

10:66-2.6 Laboratory services

(a) As required by the Clinical Laboratory Improvement Amendments of 1988 (CLIA), referenced at 42 CFR 493, all facilities or entities that perform clinical laboratory testing shall have their CLIA identification number on file with the New Jersey Medicaid and NJ KidCare fee-for-service programs.

(b) A clinic shall only claim reimbursement for those laboratory services that have been performed by them on their premises, for their patients, and for which they have received approval by the New Jersey Medicaid and NJ KidCare fee-for-service programs, as indicated in N.J.A.C. 10:66-1.3(a).

(c) Laboratory procedures are reimbursable only when performed in accordance with the applicable CLIA-mandated certificate of registration, certificate of waiver, or certificate of physician-performed microscopy procedures.

(d) Specific laboratory procedures are reimbursable when performed in conjunction with an EPSDT screening, if the requirements of (a), (b) and (c) above are met.

Recodified from N.J.A.C. 10:66-2.4 and amended by R.1998 d.577, effective December 7, 1998.

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

In (a) and (b), inserted references to NJ KidCare fee-for-service. Former N.J.A.C. 10:66-2.6, Rehabilitation, recodified to N.J.A.C. 10:66-2.13.

10:66-2.7 Mental health services

(a) Mental health services include: comprehensive intake evaluation, individual psychotherapy, off-site crisis intervention, family therapy, family conference, group psychotherapy, psychological testing, partial care, and medication management.

(b) Only one type of mental health service per beneficiary is reimbursable to an independent clinic per day. Exception: Medication management may be reimbursed when provided to a Medicaid or NJ KidCare fee-for-service beneficiary in addition to one of the following mental health services: individual psychotherapy, group psychotherapy, family therapy, and family conference.

(c) Mental health clinics shall provide mental health services by, or under the direction of, a psychiatrist.

(d) For purposes of partial care, full day means five or more hours of participation in active programming exclusive of meals; half day means at least three hours but less than five hours of participation in active programming exclusive of meals. Additional details are located at N.J.A.C. 10:66-6.

(e) An intake evaluation shall be performed within 14 days of the first encounter or by the third clinic visit, whichever is later, for each beneficiary being considered for

continued treatment. This evaluation shall consist of a written assessment that:

1. Evaluates the beneficiary's mental condition;
2. Determines whether treatment in the program is appropriate, based on the beneficiary's diagnosis;
3. Includes certification (signed statement) by the evaluation team that the program is appropriate to meet the beneficiary's treatment needs; and
4. Is made part of the beneficiary's records.
5. The evaluation for the intake process shall include a physician and an individual experienced in diagnosis and treatment of mental illness. Both criteria may be satisfied by the same individual, if appropriately qualified.

(f) A written, individualized plan of care shall be developed for each beneficiary who receives continued treatment. The plan of care shall be designed to improve the beneficiary's condition to the point where continued participation in the program (beyond occasional maintenance visits) is no longer necessary. The plan of care shall be included in the beneficiary's records and shall consist of:

1. A written description of the treatment objectives including both the treatment regimen and the specific medical/remedial services, therapies, and activities that shall be used to meet the objectives;
2. A projected schedule for service delivery which includes the frequency and duration of each type of planned therapeutic session or encounter;
3. The type of personnel that will be furnishing the services; and
4. A projected schedule for completing reevaluations of the beneficiary's condition and updating the plan of care.

(g) The mental health clinic shall develop and maintain written documentation to support each medical/remedial therapy service, activity, or session for which billing is made.

1. This documentation, at a minimum, shall consist of:
 - i. The specific services rendered, such as individual psychotherapy, group psychotherapy, family therapy, etc., and a description of the encounter itself (that is, statement of patient progress noted, significant observations noted, etc.);
 - ii. The date and time that services were rendered;
 - iii. The duration of services provided (one hour, ½ hour, etc.);
 - iv. The signature of the practitioner or provider who rendered the services;
 - v. The setting in which services were rendered; and

vi. A notation of unusual occurrences or significant deviations from the treatment described in the plan of care.

