

<u>Column Title</u>	<u>Description</u>
	NOTE: Providers billing for the injection only should use the modifier "52" (reduced service) with the appropriate HCPCS procedure code on the claim form when billing for any immunizations. The provider will be reimbursed \$2.50 for an injection. Do not use HCPCS procedure code 90799 when billing for immunizations with free vaccine.
N	Preceding any code means that qualifiers are applicable to that code.
WF	Family planning: To identify procedures performed for the sole purpose of family planning, add the modifier "WF" to only those procedure codes so indicated at N.J.A.C. 10:66-6.2.
WM	Certified nurse-midwife: To identify procedures performed by a certified nurse-midwife, add the modifier "WM" to only those procedure codes so indicated at N.J.A.C. 10:66-6.2.
WY	Only applies to billing by an ambulatory surgical center: To identify the trimester (1st trimester) of an abortion procedure, add the modifier "WY" to the procedure code.
WZ	Only applies to billing by an ambulatory surgical center: To identify the trimester (2nd trimester) of an abortion procedure, add the modifier "WZ" to the procedure code.
YR	Routine foot care podiatry: To identify routine foot care provided by a podiatrist, add the modifier "YR" to only those procedure codes so indicated at N.J.A.C. 10:66-6.2(h).
ZI	Independent clinic: To identify certain mental health services provided by independent clinic providers, add the modifier "ZI" to only those procedure codes so indicated at N.J.A.C. 10:66-6.2(f) and 10:66-6.2(o).
DESCRIPTION	Code narrative: Narratives for Level I codes are found in CPT. Narratives for Level II and III codes are found at N.J.A.C. 10:66-6.3.
FOLLOW-UP DAYS	Number of days for follow-up care.
MAXIMUM FEE ALLOWANCE	New Jersey Medicaid and NJ FamilyCare fee-for-service programs maximum reimbursement allowance 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 claim form.

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 they reflect requirements, in addition to the narrative which accompanies the CPT/HCPCS procedure code as written in the CPT, for which the provider is liable. These additional requirements must be fulfilled before reimbursement is requested.

ii. If there is no identifying symbol listed, the CPT/HCPCS procedure code narrative prevails.

(c) Listed below are both general and specific policies of the New Jersey Medicaid and NJ FamilyCare fee-for-service programs that pertain to HCPCS. Specific information concerning the responsibilities of an independent clinic provider when rendering Medicaid-covered and NJ FamilyCare fee-for-service-covered services and requesting reimbursement are located at N.J.A.C. 10:66-1 through 5, and 10:66 Appendix.

1. General requirements are as follows:

i. When filing a claim, the appropriate HCPCS procedure 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 and NJ FamilyCare fee-for-service programs as evidence that the provider personally furnished, as a minimum, the services for which it stands.

iii. When billing, the provider must enter onto the claim form a CPT/HCPCS procedure code as listed in CPT or in this subchapter (N.J.A.C. 10:66-6). If an appropriate code is not listed, place an "N/A" (not applicable) in the procedure code column and submit a narrative description of the service. If possible, insert 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 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."

1. Alphabetic and numeric symbols under "IND" and "MOD": These symbols, when listed under the "IND" and "MOD" columns, are elements of the HCPCS coding system used as qualifiers or indicators ("IND" column) and as modifiers ("MOD" column). They assist the provider in

(2) All references to time parameters shall mean the practitioner's personal time in reference to the service rendered unless it is otherwise indicated.

vi. Written records in substantiation of the use of a given procedure code must be available for review and/or inspection if requested by the New Jersey Medicaid or NJ FamilyCare fee-for-service program.

vii. All references to performance of any or all parts of a history or physical examination shall mean that for reimbursement purposes these services were personally performed by a physician, dentist, podiatrist, optometrist, certified nurse midwife, psychologist, and other program recognized mental health professionals in a mental health clinic, whichever is applicable. (Exception: Procedure Code W9820, EPSDT, permits the services of a pediatric advanced practice nurse under the direct supervision of a physician.)

2. Specific requirements concerning medicine are as follows:

i. To qualify as documentation that the service was rendered by the practitioner during an inpatient stay, the medical record must contain the practitioner's notes indicating that he or she personally:

- (1) Reviewed the patient's medical history with the patient and/or his or her family, depending upon the medical situation;
- (2) Performed an examination as appropriate;
- (3) Confirmed or revised the diagnosis; and
- (4) Visited and examined the patient on the days for which a claim for reimbursement is made.

ii. The practitioner's involvement must be clearly demonstrated in notes reflecting his or her personal involvement with the service rendered. This refers to those occasions when these notes are written into the medical record by interns, residents, other house staff members, or nurses. A counter-signature alone is not sufficient.

3. Specific requirements concerning surgery are as follows:

i. Certain of the listed procedures are commonly carried out as an integral part of a total service and, as such, do not warrant a separate charge. When such a procedure is carried out as a separate entity not immediately related to other services, the indicated value for "separate procedure" is applicable.

