

CHAPTER 66 INDEPENDENT CLINIC SERVICES

Authority

N.J.S.A. 30:4D-6, 7 and 12; 42 CFR 405.2401(b), 440.40(b),
440.90, 441 Subpart B, 441.20, 491 and 493.

Source and Effective Date

R.1998 d.577, effective November 12, 1998.
See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 66, Independent
Clinic Services, expires on May 10, 2004. See: 36 N.J.R. 324(a).

Chapter Historical Note

Chapter 66, Manual for Independent Clinic Services, was adopted as
R.1973 d.228, effective October 1, 1973. See: 5 N.J.R. 226(c), 5 N.J.R.
339(b).

Chapter 66, Manual for Independent Clinic Services, was repealed
and a new Chapter 66, Independent Clinic Services Manual, was
adopted as R.1980 d.249, effective June 30, 1980. See: 12 N.J.R.
275(b), 12 N.J.R. 418(f).

Pursuant to Executive Order No. 66(1978), Chapter 66, Independent
Clinic Services Manual, was readopted as R.1983 d.615, effective De-
cember 15, 1983. See: 15 N.J.R. 1732(a), 16 N.J.R. 145(a).

Pursuant to Executive Order No. 66(1978), Chapter 66, Independent
Clinic Services Manual, was readopted as R.1989 d.33, effective Decem-
ber 15, 1988. See: 20 N.J.R. 2562(a), 21 N.J.R. 162(a).

Chapter 66, Independent Clinic Services Manual, was repealed and a
new Chapter 66, Independent Clinic Services, was adopted as R.1993
d.641, effective December 6, 1993. See: 25 N.J.R. 4379(a), 25 N.J.R.
5528(c).

Pursuant to Executive Order No. 66(1978), Chapter 66, Independent
Clinic Services, was readopted as R.1998 d.577, effective November 12,
1998. See: Source and Effective Date. See, also, section annotations.

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SUBCHAPTER 1. GENERAL PROVISIONS

10:66-1.1 Scope of service

(a) This chapter (N.J.A.C. 10:66) describes the policies and procedures of the New Jersey Medicaid and NJ Kid-

Care fee-for-service programs pertaining to the provision of, and reimbursement for, medically necessary Medicaid-covered and NJ KidCare-covered services in an independent clinic setting. An independent clinic setting includes, but is not limited to, clinic types such as an ambulatory care facility, ambulatory surgical center, ambulatory care/family planning facility, and a Federally qualified health center.

(b) Medically necessary services provided in an independent clinic setting shall meet all applicable State and Federal Medicaid and NJ KidCare fee-for-service laws, and all applicable policies, rules and regulations as specified in the appropriate provider services manual of the New Jersey Medicaid and NJ KidCare fee-for-service programs.

(c) Independent clinic services are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are provided by a facility (freestanding) that is not part of a hospital but is organized and operated to provide medical care to outpatients, including such services provided outside the clinic by clinic personnel to any Medicaid or NJ KidCare fee-for-service beneficiary who does not reside in a permanent dwelling or does not have a fixed home or mailing address. Clinic services do not include services provided by hospitals to outpatients.

(d) The chapter is divided into six subchapters, as follows:

1. N.J.A.C. 10:66-1 contains scope of service, definitions, provisions for provider participation, prior authorization, basis for reimbursement, and recordkeeping requirements.

2. N.J.A.C. 10:66-2 contains policies and procedures pertaining to specific Medicaid-covered and NJ KidCare-covered services provided in an independent clinic setting. Where unique characteristics or requirements exist concerning a particular Medicaid-covered or NJ KidCare-covered service, the service is separately identified and discussed.

3. N.J.A.C. 10:66-3 contains information about HealthStart, a program for pregnant women and children.

4. N.J.A.C. 10:66-4 and its Appendix contain information about Federally qualified health centers, including rules governing the provision of services; the Medicaid cost report containing the forms used by Federally qualified health centers to determine Medicaid and NJ KidCare-Plan A fee-for-service reimbursement amounts; and instructions for the proper completion of the forms contained in the cost report.

5. N.J.A.C. 10:66-5 contains information about ambulatory surgical centers, including covered services, anesthesia, medical justification, facility services, and medical records.

