

CHAPTER 58A**CERTIFIED NURSE PRACTITIONER/CLINICAL
NURSE SPECIALIST****Authority**

N.J.S.A. 45:11-23 et seq.; N.J.A.C. 13:37; P.L. 1991, c. 377; N.J.S.A. 30:4D-6b(17), 7a, b and c; 30:4D-12; 1905(a)21 of the Social Security Act, 42 U.S.C. 1396d(a).

Source and Effective Date

R.1995 d.501, effective September 5, 1995.
See: 27 N.J.R. 2158(a), 27 N.J.R. 3343(a).

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Chapter 58A, Certified Nurse Practitioner/Clinical Nurse Specialist, expires on September 5, 2000.

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APPENDIX. FISCAL AGENT BILLING SUPPLEMENT**SUBCHAPTER 1. GENERAL PROVISIONS****10:58A-1.1 Introduction: certified nurse practitioner and
clinical nurse specialist**

(a) This chapter is concerned with the provision of health care services by certified nurse practitioners and clinical nurse specialists (CNP/CNS), in accordance with the New Jersey Medicaid Program policies and procedures and the standards set forth by the New Jersey Legislature (N.J.S.A. 45:11-23 et al. and P.L. 1991, c.377) and by the New Jersey Board of Nursing (N.J.A.C. 13:37-7).

(b) An approved New Jersey Medicaid CNP/CNS provider may be reimbursed for medically necessary covered services provided within the scope of her or his license, and her or his approved New Jersey Medicaid Program Provider Agreement.

(c) A CNP/CNS may enroll in the New Jersey Medicaid program and provide covered, medically necessary services as an independent practitioner, or may provide such services as part of another entity, such as a hospital or clinic, physician group practice, or a mixed practitioner practice.

10:58A-1.2 Definitions

The following words and terms, as used in this chapter, shall have the following meanings, unless the context clearly 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, 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.

“Certified nurse practitioner/clinical nurse specialist (CNP/CNS)” means a person currently licensed to practice as a registered professional nurse who is certified by the New Jersey State Board of Nursing in accordance with N.J.A.C. 13:37-7, and with N.J.S.A. 45:11-49a through d, for

similarly licensed and certified by a comparable agency of the state in which he or she practices.

“Certified nurse practitioner/clinical nurse specialist (CNP/CNS) services” means those services provided within the scope of practice of a licensed professional nurse (R.N.) and the certification as a CNP or CNS, defined by the laws and rules of the State of New Jersey, or if in practice in another state, by the laws and regulations of that state.

“Concurrent care” means care rendered to a patient by more than one practitioner/physician where the dictates of medical necessity require the services of one or more clinicians in addition to the attending clinician, so that appropriate and needed care may be provided to the patient.

“Consultation” means the professional evaluation of a patient from a perspective different from that of the treating practitioner, in order to bring enhanced clinical expertise for the benefit of the patient.

“Discipline” means a branch of instruction or learning, such as medicine, dentistry, advanced practice nursing, or chiropractic.

“Early and Periodic Screening, Diagnosis and Treatment (EPSDT)” means a preventive and comprehensive health program for Medicaid recipients through 20 years of age, including the assessment of an individual’s care needs through initial and periodic examinations (screenings), the provision of health education and guidance, and the assurance that any identified health problems are diagnosed and treated at the earliest possible time.

“Federally Qualified Health Center (FQHC)” means an entity that is receiving a grant under Section 329, 330, or 340 of the Public Health Service Act, section 1905(l) of the Social Security Act, 42 U.S.C. § 1396(l); 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.

“HealthStart” means the program of health services provided to pregnant women, infants and small children, as defined at N.J.A.C. 10:49-1.4, Administration, and at N.J.A.C. 10:58A-3.

“HealthStart Maternity Care Services” means a comprehensive package of maternity care services which includes two components, “Medical Maternity Care” and “Health Support Services.” (See N.J.A.C. 10:58A-3 for information about HealthStart Services and provider requirements for participation.)

“HealthStart Maternity (Comprehensive) Care Services Provider” means a practitioner who provides HealthStart Maternity Care services either directly, or indirectly through linkage with other practitioners, in independent clinics, hospital outpatient departments, or physicians’ offices.

“HealthStart pediatric care provider” means a group of practitioners, a hospital, an independent clinic, or practitioner approved by the New Jersey State Department of Health and the New Jersey Medicaid program to provide a comprehensive package of pediatric care services.

“Independent clinic” means a facility that is not part of a hospital, but is organized and operated in accordance with N.J.A.C. 10:66-1.1 and 42 C.F.R. 440.90.

“Mental health clinic” means a freestanding independent community facility or distinct component of a multi-service ambulatory care facility, which meets the minimum standards established by the Community Mental Health Services Act implementing rules at N.J.A.C. 10:37.