4. Specific requirements concerning radiology are as follows:

i. Values include usual contrast media, equipment and materials.

ii. Values include consultation and written report to the referring physician.

iii. S&I (Supervision and Interpretation) only for the procedure given. This code is used only when a procedure is performed by more than one physician. Values include consultation and written report.

iv. All films taken of an area which is to be subject to a contrast study will, for reimbursement purposes, be considered part of the contrast study unless stated otherwise.

v. The fee listed 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.

Administrative Correction.

See: 26 N.J.R. 797(a).

Amended by R.1998 d.577, effective December 7, 1998.

See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).

Inserted references to NJ KidCare fee-for-service and substituted references to CPT for references to CPT-4 throughout.

Amended by R.2004 d.208, effective June 7, 2004.

See: 36 N.J.R. 324(a), 36 N.J.R. 2834(a).

In (a), Substituted "Centers for Medicare & Medical Services (CMS)'s Healthcare" for "HealthCare Financing Administration's (HCFA)", "CMS" for "HCFA"; in b and (c), substituted "FamilyCare" for "KidCare" throughout.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

Amended by R.2006 d.26, effective February 6, 2006.

See: 37 N.J.R. 3538(a), 38 N.J.R. 966(a).

In (b), added a description of the "N" indicator.

10:66-6.2 HCPCS procedure code numbers and maximum fee allowance schedule

(a) Evaluation and management and other procedures

* An asterisk preceding any procedure code may also be performed in a drug treatment center.

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
				S	\$	NS	
*N	36415			1.80		1.80	
N	67221		90	283.00		241.00	
N	67225			23.00		20.00	
	90701			16.34		16.34	
	90701	52		2.50		2.50	
	90702			3.29		3.29	
	90702	52		2.50		2.50	
	90703			3.40		3.40	
	90703	52		2.50		2.50	
	90704			23.60		23.60	
	90704	52		2.50		2.50	
	90705			18.39		18.39	
	90705	52		2.50		2.50	
	90706			22.04		22.04	
	90706	52		2.50		2.50	
	90707			39.87		39.87	
	90707	52		2.50		2.50	
	90712			14.44		14.44	
	90712	52		2.50		2.50	

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	
	90713			22.80		22.80		*99385				22.00		17.00	
	90713	52		2.50		2.50		*99386				22.00		17.00	
	90714			3.03		3.03		*99387				22.00		17.00	
	90714	52		2.50		2.50		99391				16.00		14.00	
	90717			3.03		3.03		99392				22.00		17.00	
	90717	52		2.50		2.50		99393				22.00		17.00	
	90718			3.35		3.35		*99394				22.00		17.00	
	90718	52		2.50		2.50		*99395				22.00		17.00	
	90724			6.97		6.97		99396				22.00		17.00	
	90724	52		2.50		2.50		99397				22.00		17.00	
	90732			14.35		14.35		J2790				20.40		20.40	
	90732	52		2.50		2.50		J2790	22			72.07		72.07	
	90733			17.48		17.48		J3395				Average wholesale price (AWP)			
	90733	52		2.50		2.50		L W9050				27.00		NA	
	90737			25.79		25.79		L W9055				27.00		23.00	
	90737	52		2.50		2.50		L W9060	WT			23.00		18.00	
	90741			Prior authorization required				L W9061	WT			23.00		18.00	
	90742			Prior authorization required				L W9062	WT			23.00		18.00	
	90746			63.57		63.57		L W9063	WT			23.00		18.00	
L	90746	52		2.50		2.50		L W9064	WT			23.00		18.00	
N	90799			2.50		2.50		L W9065	WT			23.00		18.00	
N	90801			37.00		26.00		L W9066	WT			23.00		18.00	
	93000			16.00		16.00		L W9067	WT			23.00		18.00	
N	99150			45.00		40.00		L W9068	WT			23.00		18.00	
				Per Hour		Per Hour		L W9096				17.46		17.46	
N	99151			45.00		40.00		L W9096	52			2.50		2.50	
				Per Hour		Per Hour		L W9096	22			32.79		32.79	
	99173			5.00		5.00		L W9096	22 52			2.50		2.50	
N	*99201			16.00		14.00		L W9097				17.46		17.46	
N	*99202			16.00		14.00		L W9097	52			2.50		2.50	
N	*99203			22.00		17.00		L W9098				32.79		32.79	
N	*99204			22.00		17.00		L W9098	52			2.50		2.50	
N	*99205			22.00		17.00		L W9333				27.88		27.88	
N	*99211			16.00		14.00		L W9333	52			2.50		2.50	
N	99211	WM		NA		11.20		L W9334				27.88		27.88	
N	*99212			16.00		14.00		L W9334	52			2.50		2.50	
N	99212	WM		NA		11.20		L W9335				62.09		62.09	
N	*99213			16.00		14.00		L W9335	52			2.50		2.50	
N	99213	WM		NA		11.20		L W9338				30.27		30.27	
N	*99214			16.00		14.00		L W9338	52			2.50		2.50	
N	99214	WM		NA		11.20		W9820				23.00		18.00	
N	*99215			16.00		14.00									
N	99215	WM		NA		11.20									
N	99241			44.00		NA									
N	99242			44.00		NA									
N	99243			44.00		NA									
N	99244			62.00		NA									
N	99245			62.00		NA									
N	99251			44.00		NA									
N	99252			44.00		NA									
N	99253			44.00		NA									
N	99254			62.00		NA									
N	99255			62.00		NA		N 11975	22	30		Direct package price plus			
	99261			16.00		14.00						100.00		85.00	
	99262			16.00		14.00		N 11976		90		100.00		85.00	
	99263			16.00		14.00		N 11977	22	90		Direct package price plus			
N	99271			44.00		NA						200.00		170.00	
N	99272			44.00		NA			36416	WF		1.80		1.80	
N	99273			44.00		NA		N 55250		30		90.00		79.00	3
N	99274			62.00		NA		N 55450		30		42.00		37.00	3
N	99274	YY		50.00		NA			56820	WF		88.00		NA	
N	99274	ZZ		50.00		NA			56821	WF		113.00		NA	
N	99275			62.00		NA			57420	WF		71.00		NA	
N	99291			45.00		40.00			57421	WF		93.00		NA	
N	99292			22.50		20.00		N 57451		45		182.00		158.00	6
	99382			22.00		17.00			58301	WM		16.40		16.40	
	99383			22.00		17.00		N 58600		45		211.00		184.00	6
	*99384			22.00		17.00		N 58605		45		151.00		131.00	6

