

the OPO is designated and certified by the Secretary of the Department of Health and Human Services as the OPO for that geographical area in which the hospital is located.

(c) The covered organ transplantation procedures shall also be performed in an organ transplant center approved or certified by a nationally recognized certifying or approving body, or one designated by the Federal government. In the absence of such a certification or approval of this nationally recognized body, the approval or certification, whichever applies, shall be obtained from the appropriate body so charged in the State in which the organ transplant center is located.

(d) The candidate for transplantation shall have been accepted for the procedure by the transplant center. Such acceptance shall precede a request for prior authorization from the medical staff in the Division's Office of Utilization Management, if applicable. All out-of-State hospitalizations for transplantations require prior authorization from the MACC serving the beneficiary's county of residence (see N.J.A.C. 10:49-6.2). Prior authorization shall be required for hospitalizations for organ procurement and transplantation for Medicaid/NJ FamilyCare beneficiaries for anatomical sites not explicitly listed in (a) above.

(e) Organ transplantations shall be medically necessary. Transplantations, with the exception of cornea transplantations, shall be performed only to avert a potentially life-threatening situation for the patient.

1. If all factors pertinent to decision-making concerning the site of performance of a transplant procedure are essentially equal, preference shall be given to a New Jersey transplant center. However, Medicaid/NJ FamilyCare policy of equitable access also applies (see 42 CFR 431.52(c)).

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

In (a)1, substituted "beneficiary" for "recipient" throughout; in (d), substituted "Utilization Management" for "Health Services Administration" preceding ", if applicable.", substituted "MACC" for "MDO" in the third sentence and substituted references to beneficiaries for references to recipients throughout.

Amended by R.2012 d.124, effective July 2, 2012.
See: 43 N.J.R. 1477(a), 44 N.J.R. 1884(a).

In (d) and (e)1, inserted "/NJ FamilyCare"; and in (e)1, substituted "42 CFR" for "42CFR".

10:54-5.33 Orthopedic footwear services

(a) For purposes of the New Jersey Medicaid/NJ FamilyCare program, "an orthopedic shoe" means footwear, with or without accompanying appliances, used to prevent or correct gross deformities of the feet, which is properly fitted as to length and width, and consists of the following basic parts:

1. Correct straight last line;
2. Heels with sufficient bearing surface;
3. Toe with ample room for function;

4. Sole of sufficient weight for foot protection;
5. Rigid shank;
6. Properly fitting upper;
7. Smooth and protective lining; and
8. Snug fitting heel counter.

(b) Except as provided at N.J.A.C. 10:49-2.3, orthopedic footwear shall be reimbursed under the New Jersey Medicaid/NJ FamilyCare program when prior authorized in accordance with N.J.A.C. 10:55-1.5(c) and prescribed under the following conditions:

1. When attached to a brace or bar;
2. When part of the normal (customary, usual) post-operative or post-fracture treatment program; and/or
3. When used to correct or adapt to gross foot deformities.

(c) Services for flat foot conditions (regardless of the underlying etiology and encompassing all phases of services in connection with flat feet) shall be reimbursed as a Medicaid/NJ FamilyCare program covered service only under the following circumstances:

1. Treatment which is an integral part of post-fracture or post-operative treatment plan;
2. Supportive devices (for example, arch supports, specific additions to shoes and the like) prescribed to palliate pain and other symptoms associated with the condition;
3. Treatment where the talo-crural joint is involved; or
4. Treatment where there may be attachment of supportive device to a brace or bar.

(d) Orthopedic footwear and foot orthotics require a personally signed and dated order (prescription) by the prescribing physician for prosthetic and orthotic appliances, repair and replacement of parts for custom-made prosthetic and orthotic appliances and orthopedic footwear. The prescription shall include the following:

1. Patient's name, age, address and Health Benefits Identification (HBID) Number;
2. Relevant diagnosis(es) (including the ICD-9 code(s)) supporting the need for the orthopedic footwear and/or foot orthotics; and
3. Detailed description of the prosthetic and orthotic appliance order. Terminology such as "leg brace", "artificial limbs", or "orthopedic shoes" on a prescription is unacceptable.

(e) Prior authorization for all orthopedic footwear and foot orthotics shall be obtained by the provider of the services from the Office of Utilization Management, Division of

Medical Assistance and Health Services, Mail Code #15, PO Box 712, Trenton, New Jersey 08625-0712, except for all components of orthopedic footwear attached to a bar or brace (including the bar, brace and/or shoe) which must be obtained from the appropriate Medical Assistance Customer Center. (For a directory of the (MACCs), see N.J.A.C. 10:49, Appendix K.) (See also N.J.A.C. 10:55, Prosthetic and Orthotics Services Chapter, for other prosthetic and orthotic services.)

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

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

Amended by R.2012 d.124, effective July 2, 2012.
See: 43 N.J.R. 1477(a), 44 N.J.R. 1884(a).

