combid Spansules
Combined T.D. Caps
Cophed-C Expt
*Cor-Tar-Quin Cream
Cor-Tar-Quin Forte Cream
*Cor-Tar-Quin Lotion
Cordamine P A Tabs
Cordran-N Cream
Cordran-N Oint
Corovas Tymcaps
Corque Cream
Cort-Quin Cream
Cortin Cream
Cortisporin Cream

*Discontinued by manufacturer or proposed for DESI list and discontinued by manufacturer before action could be taken.

*Cortomycin Oint
Cycladate
Cyclandelate Caps
Cyclorex Caps
Cyclospasmol Capsules
Cyclospasmol Tablets
Cydel Capsules
Cyvaso Caps
D-Vaso Capsules
D-Vaso-S Liquid
Dainite Tablets
Dainite-KI Tablets
Daricon W/PB
Deaner Tablets
Dek-Quin Cream
Dek-Quin Lotion
Deprol Tablets
*Dianabol Tabs
Dibent-PB Tablets
Dibenzyline Capsules (Exception: Diagnosis of Pheochromocytoma)
Dicyclomine HCL W/PB Caps
Dicyclomine HCL W/PB Tabs
Dihydro Codeine Comp Caps
Dimalix Elixir
Dimetane Expect
Dimetane Expect DC
Dimetapp Elixir & Extentabs
Dipyridamole Tab (Lemmon)
Diutensen Tablets
Dixatal Elixir
Dixotuss Liquid
Domeform-HC Cream
Donabarb Tabs
Donna-Phenal Elix
Donnamor Elix
Donnatal Caps, Elix, Tabs
Donnatal #2 Tabs
Donnatal Extentabs
Donnatal Plus Liq, Tabs
Donphen Tabs
Dri-Phed W/Cod Expect
Duotrate - 30 Caps
Duotrate - 45 Caps
Durel-Cort V Cream
Durel-Cort V Oint
E.T.H. Syrup Comp
E.T.H. Tablets Comp
Eldertonic
Enarax 5 & 10
+Equagesic Tablets
Equanitrate
Equazine Tabs
*Erythrocin Top Oint
*Erythromycin Top Oint
F.E.P. Cream
Federinal Susp
Fedrinal Susp
*Florinef Lotion
Forhistal Lontabs
*Fluonid-N Cream
Gantrisin Vaginal Cream
Gecil Expect
Geravite Elixir
Geravite Inj
Geroniazol Elixir
Geroniazol Tablets
Geroniazol-TT Tablets
Gevizol Liquid
Gevizol Tablets
Glycopyrrolate W/PB Tabs
H & I Cream
H.C.I. Cream & Oint
HCV Cream
H.V.B. Cream
Haponal Tabs
Hasp Elix, Tabs
Hemorrhoidal-HC Supp
Hemorrhoidal-HC Unisert
Hemorroid-HC Supp
Hemorroidal-HC Supp
Hemusol-HC Supp
Hepto Tabs
Heptogesic Tablets
Hexabamate Tabs
Hista Clopane Caps
Histatap Elixir & TD Tabs
Hybephen Elix, Tabs
*Hybephen LA Cap
Hydrocortisone W/Iodochlorhydroxyquin
Hydrocortisone W/Neomycin
Hydromax Syrup
*Hydromet Lot
Hydrophed Syrup
Hydrophed Tabs
Hydroxy Compound Tabs
Hydroxy Ephed Syrup
Hydroxyephed Tabs
Hydroxyzine Comp Syrup
Hydroxyzine Comp Tabs
Hydroxyzine Plus Liquid
Hydroxyzine Plus Tabs
Hydroxyzine, Theoph & Ephed Tabs
Hyonatol-B Elixir, Tabs
Hyophen Tabs

*Discountinued by manufacturer or proposed for DESI list and discontinued by manufacturer before action could be taken.
+New Ethoheptazine free formula is exempt.

Hyoscyamine CP Elixir
Hyosophen Caps, Elixir, Tabs
Hypnaldyne Tabs
Hysone Ointment
ICN-Isox Tabs
Ilotycin Ointment
Iodo-HC Cream
Iodo-HC Mild Cream
Iodo-HC Ointment
Iodochlor Cream W/HC
Iodochlor Ointment W/HC
Iso-Perazine T.D. Caps
Isobid Caps
Isopropamide Caps
Isopro TDC Caps
Isopropazine Caps
*Isordil W/Phenobarb Tablets
Isoxsuprine HCL Tabs
*Kenalog-S Cream
*Kenalog-S Ointment
*Kenalog-S Lotion
Kinesed Tabs
Koro-Sulf Vaginal Cream
Lanabutazone Comp Caps
Lanvisone Cream
Levsin W/PB Drops, Elix, Tabs, Time Caps
Librax Caps
Lidaform-HC Cream
Lidaform-HC Lotion
Lidinium Caps
Lidoxide Capsules
Luftodil Tablets
Lufyllin-EPG Tabs & Elixir
Lyrizine Tablets
M-T Comp Tabs
Mannitol Hexanitrate W/PB Tabs
Maracon Tabs
Marax Syrup
Marax Syrup DF
Marax Tablets
Menic Tablets
Mepergan Fortis Capsules
Mepro Comp Tabs
Mepro-Analgesic Tabs
Mepro-Hex TM Tablets
Meprobamate-Comp Tabs W/Tridihex
Meprobamate-Plus Tabs
Meprobamate, Ethoheptazin & Aspirin Tabs
Meprobamate W/Tridihexethyl Tabs
Meprogese Tabs
Meprogesic Tabs
Meprohex Tabs
Meproplus MLT Tabs
Meprotrate-20 Tabs
Methylandrostenediol Aq. Inj.
*Meti-Derm W/Neomycin Aerosol & Oint.
Metrazol Ampuls
Metrazol Liquid
Metrazol Tablets
Midatap Elixir & Tabs
Midrin Capsules
Migral Tablets
Milpath Tablets
Miltrate Tablets
Mity-Quin Cream
Mivert Pellsules
Murray-Gesic Tabs
Mycocet Cream
Myco-Aricin Cream & Oint
Myco Cream & Oint
Myco-Triacet Cream & Oint
Myco-Tricolone Comp Cream
Mycort Cream
Mycogen Cream & Oint
Mycolog Cream & Oint
*Myconef Ointment
Mytrex Cream & Oint
N.N.G.T. Cream & Oint
Naphcon-A
Naptrate Tabs 20 mg
Naturetin-K Tablets
*Neo Aristocort Cream & Oint
*Neo Aristocort Opth Oint.
*Neo Aristoderm Aerosol
Neo Cort-Dome Cream & Lotion
Neo Decadron Top Cream
*Neo Decaspray
Neo Hytone Cream
Neo Nysta-Cort Ointment 1%
Neo-Cortef Cream, Oint & Lot
Neo-Delta-Cortef Ointment
*Neo-Diloderm Cream
*Neo-Domeform HC Cream
*Neo-Hydeltrasol Oint
*Neo-Hydeltrasol Lot
*Neo-Hytone Cream
*Neo-Magnacort Oint
Neo-Medrol Cream
*Neo-Nysta-Cort Ointment
Neo-Oxylone Ointment
Neo-Parcort Ointment
Neo-Polycin-HC
*Neo-Resulin-F

*Discontinued by manufacturer or proposed for DESI list and discontinued by manufacturer before action could be taken.

Neo-Synalar Cream
*Neo-Tarcortin Ointment
*Neomycin Sulf W/Hydrocortamate HCL Oint
Neoquess Inj., Tabs
*Neosporin Lotion
Neosporin-G Cream
NGT Cream
Niapent Elixir & Tabs
Nico-Metrazol Elixir & Tabs
Nico-Vert Capsules & Tabs
Nicotiacol Tabs
Nicotinyl Alcohol Tabs
Nicotinyl Tartrate Tabs
Nicozol Elixir & Tabs
Nilspasm Tablets T.D.
Nioric Elixir & Tabs
Nitranitol Tablets
Nitranitol W/PB Tablets
*Nitrin Tabs
Normatane Elixir
*Nycin-HC Oint
Nylidrin HCL Tabs
Nysolone Cream & Oint
Nyst-Olone Cream
*Nysta-Cort Lot
*Nystaform-HC Lotion & Oint
Nystatin Cream W/Neomycin & Triamcin
Nystatin Oint W/Neomycin & Triamcin
Omni-Tuss Susp
*Onycho-Phytex Sol
Opcon-A Opth Sol
Ophthel Liquid
Orenzyme Bitabs & Tabs
Oxaine-M Suspension
P.E.T.N. Caps 30 mg
P.E.T.N. Caps 30 mg T.D.
P.E.T.N. Caps 80 mg
P.E.T.N. Caps 80 mg T.D.
P.E.T.N. Caps 80 mg T.R.
P.E.T.N. Tabs 10 mg
P.E.T.N. Tabs 20 mg
P.E.T.N. Tabs 40 mg
P.E.T.N. Tabs 80 mg
P.E.T.N. Tabs 80 mg S.A.
P.E.T.N. Tabs 80 mg T.D.
P.E.T.N. Tabs W/PB
P.V. Tussin
Palbar Elix, Tabs
Palbar #2 Tabs
Pamate 200 Tabs
Pamate 400 Tabs
Pamine W/PB Drops, Elix, Tabs
Panzol Liq
Papase Tablets
Parafon Forte Tabs
Par Pent Liq & Tabs
Par-Eth Tablets
Par-Cream
Par Vag Supp
Parlib-X
Parothyl Tablets
Pathibamate Tablets
Pathilon Sequels
Pathilon Sequels W/PB
Pathilon Tabs 25 MG (W/PB 15mg)
Pedi-Cort-V-Cream
Penalate Elixir
Pentacort Cream
Pentraspan 30 Caps
Pentritol Tempules 30 mg
Pentritol Tempules 60 mg
Pentrol T.D. Caps 30 mg
Pentryate - 80 Caps
Pentrylan Tabs 10 mg
Peritrate W/PB Tabs
Peritrate -SA Tabs 80 mg
Peritrate-SA W/PB Tabs
Peritrate Tabs 10 mg
Peritrate Tabs 20 mg
Peritrate Tabs 40 mg
Pharma-Gesic Tabs
Pharmased Caps, Elix, Tabs
Phenergan Expect
Phenergan Expect W/Cod
Phenergan Pediatric Expectorant
Phenergan VC Expect
Phenergan VC W/Cod Expect
Phenobarbital W/Belladonna Elix, Tabs
Phenobella Tabs
Phenylbutazone Alka Caps
Phenybultazone Plus Caps
Phenylbutone-A Caps
Phenylzone-A Capsules
Potaba Capsules
Potaba Envules
Potaba Powder
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

*Discontinued by manufacturer or proposed for DESI list and discontinued by manufacturer before action could be taken.

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
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
Purebrom Elixir & Comp TD Tabs
Puretane Expect
Puretane Expect DC
Pylora Tabs
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
Relaxadon Tabs
Relaxadonna Tabs
*Robinul-PH Tabs
Rofed C. Syrup
Roniacol Elixir
Roniacol Tablets 50 mg
Roniacol Timespan
Ronigen Timetabs
Rotane Expect DC
Rotapp Elixir
Ru-Vert Liquid & Tabs
Ruhexatel W/Reserpine Tabs
Rycotin Time-Tabs
S-T Decongest Liquid
SBP Tabs
SBP Plus
Scodonnal Elix, Tabs
Scotatal Caps
Sedabel Elix, Tabs, Time Caps
Sedacord Tabs
*Sed-Tens Tymed
Sedachol Caps
Sedalix Elix
Sedapar Elix, Tabs
Senilex Tabs
Senilezol Elixir & Caps
Sinodeine Caps
Sorbitrate Tablets W/PB
Spabelin #1 and #2 Tabs
Spalix Elix, Tabs
Spasdel Caps, Elix
Spasloids Tabs
Spasmacaps Caps
Spasmate Tabs
Spasmolin Caps, Elixir Tabs
Spasmophen Elixir Tabs
Spasquid Elixir
Spastolate Elixir, Tabs, Time Caps
Speniacol Tabs
Spenpath Tabs
Spentane Expect
Spentane Expect DC
Stera-Form Cream
Steraspasmol Caps
Sterazolidin Capsules
Steroform Cream & Oint
*Supertah-HC Oint
Susano Elixir, Tabs
Su-Ton Liquid
Su-Zol Liquid
+Synalgos Caps (new & old formula)
+Synalgos-DC Caps (new and old formula)
Synalgen-DC Caps
T.C.M. Tabs
T.E.H. Comp Tabs
T.E.H. Tablets
T.T.H. Tabs

*Discontinued by manufacturer or proposed for DESI list and discontinued by manufacturer before action could be taken.
+Promethazine free formula is exempt (synalgos is an OTC).

T-Gen Supp
Tagatap Elixir & Tabs
Tamine Elixir & SR Tabs
Tega-Vert Capsules & Tabs
Tegagen Supp
Tegamide Supp
*Terra-Cortril Aerosol & Ointment
Theda CDP Plus Caps
Theda MEP Plus Tabs
Theda Prochloramide
Theophedrizine Tabs
Theophozine Liquid
Theophozine Tabs
Theophylline Plus Elixir
Theophylline, Ephed & Hydroxyzine
Theozine Syrup & Tabs
*Thephorin Expectorant
Therax Tabs
Tigan Caps
Tigan Pediatric Supp
Tigan Supp
TMC-200 Tabs
TMC-400 Tabs
Tolazoline HCL Tabs
Tranquigesic Tabs
Tri-Bamate Tablets
Tri-Statin Cream
Tri-Statin Ointment
Tri Phen Elixir
Triacin C Exp
Triacin C Syrup
Triafed-C Syrup
Triamcinolone Cream & Oint W/Nystatin Plus
Triamcinolone NNG Cream
Triamcinolone Plus Cream
Tribamate Tabs
Tridihexethyl CL W/Mepro Tabs
Trihexamate
Trimate
Trimethobenzamide Supp
Triprobamate
Tritran-400
Trocinate Tablets
Tuss-Ade Caps
Tuss-Aid Caps
Tuss-Allernade Caps
Tuss-Coryztime
Tuss-Or Caps
Tuss-Ornade Liquid & Spansules
Tuss Allergine T.D. Caps
Tuss Danabe Caps
Tuss Danbade Caps
Tuss Genade Liquid & Caps
Tussadon Improved TD Caps
Tussadon Liquid
Tussanbade Caps
Tussionex Susp, Tabs & Caps
Tuzone Tab
Uni-Com Cap
Uni-Para Plus Tabs
Uni-Prob W/PB 15mg Tabs
Vagitrol Cream & Supp
Valpin-50-PB Tablets
Valpin W/PB Elixir & Tabs
Vaso-80 Unicelles
Vasocen Tabs
Vasocon-A Drops
Vasodigen Tabs
Vasodilan INJ/Ampul
Vasodilan Tablets
Vasoprine Tablets
Vasorex Tabs
Vasostin Tabs
Veltap Elixir
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
Vistrax 5 & 10
Vita-Metrazol Elixir & Tablets
Vytone Cream
Westapp Elixir
*Westiazole Vaginal 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 and discontinued by manufacturer before action could be taken.

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

REC'D JAN 2 1985

New Jersey Health Services Program NEWSLETTER

Volume P-410

December 24, 1984

TO: Administrators - General and Psychiatric Hospitals

EFFECTIVE: Immediately

SUBJECT: Policy on Reserving Medicaid Patient's Bed When Transferred from Long-Term Care Facility to Hospital

PURPOSE: This newsletter is to inform hospital administrators that the New Jersey Medicaid Program now requires nursing homes to reserve a Medicaid patient's bed up to ten days when that patient is transferred from a Medicaid approved long-term care facility to a hospital.

BACKGROUND: Governor Kean signed L.1984, c.134, on September 5, 1984 which requires reserving the bed of a resident of a skilled nursing or intermediate care facility who is a recipient of medical assistance under L.1968, c.413, and who is discharged to a general or a psychiatric hospital. The following are quotations from the law:

1. "Every skilled or intermediate care nursing facility in this State shall maintain a bed for an eligible resident for a period not to exceed 10 days. The facility shall notify the Division of Medical Assistance and Health Services in the Department of Human Services upon the discharge of an eligible resident to a general or psychiatric hospital".

2. "If the discharged resident is unable to return to the nursing facility before the end of the 10 day period, the discharged resident shall have priority for the next available bed in the facility".

ACTION REQUIRED BY HOSPITAL: The following action by the hospital staff will facilitate the recipient's return to the long-term care facility:

1. Involve the long-term care facility in the preparation of the hospital's discharge planning;

2. Advise the facility of an anticipated discharge date;

3. Cooperate with the long-term care facility when inquiring of the recipient's progress, particularly if something unexpected happens which causes a revision to the discharge plan; and

4. Give the long-term care facility as much advance notice as possible to prepare for the return of the recipient.

When the 10 day bed reserve is exceeded and no bed is available in the long-term care facility from which the patient was transferred, the hospital must provide the level of long-term care determined by the PRO until such time as the bed is available to the Medicaid recipient.

Any questions concerning the Medicaid reserve bed policy may be directed to the Medicaid District Office Administrator.

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

REC'D JAN 25 1985

New Jersey Health Services Program NEWSLETTER

Volume P-411

February 4, 1985

TO: All Providers

SUBJECT: Direct Reimbursement from Third Party Health Insurers

EFFECTIVE: Immediately

BACKGROUND: Federal and New Jersey laws require that all other sources of payment for medical care be used before the New Jersey Medicaid Program is asked to pay.

Problems in billing third party health insurers arise when the policy holder is an absent parent who cannot be contacted to sign a claim form or when the insurer sends payment directly to the Medicaid recipient who then neglects to pay the insurance claim money to the provider.

Each Medicaid recipient, as a condition of eligibility for Medicaid benefits, assigns to the Commissioner of the Department of Human Services any rights to payment for medical care from any third party. By taking the actions given below, a provider will receive direct payment from the third party health insurer for services provided to a Medicaid recipient. This is based on N.J.S.A. 30:4D-7.1 (c).

ACTION: New Jersey Medicaid recipients are deemed to have assigned their rights to payment for medical care from any third party. Thus, the Commissioner of the Department of Human Services authorizes all approved Medicaid providers to sign private health insurance claim forms for services provided to eligible Medicaid recipients, including a claim form requiring the signature of an absent parent or guardian who cannot be contacted. This will enable providers to obtain direct reimbursement.

To obtain direct reimbursement, the provider must sign the insurance claim form in the space provided for the signature of the patient or parent/guardian. The provider's signature must be followed by the identification of the provider as: "Assignee for the Commissioner, New Jersey Department of Human Services". This statement does not apply to claim forms submitted directly to the New Jersey Medicaid Program for payment.

Please file this Newsletter with Chapter I of your New Jersey Medicaid Program Provider Manual. If you have any questions, please contact Murray Goldberg, Chief of Third Party Liability Programs, Office of Program Integrity Administration, Division of Medical Assistance and Health Services, at (609) 984-7096.

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

REC'D MAR 12 1985

New Jersey Health Services Program NEWSLETTER

Volume P-413

February 19, 1985

TO: INDEPENDENT LABORATORY PROVIDERS, PHYSICIANS AND PODIATRISTS

SUBJECT: PROCEDURE CODE REVISIONS TO THE LABORATORY SECTION OF THE PROCEDURE CODE MANUAL

EFFECTIVE: March 1, 1985

BACKGROUND: The New Jersey Medicaid Program continually updates the Procedure Code Manual as necessary. New and revised procedure codes are now being implemented for laboratory services.

Please note that procedure codes 8504, 8526, 8730 and 8761 have a change in the fee schedule only. This is in accordance with the Medicare and Medicaid Budget Reconciliation Amendments of 1984, which require the establishment of areawide fee schedules for clinical diagnostic laboratory tests. The fee schedule is set at 60% of the prevailing charge level for the area for similar clinical diagnostic laboratory tests.

ACTION: Listed below are the newly added/revised laboratory procedure codes, which will be effective for all claims received on or after March 1, 1985. Please update your Procedure Code Manual accordingly.

Procedure Code	Description	Medicaid Dollar Value
8504	Carcinoembryonic Antigen (CEA) (RIA)	22.40
8526	(RAST) Each additional Antigen	4.80
8730	Thromboplastin Generation Test (TGT)	9.00
8761	Triglycerides (Neutral Fat)	8.30

8867	Culture, Fungus (definitive) (e.g., Candida Albicans).	8.00
8868	Yeast Screen (not definitive) from Urine, Vaginal or Throat Cultures only (e.g., germ tube).	3.00
8988	House Call to Home Bound Patient in Home or Sheltered Boarding Home for purpose of obtaining blood by venous or arterial puncture. Reimbursement limited to once per trip regardless of number of patients.	10.00
8998	Visit to obtain Blood Specimens by venous or arterial puncture "First person in Nursing Home"	1.80
8999	Visit to obtain Blood Specimens by venous or arterial puncture "Each additional person in Nursing Home"	0.60

If you have any questions regarding this newsletter, please contact Phyllis Valeri, Laboratory Services, Division of Medical Assistance and Health Services, at (609) 292-7673.

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

REC'D APR 2 1985

New Jersey Health Services Program NEWSLETTER

Volume P.-414

TO: PROSTHETIC AND ORTHOTIC PROVIDERS

SUBJECT: REVISED BILLING PROCEDURES FOR SHOES

EFFECTIVE: FOR SERVICES RENDERED ON OR AFTER APRIL 15, 1985

BACKGROUND: The Division of Medical Assistance and Health Services adopted an amended rule in the New Jersey Administrative Code (N.J.A.C. 10:55-1.5, 1.8, 3.1) effective April 15, 1985. The rule deleted the current price list from the schedule of shoes. In addition, certain procedure codes identified by an asterisk (*) may be performed by providers other than certified prosthetists and orthotists.

PURPOSE: The primary purpose of this newsletter and attachment is to replace the existing schedule of shoes and shoe appliances schedule of allowances on pages 46 through 48 with the new pages with the same number. The procedure code number and narrative description remain the same; the dollar figures under the heading "maximum pair price" have been deleted.

The secondary purpose is to issue replacement pages for pages 35, 38, 41, 42, 43 which indicate the asterisked (*) procedures. There is no change in the procedure code, narrative description, or Medicaid fee schedule on these pages. This new reimbursement formula will apply only to procedure codes numbered 5120 through 5260.

ACTION: Providers will continue to complete the claim form (MC-15-C1) in the same manner, including making all appropriate entries in Item 13. Providers must attach a copy of the invoice to the contractor's copy of the claim form. The invoice must clearly identify the shoe that corresponds to the entry or entries on the claim form.

If the patient has both Medicare and Medicaid coverage, the invoice must be attached to the HCFA-1500 claim form that is submitted to the Prudential Insurance Company for payment.

The Prudential Insurance Company will process the claim and make payment by adding 50 percent to the invoice cost. If the invoice cost is excessive in comparison to invoice costs submitted by other providers, the provider may be required to supply additional information.

INSTRUCTIONS: Providers are instructed to delete Chapter IV, pages 35, 38, 41 through 43, 46 through 48 and replace them with the attached pages with the same numbers.

If there are any questions concerning the new reimbursement methodology, please contact the Prudential Insurance Company at their toll-free number, 800-582-7052.

NOTE: Prior authorization for repairs - Effective April 15, 1985 repairs or replacement of parts involving solely the mechanical aspects of a prosthetic and orthotic appliance which are $100 or less will not require prior authorization from the Medicaid District Office. If the cost of the repair or replacement exceeds $100, then prior authorization will be required.

This change occurred when the Prosthetic and Orthotic Manual (N.J.A.C. 10:55-1) was readopted pursuant to Executive Order No. 66 (1978).

PROSTHETIC DEVICES

Code	Description	Medicaid Fee
	SOCKETS	
6621	Plastic socket with shoulder cap for disarticulation	$ 250.00
6622	Plastic socket and upper arm	150.00
	ELBOW HINGES	
6625	Flexible hinges WD or BE	$ 46.00
6626	Polycentric hinges	52.00
6627	Below elbow step up hinges	65.00
6628	Outside locking hinges	156.00
6629	Stump activated locing hinges	170.00
6630	Forearm lift assist elbow	190.00
6631	Above elbow locking elbow	228.00
	WRIST UNITS	
6635	Friction wrist	$ 40.00
6636	Oval friction wrist	42.00
6637	Quick change wrist	55.00
6638	FM wrist disconnect	70.00
6639	Flexion wrist	175.00
	OTHER	
6643	Consultation without provision of an appliance Note: Must have written prescription from physician, must be documented in patient's chart.	$ 30.00
*6644	Labor charge per hour Note: Allowed for replacement or repair	35.00
*6645	Portal to portal travel time	30.00

ORTHOTIC PROCEDURES

Code	Description	Medicaid Fee
	ORTHOTIC REPLACEMENT - REPAIR (No additional labor charge)	
6705	Complete recovering of Cowhorn (not including corset front)	$ 120.00
6706	Complete recovering of Knight Spinal (not including corset front)	98.00
6707	Complete recovering of McCausland (not including corset front)	100.00
6708	Complete recovering of Williams Flexion (not including corset front)	175.00
	ORTHOTIC REPLACEMENT - REPAIR PLUS LABOR	
6709	Axillary strap	$ 10.00
6710	Perineal Strap	3.00
6711	Apron Front	25.00
6712	Corset Front	40.00
6713	Full corset front	72.00
6714	Maternity Corset front	65.00
6715	Replacement pelvic girdle	455.00
6716	Upright anterior	32.00
6717	Upright posterior	32.00
6718	Occipital pads	32.00
6719	Standard chin piece	30.00
6720	Throat mold	30.00
6721	With axillary crutches additional	39.00
6722	Gluteal straps (each)	7.50
	CORRECTION PADS - REPLACEMENT ONLY	
6727	Axilla	$ 39.00
6728	Kyphosis	25.00
6729	Lumbar bolster	25.00
6730	Lumbar or lumbar rib	39.00
6731	Sternal	39.00
6732	Thoracic	39.00
	CASTING - (When required and documented)	
*6735	Foot	50.00
*6736	Foot, Ankle	65.00
*6737	Foot, ankle, shin	70.00
6738	Foot, ankle, shin, knee	80.00
6739	Knee	60.00
6740	Thigh	85.00
6741	Full leg	140.00

ORTHOTIC PROCEDURES

Code	Description	Medicaid Fee
	KNEE ANKLE FOOT ORTHOSIS (KAFO)	
6774	Full plastic, molded to patient model (SKA floor reaction design)	$ 710.00
6775	Plastic knee ankle foot orthosis (molded to patient model)	1,120.00
	TORSION CONTROL	
6778	Bilateral rotation straps, pelvic band/belt	$ 90.00
6779	Bilateral torsion cables, hip joint, pelvic band/belt	161.00
6780	Unilateral torsion cables, hip joint, pelvic band/belt	123.00
6781	Bilateral torsion cables, ball bearing hip joints, pelvic band/belt	120.00
6782	Unilateral torsion cables, ball bearing hip joints, pelvic band/belt	82.00
	HIP	
	ABDUCTION CONTROL OF HIP JOINTS	
6785	Frejka type with cover	$ 52.00
6786	Additional Frejka cover	21.00
6787	Pavlik harness	67.00
6788	Static, pelvic band or spreader bar, thigh cuffs	280.00
6789	Static, adjustable, custom fitted (Ilfield)	105.00
6790	Static, plastic, custom fitted	105.00
6791	"A" Frame	385.00
	COMPONENTS	
	(Same code applies to order with new orthosis, and repair or replacement with existing orthosis). Additional allowance for labor on repair and/or replacement	
*6793	Heel to toe Shank	$ 30.00
6794	Limited ankle motion, each joint	32.00
6795	Dorsiflexion assist (plantar flexion resist), each joint	35.00
6796	Dorsiflexion and plantar flexion assist/resist	77.00
*6797	Split flat caliper stirrup and plate attachment	56.00
*6798	Round caliper and plate attachment	45.00
6799	Foot plate, molded to patient model, stirrup attachment	188.00
*6800	Varus/Valgus correction ("T") strap, standard; or malleolus pad	32.00
*6801	Varus/Valgus correction ("T") strap/ padded/lined	32.00
*6802	Molded inner boot	87.00
6803	Abduction bar (bilateral hip involvement), jointed adjustable	105.00

ORTHOTIC PROCEDURES

Code	Description	Medicaid Fee
	COMPONENTS CONT'D	
*6804	Straight abduction bar	$ 60.00
6805	Non-molded lacer (tibial)	110.00
6806	Lacer, molded to patient model (tibial)	190.00
6807	Pre-tibial shell molded to patient model	315.00
6808	Prosthetic type BK socket, molded to patient	420.00
6809	Calf band	34.00
6810	Calf cuff	52.00
6811	Replacement single upright, free plantar/dorsiflexion	75.00
6812	Free knee, each joint	67.00
6813	Locked knee	70.00
6814	Drop lock, each joint	70.00
6815	Bail lock, complete	75.00
6816	Disc or dial lock, each joint	125.00
6817	Lift loop for drop lock ring (extension)	74.00
6818	Knee control strap or pad (knee cap puller or varus/valgus correction strap)	54.00
6819	Thigh band (distal)	42.00
6820	Thigh band (proximal)	42.00
6821	Ischial ring or band	106.00
6822	Gluteal thigh band	82.00
6823	Distal leather thigh cuff	80.00
6824	Proximal leather thigh cuff	85.00
6825	Long thigh lacer	120.00
6826	Molded thigh lacer	210.00
6827	High roll cuff	50.00
6828	Recover ischial ring	72.00
6829	Quadrilateral socket (as prosthetic)	560.00
6900	Hip joint (free)	63.00
6901	Hip joint (flexion) 180 degree stop	75.00
6902	Hip joint, clevis type, or thrust bearing, free, each	78.00
6903	Hip joint, clevis or thrust bearing lock, each	78.00
6904	Dial lock	120.00
6905	4 way hip joint	175.00
6906	Pelvic band half	50.00
6907	Pelvic band full	72.00
6908	Pelvic belt	80.00
6909	Gluteal pad	55.00

ORTHOTIC PROCEDURES

Code	Description	Medicaid Fee
	GENERAL OR NEW ORTHOSIS OR REPAIR OR REPLACEMENT	
6915	Extension; per extension, per bar	$ 30.00
*6916	"D" ring	11.00
6917	Bullet (spring loaded) retentions	25.00
*6918	Velcro strap	18.00
6919	Joint cover	20.00
6920	Puller cuff	61.00
6921	Puller strap	40.00
*6922	Tibial torsion (built in orthosis)	40.00
*6923	Torsion twister stirrup shoe attachment (Becker)	40.00
6924	Knee cap	45.00
6925	Pull knee cap	65.00
*6926	Torsion cable	35.00
*6927	Stirrup Transfer	35.00
	OTHER	
*6939	Labor per hour NOTE: Allowed for replacement or repair	$ 35.00
6940	Consultation without provision of an appliance Note: Must have written prescription from physician, must be documented in patient's chart.	30.00
*6941	Travel time (portal to portal) Maximum 3 visits to measure-fit-deliver (Documentation & prescription required for additional visits)	30.00
	FRACTURE ORTHOSIS	
6944	Femoral fracture cast orthosis (University of Miami design), includes all necessary adjustments	$ 650.00
6945	Tibial fracture cast orthosis (University of Miami design), includes all necessary adjustments	420.00
	SUPPORTS	
6356	Hernia Support, Unilateral	$ 40.00
6357	Hernia Support, Bilateral	60.00
6358	Scrotal Truss, Unilateral	38.00
6359	Scrotal Truss, Bilateral	60.00

SHOES AND SHOE APPLIANCES SCHEDULE OF ALLOWANCES

Code

SHOES FOR CHILDREN - All regular constructed with leather sole, steel shanks.

5120 Infants up to size 6
5121 Infants from 6-1/2 to 8
5122 Child's from size 8-1/2 to 12
5123 Miss from size 12-1/2 to 3
5124 From 3-1/2 to 4
5125 From 4-1/2 to 7
5126 Boy's from 12-1/2 to 3
5127 Boy's from 3-1/2 to 7
5128 High Shoes from 12-1/2 to 3
5129 High Shoes from 3-1/2 to 4

ORTHOPEDIC SHOES - with Thomas Heels & Long Counters.

5140 Infant's up to size 6
5141 Infant's from 6-1/2 to 8
5142 Child's from size 8-1/2 to 12
5143 Misses from size 12-1/2 to 3
5144 From 3-1/2 to 4
5145 Boy's shoes from 12-1/2 to 3
5146 Boy's shoes 3-1/2 to 4
5147 Boy's shoes 4-1/2 to 6
5148 High shoes 12-1/2 to 3
5149 High shoes 3-1/2 to 4
5150 High shoes 4-1/2 to 6

5151 All extra width shoes - EE - EEE

WOMEN'S ORTHOPEDIC SHOES

5160 Oxford shoes - sizes through 10
5161 Oxford shoes - sizes 10-1/2 to 12
5162 High shoes - sizes through 10
5163 High shoes - sizes 10-1/2 to 12
5164 Bunion last oxford shoes - sizes through 10
5165 Straight inner border last oxford shoes - 1 inch heel - sizes through 10
5166 Heavy weight-long counter oxford shoes - sizes through 10
5167 Straight last oxford with out-flare, round toe box - sizes through 10
5170 All extra width shoes - EE - EEE
5171 ADDITIONAL CHARGE for oxfords over size 10
5172 ADDITIONAL CHARGE for high shoes over size 10

MEN'S SHOES - Regular with leather sole, steel shanks

5180 Size 6-1/2 to 12
5181 Size 12-1/2 to 13
5182 Size 13-1/2 and over
5183 High shoes 6-1/2 to 12
5184 High Shoes 12-1/2 to 13

SHOES AND SHOE APPLIANCES SCHEDULE OF ALLOWANCES

Code	
	MEN'S SHOES - Regular with leather sole, steel shanks
5185	Over size 13
5186	EE and EEE and EEEE
	MEN'S ORTHOPEDIC SHOES
5190	Oxfords - with Thomas Heels up to size 12
5191	High shoes - with Thoams Heels up to size 12
5192	Size 12-1/2 to 13
5193	Over size 13
5194	EE and EEE and EEEE
5195	Special shoes to accommodate Hallux Valgus
	STRAIGHT LAST OXFORDS - with or without long counters and/or Thomas Heels
5200	Size up to 6
5201	Size 6-1/2 to 8
5202	Size 8-1/2 to 12
5203	Size 12-1/2 to 3
5204	Size 3-1/2 to 4
5205	Size 4-1/2 to 7
5206	Size 7-1/2 to 9
5207	Size 9-1/2 to 12
	STRAIGHT LAST HIGH SHOES
5210	Size up to 6
5211	Size 6-1/2 to 8
5212	Size 8-1/2 to 12
5213	Size 12-1/2 to 3
5214	Size 3-1/2 to 4
5215	Size 4-1/2 to 7
	SUPINATOR SHOES (Inflare last)
5220	Babies, size 3 to 6
5221	Infants, size 6-1/2 to 8
5222	Childs, size 8-1/2 to 12
5223	Juniors, size 12-1/2 to 3
5224	Size 3 up
	PRONATOR SHOES (Outflare last)
5230	Babies - infants, size 2 to 8
5231	Child, size 8-1/2 to 12
5232	Juniors, size 12-1/2 to 4
5233	Open toe pre-walker, size 000 to 4
5234	Size 4-1/2 to 6

SHOES AND SHOE APPLIANCES SCHEDULE OF ALLOWANCES

Code	
	SURGICAL SHOES FOR BRACES - laced to toe
5240	Size up to 6
5241	Size 6-1/2 to 8
5242	Size 8-1/2 to 12
5243	Size 12-1/2 to 3
5244	Size 3-1/2 to 4
5245	Size 4-1/2 to 9
	MEN'S SURGICAL SHOES
5250	Size 6-1/2 to 12
5251	Size 2-1/2 to 6
5252	Amboot - Sizes 3 to 6
5253	Amboot - Sizes 6-1/2 to 12 - Single
5255	CHARGE FOR OVERSIZES
5260	CHARGE FOR MISMATES

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

REC'D MAR 29 1985

New Jersey Health Services Program NEWSLETTER

Volume P.-415

TO: PROVIDERS OF SHOES, MEDICAL SUPPLIES AND EQUIPMENT

SUBJECT: REVISED BILLING PROCEDURES FOR SHOES; ADDITIONAL PROCEDURE CODE LISTINGS

EFFECTIVE: FOR SERVICES RENDERED ON OR AFTER APRIL 15, 1985

BACKGROUND: The Division of Medical Assistance and Health Services adopted an amendment to the New Jersey Administrative Code (N.J.A.C. 10:55-1.5, 1.8, 3.1) effective April 15, 1985. The rule changed the basis of reimbursement for shoes. In addition, certain procedure codes may be performed by providers other than certified prosthetists and orthotists.

PURPOSE: The primary purpose of this newsletter and attachment is to explain the new method of reimbursement for shoes. In addition, those procedures which may be performed by providers other than certified prosthetists and orthotists are listed in Section 3.3.

ACTION: 1. Providers will continue to use the existing numerical codes and narrative descriptions that appear on pages 41 - 45 of the Medical Supplier Manual. Providers will continue to complete the claim form (MC-11-C4) in the same manner. A copy of the invoice must be attached to the fiscal agent copy that is submitted to the Prudential Insurance Company for payment. The invoice must clearly identify the shoe that corresponds to the entry or entries on the claim form.

If the patient has both Medicare and Medicaid coverage, the invoice must be attached to the HCFA-1500 claim form that is submitted to the Prudential Insurance Company for payment.

The Prudential Insurance Company will process the claim and make payment by adding 50 percent to the invoice cost. If the invoice cost is excessive in comparison to invoice costs submitted by other providers, the provider may be required to supply additional information. This new reimbursement formula will apply only to procedure codes numbered 5120 through 5260.

NOTE: Procedure codes 5000 through 5118 are not affected by this new reimbursement formula. Providers will be reimbursed according to the existing fee schedule. It is not necessary to submit a copy of the invoice for these particular codes.