2. Clinical progress, complications and treatment which affect prognosis and/or progress shall be documented in the beneficiary's medical record at least once a week, as well as any other information important to the clinical picture, therapy, and prognosis.

3. The individual services under partial care shall be documented on a daily basis. More substantive documentation, including progress notes and any other information important to the clinical picture, are required at least once a week.

(h) Periodic review of the beneficiary's plan of care shall take place on a regular basis (at least every 90 days during the first year and every six months thereafter).

1. The periodic review shall determine:

i. The beneficiary's progress toward the treatment objectives;

ii. The appropriateness of the services being furnished; and

iii. The need for the beneficiary's continued participation in the program.

2. Periodic reviews shall be documented in detail in the beneficiary's records and made available upon request to the New Jersey Medicaid or NJ KidCare program or its agents.

Recodified from N.J.A.C. 10:66-2.5 and 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; in (b), inserted a reference to NJ KidCare fee-for-service; and in (h)2, inserted a reference to NJ KidCare. Former N.J.A.C. 10:66-2.7, Transportation services, recodified to N.J.A.C. 10:66-2.17.

10:66-2.8 Obstetrical services

Obstetrical services, which may include obstetrical delivery, may be reimbursed when performed by a licensed physician and/or certified nurse-midwife in a licensed ambulatory care facility which is specifically approved to perform such services by the New Jersey Medicaid or NJ KidCare fee-for-service program. (See also N.J.A.C. 10:58-1.6 and 1.7, Nurse Midwifery Services chapter.)

New Rule, R.1998 d.577, effective December 7, 1998.

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

Former N.J.A.C. 10:66-2.8, Miscellaneous, recodified to N.J.A.C. 10:66-2.19.

10:66-2.9 Other services

Other services, such as evaluation and management, and minor surgery are reimbursable when billed by an independent clinic individually approved to provide the service(s) as indicated in N.J.A.C. 10:66-1.3, Provisions for provider participation. See N.J.A.C. 10:66-6 (HCPCS) for the procedure codes and maximum fee allowances corresponding to the Medicaid-reimbursable and NJ KidCare fee-for-service-reimbursable service(s).

New Rule, R.1998 d.577, effective December 7, 1998.

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

10:66-2.10 Pharmaceutical services

For covered pharmaceutical services, see the New Jersey Medicaid and NJ KidCare fee-for-service program's Pharmaceutical Services chapter, N.J.A.C. 10:51.

New Rule, R.1998 d.577, effective December 7, 1998.

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

10:66-2.11 Podiatric services

Podiatric services that are medically necessary are Medicaid or NJ KidCare fee-for-service reimbursable when performed by a licensed podiatrist in an independent clinic which is specifically approved to perform such services by the New Jersey Medicaid or NJ KidCare fee-for-service program. See the New Jersey Medicaid and NJ KidCare fee-for-service programs' Podiatry Services chapter, N.J.A.C. 10:57, for additional information.

New Rule, R.1998 d.577, effective December 7, 1998.

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

10:66-2.12 Radiological services

Specified radiological services may be reimbursed when provided in a clinic that is specifically approved to provide such services by the New Jersey Medicaid or NJ KidCare fee-for-service program, and performed by a physician who is recognized as a specialist in radiology by the New Jersey Medicaid and NJ KidCare fee-for-service programs. See the New Jersey Medicaid and NJ KidCare fee-for-service programs' Physician's Services chapter, N.J.A.C. 10:54, for additional information.

New Rule, R.1998 d.577, effective December 7, 1998.

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

10:66-2.13 Rehabilitation services

(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 or NJ KidCare fee-for-service beneficiary to his or her best functional level. Rehabilitative services shall be made available to Medicaid and NJ KidCare fee-for-service beneficiaries as an integral part of a comprehensive medical program.