6. N.J.A.C. 10:66-6 pertains to the Health Care Financing Administration's Common Procedure Coding System (HCPCS). The HCPCS procedure code system contains procedure codes and maximum fee allowances corresponding to Medicaid-reimbursable services.

(e) The Appendix following N.J.A.C. 10:66-6 pertains to the Fiscal Agent Billing Supplement. The Fiscal Agent Billing Supplement contains billing instructions and samples of forms (claim forms, prior authorization forms, and consent forms) used in the billing process.

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 NJ KidCare-covered services throughout; in (c), substituted a reference to beneficiaries for a reference to recipients; and in (d)4, inserted a reference to NJ KidCare-Plan A fee-for-service.

10:66-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context indicates otherwise:

"Ambulatory care facility" means a health care facility or a distinct part of a health care facility, licensed by the New Jersey State Department of Health and Senior Services, which provides preventive, diagnostic, and treatment services to persons who come to the facility to receive services and depart from the facility on the same day.

"Ambulatory care/family planning facility" means a health care facility or a distinct part of a health care facility, licensed by the New Jersey State Department of Health and Senior Services to provide specified surgical procedures.

"Ambulatory surgical center" means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization; has an agreement with the Health Care Financing Administration (HCFA) under Medicare to participate as an ambulatory surgical center; is licensed as an ambulatory surgical center, if required, by the New Jersey State Department of Health and Senior Services; and meets the enrollment requirements as indicated in the Administration chapter at N.J.A.C. 10:49-3.2, Enrollment process, and at N.J.A.C. 10:66-1.3, Provisions for provider participation.

"Audited financial statements" are defined in requirements set forth in N.J.A.C. 10:66-4.2. This section provides a set of guidelines so that FQHC providers will know the criteria for a satisfactory audit.

"Compensated hours" means all hours for which an employee receives compensation, payment or any form of remuneration, including regular time, overtime, vacation time, sick time, personal time, educational time, and all other compensated time.

“Dental clinic” means a freestanding independent facility, or a distinct component of a multi-service ambulatory care facility, which meets the standards for dental clinics established by the New Jersey State Board of Dentistry.

“Drug treatment center” means a facility or a distinct part of a facility which is licensed or approved by the New Jersey State Department of Health and Senior Services to provide health care for the prevention and treatment of drug addiction and drug abuse, as indicated in the Manual of Standards for Licensure of Drug Treatment Facilities, N.J.A.C. 8:42B.

“Federally qualified health center” means an entity that is receiving a grant under Section 329, 330, or 340 of the Public Health Service Act; or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under Section 329, 330, or 340 of the Public Health Service Act; or based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant; or was treated by the Secretary, for purposes of Medicare Part B, as a Federally Funded Health Center as of January 1, 1990.

“Freestanding facility” means a facility which is not located in a hospital but may, or may not, be under its auspices.

“Hour” means a standard 60-minute period.

“Independent clinic” means a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients.

“Managed care wraparound payments” means DMAHS payments made to FQHCs for the difference between the Medicaid FQHC encounter rate and amounts paid to FQHCs by managed care organizations for encounters provided to Medicaid and FamilyCare beneficiaries.

“Medicare Economic Index (MEI)” means that factor that adjusts reimbursement rates for annual inflation, which is determined in accordance with section 1842(b)(3) of the Social Security Act, 42 U.S.C. § 1395u(b)(3) and regulation at 42 C.F.R. 405.504.

“Medicare limit” means the Medicare FQHC urban payment limit as provided for in section 1833(a)(3) of the Social Security Act, 42 U.S.C. § 13951(a) and section 1861(v)(1)(A) of the Social Security Act, 42 U.S.C. § 1395(x)(v), and section 1886(d)(2)(D) of the Social Security Act, 42 U.S.C. § 1395ww(d). The Medicare limit is adjusted for inflation annually by the Medicare Economic Index (MEI) applicable to primary care services.

“Mental health clinic” means a freestanding independent community facility or distinct component of a multi-service ambulatory care facility, which meets the minimum stan-

dards established by the Community Mental Health Services Act implementing rules at N.J.A.C. 10:37.

“Personal care assistant” means a person who has:

1. Successfully completed a minimum 40-hour training program in personal care services approved by the New Jersey Medicaid and NJ KidCare programs. The individual is assigned and supervised by a registered professional nurse of a Medicaid and NJ KidCare approved personal care provider agency.

