



Volume..... P- 480.....

April 7, 1986

TO: Physicians, Hospitals and Independent Clinics

SUBJECT: MAGNETIC RESONANCE IMAGING (MRI)

EFFECTIVE: Immediately

PURPOSE: The New Jersey Medicaid Program is pleased to announce that Magnetic Resonance Imaging (MRI) is a covered service when used for the diagnosis of abnormalities in certain areas of the body.

BACKGROUND: The Medicaid Program considers MRI as a covered service concurrent with MRI acceptance by the Medicare Program as of November 22, 1985. At present, as with Medicare coverage, MRI is limited to examination of the brain, brain stem and spinal cord. As Medicare approves its use for other body sites, this Program will follow suit, accepting the same criteria.

ACTION: The HCFA Common Procedure Coding System codes (CPT-4) and maximum fee schedule for presently covered MRI procedures are as follow:

<u>HCPCS</u> <u>CODE</u>	<u>Medicaid Dollar Value</u>	
	<u>Office</u>	<u>Hosp. Based</u>
70551	\$300.00	\$84.00
72140	\$300.00	\$84.00

As always, particularly with the significant cost attached to "high tech" procedures, the physician before ordering should assure himself that the desired information cannot be obtained through other less expensive procedures.

Any questions about this Newsletter should be referred to the Prudential Insurance Company at (800) 582-7052.



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

REC'D APR 21 1986

New Jersey Health Services Program

NEWSLETTER

Volume..... **P-481**.....

April 21, 1986

TO: Pharmaceutical Services Providers, Physicians,
Podiatrists, and Dentists

SUBJECT: Suspension of Maximum Allowable Cost (MAC) for
Certain Drug Entities

The Pharmaceutical Reimbursement Board of the
Department of Health and Human Services has
suspended the Maximum Allowable Cost (MAC)
limit for the following drug entities:

Doxepin HCL, 10 mg. Capsules
Doxepin HCL, 25 mg. Capsules
Doxepin HCL, 50 mg. Capsules
Doxepin HCL, 100 mg. Capsules
Penicillin G Potassium, 800 mu. Tablets
Propantheline Br, 15 mg. Tablets

Attached is an updated MAC list (Rev. 3/86) which replaces the
list dated January 1, 1983.

If there are any questions concerning this Newsletter please call
the New Jersey Medicaid Program, Chief Pharmaceutical Consultant,
at (609) 588-2724.



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

LISTING OF MAC DRUGS

<u>DRUG ENTITY</u>	<u>MAC</u>	<u>EFFECTIVE DATE</u>
Acetaminophen W/Codeine, 300mg/30mg Tablets	\$0.0780 per Tablet	01/25/79
Acetaminophen W/Codeine, 300mg/60mg Tablets	\$0.1458 per Tablet	08/12/82
Amoxicillin, 250mg Capsules	\$0.2108 per Capsule	06/28/79
Amoxicillin, 500mg Capsules	\$0.3942 per Capsule	06/28/79
Ampicillin, 250mg Capsules	\$0.0422 per Capsule	08/12/82
Ampicillin, 500mg Capsules	\$0.1103 per Capsule	01/25/79
Ampicillin, Oral Suspension, 125mg/5ml	\$0.0114 per ml	08/12/82
Ampicillin, Oral Suspension, 250mg/5ml	\$0.0205 per ml	11/07/77
Chlordiazepoxide HCL, 5mg Capsules	\$0.0140 per Capsule	10/15/79
Chlordiazepoxide HCL, 10mg Capsules	\$0.0211 per Capsule	10/15/79
Chlordiazepoxide HCL, 25mg Capsules	\$0.0438 per Capsule	10/15/79
Diphenoxylate HCL with Atropine Sulfate, 2.5mg/0.025mg Tablets	\$0.0491 per Tablet	10/15/79
Erythromycin Stearate, 250mg Tablets	\$0.0697 per Tablet	01/25/79
Glutethimide, 500mg Tablets	\$0.0432 per Tablet	08/28/81
Hydralazine HCL, 25mg Tablets	\$0.0279 per Tablet	03/31/80
Hydralazine HCL, 50mg Tablets	\$0.0384 per Tablet	03/31/80
Hydrochlorothiazide, 25mg Tablets	\$0.0152 per Tablet	06/28/79
Hydrochlorothiazide, 50mg Tablets	\$0.0194 per Tablet	06/28/79
Meprobamate, 200mg Tablets	\$0.0108 per Tablet	01/25/79
Meprobamate, 400mg Tablets	\$0.0117 per Tablet	01/25/79
Methocarbamol, 500mg Tablets	\$0.0496 per Tablet	10/15/79
Methocarbamol, 750mg Tablets	\$0.0640 per Tablet	10/15/79
Penicillin G Potassium, 400mu Tablets	\$0.0237 per Tablet	10/15/79
Penicillin VK Oral Susp., 125mg/5ml	\$0.0109 per ml	08/12/82
Penicillin VK Oral Susp., 250mg/5ml	\$0.0160 per ml	11/07/77
Penicillin VK, 250mg Tablets	\$0.0417 per Tablet	08/12/82
Penicillin VK, 500mg Tablets	\$0.0649 per Tablet	08/12/82
Potassium Chloride, Oral Liquid 10%	\$0.0030 per ml	12/15/80
Probenecid, 0.5gm Tablets	\$0.0644 per Tablet	01/25/79
Procainamide HCL, 250mg Capsules	\$0.0383 per Capsule	08/28/81
Procainamide HCL, 375mg Capsules	\$0.0505 per Capsule	08/28/81
Procainamide HCL, 500mg Capsules	\$0.0585 per Capsule	08/28/81
Propoxyphene HCL, 65mg Capsules	\$0.0317 per Capsule	04/10/78
Propoxyphene HCL with Aspirin & Caffeine, 65mg Capsules	\$0.0330 per Capsule	04/10/78
Quinidine Sulfate, 200mg Tablets	\$0.0688 per Tablet	12/15/80
Sulfisoxazole, 500mg Tablets	\$0.0273 per Tablet	10/15/79
Tetracycline HCL, 250mg Capsules	\$0.0250 per Capsule	04/10/78
Tetracycline HCL, 500mg Capsules	\$0.0394 per Capsule	08/12/82
Tetracycline HCL, 125mg/5ml Syrup	\$0.0104 per ml	10/15/79

Please note:

These MAC Limits do not apply to unit dose packaging.

Rev. 3/86



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

New Jersey Health Services Program

NEWSLETTER

Volume: P-482

April 14, 1986

TO: Hospital Chief Executive Officers and Financial Directors

SUBJECT: RECOUPMENT OF CLAIMS PAID BY THE NEW JERSEY MEDICAID PROGRAM FOR RECIPIENTS WITH MEDICARE COVERAGE

Our records now indicate that Medicare coverage existed for a number of Medicaid recipients for whom your facility received reimbursement from the New Jersey Medicaid Program for services provided for the period between October 1, 1983 and September 30, 1984. The names and Medicare/Medicaid numbers of those Medicaid recipients, together with the details of the claims in question, appear on the attached list.

The Medicare time limit for submission of only those claims listed has been extended by Medicare to June 30, 1986. MEDICARE WILL NOT CONSIDER PAYMENT FOR THESE CLAIMS IF SUBMITTED AFTER THIS DATE.

In approximately 45 days from the date of this Newsletter, the New Jersey Medicaid Program will recoup its payments made for the claims on the attached list unless it is substantiated that the claims were previously denied by Medicare or were for services not covered by Medicare. Substantiating documentation should be sent to:

**THIRD PARTY RECOVERY UNIT, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, P.O. BOX 343, MAIN POST OFFICE, NEWARK, N.J. 07101-0343.
Telephone Number: (201) 642-0003.**

To offset the negative impact on cash flow caused by the recoupment, use the attached list as a resource to immediately prepare and submit the Medicare claims for the services in question. Magnetic tape and Blue Cross teleprocessing billers must bill these cases hard copy. All claims should be complete with an "H" in the Remark field (locator #94 on the UB-82 claim form). Billers using the Medicare Part A Remote On-Line Entry system should key an "H" in the fourth position of the Remark field (field immediately following the number of acute days).

The effort to identify Medicare and other third party coverage for claims paid by the New Jersey Medicaid program is an ongoing one and you will periodically receive listings similar to the one attached.

Any questions regarding this Newsletter or this recoupment in general should be addressed only to the THIRD PARTY RECOVERY UNIT, Division of Medical Assistance and Health Services, P.O. Box 343, Main Post Office, Newark, New Jersey 07101-0343. Telephone Number: (201) 642-0003.



April 28, 1986

TO: Independent Clinics

SUBJECT: Replacement Pages for Subchapter 3 -
HCFA Common Procedure Coding System (HCPCS)

Replacement pages are enclosed for Subchapter 3, HCFA Common Procedure Coding System of the Independent Clinic Services Manual. Incorporated into the replacement pages are all the additions and revisions made since HCPCS Codes were first transmitted in Newsletter P-436, dated June 28, 1985. The sign ">" preceding any HCPCS code indicates an addition or a revision. The additions and revisions are listed below:

1. ADDITIONS

Examination and Treatment Codes =

Immunology - 86580 (Page 7)
New Patient, etc. - 90750 (Page 7 and Appendix B/2)

Surgery Code =

Integumentary System (Nails) - 11711 (Page 9)

Radiology Services Code =

Radiologic Examination - 71035 (Page 12)

Rehabilitation Services Codes =

Audiologic Function Tests - 92557, 92566 & 92582 (Page 14 and Appendix B/15),
92562, 92563, 92564, 92590 & 92591 (Page 14)

Ambulatory Surgical Center Codes =

M0050, M0051, M0052, M0053, Z1005, Z1010, Z1015, Z1020, Z1025, Z1030, Z1035,
Z1040, Z1045, Z1050 & Z1055 (Page 15 and Appendix A/8, A/9)

Personal Care Assistant Services Codes =

Z1600, Z1605, Z1611 & Z1612 (Page 15, Appendix A/9 and Appendix B/18) Z1610 &
Z1613 (Page 15 and Appendix A/9)

2. REVISIONS

Mental Health Services Code =

Psychological testing: Maximum five (5) hours of psychometric and/or projective tests with a written report. \$15.00 per hour - Z0130 (Page 10 and Appendix A/4).

Rehabilitation Services Codes =

Audiometric Tests - 92552, 92553, 92572, 92576 & 92589 (Page 14 and Appendix B/15)

Surgery Code =

Excision of plantar verruca multiple sites, unilateral. Specialist \$37.00 and Non-Specialist \$32.00 - W1650 22 (Page Appendix A/4)

Family Planning Services Codes =

May include pelvic examination, changes in method or physician's instructions at a minimum average time of five (5) minutes or represent a visit solely for a refill supply of birth control drugs for which a prescription cannot be substituted and professional contact is not necessary. - 90040 WF (Page Appendix B/8)

Manual Maintenance: Please substitute each replacement page for the same numbered page in Subchapter 3 of the Independent Clinic Manual. Because of the additions, it was necessary to add 2 pages numbered Appendix A/9 and Appendix B/19.

If you have any questions regarding this Newsletter, please contact Prudential at (800) 582-7052.

10:66-3.2 HCPCS CODES FOR INDEPENDENT CLINIC SERVICES AND MAXIMUM FEE SCHEDULE

IND	HCPCS Code	MOD	MEDICAID DOLLAR VALUE		IND	HCPCS CODE	MOD	MEDICAID DOLLAR VALUE	
			S	\$ NS				S	\$ NS
(a) Examination and Treatment									
N	36415		1.80	1.80	N	90719		4.90	4.90
	86490		4.00	4.00	N	90724		4.70	4.70
	86510		4.00	4.00	N	90732		9.25	9.25
	86540		4.00	4.00	>N	90750		22.00	17.00
>	86580		4.00	4.00	N	90751		22.00	17.00
	86585		4.00	4.00	N	90752		22.00	17.00
N	90015		22.00	17.00	N	90753		22.00	17.00
N	90017		22.00	17.00	N	90754		22.00	17.00
N	90020		22.00	17.00	N	90760		22.00	17.00
N	90050		9.00	7.00	N	90761		22.00	17.00
N	90060		9.00	7.00	N	90762		22.00	17.00
N	90070		9.00	7.00	N	90763		22.00	17.00
N	90285		22.00	17.00	N	90764		9.00	7.00
N	90701		5.86	5.86	N	90799		2.50	2.50
N	90702		4.65	4.65		93000		16.00	16.00
N	90703		3.90	3.90	N	99150		37.00	32.00 Per Hour
N	90704		11.55	11.55	N	99151		37.00	32.00 Per Hour
N	90705		10.25	10.25	N	99160		37.00	32.00 Per Hour
N	90706		10.65	10.65					
N	90707		22.15	22.15	LN	J2790		42.40	42.40
N	90708		15.35	15.35	LN	W9090		9.90	9.90
N	90709		16.50	16.50	LN	W9095		5.45	5.45
N	90712		7.10	7.10	LN	W9820		23.00	18.00

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE	
				S	\$ NS					S	\$ NS
*	10101		30	34.00	29.00	*	11426		30	32.00	27.00
*	10120			18.00	16.00		11440		15	18.00	16.00
*	10121		30	34.00	29.00		11441		15	22.00	20.00
*	10141		30	48.00	42.00		11442		15	27.00	24.00
*	10160			13.00	11.00		11443		30	32.00	27.00
*	11000			13.00	11.00		11444		30	32.00	27.00
*	11001			6.00	5.00		11446		30	32.00	27.00
*	11040			13.00	11.00	*	11600		90	37.00	32.00
*	11041			13.00	11.00	*	11601		90	47.00	42.00
*	11042			16.00	14.00	*	11602		90	61.00	53.00
*	11043			16.00	14.00	*	11620		90	61.00	53.00
*	11100			13.00	11.00	*	11621		90	90.00	79.00
*	11400		15	18.00	16.00	*	11622		90	121.00	105.00
*	11401		15	22.00	20.00		11640		90	90.00	79.00
*	11402		15	27.00	24.00		11641		90	121.00	105.00
*	11403		30	32.00	27.00		11642		90	150.00	131.00
*	11404		30	32.00	27.00	*	11700			13.00	11.00
*	11406		30	32.00	27.00	*	11701			19.00	16.00
*	11420		15	18.00	16.00	*	11710			13.00	11.00
*	11421		15	22.00	20.00	>*	11711			19.00	16.00
*	11422		15	27.00	24.00	*	11730			10.00	10.00
*	11423		30	32.00	27.00	*	11750		30	42.00	37.00
*	11424		30	32.00	27.00	*	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		IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE	
				S	\$ NS					S	\$ NS
*	12004			30.00	26.00	*	17110			8.00	6.00
	12011			18.00	16.00	*	17200			8.00	6.00
	12013			24.00	21.00	*	17304		30	25.00	21.00
	12014			30.00	26.00	L*	W1250			18.00	16.00
	12031		30	30.00	26.00	L*	W1650			24.00	21.00
	12032		30	48.00	42.00	L*	W1650	22		37.00	32.00
*	12041		30	30.00	26.00	(g) <u>Mental Health Services</u>					
*	12042		30	67.00	59.00	N	90801	ZI		22.50	22.50
	12051		30	38.00	33.00	N	90843	ZI		8.00	8.00
	12052		30	67.00	59.00	N	90844	ZI		16.00	16.00
	13100		30	34.00	29.00	N	90847	ZI		15.00	15.00
	13101		30	68.00	63.00	N	90847	ZI		22.50	22.50
	13120		30	48.00	42.00	N	90847	22 ZI		4.50	4.50
	13121		30	106.00	92.00		90862	ZI		8.00	8.00
*	13131		30	67.00	59.00	N	90887	ZI		8.00	8.00
*	13132		30	145.00	126.00	LN	H5025	ZI		8.00	8.00
	13150		30	38.00	33.00	L	Z0100			22.50	22.50
	13151		30	82.00	71.00	>L	Z0130			15.00	15.00
	13152		30	193.00	168.00					<u>Per Hour</u>	
*	17000			8.00	6.00	L	Z0150			8.00	8.00
*	17010			11.00	8.00	L	Z0160			15.50	15.50
*	17100			18.00	15.00	L	Z0170			15.00	15.00
*	17105			27.00	24.00	L	Z0180			30.00	30.00

*An asterisk preceding any procedure code also can be done by the podiatrist.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		
				S	\$	NS					S	\$	NS
	70210			20.00				72010			40.00		
	70220			25.00				72040			15.00		
	70240			15.00				72050			20.00		
	70250			15.00				72052			25.00		
	70260			25.00				72070			15.00		
	70300			5.00				72080			15.00		
	70310			10.00				72100			20.00		
	70320			15.00				72110			25.00		
	70328			13.00				72114			20.00		
	70330			20.00				72140			300.00		
	70350			8.00			N	72170			15.00		
	70360			10.00				72180			15.00		
	70370			20.00				72190			20.00		
	70380			15.00				72200			20.00		
	70390			15.00				72220			15.00		
	70391			30.00				73000			10.00		
	70551			300.00				73010			15.00		
MN	71010			10.00				73020			15.00		
MN	71020			15.00				73030			15.00		
MN	71030			20.00				73040			15.00		
MN	71034			20.00				73041			45.00		
>	71035			5.00				73050			18.00		
	71100			15.00				73060			15.00		
	71110			20.00				73070			15.00		
	71120			15.00				73080			15.00		
	71130			20.00									

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE		
				S	\$	NS					S	\$	NS
	74420			35.00				76100	50		50.00		
	74430			15.00				76150			4.00		
	74431			25.00			L	W7200			20.00		
	74450			20.00			L	W7250			30.00		
	74451			40.00									
	74455			20.00			(k)	<u>Rehabilitation Services</u>					
	74456			35.00			N	92507			7.00	7.00	
	74470			20.00			>N	92552			11.00	11.00	
	74471			40.00			>N	92553			14.00	14.00	
MN	74710			25.00			>N	92557			19.00	19.00	
	74720			20.00			>	92562			3.00		
	74740			20.00			>	92563			3.00		
	74741			40.00			>	92564			4.00		
	74760			25.00			>N	92566			10.00		
	74761			40.00			>N	92572			20.00		
	76000			10.00			>N	92576			30.00		
	76020			15.00			>N	92582			14.00	14.00	
	76040			20.00			>N	92589			10.00	10.00	
	76061			35.00			>	92590			40.00		
	76062			90.00			>	92591			40.00		
	76080			15.00			N	97799			7.00	7.00	
	76081			20.00			L	H5300			7.00	7.00	
	76090			26.00			L	Z0270			7.00	7.00	
	76091			36.00			L	Z0280			7.00	7.00	
	76100			35.00			L	Z0300			7.00	7.00	

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MEDICAID DOLLAR VALUE			
				S	\$	NS					S	\$	NS	
(l)	<u>Vision Care Services</u>						>L	Z1020						
	(See Vision Care Manual)						>L	Z1025						
(m)	<u>Other Services</u>						>L	Z1030						
N	55250		30	90.00	79.00		>L	Z1035				80% of a base rate adjusted for a geographic variation		
N	55450		30	42.00	37.00		>L	Z1040						
N	57451		45	182.00	158.00		>L	Z1045						
	58120		15	72.00	63.00		>L	Z1050						
N	58600		45	211.00	184.00		>L	Z1055						
N	58605		45	151.00	131.00		>LN	Z1600				7.70	7.70	
N	58982		45	182.00	158.00		>LN	Z1605				6.24	6.24	
N	58983		45	182.00	158.00		>L	Z1610				25.00	25.00	
N	59840		45	79.00	68.00		>LN	Z1611				3.85	3.85	
N	59841		45	79.00	68.00		>LN	Z1612				3.12	3.12	
N	90250			9.00	7.00		>L	Z1613				20.00	20.00	
N	90260			9.00	7.00									
N	90270			9.00	7.00									
>	M0050			80% of a base rate adjusted by geographic variation										
>	M0051													
>	M0052													
>	M0053													
L	Z0330			3.75	3.75									
L	Z0335			7.25	7.25									
>L	Z1005			80% of a base rate adjusted for a geo- graphic variation										
>L	Z1010													
>L	Z1015													

IND	HCPCS CODE	MOD	DESCRIPTION	FOLLOW	MEDICAID				
				UP DAYS	DOLLAR VALUE	S	\$	NS	
>	W1650	22	Excision of plantar verruca multiple sites, unilateral		37.00		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		
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	Z0100		<u>Off-Site Crisis Intervention</u> - 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		22.50		
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>	Z0130		Psychological testing: <u>Maximum of five hours</u> of psychometric and/or projective tests with a written report.		15.00		15.00		<u>Per Hour</u>
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Partial Hospitalization: A psychiatric service whose primary purpose is to provide a planned program of milieu therapy and other treatment modalities for

<u>IND</u>	<u>HCPCS</u>		<u>DESCRIPTION</u>	<u>FOLLOW UP DAYS</u>	<u>MEDICAID DOLLAR VALUE</u>		
	<u>CODE</u>	<u>MOD</u>			<u>S</u>	<u>\$</u>	<u>NS</u>
(k)	<u>Rehabilitation Services</u>						
	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)	<u>Other Services</u>						
	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	
>	M0050		Ambulatory Surgical Center - Group 1		80% of a base rate adjusted for a geo- graphic variation		
>	M0051		Ambulatory Surgical Center - Group 2				
>	M0052		Ambulatory Surgical Center - Group 3				
>	M0053		Ambulatory Surgical Center - Group 4				
>	Z1005		Ambulatory Surgical Center - for abortion only				
>	Z1010		Ambulatory Surgical Center - 100% of Grp 1 plus 50% of Grp 1				
>	Z1015		Ambulatory Surgical Center - 100% of Grp 2 plus 50% of Grp 1				

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>DESCRIPTION</u>	<u>FOLLOW UP DAYS</u>	<u>MEDICAID DOLLAR VALUE</u>	
					<u>S</u>	<u>\$ NS</u>
>	Z1020		Ambulatory Surgical Center - 100% of Grp 2 plus 50% of Grp 2		80% of a base rate adjusted for a geographic variation	
>	Z1025		Ambulatory Surgical Center - 100% of Grp 3 plus 50% of Grp 1			
>	Z1030		Ambulatory Surgical Center - 100% of Grp 3 plus 50% of Grp 2			
>	Z1035		Ambulatory Surgical Center - 100% of Grp 3 plus 50% of Grp 3			
>	Z1040		Ambulatory Surgical Center - 100% of Grp 4 plus 50% of Grp 1			
>	Z1045		Ambulatory Surgical Center - 100% of Grp 4 plus 50% of Grp 2			
>	Z1050		Ambulatory Surgical Center - 100% of Grp 4 plus 50% of Grp 3			
>	Z1055		Ambulatory Surgical Center - 100% of Grp 4 plus 50% of Grp 4			
>N	Z1600		Personal Care Assistant Service - Individual		7.70	7.70 Per Hour
>N	Z1605		Personal Care Assistant Service - Group - Care provided involves two or more patients, with a maximum of eight patients in the same residential setting at the same time.		6.24	6.24 Per Hour
>	Z1610		Personal Care Assistant Service - Initial Nursing Assessment Visit		25.00	25.00
>N	Z1611		Personal Care Assistant Service - Individual		3.85	3.85 Per Half-Hour
>N	Z1612		Personal Care Assistant Service - Group - Care provided involves two or more patients, with a maximum of eight patients in the same residential setting at the same time.		3.12	3.12 Per Half-Hour
>	Z1613		Personal Care Assistant Service - Re-assessment Visit		20.00	20.00

CLINIC VISIT

90050 For reimbursement purpose a clinic visit will consist of care and
90060 treatment by the physician and include those procedures ordinarily
90070 performed during a clinic visit dependent upon physician's disci-
pline. 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

>90750 For reimbursement purposes, the annual health maintenance examina-
90760 tion 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

(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. Complete 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 at a minimum average time of 5 minutes or represent a visit solely for a refill supply of birth control drugs for which a prescription cannot be substituted and professional contact is not necessary.

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.

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

COMPREHENSIVE INTAKE EVALUATION

90801ZI 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.

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.

(j) RADIOLOGY SERVICES

CHEST

71010 Routine chest x-rays without medical necessity in an office (clinic)
71020 or hospital setting are not reimbursable under Program Guidelines.
71030 See Appendix C (Medical Necessity Program) at the end of this manual.
71034

PELVIS

72170 Pelvis x-ray is not eligible for separate payment when performed in
conjunction with Complete Lumbosacral Spine x-rays (72110).

HIP

73500 Procedure 73520 should be used for Bilateral Hip x-rays when both
73510 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 con-
junction 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.

>AUDIOMETRIC TESTS

92552 May be reimbursed when prescribed by a physician and performed by an
92553 audiologist. When billing a complete audiogram, Air-Bone-Speech-
92557 Discrimination Impedance Audiometry use codes 92557 and 92566.
92566 Impedance Audiometry (92566) is not reimbursable as an independent
92572 procedure.
92576
92582
92589

(m) OTHER SERVICES

ABORTION

59840 See Subchapter 2 (2.1-Abortions). Policy originally published as
59841 NJHSP Newsletter, Volume P-268, "Policy Regarding Medicaid Reim-
bursement 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.

>PERSONAL CARE ASSISTANT SERVICE

Z1600 The Personal Care Assistant performs duties as listed in the ser-
Z1605 vice definition that follows:
Z1611
Z1612

Household duties that are essential to the patient's health and
comfort - Group A - Performed by a personal care assistant include
but are not limited to:

1. Care of the patient's room and areas used by the patient;
Sweeping, vacuuming, dusting;
2. Care of kitchen; maintaining general cleanliness of refrigerator,
stove, sink and floor, dishwashing;
3. Care of bathroom; maintaining cleanliness of toilet, tub,
shower and floor;
4. Care of patient's personal laundry and bed linen (this may
include necessary ironing and mending);
5. Necessary bed-making and changing of bed linens;
6. Re-arranging of furniture to enable the patient to move about
more easily in his/her home;
7. Listing food and household supplies needed for the health and
maintenance of the patient;
8. Shopping for above supplies, conveniently storing and arranging
supplies, and doing other essential errands;
9. Planning, preparing and serving meals;

Activities of Daily Living - Group B - Performed by a personal care
assistant include but are not limited to:

1. Care of the teeth and mouth;
2. Grooming-Care of hair, including shampooing, shaving, and the
ordinary care of nails;
3. Bathing in bed, in the tub or shower;
4. Using the toilet or bed pan;
5. Changing bed linens with patient in bed;
6. Ambulation indoors and outdoors, when appropriate;
7. Helping patients in moving - from bed to chair or wheelchair,
in and out of tub and shower;
8. Eating-preparing meals, including special therapeutic diets
for the patient;

9. Dressing;
10. Relearning household skills;
11. Accompanying the patient to clinics, physician office visits, or other trips which are made for the purpose of obtaining medical diagnosis, treatment or otherwise serve a therapeutic purpose.

NOTE: Personal Care Assistant hourly service is limited to a maximum of 25 hours per week per client.



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

New Jersey Health Services Program

NEWSLETTER

Volume.....P-484.....

April 28, 1986

TO: Chief Executive Officer - Hospitals and Special Hospitals

SUBJECT: Request for a Hospital Statement, Completion of a Health Insurance Claim Form and/or Medical Records for Medicaid Patients (This Newsletter replaces New Jersey Health Service Program Newsletters P-289 and BC-190, dated 1-19-81.)

BACKGROUND: The Bureau of Administrative Control (Recovery Unit), Division of Medical Assistance and Health Services, is charged with the recoupment of Medicaid funds expended on behalf of recipients when a third party is or may be liable for making payments.

In a continuing effort to safeguard the expenditure of taxpayer dollars and to uphold public confidence in the New Jersey Medicaid Program, your cooperation is requested in notifying the Bureau of Administrative Control of any and all requests from attorneys, insurance companies, investigators, and/or recipients to either furnish copies of medical records or medical bills, or to complete insurance forms for services rendered to Medicaid patients. All personnel who handle such requests should become familiar with the following procedures.

ACTION: Whenever a request is made on behalf of a Medicaid patient for a duplicate hospital statement, a copy of his/her medical record and/or completion of an insurance form, it would be appreciated if the procedures listed below were followed.

1. Request For a Medical Record: Complete the LD-13 form and/or submit a photocopy of the request.
2. Request For a Hospital Statement and/or Request For Completion of a Health Insurance Form: Complete the LD-13 form. Release the request, stamped with the following notation:

Paid by N.J. Medicaid Program
Reimbursement Required Under the Provisions of
N.J.S.A. 30:4D-1 et. seq.

Please contact:
Division of Medical Assistance and Health Services
Bureau of Administrative Control
CN-712
Trenton, New Jersey 08625
(609) 588-2900

Also, due to an address change, it is necessary to issue a new stamp. This stamp will be provided under separate cover.

The LD-13 form letter has been revised to provide a separate area for indicating that a request for the completion of a health insurance claim form has been received. A copy of the revised form is attached and additional forms may be obtained by writing to your Fiscal Agent, The Prudential Insurance Company of America, P.O. Box 1900, Millville, New Jersey 08332 or Blue Cross and Blue Shield of New Jersey, Inc., 33 Washington Street, Newark, New Jersey 07102.

Any questions regarding this Newsletter should be directed to Leon Bartol, Chief, Bureau of Administrative Control at 609-588-2900.



STATE OF NEW JERSEY
 DEPARTMENT OF HUMAN SERVICES
 DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
 (609) 588-2900

Division of Medical Assistance and Health Services
 Bureau of Administrative Control
 CN-712
 Trenton, New Jersey 08625

Date: _____

RE: Requests for a hospital statement, the completion of a health insurance claim form and/or medical record of a Medicaid patient.

Gentlemen:

We have issued: (check appropriate box)

- a hospital statement stamped in accordance with established Medicaid procedures
- a completed health insurance claim form
- a medical record

on behalf of the following Medicaid patient:

_____ *Patient's Name* _____ *HSP (Medicaid) Case Number*

_____ *Patient's Address* _____ *Telephone Number*

hospitalized at _____ *Name of Hospital*

from _____ to _____ . This information was requested on _____ *Date*

by _____ *Name* _____ *Address*

_____ *Telephone Number* _____ *Company or Firm Requesting Information*

Very truly yours,

_____ *Title*



NEWSLETTER

New Jersey Health Services Program

Volume..... P-485.....

May 12, 1986

TO: ALL PHYSICIANS, INDEPENDENT CLINICS AND HOSPITAL ADMINISTRATORS

SUBJECT: REVISED FEES FOR THE LISTED IMMUNIZATION SERVICES

EFFECTIVE: FOR ALL NON-INSTITUTIONAL CLAIMS PROCESSED
 ON OR AFTER APRIL 22, 1986

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.

Please Note: Copyright restrictions make it impossible to print excerpts from the CPT-4 (Physician's Current Procedural Terminology Fourth Edition). To determine narratives for Level I codes (5 digits), it is necessary to refer to the CPT-4 book. For level II and Level III codes (letter and 4 digits), the complete narrative is located in the Subchapter 4 (HCPCS) of the Physician Services Manual (10:54-4.2 Appendix A) or in the Subchapter 3 (HCPCS) of the Independent Clinic Services Manual (10:66-3.2 Appendix A).

ACTION: The HCFA Common Procedure Coding System codes (CPT-4) and maximum fee schedule are as follows:

<u>HCPCS Code</u>	<u>Medicaid Dollar Value</u>
90701	10.79
90702	3.98
90703	3.85
90704	13.99
90705	12.35
90706	12.86

<u>HCPCS Code</u>	<u>Medicaid Dollar Value</u>
90707	27.24
90708	18.73
90709	20.23
90712	13.85
90719	4.88
90724	5.32
90732	11.32
J2790	42.37
W9090	11.45
W9095	5.97

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) 588-2749.



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

NEWSLETTER

New Jersey Health Services Program

Volume: P-486

May 23, 1986

TO: Hospital Chief Executive Officers and Financial Directors

SUBJECT: SECOND RECOUPMENT OF CLAIMS PAID BY THE NEW JERSEY MEDICAID PROGRAM FOR RECIPIENTS WITH MEDICARE COVERAGE

Our records further indicate that Medicare coverage existed for a number of Medicaid recipients for whom your facility received reimbursement from the New Jersey Medicaid Program for services provided for the period between October 1, 1983 and September 30, 1984. The names and Medicare/Medicaid numbers of those Medicaid recipients, together with the details of the claims in question, appear on the attached list.

The Medicare time limit for submission of only those claims listed has been extended by Medicare to June 30, 1986. MEDICARE WILL NOT CONSIDER PAYMENT FOR THESE CLAIMS IF SUBMITTED AFTER THIS DATE.

In approximately 45 days from the date of this Newsletter, the New Jersey Medicaid Program will recoup its payments made for the claims on the attached list unless it is substantiated that the claims were previously denied by Medicare or were for services not covered by Medicare. Substantiating documentation should be sent to:

THIRD PARTY RECOVERY UNIT, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, P.O. BOX 343, MAIN POST OFFICE, NEWARK, N.J. 07101-0343

Telephone Number: (201) 642-0003.

To offset the negative impact on cash flow caused by the recoupment, use the attached list as a resource to immediately prepare and submit the Medicare claims for the services in question. Magnetic tape and Blue Cross teleprocessing billers must bill these cases hard copy, using the UB-82 Medicare claim form. All claims should be complete with an "H" in the Remark field (locator #94 on the UB-82 claim form). Billers using the Medicare Part A Remote On-Line Entry system should key an "H" in the fourth position of the Remark field (field immediately following the number of acute days).

The effort to identify Medicare and other third party coverage for claims paid by the New Jersey Medicaid Program is an ongoing one and you will periodically receive listings similar to the one attached.

Any questions regarding this Newsletter or this recoupment in general should be addressed only to the THIRD PARTY RECOVERY UNIT, Division of Medical Assistance and Health Services, P.O. Box 343, Main Post Office, Newark, New Jersey 07101-0343. Telephone number: (201) 642-0003.



Volume.....P-487.....

May 26, 1986

TO: Homemaker Agencies Participating in the Community Care Program
for the Elderly and Disabled (CCPED)

SUBJECT: Change in Accreditation Time Schedule - February 1, 1987

BACKGROUND: A prior Newsletter, dated October 28, 1985, informed you that homemaker agencies participating in the Community care Program for the Elderly and Disabled must be accredited by November 1, 1986 as a condition for continued participation in the New Jersey Medicaid Program. It stated that this accreditation must be carried on by the National Homecaring Council or the Commission on Accreditation for Home Care (established by the Home Care Council of New Jersey).

The National Homecaring Council is prepared to accept and process accreditation applications. However, because the Commission on Accreditation for Home Care was newly established in New Jersey to carry out this requirement, full implementation of its accreditation program has not as yet been achieved.

ACTION The Division of Medical Assistance and Health Services, in recognition of this delay in the establishment of the accreditation process, is extending the deadline for accreditation for those agencies now providing services under the Community Care Program for the Elderly and Disabled. The new date will be FEBRUARY 1, 1987. We have been assured by the Commission on Accreditation for Home Care that this will provide sufficient time for all interested agencies to apply and be accredited. Since accreditation is also a requirement for the Division's Personal Care Assistant Service Program, agencies accredited for the Community Care Program for the Elderly and Disabled will be able to participate as the result of this accreditation as providers of personal care assistant services.

For further information and application for accreditation, please contact one or both of the following agencies:

Dr. Nancy Robinson
Accreditation Program
National Homecaring Council
235 Park Avenue South
New York, New York 10003
Telephone: 1-212-674-4900

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 H. Kurland, Administrator, Office of Home Care Programs.
Telephone: 1-609-588-2620.



June 16, 1986

TO: All Providers

SUBJECT: Medically Needy Program

EFFECTIVE: July 1, 1986

PURPOSE: The Division of Medical Assistance and Health Services is pleased to announce the expansion of the New Jersey Medicaid Program to include provision for reimbursement for services rendered to Medically Needy individuals.

ACTION: The Medically Needy program (P.L. 1985, Chapter 371) provides Medicaid coverage for certain services to New Jersey residents who meet income and asset standards and who are:

- Pregnant women, or
- Needy children under the age of 21*, or
- Aged (65 years or older), or blind or disabled

*Caution: Under the New Jersey law, the parents of these children also known as Caretaker Relatives are not covered for Medically Needy benefits.

This newsletter describes the unique characteristics of the Medically Needy program. It will help you identify Medically Needy individuals, the service limitations, and claims which may be reimbursed through the program.

1. Identifying a Medically Needy Individual: Persons eligible for the Medically Needy program are identified by means of a "Medicaid Eligibility Identification Card", known as the MEI or FD-73/178 (Refer to enclosed Provider Desk Guide). This card contains the same basic information that appears on the existing MEI card and is used in the same manner. Listed below are the unique Medically Needy characteristics of the MEI Card to help you identify a Medically Needy individual.

(a) The following is printed at the top of the card:

MEDICALLY NEEDED ELIGIBLE
CHECK PROVIDER MANUAL FOR AUTHORIZED SERVICES

(b) Valid From xxxxx to xxxxx identifies eligibility dates. The card is issued monthly; however, always review the eligibility dates because coverage may begin on any day during the month.

- (c) The date of birth and Social Security Account Number are omitted and "Medically Needy" is printed above this space.
- (d) The card lists all eligible persons in a family and the "Service Code" which applies to each eligible person. A service code is the key to identifying the Medically Needy group into which an individual falls and the corresponding services available to that Medically Needy individual. (See "Identifying Medicaid Services Available Under the Medically Needy Program" below.)

The service codes for the three groups under the Medically Needy program are:

- Service Group A - Pregnant women
- Service Group B - Needy children under the age of 21
- Service Group C - Aged (65 years or older), blind or disabled

*Caution: Service limitations are defined by service category. It is important to check the service code for each individual listed on the card.

2. Identifying Medicaid Services Available Under the Medically Needy Program:
The Medically Needy program is an expansion of the Medicaid program; therefore, Medically Needy services shall be provided in accordance with the established Medicaid rules and regulations. The following services are available to all Medically Needy groups:

LISTING OF NEW JERSEY MEDICAID PROGRAM SERVICES AVAILABLE
FOR ALL MEDICALLY NEEDY GROUPS - A, B, and C

- Physician
- Dentist
- Psychologist
- Optometrist
- Hearing aids
- Independent clinics
- Medical supplies and equipment
- Home health services
- Laboratory and X-ray services
- Optical appliances
- Medical transportation
- Personal care assistant services
- Prosthetics and orthotics

LISTING OF SPECIFIC SERVICES UNDER NEW JERSEY MEDICAID PROGRAM
AVAILABLE ONLY TO THE MEDICALLY NEEDED GROUP(S) INDICATED BELOW:

<u>SERVICE GROUP A</u>	<u>SERVICE GROUP B</u>	<u>SERVICE GROUP C</u>
<u>Pregnant Women</u>	<u>Needy Children</u>	<u>Aged, Blind or Disabled</u>
<ul style="list-style-type: none"> - Inpatient hospital - Podiatry - Medical day care - Prescribed drugs - Chiropractic services 	<ul style="list-style-type: none"> - Prescribed drugs 	<ul style="list-style-type: none"> - Medical day care - Podiatry

NEW JERSEY MEDICAID PROGRAM SERVICES NOT AVAILABLE TO THE MEDICALLY NEEDED POPULATION:

- Early Periodic Screening, Diagnosis, and Treatment (EPSDT);
- Long term care services (SNF, ICF, ICF/MR);
- Outpatient hospital services (including "Same Day Surgery" services or any services provided by a satellite outpatient facility which is reimbursed according to a hospital methodology);
- Rehabilitation services are not available for reimbursement when provided through a hospital or long-term care facility, except to pregnant women as part of their inpatient hospital services.

3. Submission of Medically Needy Claims:

A claim for service provided to a Medically Needy individual during a period of eligibility must be submitted to the appropriate New Jersey Medicaid Program Fiscal Agent, The Prudential Insurance Company of America or Blue Cross and Blue Shield of New Jersey, Inc., in the same manner as the provider submits any other claim for reimbursement for services covered under the New Jersey Medicaid Program. Claims are reimbursable at the established Medicaid rate. ALL EXISTING MEDICAID POLICIES FOR EACH PROVIDER GROUP APPLY TO MEDICALLY NEEDED, i.e.: PRIOR AUTHORIZATION, UTILIZATION REVIEW, ETC.

4. Non-Reimbursable Services: Non-covered services or services provided outside an eligibility period are not reimbursable and remain the patient's liability. However, a patient may be able to use these medical expenses to establish future Medically Needy eligibility. Your cooperation in responding to requests for proof that the patient owes you payments for these bills will assist him/her in establishing Medically Needy eligibility.

Exception: Eligibility for some individuals may not begin on the first of the month. Unpaid claims for covered services received prior to the individual's date of eligibility may qualify for reimbursement. These types of services fall into the category of "special" claims. "Special" claims are claims for covered Medically Needy services rendered to the eligible individual between the first day of the month in which eligibility is established through the actual day eligibility is established. In such cases, providers will receive a Medically Needy Claim Transmittal (FD-311 Form - Refer to Attachment) which will be developed through the eligibility determination process at the County Welfare Agency/Board of Social Services. This form will be provided on a case-by-case basis with information already completed concerning recipient identification and services potentially reimbursable. Providers will be required to enter their identification information in the upper right hand corner of the form. The FD-311 must be attached to the hard copy claim when submitting "special" claims to the Fiscal Agent for payment.

Attached you will find a Provider Desk Guide which highlights pertinent facts about the Medically Needy program. Use this as a quick reference on covered groups, covered services and billing information.

Chapter I (Administration - N.J.A.C. 10:49) of your provider services manual has been updated and will be forwarded to you in a few weeks. The information contained in this Newsletter is incorporated into that chapter under sections entitled: "Who is eligible for Medicaid"; "How to identify a covered person"; and "Services covered by the New Jersey Medicaid Program."

If you have any questions regarding this newsletter, please contact the Medically Needy Project Office at 1-800-624-4684.

Attachment - Medically Needy Claim Transmittal (FD-311 Form)
Enclosure - Provider Desk Guide



State of New Jersey
 Department of Human Services
 Division of Medical Assistance and Health Services

MEDICALLY NEEDY CLAIM TRANSMITTAL

RECIPIENT INFORMATION

HSP (Medicaid) CASE NO. _____

NAME _____

ADDRESS _____

PROVIDER INFORMATION

PROVIDER NO. _____

PROVIDER NAME _____

PROVIDER ADDRESS _____

TYPE OF SERVICE	DATE OF SERVICE	CHARGE	PAYMENT FROM OTHER SOURCE	CLIENT OBLIGATION	TOTAL FROM OTHER SOURCES
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

Provider Instructions and Information:

- The services listed above were provided to the identified individual during a covered retroactive period.
- This transmittal does not guarantee payment. Your claim will be processed in accordance with current Medicaid and Medically Needy regulations.
- Each claim form submitted for payment for services listed above must be attached to this document.
- Please enter your provider number in the appropriate space in the upper right corner.
- Any amount listed in the column entitled "Client Obligation" is the responsibility of the client and should be paid by the client directly to you.

NUMBER OF ITEMS _____

SIGNATURE _____
 Authorized Representative



REC'D JUL 28 1986

New Jersey Health Services Program

NEWSLETTER

Volume..... **P-489**

July 14, 1986

TO: Special and Private Psychiatric Hospitals

SUBJECT: Reimbursement for Level of Care Provided

EFFECTIVE: February 1, 1986 for Retrospective Utilization Review of Inpatient Services by The Peer Review Organization of New Jersey, Inc., (PRO).

PURPOSE: This letter notifies Special and Private Psychiatric Hospitals of reimbursement policy according to level of care.

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.

The 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. Criteria/guidelines for covered levels of care were distributed to Special and Private Psychiatric Hospitals by The Peer Review Organization of New Jersey, Inc., (PRO).

Action: Effective for admissions on or after February 1, 1986, Special and Private Psychiatric Hospitals are reimbursed according to the appropriate level of care provided. Payment is based on the statewide weighted average rate for all patient days identified as requiring SNF (Skilled Nursing Facility) or ICF (Intermediate Care Facility) level of care.

The weighted average New Jersey Medicaid SNF and ICF per diem rates are as follow:

<u>SNF</u>	<u>ICF</u>
\$62.17	\$54.98

Hospitals must indicate the level of care in Locator No. 2 on the UB-82 HCFA-1450 form when billing for inpatient services. (Specific instructions for completion of UB-82 HCFA-1450 were previously issued to Special and Private Psychiatric Hospitals in Newsletters BC-330 and P-477, dated April 1, 1986.)

Questions relating to Level of Care reimbursement should be directed to the appropriate Fiscal Agent:

Blue Cross and Blue Shield of New Jersey, Inc. - 201-456-2570 or 456-2534
The Prudential Insurance Company of America - 609-293-2254



REC'D JUL 28 1986

New Jersey Health Services Program

NEWSLETTER

Volume..... P-490.....

July 28, 1986

TO: Home Health and Homemaker Agencies

SUBJECT: Revisions to the Personal Care Assistant Program and the Community Care Program for the Elderly and Disabled

EFFECTIVE: August 1, 1986

PURPOSE: This Newsletter informs providers of Personal Care Assistant services and of homemaker services under the Community Care Program for the Elderly and Disabled (CCPED) that new procedure codes and reimbursement rates have been established for services provided on weekends and holidays.

Personal Care Assistant Program

The Individual and Group reimbursement rates for the hour and half-hour periods of service are as follows:

1. Personal Care Assistant service - Individual reimbursement rate - Up to \$9.30 per hour - Weekend, Holiday - Code Z1614;
2. Personal Care Assistant service - Individual reimbursement rate - Up to \$4.65 per half-hour - Weekend, Holiday - Code Z1615;
3. Personal Care Assistant service - Group reimbursement rate - Up to \$7.24 per hour - Weekend, Holiday - Code Z1616;
4. Personal Care Assistant service - Group reimbursement rate - Up to \$3.62 per half-hour Weekend, Holiday - Code Z1617.

Additionally, the Division of Youth and Family Services foster care homes have been removed from the exclusionary list of residences where personal care assistant services may be provided. This means that children living in foster care homes under the auspices of the Division of Youth and Family Services 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 services for these children is required from the Medicaid District Office in the county in which the child resides.

JUL 11 1988

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Community Care Program for the Elderly and Disabled (CCPED)

1. Homemaker service - Individual reimbursement rate - \$9.30 per hour - Weekend, Holiday - Code Z1295. (There is no half-hour code in the CCPED Program.)

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.



REC'D JUL 28 1986

New Jersey Health Services Program

NEWSLETTER

Volume..... P-491.....

July 21, 1986

TO: All Hospitals In New Jersey

SUBJECT: Utilization Review - Inpatient and Outpatient Hospital Services

PURPOSE: This Newsletter is to formally advise hospitals that the New Jersey Medicaid Program has contracted with the Peer Review Organization of New Jersey, Inc., (PRO) to perform Utilization Review (UR) in hospitals.

BACKGROUND: The New Jersey Medicaid Program has initiated revisions to its Utilization Review program. Reviews by the PRO are now being conducted retrospectively rather than concurrently.

The PRO, acting as an agent for the New Jersey Medicaid Program, has full authority to review paid hospital claims for inpatient and outpatient services. Based upon a sample selection of claims, the PRO will review corresponding patient records for medical necessity, level of care, and quality of care. The Utilization Review process and screening criteria were distributed to all hospitals by the PRO.

All hospitals are non-delegated and subject to PRO review.

When the PRO decision about the utilization of hospital services differs from the information submitted on the claim form, the PRO decision is binding. The amount previously reimbursed to the hospital for services is subject to adjustment if the PRO decision denies necessity of admission, appropriateness of services, or reduces length of stay, or level of care. Hospitals, however, may request reconsideration of the PRO decision and file an appeal.

ACTION:

(A) Utilization Review of Inpatient Services

Effective February 1, 1986, the PRO initiated the following review process for inpatient claims:

1. Acute Care (DRG) Hospitals

a. For admissions on or after February 1, 1986, the inpatient review is retrospective.

(1) For admissions prior to February 1, 1986, and continuing not later than February 28, 1986, the review was concurrent.

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(2) If the hospitalization extended beyond February 28, 1986, the services are subject to retrospective review for the period March 1, 1986, and thereafter.

b. Inpatient reviews include but are not limited to a sample of paid claims involving:

- (1) Outliers;
- (2) Outpatient/Same Day Surgery;
- (3) Transfers to other acute care facilities;
- (4) Readmissions;
- (5) Obstetrical and newborn cases;
- (6) MICU and Rebundled Services.

2. Special and Private Psychiatric Hospitals

Utilization Review for hospital stays with dates of service on or after February 1, 1986, is retrospective.

(B) Utilization Review of Outpatient Services - Acute Care (DRG) Hospitals

The PRO will review a sample of paid claims for services rendered on or after March 1, 1986. Hospitals included in this review were previously notified by the PRO. Outpatient reviews include but are not limited to the following:

1. Emergency Room services;
2. Dental services performed in the Emergency Room;
3. Same Day Surgery services;
4. MICU services.

(C) Billing Instructions - Acute Care (DRG) Hospitals

1. The PRO certification stamp on hard copy claims is discontinued for hospitalizations subject to retrospective review by the PRO.
2. In the event that the PRO decision differs from data which the hospital has submitted to the Department of Health, the hospital is responsible for resubmitting corrected data to the Department of Health.

(D) Authorization Changes

The New Jersey Medicaid Program has eliminated the following authorization procedures because the PRO Utilization Review determines whether the admission and continued stay at a hospital were appropriate and medically necessary:

1. Authorization is no longer required from the Medicaid District Office for hospitalizations extending beyond the twenty-first day in special hospitals.
2. Authorization is no longer required from the Chief Consultant, Mental Health Services, for hospitalizations extending beyond the fortieth day in psychiatric units of acute care (DRG) hospitals or private psychiatric hospitals.

(E) Appeal Process

Hospitals may appeal the PRO decision by submitting a request for reconsideration to:

The Peer Review Organization of New Jersey, Inc.
Central Division
Brier Hill Court
Building J
East Brunswick, New Jersey 08816

or

The Peer Review Organization of New Jersey, Inc.
Southern Division
1940 Route 70
Cherry Hill, New Jersey 08003

Should you have any questions, contact the PRO of New Jersey or the subcontractor designated by the PRO to perform your Utilization Review at the following telephone numbers:

PRO of New Jersey (Central Division) - 201-238-5570
PRO of New Jersey (Southern Division) - 609-424-7433
Metropolitan Peer Review Organization - 201-379-6300
Passaic Valley Professional Standards Review Organization - 201-696-3731



NEWSLETTER

New Jersey Health Services Program

Volume..... P-492

August 25, 1986

TO: All Providers

SUBJECT: Revision to Provider Services Manual
CHAPTER 49 - ADMINISTRATION (10:49)

Enclosed is a revised copy of Chapter I of your New Jersey Medicaid Program Provider Services Manual. To facilitate legal reference and cross reference, and to observe submission requirements of the New Jersey Administration Code (N.J.A.C.), the codification (numerical designations) in the revised chapter conforms with that of the N.J.A.C.

Chapter I is now entitled "Chapter 49 - Administration" (10:49). The numerical designation 10:49-1. of the N.J.A.C. indicates Subchapter 1. of Chapter 49 - Administration, Division of Medical Assistance and Health Services, under Title 10 - Department of Human Services. The second chapter of your New Jersey Medicaid Provider Services Manual, which is always specific to the type of service provided, is similarly coded or will be when that chapter is reviewed for reissue.

According to the service provided, the second chapter of a New Jersey Medicaid Provider Services Manual will be one of the following:

- | | | | |
|-------|-------------------------|-------|------------------------|
| 10:50 | Transportation | 10:60 | Home Health Care |
| 10:51 | Pharmaceutical | 10:61 | Independent Laboratory |
| 10:52 | Hospital | 10:62 | Vision Care |
| 10:53 | Special Hospital | 10:63 | Long-Term Care |
| 10:54 | Physician | 10:64 | Hearing Aid |
| 10:55 | Prosthetic and Orthotic | 10:65 | Medical Day Care |
| 10:56 | Dental | 10:66 | Independent Clinic |
| 10:57 | Podiatry | 10:67 | Psychological |
| 10:58 | Nurse-Midwifery | 10:68 | Chiropractic |
| 10:59 | Medical Supplier | | |

It is recommended that you carefully review this Chapter 49 - Administration. Information found in NEWSLETTERS addressed to "All Providers" and dated before August 1, 1986, was incorporated directly into the text, except for information about Special Programs which is found at the end of Chapter 49.

Information about the Medically Needy Program, which is the only major addition to Chapter 49, is marked with a vertical line in the left-hand margin of the pages containing Section 1.1 (a), (c), (e), and (g); Section 1.2 (b); and Section 1.4 (b).

As administrative changes occur, the New Jersey Medicaid Program will issue replacement pages to assist the provider in maintaining a manual which is current and easily read.

Manual Maintenance: Discard Chapter I (Rev.12/77) and replace with Chapter 49 - Administration (Rev.8/86).

Discard all Newsletters addressed to "All Providers" and dated before August 1, 1986.

If you have any questions about the revised Chapter 49 - Administration, please contact the Director of the Medicaid District Office in your area.

FOREWORD

The New Jersey Medical Assistance and Health Services Act (P.L. 1968, c. 413, which is codified as N.J.S.A. 30:4D-1 et seq.) established a program of assistance and services for defined groups of persons to enable them to secure quality medical care. The Act was recently amended to extend coverage to individuals who qualify under the Medically Needy provisions (P.L. 1985, c. 371, approved November 25, 1985 and amended by P.L. 1985, c. 510, approved January 21, 1986). This Act, commonly known as "Medicaid" or "Title XIX", will be referred to as the New Jersey Medicaid Program or the Program.

The New Jersey Medicaid Program is administered by the Department of Human Services, Division of Medical Assistance and Health Services, through the Division's Central Office and through Medicaid District Offices located throughout the State of New Jersey.

Reimbursement for services provided under the Program is accomplished in conformity with Federal Title XIX regulations and State law. Payments are obtained through the Division's Bureau of Claims and Accounts or through either of its two Fiscal Agents, Blue Cross and Blue Shield of New Jersey, Inc. or The Prudential Insurance Company of America, depending upon the type of service being reimbursed.

Each New Jersey Medicaid manual is designed for use by providers who are providing services to Medicaid eligible individuals. It contains informational and procedural material needed to assist the providers to understand the rules and regulations of participation in the Program, to identify eligible individuals, and to insure prompt and efficient payment of claims. Each manual consists of two chapters. The first chapter concerns general administrative policies of the New Jersey Medicaid Program and a section describing Special Programs. The second chapter is specific to the type of service provided; for example, physician services, hospital services, etc.

This manual was written in accordance with Federal and State laws, rules and regulations and with the intent to ensure that such laws, rules and regulations are uniformly applied. The codification generally follows the New Jersey Administrative Code (N.J.A.C.). The policies and procedures described were developed to achieve the goals of the Program with due consideration to the needs of Medicaid eligible individuals and to promote effective relationships with providers.

As a supplement to this manual, a newsletter system is utilized for the prompt dissemination of information concerning new policy and/or changes to the New Jersey Medicaid Program. Additionally, manual page revisions are updated as administrative changes occur. Periodically, therefore, revised sections, entire pages and entire chapters will be issued. It is recommended that these newsletters and manual page revisions be filed in your manual at the time of receipt of such documents in accordance with the instructions.

DEPARTMENT OF HUMAN SERVICES
 DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
 NEW JERSEY MEDICAID PROGRAM
TITLE 10 - CHAPTER 49 (N.J.A.C.)

ADMINISTRATION

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DIRECTORY OF MEDICAID DISTRICT OFFICES

SUBCHAPTER I. GENERAL PROVISIONS

10:49-1.1 WHO IS ELIGIBLE FOR MEDICAID?

- (a) Individuals eligible for Medicaid are divided into those eligible for all services under the New Jersey Medicaid Program (see (b) below) and those individuals (Medically Needy) eligible for only certain services (see (g) below).
- (b) The following groups are eligible for medical and health services covered under the New Jersey Medicaid Program when provided in conjunction with Program requirements specifically outlined in the second chapter of each service manual. The groups are not all inclusive:
1. Persons who are eligible to receive Supplemental Security Income (SSI) payments as determined by the Social Security Administration. Such persons are the aged (65 and over), the blind, and the disabled;
 2. A person who qualifies under the Supplemental Security Income (SSI) Program as an "ineligible spouse" of an SSI recipient as determined by the Social Security Administration;
 3. Persons who are eligible to receive financial assistance as determined by the County Welfare Agency/Board of Social Services. Such persons are:
 - i. Families with dependent children including children 18 to 21 years of age;
 - ii. Refugee Resettlement Program refugees.
 4. Persons who meet the income standards of need applicable to their circumstances under one of the financial assistance programs referred to above, but who are not receiving or do not apply for such cash assistance. Such persons are eligible for "Medicaid Only" under the New Jersey Medicaid Program;
 5. Individuals in Medicaid approved institutions who are eligible under a special income level.
 6. Persons 65 years of age and above who do not meet eligibility standards of the categorically-related assistance programs, but whose medical needs qualify them under the New Jersey State Medical Assistance to the Aged Continuation Program (MAA) (new recipients are no longer accepted in this program);
 7. Children in foster care and under supervision of the Division of Youth and Family Services (DYFS);
 8. Certain persons in State and County Governmental Psychiatric Hospitals and/or State schools for the developmentally disabled as determined eligible by the Department of Human Services;

9. Persons who would be eligible for financial assistance under one of the above programs except for a requirement that is specifically prohibited by Federal law or regulations, such as execution of a reimbursement agreement.

- (c) Newborn: Although both the mother and newborn infant may be eligible recipients on the date of delivery, the newborn infant is not immediately assigned a Person Number. In order to expedite payment to the practitioner and the hospital for inpatient hospital services rendered to a newborn during the mother's confinement, allowance has been made to reimburse providers using the mother's Health Services Program (Medicaid) Case Number and Person Number. When the mother is discharged from the hospital, services to the newborn may no longer be claimed by the practitioner and/or hospital under the mother's Person Number. The mother must contact the County Welfare Agency/Board of Social Services to obtain a Person Number for the newborn. It is the duty of the practitioner or the hospital to contact the County Welfare Agency/Board of Social Services to obtain the newborn's Person Number for billing purposes.