(b) 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 clinic. These therapy services are discussed at (c), (d) and (e) below, respectively.

1. All treatments shall be individual and shall consist of a minimum of 30 minutes.

2. A plan of treatment shall be completed during the Medicaid or NJ KidCare fee-for-service beneficiary's initial evaluation visit and retained on file.

i. The plan of treatment shall be definitive as to the type, amount, frequency, and duration of the rehabilitative services that are to be furnished and shall include the beneficiary's diagnosis and the anticipated goal(s) of the treatment.

(c) Physical therapy is a service prescribed by a physician and provided to a Medicaid or NJ KidCare fee-for-service beneficiary by or under the direction of a qualified physical therapist. Physical therapy does not include therapy which is purely palliative, such as the application of heat in any form; massage; routine calisthenics; group exercises; assistance in any activity; use of a simple mechanical device; or other services not requiring the special skill of a licensed physical therapist.

1. A physical therapist is an individual who is:

i. Licensed by the State of New Jersey as a physical therapist in accordance with N.J.A.C. 13:39A; and

ii. A graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent.

2. If treatment or services are provided in a state other than New Jersey, the physical therapist shall meet the requirements of that state, including licensure if applicable, and all applicable Federal requirements.

(d) Occupational therapy is a service prescribed by a physician and provided to a Medicaid or NJ KidCare fee-for-service beneficiary by or under the direction of a qualified occupational therapist.

1. An occupational therapist is an individual who is:

i. Registered by the American Occupational Therapy Association; or

ii. A graduate of a program in occupational therapy approved by the Committee on Allied Health Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.

2. If treatment or services are provided in a state other than New Jersey, the occupational therapist shall meet the requirements of that state, including licensure if applicable, and all applicable Federal requirements.

(e) Speech-language pathology services and audiology services are diagnostic, screening, preventive, or corrective services prescribed by a physician and provided to a Medicaid or NJ KidCare fee-for-service beneficiary by or under

the direction of a speech-language pathologist or audiologist.

1. A speech-language pathologist or audiologist is an individual who is licensed by the State of New Jersey as a speech-language pathologist or audiologist, in accordance with N.J.A.C. 13:44C, and meets all applicable Federal requirements including:

i. A Certificate of Clinical Competence in Speech-Language Pathology or Audiology from the American Speech-Language-Hearing Association;

ii. Completion of the equivalent educational requirements and work experience necessary for the certificate(s); or

iii. Completion of the academic program and in the process of acquiring supervised work experience in order to qualify for the certificate(s).

2. If treatment or services are provided in a state other than New Jersey, the speech-language pathologist or audiologist shall meet the requirements of that state, including licensure if applicable, and all applicable Federal requirements.

(f) No portion of the time spent on therapy treatments may be considered as part of the time parameters of a clinic visit. Clinic visits billed during the same day shall clearly and separately meet the time and other parameters described in the applicable HCPCS procedure codes, N.J.A.C. 10:66-6.

(g) When prior authorized, reimbursement to a clinic may be made for more than one type of rehabilitative service performed on a Medicaid or NJ KidCare fee-for-service beneficiary on the same day, for example, physical therapy and speech-language pathology.

(h) When the same type of rehabilitative service is performed on a Medicaid or NJ KidCare fee-for-service beneficiary more than once on the same day, for example, two physical therapy services, reimbursement shall be made for one service only. Likewise, when the treatment performed on a Medicaid or NJ KidCare fee-for-service beneficiary is merely a different modality within the same type of rehabilitative service, reimbursement shall be made for only one service per beneficiary per day.

Recodified from N.J.A.C. 10:66-2.6 and 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 beneficiaries for references to recipients throughout.

10:66-2.14 Renal dialysis service for end-stage renal disease (ESRD)

An independent clinic providing renal dialysis service for end-stage renal disease (ESRD) shall comply with all applicable Federal regulations and State rules as indicated at N.J.A.C. 8:43A.

New Rule, R.1998 d.577, effective December 7, 1998.
Sec: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).