- i. The individual is primarily involved in the treatment and care of mentally handicapped and developmentally disabled patients in community settings, and is employed by a State agency or by an agency under contract with a State agency.

“Prospective Payment System (PPS)” means a payment rate per encounter which is determined in accordance with 42 U.S.C. § 1396a(a) and adjusted annually by the MEI applicable to primary care services.

“Satellite” means an affiliate of a separately enrolled independent clinic. A satellite is located at a site distinct from that of the separately enrolled independent clinic but shares the same governing authority.

“Specialist” means a fully licensed physician who:

1. Is a diplomate of a specialty board approved by the American Board of Medical Specialties or the Advisory Board of the American Osteopathic Association;

2. Is a fellow of the appropriate American specialty college or a member of an osteopathic specialty college;

3. Is currently admissible to take the examination administered by a specialty board approved by the American Board of Medical Specialties or the Advisory Board of the American Osteopathic Association, or has evidence of completion of an appropriate qualifying residency approved by the American Medical Association or American Osteopathic Association;

4. Holds an active staff appointment with specialty privileges in a voluntary or governmental hospital which is approved for training in the specialty in which the physician has privileges; or

5. Is recognized in the community as a specialist by his or her peers.

“Specialist in dentistry” means an individual who is licensed to practice dentistry in the state in which treatment is provided, and whose practice is limited solely to his or her specialty, which is recognized by the American Dental Association. Additional conditions regarding the qualifications for a dental specialist for the New Jersey Medicaid and NJ KidCare fee-for-service programs are located in the New Jersey Medicaid and NJ KidCare fee-for-service programs’ Dental Services chapter, N.J.A.C. 10:56.

“Specialist in podiatry” means an individual who is licensed to practice podiatry in the state in which treatment is provided, and who is a Diplomate of the appropriate American Podiatry Association-recognized board or has been notified of admissibility to examination by the appropriate American Podiatry Association recognized board.

“Specialist in psychology” means an individual who is licensed to practice psychology in the state in which treatment is provided, and who is a Diplomate of the American Board of Professional Psychology (Diplomate Qualified) or has been notified of admissibility to the examination by the American Board of Professional Psychology (Diplomate Eligible).

Amended by R.1996 d.331, effective July 15, 1996.

See: 28 N.J.R. 1952(b), 28 N.J.R. 3573(b).

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

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

In “Personal care assistant”, inserted references to NJ KidCare throughout 1; and in “Specialist in dentistry”, inserted references to NJ KidCare fee-for-service throughout.

Amended by R.2002 d.271, effective August 19, 2002.

See: 33 N.J.R. 4087(a), 34 N.J.R. 2966(a).

Added “Managed care wraparound payments”, “Medicare Economic Index (MEI)” and “Prospective Payment System (PPS); Rewrote “Medicare limit”.

10:66-1.3 Provisions for provider participation

(a) Each independent clinic, including each satellite, shall be individually approved by the New Jersey Medicaid and NJ KidCare fee-for-service programs in conjunction with the program’s fiscal agent, for each service provided. If a clinic wishes to add a service(s), approval from the New Jersey Medicaid and NJ KidCare fee-for-service programs shall be obtained before reimbursement for the service(s) may be claimed. For additional details, see the Administration chapter, N.J.A.C. 10:49-3.2, Enrollment process, and N.J.A.C. 10:49-3.3, Providers with multi-locations.

1. A clinic’s medical staff, including physicians, dentists, and other practitioners, shall enroll in the New Jersey Medicaid and NJ KidCare fee-for-service programs, as indicated in the Administration chapter at N.J.A.C. 10:49-3.4, in order to obtain an individual Medicaid and NJ KidCare fee-for-service Provider Services Number to be used when the clinic submits a claim to the Division’s fiscal agent.

(b) Each independent clinic seeking enrollment in the New Jersey Medicaid and NJ KidCare fee-for-service programs shall possess a certificate of need and/or license, if required, from the New Jersey State Department of Health and Senior Services.

1. The facility shall provide only those services for which it is licensed or authorized to provide by the New Jersey State Department of Health and Senior Services.

2. A photocopy of the license shall be forwarded to the New Jersey Medicaid and NJ KidCare fee-for-service programs as an attachment to a clinic’s initial application for enrollment and when the license is renewed on an annual basis.