“Mental illness”, for purposes of PASARR, refers to a condition which can be disabling and/or chronic, such as schizophrenia, mood disorder, paranoia, panic or other severe anxiety disorder, as described in the *International Classification of Diseases, Ninth Revision (ICD-9(M))*, and which can lead to a chronic disability. (See PASARR, N.J.A.C. 10:58A-2.9.)

“Physician” means a doctor of medicine (M.D.) or osteopathy (D.O.) licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners or similarly licensed by a comparable agency of the state in which he or she practices.

“Practitioner” refers to a certified nurse practitioner/clinical nurse specialist (CNP/CNS) as defined by this rule. Practitioners are responsible for examining, diagnosing, treating and counseling patients, and ordering medications, within their specific scope of practice, as defined by the New Jersey Board of Nursing. On occasion, this chapter defines procedures which are provided by CNP/CNSs and by physicians; in these instances, the term “practitioner/physician” is used.

“Pre-Admission Screening and Annual Resident Review (PASARR)” means an evaluation or screening to assess potential or actual nursing facility (NF) residents in respect to mental illness and/or mental retardation, in order to assure that the resident is provided with appropriate services, and to ensure that the NF admits residents whose needs can be met by the services normally provided by the facility.

“Specialty” means a health care practice within a discipline such as pediatrics, obstetrics/gynecology, orthodontics or periodontics. A list of the specializations applicable to CNP/CNSs can be found at N.J.A.C. 10:58A-1.3(e).

10:58A-1.3 Provider participation

(a) In order to participate in the Medicaid program as a CNP/CNS practitioner, the CNP/CNS shall apply to, and be approved by, the New Jersey Medicaid program. Application for approval by the New Jersey Medicaid program as a certified nurse practitioner (CNP) or a clinical nurse specialist (CNS) requires completion and submission of the "Medicaid Provider Application" (FD-20) and the "Medicaid Provider Agreement" (FD-62).

The FD-20 and FD-62 are located as Forms #8 and #9 in the Appendix at the end of the Administration Chapter (N.J.A.C. 10:49), and may be obtained from and submitted to:

Unisys Corporation
 Provider Enrollment
 CN 4804
 Trenton, New Jersey 08650-4804

(b) In order to be approved as a Medicaid participating provider, the CNP/CNS shall be a registered professional nurse and have a current certification as a CNP or CNS, pursuant to N.J.A.C. 13:37-7.

(1) An out-of-State CNP/CNS shall have comparable documentation under the applicable state requirements of the state in which the services are provided.

(c) An applicant shall provide a photocopy of the current license and current certification at the time of the application for enrollment.

(d) In addition to the requirements specified in (a)-(c) above, the following requirements shall be met, in accordance with Federal requirements (HCFA State Medicaid Manual, Section 4415, "Nurse Practitioner Services").

1. In order to participate in the Medicaid program as a certified pediatric nurse practitioner, a pediatric nurse practitioner shall be licensed at the time of participation in accordance with the standards for pediatric nurse practitioner established by the New Jersey Board of Nursing, N.J.A.C. 13:37-7.

2. In order to participate in the Medicaid program as a certified family nurse practitioner, a family nurse practitioner shall be licensed at the time of participation in accordance with the standards for family practice nurse practitioner established by the New Jersey Board of Nursing, N.J.A.C. 13:37-7.

(e) Additional areas of specialization recognized by the New Jersey Board of Nursing currently include:

1. Adult Health;
2. Family;
3. Pediatric;
4. School;

5. Gerontological;
6. Women's Health;
7. OB/GYN;
8. Neonatal;
9. Psychiatric/Mental Health;
10. Community Health;
11. Perinatal;
12. Maternity/Child; and
13. Oncology.

(f) Upon signing and returning the Medicaid Provider Application, the Provider Agreement and other enrollment documents to Unisys, the fiscal agent for the New Jersey Medicaid program, the certified nurse practitioner/clinical nurse specialist will receive written notification of approval or disapproval. If approved, the CNP/CNS will be assigned a provider identifier number. Unisys will furnish the provider identifier number, provider number, and will provide an initial supply of pre-printed claim forms.

(g) In order to participate as a provider of HealthStart services, the CNP/CNS practicing independently or as part of a group shall be a Medicaid provider, and shall meet the HealthStart requirements as specified at N.J.A.C. 10:66-3, and at N.J.A.C. 10:58A-3, including the provider participation criteria specified in N.J.A.C. 10:58A-3.3. The CNP/CNS shall also possess a HealthStart Certificate, issued by the New Jersey Department of Health.

(h) A HealthStart provider shall have a valid HealthStart Provider Certificate. An application for a HealthStart Provider Certificate is available from:

The New Jersey Department of Health
 Division of Family Health Services
 50 East State Street, CN 364
 Trenton, N.J. 08625-0364

10:58A-1.4 Recordkeeping

(a) The certified nurse practitioner/clinical nurse specialist, in any and all settings, shall keep such legible individual records as are necessary to fully disclose the kind and extent of service(s) provided, the procedure code being billed, and the medical necessity for those services.

