

(k) Vision care services (See N.J.A.C. 10:62-4).

(l) Transportation services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				\$	NS	
LN	Z0330			4.50	4.50	
LN	Z0335			9.00	9.00	

(m) Drug treatment center services:

* An asterisk preceding any procedure code indicates that the procedure may only be provided to ACCAP-eligible individuals in the home.

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				\$	NS	
*LN	Z1830			3.50	3.50	
*LN	Z1831			4.50	4.50	
*LN	Z1832			24.00	24.00	
*LN	Z1833			12.00	12.00	
*LN	Z1834			30.00	30.00	
*LN	Z1835			22.50	22.50	
LN	Z2000			22.50	22.50	
LN	Z2001			15.00	15.00	
LN	Z2002			4.50	4.50	
LN	Z2003			16.00	16.00	
LN	Z2004			8.00	8.00	
LN	Z2005			15.00	15.00	
LN	Z2006			2.50	2.50	
LN	Z2007			8.00	8.00	
LN	Z2010			4.50	4.50	

NOTE: See N.J.A.C. 10:66-6.2(a), Evaluation and management and other procedures, for additional procedures preceded by an asterisk.

(n) Federally qualified health care services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				\$	NS	
	90844	22		150.00	150.00	
L	W9840			150.00	150.00	
L	Y3333			150.00	150.00	

(o) Personal care assistant services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				\$	NS	
L	Z1600	ZI		13.02	13.02	
L	Z1605	ZI		10.23	10.23	
L	Z1610	ZI		35.00	35.00	
L	Z1611	ZI		6.51	6.51	
L	Z1612	ZI		5.12	5.12	
L	Z1613	ZI		35.00	35.00	

(p) Miscellaneous services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				\$	NS	
	57820		15	72.00	63.00	
	58120		15	72.00	63.00	
N	59840		45	79.00	68.00	
N	59841		45	79.00	68.00	

10:66-6.3 HCPCS procedure codes and maximum fee allowance schedule for Level II & Level III codes and narratives (not located in CPT-4)

(a) Evaluation and Management and other procedures:

Ind	HCPCS Code	Mod	Description	Follow Up			Maximum Fee Allowance		
				Days	\$	NS	\$	NS	
	J2790		RhoGAM, Rho (D) Immune Globulin (Human); single dose—Micro-Dose		20.40			20.40	
	J2790	22	RhoGAM, Rho (D) Immune Globulin (Human); single dose—Full dose		72.07			72.07	
	W9060	WT	Under six weeks						
	W9061	WT	Six weeks to three months						
	W9062	WT	Three months to five months						
	W9063	WT	Five months to eight months						
	W9064	WT	Eight months to 11 months						
	W9065	WT	11 months to 14 months						
	W9066	WT	14 months to 17 months						
	W9067	WT	17 months to 20 months						
	W9068	WT	20 months to 24 months						

1. History including behavior and environmental factors;
2. Developmental assessment; and
3. Complete, unclothed physical examination by a physician or a nurse practitioner under the personal supervision of a physician, to include:
 - (a) Measurements: height, weight and head circumference;

(b) Vision and hearing screening;
and

(c) Nutritional assessment.

4. Assessment and administration of immunizations (see appropriate HCPCS procedure codes for reimbursement amounts);

5. Anticipatory guidance;

6. Arrangement for diagnosis and treatment of medical problems uncovered during the visit. This includes self-referrals and/or referrals to other providers as medically indicated;

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

(a) Sickle cell, PKU screening, as appropriate;

(b) Hemoglobin or hematocrit twice: at six to nine months and 20 to 24 months of age. (When done in conjunction with lead screening, this test is not reimbursable as a separate procedure.);

(c) Urinalysis, twice: at six to nine months and 20 to 24 months of age;

(d) Tuberculin test, twice: at 12 to 14 months and 20 to 24 months; and

(e) Lead screening (EP) at 12 to 14 months and 20 to 24 months.

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

NOTE: Laboratory procedures performed by a physician in his or her office are not reimbursable to the physician; if such procedures are performed by an outside laboratory, the laboratory shall submit a separate claim.

W9096

Hepatitis B immunoprophylaxis with Recombivax HB, 0.25 ml dose. This code applies only to newborns of HBsAg negative mothers.