2. A new list of procedure codes, narrative descriptions, and fee schedules has been added as a new Section 3.3 entitled "Prosthetic and Orthotic Codes, Descriptions and Prices - Limited Listing".

Providers will continue to use the same claim form (MC-11-C4) when billing for these items. The instructions on pages 6 and 7 of the Billing Procedures Chapter are still applicable. The Prudential Insurance Company will process the claim and make payment according to the established Medicaid fee schedule, or the provider's usual and customary charge, whichever is lower.

INSTRUCTIONS: Providers are instructed to add Section 3.3, Prosthetic and Orthotic Codes, Descriptions and Prices - Limited Listing," page 5 to Subchapter 3 of the Medical Supply and Equipment Manual.

If there are any questions concerning the new reimbursement methodology, or the new listing of procedure codes, please contact the Prudential Insurance Company at their toll-free number, 800-582-7052.

3.3 Prosthetic and Orthotic Codes, Descriptions and Prices (Limited Listing)

The following listing sets forth procedure codes, narrative descriptions, and the Medicaid fee schedule for services which may be performed by providers other than certified prosthetists and orthotists.

CODE	DESCRIPTION	MEDICAID FEE
6644	Labor charge per hour Note: Allowed for replacement or repair	$ 35.00
6645	Travel time (portal to portal)	30.00
	CASTING (when required and documented)	
6735	Foot	50.00
6736	Foot, ankle	65.00
6737	Foot, ankle, shin	70.00
	COMPONENTS	
6793	Heel to toe shank	30.00
6797	Split flat caliper stirrup and plate attachment	56.00
6798	Round caliper and plate attachment	45.00
6800	Varus/valgus correction ("T") strap, standard; or malleolus pad	32.00
6801	Varus/valgus correction ("T") strap/ padded/lined	32.00
6802	Molded inner boot	87.00
6804	Straight abduction bar	60.00
	GENERAL OR NEW ORTHOSIS OR REPAIR OR REPLACEMENT	
6916	"D" ring	11.00
6918	Velcro strap	18.00
6922	Tibial torsion (build in orthosis)	40.00
6923	Torsion twister stirrup shoe attachmert	40.00
6926	Torsion cable	35.00
6927	Stirrup transfer	35.00
	OTHER	
6939	Labor per hour Note: Allowed for replacement or repair	35.00
6941	Travel time (portal to portal)	30.00

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-416

April 1, 1985

To: NARCOTIC AND DRUG ABUSE TREATMENT CENTERS

REC'D APR 2 1985

Effective: December 1, 1984

Purpose: This Newsletter outlines the billing procedures Narcotic and Drug Abuse Treatment Centers must follow to request reimbursement for services rendered to New Jersey Medicaid recipients.

Background: Governor Kean signed an amendment (L. 1984, c. 86, approved July 18, 1984) to the New Jersey Medical Assistance and Health Services Act which permits the New Jersey Medicaid Program to reimburse for services in connection with the inpatient or outpatient treatment or care of drug abuse.

A Narcotic and Drug Abuse Treatment Center means a facility which provides services in connection with the inpatient or outpatient treatment or care of drug abuse when the treatment is prescribed by a physician and provided in a licensed hospital or in a narcotic and drug abuse treatment center approved by the Department of Health pursuant to L. 1970 c.334 (NJSA 26: 2G-21 et.seq.) and whose staff includes a medical director.

The New Jersey Medicaid Program will cover drug treatment costs only for those services eligible for federal financial participation under Title XIX of the Social Security Act. Room, board and other residential services are not covered services. Approved centers may bill only for those procedure codes which correspond to the allowable services included in their New Jersey Medicaid Provider approval letter. Mental health services provided in a Narcotic and Drug Abuse Treatment Center do not require prior authorization.

Action: Narcotic and Drug Abuse Treatment Centers must use the New Jersey Medicaid claim form MC-14 (Independent Outpatient Health Facility) to request reimbursement for services provided.

Attached are basic billing procedures, a listing of procedures codes, a filled-in sample MC-14 claim form, and instructions for completing the MC-14. A Narcotic Drug Abuse Treatment Center may only bill for those procedure codes

which correspond to the allowable services included in its New Jersey Medicaid Provider approval letter.

Staple any attachments to the original claim form being submitted for payment and send to:

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

If you have any questions regarding claim preparation, please call the Prudential Insurance Company, Medicaid Claim Division II, at 609-293-2175.

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

Narcotic and Drug Abuse Treatment Centers

Billing Procedures

The following provides the basic information necessary for the proper completion and submission of a claim form (Independent Outpatient Health Facility - MC-14). Specific instructions for completing a claim form are attached.

General Policy

Billing should be done on a monthly basis and submitted for payment as soon as possible. All claims must be received by the Fiscal Agent (Prudential) no later than 90 days after the last date the services were rendered and no later than 12 months from the earliest date of service on the claim form.

Approved Services and Procedure Codes

A procedure code list is attached. Approved Centers may only bill for those procedure codes which correspond to the allowable services included in their New Jersey Medicaid Provider approval letter.

In the attached list, Procedure Codes 9000, 0001, 9006, and 9008 for examination and treatment are the same codes listed in the New Jersey Medicaid's Independent Clinic Services Manual and are used by clinics providing different services. Thus, the "NOTE" sections under these codes relate to other clinics but not necessarily to the Narcotic and Drug Abuse Treatment Centers.

The Mental Health Services Codes in the attached listing shall be performed by a Mental Health Professional as described in the New Jersey State Department of Health's Standards for Licensure for Ambulatory Care Centers. These codes include:

9180 Family Therapy Rendered in a Narcotic and Drug Abuse Treatment Center

9181 Family Conference Rendered in a Narcotic and Drug Abuse Treatment Center

9183 Psychotherapy Rendered in a Narcotic and Drug Abuse Treatment Center - Full-Session

9187 Psychotherapy Rendered in a Narcotic and Drug Abuse Treatment Center - Half Session

9184 Group Therapy Rendered in a Narcotic and Drug Abuse Treatment Center

Multiple mental health services rendered in a Narcotic and Drug Abuse Treatment Center to one individual in the same day will not be reimbursed. Only one mental health service of a like-nature will be reimbursed in those instances where more than one is provided to an individual. Mental health services provided in a Narcotic and Drug Abuse Treatment Center do not require prior authorization.

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

Narcotic and Drug Treatment Centers

Procedure Code Listing

		Medicaid Dollar Value	
		Specialist	Non-Specialist
9000	CLINIC VISIT - INITIAL - limited for reimbursement purposes to one such examination of the same recipient by the same Independent Clinic.	22.	17.

Includes as a minimum on the record:

1) Chief complaint(s)
2) Complete history of the present illness and related systemic review including recording of pertinent negative findings
3) Complete pertinent past medical history
4) Pertinent family history
5) A full physical examination pertaining to but not limited to the history of the present illness and includes recording of pertinent negative findings
6) Working diagnosis and treatment plan including ancillary services and drugs ordered.

NOTE: Reimbursement for Code 9000 will be disallowed and the fee will be downgraded to a Code 0001, provided its criteria are met, if Procedure Code 9008, 0090*, 0086*, 9580* or 9006 has been performed within a 12 month period.

NOTE: This code will be declined if claimed for a Preventive Health Care Visits for patients age 20 or less. If visit is of a preventive health care nature, use Code 9006 or 0011*. For patients age 20 or less, Item 13C of the MC-14 (Independent Outpatient Health Facility) must carry a diagnosis compatible with at least a presumptive illness and not that of preventive health care.

* These codes are not reimbursable to a Narcotic and Drug Abuse Treatment Center unless they have other provider status with Medicaid.

	Medicaid Dollar Value	
	Specialist	Non-Specialist
0001 CLINIC VISIT - consisting of care and treatment by the physician and including those procedures ordinarily performed during a clinic visit dependent upon physician's discipline. The following will be included as a minimum in the progress notes: 1) Purpose of visit 2) Pertinent history obtained 3) Pertinent physical findings including pertinent negative physical findings based on 1) and 2) 4) Procedures - if any performed - with results 5) Lab, x-ray, and ECG, etc., ordered - with results 6) Diagnosis(s) plus treatment plan status, including drugs ordered, relative to present and pre-existing illness plus pertinent recommendations and actions NOTE: This code will be declined if claimed for a Preventive Health Care Visit for patients age 20 or less. If visit is of a preventive health care nature, use Code 0011*. For patients age 20 or less, Item 13C of the MC-14 (Independent Outpatient Health Facility) claim form must carry a diagnosis compatible with at least a presumptive illness and not that of preventive health care. NOTE: It is recommended that for patients age 20 and under, a statement as to the status of immunizations, nutrition, and development be included at appropriate intervals.	9.	7.
9006 ANNUAL HEALTH MAINTENANCE EXAMINATION THROUGH AGE 20 YEARS 1) Complete initial or interval history including past medical history, family history, social history, and systemic review. 2) Developmental and nutritional assessment. 3) Complete, unclothed, physical examination to include also the following: (a) measurements: height and weight, head circumference to age 25 months, blood pressure for children age 3 or older (b) vision and hearing screening	22.	17.

*These codes are not reimbursable to a Narcotic and Drug Abuse Treatment Center unless they have other provider status with Medicaid.

9006 continued

(4) Assessment and administration of immunizations appropriate for age and need. (See appropriate procedure code(s) 9450* through 9462* for immunization reimbursement)

5) Referral for further diagnosis and treatment or follow-up of all correctable abnormalities covered or suspected.

6) Referral to a dentist for children age 3 and older.

7) Laboratory procedures performed or referred if medically necessary. Recommended are:
   (a) Hgb. three times: 6-8 months;2-3 or 4-6; and 10-12 years.
   (b) Urinalysis a minimum of twice: 18-24 months and 13-15 years consisting of a five-tests dipstick.
   (c) Tuberculin three times: 6-8 or 9-12 months; 4-6 years, and 10-12 or 13-15 years.

Medical records should substantiate the above services and should document significant positive and negative findings. Discussion and consultation with the patient or family regarding findings should be an integral part of every examination.

NOTE: Laboratory procedures analyzed 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 and/or Urine Analysis tests should be sent to the State Department of Health.

NOTE: This procedure can be used one time during any 12 month period for the same recipient by the same Independent Clinic. For other evaluations and treatment use other appropriate procedure codes. Procedure code 9006 will be disallowed if procedure code 9580*, 0086*, 9000 or 0090* has been performed during the same 12 months by the same Independent Clinic. Code 0011* could then be applicable if criteria are met.

* These codes are not reimbursable to a Narcotic and Drug Abuse Treatment Center unless they have other provider status with Medicaid.

		Medicaid Dollar Value	
		Specialist	Non-Specialist
9008	ANNUAL HEALTH MAINTENANCE EXAMINATION - (Limited to patients age 21 and over. Where applicable, use Code 9006 for individuals ages three years through age 20).	22.	17.

Includes as a minimum on the record:

1) Interval history
2) Completing or updating the pertinent past medical history, family history and social/ personal history.
3) Complete stystemic review including all systems and pertinent negative findings.
4) Complete total systems physical examination permitting the deferment of a system for medically acceptable reason, e.g., deferment of pelvic examination in an individual under the care of a gynecologist. Pertinent negative findings of the physical examination are to be recorded.
5) Working diagnosis and treatment plan, including ancillary services and drugs order, if applicable.

NOTE: No more than one Code 9008 is reimbursable per year for the same recipient by the same Independent Clinic. Code 9008 will be disallowed if procedure code 9000 or 9006 9580*, 0090*, or 0086* has been performed during the prior 12 months by the same Independent Clinic. Code 0001 could then be applicable if criteria are met.

*These codes are not reimbursable to a Narcotic and Drug Abuse Treatment Center unless they have other provider status with Medicaid.

		Medicaid Dollar Value	
		Specialist	Non-Specialist
9180	FAMILY THERAPY RENDERED IN A NARCOTIC AND DRUG ABUSE TREATMENT CENTER	22.50	

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

9181	FAMILY CONFERENCE RENDERED IN A NARCOTIC AND DRUG ABUSE TREATMENT CENTER	15.00	

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.

9182	PRESCRIPTION VISIT RENDERED IN A NARCOTIC AND DRUG ABUSE TREATMENT CENTER	4.50	

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

9183	PSYCHOTHERAPY RENDERED IN A NARCOTIC AND DRUG ABUSE TREATMENT CENTER-FULL SESSION	16.00	

Verbal, drug augmented, or other therapy methods provided by a physician, or a professional counsellor under the direction of a physician, in a personal involvement with one patient to the exclusion of other patients and/or duties. A minimum of 50 minutes personal involvement with the patient is required. This includes a prescription visit when necessary.

		Medicaid Dollar Value	
		Specialist	Non-Specialist
9187	PSYCHOTHERAPY RENDERED IN A NARCOTIC AND DRUG ABUSE TREATMENT CENTER-HALF SESSION	8.00	

Verbal, drug augmented, or other therapy methods provided by a physician, or a professional counsellor under the direction of a physician in a personal involvement with one patient to the exclusion of other patients and/or duties. A minimum of 25 minutes personal involvement with the patient is required. This includes a prescription visit when necessary

9184	GROUP THERAPY RENDERED IN A NARCOTIC AND DRUG ABUSE TREATMENT CENTER	8.00 per person	

Verbal or other therapy methods provided by one or more physicians, 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.

9185	COMPLETE PSYCHOLOGICAL TESTING RENDERED IN A NARCOTIC AND DRUG ABUSE TREATMENT CENTER	75.00	

Five hours of psychometric and/or projective tests with a written report.

9186	METHADONE TREATMENT RENDERED IN A NARCOTIC AND DRUG ABUSE TREATMENT CENTER	2.50	

A per diem payment based on the number of days a recipient is supplied methadone during the billing period. This is an all inclusive rate for cost of drug, packaging, nursing time, and administrative costs.

8927	URINE ANALYSIS FOR DRUG ADDICTION	4.50	

To be used only when Narcotic and Drug Abuse Treatment Centers are approved for this service. To determine what level, if any, a drug is present in the urine.

9076	DRAWING OF BLOOD	1.80	

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

Completion of the MC-14 (Exhibit 1)

Item 1-4 - Copy the Patient's Name, Health Services Program (Medicaid) Case Number, and Person Number EXACTLY as it appears on the Medicaid Validation Form.

Item 5 - Indicate the patient's age.

Item 6 - Check the appropriate block, to identify the patient's sex.

Item 7 - Check the appropriate block to indicate whether the patient has other health insurance, liability coverage or No Fault Auto Coverage. If you are aware that the other coverage will not cover the services provided, please indicate so on the claim form.

- If yes, attach a copy of the decline notice or a copy of the explanation of payment from the Carrier.

Item 8 - Leave blank.

Item 9 - If not preprinted, write in the provider's name, address, and provider number.

- Enter the telephone number.

Item 10 - Check as appropriate.

- If patient's illness or injury is work related, enter the name and address of employer.

- Indicate whether injury resulted from an automobile accident.

Item 11 - Leave blank.

Item 12 - Do not write in this space; for Division use only.

Item 13.A - Enter date(s) of each visit.

13.B - Enter procedure code. Your procedure codes are listed in your approval letter.

13.C - Enter diagnosis.

13.D - Describe procedure or service.

13.E - Leave blank

13.F - Enter your standard charge for the appropriate service.

Item 14 - If patient was referred to the clinic, you must indicate the name and Individual Medicaid Practitioner (IMP) Number of referring practitioner. For non-Medicaid participating practitioners, enter "Non-Par."

Item 15 - This item must be completed.

- Enter the name and Individual Medicaid Practitioner (IMP) Number of the practitioner who actually performed the service.

Item 16 - Leave blank.

Item 17 - Under ordinary circumstances, the patient must sign the claim form when services have been received.

- The claim form to be signed shall indicate services rendered. The patient must not sign a blank claim prior to receiving services or as a condition for receiving services.

- However, when the patient's signature is unobtainable, the following procedures may be used.

i. Illiterate patient

The patient may sign by mark (X) and the signature must be witnessed by another person, (including the provider of services) who signs his name and address on the same line.

ii. Other

If a patient is physically or mentally incapable of signing, a minor child, deceased, or for other reasons his signature is not obtainable through reasonable efforts, 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 a governmental agency providing assistance.

III. Attached to the claim form or written directly on the form should be a brief explanation of the reason the patient was not personally able to sign and the the relationship of signee to the patient-recipient.

Item 18 - Read the Provider Certification carefully. The provider must sign the MC-14 before the claim can be considered for payment.

- 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

INDEPENDENT OUTPATIENT HEALTH FACILITY

Please Print

SAMPLE

08

1 Patient's Last Name	First Name	2 Patient's Street Address	Telephone Number
Doe	Susan	11 Common Place	777-1111

HSP (Medicaid) Case No.	4 Patient Person No.	5 Age	6 Sex	City	State	Zip Code
3 2 0 9 0 0 9 9 9	0 1	17	☐ Male ☒ Female	Burlington, N. J.		08554

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

8 Was this service performed as a result of an EPSDT Program Referral?
Yes ☐ No ☐

10 Was Patient's Illness or Injury connected with employment?
If Yes give Name and Address of Employer here
☐ Yes ☒ No
Did injury result from automobile accident? ☐ Yes ☒ No

9 PROVIDER OF SERVICE INFORMATION

Telephone Number: 777-2222

Medicaid Provider Number (enter only when not printed below): 000xxxxxx xxx

Name and Address:
Drug Treatment Ctr.
119 W. Street
Burlington, N. J. 08554

11 Prior Authorization Number

12 PRIOR AUTHORIZATION - FOR DIVISION USE ONLY

AUTHORIZING SIGNATURE Date

13 REPORT OF SERVICES

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
12/10/84	9000	Drug Dependence	Initial Visit		XX.XX

14 Referring Practitioner's Name

Individual Medicaid Practitioner Number

Total Charges $ XX.XX

16 Operating Practitioner's Name

Individual Medicaid Practitioner Number

15 Attending Practitioner's Name
Dr. Smith 12345678A
Individual Medicaid Practitioner Number

16a. Physician Case Manager

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) ✓ Susan Doe Date Signed 12/10/84

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 John Q Public Billing Date 12/11/84 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

Patient's Name	HSP No.	PP

Physician or Supplier ☐ Non-Spec. ☐ Spec_____area

Referred to: Date:

PLEASE VERIFY:

- ☐ Diagnosis
- ☐ PRV-Anesthesia-Asst. Surgeon
- ☐ Referring Physician
- ☐ Need Prior Auth.
- ☐ 65 or Over
- ☐ Date(s) of Service
- ☐ Breakdown
- ☐ Service Rendered
- ☐ Charge(s)
- ☐ Breakdown of
- ☐ If Doctor did Laboratory work
- ☐ HSP #
- ☐ P.P. #
- ☐ Place of Service
- ☐ Other
- ☐ See memo
- ☐ Need Signature
- ☐ Provider
- ☐ Patient
- ☐ Provider #
- ☐ Over 90 Days
- ☐ Prescription
- ☐ Approve Jam Code
- ☐ Time
- ☐ Anes.
- ☐ Psych.

charge for: _____

☐ Eligible? ☐ Reasonable?

Referring Individual's Identification _____

Claim Examiner _____ Date _____

The Prudential

MEDICARE / MEDICAID BULLETIN

85-1
Volume P-417

March 29, 1985

REC'D APR 17 1985

TO: All Providers

SUBJECT: Procedure Coding System

The Prudential Insurance Company and the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (the Division), on behalf of the Medicare and Medicaid programs, announce the implementation, as of September 1, 1985, of a new procedure coding system known as HCPCS (Health Care Financing Administration's Common Procedure Coding System).

HCPCS was developed to replace various existing systems with a single national reimbursement coding system and to satisfy operational needs for processing fee-for-service claims. HCPCS will afford providers access to a single coding system used by Medicare, Medicaid, Blue Shield and other third-party payers.

DESIGN AND STRUCTURE OF HCPCS

HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology-4th Edition (CPT-4) architecture, employing a five-position code and as many as two 2-position modifiers. Unlike the CPT-4 numeric design, the HCFA assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three-level coding system.

a) Level I Codes

These codes are adopted from CPT-4 and are to be utilized primarily by physicians and independent laboratories. Physicians and laboratories are advised to purchase copies of CPT-4 in advance of September 1, 1985. Copies are available from:

Order Department - OP-341-5
American Medical Association
P.O. Box 10946
Chicago, Illinois 60610

b) Level II Codes

These codes are assigned by HCFA for physicians and non-physician services which are not in the CPT-4; for example, optical appliances, durable medical equipment, prosthetics and orthotics, etc.

c) Level III Codes

These codes are assigned by Prudential and the Division to be used for those services not identified by CPT-4 codes or HCFA-assigned codes. Level III codes identify services unique in definition to New Jersey.

IMPLEMENTATION OF HCPCS:

In advance of the September 1, 1985 implementation of HCPCS, additional instructions to providers will be available as follows:

a) All pinfeed and EMC billers on record with Prudential will receive systems-related instructions to accommodate HCPCS codes. These instructions will be mailed in the early part of April.

b) Seminars will be held for Medicare and Medicaid providers in July and August to further acquaint providers on HCPCS and their use.

c) Medicaid enrolled providers will receive a newsletter listing HCPCS codes applicable to them.

d) Staff of Prudential and the Division will be available to assist providers on an on-going basis.

e) Medicare claims submitted with CPT-4 codes will be accepted as of April, 1985.

SUMMARY

With the implementation of the HCPCS coding system, Prudential and the Division of Medical Assistance and Health Services, in conjunction with the AMA and HCFA, anticipate significant benefit to both the Medicare and Medicaid programs as well as to providers of service who participate in these programs. Through HCPCS, claims preparation and claims processing will be simplified and result in a unified format to identify services rendered to beneficiaries and eligible individuals.

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

REC'D MAY 1 1985

New Jersey Health Services Program NEWSLETTER

Volume P-418

May 6, 1985

TO: ALL PHYSICIANS, INDEPENDENT CLINICS AND HOSPITAL ADMINISTRATORS

SUBJECT: REVISED FEES FOR THE LISTED IMMUNIZATION SERVICES

EFFECTIVE: FOR ALL CLAIMS PROCESSED ON OR AFTER MAY 6, 1985

BACKGROUND: Due to the change in cost for certain vaccines, the New Jersey Medicaid Program has revised the fee schedule for the immunizations listed in this Newsletter.

ACTION: The procedure codes and corresponding fees listed below are effective for all claims processed on or after May 6, 1985.

Procedure Code	Description	Medicaid Dollar Value
9075	RHO(D) Immune Globulin (Human) (Microdose for Abortions and Miscarriages)	42.40
9450	Immunization - Measles	10.25
9451	Immunization - Rubella	10.65
9452	Immunization - Mumps	11.55
9453	Immunization - Measles & Rubella combined vaccine (M&R)	15.35
9454	Immunization - Measles, Mumps & Rubella combined vaccine (MMR)	22.15
9455	Immunization - Diphtheria, Pertussis & Tetanus combined vaccine (DPT)	5.86
9456	Immunization - Diphtheria & Tetanus Toxoid combined vaccine (DT)	4.65
9457	Immunization - Diphtheria Toxoid	4.90

9459	Immunization - Tetanus Toxoid	3.90
9460	Immunization - Oral polio vaccine	7.10
9461	Immunization - Pneumococcal vaccine polyvalent	9.25
9462	Immunization - Rubella & Mumps combined vaccine	16.50
9445	Immunization - Influenza	4.70
9446	Immunization - Tetanus Antitoxin	5.45

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) 984-3341.

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

REC'D MAY 28 1985

New Jersey Health Services Program NEWSLETTER

Volume P-419

May 20, 1985

To: All Providers

Subject: Medicaid District Office Directory Update and Warren County MDO Jurisdiction Transfer

Effective: June 1, 1985

The Division of Medical Assistance and Health Services is issuing this newsletter to inform the providers of medical services of recent staff changes in the Medicaid District Offices.

For your convenience, attached to this newsletter is an updated Medicaid District Office directory complete with staff changes, addresses and telephone numbers.

Please note, effective June 1, 1985, Warren County Medicaid recipients will be under the jurisdiction of the Morris County Medicaid District Office. All correspondence and questions about any medical service rendered to a Medicaid eligible resident of Warren County is to be directed to:

Morris Medicaid District Office
10 Park Place, 4th Floor
Morristown, New Jersey 07960
(Telephone 201-267-1700)

If you have any questions regarding this newsletter, contact the Medicaid District Office serving your area.

REC'D MAY 28 1985

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

MEDICAID DISTRICT OFFICE		ADDRESS AND TELEPHONE NUMBER
Atlantic	William Underland, Director	1 S. New York Avenue Atlantic City, NJ 08401 Tel. 609-441-3620
Bergen	Alphonse Leone, Director	50 Main Street Hackensack, N.J. 07601 Tel. 201-488-5667
Burlington*	Helen Kern, Director Daniel Walsky, Regional Director	50 Rancocas Road Mt. Holly, N.J. 08060 Tel. 609-261-0448
Camden	Ronald Coppola, Director	Parkade Building, Rm. 207 519 Federal St. Camden, N.J.08101 Tel. 609-757-2870
Cumberland (Cape May)	Thomas Daning, Director	108 Landis Avenue Vineland, N.J. 08360 Tel. 609-696-6560
Essex	John T. Russell, Director A. Bialogowicz, Ass't Regional Director	155 Washington Street Newark, N.J. 07102 Tel. 201-648-2470, 648-3700
Gloucester (Salem)	Eleanor Chatzinoff, Director	251 N. Delsea Drive Woodbury Plaza, Suite B Deptford, N.J. 08096 Tel. 609-845-7185
Hudson	Alice Rooth, Director	2815 Kennedy Blvd. 2nd Floor Jersey City, N.J. 07306 Tel. 201-433-8011
Hunterdon (Somerset)	Daniel Cooperson, Director	84 Park Avenue, 2nd Floor Flemington, N.J. 08822 Tel. 201-782-1130
Mercer	William Bailey, Director	28 West State Street Rm. 1105 Trenton, N.J. 08608 Tel. 609-292-7315
Middlesex*	Thomas Rafferty, Director Walter Maibach, Regional Director	75 Paterson Street (basement) New Brunswick, N.J. 08903 Tel. 201-246-0653
Monmouth	Frances Garrett, Director	1200 Memorial Drive Asbury Park, N.J. 07712 Tel. 201-775-5700
Morris* (Sussex & Warren)	Marie Reed, Director John Langan, Regional Director	10 Park Place, 4th Floor Morristown, N.J. 07960 Tel. 201-267-1700
Ocean	Dennis Doderer, Director	1861 Hooper Avenue Toms River, N.J. 08753 Tel. 201-255-6226
Passaic	Raphaelle Andriola, Director	100 Hamilton Plaza (Market Street) 9th Floor, Paterson, N.J. 07505 Tel. 201-977-4077
Union	John Baxter, Director	125 Broad St., 6th Floor, Hersh Towers Elizabeth, N.J. 07201 Tel. 201-820-3135

* Denotes office where the Regional Director can be reached.
(rev. 4/85)

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STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

REC'D MAY 14 1985

New Jersey Health Services Program NEWSLETTER

Volume P-420

May 15, 1985

TO: ADMINISTRATORS OF DIAGNOSIS RELATED GROUP (DRG) HOSPITALS

SUBJECT: PAYMENT FOR HOSPITAL PATIENTS AWAITING PLACEMENT IN A LONG-TERM CARE FACILITY AT SKILLED NURSING OR INTERMEDIATE LEVEL OF CARE

EFFECTIVE: JANUARY 1, 1985

BACKGROUND: The New Jersey Medicaid Program is obligated to follow the federal law (1861(v)(1)(G)) and regulations (42 CFR 447.253(b)-(1)(B)) which require that the hospital rate of reimbursement reflect the level of care actually received. This revises the information presented under "Background" in the Newsletter Volume either P-381 or BC-273, dated January 30, 1984, under same subject, whereby the hospital was reimbursed at one rate whether the care provided was at the SNF or ICF level. All other information contained in the January 30th Newsletter remains in effect.

PURPOSE: This newsletter is to officially inform hospitals that the New Jersey Medicaid Program reimburses for services provided to hospitalized patients, who no longer require the acute level of care, at a rate commensurate with the patient's level of care while awaiting placement in a long-term care facility. Payment is the statewide weighted average rate for SNF (Skilled Nursing Facility) or ICF (Intermediate Care Facility) based on the appropriate level of care as assessed by the Professional Review Organization of New Jersey.

ACTION: Effective since January 1, 1985, hospitals are reimbursed on the basis of a statewide weighted average SNF or ICF rate for all patient days identified by the Professional Review Organization of New Jersey, or the hospital itself, as requiring SNF or ICF level of care. The weighted average New Jersey Medicaid SNF and ICF per diem rates, effective January 1, 1985, are as follow:

SNF	ICF
$ 59.03	$ 52.32

Please refer any questions regarding this Newsletter to your Fiscal Agent:

Blue Cross---------- (201) 456-2570 or 456-2534

Prudential---------- (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-421

May 28, 1985

REC'D JUN 6 1985

TO: DENTISTS, HOSPITALS, INDEPENDENT CLINICS

SUBJECT: DELAY OF CONVERSION OF CURRENT DENTAL CODES TO HCPCS (HEALTH CARE FINANCING ADMINISTRATION'S COMMON PROCEDURE CODING SYSTEM)

The New Jersey Medicaid Program wishes to inform all dentists and other providers of dental services that the New Jersey Medicaid Program's dental procedure codes currently in use will not convert to HCPCS on September 1, 1985.

This is a change from the information provided on Procedure Coding System (HCPCS) distributed to all providers in the Medicare/Medicaid Bulletin dated March 29, 1985. That Bulletin announced that HCPCS would be implemented on September 1, 1985 for all providers who submit claims on a fee-for-service basis. Dental services are now eliminated from that implementation schedule for HCPCS.

Dentists and other providers of dental service will be notified in the future when anticipated changes to the HCPCS dental codes are finalized and new plans for implementation are initiated.

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

REC'D JUN 14 1985

New Jersey Health Services Program NEWSLETTER

Volume P-422

June 17, 1985

TO: PODIATRISTS

SUBJECT: REIMBURSEMENT FOR BOARD CERTIFICATION IN SURGERY AND ORTHOPEDICS

EFFECTIVE: FOR ALL CLAIMS PROCESSED ON OR AFTER JULY 1, 1985

PURPOSE: This Newsletter is to inform Podiatrists that the New Jersey Medicaid Program will recognize for reimbursement purposes, specialists who are Board Certified in Surgery and/or Orthopedics.

BACKGROUND: The New Jersey Medicaid Program defines a Specialist as a Diplomate of the Specialty Board as recognized by the American Podiatry Association or one who has been notified of admissibility to examination by the Specialty Board as recognized by the American Podiatry Association.

ACTION: A Podiatrist who desires reimbursement as a Specialist in Podiatric Surgery or Orthopedics must submit the following documentation to The Prudential Insurance Company, Provider Enrollment Unit, P.O. Box 1900, Millville, New Jersey, 08332:

i. A copy of the Specialty certificate/permit issued by the Board as recognized by the American Podiatry Association, or

ii. A copy of the notification of admissibility to examination by the Board as recognized by the American Podiatry Association.

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-423

June 17, 1985

To: All Providers

Subject: Demonstration Project Update - Medicaid Personal Physician Plan (MP Plan)

Background: The New Jersey Medicaid Program began implementing a four year Statewide Demonstration Project called the Medicaid Personal Physician Plan (MP Plan) in July 1983. This voluntary program is offered in conjunction with the existing New Jersey Medicaid Program. In Phase I and II, the MP Plan was introduced in Morris, Sussex, Warren, Atlantic, Burlington, Camden, Mercer and Middlesex Counties. Also, in an effort to gain experience in the major urban areas of the State and because of the interest of community health centers and other providers, small "out-of-phase" projects were initiated in Essex, Passaic and Union Counties.

Phase III of the Demonstration Project will begin July 1985, and will include the remainder of the counties in the State which are Bergen, Cape May, Cumberland, Gloucester, Hudson, Hunterdon, Monmouth, Ocean, Salem and Somerset.

Purpose: This newsletter is intended to reiterate some of the basic concepts of the MP Plan in an effort to avoid claim rejections and unnecessary delays in reimbursement.

Medicaid Validation and MP Plan Identification Cards

When providing services and requesting payment for services rendered MP Plan members, always check the Medicaid eligibility validation card. A message "Valid Only With MP Plan Card" will be printed on the Medicaid Eligibility Identification Card (FD73/178) issued to SSI and DYFS Medicaid eligibles enrolled as MP Plan members. This message will also appear on the Department of Human Services Medicaid ID Card issued to AFDC and "Medicaid Only" eligibles enrolled as MP Plan members. If the eligibility card carries this message, "Valid Only With MP Plan Card", you must ask to see the MP Plan Identification Card. The member's name, physician's (case manager) name and telephone number are listed on the card.

Referral Forms

In addition, as providers must have approval from the Physician Case Manager (PCM) before providing services covered under the MP Plan and included in the capitation rates, this newsletter will serve as a reminder to all providers that the MP Plan Referral Forms must be used when ordering and/or providing services. A copy of each form is attached to the newsletter.

The MP-6 Form, Ancillary/Treatment Services Referral, must be used for all ancillary services referred, and the MP-7, Referral Services Form, must be used for all services referred, except dental services. The MP-7 form is of particular importance should a question arise as to whether or not the referral was ever authorized. The MP-7 will serve as a "proof document". Without it, the referral provider may not be reimbursed for services rendered or the PCM may have it deducted from his "referral services account". The first copy of the MP-7 is retained by the PCM; the second and third copies are sent to the referral provider, who then will complete the form with his consultation. The referral provider retains one copy and returns one copy to the PCM.

Authorization for Services

All claims submitted for services rendered MP Plan members must verify authorization from the Physician Case Manager by entering the PCM's name and Individual Medicaid Practitioner's number (IMP) on the claim form even if there is Medicare or other insurance involvement.

Do not enter the IMP number on the claim form without the PCM's authorization for each service, each encounter. The practice of entering the IMP number without proper authorization will be investigated and appropriate action taken.

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 requires prior authorization (from the Division of Medical Assistance and Health Services) will be rejected for payment, unless approved by the PCM, and the PCM's name and IMP number is included in the designated space on the appropriate claim form.

If you have any questions regarding this newsletter, contact S. Eugene Yuliano, M.D., Medical Director, Division of Medical Assistance and Health Services, CN-712, Trenton, New Jersey 08625.

The Prudential

REC'D JUN 18 1985

MEDICARE / MEDICAID BULLETIN

85-2
Volume P-424

May 28, 1985

TO: ALL Providers (except Dentists)

SUBJECT: HCPCS - Medicare/Medicaid Workshops

The Prudential Insurance Company in cooperation with the New Jersey Department of Human Services, Division of Medical Assistance and Health Services will conduct a series of Medicare/Medicaid workshops at various locations throughout the State during July and August, 1985. All office staff members responsible for billing under these programs are invited to attend.

The purpose of these workshops is to introduce and explain the HCFA Common Procedure Coding System (HCPCS), which will be implemented by both Programs in New Jersey on September 1, 1985. Emphasis will be placed on the application of HCPCS in the provider billing process for both Medicare and Medicaid claims submission.

Refreshments will be served at 8:30 a.m., with the program beginning promptly at 9:00 a.m., and concluding between 11:15 a.m. and 12:30 p.m., depending on the location. A formal Medicare and Medicaid panel presentation will be given, followed by a question and answer session. We urge you to attend the site most convenient for you.

Please complete the attached registration form and return it as soon as possible to assist us in making the necessary arrangements for each workshop. The Workshop Schedule with dates, times and locations is also attached. If you have any questions concerning registration, contact Joan Wynn - Telephone Number: (609) 653-2710.

Attention MediCAID Providers

1. Medicaid Provider Manual supplements for use with HCPCS codes will be sent to you in late June. Please review this manual material in advance of the selected workshop meeting.

2. PLEASE NOTE: Physicians, Podiatrists, Optometrists, Certified Nurse Midwives, Independent Laboratories, and Independent Clinics

   To determine the narratives for Level 1 codes used in your specialty, it is necessary to refer to CPT-4 (Physician's Current Procedural Terminology Fourth Edition). Copyright restrictions make it impossible to print excerpts from it. A copy of the 1985 edition of CPT-4 may be ordered from:

   Order Department OP-341-5
   American Medical Association
   P.O. Box 10946
   Chicago, Illinois 60610

Attachments

WORKSHOP SCHEDULE

DATE	TIME	CITY	LOCATION
July 9	8:30 a.m.-12:30 p.m.	Saddle Brook	Treadway Inn - 50 Kenney Place (Interchange Rt. 80 and Garden State Parkway, Exit 159)
July 10	8:30 a.m.-11:15 a.m.	Roseland	Prudential Insurance Company 55 N. Livingston Avenue (Exit 5B off Rt. 280 North) Use parking lots J, K, & L at rear of building.
July 11	8:30 a.m.-12:30 p.m.	North Brunswick	BaCar's Quality Inn - U.S. Hwy No. 1 (½ mile south of Rt. 130)
July 16	8:30 a.m.-12:30 p.m.	Blackwood	Camden Community College Lincoln Hall Auditorium College Drive (Little Gloucester Road)
July 17	8:30 a.m.-12:30 p.m.	Vineland	Presidential Motor Lodge Washington Room-Delsea Drive (Rt. 47 & Landis Avenue)
July 25	8:30 a.m.-12:30 p.m.	Princeton	Center for Health Affairs Auditorium-760 Alexander Rd. (Off U.S. Hwy 1)
July 30	8:30 a.m.-11:15 a.m.	Linwood	Prudential Insurance Company Route 9, New Road
August 6	8:30 a.m.-11:15 a.m.	Roseland	Prudential Insurance Company 55 N. Livingston Avenue (Exit 5B off Rt. 280 North) Use parking lots J, K, & L at rear of building.
August 8	8:30 a.m.-12:30 p.m.	Toms River	Holiday Inn - 290 State Hwy. 37 East (Exit 82 from Garden State Parkway)

PRE-REGISTRATION FOR MEDICARE/MEDICAID WORKSHOP

I (we) wish to attend the workshop which will be held in:

_____ _____
(CITY) (DATE)

NAME(S) _____

_____

_____

REPRESENTING _____
MD DO DC DPM OTHER

OFFICE ADDRESS _____

_____

OFFICE TELEPHONE
NUMBER _____

Please complete this form if you plan to attend and mail it without delay to:

Joan Wynn
Medicare Claim Division II
Prudential Insurance Company
P.O. Box 2222
Linwood, NJ 08221

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

REC'D JUL 1 1985

New Jersey Health Services Program NEWSLETTER

Volume P-425

June 24, 1985

TO: Providers of Invalid Coach and Ambulance Services

SUBJECT: LICENSURE of Invalid Coach and Ambulance Services by the New Jersey State Department of Health

EFFECTIVE: October 1, 1985

PURPOSE: This letter informs providers of Invalid Coach and Ambulance services that effective October 1, 1985, they must be licensed in order to be eligible for participation as providers under the New Jersey Medicaid Program.