In the introductory paragraph of (a) and (b), inserted "/NJ FamilyCare"; in (b)1, deleted "and/or" from the end; in the introductory paragraph of (c), inserted "/NJ FamilyCare program"; in (c)3, inserted "or"; in the introductory paragraph of (d), deleted a comma following the second occurrence of "appliances"; and rewrote (d)1.

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

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

1. Custom-made appliances must be fabricated by a person certified as a prosthetist and/or orthotist by the American Board for Certification in Orthotics, Prosthetics and Pedorthics, incorporated and fabricated in a facility accredited by the same certification board. The facility must be approved by the New Jersey Medicaid/NJ FamilyCare program to provide either prosthetic or orthotic (P & O) services or both to Medicaid/NJ FamilyCare program beneficiaries. The physician may contact the Medical Assistance Customer Center to determine which P & O dealers are eligible under the program. The P & O provider must obtain prior authorization from the Medical Assistance Customer Center to provide these services. For a listing of Medical Assistance Customer Centers, see the end of N.J.A.C. 10:49, Administration Manual, or the list can be downloaded free of charge from the Division of Medical Assistance and Health Services' website: <http://www.state.nj.us/humanservices/dmahs/home/index.html>.

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

1. Patient's name, age, address, H.S.P. (Medicaid) Case and Person Number; and

2. Relevant diagnosis(es) (including ICD-9 codes) supporting need for custom-made prosthetic and orthotic appliances; and

3. Detailed (meaningful) description of the prosthetic and orthotic appliance order. Terminology such as "leg brace", "artificial limbs", "orthopedic shoes", and so forth, on a prescription is unacceptable.

(c) The approved prosthetic and orthotic provider, upon receipt of an acceptable prescription, shall request prior authorization from the appropriate Medical Assistance Customer Center or the Podiatric Consultant, as appropriate, on a "Prior Authorization Form for Prosthetic and Orthotic Services (FD-357)."

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

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

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

Amended by R.2012 d.124, effective July 2, 2012.
See: 43 N.J.R. 1477(a), 44 N.J.R. 1884(a).

In the introductory paragraph of (a), inserted "/NJ FamilyCare"; rewrote (a)1; and deleted (a)1i.

10:54-5.35 Rehabilitative services; general

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

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

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

3. A request for retroactive authorization will be considered only when the request has been delayed by circumstances beyond the control of the hospital.

4. When the request for authorization is approved, both the request letter and the provider's claim form will be returned to the provider. When a claim is submitted for reimbursement, the provider must attach the request for approval and the approval to the UB-92 (CMS-1450), the hospital claim form.

5. If request for prior authorization is denied, the physician and/or hospital shall be notified of the reason, in writing, by the Central Office, Mental Health Services Unit, Office of Utilization Management, Division of Medical Assistance and Health Services, PO Box 712, Trenton, New Jersey 08625-0712.

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

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

In (a) introductory paragraph, substituted "beneficiary" for "recipient"; and in (b)1 and (b)5, substituted "Utilization Management" for "Health Services Administration".

Amended by R.2012 d.124, effective July 2, 2012.

See: 43 N.J.R. 1477(a), 44 N.J.R. 1884(a).

In the introductory paragraph of (a), inserted "/NJ FamilyCare" following the first occurrence of "Medicaid"; "/NJ FamilyCare program" following the second occurrence of "Medicaid"; and substituted "that" for "which"; and in (b)4, substituted "CMS" for "HCFA".

10:54-7.10 Psychiatric services (including prior authorization); hospital outpatient and other settings

(a) The following policies and procedures were developed to help ensure the appropriate utilization of hospital outpatient psychiatric services. These include the role of the evaluation team in relation to the patient's treatment regimen, with emphasis placed on intake evaluation, development of a Plan of Care (PoC), performance of periodic review for evaluation purposes, and supportive documentation for services rendered. (See N.J.A.C. 10:52-2.3 Recordkeeping and N.J.A.C. 10:66-2.5 for more specific policies and procedures for psychiatric (mental health services).

(b) Psychiatric services that are medically necessary rendered in an approved hospital outpatient department or in other settings, to a registered patient who is a Medicaid/NJ FamilyCare program beneficiary, shall not require prior authorization, except in the following situations:

1. Authorization for partial hospitalization and/or acute partial hospitalization services shall be provided in accordance with N.J.A.C. 10:52A, Psychiatric Adult Acute Partial Hospital and Partial Hospital Services.

2. Prior authorization is required for mental health services exceeding \$900.00 in reimbursement to the physician rendered to a Medicaid/NJ FamilyCare program beneficiary in any 12-month service year, commencing with the patient's initial visit, when provided in other than an inpatient hospital setting. Reimbursement shall not be paid by the program for physician psychiatric services rendered to a registered hospital outpatient.

3. Prior authorization shall be required for mental health services exceeding \$400.00 in payments in any 12-month service year rendered to a Medicaid/NJ FamilyCare program beneficiary residing in either a nursing facility or a residential health care facility.