(c) In addition to (a) and (b) above, each independent clinic shall obtain approval from the relevant Federal and State agency(ies), if required. For example:

1. For an ambulatory surgical center, an agreement with the Health Care Financing Administration (HCFA) under Medicare to participate as an ambulatory surgical center and licensure as an ambulatory surgical center, if required, by the New Jersey State Department of Health and Senior Services;

2. For a Federally qualified health center, approval by the Health Care Financing Administration as a Federally qualified health center and licensure by the New Jersey State Department of Health and Senior Services as an ambulatory care facility;

3. For an ambulatory care/family planning/surgical facility, licensure as an ambulatory care/family planning/surgical facility by the New Jersey State Department of Health and Senior Services;

4. For a dental clinic, approval by the New Jersey State Board of Dentistry and the Bureau of Dental Services, Division of Medical Assistance and Health Services (DMAHS) of the New Jersey Department of Human Services;

5. For a mental health clinic, approval by the Division of Mental Health Services of the New Jersey Department of Human Services; and

6. For child health conferences, approval by the New Jersey State Department of Health and Senior Services as indicated at N.J.A.C. 10:66-3.3.

(d) Requests for approval to perform radiological services, with Medicaid or NJ KidCare fee-for-service reimbursement, shall be submitted to the New Jersey Medicaid or NJ KidCare fee-for-service program and shall include:

1. The radiologist’s name(s) and copy(ies) of the license(s); and

2. Documentation from the New Jersey State Department of Health and Senior Services relating to the installation and safety of X-ray equipment.

(e) Each out-of-State clinic seeking reimbursement for services provided to New Jersey Medicaid and NJ KidCare fee-for-service beneficiaries shall enroll, if the clinic is approved by Title XIX (Medicaid) in its own state, in the New Jersey Medicaid and NJ KidCare fee-for-service programs as indicated in the Administration chapter at N.J.A.C. 10:49-3.2(c). Services are reimbursable under the following circumstances:

1. If the services are provided to Division of Youth and Family Services children residing out-of-State; or
2. If the services are provided in an emergency.

(f) Each Medicaid or NJ KidCare fee-for-service beneficiary's care in an independent clinic shall be under the supervision of a physician directly affiliated with the clinic. The physician shall assume professional responsibility for the services provided and thus assure that the services are medically appropriate.

(g) A physician affiliated with a clinic shall spend as much time in the facility as is necessary to assure that Medicaid and NJ KidCare fee-for-service beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of medical and dental practice.

(h) For a physician to be affiliated with a clinic, there shall be a contractual agreement or some other type of formal, written arrangement on file at the facility between the physician and the facility by which the physician is obligated to supervise the care provided to the clinic's Medicaid and NJ KidCare fee-for-service beneficiaries.

1. The contractual agreement or formal, written arrangement shall indicate the physician's responsibilities and compensation.

(i) The size of the clinic and the type of services it provides determines the number of physicians that must be affiliated with the clinic.

(j) The clinic's medical staff, including physicians, dentists, and other practitioners, shall be appropriately licensed in order to provide the medical care delivered to Medicaid and NJ KidCare fee-for-service beneficiaries.

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.

10:66-1.4 Prior authorization

(a) In addition to N.J.A.C. 10:49-6.1, this section outlines prior authorization requirements for dental, mental health, rehabilitative, and vision care services, in (b), (c), (d) and (e) below, respectively. Prior authorization requirements by the Physician Case Manager for persons participating in managed health care programs are located at N.J.A.C. 10:49-21.4(c).

(b) Dental services require prior authorization as indicated in the New Jersey Medicaid and NJ KidCare fee-for-service programs' Dental Services chapter, N.J.A.C. 10:56.

(c) Mental health services provided to each Medicaid/NJ FamilyCare beneficiary require prior authorization when payment to an independent clinic exceeds \$6,000 for that

Medicaid/NJ FamilyCare beneficiary in any 12-month period, commencing with the beneficiary's initial visit.

1. The maximum period of authorization is up to 12 months for all mental health services. Additional authorizations may be requested.

2. When requesting prior authorization, Forms FD-07 and FD-07A, "Request for Authorization of Mental Health Services and/or Mental Health Rehabilitation Services" and "Request for Prior Authorization: Supplemental Information," shall be completed and forwarded to: the Medical Assistance Customer Center (MACC) that serves the county in which the services are rendered. See the Fiscal Agent Billing Supplement, N.J.A.C. 10:66-Appendix, for instructions on the completion of the prior authorization forms.