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

(c) Family planning 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	
N	58982		45	182.00		158.00	6	*	11421		15	22.00		20.00	
N	58983		45	182.00		158.00	6	*	11422		15	27.00		24.00	
	88150			6.00		6.00		*	11423		15	32.00		27.00	
	88151			6.00		6.00		*	11424		15	32.00		27.00	
	88155			6.00		6.00		*	11426		15	32.00		27.00	
N	99201	WF		45.00		45.00			11440		15	18.00		16.00	
N	99201	WFWM		NA		31.50			11441		15	22.00		20.00	
N	99202	WF		45.00		45.00			11442		15	27.00		24.00	
N	99202	WFWM		NA		31.50			11443		15	32.00		27.00	
N	99203	WF		45.00		45.00			11444		15	32.00		27.00	
N	99203	WFWM		NA		31.50			11446		15	32.00		27.00	
N	99204	WF		45.00		45.00		*	11600		90	37.00		32.00	
N	99204	WFWM		NA		31.50		*	11601		90	47.00		42.00	
N	99205	WF		45.00		45.00		*	11602		90	61.00		53.00	
N	99205	WFWM		NA		31.50		*	11620		90	61.00		53.00	
N	99211	WF		7.60		7.60		*	11621		90	90.00		79.00	
N	99211	WFWM		NA		5.35		*	11622		90	121.00		105.00	
N	99212	WF		7.60		7.60			11640		90	90.00		79.00	
N	99212	WFWM		NA		5.35			11641		90	121.00		105.00	
N	99213	WF		7.60		7.60			11642		90	150.00		131.00	
N	99213	WFWM		NA		5.35		*	11700			13.00		11.00	
N	99214	WF		23.00		23.00		*	11701			6.00		6.00	
N	99214	WFWM		NA		16.40		*	11710			13.00		11.00	
N	99215	WF		23.00		23.00		*	11711			6.00		6.00	
N	99215	WFWM		NA		16.40		*	11730			10.00		10.00	
N	99395	WF		45.00		45.00		*	11750		30	42.00		37.00	
N	99395	WFWM		NA		31.50		*	12001			18.00		16.00	
L	W0001	WF		188.00		188.00		*	12002			24.00		21.00	
L	W0001	WFWM		NA		177.00		*	12004			30.00		26.00	
L	W0002	WF		123.00		123.00			12005		7	46.00		39.00	
L	W0002	WFWM		NA		112.00			12006		7	57.00		48.00	
L	W0004	WF		204.00		204.00			12007		7	82.50		70.00	
L	W0004	WFWM		NA		188.00			12011			18.00		16.00	
L	W0008	WF		139.00		139.00			12013			24.00		21.00	
L	W0008	WFWM		NA		123.00			12014		7	30.00		26.00	
									12031		30	30.00		26.00	
									12032		30	48.00		42.00	
								*	12041		30	30.00		26.00	
								*	12042		30	67.00		59.00	
									12051		30	38.00		33.00	
									12052		30	67.00		59.00	
									13100		30	34.00		29.00	
									13101		30	68.00		63.00	
									13120		30	48.00		42.00	
									13121		30	106.00		92.00	
								*	13131		30	67.00		59.00	
								*	13132		30	145.00		126.00	
									13150		30	38.00		33.00	
									13151		30	82.00		71.00	
									13152		30	193.00		168.00	
								*	17000			16.00		14.00	
								*	17010			42.00		36.00	
								*	17100			18.00		15.00	
								*	17105			100.00		85.00	
								*	17110			16.00		14.00	
								*	17200			16.00		14.00	
								*	17304			100.00		85.00	
								L*	W1650			24.00		21.00	
								L*	W1650		22	37.00		32.00	

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

(e) Minor surgery:

* An asterisk preceding any procedure code may also be performed by a podiatrist.