Note: Inpatient hospital services for the newborn are not covered under the Medically Needy Program.

- (d) If a patient has not applied for benefits, is unable to pay for services rendered and appears to meet the requirements for eligibility for the New Jersey Medicaid Program, the provider should encourage the patient or his/her representative to apply for benefits through the County Welfare Agency/Board of Social Services for either the Aid to Families with Dependent Children program or for the Medically Needy program; to the Social Security Administration for Supplemental Security Income benefits; or in certain cases, to the New Jersey Division of Youth and Family Services. The agency will process the application and notify the patient of the resulting determination.

1. A patient receiving services prior to the notification of eligibility should be informed that he/she is considered responsible for all charges incurred until proof of eligibility is verified. Once eligibility is verified, the provider may not bill the patient for any portion of the costs of allowable services rendered on or after the effective date of eligibility.

- (e) Medicaid Retroactive Eligibility: Persons applying for Medicaid benefits will be asked if they have unpaid medical bills incurred within the three month period immediately prior to the month of application for Medicaid. Except for Medically Needy applicants, persons indicating that they do have such bills may complete an Application for Retroactive Medicaid Eligibility (FD-74) and forward the application with all outstanding unpaid bills to the Medicaid Retroactive Eligibility Unit. An application for retroactive eligibility may be obtained by the applicant or his/her authorized agent from the County Welfare Agency/Board of Social Services, the Medicaid District Office, the Social Security Administration

District Office or the Retroactive Eligibility Unit, (Division of Medical Assistance and Health Services, CN 712-10, Trenton, New Jersey 08625). The application must be submitted within six months from the date of application for public assistance.

1. If the New Jersey Medicaid Program determines that the person was eligible for Medicaid at the time the service was rendered or item supplied, providers will be notified directly that the unpaid bills for any service/item covered by the New Jersey Medicaid Program may be reimbursable in accordance with standard Medicaid reimbursement procedures. The provider will then complete the appropriate Medicaid claim form and submit it to the Retroactive Eligibility Unit for consideration and authorization of payment.
 2. For Medically Needy persons, retroactive eligibility determinations will be completed by the County Welfare Agency/ Board of Social Services (see (g) below).
- (f) It is in the best interest of the provider to review on each visit the eligibility of patients receiving continuing services. It is especially important to review the validation of eligibility form on each visit when an extended plan of treatment has been authorized. There is no reimbursement for services performed after termination of eligibility other than by exceptional circumstances.
- (g) Medically Needy individuals are eligible for medical and health services covered under the New Jersey Medicaid Program with limitations as listed in Section 1.4. The services must be provided in conjunction with Program requirements specifically outlined in the second chapter of each service manual.
1. Individuals are determined Medically Needy eligible by the County Welfare Agency/Board of Social Services. They must meet the categorical eligibility requirements, have income and/or resources in excess of the categorical standards, and may have insufficient funds to meet their medical expenses. Medically Needy individuals must be in one of the following groups:
 - i. Pregnant women,
 - ii. Needy children (under 21 years of age),
 - iii. The aged (65 years of age or older), the blind or the disabled.
 2. There are special income and resource levels established for the Medically Needy. If an individual meets one of the above categories and has income and/or resources above categorical program levels but less than or equal to the Medically Needy income and resource levels, he/she is eligible as Medically Needy. However, if an individual meets one of the above categories and meets the Medically Needy resource level, eligibility may be established through the "spend-down"

process. "Spend-down" is the process whereby an individual may apply incurred medical expenses to offset income above the Medically Needy income level, and thereby adjust their income to meet the Medically Needy income limit. Medically Needy eligibility for all groups including the aged, blind and disabled will be determined by the County Welfare Agency/Board of Social Services for both the retroactive and prospective period.

3. Medically Needy applicants/recipients must reapply for benefits every six months. Eligibility may be established the first day of that six-month period or on any date during the six-month period that spend-down is met.
 - i. Eligibility should be verified by providers on each visit by reviewing the Medicaid Eligibility Identification Card (MEI) (FD-73/178) (see 1.2(b)). For those cards issued for the month within the six month period in which the spend-down is met, the card will reflect the date that eligibility begins after the spend-down is met.
4. Claims for Medically Needy covered services provided during an eligible period may be submitted to the program for reimbursement using standard Medicaid procedures. Services provided prior to the effective date of eligibility are the client's liability, except for certain "special" claims.
 - i. "Special" claims are claims for Medically Needy covered services that were not used to meet the spend-down and were rendered between the first of the month in which eligibility is established and the date of eligibility that appears on the Medicaid Eligibility Identification Card.
 - ii. The County Welfare Agency/Board of Social Services will identify "special" claims which may be reimbursed under the program and will provide a Medically Needy Claim Transmittal (FD-311 Form) (see Exhibit 8 at the end of this chapter). Such claims must be submitted hard copy with the FD-311 attached.

10:49-1.2 HOW TO IDENTIFY AN ELIGIBLE PERSON

All eligible persons as described below have an HSP (Medicaid) Case Number which includes a two-digit individual Person Number. This identification number appears on the validation of eligibility form which must be presented to providers of services as proof of eligibility.

- (a) An HSP (Medicaid) Case Number, as currently assigned, consists of twelve digits.
 1. The first two digits designate the County of residence of the individual at the time of eligibility.

- i. For an individual in a long-term care facility, the first two digits of the HSP (Medicaid) Case Number reflect the County of residence when the application was made but not necessarily the location where the patient is institutionalized nor the agency/county responsible for supervision of services. The Medicaid District Office serving the County designated by the first two digits may supply more information in these instances.
- ii. County Welfare Agencies/Boards of Social Services:
- | | | |
|-----------------|-----------------|---------------|
| 01 - Atlantic | 08 - Gloucester | 15 - Ocean |
| 02 - Bergen | 09 - Hudson | 16 - Passaic |
| 03 - Burlington | 10 - Hunterdon | 17 - Salem |
| 04 - Camden | 11 - Mercer | 18 - Somerset |
| 05 - Cape May | 12 - Middlesex | 19 - Sussex |
| 06 - Cumberland | 13 - Monmouth | 20 - Union |
| 07 - Essex | 14 - Morris | 21 - Warren |
2. For an individual in a State or County institution, the first two digits of the HSP (Medicaid) Case Number reflect the institution where the individual resides.
- i. State and County institutions:
- 09 - Meadowview Hospital
 - 31 - Greystone Park Psychiatric Hospital
 - 32 - Trenton Psychiatric Hospital
 - 32 - Senator Garrett W. Hagedorn Center for Geriatrics
(in this instance the use of a 600,000 series number for digits 5 through 10 must also be used to identify the institution)
 - 33 - Marlboro Psychiatric Hospital
 - 34 - Ancora Psychiatric Hospital/Ancora Developmental Center
 - 35 - North Princeton Developmental Center
 - 36 - Arthur Brisbane Child Development Center
 - 37 - Bergen Pines County Hospital
 - 38 - Essex County Psychiatric Geriatric Center

- 39 - Camden County Psychiatric Hospital
- 41 - Vineland Developmental Center
- 42 - North Jersey Developmental Center
- 43 - Greenbrook Regional Center
- 44 - Woodbine Developmental Center
- 45 - New Lisbon Developmental Center
- 46 - E. R. Johnstone Developmental Center
- 47 - Woodbridge Developmental Center
- 48 - Hunterdon Developmental Center
- 90 - Community/Special Residential Services
(Family Care)

3. The third and fourth digits of the 12-digit HSP (Medicaid) Case Number designate the category under which a person is determined eligible for the New Jersey Medicaid Program.

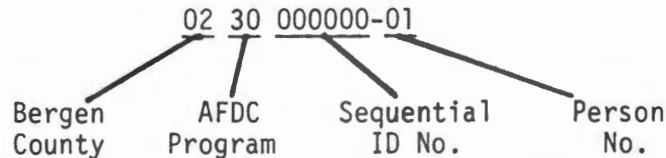
- 10 - Aged-SSI related (65 years of age or older)
- 15 - Aged-Medically Needy related
- 20 - Disabled-SSI related (under 65 years of age)
- 25 - Disabled-Medically Needy related
- 30 - Aid to Families with Dependent Children (AFDC)
- 35 - AFDC-Medically Needy related
- 50 - Blind-SSI related
- 55 - Blind-Medically Needy related
- 60 - Children in Foster Care
- 70 - Medical Assistance for Aged - A New Jersey State Program
- 80 - Refugee Program

4. The next six digits (5 through 10 of the 12-digit HSP (Medicaid) Case Number) designate the sequential identification number of the recipient(s).

5. The last two digits designate the specific Person Number assigned to each individual.

- 01 - 09 Adult (any age)
- 10 - 19 Essential Person (any age)
- 20 - 49 Children under 21

6. Example of an HSP (Medicaid) Case Number: A recipient from Bergen County receiving assistance under Aid to Families with Dependent Children (AFDC) Program could have the following HSP (Medicaid) Case No.:



- (b) Four forms are used for validation of eligibility: A New Jersey Medicaid provider may verify the client's Medicaid eligibility by means of the Department of Human Services Medicaid-ID (FD-152); Medicaid Eligibility Identification Card (FD-73/178); Validation for HSP (DYFS 16-36); or Validation of Eligibility (FD-34).

1. Department of Human Services Medicaid-ID (FD-152) (see Exhibit 1 at the end of this chapter): This validation form is issued by the appropriate County Welfare Agency/Board of Social Services to recipients of Aid to Families with Dependent Children (AFDC) and to eligible persons under the Refugee and Medicaid Only programs. The form indicates that the individual(s) is/are currently eligible for coverage for the month shown on the form. The validation form must be retained by the eligible person to whom it is issued.
 - i. This form is the sole indicator of Medicaid eligibility for person(s) listed on the form.
 - ii. Be sure to enter the name, HSP (Medicaid) Case Number, including the Person Number, exactly as it appears on the FD-152 form when requesting authorization for services or submitting a claim form.
 - iii. One of the following four messages may be printed on the top line of the FD-152 form issued by the County Welfare Agencies/Boards of Social Services. Only one message will appear on the form. If more than one applies, the message printed is chosen in the order of priority listed below. Providers are requested to take the specific action listed, as given below, for whichever one of the four messages appears:
 - (A) Message One: "NOT VALID FOR MEDICAID" - Do not honor invalidated Medicaid ID stubs. This recipient is enrolled in the Medicaid Special Status Program. The recipient and others on his/her grant must produce a

valid FD 73/178, Medicaid Eligibility Identification Card (see 2.v. below).

- (B) Message Two: "VALID ONLY WITH MP PLAN CARD" (see Appendix B).
- (C) Message Three: "RESTRICTED USE HMO-CALL" (NUMBER LISTED) or "HMO COVERAGE - CHECK HMO ID CARD - This recipient (and any member of his/her family on the AFDC grant) is enrolled in a Health Maintenance Organization (HMO). Call the telephone number, which will be listed on either the FD-152 validation card or on the HMO ID Card, to determine whether the service or the item you are being asked to provide is provided by the HMO. If you provide a service available through the HMO, you risk being denied reimbursement by the New Jersey Medicaid Program except in medical emergencies. (See Appendices for information about specific HMOs.)
- (D) Message Four: "OTHER COVERAGE" - There will be an asterisk (*) before the name of the recipient(s) covered by another health insurer. Determine the insurer and the policy number (see Section 10:49-1.7, Utilization of Insurance Benefits).

2. Medicaid Eligibility Identification Card (MEI Card) (FD-73/178) (see Exhibit 2 for the regular Medicaid Program MEI Card and Exhibit 3 for the Medically Needy Program MEI Card at the end of this chapter): This card is issued monthly or quarterly depending on the basis of the recipient's eligibility. The MEI Card is issued monthly to individuals (aged, blind and disabled) determined by the Social Security Administration to be eligible for Supplemental Security Income (SSI), monthly to individuals in the Special Status Program (see v. below) and monthly to individuals determined by the County Welfare Agency/ Board of Social Services to be eligible in the Medically Needy Program (see vi. below). It is issued quarterly for Medicaid-eligible children under the supervision of the Division of Youth and Family Services (DYFS).

- i. The MEI Card usually identifies eligibility for only one person; however, the Special Status Program identifies all eligible persons in the family and restrictions apply to all eligible persons listed on the MEI Card when issued as a Medicaid Special Status Card. Also, when the MEI Card is issued to the Medically Needy, more than one eligible person may be listed and a service code is indicated next to each name (see vi. below).
- ii. The MEI Card is valid only when signed by the eligible person or his/her representative payee/legal guardian.

- iii. The MEI Card includes an address, date of birth, Social Security Account Number and the availability of any third-party health insurance; however, for the Medically Needy Program, the date of birth and Social Security Account Number are omitted and "Medically Needy" is printed in this space. If the Medicaid client has health insurance, the name of the other insurer will be printed together with a corresponding policy number. Additionally, the type of Medicare coverage (Part A, Part B or Parts A and B) and the HIC (Medicare) Number will be included for all Medicare/Medicaid eligibles.
- iv. The MEI Card will also indicate the cardholder's enrollment in any special programs (Community Care Program for the Elderly and Disabled, see Appendix A; Medicaid Personal Physician Plan, see Appendix B; Omnicare/the hmo, see Appendix C; HCP-Health Care Plan of New Jersey, Inc., see Appendix D).
- v. The "Special Status Program" restricts the Medicaid client to a single provider of pharmaceutical services. It is issued to clients determined by New Jersey Medicaid to have misused, abused or overused their Medicaid benefits. The name and address of the pharmacy to which the client is restricted will be printed on the top of the MEI Card. A recipient is permitted to change the designated provider every three months or sooner upon demonstration of good cause and may request a hearing if such a change is denied or unduly delayed or if the recipient otherwise objects to being included in the "Special Status Program". In an effort to discourage misuse or card lending in certain instances, a message will be printed on the card alerting the provider to ask the Medicaid client for additional identification.
- vi. When the MEI Card is issued to recipients in the Medically Needy Program, the following message will be printed on the top of the card: "Medically Needy Eligible, Check Provider Manual for Authorized Services". It is important for the provider to always review the eligibility dates and to be aware that eligibility is not always established for an entire month. Coverage may begin on any day during the month. Also, a provider should always review the "service code" for each Medically Needy recipient. The service code will enable the provider to determine which services are available to each Medically Needy individual (see 1.4 for service exceptions). The service codes for the three groups under Medically Needy are:
 - (A) Group A - Pregnant women,
 - (B) Group B - Needy children,
 - (C) Group C - Aged, blind and disabled.

3. Validation for HSP (DYFS 16-36) (see Exhibit 4 at the end of this chapter): This validation form is issued by the Division of Youth and Family Services (DYFS) to certain eligible children. This form indicates eligibility for covered health services during the month shown on the form itself.
 - i. The validation form must be retained by the person to whom it is issued.
 - ii. The form is the sole indicator of eligibility for certain groups of children.
 - iii. The HSP (Medicaid) Case Number must be entered exactly as it appears on the validation form on all requests for authorization of services and when submitting claim forms.

4. Validation of Eligibility (FD-34) (see Exhibit 5 at the end of this chapter): This validation form identifies an individual who resides in a State or County institution.
 - i. The validation form is prepared and completed by the authorized Medicaid representative at the State/County institution. It is valid for a period of up to 31 days from the date of issue to a Medicaid eligible patient/resident in a State/County Governmental Psychiatric Hospital or an institution for the developmentally disabled, and is used to obtain Medicaid covered services outside of the institutional setting. The form must be returned with the patient.
 - ii. Form FD-34 requires the signature, title and telephone number of the authorized representative at the institution.
 - iii. The resident or patient of a State/County institution receiving covered health services in the community is identified by the 12-digit HSP (Medicaid) Case Number in which the first two digits identify the institution.
 - iv. The New Jersey Medicaid Program has designated specific Medicaid District Offices (see Directory of Medicaid District Offices at the end of this chapter) to handle the prior authorization requests for services for patients/residents from each institution and the family care residents who are under the jurisdiction of the Division of Developmental Disabilities. If the patient/resident's HSP (Medicaid) Case Number begins with any of the following numbers, contact the Medicaid District Office (MDO) indicated.

31 - Morris MDO

32 - Mercer MDO

- 33 - Monmouth MDO
- 34 - Camden MDO
- 36 - Monmouth MDO
- 41 - Cumberland MDO
- 42 - Passaic MDO
- 44 - Atlantic MDO
- 45 - Burlington MDO
- 47 - Middlesex MDO
- 48 - Hunterdon MDO
- 90 - Ocean MDO

10:49-1.3 ELIGIBLE PROVIDERS

- (a) An eligible provider of services is any individual, partnership, association, corporation, institution or any other public or private entity designated below, meeting applicable requirements and standards for participation in the New Jersey Medicaid Program; and, where applicable, holding a current valid license. Providers are required to complete a Medicaid Provider Application (Form FD-20) and to sign a Provider Agreement (Form FD-62) (see Exhibits 6 and 7 at the end of this chapter) or a specialized agreement, depending on the nature of the provider. All provider applicants and reapplicants defined as disclosing entities (all Medicaid providers other than an individual practitioner and/or a group of practitioners) are required to complete a HCFA form 1513, Ownership and Control Interest Disclosure Statement. Providers prior to 1973 were not required to utilize provider agreement forms; however, they must comply with all applicable State and Federal Medicaid laws, policies, rules and regulations.
1. As a condition of continued participation in the New Jersey Medicaid Program, a provider may, from time to time, be required to:
 - i. Complete a provider application form and sign a provider participation agreement.
 - ii. Complete a disclosure of ownership and control interest information statement on forms prescribed by the New Jersey Medicaid Program. This requirement is applicable only to providers who are disclosing entities.
 2. A provider who is surveyed annually, by the State survey agency (New Jersey State Department of Health), is required, upon request, to furnish ownership and control interest information.

The New Jersey Medicaid Program will not approve any provider agreement and will terminate any existing agreement or contract if the provider fails to disclose information required by this Section 1.3(a).

3. Enrollment documentation requested by the New Jersey Medicaid Program must be furnished within 35 days of the date of the written request.
- (b) Providers eligible to participate in the New Jersey Medicaid Program are:
1. Chiropractors and/or chiropractor groups;
 2. Clinics (independent outpatient health care facilities);
 3. Clinical Laboratories (independent, certified);
 4. Dentists and/or dentist groups;
 5. Hearing aid dealers;
 6. Health Maintenance Organizations (HMOs);
 7. Home Health Agencies (certified licensed);
 8. Homemaker Agencies (proprietary and voluntary non-profit);
 9. Hospitals (general);
 10. Hospitals (special);
 11. Long-term care facilities (limited to Skilled Nursing Facilities, Intermediate Care Facilities, Intermediate Care Facilities for the Mentally Retarded, and Residential Treatment Facilities);
 12. Medical and surgical supply dealers;
 13. Medical Day Care Centers;
 14. Nurse-midwives (certified);
 15. Opticians;
 16. Optometrists;
 17. Orthotists (certified);
 18. Pharmacies;
 19. Physicians and/or physician groups;
 20. Podiatrists and/or podiatrist groups;

21. Prosthetists (certified);
 22. Psychologists and/or psychologist groups;
 23. Transportation;
 24. State and County agencies which have agreed to provide personal care assistant services.
- (c) The Division may refuse to enter into a provider participation agreement with any applicant who has been suspended, debarred, disqualified or excluded by the Medicaid Program of another state.
- (d) The Division will not enter into a provider participation agreement with an applicant who has been suspended or excluded from participation in the delivery of medical care or services under Title XVIII, XIX, or XX of the Federal Social Security Act by the Secretary of the United States Department of Health and Human Services.

10:49-1.4 SERVICES COVERED BY THE NEW JERSEY MEDICAID PROGRAM

- (a) New Jersey Medicaid individuals are eligible for covered services when the services are provided in conjunction with Program requirements specifically outlined in the second chapter of each service manual; however, for Medically Needy individuals some Medicaid services are not available or are only available to certain eligible Medically Needy groups (see (b) below). Any limitations imposed will be consistent with the medical necessity of the patient's condition as determined by the attending physician or other practitioner and in accordance with standards generally recognized by health professionals and promulgated through the New Jersey Medicaid Program.

The covered services listed below, in alphabetical order, are available to the regular Medicaid population:

1. Chiropractic services;
2. Christian Science Sanatoria care and services (See Hospital Services Manual);
3. Clinic services (independent outpatient health care facility, other than hospital which provides services such as Mental Health, Family Planning, Dental, Optometric, Ambulatory Surgery, etc.);
4. Dental services;
5. Early and Periodic Screening, Diagnosis and Treatment for individuals under age 21 (EPSDT): A periodic preventative health care program for persons under age 21 designed for early detection, diagnosis and treatment of correctable

abnormalities. This Program supplements the general medical services otherwise available;

6. Family Planning services;
7. Hearing Aid services;
8. Home Care services (Home Health Care and Personal Care Assistant services);
9. Hospital services - Inpatient
 - i. Acute Care Hospitals
 - ii. Institutions for mental diseases: Limited to persons age 65 or older and children 21 years of age and under;
10. Hospital services - Outpatient;
11. Laboratory (clinical) and Radiological services;
12. Long-Term Care services (Skilled Nursing Facilities, Intermediate Care Facilities, Intermediate Care Facilities for the Mentally Retarded and Residential Treatment Facilities);
13. Medical Day Care services;
14. Medical Supplies and Equipment;
15. Mental Health services;
16. Nurse-midwifery services;
17. Optometric services;
18. Pharmaceutical services;
19. Physician's services (M.D. and D.O.);
20. Podiatric services;
21. Prosthetic and Orthotic Devices;
22. Rehabilitative services (Payments are made to eligible Medicaid providers only. No payment is made to privately practicing therapists.);
 - i. Physical therapy, as provided by a home health agency, independent clinic, long term care facility, or hospital outpatient department or in a physicians office.
 - ii. Occupational therapy, as provided by a home health agency, independent clinic, long term care facility, or hospital outpatient department.

- iii. Speech-Language Pathology services, as provided by a home health agency, independent clinic, long term care facility, or hospital outpatient department.
- iv. Audiology services provided in the office of a licensed specialist in otology or otolaryngology, or as part of independent clinic or hospital outpatient services.

23. Transportation services which include ambulance and invalid coach service, or other transportation through the County Welfare Agency/Board of Social Services, when such service is not free and available in the community, and when use of any other method of transportation is medically contraindicated.

(b) Regular Medicaid services are available to Medically Needy individuals except for the following services which are not available or are only available to certain eligible Medically Needy groups: (See the service code next to the individual's name on the Medicaid Eligibility Identification Card to ascertain the Medically Needy group under which the individual's eligibility was established; i.e. Group A - pregnant women, Group B - needy children, and Group C - aged, blind and disabled.)

1. Chiropractic services are available only to pregnant women (Group A).
2. EPSDT services are not available to any Medically Needy group.
3. Hospital services (inpatient) are available only to pregnant women (Group A).
4. Hospital services (outpatient) are not available to any Medically Needy group, including same day surgery. This exclusion also applies to a satellite outpatient facility which is reimbursed according to a hospital outpatient reimbursement methodology.
5. Long-term care services are not available to any Medically Needy group.
6. Medical day care services are available only to pregnant women, the aged, the blind and the disabled (Groups A and C). Medical day care services provided in a hospital-based facility are not available to any Medically Needy group.
7. Pharmaceutical services are available only to pregnant women and needy children (Groups A and B).
8. Podiatric services are available only to pregnant women, the aged, the blind and the disabled (Groups A and C).
9. Rehabilitative services are not available for reimbursement when provided through a hospital or long-term care facility, except to pregnant women as part of their inpatient hospital services.

10:49-1.5 GENERAL EXCLUSIONS

(a) The items listed here are general exclusions from New Jersey Medicaid Program coverage. There are certain additional specific exclusions and limitations which are detailed in the second chapter of each service manual. Payment is not made for:

1. Any service, admission or item which is not medically required for diagnosis or treatment of a disease, injury or condition;
2. Any services or items furnished in connection with elective cosmetic procedures;

NOTE: There are certain exceptions to this rule. A written certification of medical necessity and a treatment plan must be submitted by the physician to the Medicaid District Office for consideration, as prior authorization is required.

3. Private duty nursing services;
4. Services rendered by chiropractors and psychologists not licensed by the State of New Jersey;
5. Services or items furnished for any sickness or injury occurring while the covered person is on active duty in the military;
6. Services or items furnished for any condition or accidental injury arising out of and in the course of employment for which any benefits are available under the provisions of any worker's compensation law, temporary disability benefits law, occupational disease law or similar legislation, whether or not the covered person claims or receives benefits thereunder, and whether or not any recovery is obtained from a third-party for resulting damages;
7. That part of any benefits which are covered or payable under any health, accident or other insurance policy (including any benefits payable under the New Jersey Automobile Reparation Act, P.L. 1972 c.70), any other private or governmental health benefit system, or through any similar third-party liability, which also includes the provision of the Unsatisfied Claim and Judgment Fund;
8. Services or items furnished prior to or after the period for which the patient presents evidence of eligibility for coverage; Exception: Retroactive eligibility, see Section 1.1(e) of this chapter.
9. Any services or items furnished for which the provider does not normally charge;

10. Any admission, service or item requiring prior authorization, where authorization has not been obtained or has been denied;
11. Services furnished by an immediate relative or member of the covered person's household;
12. Services billed for which the corresponding health care records do not adequately and legibly document all required elements of the procedure described or procedure code utilized by the billing provider, as specified in the provider manual. Final payment will be made for the procedure which most closely corresponds to the procedure code which is actually documented in the provider's health care record. Therefore, any difference between the amount paid to the provider based on claim submitted and the procedure documented in the provider's record may be recouped by the Division of Medical Assistance and Health Services;
13. Any claim submitted by a provider for service(s) rendered to a recipient whose Medicaid Eligibility Identification Card (FD-73/178) has a printed message restricting the recipient to another provider of the same service(s). (See Section 1.2 (b) of this chapter.)

10:49-1.6 FREE SERVICES

Services provided to all persons without charge may not be billed to the New Jersey Medicaid Program. Services and items provided without charge through programs of other public or voluntary agencies (for example, New Jersey State Department of Health, New Jersey Heart Association, first aid or rescue squads, and so forth) shall be utilized to the fullest extent possible.

10:49-1.7 UTILIZATION OF INSURANCE BENEFITS

- (a) Medicaid benefits are last-payment benefits. All health and accident insurance benefits, including Medicare, Worker's Compensation and No-Fault Auto Insurance shall be used first and to the fullest extent in meeting the medical needs of the covered person. Since Medicare covers aged and certain disabled persons, providers should inquire about Medicare eligibility when rendering Medicare covered services to a person in category 10, 15, 20, 25, 50, or 55. Supplementation of available benefits shall be as follows:
 1. Title XVIII (Medicare): For those individuals who are covered under Medicare, responsibility for payment by the New Jersey Medicaid Program will be limited to the unsatisfied deductible to the extent that the combined total of payments do not exceed the maximum allowable under the Program in the absence of other coverage. (Exception: Co-insurance is reimbursable for hospital billings, long-term care facility billings, durable medical equipment and supplies, and prosthetic and orthotic devices to the extent that the combined total of payments do

not exceed the maximum allowable under the Program in the absence of other coverage.)

2. Worker's Compensation: No program payments shall be made for a patient covered by Worker's Compensation.
3. Other health insurance: When a covered person has other health insurance, the Program requires that such benefits be used first and to the fullest extent. Supplementation may be made by the Program, but the combined total paid shall not exceed the amount payable under the Program in the absence of other coverage. The Program will not supplement covered services rendered by a participating or contracting practitioner with any private health coverage program where the private plan calls for the practitioner to accept said plan's payment as payment in full. When other health insurance is involved, supplementation claims shall not be filed with the Program unless accompanied by a statement of payment or denial from the other carrier. Attachment of such information will expedite Medicaid claim processing. For exceptions, see (a) 1. of this section.
4. Claims collectible under New Jersey No-Fault Law: No Program payments will be made for services that are payable under the New Jersey Automobile Reparation Reform Act., P.L. 1972, c.70 or the New Jersey Automobile Insurance Freedom of Choice and Cost Containment Act of 1984, P.L. 1983 c.362. This includes claims payable under the Unsatisfied Claim and Judgment Fund where no private automobile insurance policy exists.
5. When a covered person has benefits available to him/her, such as those described in paragraph 1. through 3., or from any other liable third-party, an approved Medicaid provider is authorized to sign an insurance claim form for the Commissioner, based on the third-party assignment of rights, in order to receive direct payment from the insurer. This is done pursuant to N.J.S.A. 30:4D-7.1(c). The following language is to be used by the provider when completing insurance claim forms: "(signature of authorized provider), Assignee for the Commissioner, New Jersey Department of Human Services".
6. When recovery of benefits is sought by the New Jersey Medicaid Program from a liable third-party, the Commissioner authorizes the Director or his designee(s) to sign the recovery demand.

10:49-1.8 PRIOR AND RETROACTIVE AUTHORIZATION (GENERAL)

- (a) Under the Program, payment for certain services will require prior authorization except in an emergency. It is the responsibility of the provider to obtain prior authorization before furnishing or rendering service. Specific instructions are detailed in the appropriate provider manual sections.

1. "Medical emergency" means a critical illness or injury status for which prompt medical care may be crucial to saving life and limb or sparing the patient significant or intractable pain. Services provided for a medical emergency are exempt from prior authorization. Any service classified as a medical emergency, which would have been subject to prior authorization had it not been so classified, must be supported by a practitioner's statement which describes the nature of the emergency, including relevant clinical information, and must state why the emergency services rendered were considered to be immediately necessary. Simply stating an emergency existed is not sufficient.
- (b) Retroactive authorization may be granted under certain circumstances provided that the service is a part of continuing patient care and, on the basis of medical judgment, would have been authorized at the time the service was rendered. Each case is considered on its own merits. Retroactive authorization is to be an exceptional measure granted only under the following unusual circumstances:
1. "Other coverage" (Medicare, Third-Party liability, other insurance, etc.) has denied or made only partial payment of a claim for services or items requiring prior authorization and it would have been unreasonable to expect the provider to have requested authorization prior to rendering the service.
 2. An "administrative emergency" existed because communication between the provider and New Jersey Medicaid Program staff could not be established (for example, during a weekend, holiday or evening) and provision of the service should not have been delayed. This differs from a medical emergency in that the recipient's condition would not be impaired if the service was not provided (see example). In such instances, the request for retroactive authorization including an explanation of the circumstances as well as the medical documentation supporting the services must be submitted to the Medicaid District Office or Central Office, as appropriate, within five calendar days after the service was provided or initiated. If verbal authorization was obtained, confirming written documentation must follow.

Example: A patient is to be transferred from a hospital to a skilled nursing facility on a weekend but an invalid coach is required to move the patient. The invalid coach provider is unable to contact the Medicaid District Office to obtain prior authorization. It is advantageous to the Medicaid Program, the hospital and the patient to transfer on Saturday and not wait until authorization can be obtained on Monday.
 3. In situations not covered by (b) 1 and 2 (above), the New Jersey Medicaid Program follows the doctrine of reasonableness which asks, "Is it reasonable to conclude that the situation presented warrants waiver of procedural rules?"

- (c) Retroactive authorization will not be granted under the following circumstances:
1. Services the provider identified as medically emergent are determined, following the medical review by the Fiscal Agent, to be non-emergent.
 2. Services rendered were found to be medically unnecessary.
 3. The request is for appliances, such as eyeglasses, hearing aids, or other kinds of non-emergency services, when the provider fails to comply with established procedures and later seeks payment through retroactive approval.

10:49-1.9 POLICY ON OUT-OF-STATE MEDICAL CARE AND SERVICES

- (a) Prior authorization is required for all inpatient and outpatient hospital services provided outside the State of New Jersey except in the following situations:
1. Care provided in an emergency.
 2. Transfer from In-State to Out-of-State hospital if the delay results in a significant risk to life or health or unduly prolongs a hospitalization of the recipient.
 3. Care provided to Medicaid recipients residing Out-of-State at the discretion of the New Jersey Department of Human Services.
- (b) Any covered service that requires prior authorization as a prerequisite for reimbursement to New Jersey Medicaid providers also requires prior authorization if it is to be provided in any other state.
1. Services which require prior authorization are described in the specific Medicaid Provider Manual.

10:49-1.10 FISCAL AGENTS AND BUREAU OF CLAIMS AND ACCOUNTS

- a) The Division of Medical Assistance and Health Services, Bureau of Claims and Accounts directly processes and makes payment of claims for services by Long-Term Care Facilities (Skilled Nursing Facilities, Intermediate Care Facilities, Intermediate Care Facilities for the Mentally Retarded and Residential Treatment Facilities) and eligible State and County Governmental Psychiatric Hospitals.
- (b) Contracts have been negotiated on behalf of the State of New Jersey with Blue Cross and Blue Shield of New Jersey, Inc. and The Prudential Insurance Company of America to function as its Fiscal Agents.
- (c) Blue Cross and Blue Shield of New Jersey, Inc. is responsible for the processing and payment of hospital inpatient, hospital

outpatient and hospital-based home health agency claims for those providers who have selected Blue Cross and Blue Shield of New Jersey, Inc. as their Intermediary under Title XVIII (Medicare). In addition, Blue Cross and Blue Shield of New Jersey, Inc. processes pharmaceutical services claims, claims for Out-of-State hospitals and Out-of-State hospital-based home health agencies. Hospitals who have not participated in Title XVIII are assigned to Blue Cross and Blue Shield of New Jersey, Inc.

Telephone Numbers

Hospital Providers Services	-	1-201-456-2534
Recipient Eligibility	-	1-800-242-0861
Pharmacy Inquiry	-	1-800-242-0809

- (d) The Prudential Insurance Company of America handles the processing and payment of hospital inpatient, outpatient and hospital-based home health agency claims for those providers who have selected Prudential as their Intermediary under Title XVIII (Medicare), and all freestanding home health agency claims (In-State and Out-of-State). In addition, The Prudential Insurance Company of America processes claims for all other health services covered by the Program, with the exception of pharmaceutical services, SNFs, ICFs, ICFs/MR, State and some County Governmental Psychiatric Hospitals.

Telephone Numbers

General Inquiry	-	1-800-582-7052
Out-of-State Providers	-	1-609-293-2000

10:49-1.11 MEDICAL REVIEW AND EVALUATION

Under the provisions of Federal and State law, the Division of Medical Assistance and Health Services provides for continuing review and evaluation of the care and services provided under the Program. This includes review of utilization of services of practitioners and other providers.

10:49-1.12 TIMELY SUBMISSION OF CLAIMS AND CLAIM INQUIRIES

- (a) Rules concerning non-institutional provider claims (90-day time limitation) are as follows.
1. This policy applies to all providers except hospitals, special hospitals, home health agencies and long-term care facilities.
 2. All claims for payment of non-institutional goods and services must be received by the Fiscal Agent no later than 90 days after the last date the goods or services were rendered and no later than 12 months from the earliest date of service indicated on the claim form.

(b) Rules covering the New Jersey Medicaid Program certified institutional provider claims are as follows.

1. All claims for services rendered to eligible Medicaid recipients must be received by the Fiscal Agent no later than:
 - i. Twelve months from the day of discharge for inpatient hospital claims; or
 - ii. Twelve months from the earliest date of service on the claim forms for outpatient hospital or home health claims.
2. All claims for services performed in skilled nursing facilities; intermediate care facilities; ICFs/MR; residential treatment facilities, and State and County Governmental Psychiatric Hospitals must be received by the Division of Medical Assistance and Health Services no later than:
 - i. Five months from the last day of the billing month in which services were initially provided; or
 - ii. Six months from the last day of the billing month in which an improperly submitted claim was rejected; but
 - iii. Never later than 11 months from the last day of the billing month in which services were initially provided.

(c) Rules concerning inquiries to the Fiscal Agent are as follows.

1. Submitted claims-no response: Inquiries must be made no later than 180 days after the last date of service entered on the queried claim.
2. Processed claims: Inquiries must be made no later than 180 days after the adjudication date on the Statement of Claims Payment or Denial Letter.

10:49-1.13 PROHIBITION OF PAYMENT TO FACTORS

- (a) Payment for any covered services furnished to a Medicaid eligible recipient by an approved provider may not be made to or through a factor, either directly or by power-of-attorney.
- (b) A "factor" means an individual or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the individual organization for an added fee or deduction of a portion of the accounts receivable.

10:49-1.14 USE OF SERVICE BUREAU AND/OR MANAGEMENT AGENCY

- (a) Payment may be made to a business agent, such as a billing service or an accounting firm, that furnishes statements and receives

payment in the name of the provider if the agent's compensation for this service is:

1. Related to the cost of processing the billing;
 2. Not related on a percentage or other basis to the amount that is billed or collected; and
 3. Not dependent upon the collection of the payment.
- (b) If a participating provider wishes to designate a business agent to perform management, clerical and/or other services related to the claims payment process, prior authorization is required from the New Jersey Medicaid Program.
- (c) In order to obtain prior authorization the provider/agent must submit a copy of the signed agreement and power-of-attorney, if any, between the provider and the agent which contains a detailed statement of the powers and duties of the agent (including the power to sign Medicaid claim forms on behalf of the provider and the compensation arrangement) to:
- Chief, Provider Enrollment
Division of Medical Assistance and Health Services
CN-712
Trenton, New Jersey 08625
- (d) Prior authorization must be obtained for each provider/agent agreement. Authorization/approval of an agent agreement with one provider does not confer an automatic approval of any additional provider/agent agreement.
- (e) Standard Medicaid hard-copy claim forms must be used unless the provider has been authorized to submit claims via an automated data exchange billing system for all instances except where hard-copy claims are required as detailed in the appropriate provider manual.
1. If standard Medicaid claim forms are not utilized, the provider/agent must obtain prior authorization from the New Jersey Medicaid Program.
 2. In order to obtain prior authorization, the provider/agent must submit a printer's prototype of an exact replica of the Medicaid claim form and the programming instructions for completion of the form to the appropriate Fiscal Agent, The Prudential Insurance Company (P.O. Box 1900, Millville, New Jersey 08332) or Blue Cross and Blue Shield of New Jersey, Inc. (33 Washington St., Newark, New Jersey 07102).
 3. The provider/agent must assume the entire cost of printing duplicate forms at all times.

- (f) The New Jersey Medicaid Program, in authorizing/approving any provider/agent agreement, assumes no responsibility for the performance of the provider or agent. In the event that any error of the provider/agent requires special programming to be made by the Medicaid Fiscal Agent in order to have claims paid correctly, the provider/ agent must assume the entire cost of the special programming.

10:49-1.15 FRAUD AND ABUSE

The New Jersey Medicaid Program employs methods to identify situations in which a question of fraud and/or abuse in the Program may exist. The Division refers to law enforcement officials situations in which there is valid reason to suspect that fraud has been practiced.

10:49-1.16 PROVISIONS FOR APPEALS; FAIR HEARINGS

- (a) Pursuant to N.J.A.C. 10:49-5 (Fair Hearings), both providers and Medicaid-eligible persons with the New Jersey Medicaid Program have the right to file for fair hearings.
- (b) A provider may be granted a hearing because of the denial of a prior authorization request or issues involving the provider's status; for example, termination, debarment, suspension, and so forth, as described in Section 1.17, or issues arising out of the claims payment process.
- (c) A Medicaid-eligible person may be granted a hearing because his claim for medical assistance is denied or is not acted upon with reasonable promptness, or because he is aggrieved by any other agency action effecting receipt, termination, reduction or suspension of such assistance.
- (d) In order to obtain a fair hearing, the provider or the eligible person should submit a request in writing to the Director, Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625, outlining the reason for the request.
- (e) Any long-term care facility whose certification or Medicaid Provider Agreement is denied, terminated or not renewed may request a hearing in accordance with the appeals procedure described in N.J.A.C. 10:63-1.15

10:49-1.17 PROGRAM PARTICIPATION

- (a) These regulations are adopted and issued pursuant to Executive Order No. 34 dated March 29, 1976, and the authority vested in the Division of Medical Assistance and Health Services to implement the Medical Assistance Program by rules and regulations set forth in N.J.S.A. 30:4D-5.
- (b) Suspension, debarment, and disqualification are measures which shall be invoked by the Division of Medical Assistance and Health Services to exclude or render ineligible certain persons from participation

in contracts and subcontracts with the Division, or in projects or contracts performed with the assistance of and subject to the approval of the Division, on the basis of a lack of responsibility. These measures shall be used for the purpose of protecting the interests of the Division and not for punishment. To assure the Division the benefits to be derived from the full and free competition between and among such persons and to maximize the opportunity for honest competition and performance, these measures shall not be invoked for any time longer than deemed necessary to protect the interests of the Division.

1. Any individuals, including but not limited to owners, officers, administrators, assistant administrators, employees, accountants, attorneys, and management services who have been suspended, debarred or disqualified from the New Jersey Medicaid Program participation for any reason shall not be involved in any activity relating to the New Jersey Medicaid Program.
2. Providers reimbursed on a cost-related basis may not claim as allowable costs any amounts paid or credited to such individuals, and such amounts shall not be reimbursed by the Medicaid Program.
3. Providers reimbursed on a fee-for-service basis may not submit claims and shall not be reimbursed for any goods supplied or services rendered by such individuals.
4. The above policy will apply only for the period during which such individuals are suspended, debarred or disqualified from Medicaid participation.

(c) Definitions, as used in these regulations, include the following:

1. "Suspension" means an exclusion from State contracting for a temporary period of time, pending the completion of an investigation or legal proceedings.
2. "Debarment" means an exclusion from State contracting, on the basis of a lack of responsibility evidenced by an offense, failure or inadequacy of performance, for a reasonable period of time commensurate with the seriousness of the offense, failure or inadequacy of performance.
3. "Disqualification" means a debarment or a suspension which denies or revokes a qualification to bid or otherwise engage in State contracting which has been granted or applied for pursuant to statute, or rules and regulations.
4. "State" means the State of New Jersey or any of the departments or agencies in the executive branch of government with the lawful authority to engage in contracting.

5. "Person" means any natural person, company, firm, association, corporation or other entity.
 6. "State contracting" means any arrangement giving rise to an obligation to supply anything to or perform any service for the State, other than by virtue of State employment, or to supply anything to or perform any service for a private person where the State provides substantial financial assistance and retains the right to approve or disapprove the nature or quality of the goods or service or the persons who may supply or perform the same.
 7. "Provider" means any person, public or private institution, agency or business concern lawfully providing medical care, services, goods and supplies authorized under the New Jersey Medical Assistance and Health Services Act (P.L. 1968, c.413) as amended, holding, where applicable, a current valid license to provide such services or to dispense such goods or supplies.
 8. "Affiliates" means persons having an overt or covert relationship such that anyone of them directly or indirectly controls or has the power to control another.
 9. "Fiscal Agents" means the Blue Cross and Blue Shield of New Jersey, Inc. and The Prudential Insurance Company of America, or their successors.
 10. "Division" means the Division of Medical Assistance and Health Services.
- (d) Any of the following, among other things, shall constitute a good cause for suspension, debarment, or disqualification of a person engaged in State contracting, as defined herein, by the Division of Medical Assistance and Health Services:
1. Commission of a criminal offense as an incident to obtaining or attempting to obtain a public or private contract, or subcontract thereunder, or in the performance of such contract or subcontract;
 2. Violation of the Federal Organized Crime Control Act of 1970, or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, perjury, false swearing, receiving stolen property, obstruction of justice or any other offense indicating a lack of business integrity or honesty;
 3. Violation of the Federal or State antitrust statutes, or of the Federal Anti-Kickback Act (18 U.S.C. 874, 40 U.S.C. 276b, c);
 4. Violations of any of the laws governing the conduct of elections of the State of New Jersey or of its political subdivisions;

5. Violation of the "Law Against Discrimination" (P.L. 1945, c.169, C.10:5-1 et seq., as supplemented by P.L 1975, c.127), or of the act banning discrimination in public works employment (C.10:2-1 et seq.) or of the "Act prohibiting discrimination by industries engaged in defense work in the employment of persons therein" (C.114, P.L.1942, C.10:1-10 et seq.);
6. Violations of any laws governing hours of labor, minimum wage standards, prevailing wage standards, discrimination in wages, or child labor;
7. Violations of any laws, regulations or code of ethics governing the conduct of occupations or professions or regulated industries;
8. Willful failure to perform in accordance with contract specifications or within contractual time limits;
9. A record of failure to perform or of unsatisfactory performance in accordance with the terms of one or more contracts, provided that such failure or unsatisfactory performance has occurred within a reasonable time preceding the determination to debar and was caused by acts within the control of the person debarred;
10. Violation of contractual or statutory provisions regulating contingent fees;
11. Presentment for allowance or payment of any false or fraudulent claim for services or merchandise;
12. Submitting false information for the purpose of obtaining greater compensation than to which the person is legally entitled;
13. Submitting false information for the purpose of obtaining authorization requirements;
14. Failure to disclose or make available to the Division of Medical Assistance and Health Services or its authorized agent, records of services provided to Medicaid recipients and records of payments made therefore;
15. Failure to provide and maintain quality services to Medicaid recipients within accepted medical community standards as adjudged by a body of peers.
16. Engaging in a course of conduct or performing an act deemed improper or abusive of the New Jersey Medicaid Program following notification that said conduct should cease;
17. Breach of the terms of the Medicaid provider agreement entered into with the Division or failure to comply with the terms of the provider certification on the Medicaid claim form;

18. Overutilizing the New Jersey Medicaid Program by inducing, furnishing or otherwise causing an individual to receive service(s) or merchandise not otherwise required or requested by the recipient;
19. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral;
20. Violating any provision of P.L. 1968, c.413 (New Jersey Medical Assistance and Health Services Act) as amended, or any rule or regulation promulgated by the Commissioner of Human Services agencies pursuant thereto;
21. Conviction of any crime involving moral turpitude;
22. Submission of a false or fraudulent application for provider status to the Division or to its Fiscal Agents;
23. Any other cause affecting responsibility as a State contractor of such serious and compelling nature as may be determined by the Division to warrant debarment, including such conduct as may be proscribed by the laws or contracts enumerated in this subsection, even if such conduct has not been or may not be prosecuted as violations of such laws or contracts;
24. Debarment by some other department or agency in the executive branch;
25. Suspension, debarment, disqualification or exclusion from participation in the Medicaid Program of another state;
26. Suspension or exclusion from participation in the delivery of medical care or services under Title XVIII, XIX or XX of the Federal Social Security Act by the Secretary of the United States Department of Health and Human Services.

(e) Conditions for debarment are:

1. Debarment shall be made only upon approval of the director of the Division, except as otherwise provided by law.
2. The existence of any of the causes set forth in Subsection (d) of this section shall not necessarily require that a person be debarred. In each instance, the decision to debar shall be made within the discretion of the director of the Division unless otherwise required by law, and shall be rendered in the best interests of the Division.
3. All mitigating factors shall be considered in determining the seriousness of the offense, failure or inadequacy of performance and in deciding whether debarment is warranted.
4. The existence of a cause set forth in paragraphs 1 through 7 of Subsection (d) of this section shall be established upon the

rendering of a final judgment or conviction by a court of competent jurisdiction or by an administrative agency empowered to render such judgment. In the event an appeal taken from such judgment or conviction results in reversal thereof, the debarment shall be removed upon the request of the debarred person unless other cause for debarment exists.

5. The existence of a cause set forth in paragraphs 8, 9, 10 and 23 of Subsection (d) of this section shall be established by evidence which the Division or agency determines to be clear and convincing in nature.
 6. The existence of a cause set forth in paragraphs 1 through 7, 11 through 22, and 24 of Subsection (d) of this section shall be established by a preponderance of the believable evidence.
 7. Debarment for the cause set forth in paragraph 24 of Subsection (d) of this section shall be proper, provided that one of the causes set forth in paragraphs 1 through 23 of Subsection (d) was the basis for debarment by the original debarring agency. Such debarment may be based entirely on the record of facts obtained by the original debarring agency, or upon a combination of such facts and additional facts.
- (f) If the Division seeks to debar a person or his affiliates, the Division shall furnish such party with a written notice stating that debarment is being considered, setting forth the reasons for the proposed debarment and indicating that such party will be accorded an opportunity for a hearing if he/she so requests within a stated period of time. All such hearings shall be conducted in accordance with the provisions of the Administrative Procedure Act. However, where one department or agency has imposed debarment upon a party, a second department or agency may also impose a similar debarment without according an opportunity for a hearing, provided that the second agency furnishes notice of the proposed similar debarment to that party and accords that party an opportunity to present information in his behalf to explain why the proposed similar debarment should not be imposed in whole or in part.
- (g) Debarment shall be for a reasonable, definitely stated period of time which as a general rule shall not exceed five years. Debarment for an additional period shall be permitted provided that notice thereof is furnished and the party is accorded an opportunity to present information in his behalf to explain why the additional period of debarment should not be imposed.
- (h) Scope of debarment rules are:
1. Except as otherwise provided by law, a debarment may be removed or the period thereof may be reduced in the discretion of the debarring agency upon the submission of a good faith application under oath, supported by documentary evidence, setting forth substantial and appropriate grounds for the granting of relief, such as newly discovered material evidence,

- reversal of a conviction or judgment, actual change of ownership, management or control, or the elimination of the causes for which the debarment was imposed.
2. A debarment may include all known affiliates of a person, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The offense, failure or inadequacy of performance of an individual may be imputed to a person with whom he is affiliated, where such conduct was accomplished within the course of his official duty or was effected by him with the knowledge or approval of such person.
 3. Debarment, by the director, of any provider of service shall preclude such provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association to the Division of Medical Assistance and Health Services or its Fiscal Agents for any services or supplies he/she has provided under the New Jersey Medicaid Program, except for services or supplies provided prior to the debarment. No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the Division or its Fiscal Agents for any services or supplies provided by a person within such organization who has been debarred by the director, except for services or supplies provided prior to the debarment.
 4. When the provisions of this section are violated by a provider of service which is a clinic, group, corporation or other association, the director may debar such organization and/or any individual person within said organization who is responsible for such violation.
- (i) The Division may suspend a person in the public interest for any cause specified in Subsection (d) of this section, or upon a reasonable suspicion that such cause exists, or when, in the opinion of the director, such action is necessary to protect the public welfare and the interests of the medical assistance program.
- (j) Conditions for suspension are:
1. Suspension shall be imposed only upon approval of the director of the Division and upon approval of the Attorney General, except as otherwise provided by law.
 2. The existence of any cause for suspension shall not require that a suspension be imposed, and a decision to suspend shall be made at the discretion of the director of the Division and of the Attorney General, and shall be rendered in the best interests of the Division.
 3. Suspension shall not be based upon unsupported accusation, but upon adequate evidence that cause exists or upon evidence adequate to create a reasonable suspicion that cause exists.

4. In assessing whether adequate evidence exists, consideration shall be given to the amount of credible evidence which is available, to the existence or absence of corroboration as to important allegations, and to inferences which may properly be drawn from the existence or absence of affirmative facts.
 5. Reasonable suspicion of the existence of a cause described in Subsection (d) of this section may be established by the rendering of a final judgment or conviction by a court or administrative agency of competent jurisdiction, by grand jury indictment, by arrest, or by evidence that such violations of civil or criminal law did in fact occur.
 6. A suspension invoked by the Division for any of the causes described in Subsection (d) of this section may be the basis for the imposition of a concurrent suspension by another agency, which may impose such suspension without the approval of the Attorney General.
- (k) The Division may suspend a person or his affiliates provided that within ten days after the effective date of the suspension, the Division provides such party with a written notice stating that a suspension has been imposed and its effective date, setting forth the reasons for the suspension to the extent that the Attorney General determines that such reasons may be properly disclosed, stating that the suspension is for a temporary period pending the completion of an investigation and such legal proceedings as may ensue, and indicating that, if such legal proceedings are not commenced or the suspension removed within 60 days of the date of such notice, the party will be given either a statement of the reasons for the suspension and an opportunity for a hearing, if he so requests, or a statement declining to give such reasons and setting forth the agency's position regarding the continuation of the suspension. Where a suspension by the Division has been the basis for suspension by another agency, the latter shall note that fact as a reason for its suspension.
- (l) A suspension shall not continue beyond 18 months from its effective date unless civil or criminal action regarding the alleged violation shall have been initiated within that period, or unless debarment action has been commenced. Whenever prosecution or debarment action has been initiated, the suspension may continue until the legal proceedings are completed.
- (m) Scope of suspension rules are:
1. A suspension may include all known affiliates of a person, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The offense, failure or inadequacy of performance of an individual may be imputed to a person with whom he is affiliated, where such conduct was accomplished within the course of his official duty or was effectuated by him with the knowledge or approval of such person.

2. Suspension, by the director, of any provider of service shall preclude such provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association to the Division of Medical Assistance and Health Services or its Fiscal Agents for any services or supplies he/she has provided under the New Jersey Medicaid Program, except for services or supplies provided prior to the suspension. No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the Division or its Fiscal Agents for any services or supplies provided by a person within such organization who has been suspended by the director, except for services or supplies provided prior to the suspension.
3. When the provisions of this section are violated by a provider of service which is a clinic, group, corporation or other association, the director may suspend such organization and/or any individual person within said organization who is responsible for such violation.
 - (n) Exclusion from State contracting by virtue of suspension, debarment or disqualification shall extend to all State contracting and subcontracting within the control or jurisdiction of the Division. However, when it is determined essential to the public interest by the director of the Division, and upon filing of a finding thereof with the Attorney General, an exception from total exclusion may be made with respect to a particular State contract.
 - (o) Insofar as practicable, prior notice shall be given to the Attorney General and the Treasurer of any proposed suspension or debarment.
 - (p) The Division shall provide the State Treasurer with the names of all persons suspended or debarred and the effective date and term thereof, if any.
 - (q) The rules herein shall be applicable to all persons, providers, contractors, Fiscal Agents, and their affiliates who engage in State contracting with the Division as defined herein.

10:49-1.18 CIVIL RIGHTS

Federal regulations require that services provided to covered persons are given without discrimination on the basis of race, color, national origin or handicap. Therefore, payments are limited to providers of service who are in compliance with the nondiscrimination requirements of Title VI of the Civil Rights Act and Section 504 of the Rehabilitation Act of 1973.

10:49-1.19 OBSERVANCE OF RELIGIOUS BELIEF

Nothing in the Program shall be construed to require any person to undergo any medical screening, examination, diagnosis or treatment or to accept any other health care or services provided under the Program for any purpose (other than for the purpose of discovering and preventing the spread of infection or

contagious disease or for the purpose of protecting environmental health) if such person or his parent or guardian objects thereto on religious grounds.

10:49-1.20 FREE CHOICE BY COVERED PERSON AND BY PROVIDER

The concept of freedom of choice applies to both provider and recipient. An eligible person is free to choose providers of service who meet Program standards and who elect to participate. It is understood that when a provider has accepted an individual for care he/she will accept the program's policies and reimbursement for all covered services and/or items which he/she provides or delivers during that period when, by mutual agreement, the recipient is under the provider's care. In the provision of professional services, it is considered automatic that the provider will be bound by the code of ethics governing his profession. The Medicaid District Office will assist covered persons in obtaining services if the eligible person cannot locate a provider.

10:49-1.21 INTEGRITY OF THE MEDICAID PROGRAM

The New Jersey Medicaid Program, in order to continue to maintain the integrity of the Program, strictly prohibits its employees from accepting gifts or gratuities of any kind and of any value from individuals, representative provider organizations or institutions who provide services and are reimbursed through the Program. This includes the prohibition of offers of special employment, consultation fees and all other gratuities by a provider, individual or facility.

10:49-1.22 CONFIDENTIALITY OF RECORDS

- (a) All information concerning applicants and recipients acquired under this Program shall be confidential and shall not be released without the written consent of the individual or his authorized representative. If, because of an emergency situation, time does not permit obtaining consent before release, the Program shall notify the individual, his family or authorized representative immediately after releasing the information. The restriction on the disclosure of information shall not preclude the release of statistical or summary data or information in which applicants or recipients are not, and cannot, be identified; nor shall it preclude the exchange of information between providers furnishing services, Fiscal Agents of the Program and State or local government agencies for purposes directly connected with administration of the Program. Disclosure without the consent of the applicant or recipient shall be limited to purposes directly connected with the administration of the Program in accordance with Federal and State law and regulations.
- (b) The type of information about applicants and recipients that will be safeguarded by the Program includes but is not limited to:
1. Name and address;
 2. Medical services provided;
 3. Social and economic conditions or circumstances;

4. Program evaluations of personal information; and
 5. Medical data, including diagnosis and past history of disease or disability.
- (c) Purposes directly connected with the administration of the Program include but are not limited to:
1. Establishing eligibility;
 2. Determining the amount of medical assistance;
 3. Providing services for recipients; and
 4. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Program.

10:49-1.23 RECORDKEEPING AND PROVIDER CERTIFICATION REQUIREMENT

All Program providers are required to certify that the services billed on any claim were personally rendered by or under their direct personal supervision (as defined by Program regulations); that the furnished information is true, accurate and complete; and the provider agrees to keep such records as are necessary to disclose fully the extent of services provided, and to furnish information for such services as the Program may request, and agrees that where such records do not document the extent of services billed, payment adjustments will be necessary and that the services billed on any claim and the amount charged therefore are in accordance with the regulations of the New Jersey Medicaid Program; and that no part of the net amount payable under any 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. The provider also certifies that the services have been furnished in full compliance with the nondiscrimination requirements of Title VI of the Federal Civil Rights Act and Section 504 of the Rehabilitation Act of 1973, and it is understood that fraud, nondisclosure or concealment of records will be punishable under applicable Federal or State law, or both.

10:49-1.24 INDIVIDUAL MEDICAID PRACTITIONER NUMBER (IMP)

Each Medicaid participating practitioner (i.e. physician, dentist, podiatrist, optometrist, psychologist, or chiropractor) is assigned an IMP Number. The IMP Number is a unique nine (9) position practitioner identifier which is required on all Medicaid claim forms as a condition of payment.

Each practitioner should routinely supply his/her IMP Number to other providers when referring a Medicaid patient for services.