(b) Documentation of services performed by the CNP/CNS shall include, as a minimum:

1. The date of service;
2. The name of the patient;
3. The patient complaint, reason for visit;
4. Subjective findings;
5. Objective findings;

6. An assessment;
7. A plan of care, including, but not limited to, any orders for laboratory work, prescriptions for medications;
8. The signature of practitioner rendering the service; and
9. Other documentation appropriate to the procedure code being billed. (See N.J.A.C. 10:58A-4, HCPCS Codes.)

(c) In order to receive reimbursement for an initial visit, the following documentation, at a minimum, shall be placed on the record by the CNP/CNS, regardless of the setting where the examination was performed:

1. Chief complaint(s);
2. A complete history of the present illness and related systemic review-including recordings of pertinent negative findings;
3. Pertinent past medical history;
4. Pertinent family history;
5. A full physical examination pertaining to, but not limited to, the history of the present illness which includes recording of pertinent negative findings; and
6. Working diagnoses and treatment plan including ancillary services and drugs ordered.

(d) Written records in substantiation of the use of a given procedure code shall be available for review and/or inspection if requested by the New Jersey Medicaid program.

(e) Further discussion of the extent of documentation requirements can be found at N.J.A.C. 10:49-9.4, 9.5 and 9.6.

(f) Records, and the documentation of visits to patients in residential health care facilities, shall be maintained in the provider's office record. Residential health care facility records, as specified in (c) above, shall be part of the office records.

(g) In order to document the record for reimbursement purposes, the progress note for routine office visits or follow up care visits shall include the following:

1. In an office, or residential health care facility:
 - i. The purpose of the visit;
 - ii. Pertinent history obtained;
 - iii. Pertinent physical findings, including pertinent negative physical findings based on (g)1i and ii above;
 - iv. Procedures, if any, with results;
 - v. Lab, X-ray, EKG, or any other test ordered, with results; and
 - vi. A diagnosis.

2. In a hospital or nursing facility setting:
 - i. An update of symptoms;
 - ii. An update of physical symptoms;
 - iii. A resume of findings of procedures, if any done;
 - iv. Pertinent positive and negative findings of lab, X-ray or any other test;
 - v. Additional planned studies, if any, and the reason for the studies; and
 - vi. Treatment changes, if any.

(h) To qualify as documentation that the service was rendered by the practitioner during an inpatient stay, the medical record shall contain the CNP/CNS's notes indicating that the practitioner 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.

(i) The CNP/CNS's involvement shall be clearly demonstrated in notes reflecting the practitioner's personal involvement with, or participation in, the service rendered.

(j) An annual health maintenance examination for individuals under 21 years of age, shall be performed and documented in the recipient's record and shall include:

1. A history (complete initial for new patient, interval for established patient) including past medical history, family history, social history, and systemic review;
2. A developmental and nutritional assessment.
3. A complete, unclothed, physical examination to include also the following:
 - i. Measurements: height and weight; head circumference to 25 months; blood pressure for children age three or older; and
 - ii. Vision and hearing screening;
4. The assessment and administration of immunizations appropriate for age and need;
5. Provisions for further diagnosis, treatment and follow-up, by referral if necessary, of all correctable abnormalities uncovered or suspected;
6. Referral to a dentist for children age three or older;
7. The laboratory procedures performed or referred if medically necessary. Recommendations for procedure are as follows:

i. Hemoglobin/Hematocrit three times: six to eight months; two to three or four to six years; and 10 to 12 years.

ii. Urinalysis a minimum of twice: 18 to 24 months and 13 to 15 years.

iii. Tuberculin test (Mantoux): nine to 12 months; and annually thereafter.

iv. Lead screening using blood lead level determinations between six and 12 months, at two years of age, and annually up to six years of age. At all other visits, screening shall consist of verbal risk assessment and blood lead level test, as indicated; and

v. Other appropriate screening procedures, if medically necessary (for example: blood cholesterol, test for ova and parasites, STD).

8. Health education and anticipatory guidance; and

9. An offer of social service assistance; and, if requested, referral to a county welfare agency.

(k) The record and documentation of a Home Visit or House Call shall become part of the office progress notes and shall include, as appropriate, the following information:

1. The purpose of visit;

2. Pertinent history obtained;

3. Pertinent physical findings, including pertinent negative physical findings based on (k)1 and 2;

4. The procedures, if any performed, with results;

5. Lab, X-ray, ECG, etc., ordered with results; and

6. Diagnosis(es) plus treatment plan status relative to present or pre-existing illness(es) plus pertinent recommendations and actions.

10:58A-1.5 Basis of reimbursement

(a) A claim is a request for payment for a Medicaid-reimbursable or NJ KidCare-reimbursable service provided to a Medicaid eligible or NJ KidCare-eligible individual. The claim may be submitted via hard copy or by means of an approved method of automated data exchange.