(c) The request for authorization shall include the diagnosis, as set forth in the ICD-9 (latest revision), and also must include the treatment plan and progress report in detail. No post facto authorization will be granted.

1. For those Medicaid/NJ FamilyCare program beneficiaries who do not reside in a nursing facility and live in a community setting, including a residential health care facility, or for those receiving mental health services in the outpatient department of a hospital, an independent clinic or a physician's office, the request for prior authorization shall be submitted directly to Office of Utilization Management, Mental Services Unit, Division of Medical Assistance and Health Services, PO Box 712, Mail Code #18, Trenton, New Jersey 08625-0712 on the "Authorization of Mental Health Services (FD-07)" form.

2. For a Medicaid/NJ FamilyCare program beneficiary residing in a nursing facility, the request for prior authorization shall be submitted directly to the appropriate Medical Assistance Customer Center that serves that nursing facility on the "Authorization of Mental Health Services and/or Mental Health Rehabilitation Services (FD-07)" and the "Request for Prior Authorization: Supplemental Information (FD-07A)" forms.

3. When approved by the New Jersey Medicaid/NJ FamilyCare program, each authorization may be granted for a maximum period of one year. Additional authorizations may be requested.

4. The Division shall not reimburse the physician and/or hospital for both mental health services provided in the office and/or hospital or any other setting and medical day care center services provided to the same beneficiary on the same day. The Division shall also not reimburse the physician and/or hospital for both mental health services and partial hospitalization services provided to the same patient on the same day.

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

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

In (c)1, substituted "Utilization Management" for "Health Services Administration"; in (c)2, substituted "Medical Assistance Customer Center" for "Medicaid District Office"; and substituted references to beneficiary and beneficiaries for references to recipient and recipients throughout.

Amended by R.2003 d.182, effective May 5, 2003.

See: 34 N.J.R. 4303(a), 35 N.J.R. 1901(a).

Rewrote (c)2.

Amended by R.2012 d.124, effective July 2, 2012.

See: 43 N.J.R. 1477(a), 44 N.J.R. 1884(a).

Inserted "/NJ FamilyCare program" throughout; in the introductory paragraph of (b), substituted "that" for "which"; rewrote (b)1; in (c)1, substituted "08625-0712" for "08635-0712"; in (c)3, inserted "/NJ FamilyCare" and deleted "except as listed in (c)3i and ii below"; and deleted (c)3i and (c)3ii.

SUBCHAPTER 8. PHARMACEUTICAL SERVICES

10:54-8.1 Pharmaceutical; conditions for participation as provider of pharmaceutical services

(a) All covered pharmaceutical services shall be provided under the New Jersey Medicaid program shall be provided to Medicaid/NJ FamilyCare program beneficiaries within the scope of N.J.A.C. 10:49, Administration; 10:51, Pharmaceutical Services; and this subchapter.

(b) All drugs shall be prescribed.

1. "Prescribed drugs" means simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance, that are:

i. Prescribed by a practitioner licensed or authorized by the State of New Jersey, or the state in which he or she practices, to prescribe drugs and medicine within the scope of his or her license and practice;

ii. Dispensed by licensed pharmacists in accordance with rules promulgated by the New Jersey Board of Pharmacy, N.J.A.C. 13:39; and

iii. Dispensed by licensed pharmacists on the basis of a written prescription that is maintained in the pharmacist's records.

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

In (a), substituted "beneficiaries" for "recipients".
Amended by R.2012 d.124, effective July 2, 2012.
See: 43 N.J.R. 1477(a), 44 N.J.R. 1884(a).

In (a), inserted "/NJ FamilyCare program", deleted "N.J.A.C." preceding "10:51" and substituted "this subchapter" for "N.J.A.C. 10:54-8, Physician Services"; in (b)1i, substituted a semicolon for a colon at the end; and (b)1ii, substituted "rules" for "regulations".

10:54-8.2 Pharmaceutical; program restrictions affecting payment for prescribed drugs

(a) The choice of prescribed drugs shall be at the discretion of the prescriber within the limits of applicable laws. However, the prescriber's discretion is limited for certain drugs. Reimbursement may be denied if the requirements of the following rules are not met:

1. Covered and non-covered pharmaceutical services as listed in the Pharmaceutical Services chapter, N.J.A.C. 10:51-1.11 and 1.13, respectively, incorporated herein by reference;

2. Pharmaceutical services requiring prior authorization (see N.J.A.C. 10:51-1.14, incorporated herein by reference);

3. Quantity of medication (see N.J.A.C. 10:51-1.15, incorporated herein by reference);

4. Dosage and directions (see N.J.A.C. 10:51-1.16, incorporated herein by reference);

5. Telephone-rendered original prescriptions (see N.J.A.C. 10:51-1.17, incorporated herein by reference);

6. Changes or additions to the original prescription (see N.J.A.C. 10:51-1.18, incorporated herein by reference);

7. Prescription refill (see N.J.A.C. 10:51-1.19, incorporated herein by reference);

8. Prescription Drug Price and Quality Stabilization Act (N.J.S.A. 24:6E-1 et seq.) (see N.J.A.C. 10:51-1.20, incorporated herein by reference).