17.46

17.46

W9096

22

Hepatitis B immunoprophylaxis with Recombivax HB, 0.5 ml dose. This

W9097	code applies only to newborns of HBsAg negative mothers. Hepatitis B immunoprophylaxis with Recombivax HB, 0.25 ml dose. This code applies only to high risk recipients under 11 years of age (exclusive of newborns).	32.79	32.79
W9098	Hepatitis B immunoprophylaxis with Recombivax HB, 0.5 ml dose. This code applies only to high risk recipients 11 to 19 years of age.	17.46	17.46
W9099	Hepatitis B immunoprophylaxis with Recombivax HB, 1.0 ml dose. This code applies only to high risk recipients over 19 years of age.	32.79	32.79
W9333	Hepatitis B immunoprophylaxis with Engerix-B, 0.5 ml dose. This code applies only when immunizing newborns.	63.57	63.57
W9334	Hepatitis B immunoprophylaxis with Engerix-B, 0.5 ml dose. This code applies only to high risk recipients under 11 years of age (exclusive of newborns).	27.88	27.88
W9335	Hepatitis B immunoprophylaxis with Engerix-B, 1.0 ml dose. This code applies only to high risk recipients over 11 years of age	27.88	27.88
W9338	Tetramune. This code is used when administering the primary immunization series to infants and toddlers. It eliminates the need for two separate injections of DTP and Haemophilus b Conjugate Vaccine.	62.09	62.09
W9820	Early and Periodic Screening, Diagnosis and Treatment (EPSDT) through age 20.	30.27	30.27
	NOTE: If performed by outside independent laboratories, the laboratory must submit the claim. Blood sample for lead screening test should be sent to the New Jersey State Department of Health.	23.00	18.00
	NOTE: Procedure code W9820 shall be used only once for the same patient during any 12-month period by the same physician, group, shared health care facility, or practitioner(s) sharing a common record. Reimbursement for code W9820 is contingent upon the submission of both a Completed Report and Claim For		

EPSDT/HealthStart Screening and Related Procedures (MC-19) and the appropriate claim form within 30 days of the date of service.

In the absence of a completed MC-19 form, reimbursement will be reduced to the level of an annual health maintenance examination, that is, \$22.00-\$17.00

(b) Dental services (See N.J.A.C. 10:56-3).

(c) Family planning services:

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance		
					S	\$	NS
	W0001	WF	Supplying and inserting the intrauterine device "Paragard" by a physician including the post-insertion visit.		188.00		188.00
	W0001	WMWF	Supplying and inserting the intrauterine device "Paragard" by a certified nurse-midwife including the post-insertion visit.		NA		177.00
	W0002	WF	Supplying and inserting the intrauterine device "Progestasert" by a physician including the post-insertion visit.		123.00		123.00
	W0002	WMWF	Supplying and inserting the intrauterine device "Progestasert" by a certified nurse-midwife including the post-insertion visit.		NA		112.00
	W0004	WF	Removal of an IUD by a physician followed at the same visit by the insertion of the IUD "Paragard" and including the post-insertion visit.		204.00		204.00
	W0004	WMWF	Removal of an IUD by a certified nurse-midwife followed at the same visit by the insertion of the IUD "Paragard" and including the post-insertion visit.		NA		188.00
	W0008	WF	Removal of an IUD by a physician followed at the same visit by the insertion of the IUD "Progestasert" and including the post-insertion visit.		139.00		139.00
	W0008	WMWF	Removal of an IUD by a certified nurse-midwife followed at the same visit by the insertion of the IUD "Progestasert" and including the post-insertion visit.		NA		123.00

(d) Laboratory services (See N.J.A.C. 10:61-3).

(e) Minor surgery:

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance		
					\$	\$	NS
	W1650		Excision of plantar verruca, single site unilateral		24.00		21.00
	W1650	22	Excision of plantar verruca, multiple sites, unilateral		37.00		32.00

(f) Mental health services:

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance		
					\$	\$	NS
	H5025	ZI	Group therapy: Verbal or other therapy methods provided by one or more psychiatrists, or professional counselors under the direction of a psychiatrist, in a personal involvement with two or more patients, with a maximum of eight 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 by personnel of 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.		22.50		22.50
	Z0130		<p>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.</p> <p>Psychological testing: Maximum of five hours of psychometric and/or projective tests with a written report.</p> <p>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. Partial Care programs shall provide, as listed below, a full system of services necessary to meet the comprehensive</p>		25.00 Per Hour		25.00 Per Hour

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;
- Information and referral;
- Counseling;
- Daily living education;
- Community organization;
- Pre-vocational therapy;
- Recreational therapy; and
- Health related services.