Providers who need an IMP Number for billing purposes should contact the practitioner to determine if an IMP Number has been assigned to the practitioner. (Note that a practitioner who does not participate in the Medicaid Program will not have an IMP Number). If after contacting the practitioner there is still uncertainty about the IMP Number, providers

calling from New Jersey may call 1-800-582-7052 toll free for assistance. If calling from outside New Jersey call 1-609-293-2000.

10:49-1.25 RESERVED

10:49-1.26 PATIENT CERTIFICATION

- (a) A patient certification, authorization to release information and payment request, must, under ordinary circumstances, be signed before a claim for payment from a provider is processed for payment. The patient is certifying that:
1. The service(s) covered by a claim has been received;
 2. Requesting payment for those services made on his/her behalf; and
 3. Authorizing any holder of medical or other information to release to the Division of Medical Assistance and Health Services or its authorized agents any information needed for this or a related claim.
- (b) A provider who is submitting a hard-copy Medicaid claim form must, under ordinary circumstances, obtain the patient certification on the Medicaid hard-copy claim form (appropriate to the provider) unless given prior authorization by the Division of Medical Assistance and Health Services to use a standard Medicaid Patient Certification Form.
- (c) A provider who is submitting claims via an approved automated data exchange system may obtain the patient certification on a standard Medicaid Patient Certification Form which is kept on file for each service rendered and available upon request to representatives of the New Jersey Medicaid Program.
1. If a signed Medicaid Patient Certification Form is not on file for each service, Medicaid reimbursement for the service is subject to recoupment.
- (d) A Medicaid hard-copy claim form or a Medicaid Patient Certification Form must be fully completed by a provider before it is presented to the patient for signature. A Medicaid patient may not sign a blank Medicaid hard-copy claim form or a Medicaid Patient Certification Form prior to receiving services or as a condition for receiving services.
- (e) When the patient's signature is unobtainable, the following procedures may be used:
1. An illiterate patient may sign mark (x), and the signature must be witnessed by another person who signs his/her name and address on the Medicaid Patient Certification Form or on the Medicaid hard-copy claim form.

2. If a patient is physically or mentally incapable of signing, or is now deceased, the forms may be signed on his behalf by:
 - i. A parent, or
 - ii. A legal guardian, or
 - iii. A relation, or
 - iv. A friend, or
 - v. An individual provider, or
 - vi. A representative of an institution providing care or support, or
 - vii. A representative of a governmental agency providing assistance.
3. A brief explanation of the reason the patient was not personally able to sign and the relationship of the signee to the patient must be noted directly on the Medicaid hard-copy claim form or the Medicaid Patient Certification Form.

10:49-1.27 AUDITS

(a) Field Audits shall be subject to the following:

1. "Completion of the field audit" for long-term care facility providers for purposes of N.J.S.A. 30:4D-17(f) shall be defined in the following manner:
 - i. For all such audits and audit recovery cases pending on the effective date of this subsection it shall mean the date that field work is completed, or the date information requested from the provider during the course of that field work is received, whichever is later;
 - ii. For all such audits and audit recovery cases pending on March 1, 1983, which are, have been or will be referred either to the Legal Action Committee, or to Division of Criminal Justice or other agency for criminal investigation, it shall mean the date the Office of Program Integrity Administration (OPIA) receives authorization to take administrative action.
 - iii. For all such audits initiated on or after the effective date of this subsection it shall mean the date the exit conference is completed or the date information requested from the provider during the course of the exit conference is received, whichever is later.

2. "Completion of the field audit" for all other providers for purposes of N.J.S.A. 30:4D-17(f) shall be defined in the following manner:
 - i. For all such audits and audit recovery cases pending on the effective date of this subsection, it shall mean the date of final screening of the case file by the Assistant Director, Office of Program Integrity Administration (OPIA) or, if the case is referred to the Legal Action Committee or the Division of Criminal Justice, the date OPIA receives authorization to take administrative action;
 - ii. For all such audits initiated on or after the effective date of this subsection it shall mean the date of final screening of the case file by the Assistant Director, OPIA.
3. Notwithstanding any of the previous subsections, if after the screening of any provider audit initiated on or after the effective date of this regulation the Assistant Director, OPIA, determines with reasonable justification that an act or omission on the part of the provider requires additional field work, the field audit shall be considered completed when the additional field work is completed.
4. Notwithstanding any of the previous subsections, if after the screening of any provider audit initiated on or after the effective date of this subsection the Assistant Director, OPIA, determines with reasonable justification that an act or omission on the part of the provider requires that additional information or documentation be obtained from the provider, then a completed field audit shall be considered reopened and interest shall again accrue for the period beginning 20 days from the date the request for such information or documentation is received by the provider and ending on the date that all of the requested information or documentation is received by the agency making the request.
5. Notwithstanding any of the previous subsections, if all or part of any provider audit initiated on or after the effective date of this subsection is referred to the Division of Criminal Justice or other agency for criminal investigation:
 - i. In the event no criminal action results from the referral the field audit shall be considered completed one year from the date the decision was made to refer the matter for criminal investigation;
 - ii. In the event criminal action does result from the referral, the field audit shall be considered completed on the date OPIA receives authorization to take administrative action.

- (b) "Final audit" for purposes of N.J.S.A. 30:4D-7(m) only, means that point in the audit process when the Division issues to the provider an audit report specifically designated as the "final audit" for a specified period audited.

STUB NO 02030207

DEPARTMENT OF HUMAN SERVICES
MEDICAID-ID

VALID ONLY FOR THE MONTH OF
MEDICAID HSP #

NOTICE TO PROVIDER

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

VOID

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.

KI-81319

FD-152

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES
MEDICAID ELIGIBILITY IDENTIFICATION

NOTICE

CARRY THIS CARD AT ALL TIMES

Present it to the pharmacy, hospital, physician or other providers for medical services rendered in behalf of eligible persons.

Federal law makes it a crime and sets punishment for persons who have been found guilty of making any false statement or representation of a material fact to receive any benefit or payment under the medical assistance program. This Department is required to make you aware of this law and to warn you against making any false statement in an application or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended.

NON-TRANSFERABLE UNDER PENALTY OF LAW

AVISO

VOID
RECIPIENT'S SIGNATURE REQUIRED

No es válida si no está firmada. Entréguela a la farmacia, hospital, médico u otros proveedores de servicios médicos prestados a personas que reúnen las condiciones necesarias para poder usar Medicaid.

De acuerdo con la ley federal es un delito hacer una declaración falsa a fin de recibir un beneficio o pago bajo el programa de asistencia médica, y dicha ley fija pena a las personas que la infrinjan. Este Departamento le tiene que informar de dicha ley y le tiene que advertir que no haga ninguna falsa declaración en una solicitud para determinar su derecho a un beneficio, o para convertir el beneficio al uso de otra persona que no sea la destinada a recibir el mismo.

INTRANSFERIBLE BAJO PENA DE LA LEY

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

MEDICAID ELIGIBILITY IDENTIFICATION CARD 0955408



ADDITIONAL HEALTH INSURANCE

New Jersey Blue Cross
Policy No 0513011002
Medicare Part A & B
HIC No 144126300A

HSP (MEDICAID) CASE NO. PERSON NO

0310011937 01
VALID FROM 03-01-86 TO 03-31-86

144-12-6300

SOC SEC ACCT. NO. DATE OF BIRTH

Mary Smith
123 Wood Lane
Someplace, New Jersey 08060

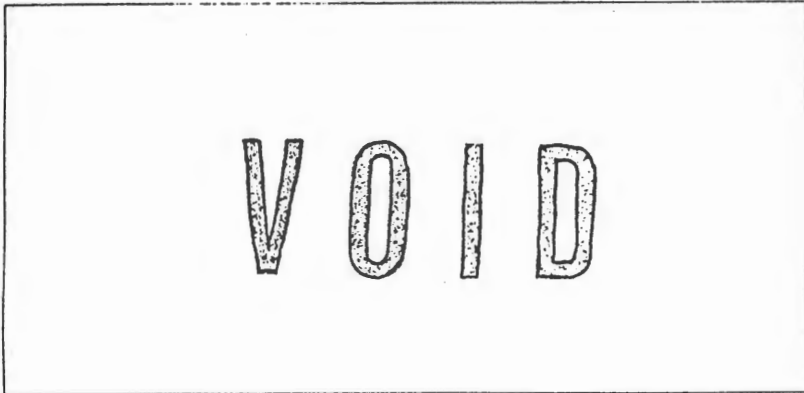
+

USE THIS CARD WHEN YOU NEED MEDICAL SERVICES

Mary Smith

RECIPIENT'S SIGNATURE

FD - 731178 (REV. 10/83)



IMPORTANT NOTICE

You must sign the front of this card on the line above the Recipient's Signature. If you are unable to sign the card, the individual representing you must sign your name, initial the card and explain his/her relationship to you.

Immediately notify the Medicaid District Office or the Division of Youth and Family Services case manager or the County Welfare Agency (as appropriate):

- 1. if you have Medicare coverage or other health insurance not listed or incorrectly listed, or
- 2. if any changes are necessary to the front of this card, or
- 3. if you have any questions regarding the use of this card, or
- 4. if this card is lost or stolen. (Unless the report of the loss or theft can be documented at the appropriate agency, you may be liable to repay Medicaid for any benefits obtained through its unauthorized use.)

FEDERAL and STATE LAW make it a crime and set the punishment for persons who have been found guilty of making any false statement or representation of a material fact to receive any benefit or payment under the Medicaid Program. The Department of Human Services is required to make you aware of this law and to warn you against making any false statement in an application or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended.

THIS CARD IS NON-TRANSFERABLE UNDER PENALTY OF LAW.
NOTICE TO PROVIDERS

The printed name which appears directly above the line for Recipient's Signature on this card is the MEDICAID eligible person. This name identifies that person ONLY (except AFDC can include spouse/children listed with PERSON NUMBERS) as being eligible for MEDICAID benefits within the time period shown. If the name of a "REPRESENTATIVE PAYEE" appears on this card, that individual is not eligible for Medicaid benefits.

* Ask the cardholder if there is Medicare coverage or other health insurance not listed. Please indicate this information in the appropriate area on the claim form. You are to bill MEDICAID only AFTER receiving denial or partial payment from the other insurance company.

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

MEDICAID ELIGIBILITY IDENTIFICATION CARD 0955408

VOID

MEDICALLY NEEDY ELIGIBLE
CHECK PROVIDER MANUAL
FOR AUTHORIZED SERVICES

ADDITIONAL HEALTH INSURANCE *
Blue Cross/Blue Shield
1912072146

HSP (MEDICAID) CASE NO. PERSON NO

0735001234

VALID FROM 03-01-86 TO 03-31-86

No Medicare Coverage

ELIGIBLE PERSONS

SMITH MARY
SMITH JOE
SMITH SUE
SMITH JOHN

PN Service Code

01 A
20 B
21 B
22 B

MEDICALLY NEEDY

SOC SEC. ACCT. NO. DATE OF BIRTH

MARY SMITH
7 MAIN STREET
ANYWHERE, NEW JERSEY 07124

+

USE THIS CARD WHEN YOU NEED MEDICAL SERVICES

MARY SMITH

RECIPIENT'S SIGNATURE

FD-73178 (REV. 10/83)

VOID

IMPORTANT NOTICE

You must sign the front of this card on the line above the Recipient's Signature. If you are unable to sign the card the individual representing you must sign your name in initial the card and explain his/her relationship to you.

Immediately notify the Medicaid District Office or the Division of Youth and Family Services case manager or the County Welfare Agency (as appropriate):

- 1. if you have Medicare coverage or other health insurance not listed or incorrectly listed, or
- 2. if any changes are necessary to the front of this card, or
- 3. if you have any questions regarding the use of this card, or
- 4. if this card is lost or stolen. (Unless the report of the loss or theft can be documented at the appropriate agency, you may be liable to repay Medicaid for any benefits obtained through its unauthorized use.)

FEDERAL and STATE LAW make it a crime and set the punishment for persons who have been found guilty of making any false statement or representation of a material fact to receive any benefit or payment under the Medicaid Program. The Department of Human Services is required to make you aware of this law and to warn you against making any false statement in an application or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended.

THIS CARD IS NON-TRANSFERABLE UNDER PENALTY OF LAW
NOTICE TO PROVIDERS

The printed name which appears directly above the line for Recipient's Signature on this card is the MEDICAID eligible person. This name identifies that person ONLY (except AFDC can include spouse/children) listed with PERSON NUMBERS) as being eligible for MEDICAID benefits within the time period shown. If the name of a "REPRESENTATIVE PAYEE" appears on this card, that individual is not eligible for Medicaid benefits.

* Ask the cardholder if there is Medicare coverage or other health insurance not listed. Please indicate this information in the appropriate area on the claim form. You are to bill MEDICAID only AFTER receiving denial or partial payment from the other insurance company.

Child's No.

Name

Case No.

VOID

VALID ONLY FOR MONTH OF

PLACEMENT REFERENCE

STATE OF NEW JERSEY
DIVISION OF YOUTH AND FAMILY SERVICES

VALIDATION
FOR HEALTH SERVICES PROGRAM

DYFS 16-26
(rev. 3/73)

NOTICE TO CLIENT

THIS VALIDATION FORM INDICATES ELIGIBILITY FOR AUTHORIZED HEALTH SERVICES PROVIDED UNDER THE NEW JERSEY HEALTH SERVICES PROGRAM.

THIS VALIDATION MUST BE PRESENTED TO THE PROVIDER OF MEDICAL SERVICES ALONG WITH THE PLASTIC IDENTIFICATION CARD.

NOTICE TO PROVIDER OF MEDICAL SERVICES

THE CASE NUMBER AND NAME ON THIS FORM MUST BE COMPARED TO THAT SHOWN ON THE PLASTIC IDENTIFICATION CARD ISSUED TO THE BEARER.

THE CLAIM FOR PAYMENT OF HEALTH SERVICES IS TO BE SUBMITTED TO THE APPROPRIATE CONTRACTOR FOR THE STATE OF NEW JERSEY ON THE REQUIRED VENDOR CLAIM FORM.

PLEASE REPORT THE CASE NAME, CASE NUMBER AND PERSON NUMBER **ACCURATELY** ON ALL CLAIM FORMS AND OTHER COMMUNICATIONS RELATING TO THE CLAIM.



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

VALIDATION OF ELIGIBILITY

Last Name	First Name	Mi	Health Services Program Case No.	Person Number
-----------	------------	----	-------------------------------------	---------------

NOTICE TO PROVIDERS

This form identifies the person listed above as eligible for authorized services under the New Jersey Health Services Program (Medicaid).

This form also serves as a validation of eligibility for up to 31 days from date of issue. All policies and procedures specified in the appropriate New Jersey Health Services Program Provider Manual are to be followed by providers when rendering services to this person.

The signature, title and telephone number of an authorized representative of the State Institution listed below must be included to validate this form.

THIS FORM IS THE PROPERTY OF THE STATE OF NEW JERSEY AND MUST BE RETURNED WITH THE PATIENT.

VOID

FD-34 (rev. 5/83)

Signature and Title of State
Institution Representative

Date of
Issue

Name of State Institution

Telephone No.



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.

VOID

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.



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

NEW JERSEY HEALTH SERVICES PROGRAM
TITLE XIX (MEDICAID)

PROVIDER AGREEMENT
BETWEEN
NEW JERSEY DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
AND

PROVIDER

VOID

PROVIDER AGREES:

1. To comply with all applicable State and Federal Medicaid laws and policy, and rules and regulations promulgated pursuant thereto;
2. To keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the Medicaid Program;
3. To furnish the Division of Medical Assistance and Health Services, the Secretary of Health and Human Services and the State Medicaid Investigation Unit with such information as may be requested from time to time, regarding any payments claimed for providing services under the Medicaid Program;
4. To comply with the requirements of Title VI of the Civil Rights Act 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.)

The provider may, on thirty days written notice to the Division, terminate this Agreement.

Date

Signature of Provider

Title



State of New Jersey
 Department of Human Services
 Division of Medical Assistance and Health Services

10:49-EXHIBIT 8

MEDICALLY NEEDEY CLAIM TRANSMITTAL

RECIPIENT INFORMATION

HSP (Medicaid) CASE NO. _____

NAME _____

ADDRESS _____

PROVIDER INFORMATION

PROVIDER NO. _____

PROVIDER NAME _____

PROVIDER ADDRESS _____

VOID

TYPE OF SERVICE	DATE OF SERVICE	CHARGE	PAYMENT FROM OTHER SOURCE	CLIENT OBLIGATION	TOTAL FROM OTHER SOURCES
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

Provider Instructions and Information:

- The services listed above were provided to the identified individual during a covered retroactive period.
- This transmittal does not guarantee payment. Your claim will be processed in accordance with current Medicaid and Medically Needy regulations.
- Each claim form submitted for payment for services listed above must be attached to this document.
- Please enter your provider number in the appropriate space in the upper right corner.
- Any amount listed in the column entitled "Client Obligation" is the responsibility of the client and should be paid by the client directly to you.

NUMBER OF ITEMS _____

SIGNATURE _____
 Authorized Representative



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

APPENDIX A

COMMUNITY CARE PROGRAM FOR THE ELDERLY AND DISABLED (CCPED) (This information was originally published in the Newsletters P-371, December 5, 1983 or BC-266, November 28, 1983; P-392 or BC-281, June 11, 1984; P-405 or BC-293, October 1, 1984; P-452 or BC-315, August 19, 1985).

Effective November 1983, the New Jersey Medicaid Program announced the beginning of a new program, the Community Care Program for the Elderly and Disabled (CCPED). The purpose of this program is to help eligible individuals to remain living in the community rather than in an institutionalized setting.

The CCPED serves all twenty-one counties and offers services to a limited enrollment of eligible persons. The program offers seven Medicaid services: Home Health Services, Medical Day Care, Medical Transportation (non-emergency), Homemaker Services, Respite Care, Social Adult Day Care and Case Management. Prior authorization from the Medicaid District Office is required of all Community Care Services except Case Management.

The Division of Medical Assistance and Health Services administers the overall program. It has the responsibility for the assessment of the Need for Skilled Nursing Facility (SNF) and Intermediate Care Facility (ICF) care and for determining which individual will be served by the program.

Recipients eligible for the Community Care Program must be:

- (1) Age 65 or over or determined disabled under the Social Security Act and receiving Social Security disability payments and eligible for Medicare benefits;
- (2) Assessed as in need of SNF/ICF care;
- (3) Receiving an income which exceeds the current SSI community standard up to the institutional cap and with assets within the institutional eligibility standard.

All recipients are required to share in the cost of the service package when the recipient's income exceeds maintenance needs as defined by program regulation, including costs of medical and remedial expenses not subject to payment by a third party. Cost sharing monies are centrally collected by the Division of Medical Assistance and Health Services.

Any questions regarding this appendix should be directed to the Office of Home Care Programs, Division of Medical Assistance and Health Services.

An Exhibit of the Medicaid Eligibility Identification Card (FD-73/178) of an enrolled CCPED recipient is reflected on the reverse side. Providers are to ask to see the card before providing services under the CCPED.

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

MEDICAID ELIGIBILITY IDENTIFICATION CARD 0955408

VOID

VALID ONLY FOR THESE PRIOR
AUTHORIZED COMM. CARE WAIVER
SERVICES: HOME HEALTH, CASE MGT,
HOMEMAKER, RESPITE, NON-EMERG. MED.
TRANS. AND MED/SOCIAL DAY CARE

ADDITIONAL HEALTH INSURANCE
NEW JERSEY BLUE CROSS
POLICY NO 0513011220
MEDICARE PART A & B
HIC NO 155125300A

HSP (MEDICAID) CASE NO PERSON NO
0310022937 01

VALID FROM 03-01-86 TO 03-31-86

155-12-5300 01/02
SOC. SEC. ACCT. NO. DATE OF BIRTH

Mary Jones
234 Bonnie Lane
Mt. Blue, New Jersey 01234

+

USE THIS CARD WHEN YOU NEED MEDICAL SERVICES
Mary Jones

RECIPIENT'S SIGNATURE

FD-73178 (REV. 10/83)

VOID

IMPORTANT NOTICE

You must sign the front of this card on the line above the Recipient's Signature. If you are unable to sign the card, the individual representing you must sign your name, initial the card and explain his/her relationship to you.

Immediately notify the Medicaid District Office or the Division of Youth and Family Services case manager or the County Welfare Agency (as appropriate):

- 1. if you have Medicare coverage or other health insurance not listed or incorrectly listed; or
- 2. if any changes are necessary to the front of this card; or
- 3. if you have any questions regarding the use of this card; or
- 4. if this card is lost or stolen. (Unless the report of the loss or theft can be documented at the appropriate agency, you may be liable to repay Medicaid for any benefits obtained through its unauthorized use.)

FEDERAL and STATE LAW make it a crime and set the punishment for persons who have been found guilty of making any false statement or representation of a material fact to receive any benefit or payment under the Medicaid Program. The Department of Human Services is required to make you aware of this law and to warn you against making any false statement in an application or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended.

THIS CARD IS NON-TRANSFERABLE UNDER PENALTY OF LAW. NOTICE TO PROVIDERS

The printed name which appears directly above the line for Recipient's Signature on this card is the MEDICAID eligible person. This name identifies that person ONLY (except AFDC can include spouse/child/ren listed with PERSON NUMBERS) as being eligible for MEDICAID benefits within the time period shown. If the name of a "REPRESENTATIVE PAYEE" appears on this card, that individual is not eligible for Medicaid benefits.

* Ask the cardholder if there is Medicare coverage or other health insurance not listed. Please indicate this information in the appropriate area on the claim form. You are to bill MEDICAID only AFTER receiving denial or partial payment from the other insurance company.



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

APPENDIX B

MEDICAID PERSONAL PHYSICIAN PLAN (MP PLAN) (This information was originally published in the Newsletters P-362 or BC-260, July 15, 1983; P-395 or BC-285, July 16, 1984; P-401 or BC-286, August 1, 1984; P-423 or BC-312, June 17, 1985.)

INTRODUCTION

The New Jersey Medicaid Program has implemented a four-year Statewide Competition Demonstration Project, called the Medicaid Personal Physician Plan (MP Plan), which provides medical care in a manner different from the present Medicaid system. The Plan is classified as a Primary Care Network or a health care delivery system whereby all of the Medicaid eligible's health care is obtained through, but not necessarily from, a single primary care provider. It was developed under guidelines established by the Health Care Financing Administration for funding which led to the inclusion of the following key elements:

1. a primary care physician who would be responsible for the provision of all primary care delivery, referral, and ancillary services for non-institutional Medicaid eligibles;
2. a capitation system of reimbursement, instead of fee-for-service, for a physician participating in the Plan as a Physician Case Manager (PCM);
3. a broker concept for marketing, enrollment, grievance system and quality assurance monitoring and Plan reporting functions;
4. the stimulation of competition among certain types of Medicaid providers by providing strengthened alternatives to primary care in the hospital Emergency Room (ER) and Outpatient Department setting (OPD).

The role of Physician Case Manager has potential to (1) discourage doctor shopping, self-referral, and inappropriate and excessive utilization of Medicaid eligible services and (2) to effect better control over almost 500 million dollars of New Jersey Medicaid's total expenditures annually without reducing quality or scope of care provided. This concept of the Physician Case Manager controlling costs has received wide support throughout the country since this role negates the need for increased government regulation and harsh budget caps.

The MP Plan will be phased in throughout the State by June 30, 1988. Participating providers are in solo practice; group practice; professional corporation or association; health maintenance organization (HMO); independent, free-standing clinic; or in a hospital affiliated entity which allows for primary care services and is not subject to DRG reimbursement principles .

PURPOSE

This report informs Medicaid providers (1) about the MP Plan, (2) about the provider's role when a Physician Case Manager refers his/her patients for services or when a MP Plan member requests a service independently, and (3) to inform providers about the procedure which must be followed when submitting claims.

The role of Medicaid eligibles as MP Plan members, of physicians as Case Managers, and of the Fiscal Agents (Blue Cross and Prudential) as claims payor is outlined in this report under the section "Background". The procedures all providers must follow when submitting claims for services rendered MP Plan members are outlined under the section "Action".

BACKGROUND

The participation of physicians and Medicaid eligibles in the Demonstration Project is voluntary. A physician may participate in the MP Plan and continue to participate in the current Medicaid Program under the usual conditions.

1. Role of Medicaid Eligible:

A Medicaid eligible who enrolls in the Plan selects a Physician Case Manager, for a minimum of six months, from a list provided by the representative. Each Medicaid eligible will have his/her own PCM, including those instances where the case manager is a member of a group practice, a Health Maintenance Organization, or similar type organization. A Medicaid eligible family may enroll in the MP Plan only if all the Medicaid eligible family members join. It is not necessary, however, for each family member to choose the same PCM.

The Plan member allows his/her PCM to coordinate all medical care and agrees to seek care only from that chosen PCM except for specifically excluded services (such as dental) or in situations where a delay would cause lasting damage to the patient's health or loss of life.

2. Role of Physician Case Manager:

The PCM is responsible for the provision of all primary care to Plan members and for management of all referral services. The PCM must review and approve all medical services and expenditures on behalf of the patient (including referrals for ancillary services, specialty care, and hospitalization) and provide or arrange for the provision of twenty-four hours, 7 days a week medical coverage. A PCM is reimbursed on a capitation basis for his/her services and for managing the care provided to his/her patients. When the PCM refers a patient to a specialist, or writes a prescription to be filled at a pharmacy, or refers the patient to an independent laboratory, the costs of these referral services will be deducted from the PCM's Capitation Accounting Fund at the existing fee-for-service schedule. Thus, the PCM must be able to exercise judgment and control over services rendered to his/her patients. This is accomplished by the

requirement that services must be authorized by the PCM before they are provided.

3. Role of Fiscal Agents:

The State will continue to pay all Medicaid providers directly through its existing claims processing system for authorized services rendered MP Plan members. The Fiscal Agents have a system for tracking claims submitted for these services. Providers will continue to submit claims for payment to the appropriate Fiscal Agent. Each claim is matched against the Medicaid eligibility MP Plan file to determine (1) whether the Medicaid recipient is a MP Plan member, (2) whether the recipient was enrolled as such when the service was provided, and (3) whether the service was authorized by the PCM. If these conditions are met, the claim will be processed.

ACTION REQUIRED

All Medicaid providers are directly affected by the MP Plan if they provide services to MP Plan members. Specific procedures must be followed in order to receive reimbursement for these services.

PLEASE NOTE: WITH EXCEPTION OF SECOND OPINION, EXISTING NEW JERSEY MEDICAID PROGRAM REGULATIONS REMAIN IN EFFECT; FOR EXAMPLE, IF A SERVICE REQUIRES AUTHORIZATION FROM THE MEDICAID DISTRICT OFFICE (MDO) OR THE DIVISION'S CENTRAL OFFICE, THIS REQUIREMENT STILL APPLIES AS WELL AS THE REQUIREMENT THAT ALL SERVICES FOR MP PLAN MEMBERS BE APPROVED BY THE PCM BEFOREHAND.

1. ACTION REQUIRED BY PHYSICIAN CASE MANAGER:

a. SUBMIT 1500 N.J. FORM

The Physician Case Manager must submit a Health Insurance Claim Form (1500 N.J.) for each encounter with a patient who is included in his/her panel of MP Plan members. The form is required for encounter data, not for billing purposes. Information on the claim must include:

- (1) The same information which is required for the fee-for-service process, i.e., description of procedure, HCPCS code, etc.;
- (2) HCPCS Code Z4000 for office dispensed drugs; include name of drug in Item No.24D.

When a PCM participates in the MP Plan as a member of a group, the PCM's name and IMP number must be included in Item #30 (Provider Social Security, I.D. No.) on the 1500 N.J. form for services rendered the MP Plan member by the PCM, as well as the group's provider number in Item #31. In situations where an MP Plan patient is referred to other members of the group, the New Jersey Medicaid

Program will not reimburse on a fee-for-service basis for these services.

A Physician Case Manager receives detailed instruction from his/her MP Plan representative about all aspects of the MP Plan and responsibilities as a PCM.

2. ACTION REQUIRED BY ALL PROVIDERS EXCEPT PCM's:

This section details the following four procedures which must be followed when providing services and requesting payment for services rendered MP Plan members:

- a. Check eligibility validation card for MP Plan message;
- b. Ask to see MP Plan Card (contains name of PCM);
- c. Receive authorization to provide service from PCM;
- d. Include PCM's name and IMP number on claim form even if there is Medicare or other insurance involvement.

3. CHECK ELIGIBILITY VALIDATION CARD FOR MP PLAN MESSAGE

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.

4. ASK TO SEE MP PLAN CARD

If the Eligibility Card carries the message "Valid Only With MP Plan Card", you must ask to see the MP Plan Card. Both cards are illustrated on the next page. You will note that the member's name, physician's (case manager) name and telephone number, and MP Plan's telephone number are listed.

VALID ONLY WITH MP PLAN CARD

STUB NO. 04189251

DEPARTMENT OF HUMAN SERVICES
MEDICAID-1)

VALID ONLY FOR THE MONTH OF
MEDICAID HSP #

NOTICE TO PROVIDER

ELIGIBLE PERSONS	PERSON #	ELIGIBLE PERSONS	PERSON #
	11	VOID	
	12		
	13		
	14		
	15		
	16		
	17		
	18		
	19		
	20		

LAST PERSON PRINTED

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

ATTENTION PROVIDERS

This card is non-transferable and is not proof of eligibility. The Medicaid Eligibility Identification Card is the member's proof of eligibility and must be presented with this card each time medical services are needed. The member agrees to abide by the rules, regulations and procedures of the Medicaid Personal Physician Plan. Unlawful use of this card is punishable by law. This card entitles the cardholder to coverage for services arranged for or approved by the Plan physician EXCEPT DENTAL SERVICES. Emergency Room services will be covered if authorized by the physician identified on the card.

EXCEPTION: Life threatening situations DO NOT require authorization.

RECIPIENT REMINDER

To arrange for unscheduled care or to receive a consultation regarding any medical problem, contact your physician for instructions. A physician is available hours a day, 7 days a week. Any questions should be directed to your MP Plan office (listed on the back of this card).

MP PLAN MEMBER IDENTIFICATION CARD



NEW JERSEY DEPARTMENT OF HUMAN SERVICES

MP-1 (7/85)

New Jersey Medicaid
Personal Physician Plan

MP Plan
Toll Free Number
1-800-792-9745

The MP Plan
EXEMPTS
you from any
COPAYMENT

MEMBER'S NAME

PHYSICIAN'S NAME

TEL. NO.

VOID			

5. RECEIVE AUTHORIZATION TO PROVIDE SERVICE FROM PHYSICIAN CASE MANAGER

Providers, with the exception of dentists, must have approval from the Physician Case Manager before providing any of the following services:

a. The following services require authorization from the Physician Case Manager:

- (1) physician services, including inpatient physician services;
- (2) certified nurse midwife services;
- (3) chiropractor services;
- (4) optometrist services;
- (5) podiatrist services;
- (6) psychologist services;
- (7) hospital services, including:
 - i. emergency room service (Note: true life or organ threatening conditions may be treated, with notification to the PCM as soon as possible);
 - ii. inpatient hospitalization; and
 - iii. outpatient clinic.
- (8) clinic services at free-standing clinics;
- (9) drugs (prescription);
- (10) home health services;
- (11) laboratory and radiology services;
- (12) long-term-care services;
- (13) medical day care;
- (14) medical equipment (durable);
- (15) hearing aids;
- (16) medical supplies;
- (17) optical appliances; and
- (18) prosthetics and orthotics.

b. The following service does not require authorization from the PCM:

dental services;

DENTIST PLEASE NOTE: A dentist who prescribes a drug for a MP Plan member must communicate this information to the PCM. The dentist must also write the PCM's name and IMP number on the prescription form as the pharmacist will need this information in order to submit a claim for payment.

c. Two referral forms have been prepared for the PCM to use when requesting services. One referral form is for services and treatment and the second is for consultations. These two forms are listed below and a copy of each is attached to this report:

- (1) Form MP-6, 4/83, - MEDICAID PERSONAL PHYSICIAN PLAN (MP PLAN) ANCILLARY/TREATMENT SERVICES REFERRAL; and

(2) Form MP-7, 9/83, - MEDICAID PERSONAL PHYSICIAN PLAN (MP PLAN) - REFERRAL SERVICES FORM.

The PCM will use these forms to indicate the service(s) requested. The PCM's IMP number is indicated for the provider's convenience. If a MP Plan member requests a service and does not have a signed referral form, the provider must contact the PCM for authorization before rendering the service.

6. INCLUDE PCM'S NAME AND IMP NUMBER ON CLAIM FORM

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

Irrespective of the mode of claim submission (hard copy or electronic medium) all claims must include the PCM's name and IMP number. A claim submitted for a service which required authorization from the PCM will be rejected for payment if it does not include the PCM's name and IMP number.

You must enter the PCM's name and IMP number in the designated space on the appropriate claim form as follows:

a. HEALTH INSURANCE CLAIM FORM (1500 N.J.):

Item 19. (Name of referring physician...):
Enter PCM's Name

Item 19a. (I.D. Number): Enter PCM's IMP number

b. HOME HEALTH CLAIM (Mc-3):

Item 20A. (Physician Case Manager Name): Enter
PCM's name (Individual Medicaid
Practitioner Number): Enter PCM's IMP
number

c. HOSPITAL CLAIM FORMS (UB-82 HCFA-1450)(1) Inpatient Hospital Claim (UB-82 HCFA-1450)

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.

PLEASE NOTE: For inpatient hospital billing, the Physician Case Manager will always be entered as the Attending Physician. If the Attending Physician's name is different from the Physician Case Manager's name, enter that information in the "Remarks" section of form as follows:

Attending Physician: Name _____ IMP _____

(2) Outpatient Hospital Claim (UB-82 HCFA-1450)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.

PLEASE NOTE: If the referring physician's name is different from the Physician Case Manager's name, enter that information in

the "Remarks" section of the form as follows:

Referring Physician: (Name) IMP Number

(3) EXCEPTION PAYMENT REQUEST FORM (MP-16)

These are instances in which a hospital provides services to a member of the MP Plan without having received a Referral Form from the patient's Physician Case Manager before services are rendered.

The hospital will then submit the claim, which will be rejected for payment. At this point, the facility will call the MP Plan Office and ask for the name of the PCM. After contacting the PCM, the hospital will either be sent the referral by the PCM, or they will be refused. The PCM does have the right to refuse a request for a retroactive referral.

When a referral is refused by the PCM, the hospital does have one more way to try to collect payment for services rendered. If they feel the care was appropriately rendered, they may submit an Exception Payment Request Form (MP-16) for each case to the MP Plan Office, D.M.A.H.S., 7 Quakerbridge Plaza, CN-712, Trenton, N.J. 08625. For more information, hospitals may contact the MP Plan Office at 1-(800) 792-9745.

- d. INDEPENDENT OUTPATIENT HEALTH FACILITY (MC-14):
 Item 16a. (Physician Case Manager): Enter PCM's name
 (Individual Medicaid Practitioner Number):
 Enter PCM's IMP number
- e. INDEPENDENT LABORATORY CLAIM (MC-13):
 Item 12. (Physician Case Manager): Enter PCM's name
 (Individual Medicaid Practitioner Number):
 Enter PCM's IMP number
- f. MEDICAL SUPPLIES AND EQUIPMENT CLAIM (MC-11):
 Item 16a. (Name and number of Prescribing
 Practitioner): Enter PCM's name and IMP
 number
- g. OPTICAL APPLIANCES (Request for Authorization and
 Payment)(MC-9):
 Item 18a. (Physician Case Manager): Enter PCM's name
 (Individual Medicaid Practitioner Number):
 Enter PCM's IMP number

- h. PRESCRIPTION CLAIM FORM (MC-6):
Item 16. (Prescriber's Individual Medicaid
Practitioner's Number): Enter PCM's
IMP number
- i. PROSTHETIC AND ORTHOTIC APPLIANCE CLAIM (MC-15):
Item 15. (Name and Number of Prescribing
Practitioner): Enter PCM's name and IMP
number

If you have any questions concerning this program, please inquire as follows:

1. Physician Case Managers serving recipients in all counties involved with the plan should contact the MP Plan Office, Quakerbridge Plaza, Bldg. 7, CN-712, Trenton, N.J. 09625 - telephone 1 (800) 792-9745.
2. All other providers should contact the appropriate Fiscal Agent, Blue Cross and Blue Shield of New Jersey, Inc. at 201-456-2534 or The Prudential Insurance Company of America at (Toll Free Number) 800-582-7052.

Attachments: Copy of Form MP-6, 4/83
Copy of Form MP-7, 9/83
Copy of From MP-16, 9/83



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

MEDICAID PERSONAL PHYSICIAN PLAN (MP PLAN)
ANCILLARY/TREATMENT SERVICES REFERRAL FORM

MP Plan Member's Name: _____ Referred To: _____
(Name of Service)

Date: _____

Member's HSP (Medicaid) Case No.: _____ Person No. _____

Physician Case Manager's Name: _____

Physician Case Manager's IMP No.: _____

Check appropriate box and specify/explain below:

CAPITATED SERVICES REQUIRING AUTHORIZATION

NON-CAPITATED SERVICES REQUIRING AUTHORIZATION

- | | | |
|--|---|--|
| <input type="checkbox"/> Laboratory services | <input type="checkbox"/> Optical Appliances | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Radiological services | <input type="checkbox"/> Home Health Care | <input type="checkbox"/> Long-Term Care |
| <input type="checkbox"/> Rehabilitation services | <input type="checkbox"/> Medical Supplies | <input type="checkbox"/> Medical Day Care |
| <input type="checkbox"/> Durable Medical Equipment | <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Prosthetics and Orthotics |

SIGNATURE: *Physician Case Manager*

Specify ancillary services requested. Explain and certify medical necessity for medical equipment.



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

MEDICAID PERSONAL PHYSICIAN PLAN (MP PLAN)
REFERRAL SERVICES FORM

MP Plan Member Name: _____ Date: _____

Member HSP (Medicaid) Case No.: _____ Person No.: _____

Name of Consultant: _____

- Consultation only Consultation with tests as needed Consultation, assume management
- Number of Authorized Visits

Statement of the Problem:

Physician Case Manager IMP No.

SIGNATURE: Physician Case Manager

Date

SIGNATURE: Consulting Physician/Provider



MEDICAID PERSONAL PHYSICIAN PLAN (MP PLAN)
EXCEPTION PAYMENT REQUEST (EPR)

Hospital Name: _____ Provider No. _____

Address: _____

Patient's Name: _____ HSP (Medicaid) No. _____

Address: _____

Physician Case Manager's Name: _____

Emergency Room Physician's Name: _____

Date and time recipient requested emergency room services:

(mo day yr.) (time) S M T W T F S
(circle one)

Level of Care Rendered: Emergency Urgent Routine

Exception Situation:

- Unable to reach physician case manager
- Emergency Room physician disagrees with physician case manager
- Patient uncontrollable
- Other

Please explain, in detail:

What was the outcome?

This Exception Payment Request (EPR) must be completed in full with specific responses or the claim will not be considered for payment. The foregoing information is true, accurate, and complete and is in keeping with the Provider Certification on the attached claim form.

Signature of Emergency Room Representative

Date

MP Plan Office

Date



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

APPENDIX C

OMNICARE/the Health Maintenance Organization (HMO) (This information was originally published in the Newsletter P-390 or BC-279, June 1, 1984.)

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 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 care or thirty (30) days of skilled nursing facility care or twenty (20) outpatient visits and thirty (30) inpatient days/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 Omnicare/the hmo an authorized EXHAUSTION OF BENEFITS form (see page 66), 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 PTan 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 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
 1138 E. Chestnut Avenue
 Building 3
 Vineland, New Jersey 08360
 (609) 696-8001

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:



Please note: If a recipient presents an ID card other than the one shown above, please refer him/her to Omnicare Member Services or call (609) 696-8004 for a replacement.

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		<u>NOTICE TO PROVIDER</u>	
ELIGIBLE PERSONS	PER #	ELIGIBLE PERSONS	PER #
1	11	VOID	
2	12		
3	13		
4 *LAST PERSON PRINTED*	14		
5	15		
6	16		
7	17		
8	18		
9	19		
10	20		
REQUEST PERSONAL IDENTIFICATION IF YOU DO NOT KNOW THE PATIENT. PLEASE REPORT THE CASE NAME, CASE NUMBER, AND PERSON NUMBER ACCURATELY ON ALL CLAIM FORMS AND OTHER COMMUNICATIONS RELATING TO THE CLAIM.			
FD-182			

Any questions regarding Omnicare should be directed to Office of Prepaid Health Care, Division of Medical Assistance and Health Services, telephone (609) 588-2721.



the hmo

EXHAUSTION OF BENEFITS FORM

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 during the remainder of the calendar year by the New Jersey Medicaid Program according to the existing rules and regulations.

A copy of this form must be submitted with all claims made to the New Jersey Medicaid Program. For more information, please contact the OMNICARE Claims Department at 696-8001.

Sincerely,

The OMNICARE Claims Department

□ ADMINISTRATIVE OFFICES
1138 E. CHESTNUT AVE., BLDG. 3-B
VINELAND, NEW JERSEY 08360
609-696-8009

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

□ MAYS LANDING CENTER
ROUTE 50 SOUTH
MAYS LANDING, N.J. 08330
609-625-9146

□ MARMORA MEDICAL CENTER
PLAZA 9, S. SHORE ROAD
MARMORA, N.J. 08223
609-390-3340



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

APPENDIX D

HEALTH CARE PLAN OF NEW JERSEY (HCP/NJ)/THE HEALTH MAINTENANCE ORGANIZATION (HMO) (This information was originally published in the Newsletter P-457 or BC-317, 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 outpatient and 30 inpatient 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 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 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		<u>NOTICE TO PROVIDER</u>	
ELIGIBLE PERSONS	PER #	ELIGIBLE PERSONS	PER #
1	11	VOID	
2	12		
3	13		
4 *LAST PERSON PRINTED*	14		
5	15		
6	16		
7	17		
8	18		
9	19		
0	20		
REQUEST PERSONAL IDENTIFICATION IF YOU DO NOT KNOW THE PATIENT.			
PLEASE REPORT THE CASE NAME, CASE NUMBER, AND PERSON NUMBER ACCURATELY ON ALL CLAIM FORMS AND OTHER COMMUNICATIONS RELATING TO THE CLAIM.			
PD-152			

Any questions regarding HCP/NJ should be directed to Office of Prepaid Health Care, Division of Medical Assistance and Health Services, telephone (609) 588-2721.



HEALTH CARE PLAN OF NEW JERSEY, INC.

(A FEDERALLY QUALIFIED HEALTH MAINTENANCE ORGANIZATION)

EXHAUSTION OF BENEFITS FORM

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

Rev. 8/86

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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, N.J. 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	1800 East Building 1800 Davis Street - Suite 301 Camden, N.J. 08104 Tel. 609-757-2870
Cumberland (Cape May)	Daniel Cooperson, Director	108 Landis Avenue Vineland, N.J. 08360 Tel. 609-696-6560
Essex	John T. Russell, Director A. Bialogowicz, Ass't. to 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)	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
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	Law Building 66 Hamilton St. 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.



NEWSLETTER

New Jersey Health Services Program

Volume..... **P-494**

September 8, 1986

TO: Independent Clinic Providers of Transportation Services

SUBJECT: Fee Increases - Transportation Services

EFFECTIVE: September 8, 1986

BACKGROUND: The New Jersey Medicaid Program is increasing the transportation reimbursement rate for independent clinics that provide transportation services, to and/or from the clinic, to Medicaid recipients. Reimbursement is limited to independent clinics that have been specifically approved by the New Jersey Medicaid Program to provide transportation services.

ACTION: Claims processed on and after September 8, 1986, for transportation services provided by independent clinics, will be reimbursed as follows:

<u>HCPCS CODE</u>	<u>DESCRIPTION</u>	<u>FEE ALLOWANCE</u>
Z0330	Transportation, one way (One way applicable when clinic transports the recipient either to or from the clinic in any one day.)	\$4.50
Z0335	Transportation, round trip (Reimbursement is limited to one round trip per day for the same recipient by the same provider.)	\$9.00

Any questions regarding this Newsletter should be directed to Peter K. Rosswaag at 609-588-2736.



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

NEWSLETTER

New Jersey Health Services Program

Volume.....P-497.....

October 6, 1986

TO: Providers of Pharmaceutical Services,
Hospital Chief Executive Officers,
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: October 13, 1986

BACKGROUND: The Division of Medical Assistance and Health Services does not reimburse for 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 (Codified as 1903(i)(5) of the Social Security Act) requires this action for all identical, related or similar drugs.

ACTION: As of October 13, 1986, the Division of Medical Assistance and Health Services will not reimburse 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 newly added to this updated list are underlined. The DESI list distributed to you on November 26, 1984 (BC-297 or P-409) may be discarded.

If you have any questions regarding this Newsletter, please contact Sanford Luger, Chief Consultant, Pharmaceutical Services, Division of Medical Assistance and Health Services, at 609-588-2724.



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 OCTOBER 13, 1986 HAVE BEEN UNDERLINED)

A.A.S. Vaginal Supp.	Anti-Spasmodic Elix
Actacin - C Syr.	Antispasmodic Caps Comp Tabs Elix Tabs
Actahist - C	Antora-B Caps
Actagen - C	Antrocol Caps, Elix, Tabs
Actamine - C Syr.	Anugard-HC Supp
Actifed - C Exp	Anucon-HC Supp
Adrenosem Salicylate Inj.	Anusol-HC Cream
Adrenosem Syrup	Anusol-HC Supp
Adrenosem Tablets	Arlarex Tabs
*Adroyd Tabs	Arlidin Tablets
Aid - Tuss Caps.	Asminorel Improved Tabs
Albalon-A Oph Solution	*Asminyl Tabs
*Alevaire Liq.	Asthmacon Capsules
Allerfrin W/Cod	Atropine W/Phenobarbital Tabs
Allerphed C Expect	Avazyme Tablets
Ambay Expect	A.V.C. Vaginal Cream
Ambecon	A.V.C. Vaginal Supp
Ambenyl Expect	Azolid-A Caps
A-Nil Expect	Bar-Don Elix, Tabs
*Anadrol 2.5 mg Tabs	Barbatose #2 Tabs
Am-Ef-Sed Capsules	Barbeloid Tabs
Am-Ephen Capsules	Barbidonna C.R. Caps Elix Tabs #2 Tabs
Amesec Enseals	Barophen Elixir
Amesec Pulvules	Bay-Ase Elixir
Ambilog Oint.	Belap Elixir, S.E. Tabs, Tabs
Ambilog Cream	Belatol Elixir, Tabs
Aminobrain-Pt Elixir	Bella-Phen Tabs
Aminophyllin and Amytal Tabs	Bellabarb Tabs
Aminophyllin Comp Caps	Belladenal Elixir, Tabs
Aminophyllin Comp Tabs	Belladenal-S Tabs
Amo-Fed Caps	Belladonna W/PB Caps, Elix, Tabs
Amobell Caps	Belladonna Alk. W/Phenobarbital
*Amodrine Tabs	Bellalphen Tabs
Amophed Capsules	Bellastal Caps, Elix, Tabs
Amphed Capsules	Bellemms #1 & 2 Tabs
*Amphocortin Cream	Bello-Phen Tabs
Ananase Tablets	Bellophene Tabs
Anaspaz-Pb Tabs	Benomine W/PB Caps
Anisotropine Meth-Br W/PB Tabs	Benomine W/PB Tabs
Anti-Spas Caps, Elix. Liq., 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	Cantil W/PB Tabs
Bentyl Tabs W/PB	<u>Cantri Vag Cream</u>
Betadine Vaginal Gel	Caquin Cream
Biobid TD Caps	Carbrital Elixir
Biocort Ointment	Carbrital Kapseals
Bio-Gan Supp	Cartrax Tablets
Biosynal-DC Caps	*Celestone W/Neomycin Cream
Bro-Phed Tabs	Cenalene Elixir
Bromalix Elixir	Cenalene Tablets S.C.
Bromanate Elixir	Cerebro-Nicin Caps
Bromanate Expect	Cetacaine BT6 Spray
Bromanate Expect DC	Cetacaine Kit
Bromanyl Expect	Cetacaine Liquid
Bromatane Expect	*Chardonna Tabs
Bromatane Expect DC	Chardonna-2 Tabs
Bromenate Expect	Chlordiazepoxide Plus Caps
Bromodiphen Comp Exp. W/Cod	Chlordiazepoxide W/Clindinium Caps
Bromonate Expect	Chlordinamide Caps
Bromonate Expect DC	Chlordinium Capsules
Bromophen Elixir & TD Tabs	Chlordinium Sealets
Bromotuss Exp. W/Cod	Chlordinium Tablets
Bromphen Comp TD Tabs	Chlorex Caps
Bromphen Comp W/Cod	Chlorofon-F Tab
Bromphen Expect	Chlorzone Forte Tab
Bromphen Expect DC	Chlorzoxazone W/APAP Tab
Bromphen Expect DC W/Cod	Chlorzoxazone W/Acetaminophen Tab
Bromphenate Expect	Chymolase Tablets
Bromphenate Expect DC	Chymoral Tablets
Brompheniramine Comp Elixir	Clindex Caps
Brompheniramine Comp Expect	Clinoxide Capsules
Brompheniramine Expect	Clipoxide Caps
Brompheniramine Expect DC	Clistin R-A Tabs
Brompheniramine, Phenylephrine & Phenylpropanolamine	*Clistin Expectorant
Brompheniramine W/Cod Expect	*Coditrate Syrup
Bromtane Expect	Co-Perazine Caps TD
Bromtane Expect DC	Co-Pyronil Caps Pediatric Caps & Susp
<u>Brondecon Elixir</u>	Com-Par Capsules
<u>Bronkolixir</u>	Com-Pro Caps
<u>Brondelate Elixir</u>	Com-Pro-Span TD Caps
Brophed Syrup	Combagen Caps
Brophed Tablets	Combid Spansules
Brophenyl Expect	Combined T.D. Caps
Brotane Expect	Cophed-C Expt
Butabarb-Belladonna Elix, Tabs	*Cor-Tar-Quin Cream
Butabell HMB Elix, Tabs	Cor-Tar-Quin Forte Cream
Butagen Alka Caps	*Cor-Tar-Quin Lotion
Butan-K Tabs	Cordamine P A Tabs
*Butazolidin Alka Capsules	Cordran-N Cream
Butibel Elix, R.A. Tabs, Tabs	Cordran-N Oint
C.D.P. Plus Caps	Corovas Tymcaps
*Caldecort Ointment (Rx)	Corque Cream
Caramiphen Edisylate & Phenylpropanolamine Caps	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	*Erythromycin Top Oint
Cycladate	F.E.P. Cream
Cyclandelate Caps	Federinal Susp
Cyclorex Caps	Fedrinal Susp
Cyclospasmol Capsules	*Florinef Lotion
Cyclospasmol Tablets	Forhista Lontabs
Cydel Capsules	*Fluonid-N Cream
Cyvaso Caps	Gantrisin Vaginal Cream
D-Vaso Capsules	Gecil Expect
D-Vaso-S Liquid	Geravite Elixir
Dainite Tablets	Geravite Inj
Dainite-KI Tablets	Geroniazol Elixir
Daricon W/PB	Geroniazol Tablets
Deaner Tablets	Geroniazol-TT Tablets
Dek-Quin Cream	Gevizol Liquid
Dek-Quin Lotion	Gevizol Tablets
Deprol Tablets	Glycopyrrolate W/PB Tabs
*Dianabol Tabs	<u>Glyceryl - T Lig</u>
Dibent-PB Tablets	<u>Guiaphed Elixir</u>
Dibenzylamine Capsules (Exception: Diagnosis of Pheochromocytoma)	H & I Cream
Dicyclomine HCL W/PB Caps	H.C.I. Cream & Oint
Dicyclomine HCL W/PB Tabs	HCV Cream
Dihydro Codeine Comp Caps	H.V.B. Cream
Dimalix Elixir	Haponal Tabs
Dimetane Expect	Hasp Elix, Tabs
Dimetane Expect DC	Hemorrhoidal-HC Supp
Dimetapp Elixir & Extentabs	Hemorrhoidal-HC Unisert
Dipyridamole Tab (Lemmon)	Hemorroid-HC Supp
Diutensen Tablets	Hemorroidal-HC Supp
Dixatal Elixir	Hemusol-HC Supp
Dixotuss Liquid	Hepto Tabs
Domeform-HC Cream	Heptogesic Tablets
Donabarb Tabs	Hexabamate Tabs
Donna-Phenal Elix	Hista Clopane Caps
Donnamor Elix	Histatap Elixir & TD Tabs
Donnatal Caps, Elix, Tabs	<u>Homapin PB Tabs</u>
Donnatal #2 Tabs	Hybephen Elix, Tabs
Donnatal Extentabs	*Hybephen LA Cap
Donnatal Plus Liq, Tabs	Hydrocortisone W/Iodochlorhydroxyquin
Donphen Tabs	Hydrocortisone W/Neomycin
Dri-Phed W/Cod Expect	Hydromax Syrup
Duotrate - 30 Caps	*Hydromet Lot
Duotrate - 45 Caps	Hydrophed Syrup
Durel-Cort V Cream	Hydrophed Tabs
Durel-Cort V Oint	Hydroxy Compound Tabs
E.T.H. Syrup Comp	Hydroxy Ephed Syrup
E.T.H. Tablets Comp	Hydroxyephed Tabs
Eldertonic	Hydroxyzine Comp Syrup
Enarax 5 & 10	Hydroxyzine Comp Tabs
+Equagesic Tablets	Hydroxyzine Plus Liquid
Equanitate	Hydroxyzine Plus Tabs
Equazine Tabs	Hydroxyzine, Theoph & Ephed Tabs
*Erythrocin Top Oint	Hyonatol-B Elixir, Tabs
	Hyophen Tabs

*Discontinued 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
 Hyosphen 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
Iophylline Elixir
 Iso-Perazine T.D. Caps
 Isobid Caps
Isogen Comp Elixir
Isolate Comp Elixir
 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
 Maraon 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
 Meprogestic Tabs

Meprohex Tabs
 Meproplus MLT Tabs
 Meprotrate-20 Tabs
Methandroid Tabs
 Methandrostenolone 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
Mudrane Tabs
Mudrane GG Elixir
Mudrane GG Tabs
 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 Oph 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-Diloderem 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
Phedorine Tabs
 Phenergan Expect
 Phenergan Expect W/Cod
 Phenergan Pediatric Expect
 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	Rofed C. Syrup
Proclan Expect VC	Roniacol Elixir
Proclan Pediatric	Roniacol Tablets 50 mg
Proclan V.C. W/Cod Expect	Roniacol Timespan
Proclan W/Cod Expect	Ronigen Timetabs
Prometh Expect	Rotane Expect DC
Prometh Expect VC W/Cod	Rotapp Elixir
Prometh W/Cod	Ru-Vert Liquid & Tabs
Prometh W/Dextrometh	Ruhexatel W/Reserpine Tabs
Prometh Pediatric	Rycotin Time-Tabs
Promethazine Comp W/Cod Expect	S-T Decongest Liquid
Promethazine Expect	SBP Tabs
Promethazine Expect DC	SBP Plus
Promethazine Expect DC W/Cod	Scodonnal Elix, Tabs
Promethazine Expect DM	Scotatal Caps
Promethazine Expect Pediatric	Sedabel Elix, Tabs, Time Caps
Promethazine Expect V.C.	Sedacord Tabs
Promethazine Expect VC W/Cod	*Sed-Tens Tymed
Promethazine Expect W/Cod	Sedachol Caps
Promethazine Expect W/Cod & Decong	Sedalix Elix
Promethazine Expect W/Decong	Sedapar Elix, Tabs
Promethazine Expect W/Phenyleph	Senilex Tabs
Promethazine Expect W/Phenyleph & Cod	Senilezol Elixir & Caps
Promethazine HCL VC Expect W/Cod	Sinodeine Caps
Promethazine HCL W/Cod	Sorbitrate Tablets W/PB
Promethazine W/Cod	Spabelin #1 and #2 Tabs
Promex W/Cod	Spalix Elix, Tabs
Promide W/PB Tabs	Spasdel Caps, Elix
Propantheline BR W/PB Tabs	Spasloids Tabs
Propazine TD Caps	Spasmacaps Caps
*Propion Gel	Spasmate Tabs
<u>Proternol SRT</u>	<u>Spasmatol Elixir</u>
Protran Plus Tabs	Spasmolin Caps, Elixir Tabs
Purebrom Elixir & Comp TD Tabs	Spasmophen Elixir Tabs
Puretane Expect	Spasquid Elixir
Puretane Expect DC	Spastolate Elixir, Tabs, Time Caps
Pylora Tabs	Speniacol Tabs
Pyribenzamine W/Ephedrine Tabs	Spenpath Tabs
*Pyribenzamine Expectorant With Ephedrine	Spentane Expect
Quadrinal Susp. & Tabs	Spentane Expect DC
Quibron-Plus Caps & Elixir	Stera-Form Cream
Racet Cream	Steraspasmol Caps
Racet Forte Cream	Sterazolidin Capsules
Racet LCD Cream	Steroform Cream & Oint
Rautrax Tablets	*Supertah-HC Oint
Rautrax-N Modified Tablets	Susano Elixir, Tabs
Rautrax-N Tablets	Su-Ton Liquid
Regal-Bid Caps	Su-Zol Liquid
Regal-DC Caps	+Synalgos Caps (new & old formula)
Regal Log Cream & Oint	+Synalgos-DC Caps (new and old formula)
Relaxadon Tabs	Synalgen-DC Caps
Relaxadonna Tabs	T.C.M. Tabs
*Robinul-PH 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
Tedral SA Tabs
Tedral Susp
 Tega-Vert Capsules & Tabs
 Tegagen Supp
 Tegamide Supp
 *Terra-Cortril Aerosol &
 Ointment
 Theda CDP Plus Caps
 Theda MEP Plus Tabs
 Theda Prochloramide
Theodrine Pediatric Susp
Theofed Susp
Theolate Elixir
 Theophedrine 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
Vagila Cream
Vagila Supp
 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

New Jersey Health Services Program

NEWSLETTER

Volume.....P-499.....

November 3, 1986

TO: Independent Laboratories

SUBJECT: Implementation of Health Insurance Claim Form (1500 N.J.)