(b) An approved New Jersey Medicaid or NJ KidCare CNP/CNS provider (see N.J.A.C. 10:58A-1.3, Provisions for participation) shall be reimbursed on a fee-for-service basis in accordance with N.J.A.C. 10:58A-4. Reimbursement shall be limited to payment for medically necessary covered services provided within the appropriate scope of practice in accordance with the individual category of certification for advanced practice. The applicable categories of advanced practice are defined by the New Jersey State Board of Nursing in N.J.A.C. 13:37-7.11 as further amended.

(c) CNP/CNS services may be reimbursed (see N.J.A.C. 10:49-7 and 10:49-8) under either of two billing mecha-

nisms provided by Medicaid or NJ KidCare for reimbursement of his or her services. The two mechanisms are: a direct billing entity as stated in this chapter, or an employee reimbursed by another Medicaid or NJ KidCare provider who bills Medicaid or NJ KidCare on behalf of the CNP/CNS's services, that is physician employer, group, clinic or hospital.

1. When a CNP/CNS is employed by a practitioner/physician group, the Medicaid or NJ KidCare program does not routinely reimburse both a CNP/CNS visit and, on the same day, a visit to an MD or DO within the same billing entity.

i. If specific circumstances should require the two same-day visits, however, the provider entity shall document the medical necessity for the second visit (see concurrent care in (a)2 below).

ii. If a patient receives care from more than one member of a group practice, a partnership or corporation in the same specialty, the total maximum fee allowance shall be the same as that for a single practitioner.

2. Concurrent care will be reimbursed under the following circumstances:

i. If concurrent care is provided, it shall be clearly documented that significant medical necessity exists for more than one clinician's services, as defined at N.J.A.C. 10:58A-1.2; and

ii. At such time as the patient's condition permits, the primary practitioner/physician shall either resume sole responsibility or transfer the patient to the practitioner/physician supplying additional (concurrent) care.

3. A nurse practitioner and her or his collaborating physician shall not bill for concurrent care except when the concurrent care is necessary for admitting a patient for inpatient hospital care, treating a medical emergency, or arranging for prescriptions for controlled drugs. Such concurrent care is normally limited to a single visit.

4. A CNP/CNS-initiated consultation to another health care professional, excluding another CNP/CNS, will be allowed under the following conditions:

i. Where a medical condition requires evaluation from more than one perspective, discipline or specialty;

ii. Where significant medical necessity exists; and

iii. Where, subsequent to the consultation, the primary practitioner will either resume sole responsibility or transfer the patient to the consultant.

5. When Division review of the documentation of a consultation fails to demonstrate medical necessity, reimbursement will be denied to the physician rendering the consultation.

6. A collaborating physician shall not bill for a consultation for the patient of the CNP/CNS. When it becomes necessary to admit a patient for inpatient hospital care, or to prescribe controlled drugs, the collaborating physician may bill for concurrent care. Such concurrent care is limited to a single visit for each episode.

(d) A CNP/CNS shall not be reimbursed as an independent provider by the New Jersey Medicaid program when the program is required to reimburse an approved provider through another mechanism for these same services, for example, a hospital or home health agency-salaried CNP/CNS whose salary is included in the Medicaid rate.

1. If a CNS/CNP is employed by a physician, a physician group, another practitioner or practitioner group, a hospital, an independent clinic or other similar health care entity who is a Medicaid provider, the CNP/CNS is referred to Physician Services (N.J.A.C. 10:54) or Hospital Services (N.J.A.C. 10:52), or Independent Clinic Services (N.J.A.C. 10:66) for regulations and billing instructions.

i. Practitioners rendering services in clinics cannot bill fee-for-service. The clinic must bill for all services rendered in the clinic setting.

(e) When billing, a CNP/CNS shall use her or his Medicaid Provider Servicing Number (MPSN) to identify each service she or he has performed as separate and distinct from services of any other provider.

(f) CNP/CNS providers shall certify that they have personally rendered any services for which they have billed.

(g) Payment for CNP/CNS services covered under the New Jersey Medicaid program is based upon the customary charge prevailing in the community for the same service but shall not exceed the "Maximum Fee Allowance Schedule" specified in N.J.A.C. 10:58-4. In no event shall the charge to the New Jersey Medicaid program exceed the charge by the provider for identical services to other individuals, groups or governmental agencies.

1. A CNP/CNS billing independently receives direct payment from Medicaid for his or her services under the provisions of this chapter. Reimbursement is on a fee-for-service basis.

2. The submittal and processing of claims requires the entry of two numbers on the claim form: the Medicaid Provider Billing Number and the Medicaid Provider Servicing Number.

i. The Medicaid Provider Billing Number and Servicing Numbers are identical when the CNP/CNS is a solo practitioner who bills Medicaid directly for his or her services. The single number is entered on the claim form as the provider billing number and the identifier of the practitioner who rendered the service.

ii. If the CNP/CNS is a member of a CNP/CNS practitioner group, the number assigned to the practitioner group will be the Medicaid Provider Billing Number. The number assigned to the CNP/CNS practitioner will be the Medicaid Provider Servicing Number. (See Fiscal Agent Billing Supplement for instructions for filling out the claim form.)

iii. When an employer of the practitioner (such as a physician, independent clinic, or similar health care organization) bills on behalf of the services rendered by a CNP/CNS practitioner, the Medicaid Provider Billing Number is the number of the employer. The identifier of the CNP/CNS practitioner rendering the service will be the Medicaid Provider Servicing Number.