3. The "Brief Clinical History" and "Present Clinical Status" sections of the FD-07A "Request for Prior Authorization: Supplemental Information" form are particularly important and must provide sufficient medical information to justify and support the proposed treatment request. Failure to comply may result in a reduction or denial of requested services.

4. A departure from the plan of care requires a new request for prior authorization when a change in the beneficiary's clinical condition necessitates an increase in the frequency and intensity of services, or change in the type of services which exceeds the cost of the services authorized.

5. Similarly, a new request for authorization is required for a medical/remedial therapy session or encounter that departs from the plan of care in terms of increased need, scheduling, frequency, or duration of services furnished (for example, unscheduled emergency services furnished during an acute psychotic episode).

6. If the request for prior authorization is approved, the Division's fiscal agent shall notify the provider in writing regarding the Division's decision; authorized date or time frame; and activation of the prior authorization number. If the request is modified, denied, or if the Division requires additional information, the provider is so notified in writing by the fiscal agent.

(d) Rehabilitative services require prior authorization from the appropriate Medicaid District Office (MDO) after the initial evaluation visit.

1. When requesting prior authorization or reauthorization, Form FD-06, Request for Prior Authorization for Rehabilitative Services, shall be completed and forwarded to the beneficiary's respective MDO. See the Fiscal Agent Billing Supplement for instructions on the completion of the prior authorization form.

2. Authorization shall be considered only when the request includes a written prescription from a licensed physician.

3. The prescription shall substantiate the need, type of treatment, objective of treatment, and an estimate of the number of treatment days.

4. The prescription shall be definitive as to type and scope. A prescription for "Physical therapy three times a week" is not acceptable.

5. The maximum period of authorization is 60 days.

i. Reauthorizations for periods not exceeding 60 days may be approved by the MDO when the request is supported by:

- (1) The physician's written prescription;
- (2) A statement of the anticipated number of treatments required; and
- (3) A progress report of the beneficiary's condition.

6. If the request for prior authorization is approved, the Division's fiscal agent shall notify the provider in writing regarding the Division's decision; authorized date or time frame; and activation of the prior authorization number. If the request is modified, denied, or if the Division requires additional information, the provider is so notified in writing by the fiscal agent.

(e) Vision care services require prior authorization as indicated in the New Jersey Medicaid and NJ KidCare fee-for-service programs' Vision Care Services chapter, N.J.A.C. 10:62.

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; and in (a), changed N.J.A.C. reference.

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

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

In (c), substituted references to NJ FamilyCare for references to NJ KidCare fee-for-service in the introductory paragraph, rewrote 2, and substituted "FD-07A "Request for Prior Authorization: Supplemental Information" " for "prior authorization" in 3.

10:66-1.5 Basis for reimbursement

(a) Except as indicated at (c) through (e) below, reimbursement to independent clinics is in accordance with the maximum fee schedule indicated at N.J.A.C. 10:66-6.2 and is based on the same fees, conditions, and definitions for corresponding services governing the reimbursement of Medicaid-participating and NJ KidCare fee-for-service-participating practitioners in "private" (independent) practice. Reimbursement is made directly to the clinic.

1. An independent clinic shall make a charge for services to all patients, except as provided by legislation, with the proviso that no charge will be made directly to the Medicaid or NJ KidCare-Plan A or B fee-for-service patient, and the charge to the New Jersey Medicaid and NJ KidCare fee-for-service programs may not exceed the charge by the clinic for identical services to other groups or individuals in the community.

(b) The HCPCS procedure code system, N.J.A.C. 10:66-6, contains procedure codes and maximum fee allowances corresponding to Medicaid-reimbursable and NJ KidCare fee-for-service-reimbursable services. An independent clinic may claim reimbursement for only those HCPCS procedure codes that correspond to the allowable services included in the clinic's provider enrollment approval letter, as indicated at N.J.A.C. 10:66-1.3(a).

1. If a HCPCS procedure code(s), approved for use by a specific clinic, is assigned both a specialist and non-specialist maximum fee allowance, the amount of the reimbursement will be based upon the status (specialist or non-specialist) of the individual practitioner who actually provided the billed service. To identify this practitioner enter the Medicaid and NJ KidCare fee-for-service Provider Services Number in the appropriate section of the claim, as indicated in the Fiscal Agent Billing Supplement, N.J.A.C. 10:66-Appendix.