10:66-2.15 Sterilization services

(a) Sterilization is any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing.

1. The individual to be sterilized shall be at least 21 years of age at the time the sterilization consent form is signed by the individual to be sterilized.

2. The individual to be sterilized shall not be mentally incompetent or institutionalized.

i. A mentally incompetent individual is an individual who has been declared mentally incompetent by a Federal, State, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

ii. An institutionalized individual is an individual who is:

(1) Involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or

(2) Confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.

3. The individual to be sterilized shall have voluntarily given informed consent in accordance with all the requirements prescribed in 42 CFR 441.257 through 441.258.

4. At least 30 days, but not more than 180 days, shall have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization.

i. In the case of premature delivery, the informed consent shall have been given at least 30 days before the expected date of delivery.

ii. If an individual desires to be sterilized at the time of delivery, the consent form should be signed by the individual no earlier than the fifth month of pregnancy to minimize the possibility of exceeding the 180 day limit.

5. Informed consent is considered to be given only if:

i. The person who obtained consent for the sterilization procedure offered to answer any questions the individual may have concerning the procedure, provided a copy of the consent form and provided orally all of the following information or advice to the individual to be sterilized:

(1) Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any Federally funded program benefits to which the individual might otherwise be entitled;

(2) A description of available alternative methods of family planning and birth control;

(3) Advice that the sterilization procedure is considered to be irreversible;

(4) A thorough explanation of the specific sterilization procedure to be performed;

(5) A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of type and possible effects of any anesthetic to be used;

(6) A full description of the benefits or advantages that may be expected as a result of the sterilization; and

(7) Advice that the sterilization shall not be performed for at least 30 days, except under the circumstances specified in (c)4 above.

ii. Suitable arrangements were made to insure that the information specified in (a)5i above was effectively communicated to any individual who is blind, deaf, or otherwise handicapped;

iii. An interpreter was provided if the individual to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent;

iv. The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained;

v. The consent form requirements of 42 CFR 441.258 were met; and

vi. Any additional requirement of State or local law for obtaining consent, except a requirement for spousal consent, was followed.

6. Informed consent may not be obtained while the individual to be sterilized is:

i. In labor or childbirth;

ii. Seeking to obtain or obtaining an abortion; or

iii. Under the influence of alcohol or other substances that affect the individual's state of awareness.

(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 KidCare 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 nurse practitioner 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.

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
				\$	NS	
	36415			1.80	1.80	
	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	
	90713			22.80	22.80	
	90713	52		2.50	2.50	
	90714			3.03	3.03	
	90714	52		2.50	2.50	
	90717			3.03	3.03	
	90717	52		2.50	2.50	
	90718			3.35	3.35	
	90718	52		2.50	2.50	
	90724			6.97	6.97	
	90724	52		2.50	2.50	
	90732			14.35	14.35	
	90732	52		2.50	2.50	
	90733			17.48	17.48	
	90733	52		2.50	2.50	
	90737			25.79	25.79	
	90737	52		2.50	2.50	
	90741			Prior authorization required		
	90742			Prior authorization required		
	90746			63.57	63.57	
L	90746	52		2.50	2.50	
N	90799			2.50	2.50	
N	90801			37.00	26.00	