(h) Reimbursement is not made for, and clients may not be asked to pay for, broken appointments.

Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).

In (a) through (c), inserted references to NJ KidCare throughout.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 without change.

10:58A-1.6 Personal contribution to care requirements for NJ KidCare-Plan C and copayments for NJ KidCare-Plan D

(a) General policies regarding the collection of personal contribution to care for or NJ KidCare-Plan C and copayments for NJ KidCare-Plan D fee-for-service are set forth in N.J.A.C. 10:49-9.

(b) Personal contribution to care for NJ KidCare-Plan C services is \$5.00 a visit for office visits, except as noted in (c) below.

1. An office visit is defined as a face-to-face contact with a medical professional, which meets the documentation requirements at N.J.A.C. 10:58A-1.4.

2. Office visits include CNP/CNS services provided in the office, patient's home, or any other site, except a hospital, where the child may have been examined by the CNP/CNS. Generally, these procedure codes are in the 90000 HCPCS series of reimbursable codes at N.J.A.C. 10:58A-4.

3. CNP/CNS services which do not meet the requirements of an office visit as defined in this chapter, such as surgical services, immunizations, laboratory or x-ray services, do not require a personal contribution to care.

(c) CNPs/CNSs shall not charge a personal contribution to care for services provided to newborns, who are covered under fee-for-service for Plan C; for family planning services, for substance abuse treatment services, for prenatal care or for preventive services, including appropriate immunizations.

(d) The copayment for CNS/CNP services under NJ KidCare-Plan D shall be \$5.00 per office visit;

1. A \$10.00 copayment shall apply for services rendered during non-office hours and for home visits.

2. The \$5.00 copayment shall apply only to the first prenatal visit.

(e) CNPs/CNSs are required to collect the copayment specified in (d) above except as provided in (f) below. Copayments shall not be waived.

(f) CNPs/CNSs shall not charge a copayment for services provided to newborns, who are covered under fee-for-service for Plan D or for preventive services, including well child visits, lead screenings and treatment, and age-appropriate immunizations.

New Rule, R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

See: 30 N.J.R. 1060(a).

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998. See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 with changes, effective September 21, 1998.

Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).

See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).

In (a), added reference to copayments for NJ KidCare-Plan D; added (d) through (f).

SUBCHAPTER 2. PROVISION OF SERVICES

10:58A-2.1 General provisions

(a) This subchapter describes the New Jersey Medicaid programs' policies and procedures for the provision of Medicaid-covered services by certified nurse practitioner/clinical nurse specialist providers. Services are separately identified and discussed only where unique characteristics or requirements exist. Unless indicated otherwise, reimbursement provisions are located in N.J.A.C. 10:58A-1.5, Basis for reimbursement.

(b) The New Jersey Medicaid program shall reimburse for CNP/CNS services provided only when the patient is an eligible Medicaid client at the time services are rendered. CNP/CNSs shall verify the patient's current eligibility status prior to providing services.

10:58A-2.2 Provisions concerning medical services

(a) For patient contacts where the patient presents with a chief complaint, the evaluation and management procedure codes at N.J.A.C. 10:58A-4.2(r)1 through 6 shall be applied.

(b) In the absence of patient complaints, the Preventive Medicine services codes and the Newborn Care code shall be applied for adults and for children. See N.J.A.C. 10:58A-4.2(r)7 and 8.

10:58A-2.3 Surgical procedures

(a) Typically, office visits are not reimbursed in combination with surgical procedures. (When two services are rendered, for example, an office visit and a surgical procedure, the program will pay the higher fee, either the visit or the procedure.) The procedure codes within the CNP/CNS scope of practice which are excluded from the general policy are: 29105 AV through 29740 AV (see N.J.A.C. 10:58A-4.2(d), (e) and (f)), 31720 AV, 36415 AV, 57150 AV and 59025 AV.

Amended by R.2000 d.144, effective April 3, 2000.

See: 31 N.J.R. 3968(a), 32 N.J.R. 1208(a).

In (a), changed excluded procedure codes references.

10:58A-2.4 Pharmaceutical services

(a) All covered pharmaceutical services provided by CNP/CNSs under the New Jersey Medicaid program shall be prescribed in accordance with N.J.A.C. 13:37-7.6 and 7.7; N.J.A.C. 10:49, N.J.A.C. 10:51, and this chapter.

(b) The Pharmaceutical Services manual, N.J.A.C. 10:51, sets forth the provisions for covered and non-covered pharmaceutical services, prior authorization, quantity of medication, administration of drugs, pharmaceutical dosage and directions, telephone-rendered original prescriptions, changes or additions to the original prescription, non-proprietary or generic dispensing, and prescription refill.