EFFECTIVE: January 1, 1987

BACKGROUND: The Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services has mandated that the Health Insurance Claim Form (HCFA 1500) be used as the common claim form by providers when billing the Medicare or Medicaid Programs for services provided.

The New Jersey Medicaid Program, in accordance with the decision of the Health Care Financing Administration, has adopted a Federally approved version of the Health Insurance Claim Form (HCFA-1500) known as the Health Insurance Claim Form (1500 N.J.). This form will replace the existing Medicaid "Independent Laboratory Claim" (Form MC-13A C2).

ACTION: Effective January 1, 1987, the New Jersey Medicaid Program will require that the Health Insurance Claim Form (1500 N.J.) be used when billing Medicaid. The MC-13A C2 form now in use will not be accepted for processing after December 31, 1986.

Please note that general Medicaid policy and the procedure for submitting claims remain unchanged. The information required on the 1500 N.J. for Medicaid purposes is basically the same as that required on the current MC-13A C2 form with some exceptions.

In order to assist providers to adapt to the new billing form, instructions specific to the New Jersey Medicaid Program for completing the 1500 N.J. are attached together with a copy of the 1500 N.J., which is single-ply. A supply will be sent to you in advance of the implementation date.

Any questions regarding the use of the 1500 N.J. should be directed to The Prudential Insurance Company of America at (609) 293-2109.

INSTRUCTIONS FOR COMPLETION OF
HEALTH INSURANCE CLAIM FORM (1500 N.J.)
FOR INDEPENDENT LABORATORIES
FOR MEDICAID BILLING

NOTE: CHECK MEDICAID BLOCK AT TOP OF FORM

- ITEM 1. Copy the patient's name EXACTLY as it appears on the Medicaid eligibility validation form.
- ITEM 2. Indicate patient's date of birth. Use six (6) digits (e.g., September 10, 1980 is written 09/10/80). If only the year is known, enter the year.
If birthdate is unavailable, submit claims without birthdate.
- ITEM 3. Not applicable.
- ITEM 4. Indicate patient's address and telephone number.
- ITEM 5. Check appropriate block to identify patient's sex.
- ITEM 6. Copy the patient's Health Insurance (Medicare) Claim Number as it appears on the Medicare Health Insurance card when the patient is covered by both Medicare and Medicaid.
- ITEM 7. Not applicable.
- ITEM 8. Copy the patient's Health Services Program (Medicaid) Case Number and Person Number EXACTLY as shown on the Medicaid eligibility validation form.
- ITEM 8a. Not applicable
- ITEM 9. Check appropriate block to indicate whether the patient has other health insurance coverage. If yes, you must attach a copy of the explanation of payment or a copy of the decline notice from the other insurance coverage.
- ITEM 10. Check as appropriate.
- ITEM 11. Not applicable.
- ITEM 12. Under ordinary circumstances, the patient must sign the claim form when services have been received.
The claim form must indicate services rendered prior to presenting it to the patient for signature.
Indicate in the block provided, the relationship of signer to the patient-recipient.
If the patient's signature is unobtainable, refer to your Medicaid Provider Manual for procedures to follow.

CONT'D

Medicaid Instructions
for 1500 N.J.
I.L.

- ITEM 13. Not applicable.
- ITEM 14. Not applicable.
- ITEM 15. Not applicable.
- ITEM 16. Not applicable.
- ITEM 16a. Not applicable.
- ITEM 17. Not applicable.
- ITEM 18. Not applicable.
- ITEM 19. Indicate the name of the prescribing practitioner unless the patient is an MP Plan member in which case you must indicate the name of the MP Plan Physician Case Manager.
- ITEM 19a. Enter the Individual Medicaid Practitioner (IMP) Number of the practitioner or Case Manager whose name is entered in Item 19.
- ITEM 20. Not applicable.
- ITEM 21. Write in the name of the facility if place of service is other than the patient's home or provider's place of business (office, etc.).
To be completed in addition to Item 24B.
- ITEM 21a. Not applicable.
- ITEM 22. Not applicable.
- ITEM 23A. Not applicable.
- ITEM 23B. EPSDT Program Referral:
Complete this item for patients under 21 years of age.
Ask the patient and/or referring physician or clinic if this service is the result of an EPSDT screening.
- ITEM 24A. Enter date(s) of each visit or service provided.
- ITEM 24B. Identify place of service by selecting appropriate alpha code as listed on the reverse side of the 1500 N.J. form under "Place of Service".
- ITEM 24C. Not applicable.
- ITEM 24D. Indicate the HCPCS code number for the service provided as listed in your Medicaid Provider Manual. If there is no code in the manual to identify the service provided, enter a narrative description of the service.

CONT'D

Medicaid Instructions
for 1500 N.J.
I.L.

- ITEM 24E. Not applicable.
- ITEM 24F. Enter quantities or units.
- ITEM 24G. Enter your usual and customary charge for each service.
- ITEM 24H. Check this column for each service related to "Family Planning".
- ITEM 24I. Not applicable.
- ITEM 25. Read the Medicaid Provider Certification on the reverse side of the 1500 N.J. form carefully and sign and date the claim form accordingly.
- ITEM 26. Not applicable.
- ITEM 27. Enter the sum total of the individual charges indicated in 24G.
- ITEM 28. Not applicable.
- ITEM 29. Not applicable.
- ITEM 30. Not applicable
- ITEM 31. If not preprinted, write provider name, address and provider number.
Enter telephone number.
- ITEM 32. Not applicable.
- ITEM 33. Not applicable.
- ITEM 34. Not applicable.

HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING THIS FORM

MEDICARE

MEDICAID

CHAMPUS

OTHER

OMB No. 0938-0006

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (First name, middle initial, last name)		2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME (First name, middle initial, last name)	
4. PATIENT'S ADDRESS (Street, city, state, ZIP code)		5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		6. PATIENT'S MEDICARE/CHAMPUS NO. (Include any letters)
Telephone No.		7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>		8. PATIENT'S MEDICAID I.D. NO.
9. OTHER HEALTH INSURANCE COVERAGE— Enter Name of Policyholder and Plan Name and Address and Policy Number		10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. ACCIDENTAL INJURY AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>		8a. INSURED'S GROUP NO. (Or Group Name)
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE <small>I Authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of Benefits in Accordance with Program Policy. For Federal Benefits I Request Payment Either to Myself or to the Person who Accepts Assignment Below.</small>		13. I Authorize Payment of Medical Benefits to Undersigned Physician or Supplier for Service Described Below.		11. INSURED'S ADDRESS (Street, city, state, ZIP code)
SIGNED _____ DATE _____		SIGNED (Insured or Authorized Person) _____		

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>	16a. IF AN EMERGENCY CHECK HERE <input type="checkbox"/>
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____	DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____	
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. public health agency)		19a. I.D. NUMBER	20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____
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 <input type="checkbox"/> NO <input type="checkbox"/> 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.		23B. WAS THIS SERVICE PERFORMED AS A RESULT OF AN EPSDT PROGRAM REFERRAL? YES <input type="checkbox"/> NO <input type="checkbox"/> PRIOR AUTHORIZATION NO. _____
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4. A. DATE OF SERVICE FROM	B. *PLACE OF SERVICE TO	C. * T.O.S.	D. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (Explain Unusual Services Or Circumstances)	E. DIAGNOSIS CODE	F. DAYS OR UNITS	G. CHARGES	H. CHECK IF FAMILY PLANNING	I. LEAVE BLANK

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part hereof.)		26. ACCEPT ASSIGNMENT YES <input type="checkbox"/> NO <input type="checkbox"/> (Medicare and CHAMPUS Only See Back)		27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
SIGNED _____ <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> OD <input type="checkbox"/> DC <input type="checkbox"/> PhD		30. PROVIDER SOCIAL SECURITY/I.D. NO.		31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS & ZIP CODE		
DATE _____		33. EMPLOYER I.D. NO.		TELEPHONE NO.		
32. PATIENT'S ACCOUNT NO.						
34. REMARKS:						



NEWSLETTER

New Jersey Health Services Program

Volume..... **P-501**

November 24, 1986

TO: All Physicians, Independent Clinics and Hospital
 Chief Executive Officers

SUBJECT: Immunization Injections: 90701 - Fee Increase
 90718 - Additional Code

EFFECTIVE: For All Non-Institutional Claims Processed
 on or after June 2, 1986

BACKGROUND: The New Jersey Medicaid Program has increased the fee for Diphtheria, Tetanus Toxoid and Pertussis (DTP) vaccine, effective with claims processed on or after June 2, 1986. The code for the adult-type vaccine for Tetanus and Diphtheria Toxoids, adsorbed (Td) has been added at the same fee presently paid for Diphtheria and Tetanus Toxoids (DT).

ACTION: The HCFA Common Procedure Coding System codes and maximum fee allowance are as follows:

<u>HCPCS Code</u>	<u>Maximum Fee Allowance</u>
90701	15.11
90718	3.98

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)588-2740.



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

NEWSLETTER

New Jersey Health Services Program

Volume P-502

December 1, 1986

TO: Hearing Aid Providers

SUBJECT: Implementation of Health Insurance Claim Form (1500 N.J.)

EFFECTIVE: January 1, 1987

BACKGROUND: The Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services has mandated that the Health Insurance Claim Form (HCFA 1500) be used as the common claim form by providers when billing the Medicare or Medicaid Programs for services provided.

The New Jersey Medicaid Program, in accordance with the decision of the Health Care Financing Administration, has adopted a Federally approved version of the Health Insurance Claim Form (HCFA-1500) known as the Health Insurance Claim Form (1500 N.J.). This form will replace the existing Medicaid "Medical Supplies and Equipment Claim" (Form MC-11-C4).

ACTION: Effective January 1, 1987, the New Jersey Medicaid Program will require that the Health Insurance Claim Form (1500 N.J.) be used when billing Medicaid. The MC-11-C4 form now in use will not be accepted for processing after December 31, 1986.

Please note that general Medicaid policy, the procedure for requesting prior authorization and the procedure for submitting claims remain unchanged. The information required on the 1500 N.J. for Medicaid purposes is basically the same as that required on the current MC-11-C4 form with some exceptions. One such exception is the use of modifiers to indicate whether the equipment is new at time of purchase (NU) or used/reconditioned (UE) at time of purchase. A modifier MUST be used. Claims which are submitted without the appropriate modifier will be returned to the provider for completion.

In order to assist providers to adapt to the new billing form, instructions specific to the New Jersey Medicaid Program for completing the 1500 N.J. are attached together with a copy of the 1500 N.J., which is single ply. A supply of claim forms will be sent to you in advance of the implementation date.

Replacement pages for the Hearing Aid Provider Manual relating to these changes will follow at a later date.

Any questions regarding the use of the 1500 N.J. should be directed to The Prudential Insurance Company of America at (609) 293-2114.

INSTRUCTIONS FOR COMPLETION OF
HEALTH INSURANCE CLAIM FORM (1500 N.J.)
FOR HEARING AID PROVIDERS
FOR MEDICAID BILLING

NOTE: CHECK MEDICAID BLOCK AT TOP OF FORM

- ITEM 1. Copy the patient's name EXACTLY as it appears on the Medicaid eligibility validation form.
- ITEM 2. Indicate patient's date of birth. Use six (6) digits (e.g., September 10, 1980 is written 09/10/80). If only the year is known, enter the year.
If birthdate is unavailable, submit claims without birthdate.
- ITEM 3. Not applicable.
- ITEM 4. Indicate patient's address and telephone number.
- ITEM 5. Check appropriate block to identify patient's sex.
- ITEM 6. Copy the patient's Health Insurance (Medicare) Claim Number as it appears on the Medicare Health Insurance card when the patient is covered by both Medicare and Medicaid.
- ITEM 7. Not applicable.
- ITEM 8. Copy the patient's H e a l t h S e r v i c e s P r o g r a m (Medicaid) Case Number and Person Number EXACTLY as shown on the Medicaid eligibility validation form.
- ITEM 8a. Not applicable
- ITEM 9. Check appropriate block to indicate whether the patient has other health insurance coverage. If yes, you must attach a copy of the explanation of payment or a copy of the decline notice from the other insurance coverage.
- ITEM 10. Check as appropriate.
- ITEM 11. Not applicable.
- ITEM 12. Under ordinary circumstances, the patient must sign the claim form when services have been received.
The claim form must indicate services rendered prior to presenting it to the patient for signature.
Indicate in the blocks provided, the relationship of signer to the patient-recipient.
If the patient's signature is unobtainable, refer to your Medicaid Provider Manual for procedures to follow.

CONT'D

Medicaid Instructions
for 1500 N.J.
Hearing Aid Providers

- ITEM 13. Not applicable.
- ITEM 14. Not applicable.
- ITEM 15. Not applicable.
- ITEM 16. Not applicable.
- ITEM 16a. Not applicable.
- ITEM 17. Not applicable.
- ITEM 18. Not applicable.
- ITEM 19. Indicate the name of the prescribing practitioner unless the patient is an MP Plan member in which case you **MUST** indicate the name of the MP Plan Physician Case Manager.
- ITEM 19a. Enter the Individual Medicaid Practitioner (IMP) Number of the practitioner or Case Manager whose name is entered in Item 19.
- ITEM 20. Not applicable.
- ITEM 21. Write in the name of the facility if place of service is other than the patient's home or provider's place of business (office, etc.). To be completed in addition to Item 24B.
- ITEM 21a. Not applicable.
- ITEM 22. Not applicable.
- ITEM 23A. Enter diagnoses for all services identified in Item 24D.
- ITEM 23B. EPSDT Program Referral:
Complete this item for patients under 21 years of age.
Ask the patient and/or referring physician or clinic if this service is the result of an EPSDT screening.
- ITEM 24A. Enter date(s) of each visit or service provided.
- ITEM 24B. Identify place of service by selecting appropriate alpha code as listed on the reverse side of the 1500 N.J. form under "Place of Service".
- ITEM 24C. Not applicable.
- ITEM 24D. Indicate the HCPCS code number with modifier for new purchase (NU) or used/reconditioned purchase (UE), for the service provided as listed in your Medicaid Provider Manual. Indicate the item number, model number, manufacturer's name, and sale amount. If there is no code in the manual to identify the service provided, enter a narrative description of the service. If a replacement within 36 months add the notation "replacement aid". If a reconditioned aid,

CONT'D

Medicaid Instructions
for 1500 N.J.
Hearing Aid Providers

add the notation "Recon" and the notation "six months warranty" and attach to the claim form an invoice or sales document showing the acquisition cost of the aid, if any, and/or the factory or laboratory invoice showing the cost of reconditioning. Indicate the number of batteries and type of custom fitted earmold. If applicable, indicate the receiver model, one cord and garment bag. For repairs indicate "Repair of new aid" if originally dispensed as a new aid. Indicate "Repair of recon aid" for repair of a reconditioned aid. For replacement earmolds, describe the earmold and attach a copy of the laboratory cost list or laboratory invoice to the claim form. For batteries and replacement parts, describe the item. Indicate whether item is new or used (reconditioned).

- ITEM 24E. Enter either the reference number or the diagnosis code from item 23A that is related to the service provided.
- ITEM 24F. Enter quantities or units.
- ITEM 24G. Enter your usual and customary charge for each service.
- ITEM 24H. Not applicable.
- ITEM 24I. Not applicable.
- ITEM 25. Read the Medicaid Provider Certification on the reverse side of the 1500 N.J. form carefully and sign and date the claim form accordingly.
- ITEM 26. Not applicable.
- ITEM 27. Enter the sum total of the individual charges indicated in 24G.
- ITEM 28. Not applicable.
- ITEM 29. Not applicable.
- ITEM 30. Not applicable.
- ITEM 31. If not preprinted, write provider name, address and provider number.
Enter telephone number.
- ITEM 32. Not applicable.
- ITEM 33. Not applicable.
- ITEM 34. For services requiring prior authorization the MDO Medical Consultant will affix his/her signature, date the authorization and cite the terms of authorization; that is, purchase or denial. The provider must assure that item 34 is complete before submitting the claim for payment.

HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING THIS FORM

MEDICARE

MEDICAID

CHAMPUS

OTHER

OMB No. 0938-0006

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 <input type="checkbox"/> FEMALE <input type="checkbox"/>	6. PATIENT'S MEDICARE/CHAMPUS NO. (Include any letters)
9. OTHER HEALTH INSURANCE COVERAGE— Enter Name of Policyholder and Plan Name and Address and Policy Number YES <input type="checkbox"/> NO <input type="checkbox"/>	7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. PATIENT'S MEDICAID I.D. NO.
10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. ACCIDENTAL INJURY AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>	8a. INSURED'S GROUP NO. (Or Group Name)	11. INSURED'S ADDRESS (Street, city, state, ZIP code)
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE <small>I Authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of Benefits in Accordance with Program Policy. For Federal Benefits I Request Payment Either to Myself or to the Person who Accepts Assignment Below.</small>		13. I Authorize Payment of Medical Benefits to Undersigned Physician or Supplier for Service Described Below.
SIGNED _____	DATE _____	SIGNED (Insured or Authorized Person) _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>	16a. IF AN EMERGENCY CHECK HERE <input type="checkbox"/>	
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____		DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____		
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. public health agency)		19a. I.D. NUMBER	20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____		
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 <input type="checkbox"/> NO <input type="checkbox"/> 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.						23B. WAS THIS SERVICE PERFORMED AS A RESULT OF AN EPSDT PROGRAM REFERRAL? YES <input type="checkbox"/> NO <input type="checkbox"/> PRIOR AUTHORIZATION NO.				
1.	2.	3.	4.							
24. A. DATE OF SERVICE		B. *PLACE OF SERVICE	C. * T.O.S.	D. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (Explain Unusual Services Or Circumstances)		E. DIAGNOSIS CODE	F. DAYS OR UNITS	G. CHARGES	H. CHECK IF FAMILY PLANNING	I. LEAVE BLANK
FROM	TO									

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part hereof.) SIGNED _____ <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> OD <input type="checkbox"/> DC <input type="checkbox"/> PhD DATE _____	26. ACCEPT ASSIGNMENT YES <input type="checkbox"/> NO <input type="checkbox"/> (Medicare and CHAMPUS Only See Back)	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
32. PATIENT'S ACCOUNT NO.	30. PROVIDER SOCIAL SECURITY/I.D. NO.	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS & ZIP CODE		
34. REMARKS:	33. EMPLOYER I.D. NO.	TELEPHONE NO.		

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program and renders payment for health benefits

provided through membership and affiliation with the Uniformed Services. Information on the patient's sponsor should be provided in items 3, 6, 7, 8, 9, and 11.

MEDICAID PAYMENTS: Authorization to Release Information, and Payment Request. I certify that the service(s) covered by this claim has been received, and request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the State Agency or its authorized Agents any information needed for this or a related claim.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE AND CHAMPUS)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in the physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

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

For CHAMPUS claims, I further certify that neither I nor any employee who rendered the services are employees or members of the Uniformed Services (refer to 5 USC 5536).

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE AND CHAMPUS INFORMATION

We are authorized by HCFA and CHAMPUS to ask you for information needed in the administration of the Medicare and CHAMPUS programs. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act as amended and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086.

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

The information we obtain to complete Medicare and CHAMPUS claims is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare or CHAMPUS and to insure that proper payment is made.

With the one exception discussed below, there are no penalties under Social Security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of Medicare or CHAMPUS claims. Failure to furnish any other information such as name or claim number, would delay payment of the claim.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations or federal agencies as necessary to administer the Medicare and CHAMPUS programs.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether worker's compensation will pay for treatment. Section 1877(a) (3) of the Social Security Act provides criminal penalties for withholding this information.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency may request.

information is true, accurate and complete; and that the services covered by this claim and the amount charged therefore are in accordance with the regulations of the Medicaid Program; and that no part of the net amount payable under this claim has been paid; and that payment of such amount will be accepted as payment in full without additional charge to the patient or to others on his behalf, with the exception of authorized deductibles and coinsurance. I also certify that services have been furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act and Section 504 of the Rehabilitation Act of 1973.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services covered by this claim were personally rendered by me or under my direct personal supervision (as defined by Program regulations); that the foregoing

I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

PLACE OF SERVICE CODES:

(IH) - Inpatient Hospital
 (OH) - Outpatient Hospital
 (O) - Doctor's Office
 (H) - Patient's Home
 (DCF) - Day Care Facility (PSY)
 (NCF) - Night Care Facility (PSY)
 (NH) - Nursing Home
 (SNF) - Skilled Nursing Facility
 (A) - Ambulance
 (OL) - Other Locations
 (IL) - Independent Laboratory
 (OMS) - Other Medical/Surgical Facility
 (RTC) - Residential Treatment Center
 (STF) - Specialized Treatment Facility
 (KC) - Independent Kidney Care Treatment Center
 (CL) - Clinic
 (ER) - Emergency Room
 (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

NEWSLETTER

New Jersey Health Services Program

Volume..... P-503

December 1, 1986

TO: Medical Suppliers (Except Hearing Aid Providers)
SUBJECT: Implementation of Health Insurance Claim Form (1500 N.J.)
EFFECTIVE: January 1, 1987

BACKGROUND: The Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services has mandated that the Health Insurance Claim Form (HCFA 1500) be used as the common claim form by providers when billing the Medicare or Medicaid Programs for services provided.

The New Jersey Medicaid Program, in accordance with the decision of the Health Care Financing Administration, has adopted a Federally approved version of the Health Insurance Claim Form (HCFA-1500) known as the Health Insurance Claim Form (1500 N.J.). This form will replace the existing Medicaid "Medical Supplies and Equipment Claim" (Form MC-11-C4).

ACTION: Effective January 1, 1987, the New Jersey Medicaid Program will require that the Health Insurance Claim Form (1500 N.J.) be used when billing Medicaid. The MC-11-C4 form now in use will not be accepted for processing after December 31, 1986.

Please note that general Medicaid policy, the procedure for requesting prior authorization and the procedure for submitting claims remain unchanged. The information required on the 1500 N.J. for Medicaid purposes is basically the same as that required on the current MC-11-C4 form with some exceptions. One such exception is the use of modifiers to indicate whether the equipment is new (NU), used (UE) or replacement of part(s) (RP). A modifier **MUST** be used along with the word "purchased" or "rental". Provided formula (enteral nutrition) will be indicated by using the modifier DD. Claims which are submitted without the appropriate modifier will be returned to the provider for completion.

In order to assist providers to adapt to the new billing form, instructions specific to the New Jersey Medicaid Program for completing the 1500 N.J. are attached together with a copy of the 1500 N.J. which is single ply. A supply of claim forms will be sent to you in advance of the implementation date.

Any questions regarding the use of the 1500 N.J. should be directed to The Prudential Insurance Company of America at (609) 293-2114.

INSTRUCTIONS FOR COMPLETION OF
HEALTH INSURANCE CLAIM FORM (1500 N.J.)
FOR MEDICAL SUPPLIERS (EXCEPT HEARING AID PROVIDERS)
FOR MEDICAID BILLING

NOTE: CHECK MEDICAID BLOCK AT TOP OF FORM

- ITEM 1. Copy the patient's name EXACTLY as it appears on the Medicaid eligibility validation form.
- ITEM 2. Indicate patient's date of birth. Use six (6) digits (e.g., September 10, 1980 is written 09/10/80). If only the year is known, enter the year.
If birthdate is unavailable, submit claims without birthdate.
- ITEM 3. Not applicable.
- ITEM 4. Indicate patient's address and telephone number.
- ITEM 5. Check appropriate block to identify patient's sex.
- ITEM 6. Copy the patient's Health Insurance (Medicare) Claim Number as it appears on the Medicare Health Insurance card when the patient is covered by both Medicare and Medicaid.
- ITEM 7. Not applicable.
- ITEM 8. Copy the patient's Health Services Program (Medicaid) Case Number and Person Number EXACTLY as shown on the Medicaid eligibility validation form.
- ITEM 8a. Not applicable
- ITEM 9. Check appropriate block to indicate whether the patient has other health insurance coverage. If yes, you must attach a copy of the explanation of payment or a copy of the decline notice from the other insurance coverage.
- ITEM 10. Check as appropriate.
- ITEM 11. Not applicable.
- ITEM 12. Under ordinary circumstances, the patient must sign the claim form when services have been received.
The claim form must indicate services rendered prior to presenting it to the patient for signature.
Indicate in the blocks provided, the relationship of signer to the patient-recipient.
If the patient's signature is unobtainable, refer to your Medicaid Provider Manual for procedures to follow.

CONT'D

Medicaid Instructions
for 1500 N.J.
Medical Suppliers
(Except Hearing Aid)

- ITEM 13. Not applicable.
- ITEM 14. Not applicable.
- ITEM 15. Not applicable.
- ITEM 16. Not applicable.
- ITEM 16a. Not applicable.
- ITEM 17. Not applicable.
- ITEM 18. Not applicable.
- ITEM 19. Indicate the name of the prescribing practitioner unless the patient is an MP Plan member in which case you **MUST** indicate the name of the MP Plan Physician Case Manager.
- ITEM 19a. Enter the Individual Medicaid Practitioner (IMP) Number of the practitioner or Case Manager whose name is entered in Item 19.
- ITEM 20. Not applicable.
- ITEM 21. Write in the name of the facility if place of service is other than the patient's home or provider's place of business (office, etc.). To be completed in addition to Item 24B.
- ITEM 21a. Not applicable.
- ITEM 22. Not applicable.
- ITEM 23A. Enter diagnoses for all services identified in Item 24D.
- ITEM 23B. EPSDT Program Referral:
Complete this item for patients under 21 years of age.
Ask the patient and/or referring physician or clinic if this service is the result of an EPSDT screening.
- ITEM 24A. Enter date(s) of each visit or service provided.
- ITEM 24B. Identify place of service by selecting appropriate alpha code as listed on the reverse side of the 1500 N.J. form under "Place of Service".
- ITEM 24C. Not applicable.

CONT'D

Medicaid Instructions
for 1500 N.J.
Medical Suppliers
(Except Hearing Aid)

- ITEM 24D. Indicate the HCPCS code number with modifier for new (NU), used (UE) or replacement of part(s) (RP) for the service provided as listed in your Medicaid Provider Manual. Indicate the item number, model number, manufacturer's name, rental or purchase, and sale amount. Provided formula (enteral nutrition) will be indicated by using the modifier DD. If there is no code in the manual to identify the service provided, enter a narrative description of the service. For services requiring prior authorization, the medical supplier must indicate whether item is to be purchased or rented and the period of rental.
- ITEM 24E. Enter either the reference number or the diagnosis code from item 23A that is related to the service provided.
- ITEM 24F. Enter quantities or units.
- ITEM 24G. Enter your usual and customary charge for each service.
- ITEM 24H. Check this column for each service related to "Family Planning".
- ITEM 24I. Not applicable.
- ITEM 25. Read the Medicaid Provider Certification on the reverse side of the 1500 N.J. form carefully and sign and date the claim form accordingly.
- ITEM 26. Not applicable.
- ITEM 27. Enter the sum total of the individual charges indicated in 24G.
- ITEM 28. Not applicable.
- ITEM 29. Not applicable.
- ITEM 30. Not applicable
- ITEM 31. If not preprinted, write provider name, address and provider number.
Enter telephone number.
- ITEM 32. Not applicable.
- ITEM 33. Not applicable.
- ITEM 34. For services requiring prior authorization the MDO Medical Consultant will affix his/her signature, date the authorization and cite the terms of authorization; that is, purchase, rental, time frames for rental, or denial. The provider must assure that item 34 is complete before submitting the claim for payment.

HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING THIS FORM

MEDICARE
 MEDICAID
 CHAMPUS
 OTHER
 OMB No. 0938-0008

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (First name, middle initial, last name)		2. PATIENT'S DATE OF BIRTH		3. INSURED'S NAME (First name, middle initial, last name)	
4. PATIENT'S ADDRESS (Street, city, state, ZIP code)		5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		6. PATIENT'S MEDICARE/CHAMPUS NO. (Include any letters)	
Telephone No.		7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>		8. PATIENT'S MEDICAID I.D. NO.	
9. OTHER HEALTH INSURANCE COVERAGE— Enter Name of Policyholder and Plan Name and Address and Policy Number		10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. ACCIDENTAL INJURY AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>		8a. INSURED'S GROUP NO. (Or Group Name)	
YES <input type="checkbox"/> NO <input type="checkbox"/>				11. INSURED'S ADDRESS (Street, city, state, ZIP code)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE <small>I Authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of Benefits in Accordance with Program Policy. For Federal Benefits I Request Payment Either to Myself or to the Person who Accepts Assignment Below.</small>				13. I Authorize Payment of Medical Benefits to Undersigned Physician or Supplier for Service Described Below.	
SIGNED _____ DATE _____				SIGNED (Insured or Authorized Person) _____	

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)		15. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION		16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>		16a. IF AN EMERGENCY CHECK HERE <input type="checkbox"/>	
17. DATE PATIENT ABLE TO RETURN TO WORK		18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____		DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____			
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. public health agency)				19a. I.D. NUMBER		20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____	
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 <input type="checkbox"/> NO <input type="checkbox"/> 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.						23B. WAS THIS SERVICE PERFORMED AS A RESULT OF AN EPSDT PROGRAM REFERRAL? YES <input type="checkbox"/> NO <input type="checkbox"/> PRIOR AUTHORIZATION NO. _____			
1. 2. 3. 4.						E. DIAGNOSIS CODE			
24. A. DATE OF SERVICE FROM	TO	B. *PLACE OF SERVICE	C. * T.O.S.	D. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (Procedure Code (Identify))	(Explain Unusual Services Or Circumstances)	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.) SIGNED _____ <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> OD <input type="checkbox"/> DC <input type="checkbox"/> PhD DATE _____		26. ACCEPT ASSIGNMENT YES <input type="checkbox"/> NO <input type="checkbox"/> (Medicare and CHAMPUS Only See Back)		27. TOTAL CHARGE		28. AMOUNT PAID		29. BALANCE DUE	
32. PATIENT'S ACCOUNT NO.		30. PROVIDER SOCIAL SECURITY/I.D. NO.		31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS & ZIP CODE					
34. COMMENTS:		33. EMPLOYER I.D. NO.		TELEPHONE NO.					

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program and renders payment for health benefits

provided through membership and affiliation with the Uniformed Services. Information on the patient's sponsor should be provided in items 3, 6, 7, 8, 9, and 11.

MEDICAID PAYMENTS: Authorization to Release Information, and Payment Request. I certify that the service(s) covered by this claim has been received, and request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the State Agency or its authorized Agents any information needed for this or a related claim.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE AND CHAMPUS)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in the physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

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

For CHAMPUS claims, I further certify that neither I nor any employee who rendered the services are employees or members of the Uniformed Services (refer to 5 USC 5536).

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422 510).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE AND CHAMPUS INFORMATION

We are authorized by HCFA and CHAMPUS to ask you for information needed in the administration of the Medicare and CHAMPUS programs. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act as amended and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086.

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

The information we obtain to complete Medicare and CHAMPUS claims is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare or CHAMPUS and to insure that proper payment is made.

With the one exception discussed below, there are no penalties under Social Security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of Medicare or CHAMPUS claims. Failure to furnish any other information such as name or claim number, would delay payment of the claim.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations or federal agencies as necessary to administer the Medicare and CHAMPUS programs.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether worker's compensation will pay for treatment. Section 1877(a) (3) of the Social Security Act provides criminal penalties for withholding this information.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency may request.

information is true, accurate and complete; and that the services covered by this claim and the amount charged therefore are in accordance with the regulations of the Medicaid Program; and that no part of the net amount payable under this claim has been paid; and that payment of such amount will be accepted as payment in full without additional charge to the patient or to others on his behalf, with the exception of authorized deductibles and coinsurance. I also certify that services have been furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act and Section 504 of the Rehabilitation Act of 1973.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services covered by this claim were personally rendered by me or under my direct personal supervision (as defined by Program regulations); that the foregoing

I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

PLACE OF SERVICE CODES:

(IH) - Inpatient Hospital
 (OH) - Outpatient Hospital
 (O) - Doctor's Office
 (H) - Patient's Home
 (DCF) - Day Care Facility (PSY)
 (NCF) - Night Care Facility (PSY)
 (NH) - Nursing Home
 (SNF) - Skilled Nursing Facility
 (A) - Ambulance
 (OL) - Other Locations
 (IL) - Independent Laboratory
 (OMS) - Other Medical/Surgical Facility
 (RTC) - Residential Treatment Center
 (STF) - Specialized Treatment Facility
 (KC) - Independent Kidney Care Treatment Center
 (CL) - Clinic
 (ER) - Emergency Room
 (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-504

December 1, 1986

TO: Prosthetic and Orthotic Providers

SUBJECT: Implementation of Health Insurance Claim Form (1500 N.J.)

EFFECTIVE: January 1, 1987

BACKGROUND: The Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services has mandated that the Health Insurance Claim Form (HCFA 1500) be used as the common claim form by providers when billing the Medicare or Medicaid Programs for services provided.

The New Jersey Medicaid Program, in accordance with the decision of the Health Care Financing Administration, has adopted a Federally approved version of the Health Insurance Claim Form (HCFA-1500) known as the Health Insurance Claim Form (1500 N.J.). This form will replace the existing Medicaid "Prosthetic and Orthotic Appliance Claim" (Form MC-15-C1).

ACTION: Effective January 1, 1987, the New Jersey Medicaid Program will require that the Health Insurance Claim Form (1500 N.J.) be used when billing Medicaid. The MC-15-C1 form now in use will not be accepted for processing after December 31, 1986.

Please note that general Medicaid policy, the procedure for requesting prior authorization and the procedure for submitting claims remain unchanged. The information required on the 1500 N.J. for Medicaid purposes is basically the same as that required on the current MC-15-C1 form with some exceptions.

In order to assist providers to adapt to the new billing form, instructions specific to the New Jersey Medicaid Program for completing the 1500 N.J. are attached together with a copy of the 1500 N.J. which is single ply. A supply of claim forms will be sent to you in advance of the implementation date.

Any questions regarding the use of the 1500 N.J. should be directed to The Prudential Insurance Company of America at (609) 293-2114.

INSTRUCTIONS FOR COMPLETION OF
HEALTH INSURANCE CLAIM FORM (1500 N.J.)
FOR PROSTHETIC AND ORTHOTIC PROVIDERS
FOR MEDICAID BILLING

NOTE: CHECK MEDICAID BLOCK AT TOP OF FORM

- ITEM 1. Copy the patient's name EXACTLY as it appears on the Medicaid eligibility validation form.
- ITEM 2. Indicate patient's date of birth. Use six (6) digits (e.g., September 10, 1980 is written 09/10/80). If only the year is known, enter the year.
If birthdate is unavailable, submit claims without birthdate.
- ITEM 3. Not applicable.
- ITEM 4. Indicate patient's address and telephone number.
- ITEM 5. Check appropriate block to identify patient's sex.
- ITEM 6. Copy the patient's Health Insurance (Medicare) Claim Number as it appears on the Medicare Health Insurance card when the patient is covered by both Medicare and Medicaid.
- ITEM 7. Not applicable.
- ITEM 8. Copy the patient's Health Services Program (Medicaid) Case Number and Person Number EXACTLY as shown on the Medicaid eligibility validation form.
- ITEM 8a. Not applicable
- ITEM 9. Check appropriate block to indicate whether the patient has other health insurance coverage. If yes, you must attach a copy of the explanation of payment or a copy of the decline notice from the other insurance coverage.
- ITEM 10. Check as appropriate.
- ITEM 11. Not applicable.
- ITEM 12. Under ordinary circumstances, the patient must sign the claim form when services have been received.
The claim form must indicate services rendered prior to presenting it to the patient for signature.
Indicate in the blocks provided, the relationship of signer to the patient-recipient.
If the patient's signature is unobtainable, refer to your Medicaid Provider Manual for procedures to follow.

CONT'D

Medicaid Instructions
for 1500 N.J.
Prosthetic & Orthotic

- ITEM 13. Not applicable.
- ITEM 14. Not applicable.
- ITEM 15. Not applicable.
- ITEM 16. Not applicable.
- ITEM 16a. Check if appropriate.
- ITEM 17. Not applicable.
- ITEM 18. Not applicable.
- ITEM 19. Indicate the name of the prescribing practitioner unless the patient is an MP Plan member in which case you **MUST** indicate the name of the MP Plan Physician Case Manager.
- ITEM 19a. Enter the Individual Medicaid Practitioner (IMP) Number of the practitioner or Case Manager whose name is entered in Item 19.
- ITEM 20. Not applicable.
- ITEM 21. Write in the name of the facility if place of service is other than the patient's home or provider's place of business (office, etc.).
To be completed in addition to Item 24B.
- ITEM 21a. Not applicable.
- ITEM 22. Not applicable.
- ITEM 23A. Enter diagnoses for all services identified in Item 24D.
- ITEM 23B. EPSDT Program Referral:
Complete this item for patients under 21 years of age.
Ask the patient and/or referring physician or clinic if this service is the result of an EPSDT screening.
- ITEM 24A. Enter date(s) of each visit or service provided.
- ITEM 24B. Identify place of service by selecting appropriate alpha code as listed on the reverse side of the 1500 N.J. form under "Place of Service".
- ITEM 24C. Not applicable.
- ITEM 24D. Indicate the HCPCS code number for the service provided as listed in your Medicaid Provider Manual. If there is no code in the manual to identify the service provided, enter a narrative description of the service.
- ITEM 24E. Enter either the reference number or the diagnosis code from item 23A that is related to the service provided.
- ITEM 24F. Enter quantities or units.

CONT'D

Medicaid Instructions
for 1500 N.J.
Prosthetic & Orthotic

- ITEM 24G. Enter your usual and customary charge for each service.
- ITEM 24H. Not applicable.
- ITEM 24I. Not applicable.
- ITEM 25. Read the Medicaid Provider Certification on the reverse side of the 1500 N.J. form carefully and sign and date the claim form accordingly.
- ITEM 26. Not applicable.
- ITEM 27. Enter the sum total of the individual charges indicated in 24G.
- ITEM 28. Not applicable.
- ITEM 29. Not applicable.
- ITEM 30. Not applicable
- ITEM 31. If not preprinted, write provider name, address and provider number.
Enter telephone number.
- ITEM 32. Not applicable.
- ITEM 33. Not applicable.
- ITEM 34. For services requiring prior authorization the MDO Medical Consultant will affix his/her signature, date the authorization and cite the terms of authorization; that is, purchase or denial. The provider must assure that item 34 is complete before submitting the claim for payment.

HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING THIS FORM

MEDICARE [] MEDICAID [] CHAMPUS [] OTHER []

OMB No. 0938-0008

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (First name, middle initial, last name)
2. PATIENT'S DATE OF BIRTH
3. INSURED'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, city, state, ZIP code)
5. PATIENT'S SEX MALE [] FEMALE []
6. PATIENT'S MEDICARE/CHAMPUS NO. (Include any letters)
7. PATIENT'S RELATIONSHIP TO INSURED SELF [] SPOUSE [] CHILD [] OTHER []
8. PATIENT'S MEDICAID I.D. NO.
9. OTHER HEALTH INSURANCE COVERAGE-- YES [] NO []
10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES [] NO [] B. ACCIDENTAL INJURY AUTO [] OTHER []
11. INSURED'S ADDRESS (Street, city, state, ZIP code)
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
13. I Authorize Payment of Medical Benefits to Undersigned Physician or Supplier for Service Described Below.

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

Table with 5 columns: 24. A. DATE OF SERVICE FROM TO, B. *PLACE OF SERVICE, C. * T.O.S., D. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (Explain Unusual Services Or Circumstances), E. DIAGNOSIS CODE, F. DAYS OR UNITS, G. CHARGES, H. CHECK IF FAMILY PLANNING, I. LEAVE BLANK

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 YES [] NO [] (Medicare and CHAMPUS Only See Back)
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. PROVIDER SOCIAL SECURITY/I.D. NO.
31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS & ZIP CODE
32. PATIENT'S ACCOUNT NO.
33. EMPLOYER I.D. NO.

34. REMARKS: TELEPHONE NO.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program and renders payment for health benefits

provided through membership and affiliation with the Uniformed Services. Information on the patient's sponsor should be provided in items 3, 6, 7, 8, 9, and 11.

MEDICAID PAYMENTS: Authorization to Release Information, and Payment Request. I certify that the service(s) covered by this claim has been received, and request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the State Agency or its authorized Agents any information needed for this or a related claim.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE AND CHAMPUS)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in the physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

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

For CHAMPUS claims, I further certify that neither I nor any employee who rendered the services are employees or members of the Uniformed Services (refer to 5 USC 5536).

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422 510).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE AND CHAMPUS INFORMATION

We are authorized by HCFA and CHAMPUS to ask you for information needed in the administration of the Medicare and CHAMPUS programs. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act as amended and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086.

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

The information we obtain to complete Medicare and CHAMPUS claims is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare or CHAMPUS and to insure that proper payment is made.

With the one exception discussed below, there are no penalties under Social Security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of Medicare or CHAMPUS claims. Failure to furnish any other information such as name or claim number, would delay payment of the claim.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations or federal agencies as necessary to administer the Medicare and CHAMPUS programs.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether worker's compensation will pay for treatment. Section 1877(a) (3) of the Social Security Act provides criminal penalties for withholding this information.

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information is true, accurate and complete; and that the services covered by this claim and the amount charged therefore are in accordance with the regulations of the Medicaid Program; and that no part of the net amount payable under this claim has been paid; and that payment of such amount will be accepted as payment in full without additional charge to the patient or to others on his behalf, with the exception of authorized deductibles and coinsurance. I also certify that services have been furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act and Section 504 of the Rehabilitation Act of 1973.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services covered by this claim were personally rendered by me or under my direct personal supervision (as defined by Program regulations); that the foregoing

I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

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 (IL) - Independent Laboratory
 (OMS) - Other Medical/Surgical Facility
 (RTC) - Residential Treatment Center
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 (KC) - Independent Kidney Care Treatment Center
 (CL) - Clinic
 (ER) - Emergency Room
 (BH) - Boarding Home

TYPE OF SERVICE CODES:

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 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

NEWSLETTER

New Jersey Health Services Program

Volume..... P-507.....

December 29, 1986

TO: Chief Executive Officers - Hospitals

SUBJECT: Outpatient Hospital Services for Medically Needy
Eligible Individuals

Effective January 1, 1987, outpatient hospital services are available to all Medically Needy eligible individuals.

Claims for all Medicaid-covered services provided in an outpatient hospital setting, except for non-emergency services in the emergency room, are reimbursable. Emergency room services are reimbursable only if provided for the treatment of injuries and significant acute medical conditions.

To allow for necessary systems development to accommodate claims processed, hospitals are asked not to submit claims for outpatient or emergency room services provided to Medically Needy eligible individuals until February 1, 1987.

Any questions regarding reimbursement for outpatient hospital services should be directed to the Division of Medical Assistance and Health Services, Bureau of Planning and Management at (609) 588-2691.



December 8, 1986

TO: Home Health Agencies
Homemaker Agencies

SUBJECT: Home and Community-Based Services Waiver for Blind or
Disabled Children and Adults (Medicaid's Model Waivers)

EFFECTIVE: Immediately

BACKGROUND: The New Jersey Medicaid Program has implemented three separate Home and Community-Based Services Waivers for Blind or Disabled Children and Adults. These are known as Medicaid's Model Waivers. These renewable federal waivers were prepared by the Division of Medical Assistance and Health Services in response to the Omnibus Budget Reconciliation Act of 1981, Section 2176, which encouraged the development of community-based services for individuals who are in need of long-term institutional care. The purpose of these programs is to help eligible individuals receive appropriate health care and remain in the community or return to the community rather than be cared for in a long-term care facility or a hospital setting.

ACTION: These Model Waiver programs serve a maximum of 50 individuals in each program or a total of 150 individuals statewide. There are no geographic limitations nor limitations on the numbers of individuals who can be served in any one county, up to the maximum for each program.

Model Waiver I became effective September 1, 1983 and was extended by the Federal Government for another year as of September 1, 1986. Model Waiver II became effective April 1, 1985, and Model Waiver III became effective April 1, 1986. Renewal applications will be made for all three programs when the approval period is exhausted.

Because of the statewideness of the programs, the small number of individuals who can be served and the cost restrictions of the programs, inquiries should be directed to the Office of Home Care Program in the Division's Central Office as the initial step in determining an individual case as applicable for the Model Waivers. The telephone number is (609) 588-2620.

Eligibility

To be eligible for the Model Waivers, individuals must:

1. Be blind or disabled children and adults.
2. Be in need of institutional care and meet, at a minimum, Medicaid's nursing home level of care criteria.

3. Have total income which exceeds the SSI community standard up to the institutional CAP, or be ineligible in the community because of SSI Deeming Rules*. Model Waiver III, however, may serve individuals who are eligible for Medicaid in the community.

Have resources which do not exceed the limits for Medicaid Only.

*NOTE: In the Model Waiver programs, the income and resources of parents and/or spouse are not deemed available to the client in determining eligibility.

Cost Effectiveness/Requirements

Each individual's service package must be no more than the cost of institutional care, determined at a projected weighted cost of hospital care or net average cost of nursing home care as determined by the Division. Each individual's case manager monitors the amount of Medicaid services which can be provided within the cost limitations of the program.

Each individual is required to share in the cost of the service package when income exceeds maintenance needs, as defined by regulation, including the cost of medical and remedial expenses not subject to payment by a third party.

Services

The Model Waiver Programs offer all New Jersey Title XIX Medicaid State Plan services, plus a new service of case management. Case management is provided to adults by those sites providing case management under the Community Care Program for the Elderly and Disabled (CCPED). Children receive case management services from New Jersey State Department of Health Special Child Health Services Units. Additionally, Model Waiver III only also offers private-duty nursing services.

Private-duty nursing services may be provided by the following types of agencies:

Home Health agencies licensed and certified by the New Jersey State Department of Health.

Voluntary non-profit homemaker/home health aide agencies approved by the New Jersey Division of Medical Assistance and Health Services.

Private employment agencies licensed by the New Jersey Department of Law and Public Safety.

Temporary help service agencies registered with the New Jersey Department of Law and Public Safety.

In order to assure quality care and to protect the health and welfare of our recipients, the DMAHS will contract with the above agencies for private-duty nursing.

Private-duty nursing may be provided by either registered professional nurses (RN) or by licensed practical nurses (LPN) employed by the above-mentioned agencies. All nurses must hold current licenses as defined in the New Jersey State Nursing Practice Act. Private-duty nursing services will be paid for on an hourly negotiated rate, not to exceed the agency's normal charges.

Private-duty nursing will be limited to sixteen (16) hours per day except as follows:

1. If indicated, for brief post-hospital periods while the caregiver(s) adjusts to the new responsibilities of caring for the discharged recipient;

In emergency situations such as the illness of the caregiver when private-duty nursing is currently being provided. In these situations, more than sixteen hours of nursing care will be given for a limited period until other arrangements are made for the safety and care of the recipient.

A decision to provide nursing care longer than sixteen hours will be made by the Medicaid District Office Medical Consultant and will be provided within the cost limitations of the program.

2. There must be a live-in primary caregiver (adult relative or significant other adult) who accepts 24-hour responsibility for the health and welfare of the recipient in order for the recipient to be provided private-duty nursing services under this waiver program.

Prior Authorization

1. Under the Model Waiver Programs, the service plan must be prior authorized by the Medical Evaluation Team in the Medicaid District Office located in the client's county of residence.
2. A Home Health Agency or Homemaker Agency requesting authorization to provide services must use the Request for Home Care Authorization or Reauthorization Form (FD-139) which is currently used for both the regular home health and personal care assistant services and in the Community Care Program for Elderly and Disabled (CCPED).
3. To request authorization for home health or personal care assistant services, the FD-139 is to be completed by the agency, as has been current practice.
4. To request authorization to provide private-duty nursing services, the FD-139 is completed by the agency as illustrated in the attached sample.

Billing Procedures

1. The Independent Outpatient Health Care Facility Claim (MC-14) form is utilized for claiming reimbursement for private-duty nursing services provided to Model Waiver clients. The FD-139, which has been

reviewed, completed and signed by the appropriate Medicaid District Office, must be attached to the MC-14 which is submitted to:

The Prudential Insurance Company of America
Unit X, Medicaid Claim Division II
P.O. Box 1900
Millville, NJ 08332

To expedite processing the MC-14 claims for private-duty nursing services only, submit them to the attention of the Section Supervisor, Medicaid Claims Division II. If necessary, telephone contact can be made to (609) 293-2175.

2. The following procedure codes are to be used when submitting claims for private-duty nursing services:

		<u>Procedure Code</u>
RN weekday	(per hour)	Z1710
LPN weekday	"	Z1715
RN weekend/evening/holiday	"	Z1720
LPN weekend/evening/holiday	"	Z1725
RN specialty weekday	"	Z1730
LPN specialty weekday	"	Z1735
RN specialty weekend/evening/holiday	"	Z1740
LPN specialty weekend/evening/holiday	"	Z1745

Approved rates are in your provider letter; however, when billing Prudential for services provided, please indicate your standard charge on the MC-14, even though the actual payment may be different. You may not charge Medicaid recipients more than you would charge other individuals.

3. A copy of a sample MC-14 illustrating private-duty nursing services is attached for your information.

The Certified Home Health Agency Cost Report (only applicable to licensed certified home health agencies)

1. All costs associated with the provision of private-duty nursing services are to be included in the routine Medicare/Medicaid cost-reporting mechanism.
2. Costs associated with private-duty nursing services are to be identified as such and included on line 17 of Form HCFA-1728-86 (6-86) Worksheet A. These costs are reflected as a non-reimbursable cost center and are not part of the skilled nursing category because

the services may not be rendered under Medicare or Medicaid and are only available under Model Waiver III.

3. Because private-duty nursing services are being treated as non-reimbursable costs, they are not to be included in Worksheets C or D-4.

This process allows the Home Health Agency to:

1. be reimbursed on a fee-for-service basis for recipients of private-duty nursing 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) 588-2620.

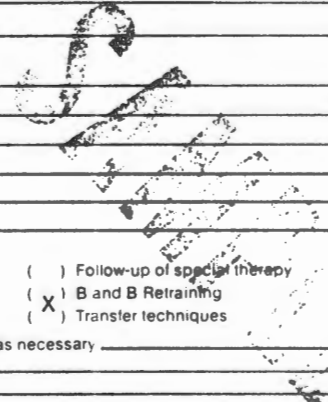
Any specific questions regarding completion of the cost report should be directed to the Provider Audit Unit, The Prudential Insurance Company of America at (609) 293-2336.



PLEASE TYPE OR PRINT

Department of Human Services
Division of Medical Assistance and Health Services
REQUEST FOR HOME CARE AUTHORIZATION OR REAUTHORIZATION

Form with sections: PATIENT INFORMATION, PROGRAM, MEDICAL, NURSING AND SOCIAL INFORMATION, REQUEST INFORMATION, AUTHORIZATION. Includes fields for patient name (SMITH, Jane), address (123 Broad Street), diagnosis (AMYOTROPHIC LATERAL SCLEROSIS), and physician signature (John Brown, M.D.).





STATE OF NEW JERSEY
 Department of Human Services
 Division of Medical Assistance and Health Services
INDEPENDENT OUTPATIENT HEALTH FACILITY

08

Please Print

1. Patient's Last Name SMITH		First Name Jane		2. Patient's Street Address 123 Broad Street		Telephone Number (609) 499-1234	
3. HSP (Medicaid) Case No. 031001193701		4. Patient Person No. 01	5. Age 72	6. Sex Male <input type="checkbox"/> Female <input checked="" type="checkbox"/>		City State Zip Code Somewhere, New Jersey 08554	
7. Other Health Insurance or Liability Coverage? (when applicable) If Yes, attach copy of Decline Notice or Explanation of Payment from Carrier No Fault Auto Coverage? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				10. Was Patient's Illness or Injury connected with employment? If Yes, give Name and Address of Employer here (when applicable) Yes <input type="checkbox"/> No <input type="checkbox"/>			
8. Was this service performed as a result of an EPSDT Program Referral? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				Did injury result from automobile accident? Yes <input type="checkbox"/> No <input type="checkbox"/>			
9. PROVIDER OF SERVICE INFORMATION Telephone Number (609) 499-7422 Name and Address XYZ Care Agency 128 Wood Avenue Somewhere, New Jersey 08554				Medicaid Provider Number (enter only when not printed below) 000800000PDN		11. Prior Authorization Number	
				12. PRIOR AUTHORIZATION - FOR DIVISION USE ONLY			
				AUTHORIZING SIGNATURE <i>Mary Jones</i>		Date 6/1/86	
				*** Place service is provided.			

A. Dates of Service	B. Procedure & Modifier Codes	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
1986					
5/1-5/4	Z1710	ALS	Private Duty Nursing RN-32 hrs.	2	704.00
5/5-5/11	Z1710	"	" -72 hrs.	2	1584.00
Note: If consecutive dates fall on two separate months, enter on two separate lines					

14. Referring Practitioner's Name Leave Blank Individual Medicaid Practitioner Number		16. Operating Practitioner's Name Leave Blank Individual Medicaid Practitioner Number		Total Charges \$ \$2,288.00	
15. Attending Practitioner's Name Leave Blank Individual Medicaid Practitioner Number		16a. Physician Case Manager Leave Blank 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.
 Have client/family sign first billing form with client's name or "John Smith for Jane Smith"; keep copy on file. For subsequent claims, write "Signature on file".
 Signature (Patient or authorized representative) _____ Date Signed _____

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.
 Attach FD-139 to each claim submitted up to ending date of authorization period.
 Provider Signature *Mary Jones* Billing Date 6/1/86 Mo / Day / Yr. 6/1/86

FOR PAYMENT MAIL TO: The Prudential Insurance Co. of America—P.O. Box 1900—Millville, N.J. 08332



TO: Independent Clinics
SUBJECT: Mental Health Services
FEE INCREASE

As a result of an appropriation by the New Jersey legislature (L. 1986, c.41), listed below are fee increases for several mental health services provided by Independent Clinic providers.

The fee increases for the following HCPCS codes are effective for claims processed on or after November 17, 1986:

<u>HCPCS CODE</u>	<u>MAXIMUM FEE ALLOWANCE</u>
90843 ZI	\$ 13.00
90844 ZI	26.00
90847 ZI	26.00
90847 ZI 22*	32.00
90801 ZI	45.00
Z0130	25.00/hr.
90887 ZI	13.00

The above codes relate respectively to individual psychotherapy (25 minute session), individual psychotherapy (50 minute session), family therapy (50 minutes), family therapy (80 minutes), initial comprehensive psychiatric evaluation, psychological testing, and family conference.

The fee increases for the following HCPCS codes are effective for claims processed on or after December 1, 1986:

<u>HCPCS CODE</u>	<u>MAXIMUM FEE ALLOWANCE</u>
Z0170	\$ 23.00
Z0180	38.50

The above codes relate respectively to partial care (1/2 day) and partial care (full day).

Any questions concerning this Newsletter should be referred to the Mental Health Services Unit at (609) 588-2719.

*Previously released as 90847 22 ZI.



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

New Jersey Health Services Program

NEWSLETTER

Volume.....P-509.....

January 5, 1987

TO: All Dentists and Independent Dental Clinics

SUBJECT: Relocation of Bureau of Dental Services

On December 18, 1986, the Bureau of Dental Services, including the Dental Claims Review Unit, relocated to:

Building #12
Quakerbridge Plaza
Quakerbridge Road
Trenton, New Jersey 08619

All claims for prior authorization, except Orthodontic Claims, should be addressed as follows:

Dental Claims Review Unit
CN-713
Trenton, New Jersey 08625

NEW TELEPHONE NUMBER: 609-588-7143

Orthodontic claims requiring prior authorization and correspondence and/or claims for the Chief of the Bureau of Dental Services and immediate staff should be addressed to:

Bureau of Dental Services
CN-713
Trenton, New Jersey 08625

NEW TELEPHONE NUMBER: 609-588-7136



Volume..... **P-510**.....

January 19, 1987

TO: All Physicians, Independent Clinics and
 *(Chief Executive Officers - Hospitals: For Informational
 Purposes Only)

SUBJECT: Revised Procedure Description of Early and Periodic Screening,
 Diagnosis, and Treatment (EPSDT) Code W9820

BACKGROUND: The New Jersey Medicaid Program revised certain statements
 presently found in the narrative of EPSDT Code W9820. The
 significant change relates to the mandating of lead screening, hemoglobin
 evaluations and urinalysis. Other appropriate screening procedures are to be
 performed if medically necessary.

* Please note EPSDT Code W9820 is not reimbursable in a hospital setting.
 This Newsletter is sent for informational purposes only.

HCPCS CODE	DESCRIPTION	MAXIMUM FEE ALLOWANCE	
		<u>S</u>	<u>NS</u>
W9820	Early and 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 examina- tion by a physician or a nurse practitioner under the personal supervision of a physician, to in- clude:		
	(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 adminis- tration of immunizations (See appropriate procedure codes for immunizations and reim- bursement.)		

HCPCS
CODE

DESCRIPTION

MAXIMUM FEE ALLOWANCE
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:
 - (a) Hemoglobin/hematocrit three times: 6-8 months, 2-3 or 4-6 years and 10-12 years
 - (b) Urinalysis a minimum of two times: 18-24 months and 13-15 years
 - (c) Tuberculin three times: 9-12 months, 4-6 years and 10-12 or 13-15 years
 - (d) Lead screening (EP test) beginning between 9-12 months and then annually up to 6 years of age
 - (e) Other appropriate screening procedures, if medically necessary

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/her patients in his/her office are reimbursable to the physician. If performed by outside independent laboratories, the laboratory must submit the claim. Blood sample for 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 care facility, or practitioners sharing a common record. This code will automatically be downgraded in payment to a follow-up preventive health care visit 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 practitioners sharing a common record.

Reimbursement for code W9820 is contingent upon the submission of both a completed MC-19 form and the 1500-NJ claim form (Physician) or MC-14 claim form (Independent Clinic) 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, i.e., \$22.00-\$17.00

Please note that the description for the code above replaces the one which appears in Subchapter 4 (HCPCS CODES FOR PHYSICIAN SERVICES) in Appendix A: Medicine/7 or in Subchapter 3 (HCPCS CODES FOR INDEPENDENT CLINIC SERVICES) in Appendix A/1.