(c) The basis for reimbursement of services provided in an ambulatory surgical center (ASC) is as follows:

1. Reimbursement shall be made for services rendered by both the ASC facility and the attending physician, if the physician is not reimbursed for surgical/medical services by the facility.

2. For facility reimbursement, surgical procedures performed in an ASC are separated into an eight-group classification system as designated at 42 CFR 416.65(c), the Federal regulations governing ASC services.

i. A single payment is made to an ASC which encompasses all facility services furnished by the ASC in connection with a covered procedure performed on a patient in a single operative session.

ii. If more than one covered surgical procedure is performed on a patient during a single operative session, payment is limited to two procedures, provided that the two procedures are performed at separate operative body sites.

(1) Full payment shall be made for the procedure with the highest Medicaid or NJ KidCare fee-for-service reimbursement allowance. Payment for the other procedure shall be at 50 percent of the applicable reimbursement allowance for that procedure. Total reimbursement may not exceed 150 percent of the primary procedure allowance.

iii. The ASC facility payment for all procedures in each group is established at a single rate, as follows:

Group	Maximum Fee Allowance
1	\$195.00
2	\$261.00
3	\$300.00
4	\$369.00
5	\$421.00

Group	Maximum Fee Allowance
6	\$541.00
7	\$585.00
8	\$627.00

Note: Should the Health Care Financing Administration (HCFA) amend the group designation for any procedure(s), the maximum fee allowance for the newly designated group shall apply and shall not be construed as a fee increase/decrease to the affected procedure(s).

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 FamilyCare 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 FamilyCare program or its agents.

(i) When requesting reimbursement for the following HCPCS procedure codes for rehabilitative services, a separate service line shall be completed for each day that the service is provided. Providers shall not "span bill" for services.

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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. Amended by R.2003 d.69, effective February 3, 2003.

See: 34 N.J.R. 3183(a), 35 N.J.R. 888(a).

In (b) and (h)2, substituted "NJ FamilyCare" for "NJ KidCare"; added (i).

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

(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
				S	NS	
*N	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	Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes. Basic Units
				S	NS						S	NS	
	93000			16.00	16.00		L	W9334	52		2.50	2.50	
N	99150			45.00	40.00		L	W9335			62.09	62.09	
				Per Hour	Per Hour		L	W9335	52		2.50	2.50	
N	99151			45.00	40.00		L	W9338			30.27	30.27	
				Per Hour	Per Hour		L	W9338	52		2.50	2.50	
	99173			5.00	5.00			W9820			23.00	18.00	
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						200.00	170.00	
N	99243			44.00	NA						1.80	1.80	
N	99244			62.00	NA		N	55250		30	90.00	79.00	3
N	99245			62.00	NA		N	55450		30	42.00	37.00	3
N	99251			44.00	NA			56820	WF		88.00	NA	
N	99252			44.00	NA			56821	WF		113.00	NA	
N	99253			44.00	NA			57420	WF		71.00	NA	
N	99254			62.00	NA			57421	WF		93.00	NA	
N	99255			62.00	NA		N	57451		45	182.00	158.00	6
	99261			16.00	14.00			58301			16.40	16.40	
	99262			16.00	14.00			58301	WM		NA	16.40	
	99263			16.00	14.00		N	58600		45	211.00	184.00	6
N	99271			44.00	NA		N	58605		45	151.00	131.00	6
N	99272			44.00	NA		N	58982		45	182.00	158.00	6
N	99273			44.00	NA		N	58983		45	182.00	158.00	6
N	99274			62.00	NA			88150			6.00	6.00	
N	99274	YY		50.00	NA			88151			6.00	6.00	
N	99274	ZZ		50.00	NA			88155			6.00	6.00	
N	99275			62.00	NA		N	99201	WF		45.00	45.00	
N	99291			45.00	40.00		N	99201	WFWM		NA	31.50	
N	99292			22.50	20.00		N	99202	WF		45.00	45.00	
	99382			22.00	17.00		N	99202	WFWM		NA	31.50	
	99383			22.00	17.00		N	99203	WF		45.00	45.00	
	*99384			22.00	17.00		N	99203	WFWM		NA	31.50	
	*99385			22.00	17.00		N	99204	WF		45.00	45.00	
	*99386			22.00	17.00		N	99204	WFWM		NA	31.50	
	*99387			22.00	17.00		N	99205	WF		45.00	45.00	
	99391			16.00	14.00		N	99205	WFWM		NA	31.50	
	99392			22.00	17.00		N	99211	WF		7.60	7.60	
	99393			22.00	17.00		N	99211	WFWM		NA	5.35	
	*99394			22.00	17.00		N	99212	WF		7.60	7.60	
	*99395			22.00	17.00		N	99212	WFWM		NA	5.35	
	99396			22.00	17.00		N	99213	WF		7.60	7.60	
	99397			22.00	17.00		N	99213	WFWM		NA	5.35	
	J2790			20.40	20.40		N	99214	WF		23.00	23.00	
	J2790	22		72.07	72.07		N	99214	WFWM		NA	16.40	
L	W9050			27.00	NA		N	99215	WF		23.00	23.00	
L	W9055			27.00	23.00		N	99215	WFWM		NA	16.40	
L	W9060	WT		23.00	18.00		N	99395	WF		45.00	45.00	
L	W9061	WT		23.00	18.00		N	99395	WFWM		NA	31.50	
L	W9062	WT		23.00	18.00		L	W0001	WF		188.00	188.00	
L	W9063	WT		23.00	18.00		L	W0001	WFWM		NA	177.00	
L	W9064	WT		23.00	18.00		L	W0002	WF		123.00	123.00	
L	W9065	WT		23.00	18.00		L	W0002	WFWM		NA	112.00	
L	W9066	WT		23.00	18.00		L	W0004	WF		204.00	204.00	
L	W9067	WT		23.00	18.00		L	W0004	WFWM		NA	188.00	
L	W9068	WT		23.00	18.00		L	W0008	WF		139.00	139.00	
L	W9096			17.46	17.46		L	W0008	WFWM		NA	123.00	
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								