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				S	NS	
	93000			16.00	16.00	
N	99150			45.00	40.00	
				Per Hour	Per Hour	
N	99151			45.00	40.00	
				Per Hour	Per Hour	
	99173			5.00	5.00	
N	*99201			16.00	14.00	
N	*99202			16.00	14.00	
N	*99203			22.00	17.00	
N	*99204			22.00	17.00	
N	*99205			22.00	17.00	
N	*99211			16.00	14.00	
N	99211	WM		NA	11.20	
N	*99212			16.00	14.00	
N	99212	WM		NA	11.20	
N	*99213			16.00	14.00	
N	99213	WM		NA	11.20	
N	*99214			16.00	14.00	
N	99214	WM		NA	11.20	
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	
	99261			16.00	14.00	
	99262			16.00	14.00	
	99263			16.00	14.00	
N	99271			44.00	NA	
N	99272			44.00	NA	
N	99273			44.00	NA	
N	99274			62.00	NA	
N	99274	YY		50.00	NA	
N	99274	ZZ		50.00	NA	
N	99275			62.00	NA	
N	99291			45.00	40.00	
N	99292			22.50	20.00	
	99382			22.00	17.00	
	99383			22.00	17.00	
	*99384			22.00	17.00	
	*99385			22.00	17.00	
	*99386			22.00	17.00	
	*99387			22.00	17.00	
	99391			14.00	14.00	
	99392			22.00	17.00	
	99393			22.00	17.00	
	*99394			22.00	17.00	
	*99395			22.00	17.00	
	99396			22.00	17.00	
	99397			22.00	17.00	
	J2790			20.40	20.40	
	J2790	22		72.07	72.07	
L	W9050			27.00	NA	
L	W9055			27.00	23.00	
L	W9060	WT		23.00	18.00	
L	W9061	WT		23.00	18.00	
L	W9062	WT		23.00	18.00	
L	W9063	WT		23.00	18.00	
L	W9064	WT		23.00	18.00	
L	W9065	WT		23.00	18.00	
L	W9066	WT		23.00	18.00	
L	W9067	WT		23.00	18.00	
L	W9068	WT		23.00	18.00	
L	W9096			17.46	17.46	
L	W9096	52		2.50	2.50	
L	W9096	22		32.79	32.79	
L	W9096	2252		2.50	2.50	
L	W9097			17.46	17.46	
L	W9097	52		2.50	2.50	
L	W9098			32.79	32.79	
L	W9098	52		2.50	2.50	
L	W9333			27.88	27.88	
L	W9333	52		2.50	2.50	
L	W9334			27.88	27.88	

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				S	NS	
L	W9334			2.50	2.50	
L	W9335	52		62.09	62.09	
L	W9335			2.50	2.50	
L	W9338	52		30.27	30.27	
L	W9338			2.50	2.50	
	W9820			23.00	18.00	

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

(c) Family planning services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				S	NS	
N	11975	22	30	Direct package plus	price	
				100.00	85.00	
N	11976		90	100.00	85.00	
N	11977	22	90	Direct package plus	price	
				200.00	170.00	
N	55250		30	90.00	79.00	3
N	55450		30	42.00	37.00	3
N	57451		45	182.00	158.00	6
	58301			16.40	16.40	
	58301	WM		NA	16.40	
N	58600		45	211.00	184.00	6
N	58605		45	151.00	131.00	6
N	58982		45	182.00	158.00	6
N	58983		45	182.00	158.00	6
	88150			6.00	6.00	
	88151			6.00	6.00	
	88155			6.00	6.00	
N	99201	WF		45.00	45.00	
N	99201	WFWM		NA	31.50	
N	99202	WF		45.00	45.00	
N	99202	WFWM		NA	31.50	
N	99203	WF		45.00	45.00	
N	99203	WFWM		NA	31.50	
N	99204	WF		45.00	45.00	
N	99204	WFWM		NA	31.50	
N	99205	WF		45.00	45.00	
N	99205	WFWM		NA	31.50	
N	99211	WF		7.60	7.60	
N	99211	WFWM		NA	5.35	
N	99212	WF		7.60	7.60	
N	99212	WFWM		NA	5.35	
N	99213	WF		7.60	7.60	
N	99213	WFWM		NA	5.35	
N	99214	WF		23.00	23.00	
N	99214	WFWM		NA	16.40	
N	99215	WF		23.00	23.00	
N	99215	WFWM		NA	16.40	
N	99395	WF		45.00	45.00	
N	99395	WFWM		NA	31.50	
L	W0001	WF		188.00	188.00	
L	W0001	WFWM		NA	177.00	
L	W0002	WF		123.00	123.00	
L	W0002	WFWM		NA	112.00	
L	W0004	WF		204.00	204.00	
L	W0004	WFWM		NA	188.00	
L	W0008	WF		139.00	139.00	
L	W0008	WFWM		NA	123.00	

(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.