									12014		7	30.00		26.00	
									12031		30	30.00		26.00	
									12032		30	48.00		42.00	
								*	12041		30	30.00		26.00	
								*	12042		30	67.00		59.00	
									12051		30	38.00		33.00	
									12052		30	67.00		59.00	
									13100		30	34.00		29.00	
									13101		30	68.00		63.00	
									13120		30	48.00		42.00	
									13121		30	106.00		92.00	
								*	13131		30	67.00		59.00	
								*	13132		30	145.00		126.00	
									13150		30	38.00		33.00	
									13151		30	82.00		71.00	
									13152		30	193.00		168.00	
								*	17000			16.00		14.00	
								*	17010			42.00		36.00	
								*	17100			18.00		15.00	
								*	17105			100.00		85.00	
								*	17110			16.00		14.00	
								*	17200			16.00		14.00	
								*	17304			100.00		85.00	
								L*	W1650			24.00		21.00	
								L*	W1650		22	37.00		32.00	

(f) Mental health 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	
N	10040			18.00		16.00		N	90801	ZI		45.00		45.00	
*	10060			13.00		11.00		N	90843	ZI		13.00		13.00	
*	10061		30	48.00		42.00		N	90844	ZI		26.00		26.00	
	10080			30.00		26.00									
*	10120			18.00		16.00									
*	10121		30	34.00		29.00									
*	10140			18.00		16.00									
*	10160			13.00		11.00									
*	11000			13.00		11.00									
*	11001			6.00		5.00									
*	11040			13.00		11.00									
*	11041			13.00		11.00									
*	11042			16.00		14.00									
*	11043			16.00		14.00									
*	11100		7	13.00		11.00									
*	11400		15	18.00		16.00									
*	11401		15	22.00		20.00									
*	11402		15	27.00		24.00									
*	11403		15	32.00		27.00									
*	11404		15	32.00		27.00									
*	11406		15	32.00		27.00									
*	11420		15	18.00		16.00									

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	
N	90847	ZI		26.00		26.00			70210			20.00			
N	90847	ZI22		32.00		32.00			70220			25.00			
	90862	ZI		4.50		4.50			70240			15.00			
	90870	ZI		32.00		26.00			70250			15.00			
N	90887	ZI		13.00		13.00			70260			25.00			
LN	H5025	ZI		8.00		8.00			70300			5.00			
L	Z0100			22.50		22.50			70310			10.00			
L	Z0130			25.00		25.00			70320			15.00			
L	Z0150			8.00		8.00			70328			13.00			
L	Z0160			15.50		15.50			70330			20.00			
L	Z0170					15.40	15.40		70350			8.00			

(g) Obstetrical services (maternity):

Ind	HCPCS		Follow Up Days	Maximum Fee Allowance			Anes. Basic Units	Ind	Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
	Code	Mod		S	\$	NS						S	\$	NS	
N	59400		60	468.00		403.00	4	MN	70551			300.00			
N	59400	WM	60	NA		328.00	4	MN	71010			10.00			
N	59410		60	320.00		272.00	4	MN	71020			15.00			
N	59410	WM	60	NA		224.00	4	MN	71030			20.00			
N	59420			16.00		14.00			71034			20.00			
N	59420	WM		NA		11.20			71100			15.00			
N	59420	22		22.00		17.00			71110			20.00			
N	59420	WM 22		NA		15.40			71120			15.00			
N	59430		0	20.00		18.00	0		71130			20.00			
N	59430	WM	0	NA		14.00	0		72010			40.00			
	59510		45	598.00		516.00	7		72040			15.00			
	59515		45	450.00		385.00	7		72050			20.00			
	59525		45	362.00		308.00	8		72052			25.00			
	59812		45	105.00		91.00	3		72070			15.00			
L	Z0250	WM		NA		40.00			72080			15.00			

(h) Podiatry services:

Ind	HCPCS		Follow Up Days	Maximum Fee Allowance			Anes. Basic Units	Ind	Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
	Code	Mod		S	\$	NS						S	\$	NS	
	29580			18.00		16.00	3		72110			25.00			
N	99211	YR		16.00		14.00			72114			20.00			
N	99212	YR		16.00		14.00			72170			15.00			
N	99213	YR		16.00		14.00			72190			20.00			
N	99214	YR		16.00		14.00			72200			20.00			
N	99215	YR		16.00		14.00			72220			15.00			
L	W2650			21.00		21.00			73000			10.00			
L	W2655			5.00		5.00			73010			15.00			

NOTE: See N.J.A.C. 10:66-6.2(f), Surgery, for additional procedures.