(c) Medicaid will reimburse the practitioner directly for the cost of the drugs described at N.J.A.C. 10:58A-4.3 and 4.4.

Amended by R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).

See: 31 N.J.R. 245(a), 31 N.J.R. 1956(a).

10:58A-2.5 Medical exception process (MEP)

(a) For pharmacy claims with service dates on or after September 1, 1999, which exceed PDUR standards recommended by the New Jersey DUR Board and approved by the Commissioners of DHS and DHSS, the Division of Medical Assistance and Health Services has established a Medical Exception Process (MEP).

(b) The medical exception process (MEP) shall be administered by a contractor, referred to as the MEP contractor, under contract with the Department of Human Services.

(c) The medical exception process shall apply to all pharmacy claims, regardless of claim media, unless there is a recommended exemption by the New Jersey DUR Board which has been approved by the Commissioners of DHS and DHSS, in accordance with the rules of those Departments.

(d) The medical exception process is as follows:

1. The MEP contractor shall contact prescribers of conflicting drug therapies, or drug therapies which exceed established PDUR standards, to request written justifica-

tion to determine medical necessity for continued drug utilization.

i. The MEP contractor shall send a Prescriber Notification Letter which includes, but may not be limited to, the beneficiary name, HSP identification number, dispense date, drug quantity, drug description. The prescriber shall be requested to provide the reason for medical exception, diagnosis, expected duration of therapy, and expiration date for medical exception.

ii. The prescriber shall provide information requested on the Prescriber Notification to the MEP contractor.

2. Following review and approval of a prescriber's written justification, if appropriate, the MEP contractor shall override existing PDUR edits through the issuance of a prior authorization number.

3. The MEP contractor shall notify the pharmacy and prescriber of the results of their review and include at a minimum, the beneficiary's name, mailing address, HSP number, the reviewer, service description, service date, and prior authorization number, if approved, the length of the approval and the appeals process if the pharmacist does not agree with the results of the review.

4. Prescribers may request a fair hearing to appeal decisions rendered by the MEP contractor concerning denied claims (see N.J.A.C. 10:49-10, Notices, Appeals and Fair Hearings).

5. Claims subject to the medical exception process which have not been justified by the prescriber within 30 calendar days shall not be authorized by the MEP contractor and shall not be covered.

New Rule, R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).

See: 31 N.J.R. 245(a), 31 N.J.R. 1956(a).

Former N.J.A.C. 10:58A-2.5, Clinical laboratory services, recodified to N.J.A.C. 10:58A-2.6.

10:58A-2.6 Clinical laboratory services

(a) "Clinical laboratory services" means professional and technical laboratory services performed by a clinical laboratory certified by HCFA in accordance with the Clinical Laboratory Improvement Act (CLIA) and ordered by a physician or other licensed practitioner, within the scope of his or her practice, as defined by the laws of the State of New Jersey and/or of the state in which the practitioner practices.

(b) Clinical laboratory services are furnished by clinical laboratories and by physician office laboratories (POLs) that meet the Health Care Financing Administration regulations pertaining to clinical laboratory services defined in the Clinical Laboratory Improvement Amendments (CLIA) of 1988, section 1902(a)(9) of the Social Security Act, 42 U.S.C. § 1396(a)(9), and as indicated at N.J.A.C. 10:61-1.2, the Medicaid program's Independent Clinical Laboratory Services manual, and N.J.A.C. 8:44 and N.J.A.C. 8:45.

(c) All independent clinical laboratories and other entities performing clinical laboratory testing shall possess certification as required by CLIA 1988, and the New Jersey Department of Health rules found in N.J.A.C. 8:44 and N.J.A.C. 8:45.

(d) A CNP/CNS may claim reimbursement for clinical laboratory services performed for his or her own patients within his or her own office, subject to the following:

1. A CNP/CNS shall meet the conditions of the CLIA regulations before she or he may perform clinical laboratory testing for Medicaid recipients; and

2. The clinical laboratory tests shall be standard clinical laboratory procedures consistent with the CNP/CNS's CLIA certification, certificate of waiver or certificate of registration as an independent clinical laboratory.

(e) When the clinical laboratory test is performed on site, the venipuncture is not reimbursable as a separate procedure: its cost is included within the reimbursement for the lab procedure.

(f) When the CNP/CNS refers a laboratory test to an independent clinical reference laboratory:

1. The clinical reference laboratory shall be certified under the CLIA as described above at (a) and (b) to perform the required laboratory test(s);

2. The clinical laboratory shall be licensed by the New Jersey State Department of Health, as described above at (b) and (c), or comparable agency in the state in which the laboratory is located;

3. The clinical laboratory shall be approved for participation as an independent laboratory provider by the New Jersey Medicaid program in accordance with (b) above, and

4. Independent clinical laboratories shall bill the New Jersey Medicaid program for all reference laboratory work performed on their premises. The CNP/CNS will not be reimbursed for laboratory work performed by a reference laboratory.