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				S	NS	
N	10040			18.00	16.00	
*	10060			13.00	11.00	

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				\$	NS	
*	10061		30	48.00	42.00	
*	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	
*	11421		15	22.00	20.00	
*	11422		15	27.00	24.00	
*	11423		15	32.00	27.00	
*	11424		15	32.00	27.00	
*	11426		15	32.00	27.00	
*	11440		15	18.00	16.00	
*	11441		15	22.00	20.00	
*	11442		15	27.00	24.00	
*	11443		15	32.00	27.00	
*	11444		15	32.00	27.00	
*	11446		15	32.00	27.00	
*	11600		90	37.00	32.00	
*	11601		90	47.00	42.00	
*	11602		90	61.00	53.00	
*	11620		90	61.00	53.00	
*	11621		90	90.00	79.00	
*	11622		90	121.00	105.00	
*	11640		90	90.00	79.00	
*	11641		90	121.00	105.00	
*	11642		90	150.00	131.00	
*	11700			13.00	11.00	
*	11701			6.00	6.00	
*	11710			13.00	11.00	
*	11711			6.00	6.00	
*	11730			10.00	10.00	
*	11750		30	42.00	37.00	
*	12001			18.00	16.00	
*	12002			24.00	21.00	
*	12004			30.00	26.00	
*	12005		7	46.00	39.00	
*	12006		7	57.00	48.00	
*	12007		7	82.50	70.00	
*	12011			18.00	16.00	
*	12013			24.00	21.00	
*	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	

(f) Mental health services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				\$	NS	
N	90801	ZI		45.00	45.00	
N	90843	ZI		13.00	13.00	
N	90844	ZI		26.00	26.00	
N	90847	ZI		26.00	26.00	
N	90847	ZI22		32.00	32.00	
N	90862	ZI		4.50	4.50	
N	90887	ZI		13.00	13.00	
LN	H5025	ZI		8.00	8.00	
L	Z0100			22.50	22.50	
L	Z0130			25.00	25.00	
L	Z0150			8.00	8.00	
L	Z0160			15.50	15.50	
L	Z0170			46.00	46.00	
L	Z0180			77.00	77.00	

(g) Obstetrical services (maternity):

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				\$	NS	
N	59400		60	468.00	403.00	4
N	59400	WM	60	NA	328.00	4
N	59410		60	320.00	272.00	4
N	59410	WM	60	NA	224.00	4
N	59420			16.00	14.00	
N	59420	WM		NA	11.20	
N	59420	22		22.00	17.00	
N	59420	WM22		NA	15.40	
N	59430		0	20.00	18.00	0
N	59430	WM	0	NA	14.00	0
N	59510		45	598.00	516.00	7
N	59515		45	450.00	385.00	7
N	59525		45	362.00	308.00	8
N	59812		45	105.00	91.00	3
L	Z0250	WM		NA	40.00	

(h) Podiatry services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				\$	NS	
N	29580			18.00	16.00	3
N	99211	YR		16.00	14.00	
N	99212	YR		16.00	14.00	
N	99213	YR		16.00	14.00	
N	99214	YR		16.00	14.00	
N	99215	YR		16.00	14.00	
L	W2650			21.00	21.00	
L	W2655			5.00	5.00	

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

(i) Radiology services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				\$	NS	
	70030			15.00		
	70100			15.00		
	70110			20.00		
	70120			15.00		
	70130			20.00		
	70140			15.00		
	70150			20.00		
	70160			15.00		
	70170			20.00		
	70190			15.00		
	70200			25.00		
	70210			20.00		
	70220			25.00		
	70240			15.00		
	70250			15.00		
	70260			25.00		