i. Products listed in the current New Jersey Drug Utilization Review Council (DURC) Formulary, (hereafter referred to as "the Formulary"), and all subsequent revisions, distributed to all prescribers and pharmacists.

ii. Non-proprietary or generic dispensing (see N.J.A.C. 10:51-1.9, incorporated herein by reference);

9. Federal regulations (42 CFR 447.301, 331-333) that set the aggregate upper limits on payment for certain multi-source drugs if Federal Financial Participation (FFP) is to be made available. The limit applies to all "maximum allowable cost" drugs (see N.J.A.C. 10:51-1.5, Basis of payment, incorporated herein by reference);

10. Drug Efficacy Study Implementation (DESI): "Less than effective drugs" subject to a Notice of Opportunity for Hearing (NOOH) by the Federal Food and Drug Administration (see N.J.A.C. 10:51-1.21 and listing of DESI drugs in Appendix A of N.J.A.C. 10:51, incorporated herein by reference);

11. Drug Manufacturers' Rebate Agreement with the Centers for Medicare and Medicaid Services (CMS) of the United States Department of Health and Human Services (see N.J.A.C. 10:51-1.22, incorporated herein by reference);

12. Medical exception process (MEP) (see N.J.A.C. 10:54-8.3);

13. In addition, diabetic testing materials, including blood glucose reagent strips, urine monitoring strips, tapes, tablets and lancets. Electronic blood glucose monitoring devices or other devices used in the monitoring of blood glucose levels are considered medical supplies and are covered services by Medicaid/NJ FamilyCare. These services may require prior authorization from the Medical Assistance Customer Center (MACC) (See N.J.A.C. 10:59, Medical Supplier Services); and

14. For claims with service dates on or after July 1, 1999, the pharmacist shall be reimbursed for the least expensive, therapeutically effective nutritional supplement or specialized infant formula, at the time of dispensing unless the prescriber indicates, in his or her own handwriting on each written prescription, or follow-up written prescription to a telephone rendered prescription, the phrase "Brand Medically Necessary."

(b) Diagnostic endoscopy: The following are the qualifiers for HCPCS procedure codes for diagnostic endoscopic procedure codes.

- 1. Respiratory System (CPT codes 30000-32999)
 - 31520 Laryngoscopy direct, with or without tracheoscopy; diagnostic newborn.
QUALIFIER: When combined with another endoscopic procedure, each procedure may be reimbursed at 100% of the maximum fee allowance.
 - 31525 Laryngoscopy direct, with or without tracheoscopy; diagnostic except newborn.
QUALIFIER: When combined with another endoscopic procedure, each procedure may be reimbursed at 100% of the maximum fee allowance.
 - 31575 Laryngoscopy, flexible fiberoptic; diagnostic
QUALIFIER: When combined with another endoscopic procedure, each procedure may be reimbursed at 100% of the maximum fee allowance.
 - 31615 Tracheobronchoscopy through established tracheostomy incision.
QUALIFIER: When combined with another endoscopic procedure, the procedure may be reimbursed at the rate of the maximum fee allowance of the procedure of the "deepest penetration".
 - 31622 Diagnostic (flexible or rigid) with or without all washing or brushing.
QUALIFIER: When combined with another endoscopic procedure, the procedure may be reimbursed at the rate of the maximum fee allowance of the procedure of the "deepest penetration".
- 2. Hemic and Lymphatic systems (CPT codes 38100-39599)
 - 39400 22 Mediastinoscopy with biopsy
QUALIFIER: Multiple surgery pricing applies.
- 3. Digestive system (CPT codes 40490-49999)
 - i. Upper gastrointestinal system
 - 43200 Esophagoscope, rigid or flexible; diagnostic, with or without removal of foreign body
QUALIFIER: When combined with another endoscopic procedure, the procedure may be reimbursed at the rate of the maximum fee allowance of the procedure of the "deepest penetration".
 - 43234 Upper gastrointestinal endoscopy simple primary examination (e.g. with small diameter flexible fiberscope)
QUALIFIER: When combined with another endoscopic procedure, the procedure may be reimbursed at the rate of the maximum fee allowance of the procedure of the "deepest penetration".
 - 43235 Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum, as appropriate; complex diagnostic
QUALIFIER: When combined with another endoscopic procedure, the procedure may be reimbursed at the rate of the maximum fee allowance of the procedure of the "deepest penetration".
 - ii. Lower gastrointestinal
 - 45300 Proctosigmoidoscopy; diagnostic (separate procedure)
QUALIFIER: When combined with another endoscopic procedure, the procedure may be reimbursed at the rate of the maximum fee allowance of the procedure of the "deepest penetration".
 - 45330 Sigmoidoscopy, flexible fiberoptic; diagnostic