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 Partial Care 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.

In order to qualify as an approved Partial Care program the Program must be certified by the Department.

Z0170	Partial Care, half day* *At least three hours but less than five hours of participation in active programming exclusive of meals.	46.00	46.00
Z0180	Partial Care, full day* *Five or more hours of participation in active programming exclusive of meals.	77.00	77.00

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.

(g) Obstetrical services (maternity):

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance		
					\$	\$	NS
	Z0250	WM	Home Delivery Pack. All drugs and supplies, etc., necessary for delivery in this setting.		NA		40.00

(h) Podiatry services:

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance		
					\$	\$	NS
	W2650		Casting for molded shoes Prior authorization is required.		21.00		21.00
	W2655		Casting for arch support Prior authorization is required.		5.00		5.00
Ind	HCPCS Code	Mod	Description	Follow Up Days	\$	\$	NS
	W7200		Foot, complete (incl. special or 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

(j) Rehabilitation services:

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance		
					\$	\$	NS
	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

(k) Vision care services (See N.J.A.C. 10:62-4).

(l) Transportation services:

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance		
					\$	\$	NS
	Z0330		Transportation, one way.		4.50		4.50
	Z0335		Transportation, round trip.		9.00		9.00

(m) Drug treatment center services:

*An asterisk preceding any procedure code indicates that the procedure may only be provided to ACCAP-eligible individuals in the home.

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance		
					S	\$	NS
	*Z1830		Methadone treatment rendered by a drug treatment center at home, per visit.		3.50		3.50
	*Z1831		Urinalysis for drug addiction at home, per visit.		4.50		4.50
	*Z1832		Psychotherapy rendered by a drug treatment center at home—full session, per visit.		24.00		24.00
	*Z1833		Psychotherapy rendered by a drug treatment center at home—half session, per visit.		12.00		12.00
	*Z1834		Family therapy rendered by a drug treatment center at home, per visit.		30.00		30.00
	*Z1835		Family conference rendered by a drug treatment center at home, per visit.		22.50		22.50
	Z2000		Family therapy rendered in a drug treatment center.		22.50		22.50
	Z2001		Family conference rendered in a drug treatment center.		15.00		15.00
	Z2002		Prescription visit rendered in a drug treatment center.		4.50		4.50
	Z2003		Psychotherapy rendered in a drug treatment center—full session.		16.00		16.00
	Z2004		Group therapy rendered in a drug treatment center, per person.		8.00		8.00
	Z2005		Psychological testing rendered in a drug treatment center, per hour; maximum of five hours.		15.00		15.00
	Z2006		Methadone treatment rendered in a drug treatment center.		2.50		2.50
	Z2007		Psychotherapy rendered in a drug treatment center—half session.		8.00		8.00
	Z2010		Urinalysis for drug addiction.		4.50		4.50

(n) Federally qualified health center services:

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance		
					S	\$	NS
	W9840		Medical encounter		150.00		150.00
	Y3333		Dental encounter		150.00		150.00
	90844	22	Medical psychotherapy		150.00		150.00

(o) Personal care assistant services:

(Applicable to clinics under contract to the Division of Mental Health and Hospitals of the Department of Human Services.)

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance		
					\$	\$	NS
	Z1600	ZI	Personal Care Assistant Services Individual, per hour		13.02		13.02
	Z1605	ZI	Personal Care Assistant Services Group, per hour		10.23		10.23
	Z1610	ZI	Personal Care Assistant Services Initial Nursing Assessment, per visit		35.00		35.00
	Z1611	ZI	Personal Care Assistant Services Individual, per hour		6.51		6.51
	Z1612	ZI	Personal Care Assistant Services Group, per hour		5.12		5.12
	Z1613	ZI	Nursing Reassessment Visit, per visit		35.00		35.00

10:66-6.4 HCPCS procedure codes—qualifiers

(a) Evaluation and management and other procedures:

1. Drawing of blood: 36415.

i. Once per visit, per patient. (Not applicable if laboratory study, in any part, is performed by the clinic.)

2. Injection (intradermal, subcutaneous, or intra-articular): 90799.

i. Reimbursement for the above injections are on a flat-fee basis and are all inclusive for the cost of the service as well as the materials. Be advised of the following:

(1) A visit for the sole purpose of an injection is reimbursable only as an injection and not as a clinic visit and 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 shall be consistent with the diagnosis and shall conform to accepted medical and pharmacological principles with respect to dosage, frequency and route of administration.