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee \$	Allowance NS	Anes. Basic Units	Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee \$	Allowance NS	Anes. Basic Units
	70300			5.00				74305			25.00		
	70310			10.00				74400			35.00		
	70320			15.00				74405			50.00		
	70328			13.00				74420			35.00		
	70330			20.00				74430			15.00		
	70350			8.00				74450			20.00		
	70360			10.00				74455			20.00		
	70370			20.00				74470			20.00		
	70380			15.00			N	74710			25.00		
	70390			15.00				74740			20.00		
	70551			300.00				76000			45.00		
MN	71010			10.00				76020			15.00		
MN	71020			15.00				76040			20.00		
MN	71030			20.00				76061			35.00		
MN	71034			20.00				76062			90.00		
	71100			15.00				76080			15.00		
	71110			20.00				76090			26.00		
	71120			15.00				76091			36.00		
	71130			20.00				76100			35.00		
	72010			40.00				76100	50		50.00		
	72040			15.00				76805			55.00		
	72050			20.00				76815			25.00		
	72052			25.00				76816			25.00		
	72070			15.00									
	72080			15.00									
	72100			20.00									
	72110			25.00									
	72114			20.00									
N	72170			15.00									
	72190			20.00									
	72200			20.00									
	72220			15.00									
	73000			10.00									
	73010			15.00									
	73020			15.00									
	73030			15.00									
	73040			15.00									
	73050			18.00									
	73060			15.00									
	73070			15.00									
	73080			15.00									
	73085			15.00									
	73090			10.00									
	73092			20.00									
	73100			10.00									
	73110			15.00									
	73115			15.00									
	73120			10.00									
	73130			15.00									
	73140			5.00									
N	73500			18.00									
N	73510			20.00									
	73520			25.00									
	73525			15.00									
	73530			30.00									
	73540			15.00									
	73550			15.00									
	73560			15.00									
	73562			15.00									
	73580			15.00									
	73590			15.00									
	73592			20.00									
	73600			10.00									
	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									

(j) Rehabilitation services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee \$	Allowance NS	Anes. Basic Units
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 NS	Anes. Basic Units
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 NS	Anes. Basic Units
*LN	Z1830			3.50		3.50
*LN	Z1831			4.50		4.50
*LN	Z1832			24.00		24.00
*LN	Z1833			12.00		12.00

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	
*LN	Z1834			30.00	30.00		L	Z1605	ZI		10.23	10.23	
*LN	Z1835			22.50	22.50		L	Z1610	ZI		35.00	35.00	
LN	Z2000			22.50	22.50		L	Z1611	ZI		6.51	6.51	
LN	Z2001			15.00	15.00		L	Z1612	ZI		5.12	5.12	
LN	Z2002			4.50	4.50		L	Z1613	ZI		35.00	35.00	
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.

(p) Miscellaneous services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				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	

(n) Federally qualified health care services:

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

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.

(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	

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

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

(b) Vision and hearing screening;
and

(c) Nutritional assessment.