Recodified from N.J.A.C. 10:58A-2.5 by R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).

See: 31 N.J.R. 245(a), 31 N.J.R. 1956(a).

Former N.J.A.C. 10:58A-2.6, Evaluation and management services, recodified to N.J.A.C. 10:58A-2.7.

10:58A-2.7 Evaluation and management services

(a) The evaluation and management codes can indicate services performed in a practitioner's office, in nursing facilities and residential health care facilities, in clinics, in Federally qualified health centers (FQHCs), and in inpatient hospitals.

(b) Reimbursement for an initial office visit or initial residential health care facility visit will be disallowed, if a preventive medicine service, EPSDT examination or office consultation was billed within a 12 month period by the same practitioner, group of practitioners, or shared health care facility sharing a common record.

(c) Provisions for initial visits, evaluation and management, are:

1. For office visits and for other care apart from inpatient hospital, providers are permitted to bill for an initial

visit only once for a specific patient, subject to the following exceptions.

i. When a shared health care facility, a group of physicians and/or other practitioners (CNPs or CNSs) share a common record, the Division will reimburse only one initial visit to that provider group.

ii. Further encounters with that patient will be billed and reimbursed by means of "established patient" codes. See N.J.A.C. 10:58A-4.1 through 4.5.

iii. Reimbursement for an initial office visit also precludes subsequent reimbursement to the same provider for an initial residential health care facility visit and vice versa.

2. If the setting is a nursing facility, the initial visit concept will still apply when considered for reimbursement purposes; however, subsequent readmissions to the same facility may be designated as initial visits, as long as a time interval of 30 days or more has elapsed between admissions.

3. In the inpatient hospital setting, the initial visit concept still applies for reimbursement purposes, except that subsequent readmissions to the same facility may be designated as Initial Visits as long as a time interval of 30 days or more has elapsed between admissions.

4. An initial hospital visit will be disallowed to the same practitioner, group of practitioners, shared health care facility, or practitioners sharing a common record who submit a claim for a consultation and transfer the patient to their service.

5. In order to use the HCPCS procedure code to bill for an Initial Visit, the CNP/CNS shall provide the minimal documentation in the record regardless of the setting where the examination was performed. See N.J.A.C. 10:58A-1.4(c).

(d) Provisions for office or other outpatient services-established patient, or subsequent hospital care: evaluation and management services:

1. This service is considered to be the routine office visit or follow-up care visit, and the visit will conform to the CPT-4 description of provider involvement and time. The setting could be office, hospital, nursing facility or residential health care facility. The documentation requirements for these visits can be found at N.J.A.C. 10:58A-1.4.

(e) In the absence of patient complaints, the procedure codes identified as preventive medicine services are applied, for adults and for children.

1. Preventive medicine services codes (new patient) are comparable, in respect to reimbursement level, to an initial visit and, therefore, may only be billed once per patient. Future use of these codes will be denied when the recipient is seen by the same practitioner, group of practitioners, or involves a shared health care facility sharing a common record.

(f) The following apply to preventive medicine services, the annual health maintenance examination, for new or established patients under the age of 21:

1. These codes are not allowable for payment when used following an EPSDT or HealthStart pediatric examination performed within the preceding 12 months for a child older than two years of age.

2. For well-child care provided to children under the age of two, the provider is urged to use age-appropriate EPSDT or pediatric HealthStart codes.

3. Preventive medicine codes may be used up to six times (at ages one, two, four, six, nine and 12 months) during the patient's first year of life and up to three times (at ages 15, 18 and 24 months) during the patient's second year of life, in accordance with the periodicity schedule of preventive visits recommended by the American Academy of Pediatrics. These codes should not be used for children under two years of age participating in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) or Pediatric HealthStart program.

(g) Concerning the Consultation procedures, in reference to CNP/CNSs; a consultation is eligible for reimbursement only when performed by a physician specialist recognized as such by this program, when the request has been made by or through the patient's attending physician or CNP/CNS, and the need for such a request would be consistent with good medical practice. CNP/CNSs will not be reimbursed for consultation procedures, but mention of these procedures is included for those instances when the CNP/CNS needs to refer her or his patient(s) for consultation, to a specialist other than her/his collaborating physician.

(h) The home services recognized as "house calls" refer to a practitioner visit limited to the provision of medical care to an individual who would be too ill to go to a practitioner's office and/or is "home bound" due to his/her physical condition. These codes do not apply to the residential health care facility or nursing facility setting.

1. For purposes of Medicaid reimbursement, "home visits" apply when the provider visits Medicaid recipients who do not qualify as "home bound."

(i) The following concern emergency department and inpatient hospital services:

1. When a practitioner sees his or her patient in the emergency room instead of his or her office, the practitioner shall use the same codes for the visit that would have been used if seen in the physician's office. Records of that visit should become part of the notes in the office chart.

2. When patients are seen by hospital-based emergency room practitioners who are eligible to bill the Medicaid program, the appropriate HCPCS code is used. These "visit" codes are listed at N.J.A.C. 10:58A-4.2.