If you have any questions regarding this newsletter, please contact Danuta Buzdygan, M.D., Pediatric Consultant, Division of Medical Assistance and Health Services at (609) 588-2718.



TO: Dentists, Independent Dental Clinics,
and Chief Executive Officers - Hospitals

SUBJECT: HCFA Common Procedure Coding System (HCPCS)

EFFECTIVE: April 1, 1987

Providers of dental services were notified (Medicare/Medicaid Bulletin (P-417) dated March 29, 1985) that the New Jersey Medicaid Program would convert to the Health Care Financing Administration's Common Procedure Coding System (HCPCS). To ensure a smooth transition period, it was necessary to delay implementation until April 1, 1987. All claims submitted on or after April 1, 1987, must include applicable HCPCS codes.

Attached is a new Subchapter 3., Ed. 4/87, HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS) of the New Jersey Medicaid Dental Services Manual. The provider should first read the Table of Contents and Introduction to Subchapter 3. to expedite effective use of this subchapter. The Introduction, for example, explains that the procedure codes for the dental HCPCS are divided into eleven categories such as "Diagnostic", "Preventive", "Endodontics", "Oral Surgery", etc., and that the eleven categories are each assigned a specific series of codes. Another aid for the provider is an index arranged according to the dental procedure.

The listing of HCPCS codes begins on page Dental/1. The listing is divided into columns under the headings: "IND", "HCPCS CODES", "MOD", "PROCEDURE DESCRIPTION" and "MAXIMUM FEE ALLOWANCE":

1. IND - (Indicator) - Lists symbols used to refer provider to information concerning the New Jersey Medicaid Program's qualifications and requirements when a procedure or service code is used.
2. HCPCS CODES - Lists the HCPCS procedure code numbers.
3. MOD - (Modifier) - Lists alphabetic or numeric characters. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance is identified by the addition of alphabetic or numeric characters at the end of the code.
4. PROCEDURE DESCRIPTION - Lists the code narrative.
5. MAXIMUM FEE ALLOWANCE - Lists the New Jersey Medicaid Program's maximum reimbursement schedule for Specialist and Non-Specialist.

There is no change in the New Jersey Medicaid Program's reimbursement schedule for dental services; however, since code numbers, narratives, qualifications to codes and reimbursement are presented in a different format, all the material should be read carefully.

Manual Maintenance: The enclosed material, Subchapter 3., Ed. 4/87, of the Dental Services Manual replaces Subchapter 3. (Procedure Codes and Descriptions), Rev. 6/84. 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. Chapter II and III of the Dental Services Manual will be similarly renumbered when they are revised and distributed at a later time.

Delete the following Newsletters from your Manual:

P-349/BC-245	January 10, 1983
P-366	October 3, 1983
P-369	November 14, 1983
P-378/BC-270	January 16, 1984
P-393/BC-282	June 18, 1984
P-421/BC-311	May 28, 1985

If you have any questions, please contact Archie H. Bell, D.D.S., Chief, Bureau of Dental Services, Division of Medical Assistance and Health Services, telephone (609) 588-7136.

SUBCHAPTER 3. Health Care Financing Administration
Common Procedure Coding System (HCPCS)

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SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:56-3.1 INTRODUCTION

- (a) The New Jersey Medicaid Program has adopted the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). Dental HCPCS follows the American Dental Association's codes on Dental Procedures and Nomenclature in order to "identify and categorize dental procedures covered under all types of third party programs. It is intended to facilitate the filing and processing of claims, data tabulation, and the collection of statistics for third party program operation."¹ The HCFA assigned codes and modifiers may contain both alphabetic and numeric characters.
- (b) The HCPCS code listed in this Subchapter are divided into eleven sections.

- Section 3.2 - Diagnostic
- Section 3.3 - Preventive
- Section 3.4 - Restorative
- Section 3.5 - Endodontics
- Section 3.6 - Periodontics
- Section 3.7 - Prosthodontics, Removable
- Section 3.8 - Maxillofacial Prosthetics
- Section 3.9 - Prosthodontics, Fixed
- Section 3.10 - Oral Surgery
- Section 3.11 - Orthodontics
- Section 3.12 - Adjunctive General Services

- (c) The basic categories and their assigned code series are as follows:

Category of Service

I.	Diagnostic	00100-00999	Y2000-Y2099
II.	Preventive	01000-01999	Y2100-Y2199
III.	Restorative	02000-02999	Y2200-Y2299
IV.	Endodontics	03000-03999	Y2300-Y2399
V.	Periodontics	04000-04999	Y2400-Y2499
VI.	Prosthodontics, Removable	05000-05899	Y2500-Y2599
VII.	Maxillofacial Prosthetics	05900-05999	Y2600-Y2699
VIII.	Prosthodontics, Fixed	06000-06999	Y2700-Y2799
IX.	Oral Surgery	07000-07999	Y2800-Y2899
X.	Orthodontics	08000-08999	Y2900-Y2999
XI.	Adjunctive General Services	09000-09999	Y3000-Y3099

1. Journal of the American Dental Association, Volume 85, October 1972 page 789.

- (d) Specific elements of the HCPCS Coding System which require the attention of the dental provider.

The lists of HCPCS code numbers in the eleven separate sections of this Subchapter 3. are arranged in tabular form with specific information for a code given under columns with titles such as: "IND", "HCPCS CODES", "MOD", "DESCRIPTION", AND "MAXIMUM FEE ALLOWANCE". The information given under each column is summarized below:

COLUMN TITLE

1. IND (Indicator) Lists symbols used to refer provider to information concerning the New Jersey Medicaid Program's qualifications and requirements when a procedure or service code is used. Explanation of indicators used in this column is given below:
 - i. "*" An asterisk (*) denotes those procedures which normally require prior authorization in order to be eligible for reimbursement under the New Jersey Medicaid Program.
 - ii. "**" A double asterisk (**) denotes those procedures which may be treated in an emergency situation when prior authorization is not feasible. These procedures must receive authorization prior to payment.
 - iii. "d" The letter (d) denotes those procedures which require that a diagnosis be entered in the appropriate item on the Dental Services Claim form (MC-10) in order to be eligible for reimbursement.
2. HCPCS CODES Lists the HCPCS procedure code numbers.
3. MOD (Modifier) Lists alphabetic or numeric characters. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance is identified by the addition of alphabetic or numeric characters at the end of the code. The New Jersey Medicaid Program's recognized modifier codes are listed with appropriate procedure codes in this Subchapter 3. The modifiers "22" and "52" are the copyright 1985, American Medical Association, Physicians' Current Procedural Terminology, Fourth Edition. The modifiers with definitions as designated for use in the New Jersey Medicaid Dental Manual are as follows:
 - i. 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. A report may also be appropriate.

NOTE: This modifier has also been applied when a

dental laboratory procedure is used in conjunction with specified chairside procedures or where an adjunctive service is rendered in addition to the basic service.

- ii. 52 — Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the practitioner's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier "52", signifying that the service is reduced.
- iii. YL — Mandibular - Lower.
- iv. YU — Maxillary - Upper.

When it is necessary for the New Jersey Medicaid Program to distinguish between services rendered in the mandibular arch as opposed to the maxillary arch and the basic codes do not make this differentiation, the modifiers "YL" and "YU" have been assigned to make this distinction.

- 4. DESCRIPTION Lists the code narrative.
- 5. MAXIMUM FEE ALLOWANCE Lists the New Jersey Medicaid Program's maximum reimbursement schedule for Specialist and Non-Specialist.
 - i. S - Denotes Specialist fee.
 - ii. NS - Denotes Non-Specialist fee.
 - iii. BR - Denotes By Report (Individual Consideration of Procedure and Fee).

This means that additional information will be required in order to properly evaluate the service and determine an appropriate fee. A copy of this report must be attached to the Dental Services Claim form (MC-10).

(e) Alphabetic and numeric symbols under "IND" & "MOD" and notes under "DESCRIPTION"

- 1. These symbols and notes when listed under the "IND", "MOD" and "DESCRIPTION" columns are elements of the HCPCS coding system. They assist the dentist 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.

2. These symbols and/or letters and/or notes must not be ignored because in certain instances requirements are created in addition to the narrative which accompanies the HCPCS code. THE PROVIDER WILL THEN BE LIABLE FOR THE ADDITIONAL REQUIREMENTS AND NOT JUST THE HCPCS CODE NARRATIVE. These requirements must be fulfilled in order to receive reimbursement.
 3. If there is no identifying symbol or note listed, the HCPCS code narrative prevails.
- (f) Policies and procedures regarding use of HCPCS

Listed below and throughout Subchapter 3. are both some general and specific policies of the New Jersey Medicaid Program relevant to HCPCS. These are not necessarily complete but may have been paraphrased from the complete policies as outlined in Subchapter 1. (Chapter II, 3/78) and Subchapter 2. (Chapter III, 3/78). This has been done so that the provider will have pertinent information available in conjunction with the procedures to be requested and/or delivered. For complete and specific policies in addition to those outlined herein, the practitioner must consult Subchapters 1. and/or 2.

1. General Requirements

- i. When requesting authorization or filing a claim, the HCPCS codes, including the referenced modifiers, must be used in conjunction with the narratives in this Subchapter.
- ii. The use of a procedure code will be interpreted by the New Jersey Medicaid Program as evidence that the dentist personally furnished, as a minimum, the service for which it stands.
- iii. For purposes of reimbursement, a dentist, dental group, shared health care facility or dentists sharing a common record are considered as a single provider.
- iv. When billing, the provider must enter into the procedure code column (Item 15B) of the Dental Services Claim form (MC-10), a HCPCS code as listed in this Subchapter. If an appropriate code cannot be found, leave the procedure code column blank and submit a narrative description of the service for authorization and fee assignment.
- v. Date(s) of service(s) must be indicated on the Dental Services Claim form (MC-10), in the records of a facility when treatment is rendered to one of its residents, and in the practitioner's own record for each service billed.

- vi. When submitting a claim, the dentist must always use her/his usual and customary fee. The fee designated for the HCPCS procedure codes represents the New Jersey Medicaid Program's maximum reimbursement for the given procedure.

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IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
10:56-3.2	00100-00999		I. DIAGNOSTIC			

(a) Clinical Oral Examination

00110	Initial Oral Examination	7.00	6.00
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NOTE 1: This is the code to be used for a Comprehensive Clinical Oral Examination of Medicaid recipients, both Initial and Periodic.

NOTE 2: This code requires a thorough observation of all conditions present in the oral cavity and contiguous structures to include:

- a. Charting of all abnormalities;
- b. Development of a complete treatment plan to be recorded in its entirety on the Dental Services Claim form (MC-10).

NOTE 3. For reimbursement of the examination:

- a. A comprehensive clinical oral examination shall be limited to once every six months for those patients through age 17, and once every 12 months for those patients 18 years of age or older except as authorized by a Dental Consultant of the New Jersey Medicaid Program;
- b. All items on the Dental Services Claim form (MC-10) must be completed;
- c. If No Other Treatment is Necessary, this fact must be noted on the Dental Services Claim form (MC-10) in the diagnosis box. The abbreviation "NOTN" may be used.

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>		
				<u>S</u>	<u>\$</u>	<u>NS</u>
	00110	22	Initial Oral Examination	8.00		7.00

NOTE 1: This code is only to be used
for EPSDT DENTAL EXAMINATIONS
(FORMERLY CODE 0119).

NOTE 2: Reimbursement is contingent
upon:

a. The completed MC-19D Form
(Fiscal Agent's Copy) must
accompany the Dental Services
Claim form (MC-10) when submitted
to the Fiscal Agent for reimburse-
ment.

b. For reimbursement, the Dental
Services Claim form (MC-10) must
be received by the Fiscal Agent no
later than 30 days from the date
of service of that exam.

c. Failure to attach the MC-19D
Form to the Dental Services Claim
form (MC-10) or to meet the timely
billing requirement will result in
reduction of the reimbursement by
\$1.00.

d	00130		Emergency Oral Examination	4.00		3.00
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NOTE: For diagnosis and/or observation
of a specific complaint - make note of
diagnosis and/or observation(s) on
Dental Services Claim form (MC-10). This
code is not reimbursable as an adjunct
to any reimbursable service except for
diagnostic radiographs.

(b) Radiographs

1. Radiographs should be limited to those normally required
to make a diagnosis, but must show all areas where treatment
is anticipated with the exception of soft tissue lesions.

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>		
				<u>S</u>	<u>\$</u>	<u>NS</u>

The originals of all radiographs must be forwarded to the Dental Consultant for evaluation of the treatment or treatment request.

- a. For complete limitations according to age and time, see 2.b. below;
- b. As part of an examination, posterior bitewings and single anterior films may be taken as needed;
- c. In an emergency situation, a radiograph(s) may be taken at any time in order to establish a diagnosis.

2. Intraoral Radiographs: (Periapical/Bitewing/Occlusal)

- a. Indicate number of films in items 13 and 15F of the Dental Services Claim form (MC-10);
- b. For a complete series of radiographs, limitations pertaining to age are found in the first note below each code, and the maximum number of radiographs reimbursable as a single radiographic study every three years without prior authorization is found in the second note below each code.

00210	52	Intraoral - Complete Series (Including Bitewings)	9.00	9.00
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NOTE 1: Limited to patients up to and including age 6.

NOTE 2: 8 films.

00210		Intraoral - Complete Series (Including Bitewings)	13.00	13.00
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NOTE 1: Limited to patients age 7 up to and including age 14.

NOTE 2: 12 films.

00210	22	Intraoral - Complete Series (Including Bitewings)	17.00	17.00
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NOTE 1: Limited to patients age 15 or older.

NOTE 2: Minimum of 16 films.

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>		
				<u>S</u>	<u>\$</u>	<u>NS</u>
	00220		Intraoral - Periapical - First Film NOTE: Or bitewing.	2.00		2.00
	00230		Intraoral - Periapical - Each Additional Film NOTE 1: Or each additional bitewing. NOTE 2: Indicate complete number of films (00220 Plus 00230) in items 13 and 15F.	1.00		1.00
	00240		Intraoral - Occlusal Film NOTE 1: Per film (maximum - two (2) films). NOTE 2: Indicate number of films in item 15F.	5.00		5.00
3. <u>Extraoral Radiographs</u>						
	00250		Extraoral, First Film NOTE 1: Indicate number of views in item 15F of the <u>Dental Services Claim form (MC-10)</u> . NOTE 2: Code to be used for lateral, anterioposterior, temporomandibular radiographs, etc. (one view).	10.00		10.00
	00260		Extraoral - Each Additional Film NOTE: Maximum reimbursable - two (2) additional views.	5.00		5.00
	00310		Sialography	15.00		15.00
	00310	22	Sialography NOTE: Includes injection of contrast material (filling and/or emptying phases).	30.00		30.00

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
	00330		Panoramic Film	10.00		10.00
*	00340		Cephalometric Film	10.00		10.00
*	00340	22	Cephalometric Film	15.00		15.00

NOTE: Includes tracing.

(c) Test and Laboratory Examinations

*	00470		Diagnostic Casts	11.50		10.00
			NOTE: Casts must have bases and be trimmed to permit articulation, per cast.			
*	00471		Diagnostic Photographs	1.00		1.00
			NOTE: Or slide, per view.			
d	00501		Histopathologic Examination	10.00		-
			NOTE 1: The gross and microscopic examination of oral tissues, both hard and soft.			
			NOTE 2: Limited to specialists in oral pathology, and Oral Diagnosis (Pathology) Departments of dental schools.			
d*	00999		Unspecified Diagnostic Procedure, By Report	BR		BR
			NOTE: Complete description of procedure and why.			

10:56-3.3 01000-01999 II. PREVENTIVE

(a) Dental Prophylaxis

1. Dental prophylaxis is the removal of calculus and stains from the supragingival and subgingival surfaces of the teeth by scaling and polishing.

a. For reimbursement purposes, dental prophylaxis shall be limited to once every six months for those patients

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
			up to and including age 17 and once every 12 months for those patients 18 years of age or older except as authorized by a Dental Consultant of the Medicaid Program.			
	01110		Prophylaxis - Adult	11.00		10.00
			NOTE: Patients 16 years of age or older, maxillary and mandibular arches.			
	01110	52	Prophylaxis - Adult	5.50		5.00
			NOTE 1: Patients 16 years of age or older, maxillary or mandibular arch.			
			NOTE 2: Code to be used if patient is <u>edentulous</u> in one arch.			
	01120		Prophylaxis - Child	8.00		7.00
			NOTE: Patients up to and including 15 years of age, maxillary and mandibular arches.			
			2. Scaling over and above that necessary under prophylaxis (see codes 01110 and 01110 52 above), the calculus must be abnormally heavy and visible to the Dental Consultant on radiograph(s). Such scaling must be authorized.			
*	Y2105		Additional Scaling	11.00		10.00
			NOTE: Patients 16 years of age or older, maxillary and mandibular arches.			
*	Y2105	52	Additional Scaling, One Arch	5.50		5.00
			NOTE 1: Patients 16 years of age or older, maxillary or mandibular arch			
			NOTE 2: Code to be used if patient is <u>edentulous</u> in one arch.			

(b) Topical Fluoride Treatment (Office Procedure)

1. Topical application of stannous fluoride or acid fluoride phosphate - one treatment following a complete prophylaxis (fee includes both services).

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
			<p>a. Reimbursement for topical fluoride treatment shall be limited to once every six months without authorization for those patients up to and including age 17, and once every 12 months for those patients 18 years of age, up to and including 20 years of age. (Not a covered service for persons 21 years of age and over). A complete prophylaxis must be performed immediately prior to the topical fluoride treatment.</p>			
	01201		Topical Applications of Fluoride (Including Prophylaxis) - Child	14.00		12.00
			<p>NOTE: Patients up to and including 15 years of age, maxillary and mandibular arches.</p>			
	01202		Topical Application of Fluoride (Including Prophylaxis) - Adult	17.00		15.00
			<p>NOTE: Patients age 16, up to and including 20 years of age, maxillary and mandibular arches.</p>			
	01202	52	Topical Application of Fluoride (Including Prophylaxis) - Adult	8.50		7.50
			<p>NOTE: Patients age 16, up to and including 20 years of age, maxillary or mandibular arch. Code to be used if patient is <u>edentulous</u> in one arch.</p>			

(c) Other Preventive Services

	01351		Sealant - Per Tooth	7.00		6.00
			<p>NOTE 1: Application of sealants is limited to a one time application to caries free and restoration free first and second permanent molars as follows:</p> <p>a. First molars: Sealants are reimbursable when applied upon eruption at ages six (6) or seven (7);</p> <p>b. Second molars: Sealants are reimbursable when applied upon</p>			

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
			eruption, at ages twelve (12) or thirteen (13).			
			NOTE 2: Sealants applied other than as detailed above are not reimbursable unless authorized by a Medicaid Dental Consultant. A complete explanation of the request must be attached.			
			NOTE 3: Since the sealants may be reimbursed only once for each tooth, the provider should make certain that sealants have not been applied previously.			
(d)	<u>Space Maintenance (Passive Appliances)</u>					
*	01510		Space Maintainer - Fixed - Unilateral	40.00		35.00
			NOTE: Utilizing band(s).			
*	01510	22	Space Maintainer - Fixed - Unilateral	59.00		51.00
			NOTE: Utilizing single stainless steel crown.			
*	01515		Space Maintainer - Fixed - Bilateral	61.00		53.00
			NOTE: Lingual or palatal arch utilizing bands.			
*	01515	22	Space Maintainer - Fixed - Bilateral	105.00		91.00
			NOTE: Lingual or palatal arch utilizing stainless steel crowns.			
*	Y2115		Tooth Processed to Arch Bar (Wire), Per Tooth	6.00		5.00
*	01525		Space Maintainer - Removable - Bilateral	69.00		60.00
	01550		Recementation of Space Maintainer	7.00		6.00

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>		
				<u>S</u>	<u>\$</u>	<u>NS</u>
*	Y2125		Unspecified Preventive Procedure, By Report	BR		BR

NOTE: Complete description of procedure(s) and why.

10:56-3.4 02000-02999 III. RESTORATIVE

(a) Reimbursement for restorations in deciduous teeth is limited to deciduous cuspids and molars of children up to and including age 9 or in deciduous incisors up to and including age 5, but not where exfoliation is imminent.

1. Exception: Prior authorization by a Medicaid Dental Consultant.

(b) Amalgam Restorations (Including Polishing)

1. Reimbursement for a restoration will include treatment of pulp exposure, lining or base, restoration, polishing of restoration, and local anesthesia or analgesia.

2. Procedure code must be selected on the basis of the number of surfaces restored per individual tooth (not on the basis of individual restorations); therefore, the fee for any surface will include one or more restorations on that surface.

3. Only one code is reimbursable per tooth except when amalgam and resin restorations are placed on the same tooth.

4. Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal or lingual surface(s) of the tooth.

5. Extensions of interproximal fillings into self cleansing areas will not be considered as additional surfaces. An additional surface will be reimbursable only when the buccal (facial) or lingual margin extends beyond the proximal one-third (1/3) of the buccal (facial) and/or lingual surface(s).

02110	Amalgam - One Surface, Primary	9.00	7.50
02120	Amalgam - Two Surfaces, Primary	14.50	13.00

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>	
				<u>S</u>	<u>NS</u>
	02130		Amalgam - Three Surfaces, Primary	20.00	18.50
	02131		Amalgam - Four Surfaces, Primary	25.50	24.00
			NOTE: Code to be utilized for four <u>or more</u> surfaces.		
	02140		Amalgam - One Surface, Permanent	9.00	7.50
	02150		Amalgam - Two Surfaces, Permanent	14.50	13.00
	02160		Amalgam - Three Surfaces, Permanent	20.00	18.50
	02161		Amalgam - Four or More Surfaces, Permanent	25.50	24.00

(c) Silicate Restorations

Silicate restorations are NOT a covered service of the New Jersey Medicaid Program.

(d) Filled or Unfilled Resin Restorations

1. Filled or unfilled resin filling material is reimbursable only when that material is utilized for teeth numbers 4 through 13 and 20 through 29 and/or C through H and M through R in each arch.

a. Exception: Prior authorization by a Medicaid Dental Consultant.

2. Proximal restorations in anterior teeth are normally considered to be single surface restorations. When access to a proximal cavity is gained by involvement of a second surface, reimbursement will be permitted for only one surface. A two (2) or three (3) surface proximal restoration will be reimbursed only when the facial and/or lingual margin(s) of the restoration extends beyond the proximal one-third (1/3) of the facial and/or lingual surface(s).

3. Extension of proximal fillings into self-cleansing areas will not be considered as additional surfaces.

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
			4. In selecting the code to be submitted for an individual tooth, please note that only one code is reimbursable per tooth except when amalgam and resin restorations are placed on the same tooth.			
			5. The fee for any surface will include one or more restorations on that surface.			
			6. Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal (facial) or lingual surface(s) of the tooth.			
			7. Reimbursement for a restoration will include treatment of pulp exposure, lining or base, restoration, polishing of restoration, and local anesthesia or analgesia.			
			8. Reimbursement will include acid etch where appropriate.			
	02330		Resin - One Surface	11.00		10.00
	02331		Resin - Two Surfaces	13.00		16.00
	02332		Resin - Three Surfaces	25.00		22.00
	02335		Resin - Four or More Surfaces or Involving Incisal Angle	31.50		28.00

(e) Gold Foil Restorations

1. Primarily for use in Dental Colleges.

*	02410		Gold Foil - One Surface	9.00		8.00
*	02420		Gold Foil - Two Surfaces	18.00		16.00
*	02430		Gold Foil - Three Surfaces	27.00		24.00

NOTE: Code to be used for three or more surfaces.

(f) Inlay Restorations

1. Primarily for use in Dental Colleges.

*	02510		Inlay - Metallic - One Surface	31.00		27.00
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IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
*	02520		Inlay - Metallic - Two Surfaces	56.00		49.00
*	02530		Inlay - Metallic - Three Surfaces	75.00		65.00
			NOTE: Code to be used for three or more surfaces.			
*	02540		Onlay - Metallic - Per Tooth (In Addition to Inlay)	23.00		20.00

(g) Crowns - Single Restoration Only

1. Authorization for crowns will be granted only when substantial loss of tooth structure exists and condition of remaining teeth and supporting tissues justify this treatment.

2. Acrylic or porcelain veneer on metal will be authorized only when esthetically necessary.

3. There is only one fee for each type of crown. Use the type of alloy most appropriate for the patient's needs.

4. The Noble Metal Classification System has been adopted as a more precise method of reporting various alloys used in dentistry. The alloys are defined on the basis of the percentage of noble metal content.

Classification	High Noble Alloy	Noble Alloy	Predominantly Base Alloy
Weight %	Au., Pd. and/or Pt. > 60% (with at least 40% Au)	Au., Pd. and/or Pt. > 25%	Au., Pd. and/or Pt. < 25%

*	02710		Crown - Resin (Laboratory)	98.00		85.00
			NOTE: Laboratory processed.			
*	02720		Crown - Resin with High Noble Metal	161.00		140.00
			NOTE: Acrylic veneer.			

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
*	02721		Crown - Resin with Predominately Base Metal NOTE: Acrylic veneer.	161.00		140.00
*	02722		Crown - Resin with Noble Metal NOTE: Acrylic veneer.	161.00		140.00
*	02750		Crown - Porcelain Fused to High Noble Metal	201.00		175.00
*	02751		Crown - Porcelain Fused to Predominately Base Metal	201.00		175.00
*	02752		Crown - Porcelain Fused to Noble Metal	201.00		175.00
*	02790		Crown - Full Cast High Noble Metal	161.00		140.00
*	02791		Crown - Full Cast Predominately Base Metal	161.00		140.00
*	02792		Crown - Full Cast Noble Metal	161.00		140.00

(h) Other Restorative Services

	02910		Recement Inlay	7.00		6.00
	02920		Recement Crown	7.00		6.00
*	02930		Prefabricated Stainless Steel Crown- Primary Tooth NOTE: Authorized only for deciduous teeth.	41.00		35.00
*	02931		Prefabricated Stainless Steel Crown- Permanent Tooth NOTE: Generally authorized only for permanent posterior teeth up to and including 17 years of age.	41.00		35.00

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE	
				S	\$ NS
*	02932		Prefabricated Resin Crown NOTE: E.G., Polycarbonate - generally authorized only for deciduous and permanent anterior teeth up to and including 15 years of age.	40.00	35.00
*	02950		Crown Buildup Including Any Pins NOTE 1: And/or post. NOTE 2: Core of composite or amalgam.	34.00	30.00
	02951		Pin Retention - Per Tooth, In Addition To Restoration NOTE 1: Per pin. NOTE 2: Maximum reimbursable - three (3) pins.	4.00	3.00
*	02952		Cast Post And Core In Addition To Crown NOTE: Post and core fabricated (cast) and cemented as a separate unit from crown.	52.00	45.00
*	02954		Prefabricated Post And Core In Addition To Crown	34.00	30.00
*	02970		Temporary (Fractured Tooth) NOTE: Temporary crown - not reimbursable in conjunction with any other restorative procedure on same tooth.	29.00	25.00
*	02999		Unspecified Restorative Procedure, By Report	BR	BR

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
10:56-3.5	03000-03999		IV. ENDODONTICS			
			(a) Authorization of endodontic treatment will be at the discretion of the Medicaid Dental Consultant, and will be influenced by the:			
			1. Age and general health of the patient;			
			2. Status of the tooth in the arch; and			
			3. Condition of the remaining dentition and supporting structures.			
			(b) <u>Pulp Capping - Direct/Indirect</u>			
			1. Pulp Capping is no longer a separately covered service under the Medicaid Program.			
			(c) <u>Therapeutic Pulpotomy</u>			
			1. A pulpotomy will be limited to a deciduous tooth, or a permanent tooth with incompletely formed roots.			
	d*	03220	Therapeutic Pulpotomy (Excluding Final Restoration)	15.00		13.00
			(d) <u>Pulpectomy</u>			
			1. A pulpectomy for deciduous teeth includes extirpation, treatment and filling of all the root canal(s) with resorbable filling material. Post-operative radiograph(s) must be available. Reimbursable only for deciduous teeth with permanent successors.			
	d*	Y2310	Pulpectomy (Excluding Final Restoration)	17.00		15.00
			(e) <u>Root Canal Therapy (Including Treatment Plan, Clinical Procedures, and Follow-Up Care)</u>			
			1. The fee for root canal therapy includes the extirpation, treatment (complete filling of all the root canal(s) with permanent material), all necessary radiographs during treatment and post-operatively, and follow-up care (excludes final restoration).			

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
2. For emergency endodontic procedures, use code 09110.						
d*	03310		One Canal (Excluding Final Restoration)	103.00		90.00
NOTE: Code to be used for incisors and cuspids (permanent).						
d*	03320		Two Canals (Excluding Final Restoration)	132.00		115.00
NOTE: Code to be used for bicuspids and all deciduous teeth without permanent successors.						
d*	03330		Three Canals (Excluding Final Restoration)	172.00		150.00
NOTE: Code to be used for molars (permanent).						
d*	03350		Apexification (Per Treatment Visit)	31.00		27.00
NOTE 1: Treatment may extend over a period of 6 to 18 months.						
NOTE 2: Maximum - two (2) visits.						

(f) Periapical Services

1. Apicoectomy will be considered for authorization and reimbursement only if one or more of the following conditions exist:

- a. Overfilled canal (previously treated tooth);
- b. Canal cannot be filled properly because of excessive root curvature or calcification;
- c. Fractured root tip that cannot be reached endodontically;
- d. Broken instrument in canal;
- e. Perforation of apical third of canal;

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
			f. Broken root canal filling lying free in periapical tissues and acting as an irritant;			
			g. Periapical pathology not resolved by previous endodontic therapy;			
			h. Periapical pathology which will not be resolved by endodontic therapy alone;			
			i. A post, post and core, or post-crown which cannot be removed.			
			2. Apicoectomy should not be performed for convenience. If endodontic treatment is necessary, but none of the above conditions exist, authorization for the apicoectomy will not be granted.			
			3. When more than one apical curettage and/or apicoectomy is performed through the same operative site, the maximum amount reimbursable by the New Jersey Medicaid Program shall be the amount specified in this schedule with the greater allowance, plus one-half of the amounts specified for each of the other procedures.			
			4. Retrograde filling(s) will be inserted when necessary in conjunction with appropriate endodontic treatment, but not in lieu of a properly filled canal.			
			5. The fee includes those post-treatment radiograph(s) determined necessary by the practitioner and must be available to the Medicaid Program upon request.			
d*	03410		Apicoectomy (Per Tooth) - First Root	55.00		48.00
d*	03411		Apicoectomy (Per Tooth) - Each Additional Root	28.00		24.00

NOTE: Maximum - two (2) additional roots.

(g) Apicoectomy performed in conjunction with endodontic procedure

1. Single stage nerve extirpation and canal filling. Services provided at same visit.

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>		
				<u>S</u>	<u>\$</u>	<u>NS</u>
d*	03410	22	Apicoectomy/Endodontic Procedure (Per Tooth) - First Root	111.50		98.50
d*	03411	22	Apicoectomy/Endodontic Procedure (Per Tooth) - Each Additional Root	44.00		36.00
			NOTE: Maximum - two (2) additional roots.			
*	03430		Retrograde Filling - Per Root	9.00		7.50
			NOTE 1: In addition to apicoectomy.			
			NOTE 2: Maximum per tooth - three (3) roots.			
d*	03440		Apical Curettage	49.00		42.00
			NOTE: Per tooth.			
*	03450		Root Amputation - Per Root	55.00		48.00
			NOTE 1: Surgical resection of entire root(s).			
			NOTE 2: Per tooth.			

(h) Other Endodontic Procedures

*	03920		Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	55.00		48.00
*	03950		Canal Preparation and Fitting of Preformed Dowel or Post	16.00		14.00
			NOTE: Without cementation.			
*	03950	22	Canal Preparation and Fitting of Preformed Dowel or Post	23.00		20.00
			NOTE: With cementation.			

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>		
				<u>S</u>	<u>\$</u>	<u>NS</u>
*	03960		Bleaching Discolored Tooth	11.00		10.00
			NOTE 1: Limited to non-vital teeth.			
			NOTE 2: Per visit.			
			NOTE 3: Reimbursement limited to two (2) visits.			
d*	03999		Unspecified Endodontic Procedure, By Report	BR		BR

10:56-3.6 04000-04999 V. PERIODONTICS

(a) Treatment for periodontics will be authorized on a very selective basis. Detailed description, radiographs, and periodontal charting are required. Reimbursement will be based upon quadrants, a portion thereof or the equivalent thereof as determined by the Medicaid Dental Consultant.

(b) Surgical Services (Including Usual Post-operative Services)

*	04210		Gingivectomy or Gingivoplasty - Per Quadrant	43.50		37.50
*	04211		Gingivectomy or Gingivoplasty - Per Tooth	6.00		5.50
*	04220		Gingival Curettage, By Report	22.50		19.50
			NOTE: Per quadrant.			
*	04260		Osseous Surgery (Including Flap Entry and Closure) - Per Quadrant	75.00		64.50
*	04261		Osseous Graft - Single Site (Including Flap Entry, Closure, and Donor Site)	BR		BR
*	04262		Osseous Graft - Multiple Sites (Including Flap Entry, Closure, and Donor Sites)	BR		BR
*	04270		Pedicle Soft Tissue Graft Procedure	32.00		28.00
			NOTE: Per site.			

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>		
				<u>S</u>	<u>\$</u>	<u>NS</u>
*	04271		Free Soft Tissue Graft Procedure (Including Donor Site)	49.00		42.00
			NOTE: Per site.			
*	04272		Apically Repositioning Flap Procedure	36.00		31.50
			NOTE: Per quadrant.			

(c) Adjunctive Periodontal Services

*	04320		Provisional Splinting - Intracoronal	18.00		16.00
			NOTE: Per tooth.			
*	04321		Provisional Splinting - Extracoronal	11.00		10.00
			NOTE 1: Per tooth.			
			NOTE 2: This code may also be used for stabilization of traumatized teeth.			
*	04340		Periodontal Scaling and Root Planing - Entire Mouth	102.00		90.00
*	04341		Periodontal Scaling and Root Planing - Per Quadrant	25.50		22.50
*	04999		Unspecified Periodontal Service, By Report	BR		BR

10:56-3.7 05000-05899 VI. PROSTHODONTICS (REMOVABLE)

(a) Dentures, both partial and complete, may be authorized when submitted evidence indicates masticatory deficiencies likely to impair the general health of the patient.

(b) Normally, there must be a three (3) month wait (for healing) between the date of the last extraction and initiation of the denture(s), partials and/or complete, except immediate denture(s).

(c) The fee for partial and complete dentures will include necessary adjustments, relines and/or rebases for a six (6) month period following insertion.

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>		
				<u>S</u>	<u>\$</u>	<u>NS</u>

(d) The fee for immediate dentures will also include the necessary adjustments, relines and/or rebases for a six (6) month period following insertion.

(e) Partial dentures must be described on the Dental Services Claim form (MC-10) indicating material to be used, position of clasps, and teeth to be replaced.

(f) PAYMENT FOR DENTURES WILL BE DENIED UNLESS ALL DENTAL PROCEDURES IN BOTH ARCHES ARE COMPLETED BEFORE IMPRESSIONS ARE TAKEN FOR AUTHORIZED DENTURES (COMPLETE AND PARTIAL).

(g) Denture relining, rebasing (jumping), or repairing are reimbursable. No additional reimbursement will be made for repair procedures in conjunction with a rebase or reline of a denture except for the replacement of missing or fractured teeth and/or clasp(s) and/or welding, and then only code(s) 05520, 05620, 05640, and/or Y2510 can be used.

1. The fee will include all necessary adjustments for a six (6) month period following insertion for relining and rebasing, and three (3) months for repairs.

(h) The patient's name must be processed into all dentures during the original fabrication or where possible during any subsequent processing procedure (repair, rebase, reline, and so forth). The Social Security number must also be included if space permits. This is MANDATORY and complies both with New Jersey Medicaid regulations in effect since May, 1978 and the "Denture I.D. Law" which became effective April 16, 1984 (N.J.S.A. 45:6-19.1 et. seq.).

(i) Complete Dentures (Including Routine Post Delivery Care)

*	05110	Complete Upper	197.00	171.00
		NOTE: Maxillary.		
*	05120	Complete Lower	202.00	176.00
		NOTE: Mandibular.		

(j) Immediate Complete Dentures (Including Six (6) Months Post Delivery Care)

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>		
				<u>S</u>	<u>\$</u>	<u>NS</u>
			1. Reimbursement also includes necessary rebases and/or relines, and so forth.			
			2. In order to qualify for immediate denture reimbursement, the denture must involve the immediate replacement of anterior teeth which may include first bicuspid (teeth nos. 5 through 12 and 21 through 28 only). Second bicuspid and molars must not be included among the qualifying teeth. The date of insertion of a denture and the extractions must carry an identical date of service. List tooth code(s) of teeth involved.			
*	05130		Immediate Upper	215.00		186.00
			NOTE 1: Maxillary.			
			NOTE 2: 1 through 4 teeth.			
*	05130	22	Immediate Upper	239.00		206.00
			NOTE 1: Maxillary.			
			NOTE 2: 5 through 8 teeth.			
*	05140		Immediate Lower	220.00		191.00
			NOTE 1: Mandibular.			
			NOTE 2: 1 through 4 teeth.			
*	05140	22	Immediate Lower	244.00		211.00
			NOTE 1: Mandibular.			
			NOTE 2: 5 through 8 teeth.			

(k) Partial Dentures (Including Routine Post Delivery Care)

1. For additional clasp(s), see Code Y2510.

*	05211		Upper Partial - Acrylic Base (Including Any Conventional Clasps and Rests)	161.00		140.00
			NOTE: Includes two (2) cast chrome clasps with rests.			

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
*	05211	52	Upper Partial - Acrylic Base - Without Clasps (Flipper)	86.00		75.00
*	05212		Lower Partial - Acrylic Base - (Including Any Conventional Clasps and Rests)	161.00		140.00
			NOTE: Includes two (2) cast chrome clasps with rests.			
*	05212	52	Lower Partial - Acrylic Base - Without Clasps (Flipper)	86.00		75.00
*	05213		Upper Partial - Predominantly Base Cast Base with Acrylic Saddles (Including any Conventional Clasps and Rests)	213.00		185.00
			NOTE: Includes two (2) cast chrome clasps with rests.			
*	05214		Lower Partial - Predominantly Base Cast Base with Acrylic Saddles (Including any Conventional Clasps and Rests)	201.00		175.00
			NOTE: Includes two (2) cast chrome clasps with rests.			

(1) Immediate replacement of anterior teeth in conjunction with partial dentures (codes 05211 through 05214 only) in addition to denture, maximum six teeth (Teeth #s 6 through 11 and 22 through 27 only).

1. Immediate partial dentures also includes necessary rebases and/or relines, and so forth.

*	Y2505		Immediate Replacement of Anterior Teeth - Per Tooth	6.00		5.00
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NOTE: List tooth code(s) of tooth
being replaced.

(m) Adjustments to Dentures - other than dentist providing denture or after the required period of post delivery care (for example, new dentures, relines, rebases - six (6) months; repairs - three (3) months, and so forth).

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
	05410		Adjust Complete Denture - Upper	7.00		6.00
	05411		Adjust Complete Denture - Lower	7.00		6.00
	05421		Adjust Partial Denture - Upper	7.00		6.00
	05422		Adjust Partial Denture - Lower	7.00		6.00

(n) Repairs to Complete Dentures - includes adjustments for three (3) months. Prior authorization is not normally necessary when Medicaid reimbursement for a repair to a denture does not exceed \$53.00 specialist fee or \$48.00 non-specialist fee.

1. Repair Broken Complete Denture Base

a. Includes replacing undamaged teeth on denture.

05510	YU	Repair Broken Complete Denture Base	34.50		30.00
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NOTE: Maxillary - Upper.

05510	YL	Repair Broken Complete Denture Base	34.50		30.00
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NOTE: Mandibular - Lower.

05520		Replace Missing or Broken Teeth - Complete Denture (Each Tooth)	5.00		5.00
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NOTE 1: Code may be used in addition to codes 05510 YU or YL above.

NOTE 2: List tooth codes of teeth being replaced.

(o) Repairs To Partial Denture - includes adjustments for three (3) months. Prior authorization is not normally necessary when Medicaid reimbursement for a repair to a denture does not exceed \$53.00 specialist fee or \$48.00 non-specialist fee.

05610	YU	Repair Acrylic Saddle or Base	34.50		30.00
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NOTE: Maxillary.

05610	YL	Repair Acrylic Saddle or Base	34.50		30.00
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NOTE: Mandibular.

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>		
				<u>S</u>	<u>\$</u>	<u>NS</u>
	05620		Repair Cast Framework	23.00		20.00
			NOTE: Welding in addition to repair procedure(s), limit two (2) per denture.			
	05630	YU	Repair or Replace Broken Clasp	52.50		48.00
			NOTE: Maxillary.			
	05630	YL	Repair or Replace Broken Clasp	52.50		48.00
			NOTE: Mandibular.			
	05640		Replace Broken Teeth - Per Tooth	5.00		5.00
			NOTE: Code 05640 may be used in addition to repair procedure(s).			
	05650		Add Tooth to Existing Partial Denture	46.00		40.00
			NOTE: To replace extracted tooth (list tooth code being replaced).			
	05660	YU	Add Clasp to Existing Partial Denture	52.50		48.00
			NOTE: Maxillary.			
	05660	YL	Add Clasp to Existing Partial Denture	52.50		48.00
			NOTE: Mandibular.			
	Y2510		Each Additional Clasp - For Repair	21.00		18.00
			NOTE 1: List tooth code being clasped.			
			NOTE 2: Code Y2510 may be used in addition to repair procedure(s).			
			NOTE 3: Code Y2510 may be used for additional clasp(s) during initial fabrication of partial denture(s), maximum two (2) per denture.			

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS

(p) Denture Rebase Procedures

1. Rebasing is the process of refitting a denture by the complete replacement of the denture base material without changing the occlusal relationship of the teeth. Includes adjustments for six (6) months.

*	05710		Rebase Complete Upper Denture	92.00	80.00
*	05711		Rebase Complete Lower Denture	92.00	80.00
*	05720		Rebase Upper Partial Denture	86.00	75.00
*	05721		Rebase Lower Partial Denture	86.00	75.00

(q) Denture Reline Procedures

1. Relining is the process of resurfacing the tissue side of a denture with new base material to make it fit more accurately.

*	05730		Reline Upper Complete Denture (Chairside)	20.00	17.00
*	05731		Reline Lower Complete Denture (Chairside)	20.00	17.00
*	05740		Reline Upper Partial Denture (Chairside)	20.00	17.00
*	05741		Reline Lower Partial Denture (Chairside)	20.00	17.00
*	05750		Reline Upper Complete Denture (Laboratory)	69.00	60.00
*	05751		Reline Lower Complete Denture (Laboratory)	69.00	60.00
*	05760		Reline Upper Partial Denture (Laboratory)	63.00	55.00
*	05761		Reline Lower Partial Denture (Laboratory)	63.00	55.00

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
<u>(r) Other Removable Prosthetic Services</u>						
1. Insertion of name and Social Security number of recipient into base material of complete or partial denture during initial fabrication, rebasing, relining or repair, per denture. This is required to comply with New Jersey Medicaid regulations in effect since May, 1978 and the "Denture I.D. Law" which became effective April 16, 1984. (N.J.S.A. 45:6-19.1 et. seq.)						
	Y2515	YU	Insertion of Identification into Denture - Maxillary - Upper	4.00		4.00
	Y2515	YL	Insertion of Identification into Denture - Mandibular - Lower	4.00		4.00
*	05899		Unspecified Removable Prosthodontic Procedure, By Report	BR		BR

10:56-3.8 05900-05999 VII. MAXILLOFACIAL PROSTHETICS

(a) Treatment Prosthesis

**	05982		Surgical Stent	50.00		43.00
*	05999		Unspecified Maxillofacial Prosthesis, By Report	BR		BR

10:56-3.9 06000-06999 VIII. PROSTHODONTICS, FIXED

(a) Each Abutment and Each Pontic Constitutes a Unit in a Bridge.

1. The Noble Metal Classification System has been adopted as a more precise method of reporting various alloys used in dentistry. The alloys are defined on the basis of the percentage of noble metal content.

Classification	High Noble Alloy	Noble Alloy	Predominantly Base Alloy
Weight %	Au., Pd. and/or Pt. > 60% (with at least 40% Au)	Au., Pd. and/or Pt. > 25%	Au., Pd. and/or Pt. < 25%

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>		
				<u>S</u>	<u>\$</u>	<u>NS</u>

2. There is only one fee for each type of pontic or crown. Use the type of alloy most appropriate for the patient's needs.

(b) Bridge Pontics

*	06210		Pontic - Cast High Noble Metal	76.00	66.00
*	06211		Pontic - Cast Predominantly Base Metal	76.00	66.00
*	06212		Pontic - Cast Noble Metal	76.00	66.00
*	06240		Pontic - Porcelain Fused to High Noble Metal	115.00	110.00
*	06241		Pontic - Porcelain Fused to Predominantly Base Metal	115.00	110.00
*	06242		Pontic - Porcelain Fused to Noble Metal	115.00	110.00
*	06250		Pontic - Resin with High Noble Metal	90.00	80.00
*	06251		Pontic - Resin with Predominantly Base Metal	90.00	80.00
*	06252		Pontic - Resin with Noble Metal	90.00	80.00

(c) Bridge Retainers - Crowns

*	06720		Crown - Resin with High Noble Metal	161.00	140.00
*	06721		Crown - Resin with Predominantly Base Metal	161.00	140.00
*	06722		Crown - Resin with Noble Metal	161.00	140.00
*	06750		Crown - Porcelain Fused to High Noble Metal	201.00	175.00
*	06751		Crown - Porcelain Fused to Predominantly Base Metal	201.00	175.00

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
*	06752		Crown - Porcelain Fused to Noble Metal	201.00		175.00
*	06790		Crown - Full Cast High Noble Metal	161.00		140.00
*	06791		Crown - Full Cast Predominantly Base Metal	161.00		140.00
*	06792		Crown - Full Cast Noble Metal	161.00		140.00

(d) Other Fixed Prosthetic Services

	06930		Recement Bridge	8.00		7.00
			NOTE 1: One abutment.			
			NOTE 2: Code may be used when recementing facing.			
	06930	22	Recement Bridge	14.00		12.00
			NOTE: Two or more abutments.			
*	06970		Cast Post and Core in Addition to Bridge Retainer	52.00		45.00
			NOTE: Post and core fabricated (cast) and cemented as a separate unit from crown.			
*	06972		Prefabricated Post and Core in Addition to Bridge Retainer	34.00		30.00
*	06980		Bridge Repair, By Report	BR		BR
*	06999		Unspecified Fixed Prosthodontic Procedure, By Report	BR		BR

10:56-3.10 07000-07999 IX. ORAL SURGERY

(a) In the event that the oral surgery service to be performed is of an emergency nature and prior authorization is normally required but not feasible, then the Dental Services Claim form (MC-10) with all necessary information should be forwarded to the Dental Consultant for authorization after completion of the service but prior to submission for reimbursement.

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
(b) Exodontia						
1. Reimbursement for dental extraction(s) will include local anesthesia, indicated alveoloplasty, and routine post-operative care.						
2. Reimbursement will be denied for the following treatment rendered without prior authorization:						
a. Extraction of teeth other than those classified as non-restorable;						
b. Extraction of one or more teeth which will necessitate a dental prosthesis; or						
c. All extractions preparatory to or in conjunction with orthodontic care.						
3. Extractions in more than one quadrant of the mouth must be justified as an emergency procedure.						
(c) <u>Extractions - Includes Local Anesthesia and Routine Post-operative Care</u>						
	07110		Single Tooth	10.50		9.00
**	07130		Root Removal - Exposed Roots	15.00		13.00
NOTE 1: Per tooth.						
NOTE 2: Root partially imbedded in bone.						
	07130	52	Root Removal - Exposed Roots	10.50		9.00
NOTE 1: Per tooth.						
NOTE 2: Root completely located in soft tissue.						
(d) <u>Surgical Extractions - Includes Local Anesthesia and Routine Post-operative Care</u>						
1. Reimbursement will not be made for extraction of impacted teeth which have not been prior authorized.						

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>		
				<u>S</u>	<u>\$</u>	<u>NS</u>
			2. Authorization will be granted only when conditions arising from such impactions warrant their removal. Extraction of asymptomatic impacted teeth or those teeth where dental/medical necessity cannot be demonstrated will not be authorized or accepted for reimbursement.			
			3. In order to qualify for a surgical removal of a tooth with partial or complete bone impaction, the following is required:			
			a. Incision of overlying soft tissue;			
			b. Removal of bone; and/or			
			c. Sectioning of tooth.			
**	07210		Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth	15.00		13.00
**	07220		Removal of Impacted Tooth - Soft Tissue	21.00		18.00
**	07230		Removal of Impacted Tooth - Partially Bony	61.00		53.00
**	07240		Removal of Impacted Tooth - Completely Bony	61.00		53.00
**	07250		Surgical Removal of Residual Tooth Roots (Cutting Procedure)	30.00		26.00

NOTE: Completely covered by bone.

(e) Other Surgical Procedures

**	07260		Oroantral Fistula Closure	72.00		63.00
			NOTE: Code may also be used for antral root recovery.			
**	07270		Tooth Re-implantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth and/or Alveolus	61.00		53.00

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
**	07270	22	Tooth Re-implantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth and/or Alveolus NOTE: Includes single stage nerve extirpation and canal filling.	86.00		75.00
*	07280		Surgical Exposure of Impacted or Unerupted Tooth for Orthodontic Reason (Including Orthodontic Attachments)	54.00		47.00
*	07281		Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption	30.00		26.00
d	07285		Biopsy of Oral Tissue - Hard NOTE: Independent procedure (laboratory must bill separately).	30.00		26.00
d	07286		Biopsy of Oral Tissue - Soft NOTE: Independent procedure (laboratory must bill separately).	18.00		16.00

(f) Alveoloplasty - Surgical Preparation of Ridge for Dentures

1. Reimbursement will be based upon quadrants, a portion thereof or the equivalent thereof as determined by the Medicaid Dental Consultant.

*	07320		Alveoloplasty Not in Conjunction With Extraction - Per Quadrant	43.50		37.50
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(g) Vestibuloplasty - including revision of soft tissues on ridges, muscle reattachment, tongue, palate, and other oral soft tissues (complete description including size and position must be submitted). Reimbursement will be based upon quadrants, a portion thereof or the equivalent thereof as determined by the Medicaid Dental Consultant.

*	07340		Vestibuloplasty - Ridge Extension (Secondary Epithelialization)	45.00		39.00
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NOTE: Including management of hypertrophied and hyperplastic tissue, Per Quadrant.

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
*	07350		Vestibuloplasty - Ridge Extension (Including Soft Tissue Grafts, Muscle Re-attachments, Revision of Soft Tissue Attachment, and Management of Hypertrophied and Hyperplastic Tissue)	118.00		102.00

NOTE: Per Quadrant.

(h) Surgical Excision of Reactive Inflammatory Lesions (Scar Tissue or Localized Congenital Lesions)

1. Includes lesions of skin, subcutaneous or mucous membranes, pyogenic granulomata and operculi).

d*	07410		Radical Excision - Lesion Diameter Up to 1.25 cm.	30.00		26.00
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d*	07420		Radical Excision - Lesion Diameter Over 1.25 cm.	42.00		37.00
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NOTE: Up to and including 3 cm.

d*	07420	22	Radical Excision - Lesion Diameter Over 3 cm.	100.00		86.00
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(i) Removal of Tumors, Cysts, and Neoplasms

1. In the excision and management of this type of lesion a biopsy report must be available.

d*	07430		Excision of Benign Tumor - Lesion Diameter Up To 1.25 cm.	30.00		26.00
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d*	07431		Excision of Benign Tumor - Lesion Diameter Over 1.25 cm.	42.00		37.00
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NOTE: Up to and including 3 cm.

d*	07431	22	Excision of Benign Tumor - Lesion Diameter Over 3 cm.	100.00		86.00
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d**	07440		Excision of Malignant Tumor - Lesion Diameter Up To 1.25 cm.	100.00		86.00
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IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
d**	07441		Excision of Malignant Tumor - Lesion Diameter Over 1.25 cm. NOTE: Up to and including 3 cm.	274.00		256.00
d**	07441	22	Excision of Malignant Tumor - Lesion Diameter Over 3 cm.	473.00		413.00
d*	07450		Removal of Odontogenic Cyst or Tumor - Lesion Diameter Up to 1.25 cm.	50.00		43.00
d*	07451		Removal of Odontogenic Cyst or Tumor - Lesion Diameter Over 1.25 cm. NOTE: Up to and including 3 cm.	100.00		87.00
d*	07451	22	Removal of Odontogenic Cyst or Tumor - Lesion Diameter Over 3 cm.	150.00		130.00
d*	07460		Removal of Non-Odontogenic Cyst or Tumor - Lesion Diameter Up To 1.25 cm.	50.00		43.00
d*	07461		Removal of Non-Odontogenic Cyst or Tumor - Lesion Diameter Over 1.25 cm. NOTE: Up to and including 3 cm.	100.00		87.00
d*	07461	22	Removal of Non-Odontogenic Cyst or Tumor - Lesion Diameter Over 3 cm.	150.00		130.00
d*	07465		Destruction of Lesion(s) by Physical Methods: Electrosurgery, Chemotherapy, Cryotherapy or Laser	18.00		15.00

(j) Excision of Bone Tissue

1. Reimbursement will be based upon quadrants, a portion thereof, or the equivalent thereof as determined by the Medicaid Dental Consultant.

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE	
				S	NS
*	07470		Removal of Exostosis - Maxilla or Mandible	43.50	37.50
			NOTE: Per quadrant.		
*	07470	22	Removal of Exostosis	90.00	79.00
			NOTE: Torus palatinus.		
d*	07480		Partial Osteotomy (Guttering or Saucerization)	211.00	184.00
d*	07490		Radical Resection of Mandible with Bone Graft	BR	BR
(k) <u>Surgical Incision</u>					
	07510		Incision and Drainage of Abscess - Intraoral Soft Tissue	13.00	16.00
	07520		Incision and Drainage of Abscess - Extraoral Soft Tissue	42.00	37.00
**	07530		Removal of Foreign Body, Skin, or Subcutaneous Areolar Tissue	13.00	16.00
**	07540		Removal of Reaction - Producing Foreign Bodies, Musculoskeletal System	51.00	45.00
**	07550		Sequestrectomy for Osteomyelitis	48.00	42.00
			NOTE: Intraoral.		
**	07550	22	Sequestrectomy for Osteomyelitis	90.00	75.00
			NOTE: Extraoral.		
d**	07560		Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body	242.00	210.00
			NOTE: Sinusotomy, maxillary (antrotomy, Caldwell-Luc), <u>unilateral</u> .		

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>		
				<u>S</u>	<u>\$</u>	<u>NS</u>
(1) <u>Treatment of Fractures - Simple</u>						
1. Open reduction involves the dissection of tissues and/or the visual inspection of the fracture site.						
**	07610		Maxilla - Open Reduction (Teeth Immobilized if Present)	182.00		158.00
**	07620		Maxilla - Closed Reduction (Teeth Immobilized if Present)	121.00		105.00
**	07620	52	Maxilla - Closed Reduction	30.00		26.00
NOTE: No manipulation or fixation.						
**	07630		Mandible - Open Reduction (Teeth Immobilized if Present)	242.00		210.00
**	07630	22	Mandible - Open Reduction (Teeth Immobilized if Present)	303.00		263.00
NOTE: Complicated-multiple surgical approaches (three (3) or more) including internal fixation, interdental fixation, skeletal pinning with extraoral fixation, and so forth.						
**	07640		Mandible - Closed Reduction (Teeth Immobilized if Present)	121.00		105.00
**	07640	52	Mandible - Closed Reduction	30.00		26.00
NOTE: No manipulation or fixation.						
**	07650		Malar and/or Zygomatic Arch - Open Reduction	121.00		105.00
**	07660		Malar and/or Zygomatic Arch - Closed Reduction	42.00		37.00
NOTE: Including towel clip technique.						
**	07660	52	Malar and/or Zygomatic Arch - Closed Reduction	30.00		26.00
NOTE: No manipulation or fixation.						

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
**	07670	YU	Alveolus - Stabilization of Teeth, Open Reduction Splinting	92.00		80.00
			NOTE 1: Maxillary alveolar fracture.			
			NOTE 2: Reduction with wiring, application of arch bar or splint, and so forth.			
**	07670	YL	Alveolus - Stabilization of Teeth, Open Reduction Splinting	92.00		80.00
			NOTE 1: Mandibular alveolar fracture.			
			NOTE 2: Reduction with wiring, application of arch bar or splint, and so forth.			
**	07680		Facial Bones - Complicated Reduction with Fixation and Multiple Surgical Approaches	242.00		210.00
			NOTE 1: Maxilla, malar and/or zygomatic arch.			
			NOTE 2: Multiple surgical approaches (three (3) or more), fixation, traction, headframe, multiple internal and/or external fixation, head cap, and so forth.			

(m) Treatment of Fractures - Compound

1. Open reduction involves the dissection of tissues and/or the visual inspection of the fracture site.

**	07710		Maxilla - Open Reduction	182.00		158.00
			NOTE: Teeth immobilized if present.			
**	07720		Maxilla - Closed Reduction	121.00		105.00
			NOTE: Teeth immobilized if present.			

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
**	07720	52	Maxilla - Closed Reduction NOTE: No manipulation or fixation.	30.00		26.00
**	07730		Mandible - Open Reduction NOTE: Teeth immobilized if present.	242.00		210.00
**	07730	22	Mandible - Open Reduction NOTE: Complicated-multiple surgical approaches (three (3) or more) including internal fixation, interdental fixation, skeletal pinning with extraoral fixation, and so forth.	303.00		263.00
**	07740		Mandible - Closed Reduction NOTE: Teeth immobilized if present.	121.00		105.00
**	07740	52	Mandible - Closed Reduction NOTE: No manipulation or fixation.	30.00		26.00
**	07750		Malar and/or Zygomatic Arch - Open Reduction	121.00		105.00
**	07760		Malar and/or Zygomatic Arch - Closed Reduction NOTE: Including towel clip technique.	42.00		37.00
**	07760	52	Malar and/or Zygomatic Arch - Closed Reduction NOTE: No manipulation or fixation.	30.00		26.00
**	07770	YU	Alveolus - Stabilization of Teeth, Open Reduction Splinting NOTE 1: Maxillary alveolar fracture. NOTE 2: Reduction with wiring, application of arch bar or splint, and so forth.	92.00		80.00

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
**	07770	YL	Alveolus - Stabilization of Teeth, Open Reduction Splinting	92.00		80.00

NOTE 1: Mandibular alveolar fracture.