(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
N	11976		90	100.00		85.00
N	11977	22	90	Direct	package plus	price
				200.00		170.00
	36416	WF		1.80		1.80
N	55250		30	90.00		79.00
N	55450		30	42.00		37.00
	56820	WF		88.00		NA
	56821	WF		113.00		NA
	57420	WF		71.00		NA
	57421	WF		93.00		NA
N	57451		45	182.00		158.00
	58301			16.40		16.40
	58301	WM		NA		16.40
N	58600		45	211.00		184.00
N	58605		45	151.00		131.00
N	58982		45	182.00		158.00
N	58983		45	182.00		158.00
	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

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

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
				\$	\$	NS	
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	
	90862	ZI		4.50		4.50	
	90870	ZI		32.00		26.00	
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
	59510		45	598.00		516.00	7
	59515		45	450.00		385.00	7
	59525		45	362.00		308.00	8
	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	
	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		

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	
	70200				25.00			N	74241				45.00		
	70210				20.00			N	74245				50.00		
	70220				25.00			N	74250				30.00		
	70240				15.00				74270				30.00		
	70250				15.00				74280				40.00		
	70260				25.00				74290				35.00		
	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			N							
	73070				15.00			N							
	73080				15.00			N							
	73085				15.00			N							
	73090				10.00			N							
	73092				20.00										
	73100				10.00			N							
	73110				15.00										
	73115				15.00										
	73120				10.00			N							
	73130				15.00			L							
	73140				5.00			L							
N	73500				18.00			L							
N	73510				20.00			L							
	73520				25.00			L							
	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			LN							
	73615				15.00			LN							
	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										

(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
	H5300				7.00		7.00
	Z0270				7.00		7.00
	Z0280				7.00		7.00
	Z0300				7.00		7.00
	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	Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
				S	\$	NS						S	\$	NS	
*LN	Z1830			3.50		3.50		L	Z1605	ZI		10.23		10.23	
*LN	Z1831			4.50		4.50		L	Z1610	ZI		35.00		35.00	
*LN	Z1832			24.00		24.00		L	Z1611	ZI		6.51		6.51	
*LN	Z1833			12.00		12.00		L	Z1612	ZI		5.12		5.12	
*LN	Z1834			30.00		30.00		L	Z1613	ZI		35.00		35.00	
*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									

(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	

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	
	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.

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.

(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.

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

W9096

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 Haemonphilus 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>\$</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>\$</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>\$</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				