- 46600 Anoscope; diagnostic (separate procedure)
QUALIFIER: This diagnostic endoscopy procedure has the least penetration: (despite the "high" HCPCS number). When combined with another endoscopic procedure in the same body system, the reimbursement is at the rate of the maximum fee allowance of any other procedure code that denotes the "deepest penetration".
- iii. Biliary tract;
 - 47550 Biliary endoscopy, intraoperative (kaleidoscope)
QUALIFIER: When combined with another endoscopic procedure, each procedure may be reimbursed at 100% of the maximum fee allowance.
 - 47552 Biliary endoscopy, intraoperative (kaleidoscope)
QUALIFIER: When combined with another endoscopic procedure, each procedure may be reimbursed at 100% of the maximum fee allowance.
- iv. Urinary system (CPT codes 50010-53899)
 - 50951 Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
QUALIFIER: When combined with another endoscopic procedure, each procedure may be reimbursed at 100% of the maximum fee allowance.
 - 50970 Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
QUALIFIER: When combined with another endoscopic procedure, each procedure may be reimbursed at 100% of the maximum fee allowance.
 - 52000 Cystourethroscopy (separate procedure)
QUALIFIER: When combined with another endoscopic procedure, each procedure may be reimbursed at 100% of the maximum fee allowance.
- v. Female genital system (CPT codes 56000-58999)
 - 57452 Colposcopy (vaginocopy); (separate procedure)
QUALIFIER: When combined with another endoscopic procedure, each procedure may be reimbursed at 100% of the maximum fee allowance.

(c) HCPCS Code Qualifiers

- 41872 Gingivoplasty
QUALIFIER: Reimbursement is based upon a dollar amount for each quadrant.
- 50590 Lithotripsy, extracorporeal shock wave (Professional Component) (PC)
QUALIFIER: For the Professional Component of lithotripsy, extracorporeal shock wave (ESWL), reimbursement includes all professional services (Professional Component pertaining to ESWL performed by the treating physician during this hospitalization, consortium visit or office visit. This code excludes reimbursement of the Technical Component of the ESWL service.
- 55250 Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)
QUALIFIER: As a primary sterilization (family planning procedure), a completed consent form must be attached to the 1500 N.J. claim form. See N.J.A.C. 10:54-5.16 for regulations on sterilizations and hysterectomy.
- 55450 Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure)