BACKGROUND: The New Jersey Administrative Code stipulates that providers of Invalid Coach and Ambulance services must meet the requirements of the New Jersey State Department of Health when standards and a licensing program are developed and adopted.

The New Jersey State Department of Health proposed a new rule (N.J.A.C. 8:40), Manual of Standards for Licensure of Invalid Coach and Ambulance Services in the New Jersey Register on November 19, 1984, which was adopted on April 15, 1985.

ACTION: EFFECTIVE ON OCTOBER 1, 1985, THE NEW JERSEY MEDICAID PROGRAM WILL PROCESS AND REIMBURSE CLAIMS ONLY FOR PROVIDERS WHO ARE DULY LICENSED.

The New Jersey State Department of Health has advised the New Jersey Medicaid Program that for the period April 15, 1985 to September 30, 1985, providers may continue to render transportation services while the Department of Health proceeds to implement the licensing regulations and procedures.

The New Jersey Medicaid Program will not pay for services rendered by an unlicensed provider of Invalid Coach or Ambulance services after September 30, 1985.

Providers who have not already applied for licensure to the New Jersey State Department of Health are advised to do so immediately. When license certification is received, the provider must submit a copy of the certification to:

Prudential Insurance Company
Provider Enrollment
P. O. Box 471
Millville, New Jersey 08332

A provider will continue to receive reimbursement for claims submitted only if the licensure process is completed by October 1, 1985.

If you have any questions about this Newsletter, please contact Peter K. Rosswaag at 609-984-7868.

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-426 June 28, 1985

To: PHYSICIANS

SUBJECT: HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

EFFECTIVE: September, 1, 1985

As announced in the Medicare/Medicaid Bulletin 85-1, Vol. P-417, the New Jersey Medicaid Program will implement HCPCS on September 1, 1985. ALL CLAIMS SUBMITTED ON OR AFTER SEPTEMBER 1, 1985 MUST INCLUDE APPLICABLE HCPCS CODES.

Attached is a new Subchapter 4, Ed. 4-85, New Jersey Medicaid's Physician Services Manual, which provides HCPCS information. It includes the following:

1. HCPCS Code Numbers (activated by New Jersey Medicaid) and Maximum Fee Schedule.

2. Codes and narratives not found in CPT-4 (Level II and Level III Codes). (Please note: To determine narratives for Level I Codes, it is necessary to refer to CPT-4 (Physicians' Current Procedural Terminology Fourth Edition). A 1985 edition may be ordered from: Order Department OP-341-5, American Medical Association, P.O. Box 10946, Chicago, Illinois, 60610.)

There is no change in the New Jersey Medicaid Program's reimbursement schedule for physician services. However, since code numbers, narratives, qualifications to codes and reimbursement are presented in a different format, all the material should be read carefully.

Any questions you have relevant to the implementation of HCPCS should be addressed at the Medicare/Medicaid workshops scheduled throughout the State during July and August (See Medicare/Medicaid Bulletin, 85-2, Vol. P-424, dated May 28, 1985).

Manual Maintenance: The enclosed material, Subchapter 4, ED. 4-85, of the Physicians Services Manual replaces PROCEDURE CODE MANUAL , Ed. 12/82. All numerical designations in Subchapter 4 conform with submission requirements of the New Jersey Administrative Code (N.J.A.C.) to facilitate legal reference and cross reference. Chapter II and III of the Physicians Services Manual will be similarly renumbered when they are revised and distributed at a later time.

The following is an addendum to the enclosed material (Laboratory Section): If any two of the following HCPCS procedure codes are performed on the same day by automated equipment and the total reimbursement of the two chemistry tests would have exceeded $7.50, the maximum reimbursement will not be more than $7.50: 82251, 82374, 82801, 83540, 83545, 83610, 83615, 83620, 83629, 83631, 84075, 84078, 84080, 84132, 84133, 84295, 84300, 84478, 82977, W8215.

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

New Jersey Health Services Program NEWSLETTER

Volume P-427 June 28, 1985

To: PROVIDERS OF VISION CARE SERVICES

Subject: HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

Effective: September 1, 1985

As announced in the Medicare/Medicaid Bulletin 85-1, Vol. P-417, the New Jersey Medicaid Program will implement HCPCS on September 1, 1985. ALL CLAIMS SUBMITTED ON OR AFTER SEPTEMBER 1, 1985 MUST INCLUDE THE APPLICABLE HCPCS CODES.

Attached is a new Subchapter 4, Ed. 4-85, New Jersey Medicaid's Vision Care Services Manual, which provides HCPCS information. It includes the following:

1. HCPCS Code Numbers (activated by New Jersey Medicaid) and Maximum Fee Schedule (excluding optical appliances).

2. Codes and narratives not found in CPT-4 (Level II and Level III Code). (Please note: To determine narratives for Level I Codes, it is necessary to refer to CPT-4 (Physicians' Current Procedural Terminology Fourth Edition). A 1985 edition may be ordered from: Order Department OP-341-5, American Medical Association, P.O. Box 10946, Chicago, Illinois, 60610.)

There is no change in the New Jersey Medicaid Program's reimbursement schedule for vision care services. However, since code numbers, narratives, qualifications to codes, and reimbursement (excluding optical appliances) are presented in a different format, all the material should be read carefully.

Any questions you have relevant to the implementation of HCPCS should be addressed at the Medicare/Medicaid workshops scheduled throughout the State during July and August (See Medicare/Medicaid Bulletin, 85-2, Vol. P-424, dated May 28, 1985).

Manual Maintenance: The enclosed material, Subchapter 4, Ed. 4-85, replaces the PROCEDURE CODE MANUAL, Ed. 12/82, and Chapter V - Optical Appliance Codes, Rev. 8/74. All numerical designations in Subchapter 4 conform with the submission requirements for the New Jersey Administrative Code (N.J.A.C.) to facilitate legal reference and cross reference. Chapter II, III and IV of the Vision Care Services Manual will be similarly renumbered when they are revised and distributed at a later time.

SUBCHAPTER 4. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

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APPENDIX A - PROFESSIONAL VISION CARE SERVICE CODES AND NARRATIVES NOT FOUND IN CPT-4 (LEVEL II AND LEVEL III CODES)

APPENDIX B - QUALIFIERS FOR PROFESSIONAL VISION CARE SERVICES

4.4 HCPCS CODES FOR OPTICAL APPLIANCES

(a) Lens Dispensing Fees

(b) Frames

(c) Single Vision Lenses, Glass or Plastic

(d) Bifocal Lenses, Glass or Plastic

(e) Trifocal Lenses, Glass or Plastic

(f) Variable Sphericity Lenses

(g) Contact Lenses

(h) Low Vision Aids

(i) Prosthetic Eyes

(j) Intraocular Lenses

(k) Miscellaneous

SUBCHAPTER 4. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:62-4.1 INTRODUCTION

(a) The New Jersey Medicaid Program utilizes the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology - 4th Edition (CPT-4) architecture, employing a five-position code and as many as two 2-position modifiers. Unlike the CPT-4 numeric design, the HCFA assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three-level coding system.

1. LEVEL I CODES (Narratives found in CPT-4)

   These codes are adapted from CPT-4 for utilization primarily by Physicians, Podiatrists, Optometrists, Certified Nurse-Midwives, Independent Clinics and Independent Laboratories. CPT-4 is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians.

   Copyright restrictions make it impossible to print excerpts from CPT-4 procedure narratives for Level I codes. Thus, in order to determine those narratives it is necessary to refer to CPT-4.

2. LEVEL II CODES (Narratives found in Appendix A)

   These codes are assigned by HCFA for physicians and non-physician services which are not in CPT-4. Level II codes are listed in APPENDIX A of each section.

3. LEVEL III CODES (Narratives found in APPENDIX A)

   These codes are assigned by the Division and the Prudential Insurance Company to be used for those services not identified by CPT-4 codes or HCFA-assigned codes. Level III codes identify services unique to New Jersey. These codes are listed in Appendix A of each section.

(b) The HCPCS codes listed in this Subchapter 4. are divided into two sections: HCPCS Codes for professional services are in section 4.3; for optical appliances, in section 4.4.

(c) GENERAL POLICIES REGARDING USE OF HCPCS FOR SERVICES AND PROCEDURES

Listed below are some of the general policies of the New Jersey Medicaid Program regarding HCPCS. Specific information concerning the responsibility of the vision care provider when rendering professional services and requesting reimbursement is listed in Subchapter 1. (Basis of Payment); for optical appliances, Subchapter 2. (Basis of Payment). Billing procedures are found in Subchapter 3.

1. When filing a claim, the HCPCS codes, including the referenced qualifiers and modifiers, must be used in conjunction with the narratives in CPT-4 or Appendix A, whichever is applicable.

2. The use of a procedure code will be interpreted by the New Jersey Medicaid Program as evidence that the practitioner personally furnished, as a minimum, the service for which it stands.

3. For purposes of reimbursement, an optometrist and/or physician; optometrists' and/or physicians' group; shared health care facility; or providers sharing a common record are considered a single provider.

4. When billing, the provider must enter into the procedure code column of space 24-D of claim form 1500-N.J. a CPT/HCPCS code as listed in CPT-4 or this Subchapter 4. If an appropriate code is not listed, place an "N/A" (not applicable) in the procedure code column and submit a narrative description of the service. If possible, insert into space 24-D a CPT code closest to the narrative description you have written.

5. For reimbursement purposes, when reference is made to any of the following services it is understood that they were performed by the optometrist or physician submitting the claim:

i. Office, Hospital, Nursing Home, or Sheltered Boarding Home Visits.

ii. Any and all parts of a history or eye examination.

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

i. Reviewed the patient's medical history <u>with the patient</u> and/or his family, depending upon the medical situation.

ii. Performed an eye examination.

iii. Confirmed or revised the diagnosis.

iv. Visited and examined the patient on the days for which a claim for reimbursement is made.

7. The billing physician's or optometrist's involvement must be clearly demonstrated in notes reflecting his/her personal involvement with the service rendered. This refers to those occasions when these notes are written into the medical record by interns, residents, other house staff members, or nurses. A <u>countersignature</u> alone is not sufficient.

8. Date(s) of service(s) must be indicated on the claim form and in the practitioner's own record for each service billed.

9. When submitting a claim, the practitioner must always use his/her usual and customary fee. The Medicaid dollar value designated for the HCPCS codes represents the New Jersey Medicaid Program's maximum payment for the given procedure.

i. All references to time parameters shall mean the physician's or optometrist's time in reference to the service rendered unless it is otherwise indicated.

10:62-4.2 ELEMENTS OF HCPCS CODING SYSTEM WHICH REQUIRE ATTENTION OF PROVIDER

(a) The lists of HCPCS codes for vision care services are arranged in tabular form with specific information for a code given under columns with titles such as: "IND", "HCPCS CODE", "MOD", "DESCRIPTION", and "MEDICAID DOLLAR VALUE". The information given under each column is summarized below:

COLUMN TITLE	
IND	(Indicator-Qualifier) Lists alphabetic symbols used to refer provider to information concerning the New Jersey Medicaid Program's qualifications and requirements when a procedure or services HCPCS code is used. Explanation of indicators and qualifiers used in this column are given below: "L" indicates that the complete narrative for the code is located in Appendix A at the end of Section 4.3. "N" indicates that the narrative of the code is limited or qualified in some manner. These qualifications are listed by procedure code in Appendix B at the end of Section 4.3. "P" indicates that prior authorization is required. (See Subchapter 1. and 2.) "R" indicates a factor necessary in a lens prescription. For proper reimbursement, the code must be listed on the claim form (MC-9) in addition to the basic lens code.
HCPCS CODE	Lists the HCPCS code numbers for professional services and vision care appliances.
MOD	Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid Program's recognized modifier codes for vision care are as follows:

MODIFIER CODE	DESCRIPTION
AP	Determination of "Refractive State" was not performed in the course of diagnostic ophthalmological examination.
YF	Optical Frame Service Fee: To be used when patient supplies his/her own Medicaid plastic frame

DESCRIPTION — Lists the code narrative. (Narratives for Level I codes are found in CPT-4. Narratives for Level II and Level III codes are found in Appendix A at the end of Section 4.3.)

MEDICAID DOLLAR VALUE — Lists New Jersey Medicaid Program's reimbursement schedule for specialists and non-specialist. If the symbols "B.R." (By Report) are listed instead of a dollar amount, it means that additional information will be required in order to properly evaluate the service. Attach a copy of the report to the 1500-N.J. claim form. For information concerning reimbursement of optical appliances, refer to Subchapter 2.

1. ALPHABETIC AND NUMERIC SYMBOLS UNDER "IND" & "MOD"

These symbols when listed under the "IND" and "MOD" columns are elements of the HCPCS coding system used as qualifiers or indicators (as in the "IND" column) and as modifiers (as in the "MOD" column). They assist the provider in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

i. These symbols and/or letters must not be ignored because in certain instances requirements are created in addition to the narrative which accompanies the CPT/HCPCS code. The provider will then be liable for the additional requirements, and not just the code narrative. These requirements must be fulfilled in order to receive reimbursement.

ii. If there is no identifying symbol listed, the CPT/HCPCS code narrative prevails.

(b) For surgical codes relevant to Ophthalmologists see Physicians Manual, Subchapter 4.

10:62-4.3 PROFESSIONAL VISION CARE SERVICES - HCPCS CODE NUMBERS AND MAXIMUM FEE SCHEDULE

*IND.	HCPCS CODE	MOD	MEDICAID DOLLAR VALUE S	NS
N	92002		22.00	-
N	92004		26.00	-
N	92012		22.00	-
N	92014		26.00	-
N	90050		9.00	-
N	90060		9.00	-
N	90070		9.00	-
N	92020		15.00	-
N	92065		10.00	-
N	92081		8.00	-
N	92082		8.00	-
N	92083		8.00	-
N	92100		8.00	-
	92120		15.00	-
	92130		15.00	-
	92225		25.00	-
	92226		21.00	-
	92235		53.00	-
	92250		10.00	-
N	92260		15.00	-
N	92280		45.00	-
	92286		12.00	-
	92541		5.00	-
	92542		8.00	-
	92544		5.00	-
	92545		5.00	-
L	W9200		10.00	-
L	W9205		60.00	-
L	W9210		25.00	-
L	W9215		9.00	-
L N	W9220		8.00	-
L	W9225		25.00	-
L N	W9230		8.00	-

*Refer to Section 4.2

APPENDIX A

PROFESSIONAL VISION CARE SERVICE CODES AND NARRATIVES NOT FOUND IN CPT-4 (LEVEL II AND LEVEL III CODES)

*IND.	HCPCS CODE	MOD	DESCRIPTION	MEDICAID DOLLAR VALUE S	NS
	W9200		Subnormal Vision Exam, a continuation after a comprehensive eye exam, with limited additional tests to determine if subnormal vision devices would benefit vision problems that cannot be normalized by conventional spectacles. NOTE: This subnormal vision examination is used as an additional procedure at the time of the original examination.	10.00	-
	W9205		Subnormal Vision Work-up with written report. Prior Authorization required. This is a battery of extensive tests and independent procedures to determine a device or a combination of devices that would permit an individual to enhance visual functions.	60.00	-
	W9210		Vision training workup and written report (prior authorization required)	25.00	-
	W9215		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 Note: It is the intent of the Program to reimburse the Ophthalmologist or the Optometrist for either a screening examination or a comprehensive eye exam-	9.00	-

*Refer to Section 4.2

*IND.	HCPCS CODE	MOD	DESCRIPTION	MEDICAID DOLLAR VALUE S	NS
			ination 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.		
N	W9220		Slit lamp examination	8.00	-
	W9225		Laser Interferometry, unilateral	25.00	-
N	W9230		Ophthalmoscopy (Fundoscopy) with Mydriasis, direct and/or indirect method (independent procedure)	8.00	-

*Refer to Section 4.2

APPENDIX B (Vision Care)

QUALIFIERS

CODES	PROCEDURE

1. COMPREHENSIVE EYE EXAMINATION

92002
92012

Comprehensive Eye Examination - Codes 92002 or 92012 are comparable to discontinued code 5400, Comprehensive Eye Examination, and refer to a new or established patient respectfully. For reimbursement purposes, the use of these codes requires as a minimum a comprehensive eye examination which shall include, with or without cycloplegics and with or without a post cycloplegic visit, the following:

i. Detailed case history;

ii. External and internal (ophthalmoscopic) examination;

iii. Refraction (objective and subjective);

iv. Gross visual fields (central and peripheral);

v. Tonometry (when indicated for patients under 35; mandatory for all patients over 35). The specific method used should be identified (that is, the finger palpation test is not acceptable);

vi. Binocular coordination testing (distance and near);

vii. The diagnosis (Ocular deficiency or deformity, visual or muscular anomaly, and so forth);

viii. Recommendations.

2. COMPREHENSIVE EYE EXAMINATION WITH DIAGNOSTIC FIELDS

92004
92014

Comprehensive Eye Examination with Diagnostic Fields - Codes 92004 or 92014 are comparable to discontinued code 5401, Comprehensive Eye Examination with Diagnostic Fields and refer to a new or established patient respectfully . For reimbursement purposes, it shall include all the criteria of procedure codes 92002 or 92012, including complete Diagnostic Visual Fields.

i. NOTE: These codes are not routinely reimbursable for a complete comprehensive eye examination. Patients should be selected for this additional service based upon history

and ophthalmologic findings during the examination, if the physical examination suggests the presence of optic or motor nerve abnormalities, or if other significant physical findings are present and documented, diagnostic visual fields studies may be selectively employed to establish or confirm the diagnosis and/or the degree of impairment.

ii. NOTE: A comprehensive eye examination with or without diagnostic fields is limited to once a year. Additional such visits will be downgraded to office visits if the criteria are met. Codes 90050, 90060, and 90070, Established Patient, are then applicable.

3. INDEPENDENT OFFICE PROCEDURES

92020
92065
92081
92082
92083
92100
92260
W9220
W9230

Independent Office Procedures - Codes 92020, 92065, 92081, 92082, 92083, 92100, 92260, W9220, and W9230 are not reimbursable when performed on the same day as Codes 90050, 90060, 90070, 92002, 92004, 92012, 92014 or W9215. The use of these codes precludes billing for any type of office visit on the same day.

4. ROUTINE OFFICE VISIT

90050
90060
90070

Codes 90050, 90060 and 90070 - Routine Office Visit or Follow-Up Visit is defined as the care and treatment by a physician, which includes those procedures ordinarily performed during a health care visit, which is dependent upon the setting and the physician's discipline. In order to document the record for reimbursement purposes, a progress note for the office visit should include the following:

i. Purpose of visit;

ii. Pertinent history obtained;

iii. Pertinent physical findings including pertinent negative findings based on the above;

iv. Procedures, if any, with results;

v. Lab., x-ray, EKG, etc., ordered with results;

vi. Diagnosis;

vii. Recommendations.

5. BRAIN-STEM-EVOKED RESPONSE TESTING

92280 Not responsible for initial testing, general screening, research studies or any situation where usefulness has not been clearly established, and therefore, is without controversy.

CPT 92280 - discontinued code 9339 - for reimbursement purposes refers to a visual brain-stem-evoked response (VBR) with interpretation. Reimbursable to hospital outpatient department as a hospital charge or to a qualified provider (office setting). The study must be personally performed by any of the following disciplines trained and experienced with VBR testing, namely Ophthalmologists, Optometrists, Neurologists, Neurosurgeons, and Psychiatrists.

Criteria for testing:

1. Inconclusive test results by standard vision testing for:

   a) neonates and infants at risk for vision loss.
   b) children and adults who cannot perform behavorial testing.

2. Suspected organic neurologic lesion within or proximal to the visual pathway.

10:62-4.4 HCPCS CODES FOR VISION CARE APPLIANCES

*IND.	HCPCS CODE	MOD	DESCRIPTION
	(a) LENS DISPENSING FEES		
	Y5110		Lens Service (Single vision lens)
	Y5112		Lens Service (Bifocal lens)
	Y5114		Lens Service (Trifocal lens)
	Y5105		Lens Service (Cataract Single Vision over + or - 10 D)
	Y5100		Lens Service (Cataract Bifocal over + or - 10 D)
	(b) FRAMES		
	V2020		Frames, purchases
	Y5150		Frames, purchase, replacement (due to unrepairable damage)
	Y5155		Frames, repair or part replacement
			Note: Frame repairs exceeding $5.00 require prior authorization
	V2035		Frames, (dispensing fee)
	V2035YF		Frames,(dispensing fee)
			Note: (YF- Patient supplied his/her own Medicaid Plastic Frame)
	(c) SINGLE VISION LENSES, GLASS OR PLASTIC		
	V2100		Sphere, single vision, plano to plus or minus 4.00, per lens
	V2101		Sphere, single vision, plus or minus 4.12 to plus or minus 7.00D, per lens
	V2102		Sphere, single vision, plus or minus 7.12 to plus or minus 20.00D, per lens
	V2103		Spherocylinder, single vision, plano to plus or minus 4.00D sphere, .12 to 2.00D cylinder, per lens

*Refer to Section 4.2

*IND.	HCPCS CODE	MOD	DESCRIPTION
	V2104		Spherocylinder, single vision, plano to plus or minus 4.00D sphere, 2.12 to 4.00D cylinder, per lens
	V2105		Spherocylinder, single vision, plano to plus or minus 4.00D sphere, 4.25 to 6.00D cylinder, per lens
P	V2106		Spherocylinder, single vision, plano to plus or minus 4.00D sphere, over 6.00D cylinder, per lens
	V2107		Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00 sphere, .12 to 2.00D cylinder, per lens
	V2108		Spherocylinder, single vision, plus or minus 4.25D to plus or minus 7.00D sphere
	V2109		Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00D sphere, 4.25 to 6.00D cylinder
P	V2110		Spherocylinder, single vision, plus or minus 4.25 to 7.00D sphere, over 6.00D cylinder, per lens
	V2111		Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00D sphere, .25 to 2.25D cylinder
	V2112		Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00D sphere, 2.25D to 4.00D cylinder
	V2113		Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00D sphere, 4.25 to 6.00D cylinder, per lens
	V2114		Spherocylinder, single vision, sphere over plus or minus 12.00D, per lens
R	V2115		Lenticular, (myodisc), per lens, single vision
R	V2116		Lenticular lens, nonaspheric, per lens, single vision
R	V2117		Lenticular, aspheric, per lens, single vision
P	V2118		Aniseikonic lens, single vision
P	V2199		Not otherwise classified, single vision lens

*Refer to Section 4.2

*IND.	HCPCS CODE	MOD	DESCRIPTION
			(d) BIFOCAL LENSES, GLASS OR PLASTIC
			(up to and including 28mm seg width, add power up to and including 3.25D)
	V2200		Sphere, bifocal, plano to plus or minus 4.00D, per lens
	V2201		Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00D per lens
	V2202		Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00D, per lens
	V2203		Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, .12 to 2.00D cylinder, per lens
	V2204		Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, 2.12 to 4.00D cylinder, per lens
	V2205		Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, 4.25 to 6.00D cylinder, per lens
P	V2206		Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, over 6.00D cylinder, per lens
	V2207		Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00D sphere, .12 to 2.00D cylinder, per lens
	V2208		Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 2.12 to 4.00D cylinder, per lens
	V2209		Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 4.25 to 6.00D cylinder, per lens
P	V2210		Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00D sphere, over 6.00D cylinder, per lens
	V2211		Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00D sphere, .25 to 2.25D cylinder, per lens
	V2212		Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 2.25 to 4.00D cylinder, per lens
	V2213		Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 4.25 to 6.00D cylinder, per lens

*Refer to Section 4.2

*IND.	HCPCS CODE	MOD	DESCRIPTION
	V2214		Spherocylinder, bifocal, sphere over plus or minus 12.00D, per lens
R	V2215		Lenticular (myodisc), per lens, bifocal
R	V2216		Lenticular, nonaspheric, per lens, bifocal
R	V2217		Lenticular, aspheric lens, bifocal
P	V2218		Aniseikonic, per lens, bifocal
P	V2219		Bifocal seg width over 28mm
P	V2220		Bifocal add over 3.25D
P	V2299		Specialty bifocal (by report)

(e) TRIFOCAL LENSES, GLASS OR PLASTIC

(up to and including 28mm seg width, add power up to and including 3.25D)

	V2300		Sphere, trifocal, plano to plus or minus 4.00D, per lens
	V2301		Sphere, trifocal, plus or minus 4.12 to plus or minus 7.00D per lens
	V2302		Sphere, trifocal, plus or minus 7.12 to plus or minus 20.00 per lens
	V2303		Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, .12 - 2.00D cylinder, per lens
	V2304		Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, 2.25 to 4.00D cylinder, per lens
	V2305		Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, 4.25 to 6.00 cylinder, per lens
P	V2306		Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, 4.25 to 6.00 cylinder, per lens
P	V2307		Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, .12 to 2.00D cylinder, per lens

*Refer to Section 4.2

*IND.	HCPCS CODE	MOD	DESCRIPTION
P	V2308		Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 2.12 to 4.00D cylinder, per lens
P	V2309		Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 4.25 to 6.00D cylinder, per lens
P	V2310		Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, over 6.00D cylinder, per lens
P	V2311		Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00D sphere, .25 to 2.25D cylinder, per lens
P	V2312		Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 2.25 to 4.00D cylinder, per lens
P	V2313		Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 4.25 to 6.00D cylinder, per lens
P	V2314		Spherocylinder, trifocal, sphere over plus or minus 12.00D, per lens
P-R	V2315		Lenticular, (myodisc), per lens, trifocal
P-R	V2316		Lenticular nonaspheric, per lens, trifocal
P-R	V2317		Lenticular, aspheric lens, trifocal
P	V2318		Aniseikonic lens, trifocal
P	V2319		Trifocal seg width over 28mm
P	V2320		Trifocal add over 3.25D
P	V2399		Specialty trifocal (by report)

(f) VARIABLE SPHERICITY LENSES

(Welsh 4 drop, hyperaspheric, double drop, etc.)

P	V2410		Variable sphericity lens, single vision, full field, glass or plastic, per lens
P	V2430		Variable sphericity lens, bifocal, full field, glass or plastic, per lens
P	V2499		Not otherwise classified, variable sphericity lens

*Refer to Section 4.2

*IND.	HCPCS CODE	MOD	DESCRIPTION
	(g) CONTACT LENSES		
P	V2500		Contact lens, pmma, spherical, per lens
P	V2501		Contact lens, pmma, toric or prism ballast, per lens
P	V2502		Contact lens pmma, bifocal, per lens
P	V2503		Contact lens pmma, color vision deficiency, per lens
P	V2510		Contact lens, gas permeable, spherical, per lens
P	V2511		Contact lens, gas permeable, toric, prism ballast, per lens
P	V2512		Contact lens, gas permeable, bifocal, per lens
P	V2513		Contact lens, gas permeable, extended wear, per lens
P	V2520		Contact lens hydrophilic, spherical, per lens
P	V2521		Contact lens hydrophilic, toric, or prism ballast, per lens
P	V2522		Contact lens hydrophilic, bifocal, per lens
P	V2523		Contact lens hydrophilic, extended wear, per lens
P	V2530		Contact lens, scleral, per lens (for contact lens modification, see 92325)
P	V2599		Not otherwise classified, contact lens
	(h) LOW VISION AIDS		
P	V2600		Hand held low vision aids and other nonspectacle mounted aids
P	V2610		Single lens spectacle mounted low vision aids
P	V2615		Telescopic and other compound lens system including distance vision telescopic, near vision telescopes and compound mircroscopic lens system

*Refer to Section 4.2

*IND.	HCPCS CODE	MOD	DESCRIPTION
	(i) PROSTHETIC EYES		
P	V2620		Prosthetic, eye, glass, stock
P	V2621		Prosthetic, eye plastic, stock
P	V2622		Prosthetic, eye. glass, custom
P	V2623		Prosthetic, eye, plastic, custom
P	V2629		Not otherwise classified, prosthetic eye
	(j) INTRAOCULAR LENSES		
P	V2630		Anterior chamber intraocular lens
P	V2631		Iris supported intraocular lens
P	V2632		Posterior chamber intraocular lens
	(k) MISCELLANEOUS		
	V2700		Balance lens, per lens
P	V2710		Slab off prism, glass or plastic, per lens
	V2715		Prism, per lens
P	V2718		Press-on lens, Fresnell prism, per lens
P	V2730		Special base curve, glass or plastic, per lens
	V2740		Tint, plastic, rose 1 or 2 per lens
P	V2741		Tint, plastic, other rose 1-2, per lens
	V2742		Tint, glass rose 1 or 2, per lens
P	V2743		Tint, glass other than rose 1 or 2 per lens
P	V2770		Occluder lens, per lens
P	V2799		Not otherwise classified
P	Y5200		Vision training devices

*Refer to Section 4.2

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

New Jersey Health Services Program NEWSLETTER

Volume P-428 June 28, 1985

To: PROVIDERS OF MEDICAL SUPPLIER SERVICES

Subject: HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

Effective: September 1, 1985

As announced in the Medicare/Medicaid Bulletin 85-1, Vol. P-417, the New Jersey Medicaid Program will implement HCPCS on September 1, 1985. Attached is a new Subchapter 3, Ed. 4-85, New Jersey Medicaid's Medical Supplier Services Manual which provides HCPCS information. It includes the HCPCS code numbers and narratives. The policy regarding the New Jersey Medciaid Program's reimbursement schedule for medical supplier services remains the same.

ALL CLAIMS SUBMITTED ON OR AFTER SEPTEMBER 1, 1985 MUST INCLUDE THE APPLICABLE HCPCS CODES. The code number must be inserted on the MC-11 claim form in section 14 B. "Item No.".

All the enclosed material should be read carefully. Any questions you have relevant to the implementation of HCPCS should be addressed at the Medicare/Medicaid Workshops scheduled throughout the State during July and August. (See Medicare/ Medicaid Bulletin, 85-2, Vol. P-424, dated May 28, 1985.)

Manual Maintenance: The enclosed material, Subchapter 3, Ed. 4-85, replaces Subchapter 3, dated 11/79, of the Medical Supplier 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-429 June 28, 1985

To: INDEPENDENT LABORATORIES

Subject: HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

Effective: September 1, 1985

As announced in the Medicare/Medicaid Bulletin 85-1, Vol. P-417, the New Jersey Medicaid Program will implement HCPCS on September 1, 1985. ALL CLAIMS SUBMITTED ON OR AFTER SEPTEMBER 1, 1985 MUST INCLUDE THE APPLICABLE HCPCS CODES.

Attached is a new Subchapter 3, Ed. 4-85, New Jersey Medicaid's Independent Laboratory Services Manual, which provides HCPCS information. It includes the following:

1. HCPCS Code Numbers (activated by New Jersey Medicaid) and Maximum Fee Schedule.

2. Codes and narratives not found in CPT-4 (Level II and Level III Codes). (Please note: To determine narratives for Level I Codes, it is necessary to refer to CPT-4 (Physicians' Current Procedural Terminology Fourth Edition). A 1985 edition may be ordered from: Order Department OP-341-5, American Medical Association, P.O. Box 10946, Chicago, Illinois, 60610.)

There is no change in the New Jersey Medicaid Program's reimbursement schedule for Independent Laboratory services. However, since code numbers, narratives, qualifications to codes, and reimbursement schedule are presented in a different format, all the material should be read carefully.

Any questions you have relevant to the implementation of HCPCS should be addressed at the Medicare/Medicaid workshops scheduled throughout the State during July and August. (See Medicare/Medicaid Bulletin, 85-2, Vol. P-424, dated May 28, 1985.)

Manual Maintenance: The enclosed material, Subchapter 3, Ed. 4-85, Independent Laboratory Services Manual replaces Chapter IV, Ed. 12/82. All numerical designations in Subchapter 3 conform with submission requirements of the New Jersey Administrative Code (N.J.A.C.) to facilitate legal reference and cross reference. Chapters II and III of the Independent Laboratory Services Manual will be similarly renumbered when they are revised and distributed at a later time.

The following is an addendum to the enclosed material:
If any two of the following HCPCS procedure codes are performed on the same day by automated equipment and the total reimbursement of the two chemistry tests would have exceeded $7.50, the maximum reimbursement will not be more than $7.50: 82251, 82374, 82801, 83540, 83545, 83610, 83615, 83620, 83629, 83631, 84075, 84078, 84080, 84132, 84133, 84295, 84300, 84478, 82977, W8215.

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-430

June 28, 1985

To: Certified Nurse Midwives

Subject: HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

Effective: September 1, 1985

As announced in the Medicare/Medicaid Bulletin 85-1, Volume P-417, the New Jersey Medicaid Program will implement HCPCS on September 1, 1985. ALL CLAIMS SUBMITTED ON OR AFTER SEPTEMBER 1, 1985 MUST INCLUDE THE APPLICABLE HCPCS CODES.

Attached is a new Subchapter 3, Ed. 4-85, New Jersey Medicaid's Certified Nurse Midwifery Services Manual which provides HCPCS information. It includes the following:

1. HCPCS Code Numbers (activated by New Jersey Medicaid) and Maximum Fee Schedule.

2. Codes and narratives not found in CPT-4 (Level II and Level III Codes). (Please note: To determine narratives for Level I Codes, it is necessary to refer to CPT-4. (Physicians' Current Procedural Terminology Fourth Edition). A 1985 edition may be ordered from: Order Department OP-341-5, American Medical Association, P. O. Box, 10946, Chicago, Illinois, 60610.

There is no change in the New Jersey Medicaid Program's reimbursement schedule for certified nurse-midwifery services. However, since code numbers, narratives, qualifications to codes, and reimbursement are presented in a different format, all the attached material should be read carefully.

Any questions you have relevant to the implementation of HCPCS should be addressed at the Medicare/Medicaid workshops scheduled throughout the State during July and August. (See Medicare/Medicaid Bulletin, 85-2, Vol. P-424, dated May 28, 1985).

Manual Maintenance: The enclosed material, Subchapter 3, Ed. 4-85, Certified Nurse Midwifery Services Manual, replaces Subchapter 3, PROCEDURE CODES, dated 1/83.

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

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SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:58-3.1 INTRODUCTION

(a) The New Jersey Medicaid Program utilizes the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology - 4th Edition (CPT-4) architecture, employing a five-position code and as many as two 2-position modifiers. Unlike the CPT-4 numeric design, the HCFA assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three-level coding system.

1. LEVEL I CODES (Narratives found in CPT-4)

   These codes are adapted from CPT-4 for utilization primarily by Physicians, Podiatrists, Optometrists, Certified Nurse-Midwives, Independent Clinics and Independent Laboratories. CPT-4 is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians.

   Copyright restrictions make it impossible to print excerpts from CPT-4 procedure narratives for Level I codes. Thus, in order to determine those narratives it is necessary to refer to CPT-4.

2. LEVEL II CODES (Narratives found in Appendix A)

   These codes are assigned by HCFA for physicians and non-physician services which are not in CPT-4. Level II codes are listed in APPENDIX A of each section.

3. LEVEL III CODES (Narratives found in APPENDIX A)

   These codes are assigned by the Division and the Prudential Insurance Company to be used for those services not identified by CPT-4 codes or HCFA-assigned codes. Level III codes identify services unique to New Jersey. These codes are listed in Appendix A of each section.

(b) GENERAL POLICIES REGARDING USE OF HCPCS FOR PROCEDURES AND SERVICES

Listed below are some of the general policies of the New Jersey Medicaid Program relevant to HCPCS. (The responsibility of the nurse-midwife when rendering specific services and requesting reimbursement is listed in Subchapter 1. Billing procedures are provided in Subchapter 2.

1. When filing a claim, the HCPCS Codes, including the referenced qualifiers and modifiers, must be used in conjunction with the narratives in the CPT-4 or Appendix A, whichever is applicable.

2. The use of a procedure code will be interpreted by the New Jersey Medicaid Program as evidence that the certified nurse-midwife (C.N.M.) personally furnished, as a minimum, the stated service.

3. For services rendered by more than one practitioner (e.g. physician or a C.N.M. in the employ of a physician or physician group), separate claim forms must be submitted by the physician or C.N.M. for the specific service rendered.

4. When billing, the provider must enter into the procedure code column of space 24-D of claim form 1500-N.J. a CPT/HCPCS code as listed in CPT-4 or Subchapter 3. If an appropriate code is not listed, place an "N/A" (not applicable) in the procedure code column and submit a narrative description of the service. If possible, insert into space 24-D a CPT code closest to the narrative description you have written.

i. For reimbursement purposes, when reference is made to any of the following services it is understood that they were performed by the C.N.M. submitting the claim:

(1) Office, Hospital, or Sheltered Boarding Home Visits.

(2) Any part of a history or physical examination.

ii. To qualify as documentation that the service was rendered by the C.N.M. during an inpatient stay, the medical record must contain the C.N.M.'s notes indicating that he/she personally:

(1) Reviewed the patient's medical history <u>with the patient</u> and/or his family, depending upon the medical situation.

(2) Performed a physical examination.

(3) Confirmed or revised the diagnosis.

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

(5) Was personally responsible for discharge of the patient.