NOTE 2: Reduction with wiring,
application of arch bar or splint,
and so forth.

**	07780		Facial Bones - Complicated Reduction with Fixation and Multiple Surgical Approaches	242.00		210.00
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NOTE 1: Maxilla, malar and/or
zygomatic arch.

NOTE 2: Multiple surgical approaches
(three (3) or more), fixation,
traction, headframe, multiple internal
and/or external fixation, head cap,
and so forth.

(n) Reduction of Dislocation and Management of Other Tempo-
Mandibular Joint Dysfunctions

**	07810		Open Reduction of Dislocation	182.00		158.00
**	07820		Closed Reduction of Dislocation	18.00		16.00
d**	07830		Manipulation under Anesthesia	18.00		16.00
			NOTE: Anesthesia additional.			
d*	07840		Condylectomy	362.00		315.00
d*	07850		Meniscectomy	362.00		315.00
d*	07860		Arthrotomy	362.00		315.00
d**	07870		Arthrocentesis	18.00		16.00

NOTE: Injection or aspiration
(Give complete details).

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
<u>(o) Repair of Traumatic Wounds</u>						
1. Describe completely, giving size and site, and so forth.						
2. Fee includes suture removal.						
**	07910	52	Suture of Recent Small Wounds	18.00		16.00
NOTE: Up to 2.5 cm.						
**	07910		Suture of Recent Small Wounds up to 5 cm.	24.00		21.00
NOTE: 2.5 cm. up to 5 cm.						
**	07910	22	Suture of Recent Small Wounds	30.00		26.00
NOTE: Over 5 cm. up to 7.5 cm.						
3. Lacerations over 7.5 cm. use code 07999.						
<u>(p) Complicated Suturing (Reconstruction Requiring Delicate Handling of Tissues and Wide Undermining for Meticulous Closure)</u>						
1. Also for irregularly shaped lacerations requiring extensive debridement.						
**	07911		Suture - Up to 5 cm.	BR		BR
**	07912		Suture - Over 5 cm.	BR		BR
<u>(q) Other Repair Procedures</u>						
*	07940		Osteoplasty - For Orthognathic Deformities	BR		BR
*	07955		Repair of Maxillofacial Soft and Hard Tissue Defects	BR		BR
*	07960		Frenulectomy (Frenectomy or Frenotomy) - Separate Procedure	32.00		28.00
d**	07980		Sialolithotomy	48.00		42.00
d*	07981		Excision of Salivary Gland	182.00		158.00

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
d*	07982		Sialodochoplasty	151.00		131.00
d*	07983		Closure of Salivary Fistula	151.00		131.00
**	07990		Emergency Tracheotomy	121.00		105.00
d**	07999		Unspecified Oral Surgery Procedure, By Report	BR		BR

NOTE: Complete description of procedure, and why.

10:56-3.11 08000-08999 X. ORTHODONTICS

(a) Minor Treatment for Tooth Guidance

1. Includes all necessary adjustments.
2. Code may also be used for Orthodontic Retention Appliances following comprehensive treatment by a previous dentist.

*	08110		Removable Appliance Therapy	115.00		100.00
*	08120		Fixed Appliance Therapy	115.00		100.00

(b) Minor Treatment to Control Harmful Habits

1. Includes all necessary adjustments.

*	08210		Removable Appliance Therapy	115.00		100.00
*	08220		Fixed Appliance Therapy	115.00		100.00

(c) Comprehensive Orthodontic Treatment - Permanent Dentition

1. Treatment of permanent dentition. Case type - fixed or removable appliances. Itemize fee for diagnostic procedures and formal treatment separately. Indicate anticipated time under treatment - maximum treatment reimbursable including retention - three (3) years. When authorized, reimbursement for comprehensive orthodontic treatment will include retention as required at no additional charge.

2. Reimbursement for the monthly fee is based on one or more visits to the practitioner during any calendar month. Reimbursement must not be requested for any month in which there is no monthly visit.

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
*	Y2910		Appliances	162.00		140.00
*	Y2920		1st Through 12th Month of Treatment (To Start On Day Insertion of Appliances Is Completed), Per Month	30.00		26.00
*	Y2930		13th Through 24th Month of Treatment, Per Month	28.00		24.00
*	Y2940		25th Through 30th Month of Treatment, Per Month	11.00		9.00
*	Y2950		31st Through 36th Month (Maximum Reimbursable Period of Treatment), Per Month	11.00		9.00

(d) Other Orthodontic Services1. Comprehensive Orthodontic Examination and/or Orthodontic Assessment Examination:

a. Reimbursement is limited to the provider or provider group who does such an examination with the intention of personally providing any orthodontic treatment necessary.

b. Reimbursement is limited to once every 12 months unless authorized.

c. Orthodontic examinations are not reimbursable for individuals age 20 or older.

d. When requesting reimbursement for the Orthodontic Assessment Examination, the Definition and Criteria for Assessing Handicapping Malocclusion Permanent Dentition form (FD-10) must accompany the Dental Services Claim form (MC-10).

Y2965	Orthodontic Examination (Comprehensive) and (Complete Orthodontic) Treatment Plan	6.00	5.00
Y2975	Orthodontic Assessment Examination, using the Handicapping Malocclusion Assessment System	6.00	5.00

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>		
				<u>S</u>	<u>\$</u>	<u>NS</u>
*	08999		Unspecified Orthodontic Procedure, By Report	BR		BR

NOTE: Complete description, diagnosis and treatment plan must be submitted.

10:56-3.12 09000-09999 XI. ADJUNCTIVE GENERAL SERVICES

(a) Unclassified Treatment

d	09110		Palliative (Emergency) Treatment of Dental Pain - Minor Procedures	7.00		6.00
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NOTE 1: Emergency treatment of dental pain or infection, palliative (flat fee for all services performed, when not covered by separately listed procedure). Diagnosis and description of treatment is required.

NOTE 2: Code to be used for initial endodontic emergency procedure. Diagnosis and description of treatment is required.

(b) Anesthesia

d**	09210		Local Anesthesia Not in Conjunction with Operative or Surgical Procedures	13.00		11.00
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NOTE: Infiltration and/or nerve block for diagnostic purposes or purposes other than anesthesia.

	09220		General Anesthesia	12.50		12.50
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NOTE 1: This code applies when the dentist performing the services (attending dentist) also administers the general anesthesia or in conjunction with oral surgery services only.

NOTE 2: Reimbursement will be made for the administration of only one general anesthesia per visit.

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS

(c) Special General Anesthesia

1. (Basic units - See American College of Anesthesiologists Relative Value Guide - 1967).

*	09220	22	Maximum 4 units	22.00	22.00
*	09220	52	Time units: Each additional 15 minute period or major portion thereof. (Limited to "table" or "chair" time only). Maximum reimbursable two (2) hours	5.50	5.50

NOTE 1: The general anesthesia codes above are limited to use in restorative dentistry alone or restorative dentistry in conjunction with other dental services requiring anesthetic management, and must receive prior authorization from the Office of the Chief, Bureau of Dental Services. These codes apply to those dentists appropriately qualified in general anesthesia and are reimbursable only to the dentist whose sole function is to administer general anesthesia.

NOTE 2: An anesthesia record must be submitted which shows elapsed anesthesia time, and pinpoints time and amounts of drugs administered, pulse rate and character, blood pressure, respiration, and so forth. The Dental Services Claim form (MC-10) for anesthesia and treatment must accompany this record to permit authorization for reimbursement.

	09240		Intravenous Sedation	10.00	9.00
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(d) Professional Consultation (Diagnostic service provided by a dentist other than practitioner providing treatment)

1. A complete report must be available.

d	09310		Consultation - Per Session	22.00	17.00
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<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>		
				<u>S</u>	<u>\$</u>	<u>NS</u>
<u>(e) Professional Visits</u>						
	09410		House Call	10.50		9.00
			NOTE: In addition to fee for service provided.			
	Y3005		Long Term Care Facility Visits	10.50		9.00
			NOTE 1: In addition to fee for service provided.			
			NOTE 2: This code is reimbursable only once per trip per facility regardless of the number of patients examined or treated.			
	09420	52	Hospital Call	9.00		7.00
			NOTE 1: Hospital visit, in addition to fee for service provided.			
			NOTE 2: Code 09420 52 will not be reimbursable in conjunction with Code 09310 or Codes 09420 22 or 09420. Not applicable in conjunction with those services which include follow-up days.			
			NOTE 3: Code 09420 52 is reimbursable only once per trip per facility regardless of the number of patients examined or treated.			
			NOTE 4: Code 09420 52 is not reimbursable when Medicaid fee for service exceeds \$25.00.			
	09420	22	Hospital Call	22.00		17.00
			NOTE 1: Code to be used for Hospital Day - Initial.			

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>		
				<u>S</u>	<u>\$</u>	<u>NS</u>

NOTE 2: Hospital record must include as a minimum:

- a. Chief Complaint(s);
- b. Complete history of the present illness and related systemic review including recording of pertinent negative findings;
- c. Complete pertinent past medical history;
- d. Pertinent family history;
- e. A full examination pertaining to the history of the present condition and including recording of pertinent negative findings; and
- f. Working diagnosis and treatment plan, including preparation of the "order sheet".
- g. If history and examination noted above are not personally done by the "billing" practitioner then this code will be downgraded to code 09420, provided that code's criteria are met.

NOTE 3: Code 09420 22 will not be reimbursed again if performed on the same recipient by the same practitioner, members of same group, members of a shared health care facility, practitioners sharing a common record or when Code 09310 has been billed in conjunction with the same hospital admission and/or stay by the same practitioner, members of the same group, members of a shared health care facility, or practitioners sharing a common record.

IND	HCPCS CODE	MOD	PROCEDURE DESCRIPTION	MAXIMUM FEE ALLOWANCE		
				S	\$	NS
	09420		Hospital Call	9.00		7.00

NOTE 1: Code to be used for Hospital Day - Subsequent.

NOTE 2: Consisting of care and treatment by the Practitioner subsequent to date of "Hospital Day - Initial" and including those procedures ordinarily performed during a hospital visit dependent upon the practitioner's discipline. The following may be included in the progress notes:

- a. Update of symptoms;
- b. Update of physical findings;
- c. Resume of findings of procedures, if any done;
- d. Laboratory, X-ray, consultations, etc., pertinent positive and negative findings;
- e. Changes or confirmations of diagnosis and progress of case;
- f. Additional planned studies, if any, and why; and
- g. Treatment changes, if any.

NOTE 3: Not reimbursable for those services that include follow-up days.

(f) Drugs

d	09610		Therapeutic Drug Injection, By Report	2.50		2.50
d**	09610	22	Therapeutic Drug Injection, By Report	13.00		11.00

NOTE: Injection of one or more muscles of mastication in conjunction with treatment of T.M.J. dysfunction.

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>	
				<u>S</u>	<u>\$ NS</u>
d*	09630		Other Drugs and/or Medicaments, By Report	BR	BR
(g) <u>Miscellaneous Services</u>					
	09910		Application of Desensitizing Medicaments	6.00	5.00
			NOTE 1: Application to a tooth, i.e., cervical sensitivity, erosions, etc.		
			NOTE 2: Specify tooth code(s).		
*	09930		Treatment of Complications (Post Surgical) - Unusual Circumstances, By Report	6.00	5.00
			NOTE: This code may also be used for post-operative treatment beyond that normally provided as part of the basic procedure or when provided by prac- titioner other than one who provided the original service or in excess of "follow-up days". (California Relative Value Study - 1964), per visit.		
*	09940		Occlusal Guards, By Report	35.00	30.00
			NOTE 1: Special periodontal appliances (including occlusal guards, athletic mouth guards and so forth).		
			NOTE 2: Office procedure.		
*	09940	22	Occlusal Guards, By Report	50.00	43.00
			NOTE 1: Special periodontal appliances (including occlusal guards, athletic mouth guards and so forth).		
			NOTE 2: Laboratory procedure.		

HCPCS CODES FOR DENTAL SERVICES

10:56-3.12

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>	
				<u>S</u>	<u>\$ NS</u>
*	09951		Occlusal Adjustment - Limited NOTE: 1 to 3 Teeth.	6.00	5.00
*	09951	22	Occlusal Adjustment NOTE: Per quadrant (minimum 6 teeth).	17.00	15.00
*	09952		Occlusal Adjustment - Complete	69.00	60.00
d**	09999		Unspecified Adjunctive Procedure, By Report	BR	BR

NOTE: To be used only where no code number exists or existing code is not precisely applicable. Complete description of condition and proposed treatment must be submitted.

REC'D JAN 30 1986



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

New Jersey Health Services Program

NEWSLETTER

Volume... P-512

January 26, 1987

To: Homemaker Agencies Participating in the Community Care Program
for the Elderly and Disabled (CCPED)

SUBJECT: Change in Accreditation Time Schedule - January 1, 1988

EFFECTIVE: Immediately

BACKGROUND: A prior newsletter, dated May 26, 1986, informed you that homemaker agencies participating in the Community Care Program for the Elderly and Disabled must be accredited by February 1, 1987, as a condition for continued participation in the New Jersey Medicaid Program. It stated that this accreditation must be carried out by the National HomeCaring Council, now a Division of the Foundation for Hospice and Home Care, or by the Commission on Accreditation for Home Care (established by the Home Care Council of New Jersey).

The National HomeCaring Council has continued to accept and process accreditation applications. However, until now, the Commission on Accreditation for Home Care, which was newly established in New Jersey, has not been ready to fully implement its accreditation program.

We have recently been informed that the Commission on Accreditation for Home Care is accepting applications for accreditation. Completed applications will be processed in the order of receipt.

All agencies currently participating in the Community Care Program for the Elderly and Disabled are expected to be accredited either by the Commission or by the National HomeCaring Council. Agencies are urged to apply as soon as possible. Experience indicates that the process of accreditation may take as long as one year, especially for agencies which have never been through any kind of accreditation or licensure process.

ACTION: The Division of Medical Assistance and Health Services, in recognition of the delay in the implementation of the accreditation process by the Commission for Accreditation for Home Care, is once again extending the deadline for accreditation for the agencies now providing services under the Community Care Program for the Elderly and Disabled. The new date will be January 1, 1988. Since accreditation is also a requirement for this Division's Personal Care Assistant Services Program, agencies accredited for the Community Care Program for the Elderly and Disabled will be able to participate as the result of this accreditation as providers of personal care assistance services.

ALBANY, N.Y. 12202

Those agencies who have never been accredited as required by this Division but are currently operating under accreditation awarded previously by the Home Care Council of New Jersey, must be accredited by the Commission on Accreditation for Home Care or the National HomeCaring Council no later than July 1, 1988 for continued participation in the Community Care Program for the Elderly and Disabled. This extended accreditation status will be carried out under conditions defined by the Home Care Council of New Jersey in concert with the Division of Medical Assistance and Health Services.

For further information and application for accreditation, please contact one or both of the following agencies:

Dr. Nancy Robinson
Accreditation Program
National HomeCaring Council
Foundation for Hospice and
Home Care
519 C Street, N.E.
Stanton Park
Washington, D.C. 20002
Telephone: 202-547-6586

Kenneth Dolan
Commission on Accreditation
for Home Care
Home Care Council of New Jersey
60 S. Fullerton Avenue
Montclair, New Jersey 07042
Telephone: 201-744-5524

Any questions regarding this newsletter or program participation should be directed to Carol H. Kurland, Administrator, Office of Home Care Programs at 609-588-2620.



REC'D FEB 5 1986

New Jersey Health Services Program

NEWSLETTER

Volume P-513

January 26, 1987

TO: All Physicians, Dentists, Podiatrists, and Pharmacists

SUBJECT: Injectable Drugs - Given by the Practitioner -
A Policy Change in the Present Procedure for Reimbursement

PURPOSE: To compensate for any inequity created when the average wholesale price per dose of an injectable drug exceeds the Medicaid reimbursement allowance of \$2.50 for an injection, the New Jersey Medicaid Program will pay for the drug that is normally supplied by the physician, dentist, or podiatrist.

ACTION: When the average wholesale cost per dose of a drug injected by the practitioner (or his employee) exceeds the \$2.50 reimbursement allowance for an injection (Code 90799), the following procedure is in order:

- (1) Write a prescription in the name of the patient for whom the drug is intended. A prior authorization number must be written on the prescription before it is sent to the pharmacy for dispensing. This number must be obtained by the practitioner from the appropriate Medicaid District Office (MDO).

(A listing of the MDOs is found at the end of Chapter 49 of your Provider Services Manual.)

- (2) The physician and podiatrist will be paid \$2.50 for giving the injection by submitting a claim for the injection (Code 90799) on the 1500-N.J. claim form. The dentist will be paid \$2.50 for giving the injection by submitting a claim for the injection (Code 09610) on the MC-10 claim form.

When the above does not apply, the published criteria for codes 90799 and 09610 remain unchanged.

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) 588-2749 or James Ryan, R.P., Assistant Chief Consultant, Pharmaceutical Services, Division of Medical Assistance and Health Services, at (609) 588-2724.



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

NEWSLETTER

New Jersey Health Services Program

Volume.....P-514.....

February 16, 1987

TO: All Providers

SUBJECT: Medicaid District Office Directory Update
Essex County Medicaid District Offices - Newark and Suburban

EFFECTIVE: March 1, 1987

The Division of Medical Assistance and Health Services is issuing this newsletter to inform all providers 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. The directory replaces the one in your provider manual dated 5/86.

Additionally, in a continuing effort to better serve the Essex County Medicaid client and provider, the Division is pleased to announce that effective March 1, 1987, there will be two Essex County Medicaid District Offices. Newark residents will be served by the Newark Medicaid District Office located at 155 Washington Street, Newark 07102, telephone: 201-648-2470. All other Essex County residents will be served by the Suburban Essex County Medicaid District Office located at 76 South Orange Avenue, Second Floor, South Orange 07079, telephone: 201-761-7441.

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



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 South New York Avenue Atlantic City, NJ 08401 Tel. 609-441-3620
Bergen	John Blake, Director	171-173 Main Street Hackensack, NJ 07601 Tel. 201-488-5667
Burlington*	Helen Kern, Director Daniel Walsky, Regional Director	50 Rancocas Road Mt. Holly, NJ 08060 Tel. 609-261-0448
Camden	Ronald Coppola, Director	1800 East Building 1800 Davis Street, Suite 301 Camden, NJ 08104 Tel. 609-757-2870
Cumberland (Cape May)	Daniel Cooperson, Director	108 Landis Avenue Vineland, NJ 08360 Tel. 609-696-6560
Essex-Newark	John T. Russell, Director	155 Washington Street Newark, NJ 07102 Tel. 201-648-2470, 648-3700
Essex-Suburban	A. Bialogowicz, Director	76 South Orange Avenue, 2nd Floor South Orange, NJ 07079 Tel. 201-761-7441
Gloucester (Salem)	Eleanor Chatzinoff, Director	251 North Delsea Drive Woodbury Plaza, Suite B Deptford, NJ 08096 Tel. 609-845-7185
Hudson	Alice Rooth, Director	2815 Kennedy Boulevard, 2nd Floor Jersey City, NJ 07306 Tel. 201-433-8011
Hunterdon (Somerset)	Caroline Krajewski, Director	84 Park Avenue, 2nd Floor Flemington, NJ 08822 Tel. 201-782-1130
Mercer	William Bailey, Director	28 West State Street, Room 1105 Trenton, NJ 08608 Tel. 609-292-7315
Middlesex*	Director Walter Maibach, Regional Director	75 Paterson Street (basement) New Brunswick, NJ 08903 Tel. 201-246-0653
Monmouth	Frances Garrett, Director	1200 Memorial Drive Asbury Park, NJ 07712 Tel. 201-775-5700
Morris* (Sussex & Warren)	Marie Reed, Director John Langan, Regional Director	10 Park Place, 4th Floor Morristown, NJ 07960 Tel. 201-267-1700
Ocean	Raphaelle Andriola, Director	1861 Hooper Avenue Toms River, NJ 08753 Tel. 201-255-6226
Passaic	Alphonse Leone, Director	Law Building 66 Hamilton Street Paterson, NJ 07505 Tel. 201-977-4077
Union	Director	125 Broad Street, 6th Floor Hersh Towers Elizabeth, NJ 07201 Tel. 201-820-3135

* Denotes office where the Regional Director can be reached.

(Rev. 3/87)



NEWSLETTER

New Jersey Health Services Program

Volume P-515

February 23, 1987

TO: Providers of Hearing Aid Services

SUBJECT: HCFA Common Procedure Coding System (HCPCS) - Revision

PURPOSE: This Newsletter informs Hearing Aid Providers that:

- (1) New HCPCS codes are added to the HCPCS listing,
- (2) Code modifiers "NU" and "UE" are discontinued, and
- (3) Replacement pages are attached to this newsletter to update the text of the Hearing Aid Manual relevant to the new HCPCS codes and use of the claim form 1500 N.J.

ACTION:

- (1) All new codes added since HCPCS codes were first transmitted in Newsletter P-435, dated June 28, 1985, are included in this newsletter. The additions are listed below:

HCPCS CODES: V5090 - Dispensing Fee
V5160 - Dispensing Fee, Binaural
V5200 - Dispensing Fee, Cros
V5240 - Dispensing Fee, Bicros

Attached are replacement pages incorporating these codes into Subchapter 4.

- (2) Instructions for filling out the Health Insurance Claim Form (1500 N.J.), as given in New Jersey Health Services Newsletter P-502, dated December 1, 1986, are incorporated into the text of the attached replacement pages for the Hearing Aid Services Manual. Please note that HCPCS Code Modifiers "NU" and "UE", referred to in Newsletter P-502 dated December 1, 1986, (Item 24 D under instructions for Completion of Health Insurance Claim Form) are deleted as the use of these modifiers is not necessary at this time.

Manual Maintenance:

1. Subchapters 1., 2. and 3.

Replacement pages are enclosed for Subchapters 1., 2., and 3. New or revised text is indicated by a vertical line in the left hand margin of the page.

Delete pages 3 and 4, printed back-to-back, dated Rev. 1/82.
Replace with pages 3 and 4, dated 2/87, printed-back-to-back.

Delete pages 11 and 12, 13 and 14, printed back-to-back, dated Rev. 1/82. Replace with page 11, dated 2/87, printed on one side; pages 12 and 13, dated 2/87, printed back-to-back; and page 14, dated 2/87, printed on one side.

(over)

Delete pages 17 and 18, 19 and 20, printed back-to-back, dated 1/82. Replace with pages 17 and 18, printed back-to-back, dated 2/87; page 19, printed on one side, dated 2/87; and page 20 (Exhibit I - FD-257 (1/82) printed on one side.

Delete page 23 (Exhibit IV - FD-244 (1/82) and page 24 (Exhibit V - Medical Supplies and Equipment Form MC-11, dated 8/78), printed back-to-back. Replace with page 23 printed on one side (Exhibit IV - FD-244 (2/85) and with page 24 (Exhibit V) Health Insurance Claim Form (1500 N.J. ED. 11-82), printed back-to-back.

Delete page 25, dated 1/82. A listing of Medicaid District Offices can be found at the end of Chapter 49 of this manual - 10:49 - Administration.

2. Subchapter 4.

Replacement pages are enclosed for Subchapter 4. New codes are indicated by the sign ">" in the left hand margin preceding the code number.

Delete page I (Index)

Change the page numbered with a Roman Numeral II to "25" and write :
Rev. 2/87

Delete page -1- (no date written) and replace with pages 26 and 27, dated 2/87, printed back-to-back.

3. The following Newsletters should be deleted:

Newsletter P-327, dated March 1, 1982, Hearing Aid Services Manual Revision.

Newsletter P-435, dated June 28, 1985, HCFA COMMON PROCEDURE CODING SYSTEM.

Newsletter P-461, dated October 21, 1985, Amending Requirement for Narrative Description on Claim Form.

Newsletter P-502, dated December 1, 1986, Implementation of Health Insurance Claim Form (1500 N.J.).

After completion of Manual Maintenance, this Newsletter may be discarded.

If you have any questions regarding this Newsletter, please contact The Prudential Insurance Company of America at (800) 582-7052.

assist in caring for the aid, the status of the patient's previous hearing aid, if any, and an assesment of whether an aid will significantly improve the patient's quality of life by increased socialization or increased involvement in activities. See Subchapter 3, Exhibit 1, - Form FD-257 to record results of the screening, which is signed by the nursing director, social worker and the treating physician. Then it is forwarded to the otologist, who will provide the otologic examination.

(b) The hearing aid prescription:

1. Monaural hearing aids may be considered, except those requiring Silver Oxide Batteries.

2. CROS, BICROS and binaural hearing aids may be considered only for children, for adults attending school, for individuals with severe high frequency loss who must use a CROS aid to prevent feedback, or for an eligible adult recipient who is gainfully employed or who is likely to be employed if a CROS, BICROS or binaural hearing aid arrangement is provided.

3. Electroacoustic characteristics for a reconditioned hearing aid may also be prescribed in addition to the specific hearing aid prescription if any of the conditions listed under this Section exists. The dispenser shall then have the option of providing either the specific aid or a reconditioned aid. Reconditioned hearing aids are subject to the conditions listed in section 10:64-1.5 (c) and may be provided if:

i. The patient is a resident of a long-term care facility;

ii. The patient is in a living arrangement other than a long-term care facility and is deemed an appropriate candidate for a reconditioned aid;

iii. The patient has had a previous aid that was lost, stolen, or destroyed within 36 months of the date that it was dispensed.

10:64-1.4 PRIOR AUTHORIZATION FOR HEARING AID

- (a) New and replacement hearing aids require prior authorization by the Medicaid District Office Medical Consultant.
- (b) The hearing aid dispenser (provider) completes all applicable items except Items 12, 25 and 34 on the Health Insurance Claim Form (1500 N.J.) and submits the form to the appropriate Medicaid District Office for prior authorization, along with the nursing home hearing aid screening form, if applicable, and the otologic and audiologic reports (see Section 1.7 concerning policies on replacement of hearing aids).
- (c) The Medicaid District Office Medical Consultant reviews the otologic and audiologic reports along with the nursing home screening form, if applicable.
 1. Claims for CROS, BICROS, binaural, and reconditioned aids will be reviewed by the audiology consultant before authorization is determined.
- (d) Authorization for a hearing aid is indicated by the signature of the Medicaid District Office Medical Consultant in Item 34 of the Health Insurance Claim Form (1500 N.J.).
- (e) The Medicaid District Office returns the original copy of the claim form to the dispenser and retains a copy of the claim form, the nursing home hearing aid screening report, and the otologic and audiologic examination reports. The dispenser may then proceed to supply the authorized item to the recipient (see Subchapter 2 for billing procedures). If the request is denied, "Authorization denied" will be indicated in Item 34 of the 1500 N.J. form and the dispenser will receive a notification letter from the Medicaid District Office.

10:64-1.5 DISPENSING OF HEARING AID

- (a) Delivery of the hearing aid shall be made to the patient within 21 days of receipt of authorization from the Medicaid District Office. If it is not possible to supply the instrument within the stated time, the dispenser shall notify the Medicaid District Office and give the reason(s) for the delay. If the patient is a first time user, the earmold shall not be dispensed until prior authorization for the hearing aid is received.
- (b) When the new hearing aid is delivered the dispenser shall:
 1. Supply the new instrument;
 2. Supply a custom-fitted earmold;
 3. Supply tubing, or cord and receiver;
 4. Issue a one month's supply of batteries;
 5. Issue a garment bag, if applicable, and any other accessories normally supplied with the type of hearing aid provided;

1. Usual and customary charge; or
2. A charge consisting of the following:
 - i. Wholesale cost of the instrument, if new; or the acquisition cost and cost of the factory or laboratory reconditioning, when applicable, if a reconditioned unit; plus
 - ii. Wholesale cost of the earmold, as per laboratory invoice or laboratory price list; plus
 - iii. A dispensing fee of \$50.00.

(e) Reimbursement for repair of a hearing aid, if not covered by the manufacturer's warranty, shall be the lower of the following:

1. Usual and customary charge; or
2. A charge consisting of the following:
 - i. Manufacturer's cost of repair; plus
 - ii. A 50 percent service fee.

(f) Reimbursement for replacement parts, if not covered by the manufacturer's warranty, shall be the lower of the following:

1. Usual and customary charge; or
2. A charge consisting of the following, depending upon the part or parts to be replaced:
 - i. Earmolds: Wholesale cost, as per laboratory invoice or laboratory price list; plus \$10.00
 - ii. Batteries, which shall be provided as a three month's supply: Manufacturer list prices less 10 per cent.
 - iii. Cords: Manufacturer list price less 10 percent.
 - iv. Receivers: Manufacturer list price less 10 percent.
 - v. Garment bags: Manufacturer list price less 10 percent.

SUBCHAPTER 2. BILLING PROCEDURES

10:64-2.1 GENERAL BILLING PROCEDURES

- (a) A claim is a bill which indicates a request for payment for Medicaid-reimbursable services provided to a Medicaid-eligible individual. The claim may be submitted hard copy or by means of an approved method of automated data exchange.
- (b) The Health Insurance Claim Form (1500 N.J.) is to be used for billing of hearing aids and equipment. For hearing aids which require prior authorization, Item 34 must be signed and dated by the Medicaid District Office Medical Consultant before the claim may be considered for payment. Before billing the Fiscal Agent the dispenser shall have the recipient sign Item 12 (Patient's or Authorized Person's Signature), and the dispenser shall sign Item 25 (Signature of Physician or Provider).

10:64-2.2 PROCEDURES FOR THE BILLING OF HEARING AIDS

- (a) The procedure for the billing of hearing aids shall be as follows:
 1. The dispenser shall attach one copy of Form FD-244 (Follow-Up to Hearing Aid Examination) to the original copy of the claim form (1500 N.J.) when submitting the claim to the Fiscal Agent for payment.
 2. If the Notice of Missed Appointment has been completed on Form FD-244, or written reason given for lack of follow-up, the dispenser shall answer questions in the bottom portion of this form, giving the following information:
 - i. The aid and earmold provided conform to the prescription as per Form FD-36; and
 - ii. The aid and earmold provided fit comfortably and adequately.
 3. If the dispenser has not received Form FD-244 from the Medicaid staff or the audiologic facility within 30 days of delivery of the aid to the patient, a copy of the Notice of Requirement for Hearing Aid Follow-up Visit shall be attached to the claim in lieu of the FD-244. On the bottom portion of this notice, the dispenser shall add a signed and dated affidavit certifying the following:
 - i. That notification regarding follow-up testing was not received within 30 days of dispensing the aid;
 - ii. That the aid and earmold provided conform to the prescription as per Form FD-36; and
 - iii. That the aid and earmold provided fit comfortably and adequately.

4. When billing the Fiscal Agent for a reconditioned hearing aid, the dispenser shall attach to the claim form the following:
 - i. A copy of the invoice or sales document showing the acquisition cost of the aid, if any; and/or
 - ii. A copy of the factory or laboratory invoice showing the cost of reconditioning.

10:64-2.3 TIMELINESS OF CLAIM SUBMISSION AND CLAIM INQUIRY

For timeliness of claim submission and claim inquiry, see Chapter 49 of this manual, Administration - 10:49-1.12.

10:64-2.4 BILLING FOR SERVICES AND MATERIALS

- (a) Billing for services and materials in the event that an aid is returned, in accordance with Section 10:64-1.6, shall be as follows:
 1. The dispenser shall prepare a new claim form showing charges for materials, manufacturer's charges, and the service fee. No prior authorization is necessary.
 2. The dispenser shall attach a copy of Form FD-244 (Follow-Up to Hearing Aid Examination) to the new claim before mailing it to the Fiscal Agent.

10:64-2.5 BILLING FOR REPAIRS

- (a) Billing for repairs shall be as follows:
 1. The dispenser shall attach one copy of the factory or laboratory invoice to the claim form (1500 N.J.) when billing the Fiscal Agent.
 2. The dispenser shall note on the claim form one of the following:
 - i. "Repair of new aid"; or
 - ii. "Repair of recon aid".

10:64-2.6 MAILING INSTRUCTIONS

- (a) Mailing instructions are as follows:
 1. Mail the original copy to:

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

Subchapter 3 - Instructions for filling out Forms and Exhibits

10:64-3.1 Completion of Nursing Home Hearing Aid Screening
(Form FD-257: Exhibit I)

(a) Instructions for completing the Nursing Home Hearing Aid Screening (Form FD-257) are as follows:

1. Item 1. thru 5. - Self Explanatory
2. Item 6. - All questions must be answered by designating checkmark in appropriate column;
3. Item 7. List any additional information or recommendations as to need of hearing aid;
4. Item 8. - Signature of Nursing Director;
5. Item 9. - Signature of Social Worker;
6. Item 10. - This is to be checked if patient is a candidate for a hearing aid and form forwarded to the otologist who will provide the otologic examination;
7. Item 11. - This is to be checked if the patient is not a candidate for a hearing aid and the completed form is to be placed in the patient's records.
8. Item 12.thru 14. - Self explanatory

10:64-3.2 Completion of the Audiologic and Hearing Aid Examinations
(Form FD-36: Exhibit II)

(a) Results of the audiologic and hearing aid examinations shall be reported on the Audiologic and Hearing Aid Examinations (Form FD-36) and shall include the following:

1. Information relative to the patient's hearing aid candidacy, including:

4. Statement as to the situations in which the recipient is using the hearing aid provided, or explanation of why the aid is not being used.
 5. Recommendation for purchase, alteration, or return of the aid to the dispenser.
 6. Signature: Form FD-244 shall be signed by the individual who has personally visited the nursing home, tested the patient, or verified a missed appointment by completing the Notice of Missed Appointment; and shall be forwarded in duplicate to the hearing aid dispenser.
- (b) In the event that it is not possible to provide follow-up within 21 days of acceptance of the aid by the patient, the audiologic facility or the Medicaid District Office shall submit to the dispenser Form FD-244, completing Notice of Missed Appointment if applicable, or writing the reason why the follow-up visit could not be completed on the bottom of the form.

10:64-3.5 INSTRUCTIONS FOR COMPLETION OF HEALTH INSURANCE CLAIM FORM
(1500 N.J.:EXHIBIT V)

- (a) Instructions for completion of Health Insurance Claim Form (1500 N.J.) are as follows:
- ITEM 1. Copy the patient's name EXACTLY as it appears on the Medicaid eligibility validation form.
 - ITEM 2. Indicate patient's date of birth. Use six (6) digits (e.g., September 10, 1980 is written 09/10/80). If only the year is known, enter the year.
If birthdate is unavailable, submit claims without birthdate.
 - ITEM 3. Not applicable.
 - ITEM 4. Indicate patient's address and telephone number.
 - ITEM 5. Check appropriate block to identify patient's sex.
 - ITEM 6. Copy the patient's Health Insurance (Medicare) Claim Number as it appears on the Medicare Health Insurance card when the patient is covered by both Medicare and Medicaid.
 - ITEM 7. Not applicable.
 - ITEM 8. Copy the patient's Health Services Program (Medicaid) Case Number and Person Number EXACTLY as shown on the Medicaid eligibility validation form.
 - ITEM 8a. Not applicable.
 - ITEM 9. Check appropriate block to indicate whether the patient has other health insurance coverage. If yes, you must attach a copy of the explanation of payment or a copy of the decline notice from the other insurance coverage.
 - ITEM 10. Check as appropriate.
 - ITEM 11. Not applicable.

- ITEM 12. Under ordinary circumstances, the patient must sign the claim form when services have been received.
The claim form must indicate services rendered prior to presenting it to the patient for signature.
Indicate in the blocks provided, the relationship of signer to the patient-recipient.
If the patient's signature is unobtainable, refer to your Medicaid Provider Manual for procedures to follow.
- ITEM 13. Not applicable.
- ITEM 14. Not applicable.
- ITEM 15. Not applicable.
- ITEM 16. Not applicable.
- ITEM 16a. Not applicable.
- ITEM 17. Not applicable.
- ITEM 18. Not applicable.
- ITEM 19. Indicate the name of the prescribing practitioner unless the patient is an MP Plan member in which case you MUST indicate the name of the MP Plan Physician Case Manager.
- ITEM 19a. Enter the Individual Medicaid Practitioner (IMP) Number of the practitioner or Case Manager whose name is entered in Item 19.
- ITEM 20. Not applicable.
- ITEM 21. Write in the name of the facility if place of service is other than the patient's home or provider's place of business (office, etc.).
To be completed in addition to Item 24B.
- ITEM 21a. Not applicable.
- ITEM 22. Not applicable.
- ITEM 23A. Enter diagnoses for all services identified in Item 24D.
- ITEM 23B. EPSDT Program Referral:
Complete this item for patients under 21 years of age.
Ask the patient and/or referring physician or clinic if this service is the result of an EPSDT screening.
- ITEM 24A. Enter date(s) of each visit or service provided.
- ITEM 24B. Identify place of service by selecting appropriate alpha code as listed on the reverse side of the 1500 N.J. form under "Place of Service".
- ITEM 24C. Not applicable.
- ITEM 24D. Indicate the HCPCS code number for the service provided as listed in your Medicaid Provider Manual. Indicate the item number, model number, manufacturer's name, and sale amount. If there is no code in the manual to identify the service provided, enter a narrative description of the service. If a replacement within 36 months, add the notation "replacement aid". If a reconditioned aid, add the notation "Recon" and the notation "six months warranty" and attach to the claim form an invoice or sales document showing the acquisition cost of the aid, if any, and/or the facility or laboratory invoice showing the cost of reconditioning. Indicate the number of batteries and type of custom fitted earmold. If applicable; indicate the receiver model, one cord and garment bag. For repairs indicate "Repair of new aid" if originally dispensed as a new aid. Indicate "Repair of recon aid" for repair of a reconditioned aid. For replacement earmolds, describe the earmold and attach a copy of the laboratory cost list or laboratory invoice to the claim form. For batteries and replacement parts, describe the item.

- ITEM 24E. Enter either the reference number or the diagnosis code from Item 23A that is related to the service provided.
- ITEM 24F. Enter quantities or units.
- ITEM 24G. Enter your usual and customary charge for each service.
- ITEM 24H. Not applicable.
- ITEM 24I. Not applicable.
- ITEM 25. Read the Medicaid Provider Certification on the reverse side of the 1500 N.J. form carefully and sign and date the claim form accordingly.
- ITEM 26. Not applicable.
- ITEM 27. Enter the sum total of the individual charges indicated in 24G.
- ITEM 28. Not applicable.
- ITEM 29. Not applicable.
- ITEM 30. Not applicable
- ITEM 31. If not preprinted, write provider name, address and provider number. Enter telephone number.
- ITEM 32. Not applicable.
- ITEM 33. Not applicable.
- ITEM 34. For services requiring prior authorization the Medicaid District Office Medical Consultant will affix his/her signature, date the authorization and terms of authorization, that is, purchase, or denial and the provider must assure that Item 34 is complete before submitting the claim for payment.



1. Patient's last name		First name		2. Patient's street address		Telephone number	
HSP (Medicaid) Case No.		4. Patient Person #	5. Age	6. Sex <input type="checkbox"/> Female <input type="checkbox"/> Male		City,	State
							ZIP code

7. HEARING AID DISPENSER
NAME AND ADDRESS: _____

8. AUDIOLOGIST OR MEDICAID STAFF MEMBER
NAME, TITLE, ADDRESS: _____

9. EAR FITTED: _____ 10. DATE AID PROVIDED: _____

11. MAKE, MODEL AND SERIAL NUMBER OF AID: _____
SPECIAL ADJUSTMENTS: _____
EARMOLD TYPE: _____ BATTERY TYPE: _____

12. SOUND-FIELD DATA (decibels or percentages) SHOWING EFFECTS OF AMPLIFICATION ON COMMUNICATION:
UNAIDED DATA:

AIDED DATA:

13. ARE THE AID AND EARMOLD APPROPRIATE AS PROVIDED? _____ IF NO, PLEASE EXPLAIN: _____

14. IS THE PATIENT USING THE AID? _____
IF YES, IN WHICH LISTENING SITUATION? _____
IF NO, PLEASE EXPLAIN: _____

RECOMMENDATIONS:
1. PURCHASE _____
2. PURCHASE WITH THE FOLLOWING ALTERATIONS: _____
3. DO NOT PURCHASE; AID TO BE RETURNED TO THE DISPENSER: _____

16. SIGNATURE OF AUDIOLOGIST OR MEDICAID STAFF MEMBER _____ DATE _____

NOTICE OF MISSED APPOINTMENT

17. DATE OF MISSED APPOINTMENT _____
18. WE (WERE) (WERE NOT) NOTIFIED IN ADVANCE
19. WAS ANOTHER APPOINTMENT MADE? YES _____ NO _____
20. DATE OF NEW APPOINTMENT: _____
21. INDICATE WHY FOLLOW-UP COULD NOT BE COMPLETED (IF OTHER THAN A "MISSED APPOINTMENT"). _____

SIGNATURE OF AUDIOLOGIST DATE

IF NOTICE OF MISSED APPOINTMENT DESIGNATES RECIPIENT DID NOT RETURN FOR FOLLOW-UP TO HEARING AID EXAMINATION, THE FOLLOWING MUST BE ANSWERED BY THE DISPENSER:

22. DID THE AID AND EARMOLD PROVIDED CONFORM TO THE PRESCRIPTION PER FORM FD-36? YES _____ NO _____
23. DID THE AID AND EARMOLD PROVIDED FIT COMFORTABLY AND ADEQUATELY? YES _____ NO _____

SIGNATURE OF DISPENSER DATE

HEALTH INSURANCE CLAIM FORM

EXHIBIT V

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 2 _____	3. INSURED'S NAME (First name, middle initial, last name) 3 _____
4. PATIENT'S ADDRESS (Street, city, state, ZIP code) _____ Telephone No. _____	5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> 7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	6. PATIENT'S MEDICARE/CHAMPUS NO. (Include any letters) _____ 8. PATIENT'S MEDICAID I.D. NO. _____
9. OTHER HEALTH INSURANCE COVERAGE— YES <input type="checkbox"/> NO <input type="checkbox"/> Enter Name of Policyholder and Plan Name and Address and Policy Number	10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. ACCIDENTAL INJURY AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>	11. INSURED'S GROUP NO. (Or Group Name) _____ 12. INSURED'S ADDRESS (Street, city, state, ZIP code) _____
13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE _____ SIGNED _____ DATE _____		14. 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 <input type="checkbox"/> NO <input type="checkbox"/>	16a. IF AN EMERGENCY CHECK HERE <input type="checkbox"/>
17. DATE PATIENT ABLE TO RETURN TO WORK _____	18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____	DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____	
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. public health agency) _____	19a. I.D. NUMBER _____	20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATE 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 <input type="checkbox"/> NO <input type="checkbox"/> CHARGES _____	

23. 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 <input type="checkbox"/> NO <input type="checkbox"/> PRIOR AUTHORIZATION NO. _____			
DATE OF SERVICE FROM	TO	PLACE OF SERVICE	T.O.S.	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (Explain Unusual Services Or Circumstances)	DIAGNOSIS CODE	DAYS OR UNITS	CHARGES	CHECK IF FAMILY PLANNING	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.) _____ SIGNED _____ _____ MD <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> OD <input type="checkbox"/> DC <input type="checkbox"/> PhD <input type="checkbox"/>	26. ACCEPT ASSIGNMENT YES <input type="checkbox"/> NO <input type="checkbox"/> (Medicare and CHAMPUS Only See Back)	27. TOTAL CHARGE _____
32. PATIENT'S ACCOUNT NO. _____	30. PROVIDER SOCIAL SECURITY/I.D. NO. _____	28. AMOUNT PAID _____
33. EMPLOYER I.D. NO. _____	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS & ZIP CODE _____ TELEPHONE NO. _____	

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program and renders payment for health benefits

provided through membership and affiliation with the Uniformed Services. Information on the patient's sponsor should be provided in items 3, 6, 7, 8, 9, and 11.

MEDICAID PAYMENTS: Authorization to Release Information, and Payment Request. I certify that the service(s) covered by this claim has been received, and request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the State Agency or its authorized Agents any information needed for this or a related claim.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE AND CHAMPUS)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in the physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

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

For CHAMPUS claims, I further certify that neither I nor any employee who rendered the services are employees or members of the Uniformed Services (refer to 5 USC 5536).

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422 510).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE AND CHAMPUS INFORMATION

We are authorized by HCFA and CHAMPUS to ask you for information needed in the administration of the Medicare and CHAMPUS programs. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act as amended and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086.

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

The information we obtain to complete Medicare and CHAMPUS claims is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare or CHAMPUS and to insure that proper payment is made.

With the one exception discussed below, there are no penalties under Social Security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of Medicare or CHAMPUS claims. Failure to furnish any other information such as name or claim number, would delay payment of the claim.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations or federal agencies as necessary to administer the Medicare and CHAMPUS programs.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether worker's compensation will pay for treatment. Section 1877(a) (3) of the Social Security Act provides criminal penalties for withholding this information.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency may request.

information is true, accurate and complete; and that the services covered by this claim and the amount charged therefore are in accordance with the regulations of the Medicaid Program; and that no part of the net amount payable under this claim has been paid; and that payment of such amount will be accepted as payment in full without additional charge to the patient or to others on his behalf, with the exception of authorized deductibles and coinsurance. I also certify that services have been furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act and Section 504 of the Rehabilitation Act of 1973.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services covered by this claim were personally rendered by me or under my direct personal supervision (as defined by Program regulations); that the foregoing

I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

PLACE OF SERVICE CODES:

- (IH) - Inpatient Hospital
- (OH) - Outpatient Hospital
- (O) - Doctor's Office
- (H) - Patient's Home
- (DCF) - Day Care Facility (PSY)
- (NCF) - Night Care Facility (PSY)
- (NH) - Nursing Home
- (SNF) - Skilled Nursing Facility
- (A) - Ambulance
- (OL) - Other Locations
- (IL) - Independent Laboratory
- (OMS) - Other Medical Surgical Facility
- (RTC) - Residential Treatment Center
- (STF) - Specialized Treatment Facility
- (KC) - Independent Kidney Care Treatment Center
- (CL) - Clinic
- (ER) - Emergency Room
- (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

10:64-4.2 HCPCS CODE NUMBERS FOR HEARING AID SERVICES

<u>HCPCS CODE</u>	<u>DESCRIPTION</u>
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
➤ V5090	Dispensing Fee
V5120	Binaural, Body
V5130	Binaural, In The Ear
V5140	Binaural, Behind The Ear
V5150	Binaural, Glasses
➤ V5160	Dispensing Fee, Binaural
V5170	Hearing Aid, Cros, In The Ear
V5180	Hearing Aid, Cros, Behind The Ear
V5190	Hearing Aid, Cros, Glasses
➤ V5200	Dispensing Fee, Cros
V5210	Hearing Aid, Bicros, In The Ear
V5220	Hearing Aid, Bicros, Behind The Ear
V5230	Hearing Aid, Bicros, Glasses
➤ V5240	Dispensing Fee, Bicros
Y4000	Reconditioned Hearing Aid
Y4100	Returned Hearing Aid
Y4200	Hearing Aid Repairs

HCPCS
CODEDESCRIPTION

Y4300	Earmolds For Hearing Aids
Y4400	Batteries For Hearing Aids
Y4500	Hearing Aid Replacement Parts and Accessories
Y4600	Miscellaneous Hearing Aid Supplies and Services



Volume.....P-516.....

Date: March 16, 1987

TO: All Providers

SUBJECT: AIDS Community Care Alternatives Program (ACCAP)

EFFECTIVE: March 1, 1987

Background: The New Jersey Medicaid Program is announcing the AIDS Community Care Alternatives Program (ACCAP), a three-year renewable Federal waiver program which offers home and community-based services to persons with Acquired Immune Deficiency Syndrome (AIDS) or with AIDS-Related Complex (ARC). This program is the first of its kind in the nation.

The waiver was prepared by the Division of Medical Assistance and Health Services in response to the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) and the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) which encourages the development of community-based services. The purpose of the program is to help eligible individuals to remain in or return to the community, rather than be cared for in a long-term care facility or hospital.

Scope: The program serves a maximum of 350 individuals at any one time in the first year, 600 in the second year, and 1,000 in the third year. Because of the anticipated turnover in eligible individuals, the program has the capacity to serve 578 unduplicated individuals in the first year; 990 unduplicated individuals in the second year; and 1650 unduplicated individuals in the third year.

The program is statewide with slots allocated to each county based upon the estimated number of AIDS/ARC individuals to be served. A slot allocation listing for year one is attached.

Administration: The Division of Medical Assistance and Health Services administers the overall program. Additionally, it has the responsibility for assessing an individual's need for care and for determining which individuals will be served by the program.

Eligibility: Individuals eligible for ACCAP must be:

°°° Diagnosed as having AIDS or ARC.

°°° In need of institutional care and meet, at a minimum,

the nursing home level of care criteria established by the New Jersey Medicaid Program.

- °°° Categorically needy - Individuals who are Medicaid eligible in the community except for those served under the Medically Needy Program; or
- °°° Optionally categorically needy - Individuals who have incomes which exceed the community standard up to the institutional cap and have resources which fall within the institutional standard. There is no deeming of spousal or parental income or resources in the determination of eligibility for ACCAP.

Optionally categorically needy individuals under the age of 65 must be determined disabled by the Social Security Administration (SSA) or by the Bureau of Medical Affairs, Division of Public Welfare, using SSA disability criteria.

All individuals determined eligible for ACCAP will receive a Medicaid validation eligibility card. Providers should verify eligibility before providing services.

Cost-Sharing: Optionally categorically needy individuals are required to share in the cost of the service package when the individual's income exceeds maintenance needs as defined by program regulation. This includes medical and remedial care expenses not subject to payment by a third party payor. There will be no deeming of spousal or parental income in the determination of the individual's cost-share liability. Cost-sharing monies are to be centrally collected by the Division of Medical Assistance and Health Services.

Services: Except for nursing home services, all services currently provided under the New Jersey Medicaid Program are available under ACCAP in accord with an individualized plan of care. Additionally, the following services are available to the eligible individual:

- °°° Case Management - This is a process in which a public health nurse or social worker (MSW) in a community agency is responsible for planning, locating, coordinating and monitoring a group of services designed to meet the individual needs of the person being served. A listing of case management sites is attached.
- °°° Private-duty Nursing (PDN) - This is care provided by licensed practical or registered professional

nurses. PDN is continuous rather than part-time or intermittent care. Nurses may be employed by licensed home health agencies, voluntary non-profit homemaker/home health aide agencies, private employment agencies and temporary-help service agencies approved by Medicaid to provide PDN services. PDN services may be provided up to 16 hours per day per person, but only when there is a live-in primary adult caregiver who accepts 24-hour per day responsibility for the health and welfare of the individual.

Agencies approved to provide private-duty nursing services under Medicaid's Model Waiver III also may provide these services under ACCAP and may bill the Medicaid Program by using the same procedure codes. Agencies interested in providing PDN services may contact the Division of Medical Assistance and Health Services, Provider Enrollment Unit. For further information on PDN, refer to Newsletter P-505, dated December 8, 1986.

- °°° Certain Narcotic and Drug Abuse Treatments at Home - The program allows drug treatment centers, approved as Medicaid providers, to provide methadone treatment, individual psychotherapy and family therapy at home.
- °°° Personal Care Assistant Services - These are health-related tasks performed in the individual's home by a certified individual who is under the supervision of a registered professional nurse. These services must be prescribed by a physician and must be provided in accord with a written plan of care. Personal care assistant services under ACCAP may exceed the regular program limitation of 25 hours per person per week. Only Medicaid approved PCA providers may provide personal care assistant services under ACCAP.
- °°° Medical Day Care - This allows for health, social and supportive services on an outpatient basis several days a week in an approved medical day care center.

Cost Limitation: Total program costs in this special waiver are limited by the number of community care slots used each year and by costs per person. The cost of each individual's service package may be no more than the cost of institutional care for that individual, determined at a projected weighted cost of hospital care or net average cost of nursing home care.

Application Process: Individuals currently eligible for Medicaid through the AFDC Program or individuals who are not currently Medicaid eligible and wish to apply for ACCAP should be directed to the County Welfare Agency/ Board of Social Services located in the county where the individual resides.

Supplemental Security Income (SSI) recipients who wish to apply for ACCAP should make application to the Institutional Services Section of the Division of Medical Assistance and Health Services by calling the toll-free number: 800-523-0593.

Provider Enrollment: All current Medicaid providers may participate in ACCAP. To enroll contact the Provider Enrollment Unit, Division of Medical Assistance and Health Services, 7 Quakerbridge Plaza, CN 712, Trenton, New Jersey 08625 (Telephone: 609-588-2905).

Questions about the program should be directed to Division of Medical Assistance and Health Services, Office of Home Care Programs at (609) 588-2620.

AIDS Community Care Alternatives Program (ACCAP)

Slot Allocation for Year One (3/1/87 to 2/29/88)

<u>County</u>	<u>Slots</u>
Atlantic	5
Bergen	24
Burlington	5
Camden	8
Cape May	2
Cumberland	2
Essex	107
Gloucester	2
Hudson	72
Hunterdon	4
Mercer	8
Middlesex	16
Monmouth	9
Morris	8
Ocean	5
Passaic	33
Salem	2
Somerset	3
Sussex	2
Union	31
Warren	2
TOTAL	350

AIDS Community Care Alternatives Program (ACCAP)

CASE MANAGEMENT SITES
(For Adults 21 Years of Age and Over)

ATLANTIC	Atlantic County Department of Health & Institutions 201 South Shore Road Northfield, NJ 08225 (609) 645-7700
BERGEN	Home and Community Health Care of Bergen County, Inc. 74 Passaic Street Ridgewood, NJ 07450 (201) 444-0040
BURLINGTON	Community Nursing Services P.O. Box 287 Mount Holly, NJ 08060 (609) 267-1950
CAMDEN	Visiting Nurse and Health Association of Camden County 608 Broadway Camden, NJ 08103 (609) 365-5617
CAPE MAY & CUMBERLAND	Community Nursing Service Department of Health City of Vineland 111 North 6th Street Vineland, NJ 08360 (609) 794-4261
ESSEX	Community Health Care of North Jersey 451 Lincoln Avenue Orange, NJ 07050 (201) 673-0158
GLOUCESTER & SALEM	Southern New Jersey Visiting Nurse Service System, Inc. P.O. Box 508 Woodbury, NJ 08096 (609) 845-0460
HUDSON	Christ Hospital Home Health Services 176 Palisade Avenue Jersey City, NJ 07306 (201) 795-8444
HUNTERDON	Hunterdon Medical Center - Home Health Services Route 31 Flemington, NJ 08822 (201) 788-6138

Case Management Sites
AIDS Community Care Alternatives Program
Page 2

MERCER Visiting Nurse Association of Trenton, Inc.
P.O. Box 7393
West Trenton, NJ 08628
(609) 695-3491

MIDDLESEX Visiting Nurse Association of Middlesex County, Inc.
1915 Old Georges Road
North Brunswick, NJ 08902
(201) 821-9500

MONMOUTH MCOSS Nursing Services, Inc.
141 Bodman Place
Red Bank, NJ 07701
(201) 747-1204

MORRIS Visiting Nurse Association of Morris County, Inc.
38 Elm Street
Morristown, NJ 07960
(201) 539-1216

OCEAN Ocean County Health Department
CN 2191
Toms River, NJ 08754
(201) 341-9700

PASSAIC Visiting Health Service of Passaic Valley
783 Riverview Drive
Box 70
Totowa, NJ 07511
(201) 256-4636

SOMERSET Somerset Valley Visiting Nurse Association, Inc.
586 E. Main Street
Bridgewater, NJ 08807
(201) 725-9355

SUSSEX Sussex County Health Department
Division of Public Health Nursing
Box 139, R.D. 3
Newton, NJ 07860
(201) 948-5400

UNION Visiting Nurse and Health Service
354 Union Avenue
Elizabeth, NJ 07208
(201) 352-5694

Visiting Nurse Association of Plainfield & North Plainfield
427 W. 7th Street
Plainfield, NJ 07060
(201) 756-2436

Case Management Sites
AIDS Community Alternatives Program
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WARREN

Public Health Nursing Agency
Warren County Health Department
151 West Washington Avenue
Washington, NJ 07882
(201) 689-6000

Special Child Health Services - Case Management Units under contract to the New Jersey State Department of Health, located in each county, will provide case management services to children up to the age of 21. Further information about these programs is available by calling the State Department of Health at (609) 984-0775.



NEWSLETTER

New Jersey Health Services Program

Volume..... P-517

Date: March 16, 1987

TO: Home Health Agencies and Homemaker Agencies
 SUBJECT: AIDS Community Care Alternatives Program (ACCAP)
 EFFECTIVE: March 1, 1987

BACKGROUND: As announced in the New Jersey Health Services Program Newsletters, P-516 and BC-366, dated March 16, 1987, the New Jersey Medicaid Program implemented the AIDS Community Care Alternatives Program (ACCAP) on March 1, 1987. This program enables eligible individuals to remain in or return to the community rather than be cared for in a long-term care facility or hospital.

ACTION: Personal Care Assistant (PCA) services under ACCAP may exceed 25 hours per week if required by the ACCAP individual. As in the regular Medicaid program, PCA services must be prior authorized by the Medicaid District Office. PCA providers must use the FD-139 form, Request for Authorization/Reauthorization of Home Care Services.