(i) Radiology services:

Ind	HCPCS		Follow Up Days	Maximum Fee Allowance			Anes. Basic Units	Ind	Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
	Code	Mod		S	\$	NS						S	\$	NS	
	70030					15.00			73110			15.00			
	70100					15.00			73115			15.00			
	70110					20.00			73120			10.00			
	70120					15.00			73130			15.00			
	70130					20.00			73140			5.00			
	70140					15.00			73140			5.00			
	70150					20.00			N			18.00			
	70160					15.00			N			20.00			
	70170					20.00						25.00			
	70190					15.00						15.00			
	70200					25.00						15.00			

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
				S	\$	NS	
	73610				13.00		
	73615				15.00		
	73620				10.00		
	73630				13.00		
	73650				10.00		
	73660				5.00		
	74000				10.00		
	74010				15.00		
	74020				15.00		
N	74220				20.00		
N	74240				40.00		
N	74241				45.00		
N	74245				50.00		
N	74250				30.00		
	74270				30.00		
	74280				40.00		
	74290				35.00		
	74305				25.00		
	74400				35.00		
	74405				50.00		
	74420				35.00		
	74430				15.00		
	74450				20.00		
	74455				20.00		
	74470				20.00		
N	74710				25.00		
	74740				20.00		
	76000				45.00		
	76020				15.00		
	76040				20.00		
	76061				35.00		
	76062				90.00		
	76080				15.00		
	76090				26.00		
	76091				36.00		
	76100				35.00		
	76100	50			50.00		
	76805				55.00		
	76815				25.00		
	76816				25.00		

(j) Rehabilitation services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
				S	\$	NS	
N	92507			7.00		7.00	
N	92552			11.00		11.00	
N	92553			14.00		14.00	
N	92557			19.00		19.00	
	92562			3.00		NA	
	92563			3.00		NA	
	92564			4.00		NA	
N	92567			5.00		NA	
N	92568			5.00		NA	
N	92572			20.00		NA	
N	92576			30.00		NA	
N	92582			14.00		14.00	
	92585			45.00		NA	
N	92589			10.00		NA	
	92590			40.00		NA	
	92591			40.00		NA	
N	97799			7.00		7.00	
L	H5300			7.00		7.00	
L	Z0270			7.00		7.00	
L	Z0280			7.00		7.00	
L	Z0300			7.00		7.00	
L	Z0310			45.00		45.00	

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

(l) Transportation services:

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

(m) Drug treatment center services:

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

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

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

(n) Federally qualified health care services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
				S	\$	NS	
L	90844	22		contract		contract	
L	W9840			contract		contract	
L	W9843			contract		contract	
L	Y3333			contract		contract	

(o) Personal care assistant services:

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

(p) Miscellaneous services:

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

Amended by R.1998 d.127, effective March 2, 1998.
 See: 29 N.J.R. 5046(a), 30 N.J.R. 827(b).
 Inserted asterisks before codes 99384, 99385, 99386, 99387, 99394 and 99395.
 Amended by R.2000 d.435, effective November 6, 2000.
 See: 32 N.J.R. 2690(a), 32 N.J.R. 3992(a).
 In (a), inserted references to HCPCS Code 90746, and deleted references to HCPCS Code W9099.
 Amended by R.2003 d.69, effective February 3, 2003.
 See: 34 N.J.R. 3183(a), 35 N.J.R. 888(a).
 In (f), inserted reference to HCPCS Code 90870.

Amended by R.2004 d.24, effective January 20, 2004.
 See: 35 N.J.R. 4037(a), 36 N.J.R. 572(a).
 In (c), added HCPCS Codes 36416, 56820, 56821, 57420, and 57421.
 Amended by R.2004 d.75, effective February 17, 2004.
 See: 35 N.J.R. 2154(a), 36 N.J.R. 952(b).
 In (f), amended HCPCS code Z0170 and deleted HCPCS code Z0180.
 Amended by R.2004 d.208, effective June 7, 2004.
 See: 36 N.J.R. 324(a), 36 N.J.R. 2834(a).
 In (n), amended the table.
 Amended by R.2006 d.26, effective February 6, 2006.
 See: 37 N.J.R. 3538(a), 38 N.J.R. 966(a).
 In (a), added HCPCS procedure codes J3395, 67221 and 67225.