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

5. Date(s) of service(s) must be indicated on the claim form and in the C.N.M.'s own record for each service billed.

6. When submitting a claim, the C.N.M. must always use his/her usual and customary fee. The "Medicaid Dollar Value" designated for the HCPCS codes represents the New Jersey Medicaid Program's maximum payment for the given procedure or service.

i. All references to time parameters shall mean the C.N.M.'s personal time in reference to the service rendered unless it is otherwise indicated.

10:58-3.2 ELEMENTS OF HCPCS CODES WHICH REQUIRES ATTENTION OF CERTIFIED NURSE-MIDWIFE

(a) The lists of HCPCS code numbers for nurse-midwifery services are arranged in tabular form with specific information for a code given under columns with titles such as: "IND", "HCPCS CODE", "MOD", "DESCRIPTION", "FOLLOW-UP DAYS", "MEDICAID DOLLAR VALUE" and "ANES BASIC UNITS". The information given under each column is summarized below:

COLUMN TITLE

IND — (Indicator-Qualifier) Lists alphabetic symbols used to refer provider to information concerning the New Jersey Medicaid Program's qualifications and requirements when a procedure or services HCPCS code is used.

Explanation of indicators and qualifiers used in this column are given below:

"L" preceding any procedure code indicates that the complete narrative for the code is located in Appendix A of this Subchapter 3.

"N" preceding any procedure code means that qualifiers are applicable to that code. These qualifiers are listed by procedure code number in Appendix B of this Subchapter 3..

HCPCS CODE — Lists the HCPCS procedure code numbers.

MOD — Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance is identified by the addition of alphabetic and/or numeric characters affixed to the code. The modifiers for C.N.M. procedures are already affixed to the codes in the HCPCS code listing. The modifiers are as follow:

WM - Midwifery: Used to identify procedures performed by C.N.M. by adding the modifier "WM" to the code.

22 - Unusual Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by affixing "22" to the usual procedure number.

DESCRIPTION — Lists the code narrative. (Narratives for Level I Codes are found in CPT-4. Narratives for Levels II and III Codes are found in Appendix A of this Subchapter 3).

FOLLOW-UP DAYS — Lists the number of days for follow-up care.

MEDICAID DOLLAR VALUE — Lists New Jersey Medicaid Program's reimbursement schedule for the C.N.M.. If the symbols "B.R." (By Report) are listed instead of a dollar amount, it means that additional information will be required in order to properly evaluate the service. Attach a copy of the report to the 1500-N.J. claim form.

ANES BASIC UNITS — B.U.V. (Basic Unit Value) + A.T. (Anesthesia Time) (units) x $6.30 (specialist) or $5.50 (non-specialist) equals reimbursement.

1. ALPHABETIC AND NUMERIC SYMBOLS UNDER "IND" & "MOD"

These symbols when listed under the "IND" and "MOD" columns are elements of the HCPCS coding system used as qualifiers or indicators (as in the "IND" column) and as modifiers (as in the "MOD" column). They assist the C.N.M. in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

i. These symbols and/or letters must not be ignored because in certain instances requirements are created in addition to the narrative which accompanies the CPT/HCPCS code as written in the CPT-4. THE C.N.M. WILL THEN BE LIABLE FOR THE ADDITIONAL REQUIREMENTS AND NOT JUST THE CODE NARRATIVE. These requirements must be fulfilled in order to receive reimbursement.

ii. If there is no identifying symbol listed, the CPT/HCPCS code narrative prevails.

10:58-3.3 HCPCS CODES FOR NURSE-MIDWIFERY SERVICES AND MAXIMUM FEE SCHEDULE

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE S $ NS	ANES BASIC UNITS
	(a) OBSTETRICAL SERVICES				
N	58300	WM	0	39.00	0.
N	58301	WM	0	11.50	0.
N	59400	WM	60	165.20	4.
N	59410	WM	60	112.00	4.
	(b) OFFICE MEDICAL SERVICES				
N	90050	WM	0	6.30	0.
	(c) HOME MEDICAL SERVICES				
N	90150	WM	0	6.30	0.
N	59420	WM	0	5.60	0.
N	59420	WM22	0	15.40	0.
N	59430	WM	0	9.10	0.
L	Z0250	WM	0	40.00	0.
N	90060	WM	0	6.30	0.
N	90160	WM	0	6.30	0.

APPENDIX A

NURSE MIDWIFERY SERVICE
CODES AND NARRATIVES NOT FOUND IN CPT-4
(Level II and Level III Codes)

IND	HCPCS CODE	MOD	DESCRIPTION	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE	ANES BASIC UNITS
	Z0250	WM	Home Delivery Pack All drugs and supplies, etc., necessary for delivery in this setting.	0	40.00	0.

APPENDIX B

(Nurse-Midwifery Services)

QUALIFIERS

HCPCS CODE	PROCEDURE
58300WM	Includes cost of device and post insertion visit and limited to within 6 week postpartum period.
58301WM	Limited to within 6 week postpartum period.
59400WM	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. Reimbursement will be decreased by the fee for the initial ante partum visit (59420WM22) if patient not seen for this visit. The total fee will also be decreased by the reimbursement sum for each subsequent ante partum visit (59420WM) which is less than seven. Obstetrical delivery per vagina when performed by a certified nurse midwife with inhospital, home, or birthing center postpartum care, whichever applies. 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 HCFA-1500/NJ claim form.
59410WM	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 HCFA-1500/NJ claim form.
59420WM	Indicate specific dates of services on HCFA-1500/NJ claim form.
59420WM22	Initial ante partum care by a certified nurse midwife (separate procedure).
59430WM	By other than the delivering physician or certified nurse midwife. One visit between the 15th and 42nd postpartum day following delivery, out of hospital.
90050WM 90060WM 90150WM 90160WM	If medical necessity dictates, corroborated by the record, then additional visits (home or office) above seven ante partum visits may be reimbursed. The claim form should clearly indicate the reason for the medical necessity and the date for each office or home visit listed.

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-431

June 28, 1985

To: PODIATRISTS

Subject: HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

Effective: September 1, 1985

As announced in the Medicare/Medicaid Bulletin 85-1, Volume P-417, the New Jersey Medicaid Program will implement HCPCS on September 1, 1985. ALL CLAIMS SUBMITTED ON OR AFTER SEPTEMBER 1, 1985 MUST INCLUDE THE APPLICABLE HCPCS CODES.

Attached is a new Subchapter 3, Ed. 4-85, New Jersey Medicaid's Podiatry Services Manual, which provides HCPCS information. It includes the following:

1. HCPCS Code Numbers (activated by New Jersey Medicaid) and Maximum Fee Schedule.

2. Codes and narratives not found in CPT-4 (Level II and Level III Codes). (Please note: To determine narratives for Level I Codes, it is necessary to refer to CPT-4. (Physicians' Current Procedural Terminology Fourth Edition). A 1985 edition may be ordered from: Order Department OP-341-5, American Medical Association, P. O. Box, 10946, Chicago, Illinois, 60610.

There is no change in the New Jersey Medicaid Program's reimbursement schedule for podiatric services. However, since code numbers, narratives, qualifications to codes, and reimbursement are presented in a different format, all the material should be read carefully.

Any questions you have relevant to the implementation of HCPCS should be addressed at the Medicare/Medicaid workshops scheduled throughout the State during July and August. (See Medicare/Medicaid Bulletin, 85-2, Vol. P-424, dated May 28, 1985).

Manual Maintenance: The enclosed material, Subchapter 3, Ed. 4-85, Podiatry Services Manual replaces PROCEDURE CODE MANUAL, Ed. 12/82. All numerical designations in Subchapter 3 conform with submission requirements of the New Jersey Administrative Code (N.J.A.C.) to facilitate legal reference and cross reference. Chapters II and III of the Podiatry Services Manual will be similarly renumbered when revised and distributed at a later time.

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-432

June 28, 1985

To: Prosthetic and Orthotic Providers of Services

Subject: HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

Effective: September 1, 1985

As announced in the Medicare/Medicaid Bulletin 85-1, Volume P-417, the New Jersey Medicaid Program will implement HCPCS on September 1, 1985. ALL CLAIMS SUBMITTED ON OR AFTER SEPTEMBER 1, 1985, MUST INCLUDE APPLICABLE HCPCS CODES.

Attached is a new Subchapter 3, Ed. 4-85, New Jersey Medicaid 's Prosthetic and Orthotic Services Manual, which provides HCPCS information. It includes the HCPCS code numbers, narratives, and Medicaid reimbursement schedule. There is no change in the New Jersey Medicaid Program's reimbursement schedule for prosthetic and orthotic services. All the attached material should be read carefully.

Any questions you have relevant to the implementation of HCPCS should be addressed at the Medicare/Medicaid workshops scheduled throughout the State during July and August. (See Medicare/Medicaid Bulletin, 85-2, Vol. P-424, dated May 28, 1985).

Manual Maintenance: The enclosed material, Subchapter 3, Ed. 4-85, replaces Chapter IV, Procedure Codes and Descriptions, of the Prosthetic and Orthotic Services Manual. All numerical designations in Subchapter 3 conform with submission requirements of the New Jersey Administrative Code (N.J.A.C.) to facilitate legal reference and cross reference. When Chapters II and III of this manual are revised, they will be similarly renumbered.

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-433

June 28, 1985

To: Providers of Ambulance and Invalid Coach Services

Subject: HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

Effective: September 1, 1985

As announced in the Medicare/Medicaid Bulletin 85-1, Volume P-417, the New Jersey Medicaid Program will implement HCPCS on September 1, 1985. ALL CLAIMS SUBMITTED ON OR AFTER SEPTEMBER 1, 1985 MUST INCLUDE APPLICABLE HCPCS CODES.

Attached is a new Subchapter 3, Ed. 4-85, New Jersey Medicaid's Transportation Services Manual, which provides HCPCS information. It includes the HCPCS code numbers, narratives, and Medicaid reimbursement schedule. The reimbursement schedule remains the same, but certain codes for dialysis and multi-load transportation services are not included in the HCPCS listing. It is anticipated that these codes will be eliminated and the change is reflected in the attached material. Further details will be forthcoming in a subsequent newsletter.

All the enclosed material should be read carefully. Any questions you have relevant to the implementation of HCPCS should be addressed at the Medicare/Medicaid workshops scheduled throughout the State during July and August (See Medicare/Medicaid Bulletin, 85-2, Vol. P-424, dated May 28, 1985).

Manual Maintenance: The enclosed material, Subchapter 3, Ed. 4-85, replaces page 21, Rev. 11/77, of Chapter II of your Transportation Services Manual. Please mark that page as "obsolete". All numerical designations in Subchapter 3 conform with the submission requirements of the New Jersey Administrative Code (N.J.A.C.) to facilitate legal reference and cross reference. Chapter II of the Transportation Services Manual will be similarly renumbered when it is revised and distributed at a later time.

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

REC'D JUL 30 1985

New Jersey Health Services Program NEWSLETTER

Volume P-434

June 28, 1985

To: PROVIDERS OF PSYCHOLOGICAL SERVICES

Subject: HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

Effective: September 1, 1985

As announced in the Medicare/Medicaid Bulletin 85-1, Vol. P-417, the New Jersey Medicaid Program will implement HCPCS on September 1, 1985. ALL CLAIMS SUBMITTED ON OR AFTER SEPTEMBER 1, 1985 MUST INCLUDE THE APPLICABLE HCPCS CODES.

Attached is a new Subchapter 3, Ed. 4-85, New Jersey Medicaid's Psychological Services Manual, which provides HCPCS information. It includes the HCPCS code numbers, narratives and Medicaid reimbursement schedule. The New Jersey Medicaid's reimbursement schedule for psychological services remains the same.

Please read the attached material carefully. Any questions you have relevant to the implementation of HCPCS should be addressed at the Medicare/Medicaid Workshops scheduled throughout the State during July and August. (See Medicare/Medicaid Bulletin, 85-2, Vol. P-424, dated May 28, 1985.)

Manual Maintenance: The enclosed material, Subchapter 3, Ed. 4-85, replaces Chapter IV, dated 9/81, of the Psychological Services Manual. All numerical designations in Subchapter 3 conform with submission requirements for the New Jersey Administrative Code (N.J.A.C.) to facilitate legal reference and cross reference. Chapters II and III of the Psychological Services Manual will be similarly renumbered when revised and distributed at a later time.

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

New Jersey Health Services Program NEWSLETTER

Volume P-435 June 28, 1985

To: PROVIDERS OF HEARING AID SERVICES MANUAL

Subject: HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

Effective: September 1, 1985

As announced in the Medicare/Medicaid Bulletin 85-1, Vol. P-417, the New Jersey Medicaid Program will implement HCPCS on September 1, 1985. Attached is a new Subchapter 4, New Jersey Medicaid's Hearing Aid Services Manual which provides HCPCS information. It includes the HCPCS code numbers and narratives. The policy regarding the New Jersey Medicaid Program's reimbursement schedule for hearing aid services remains the same.

ALL CLAIMS SUBMITTED ON OR AFTER SEPTEMBER 1, 1985 MUST INCLUDE THE APPLICABLE HCPCS CODES. The code number must be inserted on the MC-11 claim form (Medical Supplies and Equipment Claim) in section 14 B. "Item No.".

Any questions you have relevant to the implementation of HCPCS should be addressed at the Medicare/Medicaid workshops scheduled throughout the State during July and August. (See Medicare/Medicaid Bulletin, 85-2, Vol. P-424, dated May 28, 1985.)

Manual Maintenance: The enclosed material should be included in Subchapter 4 of the Hearing Aid Services Manual.

HEARING AID SERVICES MANUAL

SUBCHAPTER 4. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

INDEX

10:64-4.1 Introduction

4.2 HCPCS Codes For Hearing Aid Services

10:64-4.2 HCPCS CODES FOR HEARING AID SERVICES

HCPCS CODE	DESCRIPTION
V5030	Hearing Aid, Monaural, Body Worn, Air Conduction
V5040	Hearing Aid, Monaural, Body Worn, Bone Conduction
V5050	Hearing Aid, Monaural, In The Ear
V5060	Hearing Aid, Monaural, Behind The Ear
V5070	Glasses, Air Conduction
V5080	Glasses, Bone Conduction
V5100	Hearing Aid, Bilateral, Body Worn
	NOTE: "Y-cord" Arrangement
V5120	Binaural, Body
V5130	Binaural, In The Ear
V5140	Binaural, Behind The Ear
V5150	Binaural, Glasses
V5170	Hearing Aid, Cros, In The Ear
V5180	Hearing Aid, Cros, Behind The Ear
V5190	Hearing Aid, Cros, Glasses
V5210	Hearing Aid, Bicros, In The Ear
V5220	Hearing Aid, Bicros, Behind The Ear
V5230	Hearing Aid, Bicros, Glasses
Y4000	Reconditioned Hearing Aid
Y4100	Returned Hearing Aid
Y4200	Hearing Aid Repairs
Y4300	Earmolds For Hearing Aids
Y4400	Batteries For Hearing Aids
Y4500	Hearing Aid Replacement Parts and Accessories
Y4600	Miscellaneous Hearing Aid Supplies and Services

SUBCHAPTER 4. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:64-4.1 Introduction

(a) The New Jersey Medicaid Program adopted the Health Care Financing Administration's Common Procedure Coding System (HCPCS). The HCPCS Codes as listed in this Subchapter are relevant to Medicaid hearing aid services and must be used when filing a claim.

1. The responsibility of the hearing aid services provider when rendering services and requesting reimbursement is listed in Subchapter 1. and Subchapter 2. of the Hearing Aid 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-436

June 28, 1985

To: INDEPENDENT CLINICS

Subject: HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

Effective: September 1, 1985

As announced in the Medicare/Medicaid Bulletin 85-1, Vol. P-417, the New Jersey Medicaid Program will implement HCPCS on September 1, 1985. ALL CLAIMS SUBMITTED ON OR AFTER SEPTEMBER 1, 1985 MUST INCLUDE THE APPLICABLE HCPCS CODES.

Attached is a new Subchapter 3, Ed. 4-85, New Jersey Medicaid's Independent Clinics Services Manual, which provides HCPCS information. It includes the following:

1. HCPCS Code Numbers (activated by New Jersey Medicaid) and Maximum Fee Schedule.

2. Codes and narratives not found in CPT-4 (Level II and Level III Codes). (Please note: To determine narratives for Level I Codes, it is necessary to refer to CPT-4. (Physicians' Current Procedural Terminology Fourth Edition). A 1985 edition may be ordered from: Order Department OP-341-5, American Medical Association, P. O. Box, 10946, Chicago, Illinois, 60610.

There is no change in the New Jersey Medicaid Program's reimbursement schedule for Independent Clinics services. However, since code numbers, narratives, qualifications to codes, and reimbursement are presented in a different format, all the material should be read carefully.

Any questions you have relevant to the implementation of HCPCS should be addressed at the Medicare/Medicaid workshops scheduled throughout the State during July and August. (See Medicare/Medicaid Bulletin, 85-2, Vol. P-424, dated May 28, 1985).

Manual Maintenance: The enclosed material, Subchapter 3, Ed. 4-85, Independent Clinic Services Manual replaces Subchapter 3, Rev. 10/83.

SUBCHAPTER 3. HEALTH CARE FINANCING ADMINISTRATION COMMON PROCEDURE CODING SYSTEM (HCPCS)

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(a) Basis for HCPCS

(b) Specific Elements of HCPCS Codes Which Require Attention of Provider

(c) Policies and Procedures Regarding Use of HCPCS

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(f) Surgery

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SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:66-3.1 INTRODUCTION

(a) The New Jersey Medicaid Program utilizes the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology - 4th Edition (CPT-4) architecture, employing a five-position code and as many as two 2-position modifiers. Unlike the CPT-4 numeric design, the HCFA assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three-level coding system.

1. LEVEL I CODES (Narratives found in CPT-4)

   These codes are adapted from CPT-4 for utilization primarily by Physicians, Podiatrists, Optometrists, Certified Nurse-Midwives, Independent Clinics and Independent Laboratories. CPT-4 is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians.

   Copyright restrictions make it impossible to print excerpts from CPT-4 procedure narratives for Level I codes. Thus, in order to determine those narratives it is necessary to refer to CPT-4.

2. LEVEL II CODES (Narratives found in APPENDIX A)

   These codes are assigned by HCFA for physicians and non-physician services which are not in CPT-4. Level II codes are listed in APPENDIX A of each section.

3. LEVEL III CODES (Narratives found in APPENDIX A)

   These codes are assigned by the Division and the Prudential Insurance Company to be used for those services not identified by CPT-4 codes or HCFA-assigned codes. Level III codes identify services unique to New Jersey. These codes are listed in Appendix A of each section.

(b) SPECIFIC ELEMENTS OF HCPCS CODING SYSTEM WHICH REQUIRE ATTENTION OF PROVIDER

The lists of HCPCS code numbers for independent clinic services are arranged in tabular form with specific information for a code given under columns with titles such as: "IND", "HCPCS CODE", "MOD", "DESCRIPTION", "FOLLOW-UP DAYS" and "MEDICAID DOLLAR VALUE". The information given under these columns is summarized below:

COLUMN TITLE	
IND	(Indicator-Qualifier) Lists alphabetic symbols used to refer provider to information concerning the New Jersey Medicaid Program's qualifications and requirements when a procedure or services HCPCS code is used. Explanation of indicators and qualifiers used in this column are given below and in paragraph 1. (Alphabetic and Numeric Symbols) which follows: "L" preceding any procedure code indicates that the complete narrative for the code is located in the Appendix A at the end of the Section 3.2 (HCPCS Codes for Independent Clinic Services). "M" preceding any procedure code means that this service is a medical necessity procedure. (Refer to Appendix C at the end of the Section 3.2 (HCPCS Codes for Independent Clinic Services). "N" preceding any procedure code means that qualifiers are applicable to that code. These qualifiers are listed by procedure code number in Appendix B at the end of the Section 3.2 (HCPCS Codes for Independent Clinic Services). An asterisk preceding any procedure code also can be done by the podiatrist.
HCPCS CODE	Lists the HCPCS procedure code numbers.
MOD	Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid Program's recognized modifier code for independent clinic services are as follows:

MODIFIER CODE	DESCRIPTION
22	Unusual Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '22' to the usual procedure number.
50	Bilateral Procedures: Unless otherwise identified in the listings, bilateral procedures requiring a separate incision that are performed at the same operative session, should be identified by the appropriate five digit code describing the first procedure. The second (bilateral) procedure is identified by adding modifier '50' to the procedure number.

WF — Family Planning: Use to identify procedures performed for the sole purpose of family planning by adding the modifier 'WF' to the procedure code(s).

WM — Midwifery: Use to identify procedures performed by a certified nurse midwife by adding the modifier 'WM' to the procedure code(s).

WY — 1st Trimester: Use to identify trimester when rendering a legal abortion procedure by adding the modifier 'WY' to the procedure code.

WZ — 2nd Trimester: Use to identify trimester when rendering a legal abortion by adding the modifier 'WZ' to the procedure code.

YR — Routine Foot Care Podiatry: Use to identify routine foot care provided by a podiatrist by adding the modifier 'YR' to the procedure code(s).

ZI — Independent Clinic: Use to identify services provided by Independent Clinic providers.

DESCRIPTION — Lists the code narrative. (Narratives for Level I codes are found in CPT-4. Narratives for Levels II and III codes are found in Appendix A at the end of Section 3.2).

FOLLOW-UP DAYS — Lists the number of days for follow-up care.

MEDICAID DOLLAR VALUE — Lists New Jersey Medicaid Program's maximum reimbursement schedule for specialist and non-specialist. If the symbols "B.R." (By Report) are listed instead of a dollar amount, it means that additional information will be required in order to properly evaluate the service. Attach a copy of the report to the MC-14 claim form.

1. ALPHABETIC AND NUMERIC SYMBOLS UNDER "IND" & "MOD"

These symbols when listed under the "IND" and "MOD" columns are elements of the HCPCS coding system used as qualifiers or indicators (as in the "IND" column) and as modifiers (as in the "MOD" column). They assist the physician in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

i. These symbols and/or letters must not be ignored because in certain instances requirements are created in addition to the narrative which accompanies the CPT/HCPCS code as written in the CPT-4. THE PROVIDER WILL THEN BE LIABLE FOR THE ADDITIONAL REQUIREMENTS AND NOT JUST THE CPT/HCPCS CODE NARRATIVE. These requirements must be fulfilled in order to receive reimbursement.

ii. If there is no identifying symbol listed, the CPT/HCPCS code narrative prevails.

(c) POLICIES AND PROCEDURES REGARDING USE OF HCPCS

Listed below are both some general and specific policies of the New Jersey Medicaid Program relevant to HCPCS. Specific information concerning the responsibility of the Independent Clinic provider when rendering professional services and requesting reimbursement is listed in Subchapter 1. and Subchapter 2. of the Independent Clinic Services Manual.

1. GENERAL REQUIREMENTS

i. When filing a claim, the HCPCS Codes, including the referenced qualifiers and modifiers, must be used in conjunction with the narratives in the CPT-4 or Appendix A, whichever is applicable.

ii. The use of a procedure code will be interpreted by the New Jersey Medicaid Program as evidence that the provider personally furnished, as a minimum, the services for which it stands.

iii. When billing, the provider must enter into the procedure code column in item 13B of the Independent Outpatient Health Facility Claim Form (MC-14) a CPT/HCPCS code as listed in CPT-4 or this Subchapter 3.2. If an appropriate code is not listed, place a "N/A" (not applicable) in the procedure code column and submit a narrative description of the service. If possible, insert into space 13B a CPT code closest to the narrative description you have written.

iv. Date(s) of service(s) must be indicated on the claim form and in the provider's own record for each service billed.

v. The "Medicaid Dollar Value" as noted with these procedure codes, "S" for Specialist and "NS" for Non-Specialist, represents the maximum payment for the given procedure. When submitting a claim, the clinic must always use its usual and customary fee.

(1) Listed values for all surgical procedures include the surgery and the follow-up care for the period indicated in days in the column titled "Follow-Up Days".

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

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

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

2. MEDICINE (SPECIFIC REQUIREMENTS)

i. For reimbursement purposes, when reference is made to hospital services it is understood that they were performed by the physician, dentist, podiatrist, optometrist, etc., whichever is applicable.

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

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

(2) Performed an examination as appropriate.

(3) Confirmed or revised the diagnosis.

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

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

3. SURGERY (SPECIFIC REQUIREMENTS)

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

4. RADIOLOGY (SPECIFIC REQUIREMENTS)

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

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

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

iv. Complete Procedure - Includes the Supervision and Interpretation (S & I) plus the injection services when performed by the same physician (e.g., necessary local anesthesia, placement of needle or catheter, injection of contrast media, supervision of the study and interpretation of the results). Values include usual contrast media, equipment and materials.

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

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

10:66-3.2 HCPCS CODES FOR INDEPENDENT CLINIC SERVICES

IND	HCPCS Code	MOD	MEDICAID DOLLAR VALUE S	$	NS
(a)	Examination and Treatment				
N	36415		1.80		1.80
	86490		4.00		4.00
	86510		4.00		4.00
	86540		4.00		4.00
	86585		4.00		4.00
N	90015		22.00		17.00
N	90017		22.00		17.00
N	90020		22.00		17.00
N	90050		9.00		7.00
N	90060		9.00		7.00
N	90070		9.00		7.00
N	90285		22.00		17.00
N	90701		5.86		5.86
N	90702		4.65		4.65
N	90703		3.90		3.90
N	90704		11.55		11.55
N	90705		10.25		10.25
N	90706		10.65		10.65
N	90707		22.15		22.15
N	90708		15.35		15.35
N	90709		16.50		16.50
N	90712		7.10		7.10
N	90719		4.90		4.90
N	90724		4.70		4.70
N	90732		9.25		9.25
N	90751		22.00		17.00
N	90752		22.00		17.00
N	90753		22.00		17.00
N	90754		22.00		17.00
N	90760		22.00		17.00
N	90761		22.00		17.00
N	90762		22.00		17.00
N	90763		22.00		17.00
N	90764		9.00		7.00
N	90799		2.50		2.50
	93000		16.00		16.00
N	99150		37.00 Per Hour		32.00
N	99151		37.00 Per Hour		32.00
N	99160		37.00 Per Hour		32.00
LN	J2790		42.40		42.40
LN	W9090		9.90		9.90
LN	W9095		5.45		5.45
LN	W9820		23.00		18.00

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE S	$	NS
(b)	Dental Services					
	(See Dental Services Manual)					
(c)	Family Planning Services					
N	55250		30	90.00		79.00
N	55450		30	42.00		37.00
N	58300		30	57.00		54.00
N	58301			15.00		15.00
N	58300	WM				23.80
N	58301	WM				11.50
	82996			3.00		3.00
N	88150			3.00		3.00
N	90015	WF		25.00		25.00
N	90040	WF		4.20		4.20
N	90060	WF		10.00		10.00
N	90060	WM WF				9.10
N	90070	WF		13.00		13.00
N	90760	WF		25.00		25.00
	W5850		30	66.00		61.00

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE S	$	NS
(d)	Laboratory Services					
N	81000			1.20		1.20
N	83051			1.20		1.20
	85014			1.50		1.50
	85660			1.80		1.80
(e)	Medical Day Care					
	(See Medical Day Care Manual)					
(f)	Surgery					
	10000			13.00		11.00
	10003			13.00		11.00
	10020			13.00		11.00
N	10040			18.00		16.00
*	10060			13.00		11.00
*	10061		30	48.00		42.00
	10080			30.00		26.00
*	10100			13.00		11.00

*An asterisk preceding any procedure code also can be done by the podiatrist.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE S	$	NS
*	10101		30	34.00		29.00
*	10120			18.00		16.00
*	10121		30	34.00		29.00
*	10141		30	48.00		42.00
*	10160			13.00		11.00
*	11000			13.00		11.00
*	11001			6.00		5.00
*	11040			13.00		11.00
*	11041			13.00		11.00
*	11042			16.00		14.00
*	11043			16.00		14.00
*	11100			13.00		11.00
*	11400		15	18.00		16.00
*	11401		15	22.00		20.00
*	11402		15	27.00		24.00
*	11403		30	32.00		27.00
*	11404		30	32.00		27.00
*	11406		30	32.00		27.00
*	11420		15	18.00		16.00
*	11421		15	22.00		20.00
*	11422		15	27.00		24.00
*	11423		30	32.00		27.00
*	11424		30	32.00		27.00
*	11426		30	32.00		27.00
	11440		15	18.00		16.00
	11441		15	22.00		20.00
	11442		15	27.00		24.00
	11443		30	32.00		27.00
	11444		30	32.00		27.00
	11446		30	32.00		27.00
*	11600		90	37.00		32.00
*	11601		90	47.00		42.00
*	11602		90	61.00		53.00
*	11620		90	61.00		53.00
*	11621		90	90.00		79.00
*	11622		90	121.00		105.00
	11640		90	90.00		79.00
	11641		90	121.00		105.00
	11642		90	150.00		131.00
*	11700			13.00		11.00
*	11701			19.00		16.00
*	11710			13.00		11.00
*	11730			10.00		10.00
*	11750		30	42.00		37.00
*	12001			18.00		16.00
*	12002			24.00		21.00

*An asterisk preceding any procedure code also can be done by the podiatrist.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE S $	NS
*	12004			30.00	26.00
	12011			18.00	16.00
	12013			24.00	21.00
	12014			30.00	26.00
	12031		30	30.00	26.00
	12032		30	48.00	42.00
*	12041		30	30.00	26.00
*	12042		30	67.00	59.00
	12051		30	38.00	33.00
	12052		30	67.00	59.00
	13100		30	34.00	29.00
	13101		30	68.00	63.00
	13120		30	48.00	42.00
	13121		30	106.00	92.00
*	13131		30	67.00	59.00
*	13132		30	145.00	126.00
	13150		30	38.00	33.00
	13151		30	82.00	71.00
	13152		30	193.00	168.00
*	17000			8.00	6.00
*	17010			11.00	8.00
*	17100			18.00	15.00
*	17105			27.00	24.00
*	17110			8.00	6.00
*	17200			8.00	6.00
*	17304		30	25.00	21.00
L*	W1250			18.00	16.00
L*	W1650			24.00	21.00
L*	W1650	22		37.00	32.00

(g) Mental Health Services

N	90801	ZI		22.50	22.50
N	90843	ZI		8.00	8.00
N	90844	ZI		16.00	16.00
N	90847	ZI		15.00	15.00
N	90847	22	ZI	22.50	22.50
	90862	ZI		4.50	4.50
N	90887	ZI		8.00	8.00
LN	H5025	ZI		8.00	8.0
L	Z0100			22.50	22.5
L	Z0130			75.00	75.0
L	Z0150			8.00	8.0
L	Z0160			15.50	15.5
L	Z0170			15.00	15.0
L	Z0180			30.00	30.0

*An asterisk preceding any procedure code also can be done by the podiatrist.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE S	$	NS
(h)	Obstetrical Services (Maternity)					
N	59400		60	236.00		210.00
N	59400	WM	42			165.20
N	59410		60	160.00		144.00
N	59410	WM	42			112.00
N	59420			8.00		7.00
N	59420	22		22.00		17.00
N	59420	WM				5.60
N	59420	22 WM				15.40
N	59430			13.00		11.00
N	59430	WM				9.10
	59520		45	290.00		257.00
	59521		45	369.00		326.00
	59801		45	79.00		68.00
N	90050	WM				6.30
N	90060	WM				6.30
N	90150	WM				6.30
N	90160	WM				6.30
L	Z0250	WM				40.00
(i)	Podiatry Services					
	29580			18.00		16.00
N	90050	YR		9.00		7.00
L	W2650			21.00		21.00
L	W2655			5.00		5.00

For additional procedures see Section 3.3 (f) (Surgery)

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE S	$	NS
j)	Radiology Services					
	70030					15.00
	70040					30.00
	70050					40.00
	70100					15.00
	70110					20.00
	70120					15.00
	70130					20.00
	70140					15.00
	70150					20.00
	70160					15.00
	70170					20.00
	70171					25.00
	70190					15.00
	70200					25.00

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE S $ NS
	70210			20.00
	70220			25.00
	70240			15.00
	70250			15.00
	70260			25.00
	70300			5.00
	70310			10.00
	70320			15.00
	70328			13.00
	70330			20.00
	70350			8.00
	70360			10.00
	70370			20.00
	70380			15.00
	70390			15.00
	70391			30.00
MN	71010			10.00
MN	71020			15.00
MN	71030			20.00
MN	71034			20.00
	71100			15.00
	71110			20.00
	71120			15.00
	71130			20.00
	72010			40.00
	72040			15.00
	72050			20.00
	72052			25.00
	72070			15.00
	72080			15.00
	72100			20.00
	72110			25.00
	72114			20.00
N	72170			15.00
	72180			15.00
	72190			20.00
	72200			20.00
	72220			15.00
	73000			10.00
	73010			15.00
	73020			15.00
	73030			15.00
	73040			15.00
	73041			45.00
	73050			18.00
	73060			15.00
	73070			15.00
	73080			15.00

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE S $ NS
	73085			15.00
	73086			45.00
	73090			10.00
	73092			20.00
	73100			10.00
	73110			15.00
	73115			15.00
	73116			45.00
	73120			10.00
	73130			15.00
	73140			5.00
N	73500			18.00
N	73510			20.00
	73520			25.00
	73525			15.00
	73526			45.00
	73530			30.00
	73540			15.00
	73550			15.00
	73560			15.00
	73562			15.00
	73580			15.00
	73581			45.00
	73590			15.00
	73592			20.00
	73600			10.00
	73610			13.00
	73615			15.00
	73616			45.00
	73620			10.00
	73630			13.00
	73650			10.00
	73660			5.00
	74000			10.00
	74010			15.00
	74020			15.00
N	74220			20.00
N	74240			40.00
N	74241			45.00
N	74245			50.00
N	74250			30.00
	74270			30.00
	74280			40.00
	74290			35.00
	74305			25.00
	74310			40.00
	74400			35.00
	74405			50.00

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE S	$	NS
	74420			35.00		
	74430			15.00		
	74431			25.00		
	74450			20.00		
	74451			40.00		
	74455			20.00		
	74456			35.00		
	74470			20.00		
	74471			40.00		
MN	74710			25.00		
	74720			20.00		
	74740			20.00		
	74741			40.00		
	74760			25.00		
	74761			40.00		
	76000			10.00		
	76020			15.00		
	76040			20.00		
	76061			35.00		
	76062			90.00		
	76080			15.00		
	76081			20.00		
	76090			26.00		
	76091			36.00		
	76100			35.00		
	76100	50		50.00		
	76150			4.00		
L	W7200			20.00		
L	W7250			30.00		

(k) Rehabilitation Services

N	92507	7.00	7.00	
	92552	11.00	11.00	
	92553	14.00	14.00	
	92572	20.00		
	92576	30.00		
	92589	10.00	10.00	
N	97799	7.00	7.00	
L	H5300	7.00	7.00	
L	Z0270	7.00	7.00	
L	Z0280	7.00	7.00	
L	Z0300	7.00	7.00	

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE S	$	NS
(1)	Vision Care Services					
	(See Vision Care Manual)					
(m)	Other Services					
N	55250		30	90.00		79.00
N	55450		30	42.00		37.00
N	57451		45	182.00		158.00
	58120		15	72.00		63.00
N	58600		45	211.00		184.00
N	58605		45	151.00		131.00
N	58982		45	182.00		158.00
N	58983		45	182.00		158.00
N	59840		45	79.00		68.00
N	59841		45	79.00		68.00
N	90250			9.00		7.00
N	90260			9.00		7.00
N	90270			9.00		7.00
L	Z0330			3.75		3.75
L	Z0335			7.25		7.25

APPENDIX A

INDEPENDENT CLINIC SERVICE

CODES AND NARRATIVES NOT FOUND IN CPT-4 (Level II & Level III Codes)

IND	HCPCS CODE	MOD	DESCRIPTION	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE S	$	NS
(a)	Examination and Treatment						
	J2790		RHO(D) Immune Globulin (Human) (Microdase for abortions and miscarriages)		42.50		42.50
N	W9090		Immunization-Haemophilus-b polysaccharide vaccine		9.90		9.90
	W9095		Immunization - Tetanus Antitoxin		5.45		5.45
N	W9820		Early Periodic Screening Diagnosis and Treatment (EPSDT) Through Age 20		23.00		18.00

1. Complete initial or interval history
2. Developmental assessment
3. Complete unclothed physical examination by a physician, or a nurse practitioner under the direct personal supervision of a physician, to include:
   (a) Measurements: Head circumference to 25 months, blood pressure from age 3 and older, height and weight
   (b) Vision and hearing screening
   (c) Nutritional assessment
4. Assessment of immunizations and administration of immunizations. (See appropriate procedure code(s) 90705 through 90709 for immunization reimbursement.)

IND	HCPCS CODE	MOD	DESCRIPTION	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE S $ NS

5. Referral for further diagnosis and treatment or follow-up of all correctable abnormalities uncovered or suspected

6. Referral to a dentist for children age 3 and older

7. Appropriate laboratory procedures performed or referred if medically necessary

   (a) HGB. Three times: 6-8 months, 2-3 or 4-6 years and 10-12 years.
   (b) Urinalysis a minimum of twice: 18-24 months and 13-15 years.
   (c) Tuberculin three times: 6-8 or 9-12 months, 4-6 years and 10-12 or 13-15 years.

   Medical records should substantiate the above services and should document significant positive and negative findings. It is recommended that consultation and discussion with the patient or family regarding findings be an integral part of every examination.

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.