<p>58301 WM 58611</p>	<p>QUALIFIER: As a primary sterilization (family planning procedure), a completed consent form must be attached to the 1500 N.J. claim form. See N.J.A.C. 10:54-5.16 for regulations on sterilization and hysterectomy. Removal of intrauterine device by certified nurse midwife. Ligation or transection of fallopian tube(s) when done at the time of obstetrical delivery (caesarean section) or intra-abdominal surgery (not a separate procedure) QUALIFIER: This procedure code may be billed separately in addition to the appropriate procedure codes for primary obstetrical or abdominal surgery procedure. This also includes those obstetrical procedure codes used by HealthStart identified providers.</p>	<p>67225</p>	<p>necessary and provided on the same date of service. Modifiers LT or RT should be used on all claims for codes 67221 and 67225, whether initial or subsequent treatment Photodynamic therapy, second eye, at single session QUALIFIER: This procedure code must be billed with 67221. This procedure code must be rendered by ophthalmologists who are retinal specialists, and shall be limited to patients meeting the following criteria: Best corrected visual acuity equal to or better than 20/200 if the decreased visual acuity is caused by the macular degeneration; and Classic subfoveal choroidal neovascularization (CNV), occupying 50 percent or greater of the entire ocular lesion; and A reported ICD-9 CM diagnosis of 115.02, 115.92, 362.21 or 362.52 (exudative senile macular degeneration). NOTE: Report HCPCS procedure code 67225 on the CMS 1500 claim form for procedures performed on a second eye when both eyes are treated on the same date of service. Evaluation and management (E&M) services, fluorescent angiography (FA) and other ocular diagnostic services may also be billed separately when determined medically necessary and provided on the same date of service. Modifiers LT or RT should be used on all claims for codes 67221 and 67225, whether initial or subsequent treatment. Cochlear device implantation, with or without mastoidectomy QUALIFIER: Reimbursement limited to those cases that meet the current Medicare Selection Criteria.</p>																		
<p>59510 59514 59515</p>	<p>Caesarean delivery only including postpartum care QUALIFIER: For anesthesia during Caesarean Section, use Anesthesia reimbursement methodology including the AA modifier and indicating the standard anesthesia formula (time in units of 15 minute intervals) when used in combination with HCPCS 62278 or 62279.</p>	<p>62278</p>	<p>Injection of anesthesia substance (including narcotics), diagnostic or therapeutic; epidural, lumbar or caudal, single QUALIFIER: Only for use during labor or intractable pain, (including insertion of catheter or cannula—lumbar or caudal—single, regardless of time).</p>																		
<p>62279</p>	<p>Injection of anesthesia substance (including narcotics), diagnostic or therapeutic; epidural, lumbar or caudal, continuous QUALIFIER: Only for use during labor or intractable pain, (including insertion of catheter or cannula—lumbar or caudal—continuously, regardless of time). Reimbursement is at a flat fee unless C-Section is necessary; then, separate reimbursement for the C-Section and anesthesia using the anesthesia reimbursement formula is allowed. This procedure code may be used with HCPCS 59515.</p>	<p>66170</p>	<p>Fistula of sclera for glaucoma; trephination with iridectomy; trabeculectomy QUALIFIER: This procedure code may be billed with the following other procedure codes representing other optical procedure (HCPCS 65850, 66030, 66625, and 67500) and be reimbursed according to the multiple surgical policy.</p>																		
<p>66920</p>	<p>Discission of secondary membranous cataract QUALIFIER: This procedure code must not be billed with any other procedure code representing any other optical procedure.</p>	<p>66930</p>	<p>Removal of secondary membranous cataract QUALIFIER: This procedure code must not be billed with any other procedure code representing any other optical procedure.</p>																		
<p>66940</p>	<p>Removal of lens material; aspiration techniques, one or more stages. QUALIFIER: This procedure code must not be billed with any other procedure code representing any other optical procedure.</p>	<p>67221</p>	<p>Photodynamic therapy QUALIFIER: This procedure code may be billed with 67225. This procedure code must be rendered by ophthalmologists who are retinal specialists, and shall be limited to patients meeting the following criteria: Best corrected visual acuity equal to or better than 20/200 if the decreased visual acuity is caused by the macular degeneration; and Classic subfoveal choroidal neovascularization (CNV), occupying 50 percent or greater of the entire ocular lesion; and A reported ICD-9 CM diagnosis of 115.02, 115.92, 362.21 or 362.52 (exudative senile macular degeneration) NOTE: Report HCPCS procedure code 67225 on the CMS 1500 claim form for procedures performed on a second eye when both eyes are treated on the same date of service. Evaluation and management (E&M) services, fluorescent angiography (FA) and other ocular diagnostic services may also be billed separately when determined medically</p>																		
<p>70470 52 70482 52 70488 52 70492 52 71270 52 74170 52</p>	<p>Limited computerized axial tomography, head or body for medical necessary follow-up or monitoring QUALIFIER: For C.A.T. scan guidance (monitoring) performed in conjunction with biopsy, aspiration, puncture, injection of contrast material, placement of tube stint, drain, etc. use codes with modifier "52".</p>	<p>(d) Magnetic Resonance Imaging (MRI) Diagnostic Services:</p>	<p>QUALIFIER: An MRI service provided by physicians in an office setting may be billed to and reimbursed by Medicaid only when the recipient is other than a hospital inpatient. The Medicaid Maximum Fee Allowance is the composite rate and shall not be split between the technical component and the professional component. These rules apply to the billing of the HCPCS for MRI as follows:</p> <table border="0"> <tr><td>70540</td><td>72148</td></tr> <tr><td>70551</td><td>72156</td></tr> <tr><td>70552</td><td>72157</td></tr> <tr><td>70553</td><td>72158</td></tr> <tr><td>71550</td><td>72196</td></tr> <tr><td>72141</td><td>72220</td></tr> <tr><td>72142</td><td>73720</td></tr> <tr><td>72146</td><td>73721</td></tr> <tr><td>72147</td><td>74181</td></tr> </table>	70540	72148	70551	72156	70552	72157	70553	72158	71550	72196	72141	72220	72142	73720	72146	73721	72147	74181
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72142	73720																				
72146	73721																				
72147	74181																				
<p>72170</p>	<p>Radiologic examination, pelvis; anteroposterior only QUALIFIER: Pelvis x-ray is not eligible for separate payment when performed in conjunction with complete lumbarsacral spine x-rays (72100, 72110, 72114, 72120)</p>	<p>76805</p>	<p>Echography, pregnant uterus, B-scan and/or real time with image documentation; complete (complete fetal and maternal evaluation) QUALIFIER: Limited to one complete study per pregnancy per provider. Any additional medically necessary studies performed by the same provider will be reimbursed as HCPCS 76815 (limited study). Also, only one study (complete or limited or follow-up) can be reimbursed to the same provider on a given day.</p>																		
<p>76815</p>	<p>Echography, pregnant uterus, B-scan and/or real time with image documentation; limited (gestational age, heart beat, placental location, fetal position, or emergency in the delivery room.)</p>																				

New Patient		Established Patient	
15783	15822	19325 50	30430
15786	15823	19325	30435
15787	15824		30450
15788	15826	21120	30460
15789	15831	through	30462
15792		21198	30520
15793			

(h) Physician Administered Drugs

1. The New Jersey Division of Medical Assistance and Health Services provides physician reimbursement for the administration of medications. Reimbursement will continue to be available for the administration of the drug. The procedure code 90799 may be billed for intradermal, subcutaneous, intramuscular, or intravenous drug administration.