The following new procedure codes must be utilized when billing Medicaid for PCA services provided to individuals under ACCAP:

<u>Personal Care Assistant Services</u>	<u>Procedure Code</u>	<u>\$ Value</u>
Individual (weekdays)	Z 1820	up to \$8.30/hour
	Z 1821	up to \$4.15/½ hour
Individual (weekend/holiday)	Z 1822	up to \$9.30/hour
	Z 1823	up to \$4.65/½ hour

<u>Personal Care Assistant Services</u>	<u>Procedure Code</u>	<u>\$ Value</u>
Group - care provided involves two or more patients, with a maximum of eight patients in the same residential setting at the same time.		
Weekdays	Z 1824	up to \$6.24/hour
	Z 1825	up to \$3.12/½ hour
Weekend/holiday	Z 1826	up to \$7.24/hour
	Z 1827	up to \$3.62/½ hour
Initial Nursing Assessment Visit	Z 1828	up to \$25/visit
Nursing Reassessment Visit	Z 1829	up to \$20/visit

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 609-588-2620.



NEWSLETTER

New Jersey Health Services Program

Volume..... P-518.....

Date: March 16, 1987

TO: Narcotic and Drug Abuse Treatment Centers
 SUBJECT: AIDS Community Care Alternatives Program (ACCAP)
 EFFECTIVE: March 1, 1987

BACKGROUND: As announced in the New Jersey Health Services Program Newsletter, P-516, dated March 16, 1987, the New Jersey Medicaid Program implemented the AIDS Community Care Alternatives Program (ACCAP) on March 1, 1987. This program enables eligible individuals to remain in or to return to the community rather than be cared for in a long-term care facility or hospital.

ACTION: It is anticipated that some individuals served under this program may not be physically able to come to your center for required treatments. For the purpose of this special program only, the following services may be provided to ACCAP eligible individuals in the home:

<u>Procedure Code</u>	<u>\$ Value</u>
Z 1830 <u>Methadone Treatment rendered by a Narcotic and Drug Abuse Treatment Center at Home</u>	\$3.50/visit
<p>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.</p>	
Z 1831 <u>Urinalysis for Drug Addiction at Home</u>	\$4.50/visit
<p>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.</p>	
Z 1832 <u>Psychotherapy Rendered by a Narcotic and Drug Abuse Treatment Center at Home - Full Session</u>	\$24.00/visit

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.

<u>Procedure Code</u>		<u>\$ Value</u>
Z 1333	<u>Psychotherapy Rendered by a Narcotic and Drug Abuse Treatment Center at Home - Half Session</u>	\$12.00/visit
	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.	
Z 1834	<u>Family Therapy Rendered by a Narcotic and Drug Abuse Treatment Center at Home</u>	\$30.00/visit
	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.	
Z 1835	<u>Family Conference Rendered by a Narcotic and Drug Abuse Treatment Center at Home</u>	\$22.50/visit
	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.	

Please note that these are new procedure codes for home care and increased rates have been assigned.

If an ACCAP recipient receives narcotic and drug abuse services in your center, please bill for these services using your current procedure codes and rates.

Since ACCAP only accommodates a limited number of individuals who meet the requirements of the program, it is essential that you check eligibility for these home services before providing them. Please contact the Medicaid District Office serving your county if you have any questions.

Each ACCAP recipient will be assigned a case manager whose responsibility it is to develop an individualized service plan to meet the needs of the person being served. A listing of the case management sites is attached.

Questions about ACCAP should be directed to Carol H. Kurland, Administrator, Office of Home Care Programs, Division of Medical Assistance and Health Services at 609-588-2620.

AIDS Community Care Alternatives Program (ACCAP)

CASE MANAGEMENT SITES
(For Adults 21 Years of Age and Over)

ATLANTIC	Atlantic County Department of Health & Institutions 201 South Shore Road Northfield, NJ 08225 (609) 645-7700
BERGEN	Home and Community Health Care of Bergen County, Inc. 74 Passaic Street Ridgewood, NJ 07450 (201) 444-0040
BURLINGTON	Community Nursing Services P.O. Box 287 Mount Holly, NJ 08060 (609) 267-1950
CAMDEN	Visiting Nurse and Health Association of Camden County 608 Broadway Camden, NJ 08103 (609) 365-5617
CAPE MAY & CUMBERLAND	Community Nursing Service Department of Health City of Vineland 111 North 6th Street Vineland, NJ 08360 (609) 794-4261
ESSEX	Community Health Care of North Jersey 451 Lincoln Avenue Orange, NJ 07050 (201) 673-0158
GLOUCESTER & SALEM	Southern New Jersey Visiting Nurse Service System, Inc. P.O. Box 508 Woodbury, NJ 08096 (609) 845-0460
HUDSON	Christ Hospital Home Health Services 176 Palisade Avenue Jersey City, NJ 07306 (201) 795-8444
HUNTERDON	Hunterdon Medical Center - Home Health Services Route 31 Flemington, NJ 08822 (201) 788-6138

Case Management Sites
AIDS Community Care Alternatives Program
Page 2

MERCER Visiting Nurse Association of Trenton, Inc.
P.O. Box 7393
West Trenton, NJ 08628
(609) 695-3491

MIDDLESEX Visiting Nurse Association of Middlesex County, Inc.
1915 Old Georges Road
North Brunswick, NJ 08902
(201) 821-9500

MONMOUTH MCOSS Nursing Services, Inc.
141 Bodman Place
Red Bank, NJ 07701
(201) 747-1204

MORRIS Visiting Nurse Association of Morris County, Inc.
38 Elm Street
Morristown, NJ 07960
(201) 539-1216

OCEAN Ocean County Health Department
CN 2191
Toms River, NJ 08754
(201) 341-9700

PASSAIC Visiting Health Service of Passaic Valley
783 Riverview Drive
Box 70
Totowa, NJ 07511
(201) 256-4636

SOMERSET Somerset Valley Visiting Nurse Association, Inc.
586 E. Main Street
Bridgewater, NJ 08807
(201) 725-9355

SUSSEX Sussex County Health Department
Division of Public Health Nursing
Box 139, R.D. 3
Newton, NJ 07860
(201) 948-5400

UNION Visiting Nurse and Health Service
354 Union Avenue
Elizabeth, NJ 07208
(201) 352-5694

Visiting Nurse Association of Plainfield & North Plainfield
427 W. 7th Street
Plainfield, NJ 07060
(201) 756-2436

Case Management Sites
AIDS Community Alternatives Program
Page 3

WARREN Public Health Nursing Agency
 Warren County Health Department
 151 West Washington Avenue
 Washington, NJ 07882
 (201) 689-6000

Special Child Health Services - Case Management Units under contract to the New Jersey State Department of Health, located in each county, will provide case management services to children up to the age of 21. Further information about these programs is available by calling the State Department of Health at (609) 984-0775.



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

New Jersey Health Services Program

NEWSLETTER

Volume.....P-519.....

March 30, 1987

TO: Providers of Nurse-Midwifery Services

SUBJECT: HCFA Common Procedure Coding System (HCPCS) - Revision

Replacement pages are enclosed for Subchapter 3., HCFA Common Procedure Coding System, of the Nurse-Midwifery Services Manual. Incorporated into the replacement pages are all the additions and revisions since HCPCS was implemented September 1, 1985. The sign ">" preceding any HCPCS code indicates an addition or a revision. A vertical line on the left hand margin of written text indicates a revision. The additions and revisions are listed below:

1. Additions: 90030WM, 90040WM, 90070WM, 90080WM, 90130WM, 90140WM, 90170WM.
2. Revisions: 58300WM.

Manual Maintenance: Please substitute each replacement page accordingly in Subchapter 3. of the Nurse-Midwifery Services Manual.

If you have any questions regarding this Newsletter, please contact The Prudential Insurance Company of America, at (800) 582-7052.

10:58-3.2 ELEMENTS OF HCPCS CODES WHICH REQUIRE 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", "MAXIMUM FEE ALLOWANCE" 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.

DESCRIP-
TION

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.

MAXIMUM
FEE
ALLOWANCE 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 CODE NUMBERS AND MAXIMUM FEE SCHEDULE FOR NURSE-MIDWIFERY SERVICES

IND	HCPCS		FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE			ANES BASIC UNITS	IND	HCPCS		FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE			ANES BASIC UNITS
	CODE	MOD		S	\$	NS			CODE	MOD		S	\$	NS	
<u>(a) OBSTETRICAL SERVICES</u>															
➤N	58300	WM	0	23.80			0.	N	59420	WM	0	5.60			0.
N	58301	WM	0	11.50			0.	N	59420	WM22	0	15.40			0.
N	59400	WM	60	165.20			4.	N	59430	WM	0	9.10			0.
N	59410	WM	60	112.00			4.	L	Z0250	WM	0	40.00			0.
<u>(b) OFFICE MEDICAL SERVICES</u>															
➤N	90030	WM	0	6.30			0.	N	90060	WM	0	6.30			0.
➤N	90040	WM	0	6.30			0.	➤N	90070	WM	0	6.30			0.
N	90050	WM	0	6.30			0.	➤N	90080	WM	0	6.30			0.
<u>(c) HOME MEDICAL SERVICES</u>															
➤N	90130	WM	0	6.30			0.	N	90160	WM	0	6.30			0.
➤N	90140	WM	0	6.30			0.	➤N	90170	WM	0	6.30			0.
N	90150	WM	0	6.30			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 in-hospital, 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.

HCPCS
CODE

PROCEDURE

>90030WM If medical necessity dictates, corroborated by the record, then
>90040WM additional visits (home or office) above seven ante partum visits
90050WM may be reimbursed. The claim form should clearly indicate the
90060WM reason for the medical necessity and the date for each office or
>90070WM home visit listed.
>90080WM
>90130WM
>90140WM
90150WM
90160WM
>90170WM



March 30, 1987

TO: Providers of Medical Supplier Services

SUBJECT: HCFA Common Procedure Coding System (HCPCS) - Revision

Replacement pages are enclosed for Subchapter 3., HCFA Common Procedure Coding System, of the Medical Supplier Services Manual. Incorporated into the replacement pages are all the additions and revisions since HCPCS was implemented September 1, 1985. The sign ">" preceding any code indicates an addition or a revision. A vertical line on the left hand margin of written text indicates a revision. The additions, revisions, deletions, and modifiers are listed below:

1. Additions: E0162, E0165, E0185, E0190, E0251, E0260, X0125, E0271, E0276, X0130, E0405, E0416, E0435, E0451, X0300, E1374, E1397, E0515, E0650, E0660, E0745, E0747, E0940, E1010, E1040, E1110, E1140, E1150, E1223, E1224, E0183, E0187, E0950, E0951, E0952, E0953, E0958, E0959, E0961, E0966, E0967, E0968, E0969, E0970, E0971, E0973, E0974, E0975, E0976, E0977, E0978, E0979, E0990, E0991, E0992, E0993, E0994, E0996, E0997, E0998, E0999, E1001, E1005, X0700, A4200, A4244, A4245, A4246, A4247, A4259, X8841, X8843, X8844, X8845, A4348, A4349, A4353, A4354, A4355, A4356, A4357, A4358, X8858, A4359, X8856, X8859, X8860, X8861, X8862, A4361, X6451, A4362, X6452, X6453, A4363, A4364, X6454, X6455, X6456, A4367, A4368, A4369, A4370, X6457, X6458, X6459, A4402, A4404, A4440, A4450, A4453, X6460, X6480, X6481, X6482, X6483, X6484, X6485, X6486, A4660, A4712, A4772, A4927, B4034, B4035, B4036, B4081, B4082, B4083, B4099, B4151, B4156, B4164, B4168, B4172, B4176, X8000, X7190, B4186, B4222, B4224, B4514, B9998, B9999.
2. Revisions: E0265, E0425, E0430, E1240, A4341, A4343, A4344, A4345, A4350, A4365, A4366, X4800, X4801, X4802, X4803, X4804, X4805, X4805, X4810, B4150, B4152, B4153, B4154, B4155, B4157, B4180, B4184, B4188, B4192, B4196, B4198, B4220.
3. Deletions: E0115, E0300, E0320, E1035, B4150 DD, X8016, X8016 DD, B4153 DD, B4154 DD, X8017, X8017 DD, B4159, X7100, X7105, X7120, B4200, B4239, B4242, B4251.
4. Modifiers: RP - Replacement and Repair
NU - New Durable Medical Equipment

Manual Maintenance: Please substitute each replacement page accordingly in Subchapter 3. of the Medical Supplier Services Manual.

Please note: Section 3.4, HCPCS Codes for Orthopedic Footwear, will be revised and distributed at a later time.

If you have any questions regarding this Newsletter, please contact The Prudential Insurance Company of America, at (800) 582-7052.

MEDICAL SUPPLIER MANUAL

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

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- (b) Bathing Equipment
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- (d) Hospital Beds
- (e) Hospital Bed Accessories
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IPPB Equipment Compressors
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(Lymphedema Pump)
- (l) Safety Equipment
- (m) Transcutaneous and/or Neuromuscular
Electrical Nerve Stimulators
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- (p) Wheelchairs
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Not Otherwise Classified

3.3 HCPCS CODE NUMBERS FOR MEDICAL SUPPLIES

3.4 HCPCS CODE NUMBERS AND MAXIMUM FEE SCHEDULE FOR
ORTHOPEDIC FOOTWEAR

3.5 HCPCS CODE NUMBERS FOR HYPERALIMENTATION
EQUIPMENT AND SUPPLIES

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:59-3.1 INTRODUCTION

(a) The New Jersey Medicaid Program adopted the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). The HCPCS Codes as listed in this Subchapter are relevant to Medicaid medical supplier services and must be used when filing a claim.

1. The responsibility of the medical supplier provider when rendering services and requesting reimbursement is listed in Subchapter 1. and Subchapter 2. of the Medical Supplier Manual.

2. Services and procedures may be modified under certain circumstances. The New Jersey Medicaid Program's recognized modifier codes for medical suppliers are as follows:

- i. UE - Used Durable Medical Equipment
- ii. DD - Powdered Enteral Formulæ - this should be used when enteral powdered products are supplied
- > iii. RP - Replacement and Repair
- > iv. NU - New Durable Medical Equipment

3. "B.I." (By Invoice) means that the invoice must be attached to the MC-11 claim form. Payment will be made 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.

10:59-3.2 HCPCS CODE NUMBERS FOR DURABLE MEDICAL EQUIPMENT

HCPCS
CODE

DESCRIPTION

(a) AMBULATION DEVICES

CANES

E0100 Cane, includes Canes of All Materials, Adjustable or Fixed with tip

E0105 Cane, Quad or Three Prong, includes Canes of All Materials, Adjustable or Fixed with tips

CRUTCHES

E0110 Crutch, Forearm, includes Crutches of Various Materials, Adjustable or Fixed, Pair, Complete with tips and handgrips

E0120 Crutch Underarm includes Crutches of Various Materials, Adjustable or Fixed, Pair

WALKERS

E0130 Walker, Rigid (Pickup), Adjustable or Fixed Height

E0135 Walker, Folding (Pickup), Adjustable or Fixed Height

E0141 Walker, Wheeled, without Seat

E0145 Walker, Wheeled, with Seat and Crutch Attachments

E0146 Walker, Wheeled, with Seat

(b) BATHING EQUIPMENT

E0160 Sitz Type Bath, Portable, fits over Commode Seat

> E0162 Sitz Bath Chair

E0163 Commode Chair, Stationary, with Fixed Arms

E0164 Commode Chair, Mobile, with Fixed Arms

> E0165 Commode Chair, Stationary, with Detachable Arms

E0166 Commode Chair, Mobile, with Detachable Arms

X0050 Commode, Pivot Arm

E0167 Pail or Pan for use with Commode Chair

HCPCS
CODE

DESCRIPTION

E0179 Bathroom Equipment, includes: Rails, Seats, Stools, Benches,
any Type

(c) DECUBITUS CARE EQUIPMENT

E0180 Pressure Pad, Alternating with Pump

E0181 Pressure Pad, Alternating with Pump, Heavy Duty

➤ E0185 Decubitus Care Pad, Flotation or Gel Pad with Foam Leveling
Pad (Mattress Size)

➤ E0190 Decubitus Care Mattress, includes Flotation or Gel Mattress

(d) HOSPITAL BEDS

E0250 Hospital Bed, with side Rails, Fixed Height, with Mattress

➤ E0251 Hospital Bed, with side Rails, Fixed Height, without Mattress

E0255 Hospital Bed, with side Rails, Variable Height, (Hi-Lo), with
Mattress

➤ E0260 Hospital Bed with side Rails, Semi-Electric, Head and Foot
Adjustment, with Mattress

➤ E0265 Hospital Bed, Total Electric with Siderails (Head, Foot and
Height Adjustments, with Mattress)

➤ X0125 Clinitron Patient Support System (Clinitron Therapy Bed)

(e) HOSPITAL BED ACCESSORIES

➤ E0271 Mattress, Innerspring

E0310 Bed Side Rails, Full Length

E0315 Bed Accessories: Boards or Tables, any Type

➤ E0276 Bedpan, Fracture, Metal or Plastic

NOTE: Excluding Stainless Steel Bedpans

E0325 Urinal, Male, any material

NOTE: Excluding Stainless Steel Urinals

HCPCS
CODE

DESCRIPTION

E0326 Urinal, Female, any material

NOTE: Excluding Stainless Steel Urinals

(f) OXYGEN AND RELATED RESPIRATORY EQUIPMENT

- X0130 Demurrage (Rental of Oxygen Tank)
- E0400 Oxygen Contents, Gaseous, Per Cubic Feet
- E0405 Oxygen Contents, Gaseous, Per 100 Cubic Feet
- E0410 Oxygen Contents, Liquid, Per Pound
- E0416 Oxygen Refill for Portable Gaseous System only
(Up to 23 Cubic Feet)
- E0425 Stationary Compressed Gas System, includes use of Container,
Regulator with Flow Gauge, Humidifier Nebulizer, Cannula or
Mask and Tubing
- E0430 Oxygen System, Gaseous, Portable, includes Portable Container,
Supply Container, Regulator with Flow Gauge, Humidifier
Cannula or Mask and Tubing
- E0435 Oxygen System, Liquid, Portable, includes Portable Container,
Supply Reservoir, Flow Humidifier Cannula or Masks, Tubing
and Refill Adaptor
- E0440 Oxygen System, Liquid, Stationary, includes use of Reservoir,
Contents Indicator, Flowmeter, Humidifier, Cannula or Mask
and Tubing
- E0450 Volume Ventilator
- E0451 Volume Ventilator, Portable
- E0455 Oxygen Tent, Excluding Group or Pediatric Tents
- X0300 Croup or Pediatric Tent
- E1351 Cannula
- E1353 Regulator
- E1374 Variable Concentration Mask
- E1397 Oxygen Concentrator, High Humidity System

HCPCS
CODE

DESCRIPTION

(g) IPPB MACHINES

E0510 IPPB Machines with Automatic Valves, External Power Source includes Cylinder Regulator, Built-In Nebulization

➤ E0515 IPPB Machines with Automatic Valves, Electrically Driven with Internal Compressor Built-In Nebulization

NOTE: AP5, AP5B

(h) HUMIDIFIERS/NEBULIZERS FOR USE WITH OXYGEN IPPB EQUIPMENT

E0550 Humidifier, Durable for Extensive Supplemental Humidification during IPPB Treatments or Oxygen Delivery, e.g., Cascade

E0560 Humidifier, Durable for Supplemental Humidification during IPPB Treatment or oxygen Delivery, e.g., Cascade Jr.

X0200 Nebulizer, Pocket Size

E0570 Nebulizer, with Compressor, e.g., Devilbiss Pulmo-Aid

E0575 Nebulizer, Self-Contained, Ultrasonic

E0580 Nebulizer, Durable, Glass or Autoclavable Plastic, Bottle Type, for use with Regulator or Flowmeter

E0585 Nebulizer, with Compressor and Heater

(i) SUCTION PUMP/ROOM VAPORIZERS

E0600 Suction Pump, Home Model, Portable

E0605 Vaporizer, Room Type

(j) PATIENT LIFTS

E0625 Patient Lift, Kartop, Bathroom or Toilet

NOTE: Excluding Kartop Patient Lift

E0630 Patient Lift, Hydraulic, with Seat or Sling

(k) PNEUMATIC COMPRESSOR AND APPLIANCES (LYMPHODEMA PUMP)

➤ E0650 Pneumatic Compressor, Non-Segmental Home Model, (Lymphodema Pump)

➤ E0660 Pneumatic Appliance For Use with Pneumatic Compressor, Full Leg

HCPCS
CODE

DESCRIPTION

E0665 Pneumatic Appliance for use with Pneumatic Compressor, Full Arm

(l) SAFETY EQUIPMENT

E0700 Safety Equipment, (e.g., Belt, Harness or Vest)

(m) TRANSCUTANEOUS AND/OR NEUROMUSCULAR ELECTRICAL NERVE STIMULATORS

E0720 Tens, Two Lead, Localized Stimulation

E0730 Tens, Four Lead, Larger Area/Multiple Nerve Stimulation

➤ E0745 Neuromuscular Stimulator, Electronic Shock Unit, Non-Clinical Model

➤ E0747 Osteogenesis Stimulator (Non-Invasive)

(n) TRACTION EQUIPMENT

TRACTION-CERVICAL

E0840 Traction Frame, attached to Headboard, Simple Cervical Traction

E0850 Traction Stand, Free Standing, Simple Cervical Traction

TRACTION - OVERDOOR

E0860 Traction Equipment, Overdoor, Cervical

TRACTION - PELVIC

E0890 Traction Frame, attached to Footboard, Simple Pelvic Traction

E0900 Traction Stand, Free Standing, Simple Pelvic Traction, (e.g., Buck's)

(o) TRAPEZE EQUIPMENT AND FRACTURE FRAME

E0910 Trapeze Bars, A/K/A Patient Helper, attached to Bed, with Grab Bar

E0920 Fracture Frame, attached to Bed, includes Weights

E0930 Fracture Frame, Free Standing, includes Weights

➤ E0940 Trapeze Bar, Free Standing, Complete with Grab Bar

E0947 Fracture Frame, attachments for Complex Pelvic Traction

HCPCS
CODE

DESCRIPTION

(p) WHEELCHAIRS

WHEELCHAIR - ECONOMY

- > E1010 Economy Wheelchair, Fixed Full Length Arms, Fixed Footrest

ROLLABOUT CHAIR

- E1030 Rollabout Chair, without Arms
- E1036 Positioning Chair (Submit brand name, model number and specifications)
- > E1040 Rollabout Chair, with Fixed or Removable Arms

WHEELCHAIR - FULL - RECLINING

- E1050 Fully-Reclining Wheelchair, Fixed Full length Arms, Swing Away Detachable Elevating Legrests
- > E1110 Semi-Reclining Wheelchair, Detachable Arms, (Desk or Full Length) Elevating Legrests

WHEELCHAIR - STANDARD

- E1130 Standard Wheelchair, Fixed Full Length Arms, Fixed or Swing Away Detachable Footrests
- > E1140 Wheelchair, Detachable Arms, Desk or Full Length, Swing Away Detachable Footrests
- > E1150 Wheelchair, Detachable Arms, Desk or Full Length, Swing Away Detachable Elevating Legrests
- E1160 Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Legrests
- > E1223 Wheelchair with Detachable Arms, Footrests
- > E1224 Wheelchair with Detachable Arms, Elevating Legrests

WHEELCHAIR - AMPUTEE

- E1170 Amputee Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Legrests
- E1172 Amputee Wheelchair, Detachable Arms (Desk or Full Length) without Footrest or Legrest

HCPCS
CODE

DESCRIPTION

E1180 Amputee Wheelchair, Detachable Arms (Desk or Full Length)
Swing Away Detachable Footrests

E1190 Amputee Wheelchair, Detachable Arms (Desk or Full Length)
Swing Away Detachable Elevating Legrests

E1200 Amputee Wheelchair, Fixed Full Length Arms, Swing Away
Detachable Footrest

WHEELCHAIR - POWER

E1210 Motorized Wheelchair with Microswitch Control, Fixed Full
Length Arms, Swing Away Detachable Elevating Legrests

WHEELCHAIR - SPECIAL SIZE

E1220 Specially Sized or Constructed Wheelchairs, (Indicate Brand
Name, Model Number, and Justification)

WHEELCHAIR - LIGHTWEIGHT

> E1240 Lightweight Wheelchair, Detachable Arms, (Desk or Full
Length) Swing Away Detachable Elevating Legrest

E1250 Lightweight Wheelchair, Fixed Full Length Arms, Swing Away
Detachable Footrest

E1260 Lightweight Wheelchair, Detachable Arms (Desk or Full Length)
Swing Away Detachable Footrest

E1270 Lightweight Wheelchair, Fixed Full Length Arms, Swing Away
Detachable Elevating Legrests

WHEELCHAIR - HEAVY DUTY

E1280 Heavy Duty Wheelchair, Detachable Arms (Desk or Full Length)
Elevating Legrests

E1285 Heavy Duty Wheelchair, Fixed Full Length Arms, Swing Away
Detachable Footrest

E1290 Heavy Duty Wheelchair, Detachable Arms (Desk or Full Length)
Swing Away Detachable Footrest

E1295 Heavy Duty Wheelchair, Fixed Full Length Arms, Elevating Legrest

HCPCS
CODE

DESCRIPTION

(q) WHEELCHAIR ACCESSORIES

- > E0183 Flotation Pad, Water or Gel for Wheelchair
- > E0187 Flotation Pad, Dry for Wheelchair
- > E0950 Tray
- > E0951 Loop, Heel, Each
- > E0952 Loop, Toe, Each
- > E0953 Pneumatic, Tire, Each
- > E0958 Wheelchair Attachment to Convert any Wheelchair to One Arm Drive
- > E0959 Amputee Adapter (Device used to Compensate for Transfer of Weight Due to Lost Limbs to Maintain Proper Balance)
- > E0961 Brake Extension, For Wheelchair
- > E0966 Hook on Headrest Extension
- > E0967 Wheelchair Hand Rims with 8 Vertical Rubber Tipped Projections, Pair
- > E0968 Commode Seat, Wheelchair
- > E0969 Narrowing Device, Wheelchair
- > E0970 No. 2 Footplates, Except for Elevating Leg Rest
- > E0971 Anti-Tipping Device, Wheelchairs
- > E0973 Adjustable Height Detachable Arms, Desk or Full Length, Wheelchair
- > E0974 "Grade-Aid" (Device to prevent Rolling Back on an incline) for Wheelchair
- > E0975 Reinforced Seat Upholstery, Wheelchair
- > E0976 Reinforced Back Upholstery, Wheelchair
- > E0977 Wedge Cushion, Wheelchair

HCPCS
CODE

DESCRIPTION

- > E0978 Belt, Safety, with Airplane Buckle, wheelchair
- > E0979 Belt. Safety, with Velcro Closure, Wheelchair
- > E0990 Elevating Leg Rest, Each
- > E0991 Upholstery Seat
- > E0992 Solid Seat Insert
- > E0993 Back Upholstery
- > E0994 Arm Rest, Each
- > E0996 Tire, Solid, Each
- > E0997 Caster with a Fork
- > E0998 Caster without Fork
- > E0999 Pneumatic Tire with Wheel
- > E1001 Wheel, Single
- > E1005 Replacement, Batteries For Medically Necessary Electric Wheelchair owned by the patient

(r) REPAIRS AND REPLACEMENT SUPPLIES

- E1350 Repair or Non-Routine Service (e.g., Breaking Down Sealed Components) Requiring the Skill of a Technician

(s) DURABLE MEDICAL EQUIPMENT, NOT OTHERWISE CLASSIFIED

- E0607 Home, Blood Glucose Monitor
- E0608 Apnea Monitor
- E0776 I.V. Pole
- X0250 Pneumogram, 12-24- Hours with or without Interpretation
- > X0700 Portable, Lightweight Transporter For Handicapped Youths (Stroller)

10:59-3.3 HCPCS CODE NUMBERS FOR MEDICAL SUPPLIES

<u>HCPCS CODE</u>	<u>DESCRIPTION</u>
> A4200	Gauze Pads, Sterile or Nonsterile
> A4244	Alcohol or Peroxide Per Pint
> A4245	Alcohol Wipes, Per Box
> A4246	Betadine or PhisoHex Solution, Per Pint
> A4247	Betadine or Iodine Swabs/Wipes, Per Box
A4252	Irrigation Kits, Nonsterile
> A4259	Lancets, Per Box
> A4341	Indwelling Catheter, Foley Type, Two-Way Teflon
	<u>NOTE:</u> 5 cc
> X8841	Indwelling Catheter, Foley Type, Two-Way, Teflon, 30 cc
A4342	Indwelling Catheter, Foley Type, Two-Way, Latex
> A4343	Indwelling Catheter, Foley Type, Two-Way, Latex with Teflon Coating
	<u>NOTE:</u> 5 cc
> X8843	Indwelling Catheter, Foley Type, Latex with Teflon Coating, 30 cc
> A4344	Indwelling Catheter, Foley Type, Two-Way, All Silicone
	<u>NOTE:</u> 5 cc
> X8844	Indwelling Catheter, Foley Type, Two-Way, All Silicone, 30 cc
> A4345	Indwelling Catheter, Foley Type, Two-Way, Silicone with Elastomer Coating
	<u>NOTE:</u> 5cc
> X8845	Indwelling Catheter, Foley Type, Two-Way, Silicone with Elastomer Coating, 30 cc

<u>HCPCS CODE</u>	<u>DESCRIPTION</u>
A4346	Indwelling Catheter, Foley Type, Three Way, Latex or Teflon for Continuous Irrigation
A4347	External Catheter, Condom Type
> A4348	Urinary Collection and Retention System, Drainage Bag with Tube
> A4349	Urinary Collection and Retention System, Leg Bag with Tube
> A4350	Catheter Care Kit
> A4353	Catheter Insertion Tray, Includes Catheter and Drainage Bag
> A4354	Catheter Insertion Tray, without Tube and Drainage Bag
> A4355	Three Way Irrigation Set For Catheter
> A4356	Incontinence Clamp
> A4357	Urinary Drainage Bag
> A4358	Urinary Leg Bag
	<u>NOTE:</u> Disposable Type
> X8858	Urinary Leg Bag, Reusable Type
> A4359	Urinary Suspensory
> X8856	Catheter Clamps, (Hoffman screw, metal shutoff)
> X8859	Leg Straps
> X8860	Abdominal Straps
> X8861	Tubings to Attach Foley or External Catheter to Drainage or Leg Bag (Includes Adapter/Connector)
> X8862	Catheter Plug
A4360	Colostomy Set
> A4361	Ostomy Faceplate

NOTE: Wafer with Flange

<u>HCPCS CODE</u>	<u>DESCRIPTION</u>
> X6451	Ostomy Wafer (Barrier) with Flexible or Accordion Flange
> A4362	Ostomy Skin Barrier <u>NOTE:</u> Wafer without Flange, 4 x 4
> X6452	Ostomy Skin Barrier (Wafer without Flange) 8 x 8
> X6453	Stoma Cap
> A4363	Ostomy Liquid Barrier
> A4364	Ostomy Skin Bond or Cement
> A4365	Ostomy Bag, Disposable/Closed <u>NOTE:</u> Two Piece System
> A4366	Ostomy Bag, Reusable or Drainable <u>NOTE:</u> Open, Two Piece System
> X6454	Ostomy Bag, Closed or Open (One Piece System)
> X6455	Ostomy Bag, One Piece System with Adhesive and Seal Squibb 0227-57 to 0227-74, Hollister 360, 364, 366 or any other Manufacturer's Comparable Product
> X6456	Ostomy Bag, One Piece System with Adhesive Hollister 300, 322, 323, 327, 721, 722, 728 or any other Manufacturer's Comparable Product
> A4367	Ostomy Belt
> A4368	Stoma Wicks
> A4369	Tail Closures
> A4370	Ostomy Skin Bond or Cement, Remover
A4380	Ileostomy Set
A4390	Ileal Bladder Set
A4400	Irrigation Set for Irrigation of Ostomy
> X6457	Ostomy Irrigation Sleeve/Drain
> X6458	Ostomy Stoma Cone

<u>HCPCS CODE</u>	<u>DESCRIPTION</u>
> X6459	Ostomy Irrigator with Stoma Cone
> A4402	Ostomy Lubricant
> A4404	Ostomy Rings
	<u>NOTE:</u> Karaya Ring, Washer
A4421	Not Otherwise Classified Ostomy Supplies
A4430	Ureterostomy Set
> A4440	Not Otherwise Classified Ureterostomy Supplies
> A4450	Adhesive Tape, All Sizes
> A4453	Microporous Tape, All Sizes
> X6460	Ostomy Deodorant
> X6480	Urostomy Pouch (Two Piece)
> X6481	Urostomy Pouch, (One Piece System with Adhesive)
> X6482	Urostomy Pouch, One Piece System (with Karaya or Other Comparable Seal)
> X6483	Urostomy Adapter (Hollister or Comparable Product) 7331
> X6484	Urostomy Adapter (Squibb 0219-15 or Comparable Product)
> X6485	Convex Inserts
> X6486	Urostomy Drain Tube
A4460	Elastic Bandage, Ace
A4490	Surgical Stockings Above Knee Length, Each
A4495	Surgical Stockings Thigh Length, Each
A4500	Surgical Stockings Below Knee Length, Each
A4510	Surgical Stockings Full Length, Each
A4554	Disposable Underpads, All sizes, (e.g., Chux's)

HCPCS
CODE

DESCRIPTION

A4555	Primary Surgical Dressing Kit, (e.g., Sterile Dressings, Pads, etc.)
X7200	Hypodermic Syringes over 5cc
X7300	Rectal Syringes (per eligible Diagnosis)
A4565	Slings
A4572	Rib Belt
X6600	Elastic Support (Wrist, Ankle or Knee)
X7520	Disposable Diapers
> A4660	Sphygmomanometer/Blood Pressure Apparatus With Cuff and Stethoscope
> A4712	Water, Sterile
> A4772	Dextrose or Glucose Test Strips, Per Box
> A4927	Gloves, Sterile or Non-Sterile, Per Pair

10:59-3.5 HCPCS CODE NUMBERS FOR HYPERALIMENTATION EQUIPMENT AND SUPPLIES

<u>HCPCS CODE</u>	<u>MOD</u>	<u>DESCRIPTION</u>
<u>ENTERAL AND PARENTERAL THERAPY</u>		
<u>ENTERAL FORMULAE AND MEDICAL SUPPLIES</u>		
> B4034		Enteral Feeding Supply Kit; - Syringe (Monthly)
> B4035		Enteral Feeding Supply Kit; - Pump Fed (Monthly)
> B4036		Enteral Feeding Supply Kit; Gravity Fed (Monthly)
> B4081		Nasogastric Tubing With Stylet (E.G., Travasorb, Entriflex, Dobb Huff, Flexiflow, Etc.)
> B4082		Nasogastric Tubing Without Stylet
> B4083		Stomach Tube - Levine Type
> B4099		Enteral Supply Kit For Prepackaged Delivery System (Monthly)
> B4150		Enteral Formulae; Category I: Intact Protein/Protein Isolates (e.g., Enrich, Ensure, Ensure Powder, Isocal, Lonalac Powder, Meritene, Meritene Powder, Osmolite, Portagen Powder, Sustacal, Renu, Sustagen Powder, Travasorb) 100 Calories = 1 Unit
> B4151		Enteral Formulae; Category I-A: Blenderized Nutrients, (e.g., Compleat B, Vitaneed, Compleat B Modified) 100 Calories = 1 Unit
> B4152		Enteral Formulae; Category II: Intact Protein/Protein Isolates (Calorically Dense) (e.g., Magnacal, Isocal HCN, Sustacal HC, Ensure Plus, Ensure Plus HN) 100 Calories = 1 Unit
> B4153		Enteral Formulae; Category III: Hydrolyzed Protein/Amino Acids (e.g., Criticare HN, Ensure HN, Vivonex T.E.N. (Total Enteral Nutrition), Vivonex HN, Vital (Vital HN), Travasorb HN, Isotein HN, Osmolite HN, Precision HN, Precision Isotonic) 100 calories = 1 Unit

NOTE: DD Modifier should be used with HCPCS Code when powdered enteral products are supplied.

<u>HCPCS CODE</u>	<u>DESCRIPTION</u>
> B4154	Enteral Formulae; Category IV: Defined Formula for Special Metabolic Need, (e.g., Hepatic-Aid, Travasorb Hepatic, Travasorb MCT, Travasorb Renal, Traum-Aid, Tramacal, Aminaid) 100 Calories = 1 Unit
> B4155	Enteral Formulae; Category V: Modular Components (Protein, Carbohydrates, Fat) (e.g., Propac, Gerval Protein, Promix, Casec, Moducal, Controlyte, Polycose Liquid or Powder, Travasorb MCT, Sumacal, Microlipids, MCT oil, Nutri-Source) 100 Calories = 1 Unit
> B4156	Enteral Formulae; Category VI: Standardized Nutrients (Vivonex STD., Travasorb STD. And Precision LR) 100 Calories = 1 Unit
> B4157	Enteral Formulae; Prepackaged Delivery System and Formula (e.g., Entrition, Osmolite) 100 Calories = 1 Unit
> B4164	50% Dextrose Solution, (500 ML = 1 Unit)
> B4168	Parenteral Nutrition Solution; Amino Acid, 3.5% (500 ML = 1 Unit) - Homemix
> B4172	Parenteral Nutrition Solution; Amino Acid, 5.5% through 7% (500 ML = 1 Unit) - Homemix
> B4176	Parenteral Nutrition Solution; Amino Acid, Greater Than 7%, (500 ML = 1 Unit) - Homemix
X7110	Enteral Supply, Flexitainer Feeding Bag
X7115	Enteral Supply, Vivonex Delivery System
X8065	Gravity Set (Tubing and Container)
X8070	Enteral Tubing
E0776	IV Pole
E0777	Enteral Infusion Pump
E0779	Parenteral Infusion Pump
> X8000	Infusion Pump - Home Model For Chemotherapy
> X7190	Destructclip

HCPCS
CODE

DESCRIPTION

PARENTERAL NUTRITION SOLUTION AND SUPPLIES

- > B4180 Parenteral Nutrition Solution; Carbohydrates, Greater Than 50% (500 ML = 1 Unit) - Homemix
- > B4184 Parenteral Nutrition Solution; Lipids, 10% With Administration Set (500 ML = 1 Unit)
- > B4186 Parenteral Nutrition Solution, Lipids, 20% With Administration Set (500 ML = 1 Unit)
- > B4188 Parenteral Nutrition Solution; Compounded Amino Acid And Carbohydrate W/Electrolytes, Trace Elements, Vitamins, And Heparin, Any Strength, (Per 1000 ML) - Premix
- > B4192 Parenteral Nutrition Solution; Compounded Amino Acid And Carbohydrates With Electrolytes, Trace Elements, Heparin And Vitamins, Any Strength, Per 2000 ML - Premix
- > B4196 Parenteral Nutrition Solution; Compounded Amino Acid And Carbohydrates With Electrolytes, Trace Elements, Heparin And Vitamins, Any Strength, Per 3000 ML - Premix
- > B4198 Parenteral Nutrition Solution; Compounded Amino Acid And Carbohydrates W/Electrolytes, Trace Elements, Heparin And Vitamins, Any Strength, Over 3000 ML - Premix
- > B4220 Parenteral Nutrition Supply Kit For 1 Month - Premix
- > B4222 Parenteral Nutrition Supply Kit For 1 Month - Homemix
- > B4224 Parenteral Nutrition Administration Kit for One (1) Month
- > B4514 Parenteral Nutrition Solution, Compounded Amino Acid And Carbohydrates, With Electrolytes, Heparin, Trace Elements, And Vitamins Any Strength - 1500 Milliliters - Premix
- > B9998 NOC For Enternal Supplies
- > B9999 NOC For Parenteral Supplies



NEWSLETTER

New Jersey Health Services Program

Volume P-521

March 30, 1987

TO: Providers of Independent Laboratory Services

SUBJECT: HCFA Common Procedure Coding System (HCPCS)-Revision

Replacement pages are enclosed for Subchapter 3., HCFA Common Procedure Coding System, of the Independent Laboratory Services Manual. Incorporated into the replacement pages are all the additions and revisions since HCPCS was implemented September 1, 1985. The sign ">" preceding any HCPCS code indicates an addition or a revision. A vertical line on the left hand margin of written text indicates an addition. The additions, revisions, and deletions are listed below:

1. Additions: 80002, 80059, 83052, 84202, 84408, 85028-22, 85060, 85097, 85105, 85560, 86077, 86078, 86079, 86288, 86289, 86293, 86296, 86298, 86299, 86312, 86314, 86580, 87072, 87075, 87082, 87083, 87085, 87109, 88108, 88125, 88160, 88161, 88162, 88170, 88171, 88172, 88173, 88300, 88304, 88305, 88309, 88311, 88312, 88318, 88319, 88321, 88323, 88325, 88329, 88342, 88346, W8010, W8622, W8720, W8725.

2. Revisions: 80003, 80004, 80005, 80006, 80090, 82035, 82157, 82163, 82173, 82273, 82437, 82486, 82552, 82626, 82633, 82671, 82674, 82677, 82678, 82679, 82943, 83008, 83053, 83498, 83499, 83590, 83597, 84045, 84405, 84439, 84701, 85022, 85027, 85028, 85095, 85100, 85101, 85102, 85103, 86285, 86291, 86295, 86421, 86422, 86800, 87081, 87250, 88104, 88106, 88107, 88130, 88140, 88150, 88155, 88260, 88261, 88262, 88265, 88267, 88268, 88270, 88302, 88307, 88313, 88314, 88331, 88332, 88348.

3. Deletions: P2032, P2033.

Manual Maintenance: Please substitute each replacement page for the same numbered page in Subchapter 3. of the Independent Laboratory Services Manual. Because of the additions, it was necessary to add one page numbered "Appendix B/Pathology and Laboratory 6."

If you have any questions regarding this Newsletter, please contact The Prudential Insurance Company of America, at (800) 582-7052.

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:61-3.1 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) The responsibility of the provider when rendering specific services and requesting reimbursement is listed in both Subchapter 1. and Subchapter 2. of the Independent Laboratory Services Manual.

(c) SPECIFIC ELEMENTS OF HCPCS CODES WHICH REQUIRE ATTENTION OF PROVIDER

The lists of HCPCS code numbers for Pathology and Laboratory are arranged in tabular form with specific information for a code given under columns with titles such as: "IND", "HCPCS CODE", "MOD", "DESCRIPTION", and "MAXIMUM FEE ALLOWANCE". The information given under each column is summarized below:

COLUMN
TITLE

DESCRIPTION

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 code is used.

Explanation of indicators and qualifiers used in this column are given below:

"A" preceding any procedure code indicates that these tests can be and are frequently done as groups and combinations (profiles) on automated equipment.

"L" preceding any procedure code indicates that the complete narrative for the code is located in the Appendix A of this Pathology and Laboratory section.

"M" preceding any procedure code indicates that this service is a medical necessity procedure. Refer to Appendix D of this Pathology and Laboratory section.

"N" preceding any procedure code indicates that qualifiers are applicable to that code. These qualifiers are listed by procedure code number in Appendix B of this Pathology and Laboratory section.

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 codes are listed in Appendix C of this Pathology and Laboratory section.

DESCRIP-
TION

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 of this Pathology and Laboratory section.

MAXIMUM
FEE
ALLOWANCE

Lists New Jersey Medicaid Program's maximum reimbursement schedule for Pathology and Laboratory services. 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-13A C2 claim form.

i. The fee listed under "Office Total Fee(s)" represents the combined technical and professional component of the reimbursement for the procedure code notwithstanding 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.

ii. The fee schedule for all diagnostic Medical, Radiology and Pathology services performed in a hospital setting is indicated in the "Prof. Comp." and represents the professional component for those hospital based physicians whose contract is based on fee-for-service.

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 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.

10:61—3.2 HCPCS CODE NUMBERS AND MAXIMUM FEE SCHEDULE
PATHOLOGY/LABORATORY

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE		
			OFFICE TOTAL FEE	\$	PROF. COMP.
>N	80002		5.00		
>N	80003		6.20		
>N	80004		6.20		
>N	80005		6.20		
>N	80006		6.20		
N	80007		7.50		
N	80008		7.50		
N	80009		7.50		
N	80010		7.50		
N	80011		7.50		
N	80012		7.50		
N	80016		7.50		
N	80018		11.00		
N	80019		11.00		
	80031		4.50		
	80032		4.50		
	80033		4.50		
	80052		3.00		
N	80055		15.00		
N	80055	22	19.00		
N	80055	52	10.00		
>N	80059		30.00		
	80061		15.00		
	80061	22	23.00		
N	80070		12.00		
N	80072		12.00		
>	80090		28.80		
N	81000		1.20		
	81010		1.20		
	81030		3.00		
N	82011		3.90		
	82024		30.00		
	82030		34.00		
>	82035		24.00		

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE		
			OFFICE TOTAL FEE	\$	PROF. COMP.
A	82040		1.80		
	82055		4.50		
	82060		4.50		
	82065		4.50		
	82070		4.50		
	82087		40.00		
	82088		40.00		
	82089		40.00		
	82112		12.60		
	82137		15.00		
	82138		15.00		
	82140		6.00		
	82141		6.00		
	82143		4.20		
	82145		12.00		
	82150		4.50		
	82155		4.50		
	82156		2.40		
>	82157		29.00		
>	82163		21.00		
>N	82173		11.20		
	82175		7.20		
	82180		3.60		
	82205		12.00		
	82210		12.00		
A	82250		3.00		
A	82251		4.50		
	82265		3.00		
	82270		1.20		
>	82273		3.70		
	82290		3.00		
	82291		3.00		
	82308		34.00		
A	82310		3.00		

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE		
			OFFICE TOTAL FEE	\$	PROF. COMP.
	82315		3.00		
	82320		3.00		
	82335		.90		
	82340		3.60		
N	82365		9.00		
N	82370		9.00		
A	82374		3.30		
	82375		6.00		
	82380		6.00		
	82382		12.00		
	82383		12.00		
	82384		18.00		
	82390		6.00		
A	82435		3.00		
	82436		3.00		
>N	82437		2.60		
	82438		3.00		
A	82465		3.00		
	82470		7.00		
	82480		4.50		
>	82486		4.40		
	82525		9.00		
	82526		9.00		
	82533		17.00		
	82534		17.00		
	82540		3.00		
	82545		3.00		
	82546		3.00		
A	82550		4.80		
>	82552		7.80		
	82555		4.80		
A	82565		3.00		
	82570		3.00		
	82575		4.50		
	82595		1.50		
	82607		15.00		
	82608		15.00		

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE		
			OFFICE TOTAL FEE	\$	PROF. COMP.
>	82626		37.00		
	82628		15.00		
>	82633		48.00		
	82634		39.00		
	82640		15.00		
	82641		15.00		
	82643		15.00		
	82656		15.00		
	82660		9.00		
	82670		25.00		
>	82671		41.00		
	82672		25.00		
	82673		10.20		
>	82674		17.50		
	82676		10.20		
>	82677		28.00		
>	82678		30.00		
>	82679		25.00		
	82705		.60		
	82710		7.80		
	82715		7.80		
	82728		16.00		
	82730		5.70		
	82746		16.00		
	82785		16.00		
	82791		6.00		
	82792		6.00		
	82793		6.00		
A	82800		5.20		
>	82801		3.30		
	82926		6.00		
	82931		6.00		
	82941		16.00		
>	82943		23.00		
N	82946		13.00		
A	82947		3.00		
	82949		.60		

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE		
			OFFICE TOTAL FEE	\$	PROF. COMP.
	82954		1.50		
	82955		6.00		
A	82977		4.80		
	82985		6.60		
	82995		1.80		
	82996		3.00		
	82998		18.00		
	83001		17.00		
	83002		17.00		
	83003		16.00		
	83004		16.00		
>	83008		27.00		
	83010		12.00		
	83011		12.00		
	83012		12.00		
	83015		10.20		
	83020		6.00		
	83036		6.60		
	83040		3.00		
	83050		3.00		
N	83051		1.20		
>	83052		1.80		
>N	83053		1.80		
	83060		3.00		
	83093		3.00		
	83094		3.00		
	83095		3.00		
	83150		12.00		
	83491		12.60		
	83493		12.60		
	83494		12.60		
	83495		12.60		
	83496		12.60		
	83497		6.00		
>	83498		30.50		
>	83499		30.50		
	83523		15.00		

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE		
			OFFICE TOTAL FEE	\$	PROF. COMP.
	83525		12.00		
N	83526		10.00		
	83530		6.00		
A	83540		4.50		
	83545		4.50		
A	83550		7.20		
	83555		7.20		
	83570		6.00		
	83571		6.00		
	83578		12.60		
	83582		6.00		
	83583		12.00		
	83586		7.50		
	83587		15.00		
	83589		7.50		
>	83590		9.40		
	83593		6.00		
>	83597		9.40		
	83610		4.20		
A	83615		4.20		
	83620		4.20		
	83625		9.00		
	83626		9.00		
	83629		4.20		
	83631		4.20		
	83632		16.00		
	83645		3.00		
	83650		3.00		
	83655		9.00		
	83660		9.00		
	83661		10.50		
	83670		2.10		
	83675		2.10		
	83680		2.10		
	83690		4.50		
A	83700		3.00		
	83715		7.50		

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE		
			OFFICE TOTAL FEE	\$	PROF. COMP.
	83718		8.00		
	83720		10.00		
	83725		9.00		
	83727		17.00		
	83735		4.50		
	83740		4.50		
	83755		4.50		
	83760		4.50		
	83795		.90		
	83825		8.40		
	83830		8.40		
	83835		10.20		
	83840		4.50		
	83915		6.00		
	83970		54.00		
	83971		12.60		
	84005		3.00		
	84030		6.00		
	84031		6.00		
>	84045		19.00		
A	84060		3.60		
	84065		3.60		
A	84075		3.60		
	84078		3.60		
	84080		3.60		
	84090		3.00		
A	84100		3.00		
	84105		3.00		
	84106		1.80		
	84110		7.50		
	84118		3.00		
	84119		3.00		
	84120		7.50		
	84121		7.50		
A	84132		3.90		
	84133		3.90		
	84135		12.00		

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE		
			OFFICE TOTAL FEE	\$	PROF. COMP.
	84136		12.00		
	84138		12.00		
	84139		12.00		
	84142		15.00		
	84144		20.00		
	84146		20.00		
A	84155		1.80		
	84160		1.80		
	84165		6.00		
A	84170		6.00		
	84180		2.40		
	84185		.60		
	84190		7.50		
	84200		7.50		
>	84202		10.40		
	84203		3.00		
	84205		15.00		
	84230		15.00		
	84233		16.00		
	84234		20.00		
	84244		25.00		
	84246		25.00		
A	84295		3.90		
	84300		3.90		
M	84317		.60		
	84403		32.00		
>	84405		30.00		
>	84408		15.00		
	84420		15.00		
	84430		3.60		
	84435		6.00		
	84436		6.00		
	84437		6.00		
>	84439		10.00		
	84442		12.00		
	84443		25.00		
A	84450		3.00		

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE		
			OFFICE TOTAL FEE	\$	PROF. COMP.
	84455		3.00		
A	84460		3.00		
	84465		3.00		
A	84478		8.30		
	84479		6.00		
	84480		15.00		
	84481		15.00		
	84485		3.30		
	84488		3.30		
	84490		3.30		
A	84520		3.00		
	84525		3.00		
	84540		3.00		
	84545		6.00		
A	84550		3.00		
	84555		3.00		
	84560		3.00		
	84577		6.00		
	84580		2.10		
	84583		2.10		
	84585		12.00		
	84590		6.00		
	84605		3.60		
	84610		3.60		
	84695		12.60		
>	84701		15.00		
	84800		25.00		
	84810		12.60		
	85000		1.20		
	85002		1.20		
	85005		3.00		
N	85007		2.40		
N	85009		1.20		
	85012		1.80		
N	85014		1.50		
N	85018		1.20		
	85021		1.80		

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE		
			OFFICE TOTAL FEE	\$	PROF. COMP.
>	85022		3.00		
>	85027		4.80		
>	85028		4.80		
>N	85028	22	8.40		
N	85031		3.00		
N	85041		1.20		
	85044		1.80		
N	85048		1.20		
>	85060		8.00		8.00
>	85095		24.00		24.00
>	85097		24.00		24.00
>	85100		53.00		48.00
>	85101		29.00		24.00
>	85102		24.00		24.00
>	85103		29.00		24.00
>	85105		24.00		24.00
	85150		1.80		
	85170		.60		
	85171		.60		
	85210		3.00		
	85345		1.80		
	85347		3.00		
	85348		1.20		
	85362		3.00		
	85363		3.00		
	85364		8.40		
	85376		5.70		
	85377		5.70		
	85544		6.00		
	85555		4.80		
	85557		4.80		
>	85560		3.00		
	85575		1.80		
	85577		1.80		
	85580		1.80		
	85590		1.80		
	85595		1.80		

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE		
			OFFICE TOTAL FEE	\$	PROF. COMP.
	85610		3.00		
	85614		3.00		
	85615		4.50		
	85650		1.50		
	85651		1.50		
	85660		1.80		
	85700		9.00		
	85730		3.00		
	85732		3.00		
	86000		.90		
	86002		1.80		
	86004		1.80		
	86006		2.70		
	86008		6.00		
	86009		3.00		
	86017		4.20		
	86024		3.00		
	86028		3.00		
	86031		3.00		
	86032		3.00		
	86033		3.00		
	86038		7.80		
	86060		3.60		
	86063		1.20		
	86064		7.80		
	86067		7.80		
	86068		4.50		
>	86077		25.00		25.00
>	86078		17.00		17.00
>	86079		17.00		17.00
	86080		1.80		
	86082		1.80		
	86090		1.80		
	86095		1.80		
	86100		1.80		
	86105		1.80		
	86115		1.80		

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE		
			OFFICE TOTAL FEE	\$	PROF. COMP.
	86120		3.00		
	86140		3.00		
N	86151		22.40		
	86162		15.60		
	86163		7.80		
	86164		9.00		
	86171		4.50		
	86225		13.00		
	86244		10.20		
	86255		7.80		
	86256		9.00		
	86277		16.00		
	86280		5.40		
	86281		3.00		
>	86285		7.50		
	86286		10.00		
	86287		10.00		
>	86288		12.00		
>	86289		15.00		
>	86291		15.00		
>	86293		12.00		
>	86295		12.00		
>	86296		10.00		
>	86298		12.00		
>	86299		12.00		
	86300		3.00		
	86305		4.50		
	86310		4.50		
>	86312		14.84		
>	86314		32.33		
	86320		10.50		
	86329		16.80		
	86335		6.00		
	86337		12.00		
	86376		6.60		
	86377		6.60		
>N	86421		20.00		

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE		
			OFFICE TOTAL FEE	\$	PROF. COMP.
>N	86422		4.00		
	86423		16.00		
	86430		1.80		
	86490		4.00		
	86510		4.00		
	86540		4.00		
>	86580		4.00		
	86585		4.00		
A	86592		1.50		
	86593		3.00		
	86594		6.00		
	86595		6.00		
	86600		7.80		
	86650		12.00		
	86660		12.00		
	86662		12.00		
>	86800		13.00		
	86812		12.60		
	86813		12.60		
	87001		9.00		
	87015		5.10		
N	87040		9.00		
N	87045		9.00		
N	87060		9.00		
N	87070		9.00		
>	87072		6.00		
>	87075		9.00		
	87076		6.00		
>	87081		10.00		
>	87082		4.00		
>	87083		4.00		
	87084		3.00		
>	87085		4.00		
	87086		3.00		
	87087		2.70		
	87088		2.70		
	87101		8.00		

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE		
			OFFICE TOTAL FEE	\$	PROF. COMP.
	87102		8.00		
	87106		8.00		
>	87109		14.00		
	87116		6.00		
	87117		9.00		
	87140		3.00		
	87143		3.00		
	87145		3.00		
	87147		3.00		
	87151		3.00		
	87155		3.00		
	87158		3.00		
	87164		6.00		
	87166		6.00		
	87177		5.10		
N	87184		9.00		
	87188		6.00		
	87190		.60		
	87205		4.20		
	87206		4.20		
	87207		3.00		
	87208		5.10		
	87210		2.40		
	87211		5.10		
	87220		2.40		
>	87250		32.00		
>	88104		12.00		7.00
>	88106		12.00		7.00
>	88107		12.00		7.00
>	88108		12.00		7.00
>	88125		7.00		7.00
>	88130		9.65		7.00
>	88140		4.20		3.00
	88150		3.00		3.00
N	88155		4.20		4.20
>	88160		7.00		7.00
>	88161		12.00		7.00

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE	
			OFFICE TOTAL FEE	PROF. COMP.
>	88162		BR	BR
>	88170		30.00	30.00
>	88171		61.00	61.00
>	88172		8.00	8.00
>	88173		25.00	25.00
>N	88260		120.00	86.00
>N	88261		120.00	86.00
>N	88262		120.00	86.00
>N	88265		85.00	41.00
>N	88267		172.00	123.00
>N	88268		172.00	60.00
>N	88270		172.00	60.00
>	88300		9.35	7.00
>	88302		21.00	15.00
>	88304		26.00	19.00
>	88305		40.00	30.00
>	88307		59.00	44.00
>	88309		89.00	66.00
>	88311		4.00	4.00
>	88312		13.00	8.00
>	88313		10.00	5.00
>	88314		12.00	7.00
>	88318		7.00	7.00
>	88319		7.00	7.00
>	88321		28.00	28.00
>	88323		33.00	33.00
>	88325		44.00	44.00
>	88329		33.00	33.00
>	88331		48.00	41.00
>	88332		15.00	15.00
>	88342		9.00	7.00
>	88346		8.00	8.00
>N	88348		BR	BR
	89050		.90	
	89051		.90	
	89105		6.00	

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE	
			OFFICE TOTAL FEE	PROF. COMP.
	89125		.60	
	89132		6.00	
	89135		6.00	
	89136		6.00	
	89141		6.00	
	89160		2.10	
	89205		1.20	
	89300		2.40	
	89310		4.80	
	89320		3.00	
M	89355		.60	
N	89360		9.00	
L N	P7001		6.00	
>L	W8010		43.75	
L N	W8200		2.00	
L N	W8205		9.00	
L N	W8210		12.00	
L A	W8215		4.00	
L	W8225		18.00	
L	W8615		7.80	
L	W8620		7.80	
L	W8621		12.60	
>L	W8622		25.00	
L	W8700		3.00	
L	W8710		3.00	
>L	W8720		15.00	
>L	W8725		30.00	
L	W8900		10.00	
L	W8920		1.80	
L	W8925		.60	

**APPENDIX A
(CODES AND NARRATIVES NOT FOUND IN CPT-4)**

PATHOLOGY/LABORATORY

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>
N	P7001		CULTURE, BACTERIAL, URINE; QUANTITATIVE; SENSITIVITY STUDY	6.00
>	W8010		HEPATITIS B PROFILE; HEPATITIS B SURFACE ANTIGEN; HEPATITIS B SURFACE AN- TIBODY; HEPATITIS BE ANTIGEN AND ANTIBODY; HEPATITIS B CORE ANTIBODY	43.75
N	W8200		GLUCOSE, SERUM (SEPARATE TUBE, GREY TOP) NOTE: SUBMITTED ON SAME CLAIM, AND PERFORMED ON SAME DATE AS CHEMISTRY PROFILES	2.00
N	W8205		3 HR. GLUCOSE TOLERANCE TEST, PER 4 SPECIMENS.	9.00
N	W8210		5 HR. GLUCOSE TOLERANCE TEST, PER 6 SPECIMENS.	12.00
A	W8215		T-4 (THYROXINE) BY IMMUNOASSAY (ENZYME IMMUNOASSAY) (EMIT)	4.00
	W8225		THYROXINE - BINDING GLOBULIN WITH T4 (THYROBINDING-GLOBULIN WITH T4) (RIA) (TBG AND T4)	18.00
	W8615		ANTI-DNA, ANTI - DEOXYRIBONUCLEIC ACID, (CHEMICAL METHOD, NON-RIA)	7.80
	W8620		HERPES SIMPLEX ANTIBODIES : (HERPES SIMPLEX VIRUS, I OR II)	7.80
	W8621		HERPES SIMPLEX VIRUS, I AND II	12.60
>	W8622		HERPES SIMPLEX VIRUS ISOLATION AND IDENTIFICATION, TOTAL STUDY	25.00
	W8700		YEAST SCREEN (NOT DEFINITIVE) FROM URINE, VAGINAL OR THROAT CULTURES ONLY (EG., GERM TUBE)	3.00
	W8710		TRICHOMONAS PREPARATION - SMEAR OR HANGING DROP (SMEAR NOT ELIGIBLE FOR SEPARATE REIMBURSEMENT IF PAP SMEAR DONE ON THE SAME DAY).	3.00
>	W8720		CHLAMYDIA DIRECT SPECIMEN TEST; MICROTRACK; CHLAMYDIAZIME; CHLAMYDIA A.G. DIRECT; CHLAMYDIA TITER: CHLAMYDIA CF; CHLAMYDIA ASSAYS BY IFA AND CIS; CHLAMYDIA ISOLATION; FLUORESCENT ANTIBODY FA	15.00
>	W8725		CHLAMYDIA CULTURE	30.00
	W8900		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
	W8920		VISIT TO OBTAIN BLOOD SPECIMENS BY VENOUS OR ARTERIAL PUNCTURE "FIRST PERSON IN NURSING HOME."	1.80
	W8925		EACH ADDITIONAL PERSON IN NURSING HOME.	.60

APPENDIX B (PATHOLOGY AND LABORATORY)

QUALIFIERS

➤1. Chemistry Automated, Multichannel Tests

Applies to CPT Codes: 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018 and 80019. The following list contains those tests which can be and are frequently performed as groups and combinations (profiles) on automated multichannel equipment: Apply this methodology to the above CPT Codes. (discontinued codes were 8302 and 8306). For reporting one test, regardless of method of testing, use appropriate single test code number. For any combination of tests among those listed below use the appropriate number 80002 - 80019. Groups of the tests listed here are distinguished from multiple tests performed individually for immediate or "stat" reporting (for handling of specimen, see 99000 and 99001).