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

(a) Evaluation and Management and other procedures

Ind	HCPCS		Description	Follow Up Days	Maximum Fee Allowance		
	Code	Mod			S	\$	NS
	67221		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 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.	90	283.00		241.00
	67225		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 macular degeneration; and Classic subfoveal choroidal neovascularization (CNV), occupying 50 percent or greater of the entire ocular lesion; and		23.00		20.00

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance		
					S	\$	NS
			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.				
	J2790		RhoGAM, Rho (D) Immune Globulin (Human); single dose—Micro-Dose		20.40		20.40
	J2790	22	RhoGAM, Rho (D) Immune Globulin (Human); single dose—Full dose		72.07		72.07
	W9060	WT	Under six weeks				
	W9061	WT	Six weeks to three months				
	W9062	WT	Three months to five months				
	W9063	WT	Five months to eight months				
	W9064	WT	Eight months to 11 months				
	W9065	WT	11 months to 14 months				
	W9066	WT	14 months to 17 months				
	W9067	WT	17 months to 20 months				
	W9068	WT	20 months to 24 months 1. History including behavior and environmental factors; 2. Development assessment; and 3. Complete, unclothed physical examination by a physician or a nurse practitioner under the personal supervision of a physician, to include: (a) Measurements: height, weight and head circumference;				

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

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

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

(6) No reimbursement will be made for an injection given as a pre-operative medication or as a pre-operative local anesthetic which is part of an operative or surgical procedure since this injection would normally be included in the listed fee for such a procedure.

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

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

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

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

4. Prolonged detention: 99150 and 99151.

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

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

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

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

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

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

99202WFWM, 99203, 99203WF, 99203WFWM, 99204, 99204WF, 99204WFWM, 99205, 99205WF, 99205WFWM and 99432.

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

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

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

(1) Chief complaint(s);

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

(3) Pertinent past medical history;

(4) Pertinent family history;

(5) A full physical examination pertaining to but not limited to the history of the present illness and includes recording of pertinent negative findings; and

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

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

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

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

(1) Purpose of visit;

(2) Pertinent history obtained;

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

(4) Procedures, if any, with results;

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

(6) Diagnosis.

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

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

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

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

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

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

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

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

(A) If a consultation is performed and the patient is then transferred to the consultant's service during the course of that illness, the provider may not, in addition, bill for an Initial Visit if he or she has or intends to bill for the consultation.

(B) If there is no referring physician, then an Initial Visit code should be used instead of a consultation code.

(C) 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.

(D) Consultation codes will be declined in a clinic 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.

(E) If a prior claim for comprehensive consultation visit has been made within the preceding 12 months, then a repeat claim for this code will be denied if made by the clinic 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 limited consultation code if their criteria are met.

ii. Limited consultation: 99241, 99242, 99243, 99251, 99252, 99253, 99271, 99272, and 99273.

(1) The area being covered for reimbursement purposes is "limited" in the sense that it requires less than the requirements designated as "comprehensive" as noted above.

iii. Second opinion program consultation: 99274YY.

(1) A consultation to satisfy the requirements of the mandated "Second Opinion" program will be reimbursed only if the requirements of that program are met and the consultation has been performed by the appropriate board certified specialist who has signed a separate provider agreement and whose selection has been through the Second Opinion Referral Service (1-800-676-6562).

iv. Third opinion consultation: 99274ZZ.

(1) In the event that a patient receives two different points of view relative to a "Second Opinion" procedure, he or she may, if unable to reach a decision, request a third opinion.

(2) A third opinion consultation must be at the patient's request and under the circumstances described.

8. Critical care services: 99291 and 99292.

i. Critical care is reimbursable under codes 99291 and 99292 if the service is consistent with the following:

(1) The patient's situation requires constant physician attendance which is given by the physician to the exclusion of his or her other patients and duties and, therefore, represents what is beyond the usual service. This must be verified by the applicable records as defined by the setting and which records must show in the physician's handwriting the time of onset and time of completion of the service.

(2) All settings are applicable, such as clinic and hospital.

(3) These codes may not be used simultaneously with procedure codes that pay a reimbursement for the same time or type of service.

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

(c) Family planning services:

1. Norplant—insertion, implantable contraceptive capsules: 1197522.

i. The maximum fee allowance includes the cost of the NPS kit, the insertion of the “Norplant System” (six levonorgestrel implants), and the post-insertion visit.

ii. Modifier “22” indicates that the billing includes the cost of the kit.

2. Norplant—removal, implantable contraceptive capsules: 11976.

i. The maximum fee allowance includes the removal of the “Norplant System” (six levonorgestrel implants) and the post-removal visit.

3. Norplant—removal with reinsertion, implantable contraceptive capsules: 1197722.

i. The maximum fee allowance includes the removal/insertion of the “Norplant System” (six levonorgestrel implants) and post-removal/reinsertion visit.

4. Sterilization (male): 55250 and 55450.

i. Primary sterilization (family planning) procedure.

ii. A completed consent form shall be attached to the claim form, in accordance with N.J.A.C. 10:66-2.3.

5. Sterilization (female): 58600, 58605, 58982, and 58983.

i. These procedures are always considered a sterilization procedure. Therefore, a completed consent form shall be attached to the claim form, in accordance with N.J.A.C. 10:66-2.3.

ii. 57451: If the procedure is performed for sterilization purposes, a completed consent form shall be attached to the claim form, in accordance with N.J.A.C. 10:66-2.3.