2. However, reimbursement for the drug administered by a physician, other than immunizations, was only available if a prescription was issued and the drug was obtained from a pharmacy which directly billed the New Jersey Medicaid program.

3. Unless otherwise indicated, the Medicaid maximum fee allowance shall be based on the AWP per unit which equals one cubic centimeter (CC) or milliliter (ml). For drug vials with a volume equal to one cc or ml, the Medicaid maximum fee allowance shall be based on the cost per vial. For further information on physician administered drugs, see N.J.A.C. 10:54-8.6.

HCPCS Code	Description	Maximum Fee Allowance
J0690	Cefazolin 500 mg	\$ 1.92
J0696	Ceftriaxone 250 mg	10.24
J1100	Dexamethasone 4 mg	0.80
J1200	Diphenhydramine 50 mg	0.55
J2550	Promethazine 50 mg	0.42
J2680	Fluphenazine Decanoate 25 mg	9.50
J2790	RhoGAM, Rho (D) Immune Globulin (Human) Single dose (Micro-Dose)	20.40
J2790 22	RhoGAM, Rho (D) Immune Globulin (Human) Single dose (Full dose) (22—Services greater than usual)	72.07
J9000	Doxorubicin 10 mg	42.00
J9010	Doxorubicin 50 mg	195.50
J9020	Asparaginase 10,000 Units	50.36
J9031	BCG Live Vaccine 27 mg	152.13
J9040	Bleomycin Sulfate 15 units	255.08
J9045	Carboplatin 50 mg	72.01
J9060	Cisplatin Powder or Solution 10 mg	30.33
J9070	Cyclophosphamide 100 mg	4.91
J9100	Cytarabine 100 mg	6.72
J9130	Decarbazine 100 mg	12.00
J9190	Fluorouracil 50 mg	0.18
J9217	Lupron 7.5 mg	451.25
J9230	Mechlorethamine HCl 10 mg	10.10
J9240	Medroxyprogesterone 100 mg	9.05
J9240 22	Medroxyprogesterone 400 mg	31.50
J9260	Methotrexate Sodium 50 mg	4.75
J9280	Mitomycin 5 mg	119.08
J9360	Vinblastine Sulfate 1 mg	3.25
J9370	Vincristine 1 mg	27.50
W9095	Immunization—Tetanus antitoxin	6.60

the criteria defined by the CDC. In all such cases, the need for this vaccination must be fully documented in the recipient's medical record. In order to facilitate reimbursement for Hepatitis B immunoprophylaxis for high risk individuals, manufacturer, age, and dose specific procedure codes have been developed for use by physicians and independent clinics providing this service.

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

W9096	Hepatitis B immunoprophylaxis with Recombivax 1 HB, 0.25 ml dose. This code applies only to newborns of HBsAg negative mothers.	17.46
W9096 22	Hepatitis B immunoprophylaxis with Recombivax HB, 0.5 ml dose. This code applies only to newborns of HBsAg positive mothers.	32.79
W9097	Hepatitis B immunoprophylaxis with Recombivax HB, 0.25 ml dose. This code applies only to high risk recipients under 11 years of age (exclusive of newborns).	17.46
W9098	Hepatitis B immunoprophylaxis with Recombivax HB, 0.5 ml dose. This code applies only to high risk recipients 11-19 years of age.	32.79
W9099	Hepatitis B immunoprophylaxis with Recombivax HB, 1.0 ml dose. This code applies only to high risk recipients over 19 years of age.	63.57
W9333	Hepatitis B immunoprophylaxis with Engerix-B, 0.5 ml dose. This code applies only when immunizing newborns.	27.88
W9334	Hepatitis B immunoprophylaxis with Engerix-B, 0.5 ml dose. This code applies only to high risk recipients under 11 years of age (exclusive of newborns)	27.88
W9335	Hepatitis B immunoprophylaxis with Engerix-B, 1.0 ml dose. This code applies only to high risk recipients over 11 years of age.	62.09
W9336	Medroxyprogesterone Acetate 150 mg	36.90
W9337	Cephadrine 250 mg	2.34
W9338	TETRAMUNE, a biological combining Diphtheria, Tetanus Toxoids and Pertussis Vaccine (DTP) with Hemophilus B Conjugate Vaccine (QUALIFIER: Not to be billed separately with HCPCS 90701 or 90731).	30.27
W9339	Lupron 3.75 mg	360.63
W9343	Lupron Depot Pediatric 7.5 mg	451.25
W9344	Lupron Depot Pediatric 11.25 mg	811.25
W9345	Lupron Depot Pediatric 15 mg	902.50

Amended by R.2006 d.26, effective February 6, 2006.
See: 37 N.J.R. 3538(a), 38 N.J.R. 966(a).