Albumin	Iron
Alkaline Phosphatase	Lactic Dehydrogenase (LDH)
Bilirubin, Total	Phosphorus
Bilirubin, Direct	Potassium (K)
Blood Urea Nitrogen (BUN)	Protein, Total
Calcium	Sodium (NA)
Carbon Dioxide (CO ₂)	Total Lipids
Chlorides (Cl)	Transaminase, Glutamic Oxalacetic, (SGOT)
Cholesterol	Transaminase, Glutamic Pyruvic, (SGPT)
Creatinine	Triglycerides
Gamma Glutamyl Transpeptidase (GGTP)	T4 by Immune Assay (EMIT)
Glucose (Sugar)	Uric Acid

➤ NOTE: 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 \$5.00, the maximum reimbursement will not be more than \$5.00: 82251, 82374, 82801, 83540, 83545, 83610, 83615, 83620, 83629, 83631, 84075, 84078, 84080, 84132, 84133, 84295, 84300, 84478, 82977, W8215.

NOTE: The following calculations and ratios are not eligible for separate or additional reimbursement, and therefore, should not be included in determining the calculations allotted to the above Procedure Codes.

A/G Ratio	Globulin
BUN/Creatinine Ratio	FTI (T7)
Free Calcium	Free Thyroxine

- > NOTE: Any additional automated multichannel chemistry tests (other than those listed) performed on same date as Codes 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018 and 80019 will be reimbursed at the current allowable fee for each added test.
- > NOTE: Code (W8200) - Glucose (separate tube, gray top) (discontinued code 8607) performed on the same date as the following chemistry profiles 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018 and 80019 will be paid an additional \$2.00.

2. Code 80072 -Arthritis Panel (discontinued code 8321)

NOTE: Should include as a minimum four of the following tests:

ASO Titer	Uric Acid
C- Reactive Protein (CRP)	Alkaline Phosphatase
RA Latex (Rheumatoid Arthritis factor)	Calcium

3. Code 80070- Thyroid Panel (discontinued code 8317)

T4 by RIA, plus T3 uptake, resin (T3RU) (RT3U)

NOTE: The following calculations will be included in the fee for the Thyroid Panel:

"T7" Free Thyroxine
Index (FTI), Calculated Free Thyroxine
Index (CFT4) or Calculated Thyroxine
Iodine (T4I)

NOTE: T3 by uptake, resin (T3RU) is eligible for reimbursement only when done in conjunction with T4 by RIA as part of Thyroid profile.

4. Code 80055-52 - Obstetric profile (discontinued code 8332)

NOTE: At least four of the following tests must be included in the profile:

Blood Group (ABO)
RH Factor
Antibody screen (Atypical Antibody Identification)
Complete Blood Count (CBC) (with or without differential)
Serology (STS, VDRL, RPR)

5. Code 80055-Obstetric profile (discontinued code 8333)
with Rubella HI Antibody Titer

6. Code 80055-22 - Expanded Obstetric profile (discontinued code 8335)

NOTE: For reimbursement purposes the following must be included:

Blood Group (ABO)
RH Factor
Antibody Screen (Atypical Antibody Identification)
Complete Blood Count (CBC) (with or without differential)
Serology (STS, VDRL, RPR)
Cytology (Pap Smear)
Urinalysis
Urea Nitrogen (BUN)
Glucose
Sickle Cell
with Rubella HI Antibody Titer

7. Code 81000 - Urinalysis (discontinued code 8936)

NOTE: Stick, dip or tablet tests done on urine are considered part of the urinalysis, and therefore, are not eligible for separate reimbursement. Microscopy is required for reimbursement.

8. Code 86151 - (CEA-RIA) Carcinoembryonic Antigen. (discontinued code 8504)

NOTE: "CEA is not useful to diagnose cancer. Claims are eligible for reimbursement only when CEA is used to follow treated cases of cancer (e.g., gastro-intestinal, breast, lung) primary detection of recurrence, or for estimation of prognosis in certain cases."
(Documentation required)

9. Code 88155 - pap smear (discontinued code 8027)

NOTE: (obtaining specimen not a separate eligible service)

10. Cultures, Codes 87040, 87045, 87060, 87070, 87184, P7001 (discontinued codes 8459, 8976)

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

11. Code 82173 and 82946 -Glucagon Tolerance Test (discontinued code 8557)
(Total payment not to exceed \$65.00)

12. Code 83526 - Insulin Tolerance Test (discontinued code 8564)
(Total payment not to exceed \$70.00) (RIA)

13. Code 85031 - Complete Blood Count - CBC (discontinued code 8628)

(Components of a CBC)- maximum fee for any of the following combinations of components is \$3.00. (83051, 83053, 85007, 85009, 85014, 85018, 85041, 85048)

NOTE: For reimbursement purposes includes automated as well as manual.

14. Code 82365 and 82370 (discontinued code 8992) Calculus (stone),
Quantitative: (Infra-red spectroscopy) X-ray diffraction.

NOTE: Reimbursement not eligible for chemical methods.

- 15. Code 82437 and 89360 (discontinued code 8994) Sweat (without iontophoresis)Test

NOTE: Reimbursement not eligible for qualitative tests. For reimbursement purposes includes 82437 or 84295 at no additional cost.

16. Code 82011 (discontinued code 8897) Salicylates, quantitative only.

NOTE: Reimbursement not eligible for screening (Qualitative) tests for salicylates. (82012)

17. Code W8205 and W8210 - Glucose Tolerance (discontinued codes 8723 and 8724)

NOTE: For reimbursement purposes includes all urines for sugar.

18. Code 88260, 88261 and 88262 - Chromosome Analysis; Peripheral blood (discontinued code 8913). Rule out numerical and structural abnormalities.

NOTE: For Medicaid reimbursement purposes must include an average of 20 cells and 2-3 karyotypes analyzed, including banding.

19. Code 88265 - Chromosome Analysis: Various leukemias, bone marrow and peripheral blood (includes Philadelphia Chromosome study). (discontinued code 8913)

NOTE: For reimbursement purposes must include a minimum of 10 cells and 2 karyotypes analyzed, including banding.

20. Code 88267 - Chromosome Analysis: Amniotic Fluid Cells (Prenatal Chromosome Analysis). (discontinued code 8009)

NOTE: For reimbursement purposes must include 20 cells and 2-3 karyotypes analyzed, including banding.

21. Code 88268 and 88270 - Chromosome Analysis: Tissue Biopsy, Abortuses, etc. (discontinued code 8009) (Documentation report required)

NOTE: For reimbursement purposes as a minimum include 15-20 cells and 2-3 karyotypes analyzed, including banding.

22. Code 88280, 88285

NOTE: Additional karyotyping and cells counted are not reimbursable for Medicaid payment.

- 23. Code 80059 Hepatitis Panel: For reimbursement purposes includes:

Hepatitis Profile

Hepatitis B Surface Antigen (Australian)
Hepatitis B Surface Antigen Antibody
Hepatitis B Core Antibody
Hepatitis A Antibody

could I work... (8630) Hemogram... - 22- Service Greater than Usual)

OS The definition of a complete Hemogram is: supravital morphological study of the formed elements of the blood, hematocrit, reticulocyte count, platelet count, hemoglobin, total white count, supravital differential or phase, regular differential, total red count and indices, MCV, MCH, MCHC. A Hemogram will be reimbursed at \$8.40. Providers must indicate on the claim form what components are part of their Hemogram and use the Modifier 22.

> 25. Code 86421 (8525) Radioallergosorbent Test (Rast); up to 5 Antigens

For reimbursement purposes, payment for each individual Antigen is \$4.00 up to the first 5 Antigens. List number of Antigens in the appropriate box of the claim form.

> 26. Code 86422 (8526) 6 or more Antigens

For reimbursement purposes, payment is per each additional Antigen

> 27. Code 88348 - Not reimbursable when used as a research tool.

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



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

NEWSLETTER

New Jersey Health Services Program

Volume P-523

April 27, 1987

TO: Providers of Podiatry Services
SUBJECT: HCFA Common Procedure Coding System (HCPCS) - Revision

Replacement pages are enclosed for Subchapter 3., HCFA Common Procedure Coding System, of the Podiatry Services Manual. Incorporated into the replacement pages are all the additions and revisions since HCPCS was implemented September 1, 1985. The sign "➤" preceding any HCPCS code indicates an addition or a revision. The additions and revisions are listed below:

1. Additions: 90000, 90010, 90030, 90040, 90080, 90130, 90140, 90200, 90240, 90270, 90280, 90300, 90340, 90400, 90410, 90430, 90440, 90500, 90505, 90510, 90515, 90517, 90530, 90540, 90550, 90560, 90570, 90630, 10020, 11603, 11604, 11606, 11623, 11624, 11626, 28293.
2. Revisions: 83053, 87081.

Manual Maintenance: Please substitute each replacement page accordingly in Subchapter 3. of the Podiatry Services Manual.

If you have any questions regarding this Newsletter, please contact The Prudential Insurance Company of America, at (800) 582-7052.

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:57-3.1 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 Co. 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 CODES WHICH REQUIRE ATTENTION OF PROVIDER: The list of HCPCS codes in section 3.2 is arranged in tabular form with specific information for a code given under columns with the titles such as: "IND", "HCPCS CODE", "MOD", "DESCRIPTION", "FOLLOW-UP DAYS", "MAXIMUM FEE ALLOWANCE" 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 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 Section 3.2

"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 Section 3.2.

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 codes are listed in Appendix C at the end of Section 3.2 (Podiatry Services HCPCS code numbers and maximum fee schedule).

DESCRIP-
TION

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.

MAXIMUM
FEE
ALLOWANCE

Lists New Jersey Medicaid Program's 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 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. (For more information about anesthesia service, see Policies and Procedures Regarding Use of HCPCS (c) 3.v. which follows.)

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

10:57-3.2 PODIATRY SERVICES HCPCS CODE NUMBERS AND
MAXIMUM FEE SCHEDULE

(a) MEDICINE

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE		IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE	
			S	\$ NS				S	\$ NS
➤N	90000		22.00	17.00	➤N	90270		9.00	7.00
➤N	90010		22.00	17.00	➤N	90280		9.00	7.00
N	90015		22.00	17.00	➤N	90300		22.00	17.00
N	90017		22.00	17.00	N	90315		22.00	17.00
N	90020		22.00	17.00	N	90320		22.00	17.00
➤N	90030		9.00	7.00	➤N	90340		9.00	7.00
➤N	90040		9.00	7.00	N	90350		9.00	7.00
N	90050		9.00	7.00	N	90360		9.00	7.00
N	90060		9.00	7.00	N	90370		9.00	7.00
N	90070		9.00	7.00	➤N	90400		22.00	17.00
➤N	90080		9.00	7.00	➤N	90410		22.00	17.00
➤N	90130		9.00	7.00	N	90415		22.00	17.00
➤N	90140		9.00	7.00	N	90420		22.00	17.00
N	90150		9.00	7.00	➤N	90430		9.00	7.00
N	90160		25.00	25.00	➤N	90440		9.00	7.00
N	90170		25.00	25.00	N	90450		9.00	7.00
➤N	90200		22.00	17.00	N	90460		9.00	7.00
N	90215		22.00	17.00	N	90470		9.00	7.00
N	90220		22.00	17.00	➤N	90500		9.00	7.00
➤N	90240		9.00	7.00	➤N	90505		9.00	7.00
N	90250		9.00	7.00	➤N	90510		9.00	7.00
N	90260		9.00	7.00	➤N	90515		9.00	7.00

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE	
			S	\$ NS
>N	90517		9.00	7.00
>N	90530		9.00	7.00
>N	90540		9.00	7.00
>N	90550		9.00	7.00
>N	90560		9.00	7.00
>N	90570		9.00	7.00
N	90600		22.00	-
N	90605		22.00	-
N	90610		22.00	-
N	90620		37.00	-
>N	90630		37.00	-
N	90799		2.50	2.50

IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE	
			S	\$ NS

(b) SURGERY

IND	HCPCS		FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE			ANES BASIC UNITS	IND	HCPCS		FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE			ANES BASIC UNITS
	CODE	MOD		S	\$	NS			CODE	MOD		S	\$	NS	
	10000		0	13.00	11.00	3.		11404		30	32.00	27.00	3.		
	10003		0	13.00	11.00	3.		11406		30	32.00	27.00	3.		
>	10020		0	13.00	11.00	3.		11420		15	18.00	16.00	3.		
	10060		0	13.00	11.00	3.		11421		15	22.00	20.00	3.		
	10061		30	48.00	42.00	4.		11422		15	27.00	24.00	3.		
	10100		0	13.00	11.00	3.		11423		30	32.00	27.00	3.		
	10101		30	34.00	29.00	3.		11424		30	32.00	27.00	3.		
	10120		0	18.00	16.00	3.		11426		30	32.00	27.00	3.		
	10121		30	34.00	29.00	4.		11600		90	37.00	32.00	3.		
	10140		0	18.00	16.00	3.		11601		90	47.00	42.00	3.		
	10141		30	48.00	42.00	3.		11602		90	61.00	53.00	3.		
	10160		0	13.00	11.00	3.	>	11603		90	70.00	61.00	3.		
N	11000		0	13.00	11.00	4.	>	11604		90	80.00	70.00	3.		
N	11001		0	6.00	5.00	3.	>	11606		90	92.00	80.00	3.		
	11040		0	13.00	11.00	3.		11620		90	61.00	53.00	4.		
	11041		0	13.00	11.00	3.		11621		90	90.00	79.00	4.		
	11042		0	16.00	14.00	3.		11622		90	121.00	105.00	4.		
	11043		0	16.00	14.00	3.	>	11623		90	140.00	121.00	4.		
	11044		0	48.00	42.00	3.	>	11624		90	162.00	139.00	4.		
	11100		0	13.00	11.00	4.	>	11626		90	186.00	160.00	4.		
	11400		15	18.00	16.00	3.		11700		0	13.00	11.00	3.		
	11401		15	22.00	20.00	3.		11701		0	19.00	16.00	3.		
	11402		15	27.00	24.00	3.		11710		0	13.00	11.00	3.		
	11403		30	32.00	27.00	3.		11711		0	19.00	16.00	3.		

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE			ANES BASIC UNITS
				S	\$	NS	
	11730		0	10.00	10.00		3.
	11750		30	42.00	37.00		3.
	12001		0	18.00	16.00		3.
	12002		0	24.00	21.00		3.
	12004		0	30.00	26.00		3.
	12041		30	30.00	26.00		3.
	12042		30	67.00	59.00		4.
	13131		30	67.00	59.00		4.
	13132		30	145.00	126.00		4.
	13300		30	242.00	210.00		4.
	14040		60	193.00	168.00		4.
	14041		60	242.00	210.00		4.
	17000		0	8.00	6.00		3.
	17010		0	11.00	8.00		3.
	17100		0	18.00	15.00		3.
	17105		0	27.00	24.00		3.
	17110		0	8.00	6.00		3.
	17200		0	8.00	6.00		3.
	17304		30	25.00	21.00		3.
	17305		30	8.00	6.00		3.
	17310		30	BR	BR		3.
	20000		0	18.00	16.00		3.
	20005		0	45.00	40.00		4.
N	20520		7	51.00	45.00		3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE			ANES BASIC UNITS
				S	\$	NS	
N	20550		0	13.00	11.00		0.
	20600		0	13.00	11.00		3.
N	20605		0	13.00	11.00		3.
	20650		0	55.00	47.00		4.
	20670		0	24.00	21.00		3.
N	20680		21	121.00	105.00		4.
N	20680-52		21	61.00	53.00		4.
	27530		30	74.00	65.00		3.
	27532		90	121.00	105.00		3.
	27534		90	145.00	126.00		3.
	27536		90	242.00	210.00		3.
	27603		30	BR	BR		3.
	27604		0	13.00	11.00		3.
	27610		60	182.00	158.00		3.
	27611		60	182.00	158.00		3.
	27613		0	13.00	11.00		4.
	27620		60	182.00	158.00		3.
	27625		90	211.00	184.00		3.
	27630		30	90.00	79.00		3.
	27640		60	211.00	184.00		4.
	27641		60	211.00	184.00		4.
	27648		0	61.00	53.00		3.
	27650		90	227.00	197.00		4.
	27658		90	121.00	105.00		3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE		ANES BASIC UNITS	IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE		ANES BASIC UNITS
				S	\$ NS						S	\$ NS	
	27659		90	121.00	105.00	3.		27806		90	161.00	140.00	3.
	27664		90	90.00	79.00	3.		27810		90	121.00	105.00	3.
	27665		90	90.00	79.00	3.		27812		90	145.00	126.00	3.
	27685		90	151.00	131.00	4.		27814		90	211.00	184.00	3.
	27686		90	202.00	175.00	3.		27818		90	121.00	105.00	3.
	27695		90	302.00	263.00	3.		27820		90	141.00	123.00	3.
	27698		90	227.00	197.00	3.		27822		90	242.00	210.00	3.
	27700		90	249.00	216.00	3.		27823		90	242.00	210.00	3.
	27705		90	272.00	236.00	3.		27832		90	164.00	142.00	3.
	27707		90	113.00	100.00	3.		27840		45	61.00	53.00	0.
	27752		90	121.00	105.00	3.		27842		45	61.00	53.00	3.
	27754		90	145.00	126.00	3.		27844		45	152.00	131.00	3.
	27756		90	211.00	184.00	3.		27846		90	305.00	263.00	3.
	27760		90	79.00	68.00	3.		27850		0	61.00	53.00	3.
	27762		90	79.00	68.00	3.		27852		60	284.00	247.00	4.
	27764		90	105.00	91.00	3.		27860		0	61.00	53.00	3.
	27766		90	151.00	131.00	3.		27870		90	302.00	263.00	3.
	27781		30	45.00	39.00	3.		28001		0	13.00	11.00	3.
	27782		90	61.00	53.00	3.		28002		0	24.00	21.00	3.
	27784		90	121.00	105.00	3.		28008		60	61.00	53.00	3.
	27788		90	79.00	68.00	3.		28010		0	24.00	21.00	3.
	27790		90	105.00	91.00	3.		28011		0	37.00	32.00	3.
	27792		90	151.00	131.00	3.		28020		60	109.00	95.00	3.
	27802		90	121.00	105.00	3.		28022		60	109.00	95.00	3.
	27804		90	161.00	140.00	3.		28024		60	37.00	32.00	3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE		ANES BASIC UNITS
				S	\$ NS	
	28080		30	121.00	105.00	3.
	28090		30	90.00	79.00	3.
	28092		30	61.00	53.00	3.
	28100		60	121.00	105.00	4.
	28108		60	121.00	105.00	4.
	28114		90	242.00	210.00	3.
	28120		60	90.00	79.00	4.
	28121		60	90.00	79.00	4.
	28122		60	90.00	79.00	4.
	28123		60	90.00	79.00	4.
	28124		60	90.00	79.00	4.
	28140		60	121.00	105.00	3.
	28150		90	90.00	79.00	3.
	28160		90	90.00	79.00	3.
	28190		0	18.00	16.00	3.
	28192		30	34.00	29.00	4.
	28193		30	34.00	29.00	4.
	28200		90	121.00	105.00	3.
	28208		90	61.00	53.00	3.
	28220		60	113.00	99.00	3.
	28222		60	139.00	119.00	3.
	28225		60	113.00	99.00	3.
	28226		60	139.00	119.00	3.
	28230		30	42.00	37.00	3.
	28232		60	139.00	119.00	3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE		ANES BASIC UNITS
				S	\$ NS	
	28234		60	139.00	119.00	3.
	28240		30	61.00	53.00	3.
	28262		90	121.00	105.00	3.
	28280		45	61.00	53.00	3.
N	28285		90	90.00	79.00	3.
N	28288		21	72.00	63.00	3.
	28290		60	90.00	79.00	3.
	28292		90	139.00	121.00	3.
	28293		90	242.00	210.00	3.
	28294		90	141.00	123.00	3.
	28306		90	113.00	100.00	3.
	28308		90	113.00	100.00	3.
	28315		60	55.00	47.00	3.
	28400		30	68.00	59.00	3.
	28405		90	90.00	79.00	3.
	28410		90	113.00	99.00	3.
	28415		90	151.00	131.00	3.
	28430		30	82.00	72.00	3.
	28435		90	90.00	79.00	3.
	28440		90	113.00	99.00	3.
	28450		30	41.00	36.00	3.
	28455		90	61.00	53.00	3.
	28460		90	90.00	79.00	3.
	28465		90	121.00	105.00	3.
	28470		30	18.00	16.00	3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE		ANES BASIC UNITS
				S	\$ NS	
	28475		90	42.00	37.00	3.
	28480		90	63.00	56.00	3.
	28485		90	90.00	79.00	3.
N	28490		30	18.00	16.00	3.
	28495		30	30.00	26.00	3.
	28500		45	90.00	79.00	3.
	28510		30	18.00	16.00	3.
	28515		30	30.00	26.00	3.
	28520		45	79.00	63.00	3.
	28540		45	61.00	53.00	0.
	28545		45	61.00	53.00	3.
	28550		45	107.00	92.00	3.
	28555		90	211.00	184.00	3.
	28570		45	61.00	53.00	0.
	28575		45	61.00	53.00	3.
	28580		45	107.00	92.00	3.
	28585		90	211.00	184.00	3.
	28600		45	61.00	53.00	0.
	28605		45	61.00	53.00	3.
	28610		45	104.00	91.00	3.
	28630		45	61.00	53.00	0.
	28640		45	104.00	91.00	3.
	28645		90	121.00	105.00	3.
	28660		0	13.00	11.00	0.
	28670		45	18.00	16.00	3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE		ANES BASIC UNITS
				S	\$ NS	
	28675		60	47.00	40.00	3.
	28715		90	272.00	236.00	3.
	28725		90	182.00	158.00	3.
	28740		90	166.00	126.00	3.
N	28750		90	90.00	79.00	3.
N	28755		90	90.00	79.00	3.
	28760		90	200.00	173.00	3.
	28800		90	211.00	184.00	3.
	28805		90	211.00	184.00	3.
	28810		90	121.00	105.00	3.
	28820		45	42.00	37.00	3.
	28820-51		45	63.00	56.00	3.
	28825		45	42.00	37.00	3.
	28825-51		45	63.00	56.00	3.
	29405		0	42.00	37.00	3.
	29425		0	47.00	42.00	3.
	29450		0	24.00	21.00	3.
	29455		0	37.00	32.00	3.
	29515		0	42.00	37.00	3.
N	29580		0	18.00	16.00	3.
	29700		0	14.00	12.00	3.
	29730		0	9.00	8.00	3.
	29740		0	9.00	8.00	3.
	29750		0	9.00	8.00	3.
	29751		0	15.00	13.00	3.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE		ANES BASIC UNITS
				S	\$ NS	
N	36415		0	1.80	1.80	0.
	64450		0	13.00	11.00	0.
	64702		90	79.00	68.00	3.
	64704		90	105.00	91.00	3.
	64708		90	242.00	210.00	3.
	64774		30	42.00	37.00	3.
	64776		30	53.00	45.00	3.
	64782		30	79.00	68.00	3.
	64784		30	131.00	114.00	4.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE		ANES BASIC UNITS
				S	\$ NS	
	64834		90	105.00	91.00	3.
	64856		90	210.00	183.00	3.
L	W1250		0	18.00	16.00	3.
L	W1650		0	24.00	21.00	3.
L	W1650	22	0	37.00	32.00	3.
L	W2600		90	151.00	131.00	3.
L	W2620		90	90.00	79.00	3.
L	W2650		0	21.00	21.00	0.
L	W2655		0	5.00	5.00	0.

(c) RADIOLOGY

<u>IND</u>	<u>HCPCS Code</u>	<u>MOD</u>	<u>MAXIMUM FEE ALLOWANCE</u>		<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>MAXIMUM FEE ALLOWANCE</u>	
			<u>S</u>	<u>\$ NS</u>				<u>S</u>	<u>\$ NS</u>
	73560		15.00	15.00		73620		10.00	10.00
	73562		15.00	15.00		73630		13.00	13.00
	73590		15.00	15.00		73650		10.00	10.00
	73600		10.00	10.00		73660		5.00	5.00
	73610		13.00	13.00	L	W7200		20.00	20.00

(d) PATHOLOGY & LABORATORY SERVICES

<u>IND</u>	<u>HCPCS Code</u>	<u>MOD</u>	<u>MAXIMUM FEE ALLOWANCE</u>		<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>MAXIMUM FEE ALLOWANCE</u>	
			<u>S</u>	<u>\$ NS</u>				<u>S</u>	<u>\$ NS</u>
N	81000		1.20	1.20	3	87081		10.00	10.00
	82947		3.00	3.00		87101		8.00	8.00
	83051		1.20	1.20		87102		8.00	8.00
3	83053		1.80	1.80		87106		8.00	8.00
	86595		6.00	6.00	N	87184		9.00	9.00
N	87040		9.00	9.00		87210		2.40	2.40
N	87070		9.00	9.00		87220		2.40	2.40
	87076		6.00	6.00					

APPENDIX A

PODIATRY SERVICES

CODES AND NARRATIVES NOT FOUND IN CPT-4 (Level II and Level III Codes)

SURGERY CODES

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>DESCRIPTION</u>	<u>FOLLOW UP DAYS</u>	<u>MAXIMUM FEE ALLOWANCE S \$ NS</u>	<u>ANES BASIC UNITS</u>
	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.	0	18.00 16.00	3.
	W1650		Excision of plantar verruca, single site unilateral	0	24.00 21.00	3.
	W1650	22	Excision of plantar verruca, multiple sites unilateral	0	37.00 32.00	3.
	W2600		Arthroplasty, lesser toes, with or without tendon transfer	90	151.00 131.00	3.
	W2620		Plastic or reconstructive surgery, toe, one joint	90	90.00 79.00	3.
	W2650		Casting for molded shoes	0	21.00 21.00	0.
			Prior authorization is required. Attach to your 1500-N.J. claim form.			
	W2655		Casting for arch support	0	5.00 5.00	0.
			Prior authorization is required. Attach to your 1500 N.J. claim form.			

RADIOLOGY CODE

W7200	Radiologic examination; foot, complete including special os calcis view	20.00 20.00
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APPENDIX B (Podiatry Services)

QUALIFIERS

HCPCS
CODE

QUALIFIERS

INITIAL VISITS - NEW PATIENT

- 90000 When reference is made in your CPT manual to New Patient or Initial Care, the intent of Medicaid is to consider this service as the Initial Visit.
- 90010
90015
90017
90020
- 90200 If the setting for this Initial Visit is an Office, or Sheltered Boarding Home, then for reimbursement purposes, it is limited to a single visit with the future use of this code then reimbursed as a Routine or Follow-Up visit. This is applicable if this examination of the recipient is by the same physician, group of physicians, involves a shared health care facility or group of physicians sharing a common record.
- 90215
90220
- 90300 Reimbursement for an Initial Office Visit also precludes subsequent reimbursement for an Initial Sheltered Boarding Home Visit and vice versa.
- 90315
90320
- 90400
➤ 90410
90415
90420

Reimbursement for an Initial Office Visit or Sheltered Boarding Home Visit will be disallowed and the fee downgraded to a routine visit, if an annual examination or EPSDT examination were billed within a twelve month period, by the same physician, group, shared health care facility, or practitioners sharing a common record.

If the setting is Skilled Nursing, Intermediate Care, Long Term Care Facility or Hospital, the Initial Visit concept will still apply when considered for reimbursement purposes despite CPT reference to the terms Initial Care or Initial Hospital Care as applying to a new or established patient.

Subsequent readmissions to the same facility may be designated as Initial Visits as long as a time interval of 30 days or more has elapsed between admissions.

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.

Example:

1. Chief complaint(s).

QUALIFIERS

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.
6. Working diagnoses and treatment plan including ancillary service and drugs ordered.

- NOTE: (1) Home and Boarding Home records should be part of the office records.
- (2) If the history and physical examination noted above is not personally performed by the billing physician in a hospital or health care facility, then reimbursement will be downgraded to a routine visit if that criteria is met, e.g., daily hospital care, subsequent skilled nursing visit, etc.

ROUTINE VISIT OR FOLLOW-UP CARE VISIT

- 90030 Routine visit or Follow-Up Visit is defined as the care and
➤ 90040 treatment by a physician, which includes those procedures
90050 ordinarily performed during a health care visit, which is
90060 dependent upon the setting and the physician's discipline.
90070
- 90080 The setting could be office, hospital, skilled nursing,
➤ 90240 intermediate care, long term care facilities, nursing home or
90250 boarding home. Prior authorization is required where more
90260 than one visit a month would be necessary for routine foot
90270 care.
- 90280
- 90340 In order to document the record for reimbursement purposes, a
90350 progress note for the noted visits should include the
90360 following:
90370
- 90430 1. In an Office, or Boarding Home setting.
➤ 90440 a) Purpose of visit;
90450
90460 b) Pertinent history obtained
90470
- 90500
➤ 90505

QUALIFIERS

> 90510
> 90515
> 90517
> 90530
> 90540
> 90550
> 90560
> 90570

c) Pertinent physical findings including pertinent negative findings based on the above.

HOME VISITS

> 90130
> 90140
90150
90160
90170

Home Visit (House Call) - does not apply to Sheltered Boarding Home or Nursing Home Setting.

A Physician visit limited to care and treatment of an individual who by contemporary standards would be too ill to go to a physician's office and/or is "home bound" due to his/her physical disability. If more than one patient is seen on the visit, the fee for the additional visit will be as if it were performed in the office. When billing for a second or subsequent patient treated during the same visit, the visit should be billed as a 90150.

The record and documentation of a home visit shall become part of the office progress notes and shall include, as appropriate, the following instructions:

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, ECG, etc, ordered with results;
6. Diagnosis(s) plus treatment plan status relative to present or pre-existing illness(s) plus pertinent recommendations and actions.

NOTE: The new "Home Visit (House Call)" code does not distinguish between specialist and non-specialist. Also, the Initial Home Visit is being dropped as a separate entity.

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. Two types of consultation are recognized for reimbursement - one limited in extent and one comprehensive in scope.

HCPCS
CODE

QUALIFIERS

Limited Consultation:

90600
90605
90610

Appropriate CPT codes which are presently compatible are Codes 90600, 90605 and 90610. The area being covered for reimbursement purposes is "limited" in the sense that it requires less than the requirements designated as "comprehensive" as noted below.

Comprehensive Consultation:

90620
> 90630

In order to receive reimbursement for CPT Code 90620 & 90630 which replaces the discontinued Code 9030 (consultation comprehensive), the same criteria must be met that had been previously required, namely, the performance of a total systems evaluation by history and physical examination including a total systems review and total system physical examination. The alternative to that would be the utilization of one or more hours of the consulting physician's personal time in the performance of the consultation.

Reimbursement for Code 90620 & 90630 (Comprehensive Consultation) requires the following applicable statements or language essentially similar to those statements to be inserted into Item 34 of the 1500 N.J. Claim Form. The form is to be signed by the provider who performed the consultation.

1. I personally performed a total (all) systems evaluation by history and physical examination, or
2. This consultation utilized 60 or more minutes of my personal time.

Failure to comply with the above will result in the consultation being downgraded to the reimbursement of Code 90610.

The following rules regarding consultations should also be recognized:

1. If a consultation is performed in an inpatient or outpatient setting and the patient is then transferred to the consultant's service during that course of illness then the provider may not, in addition, bill for an Initial Visit if he has or intends to bill for the consultation.
2. If there is no referring physician, then an Initial Visit code should be used instead of a consultation code.

QUALIFIERS

3. If the patient is seen for the same illness on repeated visits, by the same consultant, then these visits are considered as routine visits or follow-up care visits and not as consultations. In addition, the criteria for concurrent care would need to be met to warrant reimbursement.
4. Consultation codes 90600, 90605, 90610, 90620 and 90630 will be declined in an Office or Boarding home setting if the consultation has been requested by or between members of the same group, shared health care facility or physicians sharing common records. A routine visit code is applicable under these circumstances.
5. If a prior claim for code 90620 and 90630 has been made within the preceding 12 months, then a repeat claim for this code will be denied if made by the same physician, physician group, shared health care facility or physicians using a common record except in those instances where the consultation required the utilization of one hour or more of the physician's personal time. Otherwise, applicable codes would be 90600, 90605, or 90610 if their criteria are met.

90799

Injection policy and drugs dispensed by a podiatrist. Payment will be made for intradermal, subcutaneous, intramuscular, or intravenous injections in the office or home (not nursing home).

1. The drug administration must be consistent with the diagnosis.
2. Injections before a surgery or nerve blocks are ineligible.
3. Sclerosing solution or anything injected into a neuroma or tumor would be considered as a visit.
4. PRV 20600 or 20605 can only be given when the injection is into a joint.

(Ankle can be considered a joint).
5. An injection into the bursa or an injection for bursitis would be coded PRV 20600 or 20505.
6. Cortisone or steroid injections would be eligible as long as they were injected into the foot. PRV 90799 should be used.

HCPCS
CODE

QUALIFIERS

87040
>87070
>87076
>87101
87184

CULTURES

NOTE: These codes may only be billed when a pathogenic micro-organism is reported. A culture that indicates no growth or normal flora must be billed as a presumptive culture.



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

New Jersey Health Services Program

NEWSLETTER

Volume P-524

April 27, 1987

TO: Providers of Independent Clinic Services
SUBJECT: HCFA Common Procedure Coding System (HCPCS) - Revision

Replacement pages are enclosed for Subchapter 3, HCFA Common Procedure Coding System, of the Independent Clinic Services Manual. Incorporated into the replacement pages are all the additions and revisions since HCPCS was implemented September 1, 1985. The sign "➤" preceding any HCPCS code indicates an addition or a revision. A vertical line on the left hand margin of written text indicates a revision. The additions and revisions are listed below:

1. Additions: 90000, 90010, 90030, 90040, 90080, 90718, 90000WF, 90010WF, 90030WF, 90050WF, 90080WF, 90030WM, 90040WM, 90070WM, 90080WM, 90130WM, 90140WM, 90170WM, 90030YR, 90040YR, 90060YR, 90070YR, 90080YR, 90240, 90280.
2. Revisions: 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90709, 90712, 90719, 90724, 90732, J2790, W9090, W9095, 90801ZI, 90843ZI, 90844ZI, 90847ZI, 90847ZI22, 90887ZI, Z0130, Z0170, Z0180, 59420WM22, Z0330, Z0335.

Manual Maintenance: Please substitute each replacement page accordingly in Subchapter 3 of the Independent Clinic Services Manual.

If you have any questions regarding this Newsletter, please contact The Prudential Insurance Company of America, at (800) 582-7052.

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 "MAXIMUM FEE ALLOWANCE". The information given under these columns is summarized below:

- 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.

MAXIMUM FEE ALLOWANCE 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 appropriate HCPCS Codes must be used in conjunction with modifiers when 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 "MAXIMUM FEE ALLOWANCE" 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.

10:66-3.2 HCPCS CODE NUMBERS AND MAXIMUM FEE SCHEDULE FOR INDEPENDENT CLINIC SERVICES

IND	HCPCS Code	MOD	MAXIMUM FEE ALLOWANCE		IND	HCPCS CODE	MOD	MAXIMUM FEE ALLOWANCE	
			S	\$ NS				S	\$ NS
(a) <u>Examination and Treatment</u>									
N	36415		1.80	1.80	>N	90706		12.86	12.86
	86490		4.00	4.00	>N	90707		27.24	27.24
	86510		4.00	4.00	>N	90708		18.73	18.73
	86540		4.00	4.00	>N	90709		20.23	20.23
	86580		4.00	4.00	>N	90712		13.85	13.85
	86585		4.00	4.00	>	90718		3.98	3.98
> N	90000		22.00	17.00	>N	90719		4.88	4.88
> N	90010		22.00	17.00	>N	90724		5.32	5.32
N	90015		22.00	17.00	>N	90732		11.32	11.32
N	90017		22.00	17.00	N	90750		22.00	17.00
N	90020		22.00	17.00	N	90751		22.00	17.00
> N	90030		9.00	7.00	N	90752		22.00	17.00
> N	90040		9.00	7.00	N	90753		22.00	17.00
N	90050		9.00	7.00	N	90754		22.00	17.00
N	90060		9.00	7.00	N	90760		22.00	17.00
N	90070		9.00	7.00	N	90761		22.00	17.00
> N	90080		9.00	7.00	N	90762		22.00	17.00
N	90285		22.00	17.00	N	90763		22.00	17.00
> N	90701		15.11	15.11	N	90764		9.00	7.00
> N	90702		3.98	3.98	N	90799		2.50	2.50
> N	90703		3.85	3.85		93000		16.00	16.00
> N	90704		13.99	13.99	N	99150		37.00	32.00
> N	90705		12.35	12.35				Per Hour	

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE	
				S	NS
N	99151			37.00	32.00
				Per Hour	
N	99160			37.00	32.00
				Per Hour	
>LN	J2790			42.37	42.37
>LN	W9090			11.45	11.45
>LN	W9095			5.97	5.97
LN	W9820			23.00	18.00

(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	90000	WF		25.00	25.00
>N	90010	WF		25.00	25.00
N	90015	WF		25.00	25.00
>N	90030	WF		4.20	4.20
N	90040	WF		4.20	4.20

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE	
				S	NS
>N	90050	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	90080	WF		13.00	13.00
N	90760	WF		25.00	25.00
	W5850		30	66.00	61.00

(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) Minor 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	MAXIMUM FEE ALLOWANCE		IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE	
				S	\$ NS					S	\$ NS
*	12004			30.00	26.00	*	17110			8.00	6.00
	12011			18.00	16.00	*	17200			8.00	6.00
	12013			24.00	21.00	*	17304		30	25.00	21.00
	12014			30.00	26.00	L*	W1250			18.00	16.00
	12031		30	30.00	26.00	L*	W1650			24.00	21.00
	12032		30	48.00	42.00	L*	W1650	22		37.00	32.00
*	12041		30	30.00	26.00						
*	12042		30	67.00	59.00						
	12051		30	38.00	33.00	›N	90801	ZI		45.00	45.00
	12052		30	67.00	59.00	›N	90843	ZI		13.00	13.00
	13100		30	34.00	29.00	›N	90844	ZI		26.00	26.00
	13101		30	68.00	63.00	›N	90847	ZI		26.00	26.00
	13120		30	48.00	42.00	›N	90847	ZI 22		32.00	32.00
	13121		30	106.00	92.00		90862	ZI		4.50	4.50
*	13131		30	67.00	59.00	›N	90887	ZI		13.00	13.00
*	13132		30	145.00	126.00	LN	H5025	ZI		8.00	8.00
	13150		30	38.00	33.00	L	Z0100			22.50	22.50
	13151		30	82.00	71.00	›L	Z0130			25.00	25.00
	13152		30	193.00	168.00					Per Hour	
						L	Z0150			8.00	8.00
*	17000			8.00	6.00	L	Z0160			15.50	15.50
*	17010			11.00	8.00	›L	Z0170			23.00	23.00
*	17100			18.00	15.00	›L	Z0180			38.50	38.50
*	17105			27.00	24.00						

(g) Mental Health Services

*An asterisk preceding any procedure code also can be done by the podiatrist.

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE	
				S	\$ NS
(h) <u>Obstetrical Services (Maternity)</u>					
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	WM 22			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	90030	WM			6.30
>N	90040	WM			6.30
N	90050	WM			6.30
N	90060	WM			6.30
>N	90070	WM			6.30
>N	90080	WM			6.30
>N	90130	WM			6.30
>N	90140	WM			6.30
N	90150	WM			6.30
N	90160	WM			6.30

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE	
				S	\$ NS
>N	90170	WM			6.30
L	Z0250	WM			40.00
(i) <u>Podiatry Services</u>					
	29580				18.00 16.00
>N	90030	YR			9.00 7.00
>N	90040	YR			9.00 7.00
N	90050	YR			9.00 7.00
>N	90060	YR			9.00 7.00
>N	90070	YR			9.00 7.00
>N	90080	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)					
(j) <u>Radiology Services</u>					
	70030				15.00
	70040				30.00
	70050				40.00
	70100				15.00
	70110				20.00
	70120				15.00
	70130				20.00

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE			IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE		
				S	\$	NS					S	\$	NS
	70140			15.00			MN	71020			15.00		
	70150			20.00			MN	71030			20.00		
	70160			15.00			MN	71034			20.00		
	70170			20.00				71035			5.00		
	70171			25.00				71100			15.00		
	70190			15.00				71110			20.00		
	70200			25.00				71120			15.00		
	70210			20.00				71130			20.00		
	70220			25.00				72010			40.00		
	70240			15.00				72040			15.00		
	70250			15.00				72050			20.00		
	70260			25.00				72052			25.00		
	70300			5.00				72070			15.00		
	70310			10.00				72080			15.00		
	70320			15.00				72100			20.00		
	70328			13.00				72110			25.00		
	70330			20.00				72114			20.00		
	70350			8.00				72140			300.00		
	70360			10.00			N	72170			15.00		
	70370			20.00				72180			15.00		
	70380			15.00				72190			20.00		
	70390			15.00				72200			20.00		
	70391			30.00				72220			15.00		
	70551			300.00				73000			10.00		
MN	71010			10.00				73010			15.00		

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>FOLLOW UP DAYS</u>	<u>MAXIMUM FEE ALLOWANCE</u>			<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>FOLLOW UP DAYS</u>	<u>MAXIMUM FEE ALLOWANCE</u>		
				<u>S</u>	<u>\$</u>	<u>NS</u>					<u>S</u>	<u>\$</u>	<u>NS</u>
	73020			15.00				73540			15.00		
	73030			15.00				73550			15.00		
	73040			15.00				73560			15.00		
	73041			45.00				73562			15.00		
	73050			18.00				73580			15.00		
	73060			15.00				73581			45.00		
	73070			15.00				73590			15.00		
	73080			15.00				73592			20.00		
	73085			15.00				73600			10.00		
	73086			45.00				73610			13.00		
	73090			10.00				73615			15.00		
	73092			20.00				73616			45.00		
	73100			10.00				73620			10.00		
	73110			15.00				73630			13.00		
	73115			15.00				73650			10.00		
	73116			45.00				73660			5.00		
	73120			10.00				74000			10.00		
	73130			15.00				74010			15.00		
	73140			5.00				74020			15.00		
N	73500			18.00			N	74220			20.00		
N	73510			20.00			N	74240			40.00		
	73520			25.00			N	74241			45.00		
	73525			15.00			N	74245			50.00		
	73526			45.00			N	74250			30.00		
	73530			30.00				74270			30.00		

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE			IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE		
				S	\$	NS					S	\$	NS
	74280			40.00				76080			15.00		
	74290			35.00				76081			20.00		
	74305			25.00				76090			26.00		
	74310			40.00				76091			36.00		
	74400			35.00				76100			35.00		
	74405			50.00				76100	50		50.00		
	74420			35.00				76150			4.00		
	74430			15.00			L	W7200			20.00		
	74431			25.00			L	W7250			30.00		
	74450			20.00			(k)	<u>Rehabilitation Services</u>					
	74451			40.00			N	92507			7.00	7.00	
	74455			20.00			N	92552			11.00	11.00	
	74456			35.00			N	92553			14.00	14.00	
	74470			20.00			N	92557			19.00	19.00	
	74471			40.00				92562			3.00		
MN	74710			25.00				92563			3.00		
	74720			20.00				92564			4.00		
	74740			20.00			N	92566			10.00		
	74741			40.00			N	92572			20.00		
	76000			10.00			N	92576			30.00		
	76020			15.00			N	92582			14.00	14.00	
	76040			20.00			N	92589			10.00	10.00	
	76061			35.00				92590			40.00		
	76062			90.00				92591			40.00		

IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE		IND	HCPCS CODE	MOD	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE	
				S	NS					S	NS
N	97799			7.00	7.00		M0050			80% of a base rate adjusted by geographic variation	
L	H5300			7.00	7.00		M0051				
L	Z0270			7.00	7.00		M0052				
L	Z0280			7.00	7.00		M0053				
L	Z0300			7.00	7.00	>L	Z0330			4.50	4.50
(1)	<u>Vision Care Services</u>					>L	Z0335			9.00	9.00
	(See Vision Care Manual)					L	Z1005			80% of a base rate adjusted for a geo- graphic variation	
(m)	<u>Other services</u>					L	Z1010				
N	55250		30	90.00	79.00	L	Z1015				
N	55450		30	42.00	37.00						
N	57451		45	182.00	158.00	L	Z1020				
	58120		15	72.00	63.00	L	Z1025				
N	58600		45	211.00	184.00	L	Z1030				
N	58605		45	151.00	131.00	L	Z1035			80% of a base rate adjusted for a geographic variation	
N	58982		45	182.00	158.00	L	Z1040				
N	58983		45	182.00	158.00	L	Z1045				
N	58983		45	182.00	158.00	L	Z1050				
N	59840		45	79.00	68.00	L	Z1055				
N	59841		45	79.00	68.00	LN	Z1600			7.70	7.70
>N	90240			9.00	7.00	LN	Z1605			6.24	6.24
N	90250			9.00	7.00	L	Z1610			25.00	25.00
N	90260			9.00	7.00	LN	Z1611			3.85	3.85
N	90270			9.00	7.00	LN	Z1612			3.12	3.12
>N	90280			9.00	7.00	L	Z1613			20.00	20.00

APPENDIX A

INDEPENDENT CLINIC SERVICE

CODES AND NARRATIVES NOT FOUND IN CPT-4 (Level II & Level III Codes)

<u>IND</u>	<u>HCPCS</u>		<u>DESCRIPTION</u>	<u>FOLLOW</u>	<u>MAXIMUM</u>	
	<u>CODE</u>	<u>MOD</u>		<u>UP</u>	<u>FEE</u>	<u>ALLOWANCE</u>
				<u>DAYS</u>	<u>S</u>	<u>\$ NS</u>
(a)	<u>Examination and Treatment</u>					
>	J2790		RHO(D) Immune Globulin (Human) (Microdase for abortions and miscarriages)		42.37	42.37
> N	W9090		Immunization-Haemophilus-b polysaccharide vaccine		11.45	11.45
>	W9095		Immunization - Tetanus Antitoxin		5.97	5.97
> N	W9820		Early and 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 personal supervision of a physician, to include:			
			(a) Measurements: Head cir- cumference 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 immuni- zations. (See appropriate procedure codes for immunizations and reimbursement.)			

IND HCPCS
CODE MOD

DESCRIPTION

FOLLOW MAXIMUM
UP FEE
DAYS ALLOWANCE
 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:
 - (a) Hemoglobin/hematocrit three times: 6-8 months, 2-3 or 4-6 years and 10-12 years
 - (b) Urinalysis a minimum of two times: 18-24 months and 13-15 years.
 - (c) Tuberculin three times: 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/her patients in his/her office are reimbursable to the physician. If performed by outside independent laboratories, the laboratory must submit the claim. Blood sample for 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

<u>IND</u>	<u>HCPCS</u> <u>CODE</u>	<u>MOD</u>	<u>DESCRIPTION</u>	<u>FOLLOW</u>	<u>MAXIMUM</u>	
				<u>UP</u>	<u>FEE</u>	
				<u>DAYS</u>	<u>S</u>	<u>\$ NS</u>

care facility, or practitioners sharing a common record. This code will automatically be downgraded in payment to a follow-up preventive health care visit 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 practitioners sharing a common record.

Reimbursement for code W9820 is contingent upon the submission of both a completed MC-19 form and the 1500 NJ claim form (Physician) or MC-14 claim form (Independent Clinic) 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, 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
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(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

<u>IND</u>	<u>HCPCS</u> <u>CODE</u>	<u>MOD</u>	<u>DESCRIPTION</u>	<u>FOLLOW</u>	<u>MAXIMUM</u>	
				<u>UP</u> <u>DAYS</u>	<u>FEE</u> <u>ALLOWANCE</u>	<u>S</u>
	W1650	22	Excision of plantar verruca multiple sites, unilateral		37.00	32.00
(g) <u>Mental Health Services</u>						
	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		<u>Off-Site Crisis Intervention</u> - 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	22.50
>	Z0130		Psychological testing: <u>Maximum of five hours</u> of psychometric and/or projective tests with a written report.		25.00	25.00
			<u>Partial Hospitalization</u> : A psychiatric service whose primary purpose is to provide a planned program of milieu therapy and other treatment modalities for		<u>Per Hour</u>	

IND	HCPCS		DESCRIPTION	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE		
	CODE	MOD			S	\$	NS
			In order to qualify as an approved Partial Care Program the program must be certified by the Department.				
>	Z0170		Partial Care, half day		23.00	23.00	
>	Z0180		Partial Care, full day		38.50	38.50	
			¹ These services may be provided directly or arranged by PC staff, through other Program Elements or agencies, to avoid duplication.				
			<u>NOTE:</u> 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.				
			<u>(h) Obstetrical Services (Maternity)</u>				
	Z0250	WM	Home Delivery Pack. All drugs and supplies, etc., necessary for delivery in this setting.		40.00		
			<u>(i) Podiatry</u>				
	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	
			<u>(j) Radiology Services</u>				
	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		DESCRIPTION	FOLLOW UP DAYS	MAXIMUM FEE ALLOWANCE	
	CODE	MOD			S	\$ NS
(k)	<u>Rehabilitation Services</u>					
	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)	<u>Other Services</u>					
>	Z0330		Transportation, one way (one way applicable when clinic transports the recipient either to or from the clinic in any one day).		4.50	4.50
>	Z0335		Transportation, round trip (Reimbursement is limited to one round trip per day for the same recipient by the same provider.)		9.00	9.00
	M0050		Ambulatory Surgical Center - Group 1		80% of a base rate adjusted for a geo- graphic variation	
	M0051		Ambulatory Surgical Center - Group 2			
	M0052		Ambulatory Surgical Center - Group 3			
	M0053		Ambulatory Surgical Center - Group 4			
	Z1005		Ambulatory Surgical Center - for abortion only			
	Z1010		Ambulatory Surgical Center - 100% of Grp 1 plus 50% of Grp 1			
	Z1015		Ambulatory Surgical Center - 100% of Grp 2 plus 50% of Grp 1			

<u>IND</u>	<u>HCPCS CODE</u>	<u>MOD</u>	<u>DESCRIPTION</u>	<u>FOLLOW</u>	<u>MAXIMUM</u>	
				<u>UP</u>	<u>FEE</u>	
				<u>DAYS</u>	<u>S</u>	<u>\$ NS</u>
	Z1020		Ambulatory Surgical Center - 100% of Grp 2 plus 50% of Grp 2			
	Z1025		Ambulatory Surgical Center - 100% of Grp 3 plus 50% of Grp 1			
	Z1030		Ambulatory Surgical Center - 100% of Grp 3 plus 50% of Grp 2			
	Z1035		Ambulatory Surgical Center - 100% of Grp 3 plus 50% of Grp 3			
	Z1040		Ambulatory Surgical Center - 100% of Grp 4 plus 50% of Grp 1			
	Z1045		Ambulatory Surgical Center - 100% of Grp 4 plus 50% of Grp 2			
	Z1050		Ambulatory Surgical Center - 100% of Grp 4 plus 50% of Grp 3			
	Z1055		Ambulatory Surgical Center - 100% of Grp 4 plus 50% of Grp 4			
>	Z1600		Personal Care Assistant Service - Individual		8.30	8.30 Per Hour
	Z1605		Personal Care Assistant Service - Group - Care provided involves two or more patients, with a maximum of eight patients in the same residential setting at the same time.		6.24	6.24 Per Hour
	Z1610		Personal Care Assistant Service - Initial Nursing Assessment Visit		25.00	25.00
>	Z1611		Personal Care Assistant Service - Individual		4.15	4.15 Per Half-Hour
	Z1612		Personal Care Assistant Service - Group - Care provided involves two or more patients, with a maximum of eight patients in the same residential setting at the same time.		3.12	3.12 Per Half-Hour
	Z1613		Personal Care Assistant Service - Re-assessment Visit		20.00	20.00

APPENDIX B

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

➤90000 Limited for reimbursement purposes to one such examination of the
➤90010 same recipient by the same Independent Clinic.

90015

90017

90020

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, 90015WF, 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

➤90030 For reimbursement purposes a clinic visit will consist of care and
➤90040 treatment by the physician and include those procedures ordinarily
90050 performed during a clinic visit dependent upon physician's disci-
90060 pline. The following will be included as a minimum in the progress
90070 notes:
➤90080

- 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

90750 For reimbursement purposes, the annual health maintenance examina-
90760 tion 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

➤90240 For sick babies use appropriate subsequent hospital care code:
90250
90260 1. Routine Visit Care - 90240, 90250, 90260, 90270 and 90280
90270
➤90280 2. If Prolonged Detention Codes are applicable - 99150, 99151 or
99160
99150
99151
99160

INFANT, CHILD AND ADOLESCENT CARE

90701 Immunization Procedures - The reimbursement for an immunization
90702 procedure includes the service and the materials. If the criteria
90703 for an office visit can also be met, then the immunization and the
90704 office visit may be claimed utilizing the appropriate procedure
90705 codes.
90706
90707 In the event there is the need for a specific immunization not
90708 listed as a covered service, the provider should obtain prior
90709 authorization from the Medicaid District Office prior to the admi-
90712 nistration of the vaccine.
90719
90724 Early Periodic Screening Diagnosis And Treatment (EPSDT) is found
90732 under code W9820 in Appendix A.
J2790
W9090
W9095
W9820

(b) DENTAL SERVICES

(See Dental Services Manual.)

(c) FAMILY PLANNING SERVICES

INITIAL MEDICAL VISIT

>9000WF Family Planning to include each of the following:

>9001WF

90015WF

- i. Medical, social, obstetrical history
- ii. Complete 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

>9003WF

9004WF

>9005WF

May include pelvic examination, changes in method or physician's instructions at a minimum average time of 5 minutes or represent a visit solely for a refill supply of birth control drugs for which a prescription cannot be substituted and professional contact is not necessary.

MEDICAL REVISIT - FAMILY PLANNING

9006WF

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

9007WF

>9008WF

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.

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.

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

➤ 90847ZI22 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.

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

➤59420WM22 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

➤90030WM
➤90040WM
90050WM
90060WM
➤90070WM
➤90080WM
➤90130WM
➤90140WM
90150WM
90160WM
➤90170WM

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

➤90030YR
➤90040YR
90050YR
➤90060YR
➤90070YR
➤90080YR

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.

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

➤90240 Hospital Day - consisting of care and treatment by the physician
90250 and including those procedures ordinarily performed during a
90260 hospital visit dependent upon the physician's discipline. The
90270 following will be included as a minimum in the progress notes:
➤90280

- (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