NOTE: Procedure code W9820 can be used only once for the same patient during any 12 month period by the same physician, group, shared health

IND	HCPCS CODE	MOD	DESCRIPTION	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE S	$	NS
			care facility, or practitioners sharing a common record. If used following an annual health maintenance examination (90751, 90752, 90753, 90754, 90761, 90762 and 90763) within the preceding 12 months by the same physician, group, shared health care facility or practitioner sharing a common record, this code will automatically be downgraded in payment to a follow-up preventative health care visit. Reimbursement for code W9820 is contingent upon the following conditions: Unless a completed MC-19 form accompanies the MC-14 Claim Form within 30 days of the date of service, reimbursement will be reduced to the level of an annual health maintenance examination. i.e., $22.00-$17.00.				
(c)	Family Planning Services						
	W5850		Removal of I.U.D. followed at the same time by the insertion of a new intracervical of interuterine device for contraception. (Includes cost of device and post-insertion visit.)	30	66.00		61.00
(f)	Surgery						
	W1250		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).		18.00		16.00
	W1650		Excision of plantar verruca, single site unilateral		24.00		21.00

IND	HCPCS CODE	MOD	DESCRIPTION	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE $	$	NS
	W1650	22	Excision of plantar verruca multiple sites, unilateral		32.00		32.00
(g)	Mental Health Services						
	H5025	ZI	Group therapy: 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.		8.00		8.00
	Z0100		Off-Site Crisis Intervention - An emergency procedure provided by personnel of a mental health center to a known client at a location other than the grounds or buildings of the mental health center. Request for this service shall be initiated by the client or other interested person to meet the immediate needs of the client who is unable to present himself at the center. The procedure includes rapid intervention, written evaluation and recommendation of a treatment plan. Use of procedure is limited to twice in six months.		22.50		22.50
	Z0130		Complete psychological testing: five hours of psychometric and/or projective tests with a written report.		75.00		75.00
			Partial Hospitalization: A psychiatric service whose primary purpose is to provide a planned program of milieu therapy and other treatment modalities for				

IND	HCPCS CODE	MOD	DESCRIPTION	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE S	$	NS
			non-residential patients. This includes a prescription visit when necessary. A progress note shall be entered in the record no less frequently than once per calendar week. The record shall also contain a roster or other formal instrument to indicate the attendance of a recipient at a partial hospitalization session.				
	Z0150		Half Day (3 hours minimum)		8.00		8.00
	Z0160		Full Day (5 hours minimum)		15.50		15.50

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

Partial Care: A mental health service whose primary purpose is to maximize the client's independence and community living skills in order to reduce unnecessary hospitalization. It is directed toward the acute and chronically disabled individual. PC programs shall provide, as listed below, a full system of services necessary to meet the comprehensive needs of the individual client. Services shall be provided or arranged for, to meet the individual needs of participating clients. These services shall include:

Assessment and evaluation;
Service procurement;
Therapy[1];
Information and referral;
Counseling;

IND	HCPCS CODE	MOD	DESCRIPTION	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE S $ NS

Daily living education;
Community organization;
Employment/employment readiness[1];
Housing/placement[1];
Legal[1];
Recreation[1];
Education (for children's Partial Care)[1];
Transportation[1];
Health-related[1].

Partial Care programs shall be available daily for five days a week, with additional planned activities each week, during evening and/or weekend hours as needed. Individual clients need not attend every day but as needed. Partial Care programs specifically developed for children may be available four days a week, with one evening and/or weekend activity(ies).

The staff of the Partial Care Program should include a Director who shall be a qualified professional from the specialties of psychiatry, psychology, social work, psychiatric nursing, vocational rehabilitation, or a related field with training and/or experience in direct service provision and administration. A qualified psychiatrist shall be available to the PC program on a regularly scheduled basis, for consultation. Other staff deemed necessary to implement a Partial Care Program which meets the requirement of this section should include qualified mental health professionals, paraprofessionals and volunteers.

IND	HCPCS CODE	MOD	DESCRIPTION	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE S	$	NS
			In order to qualify as an approved Partial Care Program the program must be certified by the Department.				
	Z0170		Half Day (3 hours minimum)		15.00		15.00
	Z0180		Full Day (5 hours minimum)		30.00		30.00
			[1]These services may be provided directly or arranged by PC staff, through other Program Elements or agencies, to avoid duplication.				
			NOTE: Except for transportation these rates reflect full payments with a prohibition against multiple billing for more than one service to a Medicaid patient in a given day.				
(h)	Obstetrical Services (Maternity)						
	Z0250	WM	Home Delivery Pack. All drugs and supplies, etc., necessary for delivery in this setting.			40.00	
(i)	Podiatry						
	W2650		Casting for molded shoes Prior authorization is required. Attach to your MC-14 claim form.		21.00		21.00
	W2655		Casting for arch support Prior authorization is required. Attach to your MC-14 claim form.		5.00		5.00
(j)	Radiology Services						
	W7200		Foot, complete (incl. special os calcis views)		20.00		20.00
	W7250		Colon, barium enema, with or without K.U.B. air contrast only (with fluoroscopy by the radiologist).		30.00		30.00

IND	HCPCS CODE	MOD	DESCRIPTION	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE S	$	NS
(k)	Rehabilitation Services						
	H5300		Occupational therapy		7.00		7.00
	Z0270		Physical-therapy-initial visit, per individual, per provider		7.00		7.00
	Z0280		Occupational therapy-initial visit, per individual, per provider		7.00		7.00
	Z0300		Speech-Language-Therapy-initial visit, per individual, per provider		7.00		7.00
(m)	Other Services						
	Z0330		Transportation, one way (one way applicable when clinic transports the recipient either to or from the clinic in any one day).		3.75		3.75
	Z0335		Transportation, round trip (Reimbursement is limited to one round trip per day for the same recipient by the same provider.)		7.25		7.25

APPENDIX B

(Independent Clinic Services)

QUALIFIERS

(a) EXAMINATION AND TREATMENT

DRAWING OF BLOOD

36415 Once per visit per patient (not applicable if lab study, in any part, is to be performed by the clinic).

CLINIC VISIT - INITIAL

90015
90017
90020 Limited for reimbursement purposes to one such examination of the same recipient by the same Independent Clinic.

Includes as a minimum on the record:

i. Chief complaint(s)

ii. Complete history of the present illness and related systemic review including recording of pertinent negative findings

iii. Complete pertinent past medical history

iv. Pertinent family history

v. A full physical examination pertaining to but not limited to the history of the present illness and includes recording of pertinent negative findings

vi. Working diagnosis and treatment plan including ancillary services and drugs ordered.

NOTE: Reimbursement for Codes 90015-90020 will be disallowed and the fee will be downgraded to Codes 90050-90070, provided its criteria are met, if Procedure Code 90760, 90*015WF, W9820 or 90761 has been performed within a 12 month period.

NOTE: This code will be declined if claimed for a Preventive Health Care Visit for patients age 20 or less. If visit is of a preventive care nature, uses Codes 90761 or 90050-90070. For patients age 20 or less, Item 13C of the MC-14 (Independent Outpatient Health Facility) must carry a diagnosis compatible with at least a presumptive illness and not that of preventive health care.

CLINIC VISIT

90050
90060
90070

For reimbursement purpose a clinic visit will consist of care and treatment by the physician and include those procedures ordinarily performed during a clinic visit dependent upon physician's discipline. The following will be included as a minimum in the progress notes:

i. Purpose of visit

ii. Pertinent history obtained

iii. Pertinent physical findings including pertinent negative physical findings based on 1) and 2)

iv. Procedures - if any performed-with results

v. Lab, x-ray, and ECG, etc., ordered-with results

vi. Diagnosis(s) plus treatment plan status, including drugs ordered, relative to present and pre-existing illness plus pertinent recommendations and actions

NOTE: This code will be declined if claimed for a Preventive Health Care Visit for patients age 20 or less. If visit is of a preventive health care nature, use Code 90764. For patients age 20 or less, Item 13C of the MC-14 (Independent Outpatient Health Facility) claim form must carry a diagnosis compatible with at least a presumptive illness and not that of preventive health care.

NOTE: It is recommended that for patients age 20 and under, a statement as to the status of immunizations, nutrition, and development be included at appropriate intervals.

ANNUAL HEALTH MAINTENANCE EXAMINATION - AGE 21 AND OVER

90760

For reimbursement purposes, the annual health maintenance examination limited to patients age 21 and over must contain as a minimum the following information on the record. It also will be limited to a maximum of one such examination a year and also is limited to an office type setting. It must be justified by Medical Necessity. The record should show:

1. Interval history.

2. Completing or updating the pertinent past medical history, family history and social/personal history.

3. Complete systemic review including all systems and pertinent negative findings. Complete total systems physical examination

permitting the deferment of a system for medically acceptable reason, e.g., deferment of pelvic examination in an individual under the care of a gynecologist. Pertinent negative findings of the physical examination are to be recorded.

4. Working diagnosis and treatment plan, including ancillary services and drugs ordered, if applicable.

An Annual Examination will be disallowed if an Initial Clinic Visit or an Annual Examination has been performed during the prior twelve months by the same clinic, group, shared health care facility or practitioners sharing common records. Routine office visit could then be applicable if criteria are met.

ROUTINE NEWBORN CARE - WELL BABY

90285 CPT Code 90285 - Routine Hospital Newborn Care. For reimbursement purposes, code 90285 requires a minimum routine newborn care by a physician other than the physician(s) rendering maternity service, complete initial and complete discharge physical examination, conference(s) with the parent(s), all documented in the records.

NEWBORN CARE - "SICK" BABY

90250
90260
90270 For sick babies use appropriate subsequent hospital care code:

1. Routine Visit Care - 90250, 90260 and 90270

99150
99151
99160 2. If Prolonged Detention Codes are applicable - 99150, 99151 or 99160

INFANT, CHILD AND ADOLESCENT CARE

90701
90702
90703
90704
90705
90706
90707
90708
90709
90712
90719
90724
90732
J2790
W9090
W9095
W9820

Immunization Procedures - The reimbursement for an immunization procedure includes the service and the materials. If the criteria for an office visit can also be met, then the immunization and the office visit may be claimed utilizing the appropriate procedure codes.

In the event there is the need for a specific immunization not listed as a covered service, the provider should obtain prior authorization from the Medicaid District Office prior to the administration of the vaccine.

Early Periodic Screening Diagnosis And Treatment (EPSDT) is found under code W9820 in Appendix A.

ANNUAL HEALTH MAINTENANCE EXAMINATION THROUGH 20 YEARS

90751
90752
90753
90754
90761
90762
90763

For reimbursement purposes, these codes appropriately reflect the age groups listed in the CPT narrative. They will reflect old as well as new patients and must include the following information on the chart.

1. History (complete initial for new patient, interval for established patient) including past medical history, family history, social history, and systemic review.

2. Developmental and nutritional assessment.

3. Complete, unclothed, physical examination to include also the following:

   (a) measurements: height and weight, blood pressure for children age 3 or older;

   (b) vision and hearing screening.

4. Assessment of and administration of immunizations appropriate for age and need.

5. Further diagnosis, treatment and follow-up, by referral if necessary, of all correctable abnormalities uncovered or suspected.

6. Referral to a dentist for children age 3 or older.

7. Laboratory procedures performed or referred if medically necessary. Recommendations are:

   (a) Hgb. twice: 3-6 years; and 10-12 years.

   (b) Urinalysis at least once between 13-15 years.

   (c) Tuberculin twice: 4-6 years; and 10-12 or 13-15 years.

8. Anticipatory guidance.

9. Offer of social service assistance; if requested, direct patient to county social service worker.

Note: Medical records should substantiate the above services and should document significant positive and negative findings. Discussion and consultation with the patient or family regarding findings should be an integral part of every examination.

Note: Annual health maintenance codes 90751, 90752, 90753, 90754, 90761, 90762, and 90763, apply from age 0 through 20 and may be used only once in a 12-month period. If used following an EPSDT examination performed within the preceding 12 months or more frequently

than once in 12 months, these codes will automatically be downgraded in payment to a follow-up office Preventive Health Care Visit if the medical need is justified.

CLINIC VISIT - PEDIATRIC PREVENTIVE HEALTH CARE

90764 For reimbursement purposes, this code extends through age 20. This code reflects follow-up office preventive health care for established patients. Reimbursement for this code requires as a minimum the performance of the procedures listed in the following chart as they pertain to the appropriate age group.

AGE[1]	1 mo	2 - 3 mos	4 - 5 mos	6 - 8 mos	9 - 12 mos	13 - 17 mos	18 - 24 mos	25 - 48 mos	5 - 6 yrs	7 - 9 yrs	10 - 11 yrs	12 - 15 yrs	16 - 20 yrs
HISTORY													
INITIAL						AT FIRST VISIT							
INTERVAL	X	X	X	X	X	X	X	X	X	X	X	X	X
MEASUREMENTS													
HEIGHT & WEIGHT	X	X	X	X	X	X	X	X	X	X	X	X	X
HEAD CIRCUMFERENCE	X	X	X	X	X	X	X						
BLOOD PRESSURE								X	X	X	X	X	X
SENSORY SCREENING													
SIGHT	X	X		X				X	orX	X	X	X	X
HEARING								X	orX				
SYSTEMIC REVIEW	X	X	X	X	X	X	X	X	X	X	X	X	X
DEVELOPMENTAL APPRAISAL	X	X	X	X	X	X	X	X	X	X	X	X	X
NUTRITIONAL ASSESSMENT	X	X	X	X	X	X	X	X	X	X	X	X	X
PHYSICAL EXAM,(UNCLOTHED)	X	X	X	X	X	X	X	X	X	X	X	X	X
IMMUNIZATIONS[2]		X	X	X		X	X		X			X	
PROCEDURES													
*TUBERCULIN TEST[3]				X	or X				X		X	or X	
*HGB OR HEMATOCRIT				X				X	orX		X		
*URINALYSIS							X				X		
URINE CULTURE (OPTIONAL								X	X	X			
OTHERS AS INDICATED													
DISCUSSION AND COUNSELING	X	X	X	X	X	X	X	X	X	X	X	X	X
DENTAL SCREENING	X	X	X	X	X	X	X	X	X	X	X	X	X
REFER FOR INITIAL DENTAL EXAM								X					

The above is endorsed by the Maternal and Child Health Program of the New Jersey State Department of Health. Service rendered must be documented in record.

[1]If child comes under care for first time at any point on the schedule or if any items are not accomplished at the suggested age the schedule should be brought up-to-date.

[2]Review of immunizations at each visit and administration of immunizations appropriate for age and need. (See appropriate procedure code(s) for immunization reimbursement.)

[3]May be indicated more frequently in certain areas. Should be administered prior to or simultaneously with measles immunization.

[4]Further diagnosis, treatment and follow-up by referral to self or other appropriate professional, of all correctible abnormalities suspected or uncovered.

[5]Offer of social service assistance; if requested, direct patient to county social service worker.

*These items are recommended.

INJECTION (Intradermal, Subcutaneous, Intravenous, or Intraarterial)

90799 Reimbursement for the above injections are a flat fee basis and are all inclusive for the cost of the service and the drug or vaccine. Be advised of the following.

i. A visit for the sole purpose of an injection is reimbursable as an injection and not as a visit plus an injection.

However, if the criteria of a clinic visit is met, an injection may, if medically indicated, be considered as an add-on to the visit. The drug administered must be consistent with the diagnosis and conform to accepted medical and pharmacological principles in respect to dosage, frequency and route of administration

ii. Intravenous and intraarterial injections are reimbursed only when performed by the physician.

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

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

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

vi. No reimbursement will be made for estrogen injections given for the treatment of Menopausal Syndrome.

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

viii. Insert procedure code number 90799 as a separate item on the MC-14 form under Item 13B. This is to be followed by the name, dose of drug and route of administration. The complete diagnosis, for which the injection was given, must be inserted on the same line in Item 13C.

ix. Injectable prescription drugs are not a reimbursable item to provider or recipient.

Exception: (obtained by prescription from a pharmacy provider)

(1) Parenteral anti-neoplastic drugs F.D.A. approved.

(2) 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.

(3) Drugs to be administered to a patient by other than the clinic or the employee. Physician's prescription must carry the legend "MEDICAID AUTHORIZED". Prior authorization is required.

(4) Insulin

(5) Hymenoptera Venom for Immuno-therapy - Prior authorization required from medical/consultant Local Medicaid Office.

PROLONGED DETENTION

99150
99151
99160

Prolonged Detention with or without Critical Care will be covered under CPT 99150, 99151, and 99160 but the service must be consistent with the following narrative in order to be reimbursed.

The patient's situation requires constant physician attendance which is given by the physician to the exclusion of his other patients and duties and, therefore, for him, represents what is beyond the usual service. This must be verified by the applicable records as defined by the setting and which records must show in the physician's handwriting the time of onset and time of completion of the service. All settings are applicable such as office, hospital, home, sheltered boarding home and nursing home.

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

NOTE: The basis for this type of claim should be apparent on the MC-14 claim form. The listed fee of $37 for specialist, $32 for non-specialist is per hour.

(b) DENTAL SERVICES

(See Dental Services Manual.)

(c) FAMILY PLANNING SERVICES

INITIAL MEDICAL VISIT

90015WF Family Planning to include each of the following:

i. Medical, social, obstetrical history

ii. Compelte pelvic examination - including visual inspection of the cervix

iii. Breast examination

iv. Papanicolaou smear (excludes cytology study)

v. Contraceptive counseling with referral as indicated

This code includes cost of birth control drugs dispensed. A prescription cannot be substituted.

Procedure code 90015WF will be disallowed if procedure codes 90015-90020, 90760 or 90015WF has been performed during the prior 12 months by the same provider.

ROUTINE OR FOLLOW-UP VISIT - BRIEF

90040WF May include pelvic examination, changes in method or physician's instructions. Minimum average time is five (5) minutes.

MEDICAL REVISIT - FAMILY PLANNING

90060WF May include pelvic examination, changes in method or physicians' instructions. This code includes cost of birth control drugs dispensed. A prescription cannot be substituted.

ROUTINE OR FOLLOW-UP VISIT - PROLONGED

90070WF May include pelvic examination, changes in method or physicians' instructions. Involves 20 or more minutes of personal time in patient contact, including documentation of time as well as adequate significant progress notes on the clinic record. This code includes costs of birth control drugs dispensed. A prescription cannot be substituted.

ANNUAL MEDICAL REVISIT

90760WF Family Planning to include each of the following:

i. Updating medical, social, obstetrical history

ii. Complete pelvic examination including visual inspection of cervix

iii. Breast examination

iv. Papanicolaou smear (excludes cytology study) with referral when indicated

This code includes costs of birth control drugs dispensed. A prescription cannot be substituted.

Procedure code 90760WF will be disallowed if procedure codes 90015-90020, 90760 or 90015WF has been performed during the prior 12 months by the same provider.

INSERTION OF IUD

58300 Insertion of intra-cervical or intrauterine device for contraception (Includes costs of device and post insertion visit)

PRIMARY STERILIZATION (FAMILY PLANNING) PROCEDURE

55250
55450 Note: Completed consent form must be attached to 1500-N.J. claim form. See Subchapter 1 (1.8 (a) thru (c) Sterilization). Policy originally published as New Jersey Health Services Program Newsletter P-334, dated 5/17/82, with subsequent revisions.

CYTOLOGY SMEAR

88150 Cytology smear (e.g. Papanicolaou), (PAP) cervical and/or vaginal (obtaining specimen not an eligible service with or without diagnosis)

FAMILY PLANNING SERVICES BY CERTIFIED NURSE-MIDWIFE

INSERTION/REMOVAL OF IUD

58300WM Insertion of intracervical or intrauterine device for contraception by the 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 six-week post-partum period.

58301WM 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 six-week post-partum period.

ROUTINE OR FOLLOW-UP VISIT BY A NURSE-MIDWIFE

90060WMWF Routine or follow-up visit, prolonged - provided by a certified nurse-midwife and limited to within the six week post-partum period: may involve pelvic examination, changes in method or instructions. Involves 20 or more minutes of personal time in patient contact, including documentation of time as well as adequate significant progress notes on the clinic record. This 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).

(d) LABORATORY SERVICES

URINALYSIS (Chemical and Microscopic)

81000 Note: Stick, Dip or Tablet Test done on urine are considered part of the urinalysis, and, therefore are not eligible for reimbursement.

HEMOGLOBLIN (Photoelectric method only)

83051 Note: Reimbursement not eligible for other method.

(e) MEDICAL DAY CARE (See Medical Day Care Manual)

(f) SURGERY

An asterisk preceding any procedure code also can be done by the podiatrist.

10040 Limited to severe acne. For less than severe acne, utilize a procedure code for an office visit.

(g) MENTAL HEALTH SERVICES

INITIAL COMPREHENSIVE PSYCHIATRIC EVALUATION

90801ZI This code requires for reimbursement purposes a minimum of 90 minutes of direct personal clinical involvement with the patient or

family member. The CPT narrative otherwise remains applicable. No more than one claim for the code 90801 is reimbursable per the same recipient, per the same physician, per year.

INDIVIDUAL PSYCHOTHERAPY - 25 Minute Session

90843ZI This code requires for reimbursement purposes a minimum of 25 minutes of direct personal clinical involvement with the patient and/or family member.

INDIVIDUAL PSYCHOTHERAPY - 50 Minute Session

90844ZI This code requires for reimbursement purposes a minimum of 50 minutes of direct personal clinical involvement with the patient and/or family member.

FAMILY THERAPY

90847ZI This code requires for reimbursement purposes a minimum of 50 minutes of direct personal clinical involvement with the patient and/or family member. The CPT narrative otherwise remains applicable.

FAMILY THERAPY

9084722ZI This code requires for reimbursement purposes a minimum of 80 minutes of direct personal clinical involvement with the patient and/or family member. The CPT narrative otherwise remains applicable.

FAMILY CONFERENCE

90887ZI This code requires for reimbursement purposes a minimum of 25 minutes of direct personal clinical involvement with the patient, family member or caretaker. The CPT narrative otherwise remains applicable.

GROUP PSYCHOTHERAPY

H5025ZI This code requires for reimbursement purposes a minimum of 90 minutes of direct clinical involvement with the patient as a member of a group of which 10 minutes can be used for documentation. The maximum number of the group is 8 and the reimbursement is per person per group session.

(h) OBSTETRICAL SERVICES (MATERNITY)

TOTAL OBSTETRICAL CARE

59400 i. Ante partum care consisting of initial ante partum visits and seven subsequent ante partum visits. Specific dates of all visits are to be listed on the Independent Outpatient Health Facility Claim form (MC-14).

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

If medical necessity dictates corroborated by the record, additional visits above seven ante partum may be reimbursed under procedure code 90040-90070 (routine or follow-up clinic visit). The claim form shall clearly indicate the reason for the medical necessity and date for each 90040-90070 listed.

ii. Obstetrical delivery with in-hospital post-partum care (with or without low forceps and/or episiotomy or a vaginal delivery full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours). This shall also include one visit between the 15th and 60th post-partum day following delivery and out of hospital. Include name of hospital and delivery date on the MC-14.

VAGINAL DELIVERY

59410 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 name of hospital and delivery date on the MC-14.

SUBSEQUENT ANTE PARTUM VISIT

59420 Subsequent ante partum visit (separate procedure). Indicate specific dates of service.

INITIAL ANTE PARTUM VISIT

5942022 Initial ante partum visit (separate procedure)

POST-PARTUM CARE

59430 Post-partum care (other than delivering physician) one visit between 15th and 60th post-partum day following delivery, out of hospital (separate procedure)

OBSTETRICAL SERVICES (MATERNITY) BY A NURSE-MIDWIFE

TOTAL OBSTETRICAL CARE

59400WM Total obstetrical care when given by a certified nurse-midwife and includes:

i. 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 Independent Outpatient Health Facility claim form MC-14).

NOTE: Reimbursement will be decreased by the fee for the initial ante partum visit (code 5942022WM) 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 59420WM) which is less than seven.

NOTE: If medical necessity dictates, corroborated by the record, additional visits above seven ante partum may be reimbursed under procedure code 90050WM (routine or follow-up visit). The claim form should clearly indicate the reason for the medical necessity and date for each code 90050WM listed.

ii. Obstetrical delivery per vagina with or without episiotomy including post-partum 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 post-partum day following delivery and out of the hospital. Include delivery date on the Independent Outpatient Health Facility claim form (MC-14).

VAGINAL DELIVERY

59410WM Obstetrical delivery per vagina with or without episiotomy including post-partum 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 post-partum day following delivery and out of hospital.

Include delivery date on the Independent Outpatient Health Facility claim form (MC-14).

SUBSEQUENT ANTE PARTUM VISIT

59420WM Subsequent ante partum visits provided by a certified nurse-midwife (separate procedure). Indicate specific dates of service.

INITIAL ANTE PARTUM VISIT

5942022WM Initial ante partum visit provided by a certified nurse-midwife (separate procedure).

POST-PARTUM CARE

59430WM Post-partum 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 post-partum day following delivery. Include delivery date on the Independent Outpatient Health Facility claim form (MC-14). (separate procedure)

CLINIC OR HOME VISITS

90050WM
90060WM
90150WM
90160WM 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.

(i) PODIATRY SERVICES

For additional procedures, see Section 3.3 (f) (Surgery).

ROUTINE OR FOLLOW-UP CLINIC VISIT

90050YR Routine or follow-up clinic visit - Podiatry consisting of routine care and treatment by the podiatrist. To include significant written progress notes and office records which demonstrate positive findings and treatment changes.

(j) RADIOLOGY SERVICES

CHEST

71010
71020
71030
71034

Routine chest x-rays without medical necessity in an office (clinic) or hospital setting are not reimbursable under Program Guidelines. See Appendix C (Medical Necessity Program) at the end of this manual.

PELVIS

72170 Pelvis x-ray is not eligible for separate payment when performed in conjunction with Complete Lumbosacral Spine x-rays (72110).

HIP

73500
73510

Procedure 73520 should be used for Bilateral Hip x-rays when both hips are x-rayed instead of billing separately for each hip (73500, 73510).

ESOPHAGUS

74220 (With fluoroscopy by the radiologist)

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

PELVIMETRY

74710 NOTE: Use of the code for pelvimetry requires written evidence of medical necessity to accompany the Independent Outpatient Health Facility claim form (MC-14). See Appendix C at the end of Section 3.2.

(k) REHABILITATION SERVICES

SPEECH THERAPY

92507 Minimum time 30 minutes. Prior authorization required. Prescribed by a licensed physician, performed by a qualified speech-language pathologist.

PHYSICAL THERAPY

97799 Individual treatment session

Minimum time 30 minutes. No more than three patients can be treated simultaneously. Prior authorization required. Consists of any one or a combination of the following modalities, prescribed by a licensed physician, performed by a qualified physical therapist and related to the patient's active treatment regimen.

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

(2) Graduated range of motion exercises

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

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

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

(m) OTHER SERVICES

HOSPITAL VISIT

90250
90260
90270 Hospital Day - consisting of care and treatment by the physician and including those procedures ordinarily performed during a hospital visit dependent upon the physician's discipline. The following will be included as a minimum in the progress notes:

(1) Update of symptoms

(2) Update of physical findings

(3) Resume of findings of procedures, if any done

(4) Lab, x-ray, ECG, consultations, etc., pertinent positive and negative findings.

(5) Changes or confirmations of diagnosis and progress of case

(6) Additional planned studies, if any, and why

(7) Treatment changes, if any

STERILIZATION

MALE

Primary Sterilization (Family Planning) Procedure:

55250
55450

Note: Completed consent form must be attached to 1500-N.J. claim form. See Subchapter 1 (1.8 (a) thru (c) Sterilization). Policy originally published as New Jersey Health Services Program Newsletter P-334, dated 5/17/82, with subsequent revisions.

FEMALE

57451

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.

Note: Completed consent form must be attached to 1500-N.J. claim form. See Subchapter 1 (1.8 (a) thru (c) Sterilization). Policy originally published as New Jersey Health Services Program Newsletter P-334, dated 5/17/82, with subsequent revisions.

58600

Primary Sterilization (Family Planning) Procedure

Note: Completed consent form must be attached to 1500-N.J. claim form. See Subchapter 1 (1.8 (a) thru (c) Sterilization) or New Jersey Health Services Program Newsletter P-334, 5/17/82 and subsequent revisions.

Note: Tubal sterilization procedure at the time of caesarean section, will carry no additional allowance.

58605

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).

Note: Completed consent form must be attached to 1500-N.J. claim form. See Subchapter 1 (1.8 (a) thru (c) Sterilization) or New Jersey Health Services Program Newsletter P-334, 5/17/82 and subsequent revisions.

58982
58983

Primary Sterilization. (Family Planning Procedure. Procedure by Laparoscopy with or without dilation and curettage.

Note: Completed consent form must be attached to 1500-N.J. claim form. See Subchapter 1 (1.8 (a) thru (c) Sterilization) or New Jersey Health Services Program Newsletter P-334, dated 5/17/82, and subsequent revisions.

(m) OTHER SERVICES

ABORTION

59840
59841

See Subchapter 2 (2.1-Abortions). Policy originally published as NJHSP Newsletter, Volume P-268, "Policy Regarding Medicaid Reimbursement for Abortions" FD-179 form must be attached to the 1500-N.J. claim form.

NOTE: Trimester of pregnancy must be identified on the 1500-N.J. claim form by using modifier "WY" for 1st trimester or "WZ" for 2nd trimester.

APPENDIX C

MEDICAL NECESSITY PROGRAM

(This information was originally published in Newsletters: P-217, December 26, 1977; P-298, May 15, 1981; P-354, April 11, 1983.)

The New Jersey Medicaid Program on January 1, 1978, adopted a Medical Necessity Program similar to the Blue Shield Association's Medical Necessity Program and concurrent with its implementation by Blue Shield of New Jersey.

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

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

Physicians are required to maintain written records that substantiate the use of a given procedure code. These records must be available for review and/or inspection if requested by the New Jersey Medicaid Program.

These procedures fall into the following four categories:

(1) New procedures of unproven value.

(2) Established procedures of questionable current usefulness.

(3) Procedures which tend to be redundant when performed in combination with other procedures.

(4) Diagnostic procedures which are unlikely to provide a practitioner with additional information when they are repeated.

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

(1) If the only purpose for inpatient admission was to provide these procedures, both physician and hospital claims will be denied; if already paid, will be subject to recovery.

(2) If the only purpose for outpatient admission was to provide these procedures, the hospital's claim and the physician's claim (if applicable) will be denied; if already paid, will be subject to recovery.

(3) If laboratory procedures (diagnostic studies 1 through 5) are performed on an ambulatory basis by an independent laboratory or a physician, such claims will be denied but may not necessarily include claims for office visits; if already paid, will be subject to recovery.

SURGICAL PROCEDURES

The following Surgical Procedures are not eligible for reimbursement unless the claim form is accompanied by an acceptable written justification supporting the medical necessity.

NOTE: The regulations apply to procedures 14 through 20 only when they are performed under the circumstances given.

(1) Ligation of internal mammary arteries, unilateral or bilateral

(2) Radical Hemorrhoidectomy, Whitehead type, including removal of entire pile bearing area

(3) Omentopexy for establishing collateral circulation in portal obstruction

(4) Kidney decapsulation, unilateral and bilateral

(5) Perirenal insufflation

(6) Nephropexy: fixation or suspension of kidney (independent procedure)

(7) Circumcision, female

(8) Hysterotomy, non-obstetrical, vaginal

(9) Supracervical hysterectomy: subtotal hysterectomy, with or without tubes and/or ovaries, one or both

(10) Uterine suspension

(11) Uterine suspension with presacral sympathectomy

(12) Hypogastric or presacral neurectomy (independent procedure)

(13) Ligation of thyroid arteries (independent procedure)

(14) Fascia lata by stripper, as treatment for lower back pain

(15) Fascia lata by incision and area exposure, with removal of sheath as treatment for lower back pain

(16) Ligation of femoral vein, unilateral or bilateral, as treatment for post phlebitic syndrome

(17) Excision of carotid body tumor, with or without excision of carotid artery, as treatment for asthma

(18) Sympathectomy, thoracolumbar, unilateral or bilateral, as treatment for hypertension

(19) Sympathectomy, lumbar, unilateral or bilateral, as treatment for hypertension

(20) Splanchnicectomy, unilateral or bilateral, as treatment for hypertension

(21) Fabric wrapping of abdominal aneurysm

(22) Extra-intracranial arterial bypass for stroke

DIAGNOSTIC PROCEDURES

Routine payment is not permissible for the following Diagnostic Procedures unless the claim is accompanied by an acceptable written justification supporting the medical necessity.

(1) Basal metabolic rate (BMR)

(2) Protein bound iodine (PBI)

(3) Icterus index

(4) Ballistocardiogram (BCG)

(5) Phonocardiogram with interpretation and report, and with indirect carotid artery tracing or similar study

(6) Angiocardiography, using CO2 method, supervision and interpretation only

(7) Angiocardiography, single plane, supervision and interpretation in conjunction with cineradiography

(8) Angiocardiography, multi-plane, supervision and interpretation in conjunction with cineradiography

(9) Angiography-coronary, unilateral, selective injection, supervision and interpretation only, single view unless emergency

(10) Angiography - extremity, unilateral, supervision and interpretation only, single view unless emergency

(11) Bronchoscopy, with injection of contrast medium for bronchography

(12) Bronchoscopy, with injection of radioactive substance

(13) PRENATAL ULTRASONOGRAPHY

Prenatal ultrasonography will be considered medically necessary when it is documented in the physician's record as being performed for one of the indications outlined by the Society of Obstetrical and Gynecological Ultrasonographers as noted below:

a. Determination of fetal viability where abortion or intrauterine demise is clinically suspected.

b. Dating a pregnancy in late registrants or where there is a discrepancy between clinical and historical data in the first trimester.

c. Determination of placental position in patients with vaginal bleeding or a fetus in an unstable lie.

d. Evaluation of a pregnancy when there is a discrepancy between uterine size and dates at any stage in pregnancy.

e. Use prior to amniocentesis to determine the optimal site of needle insertion.

f. Monitoring fetal growth where intrauterine growth retardation is suspected.

g. Evaluation when multiple gestation is suspected.

h. Evaluation when fetal anomaly is suspected.

i. Determination of fetal size or maturity in breech presentation.

j. Evaluation of amniotic fluid quantity in cases of oligohydramnios, polyhydramnios, and clinically suspected premature rupture of the membranes.

k. Evaluation of post-term pregnancies.

l. Evaluation of possible molar pregnancies.

m. Use as an adjunct to special procedures such as intrauterine transfusion, placental aspiration, and fetoscopy.

n. Evaluation of pelvic masses during pregnancy.

If ultrasonography is utilized for any other indication, the physician is required to enter in the medical records sufficient documentation of medical necessity.

(14) PRENATAL LABORATORY TESTS

The following procedures are the only laboratory tests routinely considered medically necessary during pregnancy:

a. CBC

b. Urinalysis-including microscopic

c. Blood type and RH factors

d. Serology

e. Antibody screening

f. Rubella Titer

A physician must substantiate in his records the medical need for utilizing any other prenatal laboratory test.

(15) PELVIMETRY, WITH OR WITHOUT PLACENTAL LOCALIZATION

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 this procedure to the group of procedure codes requiring evidence of Medical Necessity.

(16) OBSOLETE OR UNRELIABLE DIAGNOSTIC TESTS

The New Jersey Medicaid Program is requiring documentation of medical necessity for those lab and skin tests that Medicare has declared obsolete or unreliable (refer to Medicare Bulletin 80-10, July 1980).

The specific tests listed below will be reimbursed only when written medical justification accompanies the claim form.

Starch, feces, screening

Gastric Analysis, Tubeless

When used to cover the following skin tests:

a. Skin Test - cat scratch fever

b. Skin Test - lymphopathia venereum

c. Skin Test - actinomycosis

d. Skin Test - brucellosis

e. Skin Test - leptospirosis

f. Skin Test - psittacosis

g. Skin Test - trichinosis

Circulation time, one test

(17) ROUTINE CHEST X-RAYS

The President's Committee on Radiation Exposure has recommended the elimination of all routine x-rays and the utilization of only those radiologic procedures deemed medically indicated. The New Jersey Medicaid Program, in accordance with this recommendation, no longer reimburses physicians for chest x-rays routinely performed in the physician's office as part of an initial evaluation or annual physical examination.

Physicians will continue to be reimbursed for chest x-rays performed in their office for diagnostic purposes. The physician must document the medical necessity for the procedure in the patient record.

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

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REC'D JUL 30 1985

TO: MEDICAL SUPPLIER PROVIDERS

SUBJECT: POLICY CLARIFICATION: CLAIMS FOR TOTAL PARENTERAL NUTRITION (TPN) NUTRIENTS AND SUPPLIES

EFFECTIVE: IMMEDIATELY

PURPOSE: This Newsletter outlines the information required on claim forms in order that the claims for reimbursement for TPN solutions, equipment and supplies may be processed in an efficient and consistent manner.

BACKGROUND: A review of claims submitted relative to TPN indicated the need to clarify the policy on reimbursement and to review the procedure on submission of claims.

ACTION: The New Jersey Medicaid Program will pay the provider's usual and customary charge or the MediCARE prevailing allowance, whichever is less for TPN nutrients and supplies. Medical Supplier providers must complete the claim form MC-11 (Medical Supplies and Equipment) in the usual manner. However, the following items must be addressed; if not, the claim will be returned to the provider for completion and/or correction.

1. From/to dates should be clearly stated. (Item 14A)

2. Dates must not overlap from claim to claim.

3. The items being supplied should be specifically indicated on the claim. (Item 14C)

4. When billing for TPN solutions and fat emulsions, the amount of solution in mililiters per day should be included. (Item 14C)

5. Payments for supplies and for the rental of the pump and IV pole are based on daily rates. Thus, it is important that the number of days are included for these items. It is preferable that one month's supplies be billed for at one time and that the rental dates be the same every month. (Item 14E)

6. All claims should include the diagnosis (Item 12) and the Individual Medicaid Practitioner (IMP) number of the referring doctor. (Item 16)

NOTE: Effective 60 days from the date of this Newsletter, claims that do not conform to the billing instructions outlined above will be returned to the provider for completion and inclusion of missing information.

Attached is a filled-in sample MC-11 claim form.

If you have any questions regarding this Newsletter, please call the New Jersey Medicaid Program, Chief Pharmaceutical Consultant at (609) 292-3756.