6. Initial medical visit: 99201WF, 99201WFWM, 99202WF, 99202WFWM, 99203WF, 99203WFWM, 99204WF, 99204WFWM, 99205WF, and 99205WFWM.

i. Family planning to include each of the following:

(1) Medical, social, obstetrical history

(2) Complete pelvic examination—including visual inspection of the cervix

(3) Breast examination

(4) Papanicolaou smear (excludes cytology study)

(5) Contraceptive counseling with referral as indicated.

ii. Includes the cost of birth control drugs dispensed. A prescription cannot be substituted.

iii. These procedure codes (initial medical visit) will be disallowed if procedure codes 99201, 99201WF, 99201WFWM, 99202, 99202WF, 99202WFWM, 99203,

99203WF, 99203WFWM, 99204, 99204WF, 99204WFWM, 99205, 99205WF, 99205WFWM and 99432 have been performed during the prior 12 months by the same provider.

7. Routine or follow-up visit—brief: 99211WF, 99211WFWM, 99212WF, 99212WFWM, 99213WF, and 99213WFWM.

i. May include pelvic examination, changes in method or physician’s or certified nurse-midwife’s instructions at a minimum average time of five minutes, or a visit solely for a refill supply of birth control drugs for which a prescription cannot be substituted and professional contact is not necessary.

8. Medical revisit—family planning: 99214WF and 99214WFWM.

i. May include pelvic examination or changes in method or physician’s or certified nurse-midwife’s instructions. This code includes the cost of birth control drugs dispensed. A prescription cannot be substituted.

9. Routine or follow-up visit—prolonged: 99215WF and 99215WFWM.

i. May include pelvic examination or changes in method or physician’s or certified nurse-midwife’s 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 procedure code includes the cost of birth control drugs dispensed. A prescription cannot be substituted.

10. Annual medical revisit: 99395WF and 99395WFWM.

i. Family planning to include each of the following:

(1) Updating medical, social, obstetrical history;

(2) Complete pelvic examination including visual inspection of cervix;

(3) Breast examination; and

(4) Papanicolaou smear (excludes cytology study) with referral when indicated.

ii. This code includes the cost of birth control drugs dispensed. A prescription cannot be substituted.

iii. Procedure code 99395WF will be disallowed if procedure codes 99201, 99201WF, 99201WFWM, 99202, 99202WF, 99202WFWM, 99203, 99203WF, 99203WFWM, 99204, 99204WF, 99204WFWM, 99205, 99205WF, 99205WFWM and 99432 have been performed during the prior 12 months by the same provider.

11. Code G0001 WF This service is reimbursable to the Family Planning Clinic only when the specimen is

referred out to an independent clinical laboratory for testing.

Note: Physicians/practitioners and Family Planning Clinics cannot bill when the tests are completed on the premises and are not referred out to independent clinical laboratories.

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

(e) Minor surgery:

1. Acne surgery (for example, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules): 10040.

i. Excision must involve the use of a scalpel and an expressor, but not an expressor alone. This code is limited to severe acne. For less than severe acne, utilize the procedure codes for routine office visits.

(f) Mental health services:

1. Comprehensive intake evaluation: 90801ZI.

i. 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.

ii. 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.

2. Individual psychotherapy—25 minute session: 90843ZI.

i. This code requires, for reimbursement purposes, a minimum of 25 minutes of direct personal clinical involvement with the patient and/or family member.

3. Individual psychotherapy—50 minute session: 90844ZI.

i. This code requires, for reimbursement purposes, a minimum of 50 minutes of direct personal clinical involvement with the patient and/or family member.

4. Family therapy: 90847ZI.

i. 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.

5. Family therapy: 90847ZI22.

i. 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.

6. Family conference: 90887ZI.

i. This code requires, for reimbursement purposes, a minimum of 25 minutes of direct personal clinical involvement with patient, family member or caretaker. The CPT narrative otherwise remains applicable.

7. Group psychotherapy: H5025ZI.

i. 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 eight and the reimbursement is per person, per group session.

(g) Obstetrical services (maternity):

1. Total obstetrical care: 59400.

i. Antepartum care consisting of initial antepartum visits and seven subsequent antepartum visits. Specific date of all visits are to be listed on the claim form.

(1) Reimbursement will be decreased by the fee for the initial antepartum visit (5942022) if not seen for this visit. The total fee will also be decreased by the reimbursement sum for each subsequent antepartum visit (59420) which is less than seven.

(2) If medical necessity dictates, corroborated by the record, additional visits above seven antepartum may be reimbursed under the procedure codes for routine or follow-up clinic visit. The claim form shall clearly indicate the reason for the medical necessity and date for each listed.

ii. Obstetrical delivery with in-hospital postpartum care (with or without low forceps and/or episiotomy or a vaginal delivery full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours).