(2) Intravenous and intraarterial injections are reimbursable only when performed by the physician.

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

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

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

(6) 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 listed fee for such a procedure.

(7) Insert procedure code 90799 as a separate item on the claim, followed by the name, dose of drug, and route of administration. The complete diagnosis, for which the injection was given, shall be indicated on the claim.

3. General clinical psychiatric diagnostic or evaluative interview procedures: 90801.

i. This code requires for reimbursement purposes a minimum of 50 minutes of direct personal clinical involvement with the patient or family member. The CPT narrative otherwise remains applicable.

ii. No more than one claim for the code 90801 is reimbursable per the same recipient, per the same physician, per year.

4. Prolonged detention: 99150 and 99151.

i. Prolonged detention with or without critical care will be covered under CPT 99150 and 99151, but the service shall be consistent with the following narrative in order to be reimbursed:

(1) The patient's situation requires constant physician attendance which is given by the physician to the exclusion of other patients and duties. This must be verified by the applicable records as defined by the setting.

(2) Records shall show in the physician's handwriting the time of onset and time of completion of the service.

ii. This code may not be used simultaneously with procedure codes that pay a reimbursement for the same time or type of service.

iii. The basis for this type of claim should be apparent on the claim form. The listed fees of \$37.00 for specialist and \$32.00 for non-specialist are per hour.

5. Evaluation and management—new patient (excludes preventive health care for patients through 20 years of age): 99201, 99201WF, 99201WFWM, 99202, 99202WF, 99202WFWM, 99203, 99203WF, 99203WFWM, 99204, 99204WF, 99204WFWM, 99205, 99205WF, 99205WFWM and 99432.

i. When reference is made in the CPT manual to "Office—New Patient," the intent of the Medicaid program is to consider this service as the initial visit.

ii. Reimbursement for an initial clinic visit will be disallowed, if a preventive medicine service, EPSDT examination or clinic consultation were billed within a twelve month period by a clinic.

iii. It is also to be understood that in order to receive reimbursement for an initial visit, the following minimal documentation must be on the record regardless of the setting where the examination was performed. For example:

(1) Chief complaint(s);

(2) Complete history of the present illness and related systemic review, including recordings of pertinent negative findings;

(3) 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; and

(6) Working diagnoses and treatment plan including ancillary services and drugs ordered.

6. Evaluation and management services—established patient (excludes preventive health care for patients through 20 years of age): 99211, 99211WM, 99211WF, 99211WFWM, 99212, 99212WF, 99212WFWM, 99212WM, 99213, 99213WF, 99213WFWM, 99213WM, 99214, 99214WF, 99214WFWM, 99214WM, 99215, 99215WF, 99215WFWM, and 99215WM.

i. Routine visit or follow-up care visit is defined for purposes of Medicaid reimbursement as the care and treatment by a physician or certified nurse-midwife, as appropriate, which includes those procedures ordinarily performed during a health care visit, which are dependent upon the setting and the physician's discipline.

ii. In order to document the record for reimbursement purposes, a progress note for the noted visits should include the following:

(1) Purpose of visit;

(2) Pertinent history obtained;

(3) Pertinent physical findings including pertinent negative findings based on the above;

(4) Procedures, if any, with results;

(5) Lab, X-ray, EKG, etc., ordered with results; and

(6) Diagnosis.

7. Consultations: A consultation is recognized for reimbursement only when performed by a specialist recognized as such by this Program and the request has been made by or through the patient's attending physician and the need for such a request would be consistent with good medical practice.

i. Comprehensive consultation: 99244, 99245, 99254, 99255, 99274 and 99275.

(1) In order to receive reimbursement for these HCPCS codes, the performance of a total systems evaluation by history and physical examination, including a total systems review and total system physical examination are required.

(2) An alternative to (a)7i(1) above would be the utilization of one or more hours of the consulting physician's personal time in the performance of the consultation.

(3) Reimbursement for HCPCS codes 99244, 99245, 99254, 99255, 99274 and 99275 (Comprehensive Consultation) requires the following applicable statements, or language essentially similar to those statements, to be inserted in the "remarks section" of the claim form. The form is to be signed by the provider who performed the consultation.

(A) I personally performed a total (all) systems evaluation by history and physical examination; or

(B) This consultation utilized 60 or more minutes of my personal time.

(4) The following rules regarding consultations shall also be recognized.