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

MEDICAL SUPPLIES AND EQUIPMENT CLAIM (PLEASE PRINT)

14

1. Patient's Last Name: Doe — First Name: John
2. Patient's Street Address: 101 Common Place — Telephone Number: 609-555-1111
City: Trenton — State: N.J. — Zip Code: 08625
3. HSP (Medicaid) Case No.: 0 3 2 0 9 9 9 9 9 9 — 4. Patient Person No.: 0 1 — 5. Age: 50 — 6. Sex: [X] Male [ ] Female
7. Other Health Insurance or Liability Coverage? [ ] Yes [X] No
If Yes, attach a copy of Decline Notice or Explanation of Payment from Carrier.
No Fault Auto coverage? [ ] Yes [X] No
(If MEDICARE — See Section 304 of Manual)
8. Was Patient's Illness or Injury connected with employment? [ ] Yes [X] No
If Yes, give Name and Address of Employer here.
10. Did injury result from automobile accident? [ ] Yes [X] No
9. PROVIDER OF SERVICE INFORMATION
Telephone Number: 609 - 111-5555
Medicaid Provider Number (Enter only when not printed below): 123456789 012
Name and Address:
Medical Supplier Provider
1 Trenton Rd.
Trenton, N.J. 08625
11. Prescription Attached [ ] Yes [ ] No
12. Primary Diagnosis: Chrohn's Disease Malnutrition — Secondary Diagnosis:
13. Was this service performed as a result of an EPSDT Program Referral? [ ] Yes [X] No

FOR FISCAL AGENT'S USE

TOTAL AMOUNT A	TOTAL AMOUNT B	CODE	PRESCRIBING PRACTITIONER	AUTH	JAM	3rd PLC
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. Date of Service	B. Item No.	C. Description of Item Provided: Manufacturer's Name	Model Number	NEW	USED	D. Quan.	E. Rental per Month	E. Sale Amount	F. Charges
1/1-1/31/85	PRxxxx	Parenteral	I.V. Pole			31 days	31.00	xx.xx	$31.00
1/1-1/31/85	PRxxxx	Parenteral	Nutrients, 2l /day			31 days			xx.xx
1/1-1/31/85	PRxxxx	Parenteral	Supplies (attach sheets) Please						xx.xx
1/1-1/31/85	PRxxxx	Lipid Emulsion	500 ml 20%/day			31 days			xx.xx

15. AUTHORIZING SIGNATURE (Medical Consultant) (For Division Use Only) — PERIOD OF RENTAL AUTHORIZATION
Date — to — TOTAL CHARGES $xxx.xx

16. Name and Number of Prescribing Practitioner
Name: Dr. Smith — Individual Medicaid Practitioner No.: 12345678A
17. Is Patient in a Long Term Care Facility? [ ] Yes [X] No
If Yes, give the Name and Address of the Facility.
16a. Physician Case Manager — Individual Medicaid Practitioner Number

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 by 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. I agree that ownership of such equipment will vest in the Division of Medical Assistance and Health Services and that I will be entitled to the use of the equipment until it is no longer needed.
[ ] Auth. Rep.
Relationship: Check if other than patient [ ] Relative [ ] Other
Patient Signature _____ Date 2/15/85

FOR CONTRACTOR'S USE ONLY

CARD	DATES OF SERVICE FROM YR	FROM MO	FROM DAY	TO MO	TO DAY	ITEM #	AMOUNT A	AMOUNT B	CODE	R/P	JAM
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			
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			
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			
6											
1	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			
7											
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			
8											

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 service 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 _____ Billing Date Mo./Day/Yr. 3/1/85

FOR PAYMENT MAIL TO:
The Prudential Insurance Co. of America
P.O. Box 1900
Millville, N.J. 08332

MC-11-C4 (2-85)

FISCAL AGENT COPY

MEDICAID 32916 PART I ED 2-85

FOR CONTRACTOR'S USE ONLY

Patient's Name	HSP No.	PP

Physician or Supplier ☐ Non-Spec. ☐ Spec_____area

Referred to:	Date:

PLEASE VERIFY:

- ☐ Diagnosis
- ☐ PRV-Anesthesia-Asst. Surgeon
- ☐ Referring Physician
- ☐ Need Prior Auth.
- ☐ 65 or Over
- ☐ Date(s) of Service
  - ☐ Breakdown
- ☐ Service Rendered
- ☐ Charge(s)
  - ☐ Breakdown of
- ☐ If Doctor did Laboratory work
- ☐ HSP #
  - ☐ P.P. #
- ☐ Place of Service
- ☐ Other
  - ☐ See memo
- ☐ Need Signature
  - ☐ Provider
  - ☐ Patient
- ☐ Provider #
- ☐ Over 90 Days
- ☐ Prescription
- ☐ Approve Jam Code
- ☐ Time
  - ☐ Anes.
  - ☐ Psych.

charge for: _____

☐ Eligible? ☐ Reasonable?

Referring Individual's Identification _____

Claim Examiner _____ Date _____

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

REC'D JUL 25 1985

New Jersey Health Services Program NEWSLETTER

Volume P-438

August 1, 1985

To: Home Health Agencies (Certified, Licensed)
(Excluding Hospital-Based Home Health Agencies)
Homemaker Agencies (Voluntary Non-Profit)

Subject: Additional Procedure Codes - Personal Care Assistant Services

Effective: Immediately

Background: A review of the claims processed for Personal Care Assistant Services has indicated the need to establish new procedure codes for one-half (1/2) hour of service in addition to the existing one-hour codes. (See New Jersey Health Services Program Newsletter No. P-386, dated March 19, 1984.) The purpose of this newsletter is to introduce the new procedure codes to the providers of Personal Care Assistant services.

Action: The following new procedure codes are to be used as appropriate when submitting claims for the Personal Care Assistant Program.

	Procedure Code	Medicaid Dollar Value
Personal Care Assistant Services (Individual)	9428	Up to $4.00 per half-hour
Personal Care Assistant Services (Group) - Care involves two or more patients, with a maximum of eight patients in the same residental setting at the same time	9429	Up to $3.00 per half-hour, per patient

The existing procedure codes, 0056 and 0057, which allow for the billing of an hour of service are to be used as appropriate. The reimbursement methodology remains unchanged.

The FD-139, Request of Home Care Authorization or Reauthorization, remains the authorization document and the MC-14, Independent Outpatient Health Facilty, continues to be used for billing.

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.

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-440

August 5, 1985

To: PROVIDERS OF MEDICAL DAY CARE SERVICES

Subject: HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

Effective: September 1, 1985

As announced in the Medicare/Medicaid Bulletin 85-1, Volume P-417, the New Jersey Medicaid Program will implement HCPCS on September 1, 1985.

All CLAIMS SUBMITTED ON OR AFTER SEPTEMBER 1, 1985 MUST INCLUDE APPLICABLE HCPCS CODES. The HCPCS code numbers for Medical Day Care services are as follows:

HCPCS CODE	DESCRIPTION
Z0300	Initial visit, speech-language therapy
Z0270	Initial visit, physical therapy
92507	Speech-language therapy
97799	Physical therapy
90050	Medical day care visit

Code numbers 0032, 0030, 0001 which are printed on the FD-140 form (Request for Medical Day Care Authorization or Reauthorization) will be deleted when the form is reprinted.

Manual Maintenance: The enclosed page 14 (Rev. 9/85), replaces page 14 (Rev. 5/84) of the Medical Day Care Services Manual.

Questions concerning this Newsletter should be addressed to the New Jersey Medicaid Fiscal Agent. (Prudential - Telephone: 609-293-2254.)

2. Items 5-6 — Self-explanatory;

3. Items 7-8 — Self-explanatory;

4. Item 9 — Name, address, and telephone number of provider: This information may be preprinted;

5. Item 10 — Not applicable;

6. Item 11 — Authorization: Insert in this space "authorization (or reauthorization) form FD-140 is attached";

7. Item 12 — Not to be completed;

8. Item 13 — Report of services:

   i. Item A — Enter each date on which service has been provided. Use a separate line for medical day care visit, for physical therapy treatment, for speech-language therapy treatment;

      NOTE: A visit means attendance at the medical day care center by the participant which consists of seven hours portal to portal.

   ii. Item B — Enter separately the HCPCS code for medical day care visit (90050) or for physical therapy treatment (97799) or for speech-language therapy treatment (92507); for an initial evaluation visit for rehabilitative therapy only, enter separately the HCPCS code for physical therapy (Z0270) or for speech-language therapy (Z0300);

   iii. Item C — Specify primary diagnosis;

   iv. Item D — Corresponding with the procedure code as outlined above enter the following wording: Medical day care visits or physical therapy treatment(s) or speech-language therapy treatment(s) including only the number of visits (or treatments) and the appropriate rate for each visit or treatment(s);

   v. Item E — Not applicable;

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-441

August 5, 1985

To: Home Health Agencies
Homemaker Agencies (Voluntary, Non-Profit)

Subject: HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)
Personal Care Assistant Service and
Community Care Program for the Elderly and Disabled

Effective: September 1, 1985

Purpose: This Newsletter lists the new HCPCS codes for Personal Care Assistant service and the Community Care Program for the Elderly and Disabled. It is for the information of all agencies, but requires close attention by those agencies approved by the New Jersey Medicaid Program for participation in these programs.

Background: As announced in the Medicare/Medicaid Bulletin 85-1, Volume P-417, the New Jersey Medicaid Program will implement HCPCS on September 1, 1985. HCPCS codes are applicable to both the Personal Care Assistant Program and the Community Care Program for the Elderly and Disabled. Home Health Agencies and Homemaker Agencies were introduced to these two Programs as outlined below:

Personal Care Assistant Program:
Home Health Agencies--- P-386, 3/19/84 and P-403, 8/27/84
Homemaker Agencies----- P-386, 3/19/84

Community Care Program for the Elderly and Disabled:
Home Health Agencies----------P-374, 1/9/84
Hospital-Based Home Health Agency-----P-400, 9/1/84
Homemaker Agencies----------P-375, 1/9/84

Action: All CLAIMS SUBMITTED ON OR AFTER SEPTEMBER 1, 1985 MUST INCLUDE APPLICABLE HCPCS CODES for Personal Care Assistant Service or services covered under the Community Care Program for the Elderly and Disabled.

HCPCS code number listings are attached. One list is designated for Home Health Agencies and the other, for Homemaker Agencies.

Questions concerning this Newsletter should be addressed to the New Jersey Medicaid Fiscal Agent. (Prudential - Telephone: 609-293-2175.)

HCPCS CODES FOR HOME HEALTH AGENCIES

PERSONAL CARE ASSISTANT SERVICE

HCPCS CODE	Discontinued Code	DESCRIPTION
Z1610	(0055)	Initial Nursing Assessment Visit
Z1600	(0056)	Personal Care Assistant Service (Individual/hourly)
Z1605	(0057)	Personal Care Assistant Service (Group/hourly)
Z1611	(9428)	Personal Care Assistant Service (Individual/½ hour)
Z1612	(9429)	Personal Care Assistant Service (Group/½ hour)

COMMUNITY CARE PROGRAM FOR THE ELDERLY AND DISABLED

HCPCS CODE	Discontinued Code	DESCRIPTION
		Home Health Agencies (Excluding Hospitasl-Based)
Z1245	(0023)	Home Health Aide Visit, up to 4 hours
Z1250	(0024)	Home Health Aide Visit, 5 to 8 hours
Z1255	(0025)	Physical Therapy, daily
Z1260	(0026)	Speech-Language Therapy, daily
Z1265	(0027)	Occupational Therapy, daily
Z1270	(0028)	Medical Social Services Visit, daily
Z1275	(0029)	Skilled Nursing Care Visit, daily
Z1280	(0042)	Medical Supplies
Z1200	(0077)	Homemaker, hourly
Z1210	(0093)	Respite Care, 8 hour day
Z1215	(0094)	Respite Care, 8 hour night
Z1220	(0095)	Respite Care, 12 hour day
Z1225	(0096)	Respite Care, 12 hour night
Z1230	(0097)	Respite Care, 24 hours
		Hospital-Based Home Health Agency
Z1300	(9431)	Hospital-based (H.B.) Home Health Aide (HHA) - 1 hour
Z1305	(9432)	H.B. HHA - 2 hours
Z1310	(9433)	H.B. HHA - 3 hours
Z1315	(9434)	H.B. HHA - 4 hours
Z1320	(9435)	H.B. HHA - 5 hours
Z1325	(9436)	H.B. HHA - 6 hours
Z1330	(9437)	H.B. HHA - 7 hours
Z1335	(9438)	H.B. HHA - 8 hours
Z1255	(0025)	Physical Therapy, daily
Z1260	(0026)	Speech-Language Therapy, daily
Z1265	(0027)	Occupational Therapy, daily
Z1270	(0028)	Medical Social Services Visit, daily
Z1275	(0029)	Skilled Nursing Care Visit, daily
Z1280	(0042)	Medical Supplies
Z1210	(0093)	Respite Care, 8 hour day
Z1215	(0094)	Respite Care, 8 hour night
Z1220	(0095)	Respite Care, 12 hour day
Z1225	(0096)	Respite Care, 12 hour night
Z1230	(0097)	Respite Care, 24 hours

HCPCS CODES FOR HOMEMAKER AGENCIES

PERSONAL CARE ASSISTANT SERVICE

HCPCS CODE	Discontinued Code	DESCRIPTION
Z1610	(0055)	Initial Nursing Assessment Visit
Z1600	(0056)	Personal Care Assistant Service (Individual/hourly)
Z1605	(0057)	Personal Care Assistant Service (Group/hourly)
Z1611	(9428)	Personal Care Assistant Service (Individual/½ hour)
Z1612	(9429)	Personal Care Assistant Service (Group/½ hour)

COMMUNITY CARE PROGRAM FOR THE ELDERLY AND DISABLED

HCPCS CODE	Discontinued Code	DESCRIPTION
Z1200	(0077)	Homemaker, hourly
Z1205	(0098)	Initial Evaluation, RN
Z1210	(0093)	Respite Care, 8 hour day
Z1215	(0094)	Respite Care, 8 hour night
Z1220	(0095)	Respite Care, 12 hour day
Z1225	(0096)	Respite Care, 12 hour night
Z1230	(0097)	Respite Care, 24 hour

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-442

August 5, 1985

To: SOCIAL ADULT DAY CARE CENTERS

Subject: HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)
Community Care Program for Elderly and Disabled

Effective: September 1, 1985

As announced in the Medicare/Medicaid Bulletin 85-1, Volume P-417, the New Jersey Medicaid Program will implement HCPCS on September 1, 1985. HCPCS codes are applicable to the Community Care Program for the Elderly and Disabled. (This Program was introduced to Social Adult Day Care Centers in Newsletter P-377, January 9, 1984).

The HCPCS code for the Social Adult Day Care under the Community Care Program for the Elderly and Disabled is:

HCPCS CODE	Discontinued Code	DESCRIPTION
Z1235	(0079)	Social Adult Day Care, daily

All CLAIMS SUBMITTED ON OR AFTER SEPTEMBER 1, 1985 MUST INCLUDE HCPCS Code Z1235 for Social Adult Day Care service.

Questions concerning this Newsletter should be addressed to the New Jersey Medicaid Fiscal Agent. (Prudential - Telephone: 609-293-2175.)

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-443

August 5, 1985

To: INDEPENDENT MENTAL HEALTH CLINICS UNDER CONTRACT TO THE DEPARTMENT OF HUMAN SERVICES, DIVISION OF MENTAL HEALTH AND HOSPITALS

Subject: HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS) Personal Care Assistant Service

Effective: September 1, 1985

As announced in the Medicare/Medicaid Bulletin 85-1, Volume P-417, the New Jersey Medicaid Program will implement HCPCS on September 1, 1985. HCPCS codes are applicable to the Personal Care Assistant service. (This service was introduced to Mental Health Clinics in Newsletter P-385, March 19, 1984).

The HCPCS codes for Personal Care Assistant service are:

HCPCS CODE	Discontinued Code	DESCRIPTION
Z1610	(0055)	Initial Nursing Assessment Visit
Z1600	(0056)	Personal Care Assistant Service (Individual/hourly)
Z1605	(0057)	Personal Care Assistant Service (Group/hourly)
Z1611	(9428)	Personal Care Assistant Service (Individual/½ hour)
Z1612	(9429)	Personal Care Assistant Service (Group/½ hour)

All CLAIMS SUBMITTED ON OR AFTER SEPTEMBER 1, 1985 MUST INCLUDE APPLICABLE HCPCS CODES for Personal Care Assistant Service.

Questions concerning this Newsletter should be addressed to the New Jersey Medicaid Fiscal Agent. (Prudential - Telephone: 609-293-2175.)

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-444

August 26, 1985

TO: NARCOTIC AND DRUG ABUSE TREATMENT CENTERS

REC'D AUG 27 1985

SUBJECT HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

EFFECTIVE September 1, 1985

PURPOSE This Newsletter includes new codes (HCPCS) which must be used when submitting claims on or after September 1, 1985.

BACKGROUND: As announced in the Medicare/Medicaid Bulletin 85-1, Vol. P-417, the New Jersey Medicaid Program will implement HCPCS on September 1, 1985.

ACTION: ALL CLAIMS SUBMITTED ON OR AFTER SEPTEMBER 1, 1985 MUST INCLUDE HCPCS CODES.

The attached listing of HCPCS code numbers includes the following information: HCPCS code numbers matched to the discontinued code number; narrative description of the procedure code (or referral to CPT-4*); and the New Jersey Medicaid Program's reimbursement schedule.

*HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology-4th Edition (CPT-4) for certain Level I codes, which are those used primarily by physicians and Independent Clinics. Copyright restrictions make it impossible to print excerpts from CPT-4 procedure narratives. Thus, in order to determine those narratives it is necessary to refer to CPT-4. If a CPT-4 is not available, a 1985 edition may be ordered from: Order Department - OP-314-5, American Medical Association, P.O. Box 10946, Chicago, Illinois, 60610.

There is no change in the New Jersey Medicaid Program's reimbursement schedule. However the method of billing HCPCS code Z2005 has been changed to an hourly rate . When billing this code, please indicate the number of hours of service on the claim form. Also, the procedure for completing the Independent Outpatient Health claim form (MC-14) remains the same. Any qualification to a code appears directly under the narrative.

Questions concerning the use of HCPCS codes should be addressed to the New Jersey Medicaid Program's Fiscal Agent: Prudential Insurance Company, Medicaid Claim Division II, at 609-293-2175.

Attachment: The attached pages replace pages one (1) through seven (7) of the attachment to Newsletter P-416, dated April 1, 1985.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

Narcotic and Drug Abuse Treatment Centers

Billing Procedures

The following provides the basic information necessary for the proper completion and submission of a claim form (Independent Outpatient Health Facility - MC-14). Specific instructions for completing a claim form are attached.

General Policy

Billing should be done on a monthly basis and submitted for payment as soon as possible. All claims must be received by the Fiscal Agent (Prudential) no later than 90 days after the last date the services were rendered and no later than 12 months from the earliest date of service on the claim form.

Approved Services and Procedure Codes

A HCPCS code listing is attached. Approved Centers may only bill for those procedure codes which correspond to the allowable services included in their New Jersey Medicaid Provider approval letter.

The Mental Health Services Codes in the attached listing shall be performed by a Mental Health Professional as described in the New Jersey State Department of Health's Standards for Licensure for Ambulatory Care Centers. These codes include:

Z2000 Family Therapy Rendered in a Narcotic and Drug Abuse Treatment Center

Z2001 Family Conference Rendered in a Narcotic and Drug Abuse Treatment Center

Z2003 Psychotherapy Rendered in a Narcotic and Drug Abuse Treatment Center - Full-Session

Z2007 Psychotherapy Rendered in a Narcotic and Drug Abuse Treatment Center - Half Session

Z2004 Group Therapy Rendered in a Narcotic and Drug Abuse Treatment Center

Multiple mental health services rendered in a Narcotic and Drug Abuse Treatment Center to one individual in the same day will not be reimbursed. Only one mental health service of a like-nature will be reimbursed in those instances where more than one is provided to an individual. Mental health services provided in a Narcotic and Drug Abuse Treatment Center do not require prior authorization.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

HCPCS CODES FOR NARCOTIC AND DRUG ABUSE TREATMENT CENTERS

HCPCS CODES	Discontinued Medicaid Code	PROCEDURE	Medicaid Dollar Value Specialist	Non-Specialist
90015			$ 22.00	17.00
90017	(9000)	See CPT-4 for narrative	22.00	17.00
90020			22.00	17.00

The initial clinic visit is limited for reimbursement purposes to one such examination of the same patient by the same Independent Clinic.

Includes as a minimum on the record:

1) Chief complaint(s)
2) Complete history of the present illness and related systemic review including recording of pertinent negative findings
3) Complete pertinent past medical history
4) Pertinent family history
5) A full physical examination pertaining to but not limited to the history of the present illness and includes recording of pertinent negative findings
6) Working diagnosis and treatment plan including ancillary services and drugs ordered.

NOTE: Reimbursement for an Initial Clinic Visit will be disallowed and the fee downgraded to a Routine Clinic Visit if a previous Initial Clinic Visit or Annual Examination was billed within a twelve month period for the same recipient by the same provider.

NOTE: These codes will be declined if claimed for a Preventive Health Care Visit.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

HCPCS CODES	DISCONTINUED MEDICAID CODE	PROCEDURE	MEDICAID DOLLAR VALUE SPECIALIST	NON-SPECIALIST
90050			$ 9.00	7.00
90060	(0001)	See CPT-4 for narrative	9.00	7.00
90070			9.00	7.00

For reimbursement purposes, a clinic visit will consist of care and treatment by the physician and include those procedures ordinarily performed during a clinic visit dependent upon physician's discipline. The following will be included as a minimum in the progress notes:

1) Purpose of visit
2) Pertinent history obtained
3) Pertinent physical findings including pertinent negative physical findings based on 1) and 2)
4) Procedures - if any performed - with results
5) Lab, x-ray, and ECG, etc., ordered - with results
6) Diagnosis(s) plus treatment plan status, including drugs ordered, relative to present and pre-existing illness plus pertinent recommendations and actions

NOTE: These codes will be declined if claimed for a Preventive Health Care Visit.

HCPCS CODES	DISCONTINUED MEDICAID CODE	PROCEDURE	MEDICAID DOLLAR VALUE SPECIALIST	NON-SPECIALIST
90751			$22.00	17.00
90752	(9006)	See CPT-4 for narrative	22.00	17.00
90753			22.00	17.00
90754			22.00	17.00
90761			22.00	17.00
90762			22.00	17.00
90763			22.00	17.00

For reimbursement purposes, these codes appropriately reflect the age groups listed in the CPT-4 narrative. They will reflect old as well as new patients. An annual health maintenance examination through age 20 years consists of:

1) Complete initial or interval history including past medical history, family history, social history, and systemic review.
2) Developmental and nutritional assessment.
3) Complete, unclothed, physical examination to include also the following:
   (a) measurements: height and weight, blood pressure for children age 3 or older
   (b) vision and hearing screening
4) Assessment and administration of immunizations appropriate for age and need.
5) Referral for further diagnosis and treatment or follow-up of all correctable abnormalities covered or suspected.
6) Referral to a dentist for children age 3 and older.
7) Laboratory procedures to be referred if medically necessary. Recommended are:
   (a) Hgb. twice: 3-6 years; and 10-12 years
   (b) Urinalysis at least once between 13-15 years
   (c) Tuberculin twice: 4-6 years; and 10-12 or 13-15 years
8) Anticipatory guidance.

Medical records should substantiate the above services and should document significant positive and negative findings. Discussion and consultation with the patient or family regarding findings should be an integral part of every examination.

NOTE: If the laboratory procedure (HCPCS Code Z2010) is analyzed by a physician under the auspices of the Narcotic and Drug Abuse Treatment Center, it is reimbursable to the Treatment Center. If performed by an outside independent laboratory, the laboratory must submit the charge for the service on their claim.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

HCPCS CODES	DISCONTINUED MEDICAID CODE	PROCEDURE	MEDICAID DOLLAR VALUE SPECIALIST	NON-SPECIALIST
90050			$ 9.00	7.00
90060	(0001)	See CPT-4 for narrative	9.00	7.00
90070			9.00	7.00

For reimbursement purposes, a clinic visit will consist of care and treatment by the physician and include those procedures ordinarily performed during a clinic visit dependent upon physician's discipline. The following will be included as a minimum in the progress notes:

1) Purpose of visit
2) Pertinent history obtained
3) Pertinent physical findings including pertinent negative physical findings based on 1) and 2)
4) Procedures - if any performed - with results
5) Lab, x-ray, and ECG, etc., ordered - with results
6) Diagnosis(s) plus treatment plan status, including drugs ordered, relative to present and pre-existing illness plus pertinent recommendations and actions

NOTE: These codes will be declined if claimed for a Preventive Health Care Visit.

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HCPCS CODES	DISCONTINUED MEDICAID CODE	PROCEDURE	MEDICAID DOLLAR VALUE SPECIALIST	NON-SPECIALIST
90751			$22.00	17.00
90752	(9006)	See CPT-4 for narrative	22.00	17.00
90753			22.00	17.00
90754			22.00	17.00
90761			22.00	17.00
90762			22.00	17.00
90763			22.00	17.00

For reimbursement purposes, these codes appropriately reflect the age groups listed in the CPT-4 narrative. They will reflect old as well as new patients. An annual health maintenance examination through age 20 years consists of:

1) Complete initial or interval history including past medical history, family history, social history, and systemic review.
2) Developmental and nutritional assessment.
3) Complete, unclothed, physical examination to include also the following:
   (a) measurements: height and weight, blood pressure for children age 3 or older
   (b) vision and hearing screening
4) Assessment and administration of immunizations appropriate for age and need.
5) Referral for further diagnosis and treatment or follow-up of all correctable abnormalities covered or suspected.
6) Referral to a dentist for children age 3 and older.
7) Laboratory procedures to be referred if medically necessary. Recommended are:
   (a) Hgb. twice: 3-6 years; and 10-12 years
   (b) Urinalysis at least once between 13-15 years
   (c) Tuberculin twice: 4-6 years; and 10-12 or 13-15 years
8) Anticipatory guidance.

Medical records should substantiate the above services and should document significant positive and negative findings. Discussion and consultation with the patient or family regarding findings should be an integral part of every examination.

NOTE: If the laboratory procedure (HCPCS Code Z2010) is analyzed by a physician under the auspices of the Narcotic and Drug Abuse Treatment Center, it is reimbursable to the Treatment Center. If performed by an outside independent laboratory, the laboratory must submit the charge for the service on their claim.

NOTE: If these procedures are performed within a twelve month period of an Initial Clinic Visit or an Annual Examination for the same recipient by the same provider, it will be downgraded to a Routine Clinic visit.

HCPCS CODES	Discontinued Medicaid Code	Procedure	Medicaid Dollar Value Specialist	Non-Specialis
90750	(9008)	See CPT-4 for narrative	$ 22.00	17.00
90760			22.00	17.00

For reimbursement purposes, the annual health maintenance examination is limited to patients age 21 and over. Where applicable, use appropriate CPT-4 (HCPCS) codes for individuals up to age 20.

Includes as a minimum on the record:

1) Interval history
2) Completing or updating the pertinent past medical history, family history and social/personal history.
3) Complete systemic review including all systems and pertinent negative findings.
4) Complete total systems physical examination permitting the deferment of a system for medically acceptable reason, e.g., deferment of pelvic examination in an individual under the care of an gynecologist. Pertinent negative findings of the physician's examination are to be recorded.
5) Working diagnosis and treatment plan, including ancillary services and drug order, if applicable.

NOTE: If this procedure is performed within a twelve month period of an Initial Clinic Visit or an Annual Examination for the same recipient by the same provider, it will be downgraded to a Routine Clinic Visit.

HCPCS CODES	DISCONTINUED MEDICAID CODE	PROCEDURE	MEDICAID DOLLAR VALUE
Z2000	(9180)	FAMILY THERAPY RENDERED IN A NARCOTIC AND DRUG ABUSE TREATMENT CENTER Therapy with the patient and with one or more family members present. Verbal or other therapy methods are provided by a physician, or a professional counsellor under the direction of a physician, in personal involvement with the patient and the family to the exclusion of other patients and/or duties. A minimum session 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.	$22.50
Z2001	(9181)	FAMILY CONFERENCE RENDERED IN A NARCOTIC AND DRUG ABUSE TREATMENT CENTER 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.	$15.00
Z2002	(9182)	PRESCRIPTION VISIT RENDERED IN A NARCOTIC AND DRUG ABUSE TREATMENT CENTER A visit with a physician for review and evaluation of the medication history of the patient and the writing, or renewal of prescription, as necessary.	$ 4.50
Z2003	(9183)	PSYCHOTHERAPY RENDERED IN A NARCOTIC AND DRUG ABUSE TREATMENT CENTER-FULL SESSION Verbal, drug augmented, or other therapy methods provided by a physician, or a professional counsellor under the direction of a physician, in a personal involvement with one patient to the exclusion of other patients and/or duties. A minimum of 50 minutes personal involvement with the patient is required. This includes a prescription visit when necessary.	$16.00

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HCPCS CODES	DISCONTINUED MEDICAID CODE	PROCEDURE	MEDICAID DOLLAR VALUE
Z2007	(9187)	PSYCHOTHERAPY RENDERED IN A NARCOTIC AND DRUG ABUSE TREATMENT CENTER - HALF SESSION Verbal, drug augmented, or other therapy methods provided by a physician, or a professional counsellor under the direction of a physician in a personal involvement with one patient to the exclusion of other patients and/or duties. A minimum of 25 minutes personal involvement with the patient is required. This includes a prescription visit when necessary	$ 8.00
Z2004	(9184)	GROUP THERAPY RENDERED IN A NARCOTIC AND DRUG ABUSE TREATMENT CENTER Verbal or other therapy methods provided by one or more physicians, or professional counsellors under the direction of a physician, 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.	$ 8.00 per person
Z2005	(9185)	PSYCHOLOGICAL TESTING RENDERED IN A NARCOTIC AND DRUG ABUSE TREATMENT CENTER Psychometric and/or projective tests with a written report.	$15.00 per hour (maximum of five hours)
Z2006	(9186)	METHADONE TREATMENT RENDERED IN A NARCOTIC AND DRUG ABUSE TREATMENT CENTER A per diem payment based on the number of days a recipient is supplied methadone during the billing period. This is an all inclusive rate for cost of drug, packaging, nursing time, and administrative costs.	$ 2.50
Z2010	(8927)	URINE ANALYSIS FOR DRUG ADDICTION To be used only when Narcotic and Drug Abuse Treatment Centers are approved for this service. To determine what level, if any, a drug is present in the urine.	$ 4.50
36415	(9076)	See CPT-4 for narrative DRAWING OF BLOOD. Once per visit per patient (not applicable if lab study, in any part, is to be performed by the clinic).	$ 1.80

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-445

August 5, 1985

To: AGENCIES PROVIDING CASE MANAGEMENT SERVICE

Subject: HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)
Community Care Program for the Elderly and Disabled (CCPED) and
Medicaid Model Waiver 1 and 2 (MMW1&2)

Effective: SEPTEMBER 1, 1985

As announced in the Medicare/Medicaid Bulletin 85-1, Volume P-417, the New Jersey Medicaid Program will implement HCPCS on September 1, 1985.

All CLAIMS SUBMITTED ON OR AFTER SEPTEMBER 1, 1985 MUST INCLUDE HCPCS CODES. The HCPCS code numbers for Case Management service are as follows:

	HCPCS CODE	DISCONTINUED Medicaid Code	DESCRIPTION
(CCPED)	Z1240	(0078)	Case Management, monthly
(MMW1&2)	Z1700	(0099)	Case Management, monthly

Questions concerning this Newsletter should be addressed to the New Jersey Medicaid Program's Fiscal Agent: (The Prudential Insurance Company - Telephone: 609-293-2175.)

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-446

August 19, 1985

TO: INDEPENDENT CLINICS

SUBJECT: MENTAL HEALTH SERVICES - PRIOR AUTHORIZATION

EFFECTIVE: IMMEDIATELY

PURPOSE: This newsletter is to inform New Jersey Medicaid Independent Clinic providers that the threshold limit for mental health services has been raised from $300 to $600 before prior authorization is required.

BACKGROUND: Previously, prior authorization from the New Jersey Medicaid Program was required for all mental health services in excess of $300 reimbursement for any one Medicaid eligible patient, in any 12-month period, commencing with the patient's initial visit. The Division has raised the threshold to $600 before prior authorization is required. This new policy applies to mental health services provided in Independent Clinics.

ACTION: Prior authorization for continuing services is required when the Independent Clinic has been reimbursed $600 by the New Jersey Medicaid Program for mental health services rendered to a Medicaid eligible patient, in any 12-month period, commencing with the patient's initial visit.

Any questions regarding this Newsletter should be directed to Raymond B. Reinhart, Jr., M.D., Chief Consultant, Mental Health Services, Division of Medical Assistance and Health Services (Telephone 609-292-8198).

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Department of Human Services

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New Jersey Health Services Program NEWSLETTER

Volume P-447

August 5, 1985

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: HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

EFFECTIVE: September 1, 1985

As announced in the Medicare/Medicaid Bulletin 85-1, Volume P-417, the New Jersey Medicaid Program will implement HCPCS on September 1, 1985. HCPCS codes are applicable to the Alcoholism Treatment Service Project. (See Newsletter P-348, January 10, 1983).

ALL CLAIMS SUBMITTED ON OR AFTER SEPTEMBER 1, 1985, MUST INCLUDE APPLICABLE HCPCS CODES. The HCPCS code number listings for Alcoholism Treatment Service are attached.

Maintenance: The enclosed material, pages 5, 6, and 7 dated as Rev. 9/85, replaces pages 5 and 6 of the Newsletter P-348, January 10, 1983.

Questions concerning this Newsletter should be addressed to the New Jersey Medicaid Fiscal Agent. (Prudential - telephone: 609-292-2254).

Health Care Financing Administration
Common Procedure Coding System (HCPCS)

INPATIENT ALCOHOLISM DETOXIFICATION CODES:

HCPCS CODE	DISCONTINUED CODE	DESCRIPTION
		ROUTINE CARE - inpatient alcoholism detoxification services.
Z3111	(1011)	Patient discharged
Z3112	(1012)	Still patient
Z3113	(1013)	Benefits exhausted
		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.).
		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.
		LABORATORY TEST - inpatient alcoholism detoxification ancillary service.
Z3121	(1021)	Patient discharged
Z3122	(1022)	Still patient
Z3123	(1023)	Benefits exhausted
		PHARMACY - inpatient alcoholism detoxification ancillary service.
Z3131	(1031)	Patient discharged
Z3132	(1032)	Still patient
Z3133	(1033)	Benefits exhausted
		MEDICAL SUPPLIES - inpatient alcoholism detoxification ancillary service.
Z3141	(1041)	Patient discharged
Z3142	(1042)	Still patient
Z3143	(1043)	Benefits exhausted
		PSYCHIATRIC EVALUATION - inpatient alcoholism detoxification ancillary service.
Z3151	(1051)	Patient discharged
Z3152	(1052)	Still patient
Z3153	(1053)	Benefits exhausted

INPATIENT ALCOHOLISM TREATMENT AND REHABILITATION CODES:

HCPCS CODE	DISCONTINUED CODE	DESCRIPTION
		ROUTINE CARE - inpatient alcoholism treatment and rehabilitation services.
Z3211	(2011)	Patient discharged
Z3212	(2012)	Still patient
Z3213	(2013)	Benefits exhausted
		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.
		LABORATORY TEST - inpatient alcoholism treatment and rehabilitation ancillary service.
Z3221	(2021)	Patient discharged
Z3222	(2022)	Still patient
Z3223	(2023)	Benefits exhausted
		PHARMACY - inpatient alcoholism treatment and rehabilitation ancillary service.
Z3231	(2031)	Patient discharged
Z3232	(2032)	Still patient
Z3233	(2033)	Benefits exhausted
		MEDICAL SUPPLIES - inpatient alcoholism treatment and rehabilitation ancillary service.
Z3241	(2041)	Patient discharged
Z3242	(2042)	Still patient
Z3243	(2043)	Benefits exhausted
		PSYCHIATRIC EVALUATION - inpatient alcoholism treatment and rehabilitation ancillary service.
Z3251	(2051)	Patient discharged
Z3252	(2052)	Still patient
Z3253	(2053)	Benefits exhausted

OUTPATIENT ALCOHOLISM TREATMENT CODES:

HCPCS CODE	DISCONTINUED CODE	DESCRIPTION
		ROUTINE VISITS - outpatient alcoholism treatment services.
Z3311	(3011)	Patient discharged
Z3312	(3012)	Still patient
Z3313	(3013)	Benefits exhausted
		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.
		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.
Z3351	(3051)	Patient discharged
Z3352	(3052)	Still patient
Z3353	(3053)	Benefits exhausted
		TRANSPORTATION - outpatient alcoholism treatment ancillary service.
Z3361	(3061)	Patient discharged
Z3362	(3062)	Still patient
Z3363	(3063)	Benefits exhausted
		HOME VISIT - outpatient alcoholism treatment ancillary service.
Z3371	(3071)	Patient discharged
Z3372	(3072)	Still patient
Z3373	(3073)	Benefits exhausted

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Department of Human Services

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New Jersey Health Services Program NEWSLETTER

Volume P-449

August 5, 1985

To: Long Term Care Facilities approved for Respite Care under Community Care Program for the Elderly and Disabled (CCPED)

Subject: HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

Effective: September 1, 1985

As announced in the Medicare/Medicaid Bulletin 85-1, Volume P-417, the New Jersey Medicaid Program will implement HCPCS on September 1, 1985.

All CLAIMS SUBMITTED ON OR AFTER SEPTEMBER 1, 1985 MUST INCLUDE HCPCS CODE Z1285 for Respite Care Service.

HCPCS CODE	DISCONTINUED Medicaid Code	DESCRIPTION
Z1285	(0092)	Respite Care, Nursing Home, Daily

Questions concerning this Newsletter should be addressed to the New Jersey Medicaid Program's Fiscal Agent: (The Prudential Insurance Company - Telephone: 609-293-2175.)

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-450

August 5, 1985

To: CHIROPRACTIC SERVICE PROVIDERS

Subject: HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

Effective: September 1, 1985

As announced in the Medicare/Medicaid Bulletin 85-1, Volume P-417, the New Jersey Medicaid Program will implement HCPCS on September 1, 1985.