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

5. Anticipatory guidance;

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

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

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

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

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

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

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

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

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

W9096

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

17.46

17.46

Ind	HCPCS		Description	Follow Up Days	Maximum Fee Allowance		
	Code	Mod			S	\$	NS
	W9096	22	Hepatitis B immunoprophylaxis with Recombivax HB, 0.5 ml does. This code applies only to newborns of HBsAg negative mothers.		32.79		32.79
	W9097		Hepatitis B immunoprophylaxis with Recombivax HB, 0.25 ml dose. This code applies only to high risk beneficiaries under 11 years of age (exclusive of newborns).		17.46		17.46
	W9098		Hepatitis B immunoprophylaxis with Recombivax HB, 0.5 ml dose. This code applies only to high risk beneficiaries 11 to 19 years of age.		32.79		32.79
	W9099		Hepatitis B immunoprophylaxis with Recombivax HB, 1.0 ml dose. This code applies only to high risk beneficiaries over 19 years of age.		63.57		63.57
	W9333		Hepatitis B immunoprophylaxis with Engerix-B, 0.5 ml does. This code applies only when immunizing newborns.		27.88		27.88
	W9334		Hepatitis B immunoprophylaxis with Engerix-B, 0.5 ml dose. This code applies only to high risk beneficiaries under 11 years of age (exclusive of newborns).		27.88		27.88
	W9335		Hepatitis B immunoprophylaxis with Engerix-B, 1.0 ml dose. This code applies only to high risk beneficiaries over 11 years of age.		62.09		62.09
	W9338		Tetramune. this code is used when administering the primary immunization series to infants and toddlers. It eliminates the need for two separate injections of DTP and Haemophilus b Conjugate Vaccine.		30.27		30.27
N	W9820		Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) through age 20. NOTE: If performed by outside independent laboratories, the laboratory must submit the claim. Blood sample for lead screening test should be sent to the New Jersey State Department of Health and Senior Services. NOTE: Procedure code W9820 shall be used only once for the same patient during any 12-month period by the same physician, group, shared health care facility, or practitioner(s) sharing a common record. Reimbursement for code W9820 is contingent upon the submission of both a completed Report and Claim For EPSDT/HealthStart Screening and Related Procedures (MC-19) and the appropriate claim form within 30 days of the date of service. In the absence of a completed MC-19 form, reimbursement will be reduced to the level of an annual health maintenance examination, that is, \$22.00-\$17.00.		23.00		18.0

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

(c) Family planning services:

IND	HCPCS		Description	Follow Up Days	Maximum Fee Allowance		
	Code	Mod			S	\$	NS
	G0001	WF	Routine Venipuncture		1.80		1.80
	W0001	WF	Supplying and inserting the intrauterine device 'Paragard' by a physician including the post-insertion visit.		188.00		188.00
	W0001	WMWF	Supplying and inserting the intrauterine device 'Paragard' by a certified nurse-midwife including the post-insertion visit.		NA		177.00
	W0002	WF	Supplying and inserting the intrauterine device 'Progestasert' by a physician including the post-insertion visit.		123.00		123.00
	W0002	WMWF	Supplying and inserting the intrauterine device 'Progestasert' by a certified nurse-midwife including the post-insertion visit.		NA		112.00

<u>IND</u>	<u>HCPCS Code</u>	<u>Mod</u>	<u>Description</u>	<u>Follow Up Days</u>	<u>Maximum Fee</u> <u>\$</u>	<u>Allowance</u> <u>NS</u>
	W0004	WF	Removal of an IUD by a physician followed at the same visit by the insertion of the IUD 'Paragard' and including the post-insertion visit.		204.00	204.00
	W0004	WMWF	Removal of an IUD by a certified nurse-midwife followed at the same visit by the insertion of the IUD 'Paragard' and including the post-insertion visit.		NA	188.00
	W0008	WF	Removal of an IUD by a physician followed at the same visit by the insertion of the IUD 'Progestasert' and including the post-insertion visit.		139.00	139.00
	W0008	WMWF	Removal of an IUD by a certified nurse-midwife followed at the same visit by the insertion of the IUD 'Progestasert' and including the post-insertion visit.		NA	123.00

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

(e) Minor surgery:

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

(f) Mental health services:

<u>Ind</u>	<u>HCPCS Code</u>	<u>Mod</u>	<u>Description</u>	<u>Follow Up Days</u>	<u>Maximum Fee</u> <u>\$</u>	<u>Allowance</u> <u>NS</u>
	H5025	ZI	Group therapy: Verbal or other therapy methods provided by one or more psychiatrists, or professional counselors under the direction of a psychiatrist, in a personal involvement with two or more patients, with a maximum of eight patients. A minimum session of 1½ hours is required. This includes preparation time in addition to the 1½ hours session time.		8.00	8.00
	Z0100		Off-Site Crisis Intervention—An emergency procedure by personnel of a mental health clinic to an outpatient			