In (c), corrected the placement of HCPCS code 66170 and added the qualifiers for the new HCPCS procedure codes 67221 and 67225.

Amended by R.2007 d.188, effective June 18, 2007.
See: 39 N.J.R. 337(a), 39 N.J.R. 2360(a).

In the table in (d), in the first Qualifier paragraph, deleted "only" following "may", inserted "only" following "reimbursed by Medicaid" and substituted "shall" for "must"; and in the Qualifier paragraph of the entry for 90801, deleted the final sentence.

10:54-9.9 Pathology and Laboratory HCPCS Codes-Qualifiers

(a) Qualifiers for pathology and laboratory services are summarized below:

(i) Hepatitis B Vaccine: Coverage is available for post exposure prophylaxis and for vaccination of individuals in selected high risk groups, regardless of age, in accordance with

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. 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. Laboratory chemistry tests performed on your automated equipment in addition to laboratory chemistry tests listed must be billed as 80002-80019 as part of the automated multichannel test listing.

Acid-Phosphatase	Creatinine
Albumin	Gamma Glutamyl Transpeptidase (GGTP)
Alkaline Phosphatase (ALT, SGPT)	Glucose (Sugar)
Aspartate Aminotransferase (AST, SGOT)	Iron
Aspartate Aminotransferase	Iron Binding Capacity
Amylase	Lactic Dehydrogenase (LD)
Bilirubin, Total	Lipoprotein (HDL Cholesterol)
Bilirubin, Direct	Magnesium
Blood Urea Nitrogen (BUN)	Phosphorus
Calcium	Potassium (K)
Carbon Dioxide (CO ₂)	Protein, Total
Chlorides (Cl)	Sodium (NA)
Cholesterol	Triglycerides
Creatine Kinase (CK, CPK)	Uric Acid

NOTE 1: 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: 82040, 82150, 82250, 82251, 82310, 82374, 82435, 82465, 82550, 82565, 82947, 82977, 83540, 83550, 83615, 83718, 83735, 84060, 84075, 84100, 84132, 84155, 84295, 84450, 84460, 84478, 84520, 84550.

NOTE 2: The following calculations and ratios are not eligible for separate or additional reimbursement. Mathematical calculations listed below are not reimbursable.

A/G Ratio	Globulin
BUN/Creatinine Ratio	FTI (T7)
Free Calcium	Free Thyroxine

NOTE 3: Any additional automated multichannel chemistry tests performed on same date as Codes 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018, and 80019 will not be reimbursed at the current allowable fee for each added test when performed on automated multichannel equipment.

NOTE 4: Code (W8200)—Glucose (separate tube, gray top) 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. Codes 80050, 80055, 80058, 80059, 80061, 80072, 80090, 80091, 80092.—The panels listed must include the laboratory tests assigned by the CPT-4 as the components of the panel. The tests listed with each of the panels identify the defined components of that panel. If any three laboratory tests included in the panel are billed a la carte, the tests must be billed as the panel. The laboratory provider may not charge Medicaid more than the lowest charge level offered to another provider. The lowest charges for the laboratory test comprising the panel must aggregate as equivalent to or greater than the listed panel fee.

NOTE 1: Code 80091—Thyroid panel

Reimbursement not eligible for 84439 when billed in conjunction with 80091 on same day.

NOTE 2: Code 80092—Thyroid panel with TSH

Code 84443—TSH will not be paid a separate reimbursement when performed in conjunction with 80091 or 80092.

3. Codes 82487, 82488, and 82489—Chromatography—must list substance (compound) tested for in block 34 (REMARKS) of the claim form.

4. Code 82728—Ferritin

When the procedure for ferritin is performed in combination with Vitamin B12 or Folate or any of the chemistry analytes listed on codes 80002-80019, the maximum reimbursable fee for code 82728 is \$5.00.

5. Code 84081—Phosphatidylglycerol—test done on newborn or amniotic fluid to determine fetal lung maturity.

6. Code 84202—Protoporphyrin, RBC; quantitative—Utilize only for testing of anemia. Utilize code 84203—Protoporphyrin, RBC; screen when testing for anemia. Code 84203 will not be reimbursed when billed in conjunction with code 83655—Blood lead determination (quantitative).

7. Code 84620—Xylose absorption tests, blood and/or urine (D-xylose tolerance test), includes serum & urine levels, up to 5 hourly specimens.

8. Codes 85023 and 85025—Hematology

NOTE: For purpose of reimbursement based on this schedule, a complete blood count (CBC) includes a hematocrit, hemoglobin determination, RBC count, RBC indices, WBC count and differential WBC count (see codes 85021 and 85022), for a platelet count with a CBC (see codes 85023-85025).

Hematology codes 85014, 85018, 85041 and 85048 will not be reimbursed in conjunction with codes for blood count with hemogram (85021, 85022, 85023, 85024, 85025, and 85027).