There is no change in the New Jersey Medicaid Program's reimbursement schedule for chiropractic services. All CLAIMS SUBMITTED ON OR AFTER SEPTEMBER 1, 1985 MUST INCLUDE HCPCS CODE A2000 for Manipulation of Spine Service.

HCPCS CODE	DISCONTINUED Medicaid Code	DESCRIPTION
A2000	(9080)	Manipulation of Spine

Questions concerning this Newsletter should be addressed to the New Jersey Medicaid Program's Fiscal Agent: (The Prudential Insurance Company - Telephone: 609-293-2186.)

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-451

August 12, 1985

TO: TRANSPORTATION PROVIDERS

SUBJECT: MEDICAID POLICY CHANGES AFFECTING INVALID COACH SERVICES

EFFECTIVE: AUGUST 19, 1985

PURPOSE: THIS NEWSLETTER INFORMS PROVIDERS OF INVALID COACH SERVICES THAT POLICY REGARDING TRANSPORTATION ALLOWANCES AND OXYGEN IS REVISED.

ACTION:

TRANSPORTATION ALLOWANCES

Reimbursement differentials are eliminated for the transport of patients in multiple load situations and the transport of patients receiving dialysis treatments. For invalid coach services rendered on or after August 19, 1985, providers will be reimbursed for each patient transported in accordance with the following procedure codes:

Procedure Codes	Description	Maximum Allowance
6111	Invalid Coach - one way, per patient	$17.00
6113	Invalid Coach - round trip, per patient	$34.00

OXYGEN

Current Medicaid policy no longer requires that invalid coach vehicles carry oxygen. However, if the provider of invalid coach services elects to carry oxygen, then the provider must comply with the regulations established by the New Jersey State Department of Health. (See N.J.A.C. 8:40-4.9).

If there are any questions regarding this Newsletter, please contact Peter K. Rosswaag at (609) 984-7868.

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

REC'D AUG 20 1985

New Jersey Health Services Program NEWSLETTER

Volume P-452

August 19, 1985

TO: All Providers and Those Interested in Provider Enrollment

SUBJECT: Community Care Program for the Elderly and Disabled (CCPED) - Phase III

EFFECTIVE: October 1, 1985

PURPOSE: The New Jersey Medicaid Program announces Phase III of the Community Care Program for Elderly and Disabled with extension of services to the five remaining counties of Camden, Cumberland, Essex, Monmouth and Union as of October 1, 1985.

BACKGROUND: With the implementation of Phase III, the Community Care Program for the Elderly and Disabled will be available to Medicaid eligible individuals throughout the state.

General information about CCPED was issued to all providers via New Jersey Health Services Newsletters P-371/BC-266, dated December 5, 1983. Changes to the Program were noted in Newsletters P-392/BC-281, dated June 11, 1984, and P-405, dated October 1, 1984, to all providers. Providers of pharmaceutical services were advised of Program changes via Newsletter BC-292, dated September 24, 1984.

The Community Care Program for Elderly and Disabled offers seven home care services: (1) Case Management; (2) Home Health services; (3) Homemaker services; (4) Medical Day Care; (5) Social Day Care; (6) Respite services; and (7) Transportation (medical non-emergency). All services require prior authorization except Case Management.

The eligibility criteria remain the same. Recipients eligible for this Program must:

1. Be 65 or over, or determined disabled under the Social Security Act and receiving Social Security disability payments, and eligible for Medicare.

2. Be assessed in need of Skilled Nursing Facility/Intermediate Care Facility (SNF/ICF) Care; and

3. Have an income which exceeds the appropriate SSI community standard up to the standard for institutional care (currently $975 per month).

Home Health Agencies, Homemaker Agencies, and providers of Medical Day Care and Social Adult Day Care services are again referred for specific information about provider enrollment, prior authorization, billing procedures and procedure codes to Newsletters applicable to their services as listed below:

Home Health Agency Providers to P-374, dated January 9, 1984.

Hospital-Based Home Health Agencies, to P-400 or BC-291 dated September 17, 1984.

Homemaker Agencies, to P-375, dated January 9, 1984.

Medical Day Care Providers, to P-376, dated January 9, 1984.

Social Adult Day Care Centers, to P-377, dated January 9, 1984.

ACTION: Homemaker Agencies, Home Health Agencies, Social Adult Day Care Centers, and Medical Day Care Centers wishing to serve clients residing in the Phase III counties and who are not already enrolled as CCPED providers should contact at this time:

Gregory Danese, Esq., Chief
Provider Enrollment Unit
Division of Medical Assistance
and Health Services
CN-712
Trenton, New Jersey 08625
(609) 292-1921

The Case Management Sites for Phase III counties are as follows:

County	Case Management Site
Camden	Camden County Board of Social Services 600 Market Street Camden, NJ 08101 (601) 757-8800
Cumberland	Cumberland County Board of Social Services 13 North East Boulevard Vineland, NJ 08360 (609) 691-4600
Essex	Community Health Care of North Jersey 451 Lincoln Avenue Orange, NJ 07050 (201) 673-0158

Monmouth	MCOSS Nursing Services, Inc. 141 Bodman Place Red Bank, NJ 07701 (201) 747-1204
Union	*Union County Division on Aging Union County Administration Bldg. Elizabeth, NJ 07207 (201) 527-4200

*Case Management Services will be provided through:

Visiting Nurse and Health Services
354 Union Avenue
Elizabeth, NJ 07208
(201) 352-5694

and

Visiting Nurse Association of Plainfield & North Plainfield
427 W. 7th Street
Plainfield, NJ 07060
(201) 756-2436

Any questions regarding this Newsletter should be directed to Carol H. Kurland, Administrator, Office of 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

REC'D SEP 9 1985

New Jersey Health Services Program NEWSLETTER

Volume P-454

August 26, 1985

TO: Providers of Prosthetic and Orthotic Services

SUBJECT: Increase in Reimbursement for Orthopedic Shoe Appliances

EFFECTIVE: September 1, 1985

The New Jersey Medicaid Program is pleased to announce an increase in reimbursement for orthopedic shoe appliances.

The attached pages list the new "Medicaid Dollar Value" as well as the HCPCS code numbers and descriptions.

Manual Maintenance: The enclosed pages 15, 16, 18, and 19, dated as Rev. 9/85, replace the same page numbers, dated as Ed. 4/85, in Subchapter 3, HCFA Common Procedure Coding System (HCPCS).

If there are any questions concerning this Newsletter, please contact Frederick Greenfield, D.P.M., Chief Consultant, Podiatry Services, Division of Medical Assistance and Health Services (Telephone 609 - 292-8157).

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L2770	Additions to Lower Extremity Orthoses, Stainless Steel- Per Bar or Joint	30.00
X3680	Travel Time per Hour (Specify Time Involved)	30.00

(e) ORTHOPEDIC SHOES, SHOE MODIFICATIONS AND TRANSFERS

FOOT

(INSERT, REMOVABLE, MOLDED TO PATIENT MODEL)

L3000	Foot, Insert, Removable, Molded to Patient Model, "UCB" Type, Berkeley Shell, Each	30.00
L3010	Foot, Insert, Removable, Molded to Patient Model, Longitudinal Arch Support, Each	30.00
L3020	Foot, Insert, Removable, Molded to Patient Model, Longitudinal/ Metatarsal Supports, Each	30.00
X4290	Filler for Amputee Toes	16.00
L3030	Foot, Insert, Removable, Formed to Patient Foot, Each-Arch Supports, Removable, Premolded, Each	30.00
X4800	Arch Support, Foot Plates: (Plaster cast taken by Vendor) Leather - Whitman Ordinary	50.00
X4801	Arch Support, Foot Plates: (Plaster cast taken by Vendor) Leather - Mayer	45.00
X4802	Arch Support, Foot Plates: (Plaster cast taken by Vendor) Leather - Schaffer	45.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
X4803	Arch Support, Foot Plates: (Plaster cast taken by Vendor) Leather - Schaffer with metatarsal pad	40.00
X4804	Arch Support, Foot Plates: (Plaster cast taken by Vendor) Leather - Whitman Combination	57.00
X4805	Arch Support, Foot Plates: (Plaster cast taken by Vendor) Leather - Rohadur Plastic	47.00
X4810	Velcro Straps, Attached to a pair of Shoes	14.00
L3100	Hallus-Valgus Night Dynamic Splint	15.00
	(ABDUCTION AND ROTATION BARS)	
L3140	Foot, Abduction Rotation Bars (Dennis Browne Type), attached to Shoe	15.00
L3150	Foot, Abduction Rotation Bars (Dennis Browne Type), clamped to Shoe	15.00
L3160	Foot-Torque Heels	10.00
	(SPACE SHOES)	
X4850	Space Shoe Rubber Raise for Shoe: 1/4" Raise	8.00
X4851	Space Shoe Rubber Raise for Shoe: 1/2" Raise	9.00
X4852	Space Shoe Rubber Raise for Shoe: 3/4" Raise	13.00
X4853	Space Shoe Rubber Raise for Shoe: 1" Raise	20.00
X4854	Space Shoe Rubber Raise for Shoe: Each additional 1/2" Raise	8.00
	(CASTINGS)	
X4890	Foot	50.00

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
L3230	Orthopedic Footwear, Custom Shoes Depth Inlay	*B.I.
L3250	Orthopedic Footwear, Custom Molded Shoe, Removable Inner Mold, Prosthetic Shoe, Each	100.00
	SHOE MODIFICATION	
	(LIFTS)	
L3310	Lifts-Elevation, Heel and Sole, Neoprene, per Inch	17.50
L3320	Lifts-Elevation, Heel and Sole, Cork, per Inch	42.00
	(WEDGES)	
L3340	Heel Wedge, Sach	6.00
L3350	Heel Wedge	6.00
L3360	Sole Wedge-Outside Sole	8.00
L3370	Sole Wedge-Between Sole	8.00
L3390	Outflare Wedge	24.00
L3400	Metatarsal Bar Wedge-Rocker	16.00
L3410	Metatarsal Bar Wedge-Between Sole	8.00
L3420	Full Sole and Heel Wedge *Between Sole*	16.00
	(HEELS)	
L3460	Heel-New Rubber, Standard	6.00
L3470	Heel-Thomas Extended to Ball	12.00
L3480	Heel-Pad and Depression for Spur	12.00
L3485	Heel-Pad, Removable for Spur	6.00

*B.I. - By Invoice Plus 50%

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
	(MISCELLANEOUS SHOE ADDITIONS)	
L3510	Miscellaneous Shoe Additions, Insole Rubber	4.00
L3530	Miscellaneous Shoe Additions, Sole-Half	8.00
L3540	Miscellaneous Shoe Additions, Sole-Full	16.00
	(TRANSFERS OR REPLACEMENT)	
L3600	Transfers of an Orthosis From One Shoe to Another, Caliper Plate Existing	16.00
L3610	Transfers of an Orthosis From One Shoe to Another, Caliper Plate New	35.00
L3620	Transfers of an Orthosis From One Shoe to Another, Solid Stirrup Existing	16.00
L3630	Transfers of an Orthosis From One Shoe to Another, Solid Stirrup New	35.00
L3640	Transfers of an Orthosis From One Shoe To Another, Dennis Browne Splint (Riveton), Both Shoes	10.00
X4280	Velcro Straps used with Orthoses	18.00

(f) Upper Limb

NOTE: The procedures in this section are considered as 'Base' or 'Basic Procedures' and may be modified by listing procedures from the 'Additions Section' and adding them to the base procedure.

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

REC'D AUG 30 1985

New Jersey Health Services Program NEWSLETTER

Volume P-455

August 26, 1985

TO: DRG Hospitals - Chief Executive Officers

SUBJECT: Reimbursement For Mobile Intensive Care Unit (MICU) Services

EFFECTIVE: Retroactive To January 1, 1984

PURPOSE: This Newsletter is to advise hospitals that reimbursement by the New Jersey Medicaid Program for inpatient and outpatient related MICU services provided to Medicaid-eligible patients is allowable.

BACKGROUND: The New Jersey State Department of Health has received federal approval of a grant under section 2320 of the "Medicare and Medicaid Reconciliation Amendments of 1984", which waives Medicare and Medicaid reimbursement principles. This approval enables hospitals which are participants in the three year demonstration project, "New Jersey Mobile Intensive Care System", to receive reimbursement for Mobile Intensive Care Unit (MICU) services on both an inpatient and outpatient basis.

ACTION: Only those MICU services which were provided on or after January 1, 1984, are eligible for reimbursement by Medicaid. Hospitals must not submit claims for MICU services which have been written off as bad debt or uncompensated care.

Hospitals are advised to submit claims for inpatient and outpatient-related MICU services as follows:

INPATIENT CLAIMS

1) Inpatient claims submitted with 1984 discharge dates which included charges for eligible MICU services and were paid exclusive of the MICU charges, may be resubmitted in one batch on the UB-PS form. Multiple MICU adjustment requests submitted at different times will not be considered. These claims must be received by the Medicaid Fiscal Agent by October 31, 1985.

2) Inpatient claims submitted with 1985 discharge dates which included charges for eligible MICU services and were paid exclusive of the MICU charges, may be resubmitted to the Medicaid Fiscal Agent in accord with regular adjustment procedures.

3) Inpatient claims with charges for eligible MICU services which were not previously submitted may now be submitted. Claims reflecting patient discharge dates prior to September 1, 1984, must be submitted hard copy on the UB-82 claim form and received by the Medicaid Fiscal Agent no later than October 31, 1985. Claims with discharge dates on and after September 1, 1984, may be submitted either by teleprocessing or tape provided the date of submission is within twelve (12) months of the discharge date. Hard copy claims are to be submitted on the UB-82 claim form.

4) Copies of all original claims must reflect the MICU charge (Revenue Code 543).

OUTPATIENT CLAIMS

1) Outpatient claims for MICU services must only be submitted hard copy on the Outpatient Hospital Claim Form (MC-4). List each MICU service on form (MC-4) under Item 30, Service Line 27, marked "Other"; the description "MICU" must also be entered in the "Remarks" section.

2) Outpatient claims for eligible MICU services provided during 1984 must be received by the Medicaid Fiscal Agent by October 31, 1985.

3) Outpatient claims for eligible MICU services provided after December 31, 1984, must be submitted to the Medicaid Fiscal Agent within twelve months of the date of service.

ADJUSTMENT REQUESTS

1) All adjustment requests for MICU payments must be submitted in one package to the Medicaid Institutional Claims Manager at the Medicaid Fiscal Agent's office. Submission of multiple MICU adjustment requests by any provider will not be considered.

2) The payment for these adjustments will be made off-system in a single payment and will not appear on your Medicaid payment voucher. In order to be considered for payment, the adjustment request must be received by the Medicaid Fiscal Agent no later than October 31, 1985.

NOTE: ANY ADJUSTMENT REQUEST RECEIVED IN A MANNER OTHER THAN DESCRIBED IN THIS NEWSLETTER WILL NOT BE CONSIDERED.

Prospective claims will be subject to utilization review by the Peer Review Organization of New Jersey. MICU claims will be evaluated for the proper documentation of care, medical necessity, and appropriateness of service.

Please refer any questions regarding this newsletter to your Medicaid Fiscal Agent:

Blue Cross - 201-456-2534

Prudential - 609-293-2045

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

REC'D SEP 9 1985

New Jersey Health Services Program NEWSLETTER

Volume P-456

September 9, 1985

TO: Transportation Providers

SUBJECT: Reimbursement Increase for Invalid Coach and Ambulance Services

EFFECTIVE: September 16, 1985

PURPOSE: This Newsletter informs providers of invalid coach and ambulance services of increases in reimbursement for transportation services by the New Jersey Medicaid Program.

ACTION: All claims submitted on and after September 16, 1985 for invalid coach and ambulance services will be reimbursed as follows:

	HCPCS Code	Description	Medicaid Dollar Value
AMBULANCE	A0010	Ambulance Service, Basic Life Support (BLS) Base Rate, Emergency Transport, One Way	$30.00
	A0222	Ambulance Service, Return Trip, Transport NOTE: For Medicaid reimbursement purposes A0222 is applicable to round trips only.	$60.00
INVALID COACH	A0130	Non-Emergency Transportation: Wheelchair Van NOTE: Invalid Coach, One Way, Per Patient	$20.00
	Y0060	Invalid Coach-Round Trip, Per Patient	$40.00
MILEAGE	A0020	Mileage - Ambulance Service, (BLS) Per Mile, Transport, One Way	$ 1.00 per loaded mile

NOTE: For Medicaid reimbursement purposes, mileage both one way and round trip is payable at $1.00 per loaded mile in both the ambulance and invalid coach. A0020 is to be used to identify all mileage charges.

NOTE: Maximum of three patients for Invalid Coach at one time - except for patients transported to receive dialysis treatments where a maximum of four patients is allowed. Medicaid will pay mileage for only one patient in a multiple load from the farthest location to the destination (and back if a round trip). Provider must submit all claims for multiple load patients together and certify on the claim forms that they are charging mileage only for the one patient who is being transported the farthest distance.

If there are any questions regarding this Newsletter, please contact Peter K. Rosswaag at (609) 984-7868.

STATE OF NEW JERSEY

Department of Human Services

Division of Medical Assistance and Health Services

REC'D OCT 4 1985

New Jersey Health Services Program NEWSLETTER

Volume P-457

October 1, 1985

To: All Providers

Subject: Medicaid Eligible Residents in the Counties of Gloucester and Burlington Participating as Health Care Plan of New Jersey Subscribers

Effective: October 1, 1985

Background: Health Care Plan of New Jersey (HCP/NJ), a Health Maintenance Organization (HMO) located in Medford, 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 the counties of Gloucester and Burlington, and who choose to be subscribers to Health Care Plan of New Jersey.

The services provided by Health Care Plan of New Jersey 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 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 13);
8. Ambulance service required for emergency medical care;
9. Family Planning services and supplies;
10. Skilled Nursing Care (up to 30 days per year, per enrollee)*;
11. Podiatric services;
12. Optometric services;
13. Mental Health services (20 out-patient and 30 in-patient days/year/enrollee)*;
14. Diagnosis and required medical treatment, and referral services for the abuse or addiction to alcohol or drugs, including detoxification; and
15. Routine Medical Supplies.

* When during a calendar year sixty (60) visits for home health care or thirty (30) days of skilled nursing facility care or twenty (20) outpatient visits or thirty (30) inpatient days

for mental health services, per year/enrollee 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 Health Care Plan of New Jersey an authorized EXHAUSTION OF BENEFITS form, a copy of which must be submitted with all claims.

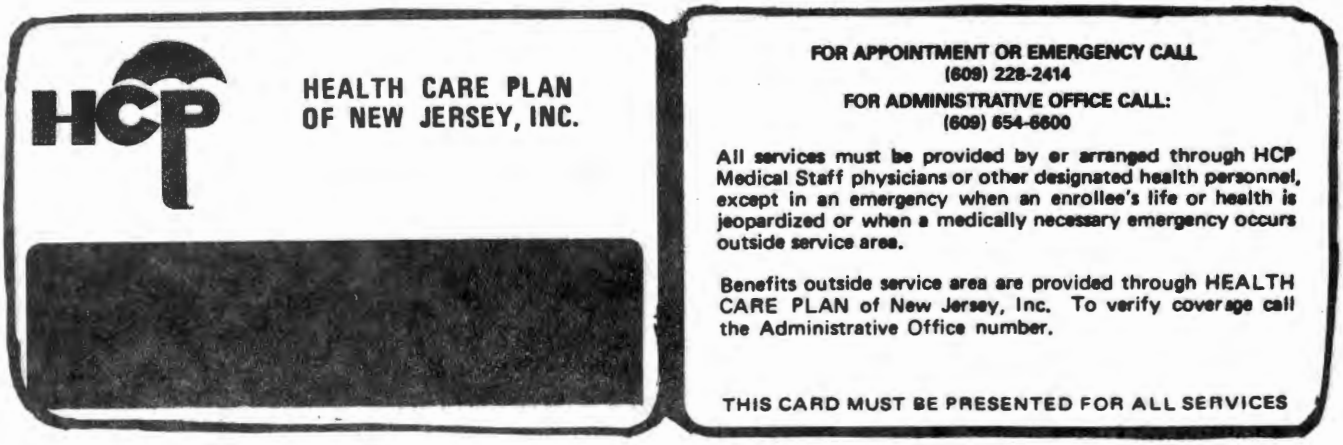
The following services or items are not provided by the Health Care Plan of New Jersey and Medicaid eligible subscribers of the Plan may secure these services from Medicaid providers who will be reimbursed under the existing rules and regulations of the New Jersey Medicaid Program:

1. Dental services;
2. Prosthetic and Orthotic appliances;
3. Medical Day Care;
4. Invalid Coach;
5. Hearing Aids;
6. Pharmaceutical services;
7. Optical appliances.
8. Chiropractic services; and
9. Durable Medical equipment.

Subscribers of Health Care Plan of New Jersey are entitled to receive emergency care services from any provider. Except in a life-threatening situation, emergency room services will be covered only if authorized by a physician from Health Care Plan of New Jersey, provided the patient is within a twenty-five (25) mile radius of a Health Care Plan of New Jersey facility. Outside a twenty-five (25) mile radius, emergency care will be covered without prior authorization provided the patient notifies Health Care Plan of New Jersey within forty-eight (48) hours of receiving medical services. Hospital and physician claims should be submitted to:

Health Care Plan of New Jersey, Inc.
165 Old Marlton Pike, Rt. 70,
Medford, New Jersey 08055.

An example of the Health Care Plan of New Jersey Subscriber Identification Card is shown below:



The County Welfare Agencies will be issuing altered check stubs to Medicaid eligible individuals who choose to become subscribers. Following is an example of the altered check stub which states on top of the card:

"RESTRICTED USE-HMO, CALL (609) 654-6600"

RESTRICTED USE HMO CALL 609-654-6600 STUB NO. 02201528

DEPARTMENT OF HUMAN SERVICES
MEDICAID-ID

VALID ONLY FOR THE MONTH OF JANUARY 1985

MEDICAID HSP # 0134567890

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

NOTICE TO PROVIDER

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 S. Eugene Yuliano, M.D., Director, Office of Prepaid Health Care, Division of Medical Assistance and Health Services, CN-712, Trenton, New Jersey 08625.

BETTER HEALTH THROUGH BETTER HEALTH MAINTENANCE

EXHAUSTION OF BENEFITS FORM

HEALTH CARE PLAN OF NEW JERSEY, INC.

(A FEDERALLY QUALIFIED HEALTH MAINTENANCE ORGANIZATION)

Dear Provider:

This is to inform you that _____, a member of the Health Care Plan of New Jersey has exhausted the _____ days of coverage for your services. A Plan subscriber may continue to receive these services, however, and 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, 609-654-6600.

Sincerely,

The Health Care Plan of New Jersey

Reply Correspondence to:

☐ **ADMINISTRATION OFFICE** • 165 OLD MARLTON PIKE, MEDFORD, NEW JERSEY 08055 • (609) 654-6600
☐ **MEDFORD HEALTH CENTER** • 165 OLD MARLTON PIKE, MEDFORD, NEW JERSEY 08055 • (609) 654-9400 • (609) 235-1400
☐ **CHERRY HILL HEALTH CENTER** • 712 HADDONFIELD ROAD, CHERRY HILL, NEW JERSEY 08002 • (609) 488-0300
☐ **GLOUCESTER HEALTH CENTER** • 500 COUNTY HOUSE ROAD, SEWELL, NEW JERSEY 08080 • (609) 228-2414

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

REC'D OCT 4 1985

New Jersey Health Services Program NEWSLETTER

Volume P-458

September 30, 1985

TO: All Dentists and Independent Dental Clinics

SUBJECT: Renewal of General Anesthesia Permits

EFFECTIVE: November 1, 1985

BACKGROUND: All dental general anesthesia permits issued by the New Jersey State Board of Dentistry will expire on October 31, 1985. 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, 1985.

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, 1985, 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, 1985, 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 - July 1983), 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

REC'D OCT 14 1985

New Jersey Health Services Program NEWSLETTER

Volume P-460

September 30, 1985

TO: Physicians, Dentists, Podiatrists, and Providers of Pharmaceutical Services

SUBJECT: Pharmacy Audits - Addition to Procedures

PURPOSE: This Newsletter requests the cooperation of providers when pharmacies are audited and confirmation of prescriptions, especially telephoned prescription orders, are needed.

BACKGROUND: The New Jersey Medicaid Program's Fiscal Agent, Blue Cross of New Jersey, routinely audits pharmacy providers to review adherence to Medicaid/PAAD prescription rules and regulations. It is noted that many prescriptions are filled from telephone requests as well as from original written prescriptions. There is frequently a need to confirm the authenticity of telephoned prescriptions.

ACTION: This Newsletter is for informational purposes only, to advise physicians, dentists, and podiatrists that New Jersey Medicaid (Blue Cross) will be visiting or calling in the future to confirm the findings of a pharmacy audit.

Any questions concerning this Newsletter should be addressed to Sanford Luger, Chief Pharmaceutical Consultant, Division of Medical Assistance and Health Services, at (609) 292-3756.

REC'D OCT 17 1985

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-461

October 21, 1985

TO: All Non-Institutional Providers

SUBJECT: Amending Requirement for Narrative Description on Claim Form

BACKGROUND: The New Jersey Medicaid Program always required the use of a narrative description as well as a procedure code when a claim form was submitted for a service rendered. That requirement was changed in conjunction with implementation of the Health Care Financing Administration's Common Procedure Coding System (HCPCS).

ACTION: Providers no longer need to include a narrative description of the procedure code. However, if a service requires prior authorization and the claim form is used both as an authorization and billing form, a narrative description as well as procedure code must still be included. A narrative description of the procedure code need not be included on the claim form for a service which requires a special authorization form.

Providers may also elect to include the narrative description as well as the code under the following circumstances:

1. The service is more clearly defined by the inclusion of both code and narrative;

2. The provider is unable to locate a code relevant to the service rendered.

Any questions concerning this Newsletter may be referred to the New Jersey Medicaid Program's fiscal agent, the Prudential Insurance Company (Telephone 1-800-582-7052).

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

REC'D OCT 29 1985

New Jersey Health Services Program NEWSLETTER

Volume P-462

October 28, 1985

TO: DRG Hospitals - Chief Executive Officers

SUBJECT: Reimbursement Policy for Non-Physician Services, Equipment/ Supplies Provided To Hospital Inpatients (Rebundling)

EFFECTIVE: Retroactive to January 24, 1984

PURPOSE: This Newsletter is to officially inform DRG hospitals of the New Jersey Medicaid Program's policy and procedures for reimbursement of the non-physician services, equipment/supplies provided by outside vendors to Medicaid-eligible patients.

BACKGROUND: Pursuant to Section 1862 (a) (14) of the Social Security Act (42 U.S.C. 1395y), and N.J.S.A. 26: 2H-1 et. seq., the New Jersey Medicaid Program reimburses hospitals on the basis of an all payer system. In accord with this policy, the New Jersey Medicaid Program will allow the hospital to bill for non-physician services, equipment/ supplies provided to a Medicaid inpatient when the hospital is billed by an outside vendor. This rebundled process is referred to as "rebundled services".

REBUNDLED SERVICES - POLICY AND PROCEDURES

1. THE HOSPITAL IS RESPONSIBLE FOR REIMBURSING THE VENDOR OF THE REBUNDLED SERVICES. Vendors may no longer bill the New Jersey Medicaid Program directly for services rendered to hospital inpatients. The vendor must submit a bill to the hospital.

2. Only those rebundled services which were provided on or after January 24, 1984 are eligible for reimbursement by Medicaid.

3. Hospitals must not submit claims for rebundled services which have been written off as bad debt or uncompensated care.

4. Neither the mark-up factor nor the payer factor is to be applied by the hospital to charges for services, equipment/supplies identified as "rebundled".

5. Private duty nurse service must not be billed as a rebundled service.

6. The hospital is expected to act as a prudent purchaser of rebundled services.

7. Hospitals must maintain a copy of the vendor invoice for post payment audit purposes.

8. The appropriate revenue code as indicated in this Newsletter must be assigned by the hospital to the rebundled services.

9. Evaluation of the hospital's adherence to these procedures will be accomplished through the Peer Review Organization (PRO) of New Jersey and the Medicaid Fiscal Agent.

ACTION: SUBMISSION OF CLAIMS FOR ADJUSTMENTS

The hospital may submit claims to the New Jersey Medicaid Program for specific non-physician services, equipment/supplies provided to Medicaid-eligible hospital inpatients as follows:

1. Reimbursement is applicable retroactively to January 24, 1984. Identify those rebundled services provided to Medicaid inpatients on or after January 24, 1984 which were billed by an outside vendor.

2. Claims submitted with 1984 discharge dates which included charges for eligible rebundled services and were paid exclusive of the rebundled service charge must be resubmitted in one batch on the UB-PS form. Multiple rebundled service adjustment requests submitted at different times will not be considered. These claims must be received by the Medicaid Fiscal Agent by December 31, 1985.

3. Claims with charges for eligible rebundled services which were not previously submitted may now be submitted. Claims reflecting patient discharge dates prior to January 1, 1985, must be submitted hard copy on the UB-82 claim form and received by the Medicaid Fiscal Agent no later than December 31, 1985. Claims with discharge dates on and after January 1, 1985, may be submitted either by teleprocessing or tape provided that the date of submission is within twelve (12) months of the discharge date. Hard copy claims are to be submitted on the UB-82 claim form.

4. Claims submitted with 1985 discharge dates which included charges for eligible rebundled services and were paid exclusive of the rebundled service charges may be resubmitted to the Medicaid Fiscal Agent in accord with regular adjustment procedures.

SUBMISSION OF REQUESTS FOR ADJUSTMENTS

1. All adjustment requests for payments of rebundled services must be submitted in one package to the Medicaid Insitutional Claims Manager at the Medicaid Fiscal Agent's office. Submission of multiple rebundled service adjustment requests by any provider will not be considered.

2. The payment for the adjustments to 1984 discharge claims will be made off-system in a single payment and will not appear on your Medicaid payment voucher. In order to be considered for payment, the adjustment requests must be received by the Medicaid Fiscal Agent no later than December 31, 1985.

   NOTE: ANY ADJUSTMENT REQUEST RECEIVED IN A MANNER OTHER THAN DESCRIBED IN THIS NEWSLETTER WILL NOT BE CONSIDERED.

Inquiries regarding this Newsletter may be directed to your Medicaid Fiscal Agent:

Blue Cross - 201-456-2534

Prudential - 609-293-2045

ELIGIBLE REBUNDLED SERVICES ARE NON-PHYSICIAN SERVICES, EQUIPMENT/SUPPLIES FURNISHED TO HOSPITAL INPATIENTS BY AN OUTSIDE VENDOR AND ARE COMPONENTS OF THE FOLLOWING:

DESCRIPTION	REVENUE CODE
Pharmacy (may only be used when billing for items furnished after February 1, 1985)	070
Physical therapy and speech language pathology furnished by an outpatient therapy provider	071
Pacemaker (Cardiac)	072
Artificial Limb (Prosthesis)	073
Implant Lens (Intraocular Lens)	074
Orthotics or Durable Medical Equipment	075
Medical/Surgical Supplies used for reduction of fractures and dislocations	076
Clinical Lab Tests (Independent Laboratory or Hospital Laboratory)	077
CAT Scans	078
Electromyogram (EMG)	079
Digital Angiogram	080
Other Radiology	081
Holter Monitor	082
Echocardiogram	083
Other Cardiology	084
Audiology (Independent Audiologist)	085
Cardiac Catheterization	086
Dialysis	087
Ambulance and Invalid Coach (Patient remains an inpatient of the hospital. Round trip service only).	088
Psychological Testing (Independent Psychologist)	089

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-463

November 11, 1985

TO: Independent Laboratory Providers

SUBJECT: Regulation on Laboratory Reimbursement

EFFECTIVE: Immediately

BACKGROUND: There have been inquiries about the meaning of a section of the New Jersey Administrative Code 10:61-1.5 (Independent Laboratory Services) which reads as follows:

"Reimbursement shall be on the basis of the lowest professional charge, not to exceed an allowance determined reasonable by the Commissioner (Human Services), and further limited by Federal policy relative to payment of practitioners and other individual providers. In no event shall the charge to Medicaid from a laboratory exceed the lowest charge to other providers for the specific service."

ACTION: An independent laboratory must give the New Jersey Medicaid Program the benefit of the lowest charge or discounted prices that it lists or offers to any individual, agency, third party payor or any other provider.

If there are any questions concerning this Newsletter please contact Phyllis Ann Valeri, Laboratory Consultant, Division of Medical Assistance and Health Services at 609-292-7673.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

REC'D NOV 6 1985

New Jersey Health Services Program NEWSLETTER

Volume P-464

October 28, 1985

TO: Homemaker and Home Health Agencies Participating in the Personal Care Assistant Program and the Community Care Program for the Elderly and Disabled

SUBJECT: 1. Accreditation Requirements for Program Participation
2. Inclusion of Proprietary Homemaker Agencies as Providers of Personal Care Assistant Service Providers

EFFECTIVE: November 1, 1985

BACKGROUND: Policy changes were recently proposed and adopted in the New Jersey Administrative Code (N.J.A.C.10:60-1.2) allowing for the inclusion of proprietary homemaker agencies in addition to the voluntary non-profit homemaker agencies already participating in the Personal Care Assistant Program. Accreditation for all homemaker agencies is also a condition for program participation. Home Health Agencies (certified licensed) are not subject to this accreditation requirement.

ACTION: The Division of Medical Assistance and Health Services now requires that homemaker agencies be accredited by either the National Home Caring Council or the Commission on Accreditation established by the Home Care Council of New Jersey as a condition for participation in the New Jersey Medicaid Program.

PERSONAL CARE ASSISTANT PROGRAM:

The accreditation requirement must be met by all proprietary homemaker agencies wishing to participate in the Personal Care Assistant Program. The Division will recognize the current accreditation status of all voluntary non-profit homemaker agencies participating as Medicaid providers in the Personal Care Assistant Program until the completion of their accreditation cycle, after which time the new accreditation process must be initiated in order to continue as a Medicaid provider.

COMMUNITY CARE PROGRAM FOR THE ELDERLY AND DISABLED:

No new applications under the Division's current standards review system will be accepted after May 1, 1986. Those homemaker agencies now providing services under the Community Care Program for the Elderly and Disabled (CCPED), as well as new agencies wishing to participate in the CCPED must be accredited by November 1, 1986.

For further information and application for accreditation, please contact one or both of the following agencies:

Ms. Nancy Robinson
Accreditation Program
National Home Caring Council
235 Park Avenue South
New York, N.Y. 10003
Telephone: 1-212-674-4990

Mr. Kenneth Dolan
Commission on Accreditation
for Home Care
Home Care Council of New Jersey
60 S. Fullerton Avenue
Montclair, New Jersey 07042
Telephone: 1-201-744-5524

Any questions regarding this newsletter or program participation should be directed to Carol Kurland, Administrator, Office of Home Care Programs, (609) 292-1940

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

REC'D NOV 6 1985

New Jersey Health Services Program NEWSLETTER

Volume P-465

November 11, 1985

TO: Hospital Chief Executive Officers

SUBJECT: Community Care Program For The Elderly And Disabled (CCPED) - Phase III

PURPOSE: This Newsletter is intended to alert hospital discharge planners to the services of the Community Care Program for the Elderly and Disabled offered by the New Jersey Medicaid Program. The CCPED Program offers home care services to eligible individuals as an alternative to nursing home placement.

BACKGROUND: With the extension of the Community Care Program for the Elderly and Disabled to the remaining five counties of Camden, Cumberland, Essex, Monmouth and Union, (Phase III), CCPED is available throughout the State as of October 1, 1985.

The Community Care Program for the Elderly and Disabled offers seven home care services: (1) Case Management; (2) Home Health services; (3) Homemaker services; (4) Medical Day Care; (5) Social Day Care; (6) Respite services; and (7) Transportation (medical non-emergency). All services require prior authorization except Case Management.

The eligibility criteria remain the same. Recipients eligible for this Program must:

1. Be 65 or over, or determined disabled under the Social Security Act and receiving Social Security disability payments, and eligible for Medicare.

2. Be assessed in need of Skilled Nursing Facility/Intermediate Care Facility (SNF/ICF) Care; and

3. Have an income which exceeds the appropriate SSI community standard up to the standard for institutional care (currently $975 per month).

For more background information concerning the CCPED Program, hospital discharge planners are referred to the previously issued Newsletters as listed below:

P-371/BC-266, dated December 5, 1983;
P-392/BC-281, dated June 11, 1984;
P-405/BC-293, dated October 1, 1984;
P-452/BC-315, dated August 19, 1985.

ACTION: Hospital discharge planners who are interested in referring clients for the CCPED Program should first consult with their local county welfare agency for determination of financial eligibility for CCPED.

Any questions regarding the CCPED Program can also be directed to the Medicaid District Office serving your county. A current list of Medicaid District Offices is attached.