(1) This shall also include one visit between the 15th and 60th day postpartum day following delivery and out of hospital. Include name of hospital and delivery date on the claim.

2. Vaginal delivery: 59410.

i. Vaginal delivery full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours.

ii. This shall also include one visit between the 15th and 60th postpartum day following delivery and out of hospital. Include name of hospital and delivery date on the claim.

3. Subsequent antepartum visit: 59420.

5. Family therapy rendered by a drug treatment center for an ACCAP-eligible individual at home, per visit: Z1834.

i. 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.

ii. A minimum session of one and one half 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.

iii. The clinic may bill only for the patient and not for other family members.

6. Family conference rendered by a drug treatment center for an ACCAP-eligible individual at home, per visit: Z1835.

i. 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.

ii. 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.

7. Family therapy rendered in a drug treatment center: Z2000.

i. 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.

ii. A minimum session of one and one half 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.

iii. The clinic may bill only for the patient and not for other family members.

8. Family conference rendered in a drug treatment center: Z2001.

i. 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.

ii. 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.

9. Prescription visit rendered in a drug treatment center: Z2002.

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

10. Psychotherapy rendered in a drug treatment center—full session: Z2003.

i. 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.

ii. A minimum of 50 minutes personal involvement with the patient is required. This includes a prescription visit when necessary.

11. Group therapy rendered in a drug treatment center, per person: Z2004.

i. Verbal or other therapy methods provided by one or more physicians, or professional counsellors under the direction of physician, in a personal involvement with two or more patients, with a maximum of eight patients.

ii. A minimum session of one and one half hours is required. This includes preparation time in addition to the one and one half hours session time.

12. Psychological testing rendered in a drug treatment center, per hour; maximum of five hours: Z2005.

i. Psychometric and/or projective tests with a written report.

13. Methadone treatment rendered in a drug treatment center: Z2006.

i. A per diem payment based on the number of days a beneficiary is supplied methadone during the billing period. This rate includes the cost of the drug, packaging, nursing time, and administrative costs.

14. Psychotherapy rendered in a drug treatment center—half session: Z2007.

i. 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.

ii. A minimum of 25 minutes personal involvement with the patient is required. This includes a prescription visit when necessary.

15. Urinalysis for drug addiction: Z2010.

i. To determine what level, if any, a drug is present in the urine.

ii. To be used only by a drug treatment center specifically approved by the Program to provide this service.

16. Drawing of blood; see CPT-4 for narrative: 36415.

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

(n) Miscellaneous services:

1. Abortion: 59840 and 59841.

i. See N.J.A.C. 10:66-2.8; FD-179 form shall be attached to the claim form.

ii. For claims submitted by ambulatory surgical centers only, the trimester of pregnancy shall be identified on the claim form by using modifier "WY" for first trimester or "WZ" for second trimester.

Administrative Correction.

26 N.J.R. 797(a).

Amended by R.1998 d.577, effective December 7, 1998.

See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).

Substituted references to beneficiaries for references to recipients throughout; and in (a)6i, inserted a reference to NJ KidCare fee-for-service.

Amended by R.2003 d.15, effective January 6, 2003.

See: 34 N.J.R. 2676(a), 35 N.J.R. 230(c).

Added (c)11.

10:66-6.5 HealthStart

(a) HealthStart Maternity Care code requirements are as follows:

HPPCP Code	Mod	Description	Maximum Fee Allowance		WM
			\$	NS \$	
W9025		HealthStart Initial Antepartum Maternity Medical Care Visit	72.00	69.00	
W9025	WM	HealthStart Initial Antepartum Maternity Medical Care Visit by Certified Nurse Midwife 1. History, including system review 2. Complete physical examination 3. Risk assessment 4. Initial care plan 5. Patient counseling and treatment 6. Routine and special laboratory tests on site, or by referral, as appropriate 7. Referral for other medical consultations, as appropriate (including dental) 8. Coordination with the HealthStart Health Support Services provider, as applicable.			67.00
W9026		HealthStart Subsequent Antepartum Maternity Medical Care Visit	22.00	21.00	
W9026	WM	HealthStart Subsequent Antepartum Maternity Medical Care Visit by Certified Nurse Midwife 1. Interim history 2. Physical examination 3. Risk assessment 4. Review of plan of care 5. Patient counseling and treatment			19.00

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

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

3. The enhanced reimbursement (that is, HealthStart procedure codes) for delivery and postpartum care shall be claimed only for a patient who received at least one antepartum HealthStart Maternity Medical or Health Support Service.

4. The modifier "WM" in the HCPCS lists of codes refers to those services provided by certified nurse midwives; include the modifier at the end of each code.

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

i. Laboratory procedures performed by an outside laboratory shall be reimbursed to the laboratory. The clinic may submit a claim for a venipuncture using procedure code 36415 when necessary to collect blood specimens.

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