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

MEDICAID DISTRICT OFFICE		ADDRESS AND TELEPHONE NUMBER
Atlantic	William Underland, Director	1 S. New York Avenue Atlantic City, NJ 08401 Tel. 609-441-3620 (SCAN) 541-3620)
Bergen	Alphonse Leone, Director	50 Main Street Hackensack, N.J. 07601 Tel. 201-488-5667
Burlington* Daniel Walsky, Regional Director	Helen Kern, Director	50 Rancocas Road Mt. Holly, N.J. 08060 Tel. 609-261-0448
Camden	Ronald Coppola, Director	Parkade Building, Rm. 207 519 Federal St. Camden, N.J.08101 Tel. 609-757-2870 (SCAN) 543-2870)
Cumberland (Cape May)	Daniel Cooperson, Director	108 Landis Avenue Vineland, N.J. 08360 Tel. 609-696-6560 (SCAN) 521-6560)
Essex A. Bialogowicz, Ass't. to Regional Director	John T. Russell, Director	155 Washington Street Newark, N.J. 07102 Tel. 201-648-2470, 648-3700 (SCAN) 221-2470, 221-3700)
Gloucester (Salem)	Eleanor Chatzinoff, Director	251 N. Delsea Drive Woodbury Plaza, Suite B Deptford, N.J. 08096 Tel. 609-845-7185
Hudson	Alice Rooth, Director	2815 Kennedy Blvd. 2nd Floor Jersey City, N.J. 07306 Tel. 201-433-8011
Hunterdon (Somerset)	Caroline Krajewski, Director	84 Park Avenue, 2nd Floor Flemington, N.J. 08822 Tel. 201-782-1130
Mercer	William Bailey, Director	28 West State Street Rm. 1105 Trenton, N.J. 08608 Tel. 609-292-7315 (SCAN) 322-7315)
Middlesex* Walter Maibach, Regional Director	Thomas Rafferty, Director	75 Paterson Street (basement) New Brunswick, N.J. 08903 Tel. 201-246-0653
Monmouth	Frances Garrett, Director	1200 Memorial Drive Asbury Park, N.J. 07712 Tel. 201-775-5700 (SCAN) 321-0155)
Morris* (Sussex & Warren) John Langan, Regional Director	Marie Reed, Director	10 Park Place, 4th Floor Morristown, N.J. 07960 Tel. 201-267-1700
Ocean	Dennis Doderer, Director	1861 Hooper Avenue Toms River, N.J. 08753 Tel. 201-255-6226
Passaic	Raphaelle Andriola, Director	100 Hamilton Plaza (Market Street) 9th Floor, Paterson, N.J. 07505 Tel. 201-977-4077 (SCAN) 226-4069)
Union	John Baxter, Director	125 Broad St., 6th Floor, Hersh Towers Elizabeth, N.J. 07201 Tel. 201-820-3135 (SCAN) 446-3135)

* Denotes office where the Regional Director can be reached.
(Rev. 8/85)

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

REC'D DEC 2 1985

New Jersey Health Services Program NEWSLETTER

Volume P-466

November 25, 1985

TO: Chief Executive Officers - All Hospitals

SUBJECT: New Legislation Regarding Long-Term Care Private Pay Contracts and Discrimination Against Medicaid Eligible Patients

PURPOSE: This is an informational newsletter alerting hospital discharge planners that effective August 23, 1985 Section 6 of L. 1985, c.303, prohibits long-term care facilities (LTCFs) from requiring private pay contracts or donations on behalf of Medicaid eligible patients. This newsletter also provides information relevant to other sections of L. 1985, c.303.

BACKGROUND: Governor Thomas H. Kean signed L. 1985, c.303, on August 23, 1985. It is an Act concerning patients in certain health care facilities, amending and supplementing L. 1945, c. 169 (Civil Rights Act), amending and supplementing L. 1968, c.413 (C.30:4D-1 et seq. - New Jersey Medicaid Act).

A bulletin was issued to all New Jersey long-term care facilities on August 30, 1985, notifying them of this recent legislation.

The following is a brief analysis of Section 6 (Private Pay Contracts) of the New Jersey Medicaid law which took effect August 23, 1985. An explanatory paragraph is given for each subsection of Section 6 which, in certain instances, is followed by the actual wording of the Law.

In general, Section 6 prohibits LTCFs from requiring private pay contracts or donations under certain conditions on behalf of Medicaid eligible patients. To enforce this prohibition the law establishes both criminal and civil penalties.

Subsection (a) of Section 6 prohibits LTCFs from soliciting gifts, money or donations from the families of Medicaid patients as a precondition for admission or as a condition for the patient's continued stay in the facility. It does not prohibit a patient's family from making a purely voluntary contribution or restrict voluntary donations by charitable, religious or philanthropic sources.

> Section 6.a. "No person shall at any time knowingly charge, solicit, accept or receive, in addition to any amount otherwise required to be paid under P.L.1968,c.413 (C.30:4D-1 et seq.) any gift, money, donation or other consideration other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient as a precondition of admitting a patient to a skilled nursing facility or intermediate care facility or as a requirement for a patient's continued stay in the facility when the cost of the services provided therein to the patient is paid for in whole or in part under P.L.1968,c.413 (C.30:4D-1 et seq.). A person who violates this subsection is guilty of a crime of the third degree."

Subsection (b) of Section 6 prohibits LTCFs from requiring a Medicaid eligible patient or his family to enter into a private pay contract for a period of time before Medicaid payments are accepted.

> Section 6.b. "No person shall knowingly require as a condition of accepting payment under P.L.1968,c.413 (C.30:4D-1 et seq.) that a person financially eligible for benefits or his family member pay or enter into an agreement to pay as a private patient at a skilled nursing or intermediate care facility for any period. A person who violates this subsection is guilty of a crime of the third degree."

Subsection (c) of Section 6 prohibits LTCFs from requiring a Medicaid eligible patient or his family to enter into a private pay contract for the continued stay of the patient in the facility before Medicaid payments are accepted.

> Section 6.c. "No person shall knowingly require as a condition of continued stay at a skilled nursing facility or intermediate care facility that a person financially eligible for benefits under P.L.1968,c.413 (C.30:4D-1 et seq.) or his family member pay any sum of money, or other consideration, including the furnishing of an agreement by a family member which obligates that party to pay for care rendered a financially eligible person. A person who violates this subsection is guilty of a crime of the third degree."

Any violation of subsections (a), (b) or (c) constitutes a crime of the third degree which is punishable by a fine of up to $7,500 and/or imprisonment for a period of between 3 and 5 years.

Subsection (d) of Section 6 exempts life care communities from the prohibitions in subsections (a), (b), and (c).

> Section 6.d. "The provision of subsections a.,b.and c. of this section shall not apply to agreements to provide continuing care between a life care community, as defined by regulation, and a person financially eligible for benefits under P.L.1968,c.413 (C.30:4D-1 et seq.)".

In addition to the criminal penalties mentioned above, this law also provides for the imposition of civil penalties for violations of subsections (a), (b) and (c).

Specifically, subsection (e) provides that any person who violates subsection (a) by soliciting a donation as a precondition for admission or for the continued stay of the patient will be liable for:

1. Repaying the amount of the donation to the person plus interest;
2. Payment to the State of 3 times the amount of the donation; and
3. Payment to the State of $5,000 for each claim submitted for reimbursement for a period in which a donation was solicited.

Subsection (f) provides that any person who violates subsections (b) or (c) by requiring a Medicaid patient or his family to enter into a private pay contract will be liable for:

1. Repaying the patient or family the amount of the payments made on the private pay contract plus interest and attorney's fees; and
2. Payment to the State of a penalty in the amount of $5,000.

Furthermore, the Law amends the Civil Rights Act, effective November 21, 1985, to provide that:

"It shall be an unlawful discrimination for any skilled nursing or intermediate care facility which is a Medicaid provider pursuant to P.L.1968,c.413 (C.30:4D-1 et seq.) and whose Medicaid occupancy level is less than the Statewide occupancy level to deny admission to a qualified Medicaid applicant when a nursing home bed becomes available; except that this requirement shall not be construed to apply to the transfer of a resident from a residential unit to a nursing care unit within a facility, as defined by regulation, or prohibit a life care community, as defined by regulation, from contracting with its own residents for prior rights to beds in the nursing care unit of the community."

"The Commissioner of Human Services shall modify this requirement based on the licensed bed capacity and the financial condition of a facility but in no case shall the Medicaid occupancy level of that facility be less than 35%. The commissioner shall by September 1 of each year provide the Institutions, Health and Welfare Committee of the Senate, the Corrections, Health and Human Services Committee of the General Assembly, and the Governor with a report stating in specific detail the adverse financial condition of each facility exempted from this requirement. The criteria used by the commissioner to modify this requirement shall be contained in regulations which he shall adopt pursuant to the 'Administrative Procedure Act,' P.L.1968,c.410 (C.52-14B-1 et seq.), and a list of all skilled nursing or intermediate care facilities granted a modification by the commissioner shall be published in the New Jersey Register within one month of the commissioner's granting of the modification. Nothing in this section shall be construed to prohibit a religiously affiliated skilled nursing or intermediate care facility from utilizing religious affiliation as a uniform qualification for admission."

....."'Medicaid Occupancy level' means the average number of Medicaid recipients residing in a skilled nursing or intermediate care facility divided by the total number of licensed beds in the facility during that month. The Department of Human Services shall compile this information on a monthly basis and it shall be made available to the public upon request. This information shall be provided to the Division on Civil Rights on a monthly basis."

....."'Statewide occupancy level' means 45% of the total number of licensed beds in a skilled nursing or intermediate care facility for the first year following the effective date of this amendatory and supplementary act. For each year thereafter, the Commissioner of Human Services shall annually determine the Statewide occupancy level based on the commissioner's projection of the need for nursing facility bed space for qualified Medicaid applicants for that year, but the level shall not be less than 45%". .....

"'Qualified Medicaid Applicant' means an individual who is qualified or eligible to receive skilled nursing or intermediate care facility services which are reimbursable by the Medicaid program pursuant to P.L.1968,c.413 (C.30:4D-1 et seq.)."

"A person or agency having knowledge that a skilled nursing or intermediate care facility whose Medicaid occupancy level is less than the Statewide occupancy level has denied admission to a qualified Medicaid applicant, shall promptly report this information to the Division on Civil Rights of the Department of Law and Public Safety."

Any questions concerning the new legislation and this newsletter should be submitted, in writing, to Thomas M. Russo, Director, Division of Medical Assistance and Health Services, CN-712, Trenton, New Jersey 08625.

Subsection (g) provides that the Attorney General may bring an action to recover the civil penalties on behalf of both the Department of Human Services and the person who made the payments. In addition, the person who made the payments may institute his own action to recover the payments.

The following additional sections of the Medicaid law shall be effective November 21, 1985.

Section 7. "If an applicant is determined to be eligible under P.L.1968,c.413 (C.30:4D-1 et seq.) retroactively and the provider bills the applicant directly for the services and benefits rendered during the retroactive period, the provider shall, upon notification of the applicant's retroactive eligibility, submit claims for reimbursement for covered services or benefits rendered during the retroactive period. Upon certification that the applicant is so eligible, the provider shall reimburse the applicant or other person who has made prior payment to the provider."

Section 8. "The commissioner may establish adjusted reimbursement rates for skilled nursing and intermediate care facilities which experience financial hardship due to an average monthly Medicaid recipient census in excess of a percentage of licensed bed capacity as determined by the commissioner. The adjusted rates shall be adopted pursuant to the 'Administrative Procedure Act,' P.L.1968,c.410 (C.52:14B-1 et seq.)."

Section 9.a. "If a skilled nursing or intermediate care facility notifies the commissioner within 180 days following the date of enactment of this amendatory and supplementary act that the facility shall no longer be a Medicaid provider and that the facility has one or more Medicaid eligible patients residing therein, the commissioner may, at the request of the facility, permit the facility to continue to provide skilled nursing or intermediate care services to those Medicaid eligible patients residing therein without being required to admit any new Medicaid eligible patients.

The commissioner may grant a facility's request to do so if the request is in the best interests of the Medicaid eligible patients residing therein. For the period of time that the Medicaid eligible patients continue to reside in the facility, that facility shall comply with all applicable provisions of P.L.1968,c.413 (C.30:4D-1 et seq.).

Section 9.b. "If a skilled nursing or intermediate care facility which withdraws as a Medicaid provider pursuant to this section subsequently reapplies to the department to become a Medicaid provider, the commissioner may require as a condition of becoming a Medicaid provider that the facility enter into a three year Medicaid provider contract with the department."

Section 12. "Each skilled nursing facility and intermediate care facility shall post a statement of the provisions of this amendatory and supplementary act that apply to that facility in a prominent place in the facility, and a copy of the statement shall be given to each person who applies for admission at the time of application."

Section 13. "The Commissioner of Human Services shall report annually to the Governor and the Legislature on the effect of the provisions of this amendatory and supplementary act on reducing the shortage of skilled nursing and intermediate care facility bed space for Medicaid recipients, the status of the availability of bed space throughout the State and whether any additional admissions requirements are necessary to ensure an adequate number of skilled nursing and intermediate care facility beds for Medicaid eligible persons."

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

REC'D DEC 12 1985

New Jersey Health Services Program NEWSLETTER

Volume P-467

December 9, 1985

TO: All Practitioners Using the 1500 NJ Claim Form

SUBJECT: New Jersey Edition (HCFA) 1500 Claim Form

EFFECTIVE: Immediately

BACKGROUND: We have been advised that effective October 30, 1985, the Federal Health Care Financing Administration (HCFA) disallows any costs associated with the production or distribution of the HCFA 1500 Claim Form for Medicare providers. Therefore, the HCFA 1500 Claim Form will no longer be provided free of charge to Medicare providers.

ACTION: The New Jersey Medicaid Program is pleased to announce that the New Jersey Edition of the 1500 Claim Form will continue to be provided free of charge to Medicaid providers. Forms may be ordered from the Prudential Insurance Company in the usual manner.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

REC'D DEC 26 1985

New Jersey Health Services Program NEWSLETTER

Volume P-468

December 16, 1985

TO: CHIEF EXECUTIVE OFFICERS - HOSPITALS

SUBJECT: Laboratory Services (OUTPATIENT)
HCPCS (Health Care Financing Administration Common Procedure Coding System)

EFFECTIVE: FOR ALL OUTPATIENT HOSPITAL CLAIMS SUBMITTED ON OR AFTER FEBRUARY 1, 1986

PURPOSE: This Newsletter is to inform hospital providers that they must include HCPCS codes when submitting claims for pathology/laboratory procedures performed on Medicaid outpatients. It is anticipated that UB-82 HCFA-1450 will be in effect for Medicaid outpatient claims as of February 1, 1986.

BACKGROUND: The Deficit Reduction Act of 1984 (DEFRA) requires that hospital laboratory services be reimbursed on a fee-for-service basis. This reimbursement policy is waived for all hospitals in New Jersey as a result of the New Jersey DRG system. All hospitals in New Jersey will continue to be reimbursed on the basis of reasonable charges. However, all hospitals must use HCPCS codes for data collection purposes.

ACTION: For appropriate lead time for claims processing purposes, all hard copy outpatient claims submitted on or after January 27, 1986, for outpatient pathology/laboratory procedures must include HCPCS codes on the UB-82 HCFA-1450 in conjunction with the appropriate uniform billing revenue codes. Teleprocessing and/or remote screens will require HCPCS coding with all outpatient claims entered on/or after February 1, 1986.

HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology-4th Edition (CPT-4). Pathology/Laboratory procedure codes are described in the CPT-4 under code numbers 80002-89399. In addition, a list of pathology/laboratory procedures not listed in the CPT-4 is attached to this newsletter.

As indicated in the MEDICARE/MEDICAID BULLETIN, Procedure Coding System, dated March 29, 1985, a CPT-4 is available from:

Order Department - OP-341-5
American Medical Association
P.O. Box 10946
Chicago, Illinois 60610

Hospitals must utilize the National Uniform Bill, UB-82 HCFA-1450 by February 1, 1986. Further instructions about the submission of UB-82 claims both hard-copy and teleprocessed will be forwarded under separate cover.

NOTE- Any hard copy outpatient claim received by the fiscal agent which is not in compliance with this newsletter will be returned to the hospital for correction/completion.

Please refer any questions regarding this Newsletter to your Fiscal Agent:

Blue Cross .....(201) 456-2534

Prudential .....(609) 293-2254

New Jersey Medicaid Program
HCFA Common Procedure Coding System (HCPCS)

PATHOLOGY/LABORATORY

(CODES AND NARRATIVES NOT FOUND IN CPT-4)

HCPCS CODE	PROCEDURES DESCRIPTION
P2032	Icterus Index, Blood
P2033	Thymol Turbidity, Blood
P7001	Culture, Bacterial, Urine; Quantitative, Sensitivity Study
W8200	Glucose, Serum (Separate Tube, Grey Top)
	NOTE: Submitted on same claim, and performed on same date as chemistry profiles
W8205	3 Hr. Glucose Tolerance test, per 4 specimens.
W8210	5 Hr. Glucose Tolerance test, per 6 specimens.
W8215	T-4 (Thyroxine) by Immunoassay (Enzyme Immunoassay) (EMIT)
W8225	Thyroxine - Binding Globulin with T4 (Thyrobinding-Globulin with T4) (RIA) (TBG and T4)
W8615	Anti-DNA, Anti - Deoxyribonucleic Acid, (Chemical Method, Non-RIA)
W8620	Herpes Simplex Antibodies: (Herpes Simplex Virus, I or II)
W8621	Herpes Simplex Virus, I and II
W8622	Herpes Simplex Virus, Isolation and Identification, Total Study
W8700	Yeast Screen (Not definitive) from Urine, Vaginal or Throat Cultures only eg., Germ Tube)
W8710	Trichomonas Preparation - Smear or Hanging Drop
	(Smear not eligible for separate reimbursement if Pap smear done on the same day).

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

REC'D DEC 26 1985

New Jersey Health Services Program NEWSLETTER

Volume P-469

December 16, 1985

TO: Chief Executive Officers - Hospitals

SUBJECT: National Uniform Bill - UB-82 HCFA-1450 - Outpatient Claims

EFFECTIVE: February 1, 1986

PURPOSE: This Newsletter provides hospital billing office personnel with revised instructions for billing the New Jersey Medicaid Program for outpatient claims.

BACKGROUND: Hospitals must utilize the National Uniform Bill, UB-82 HCFA-1450, when billing hard copy for outpatient services. In conjunction with the change to the UB-82 claim form, the New Jersey Medicaid Program will require that hospitals use HCPCS codes for outpatient diagnostic laboratory services to identify the specific laboratory tests performed for Medicaid outpatients. There will be no change in reimbursement methodology for these services.

ACTION: Hospitals must utilize the UB-82 claim form when billing hard copy for outpatient services. While the effective date of UB-82 for outpatient claims is February 1, 1986, hospitals are instructed to submit all outpatient claims on and after January 27, 1986, using UB-82 in order to allow for appropriate lead time for claims processing purposes. The guidelines issued by the New Jersey State Department of Health are to be used for completing the UB-82 form. Most of the Medicaid required items and the corresponding instructions in the guidelines are self-explanatory. However, to avoid confusion, those items that need further clarification in order to meet New Jersey Medicaid Program billing requirements are noted with attached instructions. Billing examples are also attached to the instructions. All other New Jersey Medicaid Program policies and procedures with regard to outpatient claims remain unchanged.

Inquiries regarding this newsletter may be directed to your Medicaid Fiscal Agent:

Blue Cross - 201-456-2534
Prudential - 609-293-2254

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

REC'D JAN 14 1986

New Jersey Health Services Program NEWSLETTER

Volume P-471

December 30, 1985

TO: All Physicians, Pharmacies, Independent Laboratories, Medical Suppliers, Psychologists, Prosthetic and Orthotic Providers, Transportation Providers, and Chief Executive Officers of DRG Hospitals

SUBJECT: Reimbursement Policy for Non-Physician Services and Equipment/ Supplies Provided to Hospital Inpatients (Rebundling)

EFFECTIVE: Retroactive to January 24, 1984

PURPOSE: This Newsletter is to officially inform providers of the New Jersey Medicaid Program's change in reimbursement policy for non-physician services and equipment/supplies furnished by outside providers to Medicaid-eligible inpatients in DRG Hospitals.

BACKGROUND: All DRG hospitals were officially informed that certain non-physician services and equipment/supplies received by Medicaid inpatients must be furnished by the hospital either directly or under arrangement. In accord with this policy, the hospital will bill the New Jersey Medicaid Program for non-physician services, equipment/supplies provided to a Medicaid inpatient when it is billed by an outside vendor. This is referred to as "Rebundling".

ACTION:

1. Outside Medicaid providers of rebundled services may no longer bill the New Jersey Medicaid Program directly for services rendered to hospital inpatients.

2. The provider must submit a bill/invoice to the hospital at the time the rebundled service is provided.

3. The hospital is responsible for reimbursing the provider of the rebundled service.

4. Outside Medicaid providers who have already received payment for these rebundled services on a fee-for-service basis may not now submit claims.

5. Outside providers who have not yet submitted a bill/invoice for reimbursement for a rebundled service, or who have submitted a claim which was returned as not payable, must submit or resubmit a bill/invoice to the hospital by January 31, 1986, in accord with the directives of this Newsletter.

6. Attached is a list of applicable rebundled services.

Inquiries regarding this Newsletter may be directed to your Medicaid Fiscal Agent:

Blue Cross - 201-456-2534
Prudential - 609-292-2254

REBUNDLED SERVICES ARE NON-PHYSICIAN SERVICES AND EQUIPMENT/SUPPLIES FURNISHED TO DRG HOSPITAL INPATIENTS BY AN OUTSIDE PROVIDER AND ARE COMPONENTS OF THE FOLLOWING:

DESCRIPTION

Pharmacy (Exceptional Items-which may only be used when billing for items furnished after February 1,1985)

Physical therapy and speech language pathology furnished by an outpatient therapy provider

Pacemaker (Cardiac)

Artificial Limb (Prosthesis)

Implant Lens (Intraocular Lens)

Orthotics or Durable Medical Equipment

Medical/Surgical Supplies used for reduction of fractures and dislocations

Clinical Lab Tests (Independent Laboratory or Hospital Laboratory)

CAT Scans

Electromyogram (EMG)

Digital Angiogram

Other Radiology

Holter Monitor

Echocardiogram

Other Cardiology

Audiology (Independent Audiologist)

Cardiac Catheterization

Dialysis

Ambulance and Invalid Coach (Patient remains an inpatient of the hospital.Round trip service only)

Psychological Testing (Independent Psychologist)

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-472

December 30, 1985

TO: Medical Supplier Providers

REC'D JAN 24 1986

SUBJECT: Increase In Reimbursement For Labor Charges

EFFECTIVE: January 6, 1986

PURPOSE: The New Jersey Medicaid Program is pleased to announce an increase in reimbursement for labor charges relevant to repair of durable medical equipment.

ACTION: Labor charges for repair of durable medical equipment will be paid at $20.00 per hour, divided into quarter hour increments, on all claims submitted after January 5,1986.

If there are any questions concerning this Newsletter, please call the New Jersey Medicaid Program, Chief Pharmaceutical Consultant at (609) 588-2724.

RECEIVED 05 1986

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P-473

January 27, 1986

TO: Independent Mental Health Clinics Under Contract to the Department of Human Services, Division of Mental Health and Hospitals

SUBJECT: Revisions to the Personal Care Assistant Program

EFFECTIVE: January 6, 1986

PURPOSE: This Newsletter will inform providers of the Personal Care Assistant program that personal care assistant services may now be provided for a maximum of 25 hours per week, an increase of 5 hours. It will also inform the providers that the Individual and Group service reimbursement rate for the hour and half-hour periods of service have been increased as follows:

1. Personal Care Assistant service - Individual reimbursement rate - $7.70 per hour - Code Z1600;

2. Personal Care Assistant service - Individual reimbursement rate - 3.85 per half-hour - Code Z1611;

3. Personal Care Assistant Service - Group reimbursement rate - $6.24 per hour - Code Z1605; and

4. Personal Care Assistant Service - Group reimbursement rate - $3.12 per half-hour - Code Z1612.

A nursing reassessment visit has been established. This visit, which requires prior authorization by the Division of Mental Health and Hospitals, will be reimbursed at a rate of $20.00 per visit utilizing Code Z1613. This reassessment visit to re-evaluate the need for continued care may be provided once every six months, or more frequently if the condition warrants.

In addition, the Personal Care Assistant program and the Home Health program may now be provided simultaneously, as long as the services of the home health aide and the personal care assistant worker are not provided at the same time to the same patient. The main purpose of this change is to allow for the provision of skilled nursing services from the Home Health program at the same time the personal care assistant worker is being utilized. It is not the Division's intent for the home health aide to supplement the service of the personal care assistant worker.

Any questions regarding this Newsletter should be directed to Carol Kurland, Administrator, Office of Home Care Programs, Division of Medical Assistance and Health Services at (609) 588-2620.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

REC'D FEB 03 1986

New Jersey Health Services Program NEWSLETTER

Volume P-474

January 27, 1986

TO: Home Health and Homemaker Agencies Participating in the Personal Care Assistant Program and the Community Care Program for the Elderly and Disabled

SUBJECT: Revisions to the Personal Care Assistant Program and the Community Care Program for the Elderly and Disabled

EFFECTIVE: January 6, 1986

PURPOSE: This Newsletter will inform providers of the Personal Care Assistant program that personal care assistant services may now be provided for a maximum of 25 hours per week, an increase of 5 hours. It will also inform providers of the Personal Care Assistant program and the Community Care Program for the Elderly and Disabled that the service rates have been increased and that a nursing reassessment visit has been established.

Personal Care Assistant Program

The Individual and Group reimbursement rate for the hour and half-hour periods of service have been increased as follows:

1. Personal Care Assistant service - Individual reimbursement rate - $8.30 per hour - Code Z1600;

2. Personal Care Assistant service - Individual reimbursement rate - $4.15 per half-hour - Code Z1611;

3. Personal Care Assistant service - Group reimbursement rate - $6.24 per hour - Code Z1605;

4. Personal Care Assistant service - Group reimbursement rate - $3.12 per half-hour - Code Z1612.

A nursing reassessment visit has been established. This visit, which requires prior authorization from the Medicaid District Office serving your area, will be reimbursed at a rate of $20.00 per visit utilizing Code Z1613. This reassessment visit to reevaluate the need for continued care may be provided once every six months, or more frequently if the condition warrants.

In addition, the Personal Care Assistant program and the Home Health program may now be provided simultaneously, as long as the services of the home health aide and the personal care assistant worker are not provided at the same time to the same patient. The main purpose of this change is to allow for the provision of skilled nursing services from the Home Health program at the same time the personal care

assistant worker is being utilized. It is not the Division's intent for the home health aide to supplement the service of the personal care assistant worker.

The Division of Developmental Disabilities' (formerly the Division of Mental Retardation) adult foster care homes have been removed from the exclusionary list of residences where personal care assistant services may be provided. This means that patients who live in adult foster care homes sponsored by the Division of Developmental Disabilities may now be served by the Personal Care Assistant program if they are found to be medically in need of these services. Prior authorization of personal care assistant service for these patients is required from the Medicaid District Office.

Community Care Program for the Elderly and Disabled

1. Homemaker service - Individual
   reimbursement rate - $8.30 per hour - Code Z1200;

A nursing reassessment visit provided under the auspices of the Community Care Program for the Elderly and Disabled will be reimbursed at a rate of $20.00 per visit utilizing Code Z1290. The reassessment visit to reevaluate the need for continued care may be provided once every six months, or more frequently if the condition warrants.

Any questions regarding this Newsletter should be directed to Carol Kurland, Administrator, Office of Home Care Programs, Division of Medical Assistance and Health Services at (609) 588-2620.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

New Jersey Health Services Program **NEWSLETTER**

Volume P-475

February 10, 1986

TO: Independent Clinics

SUBJECT: Replacement Pages for Independent Clinic Services Manual
Ambulatory Surgical Centers (ASC)

1. This Newsletter encloses revised pages for the Independent Clinic Services Manual relevant to New Jersey Medicaid Program regulations recently adopted in the New Jersey Administrative Code (N.J.A.C. 10:66-1.6 and 1.7) for Ambulatory Surgical Centers.

2. The vertical lines indicated on the left side in the attached replacement pages are reflective of current revisions to Subchapter 1, sections 1.6 and 1.7 of the Independent Clinic Services Manual.

Manual Maintenance:

Replace page numbered 10 & 11, Revised 5/80, Subchapter 1, with the attached page numbered 10 & 10.1, Revised 1/86, and add the subsequent pages, numbered 10.2 & 10.3 and 11.

Replace page numbered 15 & 16, Revised 5/80, Subchapter 1, with the attached page numbered 15 & 15.1, Revised 1/86, and add the subsequent page, numbered 15.2 & 16.

Any questions regarding this Newsletter may be directed to Jacqueline Lawrence (Provider Enrollment Unit) at 609-588-2905.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

New Jersey Health Services Program **NEWSLETTER**

Volume P-476

February 10, 1986

TO: Homemaker and Home Health Agencies Participating in the Personal Care Assistant Program (PCA) and the Community Care Program for the Elderly and Disabled (CCPED)

SUBJECT: 1. Clarification of Billing Instructions for PCA/CCPED
2. Expansion of Narrative Description for Respite Care Procedure Codes

EFFECTIVE: Immediately

BACKGROUND: A review of processed claims has indicated a need for clarification of billing procedures relating to the Independent Outpatient Health Facility Claim Form (MC-14), the Request for Home Care Authorization or Reauthorization (FD-139), and a need to expand the narrative description of the respite care procedure codes.

ACTION: Billing instructions for completion of the MC-14 claim form and FD-139 form are as follows:

1. On (MC-14) Claim Form - Section 13. Report of Services, under Item 13A. - "Dates of Service" -

   (a) All dates must include the year.

   (b) Only one calendar year may be entered on a single claim form.

   (c) Only two dates may be entered on each line, unless they include consecutive dates, such as: listing 11/1, 11/2, 11/3 and 11/4.

   EXCEPTION: If consecutive dates fall on two different months, each monthly date must be entered on separate lines.

   (d) When billing for half-hours of personal care assistant service, indicate all half-hour charges on separate lines. The hourly personal care assistant service, regardless of whether or not services were rendered on the same day(s), should be entered separately.

   Example: 9/5/85- 3½ hours of personal care assistant service (individual) should be billed as: 9/5/85- Z1600 personal care assistant service (individual/ 3 hours) on one line, and 9/5/85- Z1611 personal care assistant

service (individual/½ hour), should be entered on a separate line.

Note: Half-hour billing may not be used in the CCPED Program.

(e) Only six lines may be used in Section 13. Do not go beyond lines allowed on the form.

2. Under Item 13B. - "Procedure Code" - The relevant HCPCS procedure code entered should match the service authorized on the FD-139 form.

3. Under Item 13D. - In addition to describing the procedure or service in this section, indicate the total number of hours for each line of claims. The number of hours indicated in item 13D. should be identical to or less than the hours listed on the FD-139 form.

4. Under Item 13E. - The place of service must be entered in this block by an identifying number as indicated below:

   2 - Patient's home

   4 - Boarding house

   9 - Other- Medicaid District Office/County Welfare Board (Only to be used for Case Management Service).

5. Case Management Services should be billed on a separate MC-14 Claim Form, not on the same claim form with other services.

6. A uniform billing week consisting of Monday to Sunday is preferable for billing purposes.

7. FD-139 form - Item 22. must be clearly stated. Avoid use of medical symbols. Label all numbers.

   EXAMPLE: 4 hours, 5x week; not 4 x 5.

The revised descriptions for respite care procedure codes are indicated by underlines as follows:

HCPCS CODE	Discontinued Code	DESCRIPTION
Z1220	(0095)	Respite Care Day- over 8 hours, up to 12 hours
Z1225	(0096)	Respite Care Night- over 8 hours, up to 12 hours
Z1230	(0097)	Respite Care over 12 hours- up to 24 hours

Any questions regarding this Newsletter should be directed to Prudential at 609-293-2175.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

New Jersey Health Services Program **NEWSLETTER**

Volume P-477

April 1, 1986

TO: Chief Executive Officers - Special Hospitals and Private Psychiatric Hospitals

SUBJECT: Submission of Inpatient Claims on UB-82 HCFA-1450

EFFECTIVE: February 1, 1986

PURPOSE: This Newsletter is to officially inform Special and Private Psychiatric Hospitals to use the UB-82 HCFA-1450 form when billing the New Jersey Medicaid Program for inpatient hospital services provided on or after February 1, 1986. In addition, this Newsletter provides instructions for those items that require further clarification for completion on the form.

BACKGROUND: The Health Care Financing Administration has instructed State Medicaid Agencies to use exclusively a common hospital billing form, the UB-82 HCFA-1450.

ACTION: All claims for Medicaid patients must be submitted on the UB-82 HCFA-1450. Instructions for completion of a few specific items on the form are attached to this Newsletter.

Any inpatient claim not in compliance with this Newsletter when submitted to the fiscal agent will be returned to the hospital for correction.

Any questions you may have regarding the use of the UB-82 HCFA-1450 should be referred to the appropriate Medicaid Fiscal Agent.

Blue Cross and Blue Shield of New Jersey, Inc.---- 201-456-2534

The Prudential Insurance Company---------- 609-293-2254

Locator Number 77: Principal Diagnosis Code
Enter the ICD-9-CM code which describes the principal diagnosis that exists at time of admission or develops subsequently that has an affect on the length of stay.
When entering ICD-9-CM diagnosis codes, be sure to add trailing zeroes, if necessary, to make the entry 5 digits.

Locator Number 78, 79, 80, 81: Other Diagnosis Codes
Enter the ICD-9-CM codes which describe additional conditions that co-exist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay. There is no need to repeat the same ICD-9-CM codes.
When entering ICD-9-CM diagnosis codes, be sure to add trailing zeroes, if necessary, to make the entry 5 digits.

Locator Number 84: Principal Procedure Code and Date
Enter the ICD-9-CM procedure code which describes the principal surgical procedure performed, if any. Be sure to add a trailing zero, if necessary, to make the entry 4 digits.
The date the principal surgical procedure was performed is to be entered in MMDDYY format.

Locator Number 92: Attending Physician ID
Medicaid is requiring only the Individual Medicaid Practitioner (IMP) Number.
Since residents, interns, and other house staff members have not been assigned IMP numbers, it will be necessary to enter the IMP number of the licensed physician who provides the direct personal supervision of the resident, intern, or house staff member. If the physician is not a participating Medicaid Practitioner, enter nine "8s".

Locator Number 93: Other Physician ID
If a surgical procedure is entered in Locator Number 84, enter the operating surgeon's nine digit Individual Medicaid Practitioner (IMP) Number.
If the operating surgeon is not a Medicaid participating physician, enter nine "8s".
If the operating practitioner is a resident, intern, or house staff member, enter the IMP number of the supervising physician.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

New Jersey Health Services Program **NEWSLETTER**

Volume P-478

March 31, 1986

TO: Independent Mental Health Clinics Under Contract to The Department of Human Services, Division of Mental Health and Hospitals

SUBJECT: Clarification of Billing Instructions on MC-14 Claim Form and FD-139 Form

EFFECTIVE: Immediately

BACKGROUND: A review of claims processed for personal care assistant services has indicated a need for clarification of billing procedures relating to the Independent Outpatient Health Facility Claim Form (MC-14), and the Request for Home Care Authorization or Reauthorization (FD-139).

ACTION: Billing instructions for completion of the MC-14 claim form and FD-139 form are as follows:

I. On (MC-14) Claim Form - Section 13. Report of Services

Only six lines may be used in this section. Do not go beyond lines allowed on the form.

A uniform billing week consisting of Monday to Sunday is preferable for billing purposes.

1. Under Item 13A. - Dates of Service

(a) All dates must include the year.

(b) Only one calendar year may be entered on a single claim form.

(c) Only two dates may be entered on each line, unless they include consecutive dates, such as: listing 11/1, 11/2, 11/3, and 11/4.

EXCEPTION: If consecutive dates fall on two different months, each monthly date must be entered on separate lines.

(d) When billing for half-hours of personal care assistant service and a line entry includes a half-hour in its total charge, that half-hour must be entered on a separate line.

EXAMPLE: Personal care assistant service (individual) provided on 9/5/86 - 3½ hours, 9/6/86 - 3½ hours, and 9/7/86 - 2½ hours, should be billed as: 9/5, 9/6, 9/7/86 - Z1600 personal care assistant service (individual/hour) - 9 hours, on one line, and 9/5 thru 9/7/86 - Z1611 personal care assistant service (individual/½ hour) - ½ hour, should be entered on a separate line.

2. Under Item 13B. - Procedure Code - The relevant HCPCS procedure code entered should match the service authorized on the FD-139 form.

3. Under Item 13D. - In addition to describing the procedure or service in this section, indicate the total number of hours for each line of claims. The number of hours indicated in item 13D. should be identical to or less than the hours listed on the FD-139 form.

4. Under Item 13E. - The place of service must be entered in this block by an identifying number as indicated below:

2 - Patient's home

4 - Boarding house

9 - Rooming house

II. FD-139 form - Item 22. must be clearly stated. Avoid use of medical symbols. Label all numbers.

EXAMPLE: 4 hours, 5x week; not 4 x 5.

Any questions regarding this Newsletter should be directed to the Prudential Insurance Company at 609-293-2175.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

REC'D MAR 6 1986

New Jersey Health Services Program NEWSLETTER

Volume P-479

March 10, 1986

TO: Independent Clinics

SUBJECT: Mental Health Services (New Clinic Procedures)

PURPOSE: The New Jersey Medicaid Program is pleased to bring to your attention the adoption of the following two mental health procedure codes.

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE
Z0100	Off-Site Crisis Intervention - An emergency procedure by personnel of a mental health clinic to an outpatient individual at locations other than the grounds or buildings of the clinic. Request for this service shall be initiated by the patient or other interested individual to meet the immediate needs of the patient, who is unable to present himself at the clinic. The procedure includes rapid intervention, written evaluation and a treatment plan. Use of procedure is limited to twice in six months for any one patient. This procedure is not applicable to institutionalized patients.	$22.50
90801ZI	Comprehensive Intake Evaluation - An initial procedure performed at a mental health clinic to assess a new patient and recommend an appropriate treatment plan or additional diagnostic studies. The procedure includes initial interviews with the patient and other involved individuals, conferences with referral sources, examination of written material provided by the patient or others, staff conferences and written evaluation and treatment plan including recommendations for further consultations, studies or additional information. Although this procedure may be performed by a single individual, it is expected that it should be a team approach and of one and one-half hours duration. Use of procedure is limited to once per year for any one patient.	$22.50

Please note that the descriptions for the two codes above replace those which appear in Subchapter 3 (HCPCS CODES FOR INDEPENDENT CLINIC SERVICES) in Appendix A/4 for Z0100 and Appendix B/10 for 90801ZI.

If you have any questions regarding this Newsletter, please contact Raymond Reinhart, Jr., M.D., Chief Consultant, Mental Health Services, Division of Medical Assistance and Health Services, at 609-588-2719.