3. Critical care/prolonged services will be covered when the patient's situation requires constant practitioner attendance which is given by the practitioner to the exclusion of his or her other patients and duties, and therefore, for him or her, represents what is beyond the usual service.

i. Critical care/prolonged success shall be verified by the applicable records as defined by the setting. The records shall show in the practitioner's handwriting the time of onset and time of completion of the service. All settings are applicable such as office, hospital, home, residential health care facility and nursing facility.

ii. The reimbursement for the "critical care" or prolonged services utilizes the time parameter, and is all-inclusive, meaning that it will be the only payment for care provided by the practitioner to the patient at that time. The specific procedures performed during that patient encounter will not be reimbursed in addition to the "critical care/prolonged services" payment.

4. For reimbursement purposes, routine hospital "newborn care for a well baby" requires, as a minimum, routine newborn care by a practitioner other than the practitioner(s) rendering maternity service.

i. "Newborn care for a well baby" includes complete initial and complete discharge physical examination, and conference(s) with the parent(s). These examinations shall be documented in the newborn's medical record.

ii. This code applies to healthy newborns and the fee for this service is all-inclusive. Consequently, the provider may not bill multiple units or bill for visits made on the subsequent day or the discharge day for a healthy newborn.

iii. For sick babies, use the appropriate hospital care code, as indicated at N.J.A.C. 10:58A-4.2.

Recodified from N.J.A.C. 10:58A-2.6 by R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).

See: 31 N.J.R. 245(a), 31 N.J.R. 1956(a).

Former N.J.A.C. 10:58A-2.7, Family planning services, recodified to N.J.A.C. 10:58A-2.8.

10:58A-2.8 Family planning services

(a) Family planning services include medical history and physical examination (including pelvic and breast); the ordering of diagnostic and laboratory tests; the prescribing of drugs and biologicals, medical devices and supplies; and providing continued medical supervision, counseling, and continuity of care.

1. The New Jersey Medicaid program shall not reimburse for services for the diagnosis or treatment of infertility. Services provided primarily for the diagnosis and treatment of infertility, including related office visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures shall not be covered by the New Jersey Medicaid program.

i. Exception: When a service is provided that is ordinarily considered an infertility service, but is provided for another purpose, the CNP/CNS shall submit the claim with supporting documentation for medical review and approval of payment to the Division of Medical Assistance and Health Services, Office of Medical Affairs and Provider Relations, PO Box 712, (Mail Code #14), Trenton, New Jersey, 08625-0712.

(b) The Norplant System (NPS) is a Medicaid-covered service provided to reproductive-age women with established regular menstrual cycles, in conformance with the prescribing information approved by the Food and Drug Administration. Patient education and counseling shall be provided relating to the NPS, including pre- and post-insertion instructions, indications, contraindications, benefits, risks, side effects, and other contraceptive modalities.

1. A clinic or office visit relating only to the insertion or removal of the Norplant System (NPS) shall not be reimbursable on the day of the insertion or removal. Only two insertions and two removals of the NPS per recipient shall be reimbursed during a five year continuous period. The practitioner shall not be reimbursed for the NPS in conjunction with other forms of contraception, for example, intra-uterine device or Depoprovera injection.

Recodified from N.J.A.C. 10:58A-2.7 by R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).

See: 31 N.J.R. 245(a), 31 N.J.R. 1956(a).

Former N.J.A.C. 10:58A-2.8, Mental health services, recodified to N.J.A.C. 10:58A-2.9.

10:58A-2.9 Mental health services

(a) Certified nurse practitioners/clinical nurse specialists who are certified in the advanced practice category of "Psychiatric/Mental Health" (CNP/CNS, Psychiatric/Mental Health) are qualified to perform and be reimbursed independently for psychiatric evaluations for the New Jersey Medicaid program.

1. For each psychiatric therapy patient contact, written documentation shall be developed and maintained to support each medical or remedial therapy, service, activity, or session for which billing is made. The documentation shall consist of the following:

- i. The specific services rendered and modality used, such as individual, group, and/or family therapy;
- ii. The date services were rendered;
- iii. The duration of services provided (1 hour, 1/2 hour);
- iv. The signature of the CNP/CNS, Psychiatric/Mental Health, who rendered the service;
- v. The setting in which services were rendered;

vi. A notation of impediments, unusual occurrences or significant deviations from the treatment described in the Plan of Care;

vii. Notations of progress, impediments, treatment, or complications; and

viii. Other relevant information.

(b) Prior authorization for mental health services shall be required when services are rendered in certain settings:

1. Prior authorization for inpatient hospital mental health services is not required.

2. For services provided in nursing facilities and all facilities covered under the Rooming and Boarding House Act of 1979 (RBHA '79), N.J.S.A. 55:13B-1 et seq., prior authorization shall be required for mental health services exceeding \$400.00 in payments in any 12-month service year rendered to a Medicaid recipient residing in either a nursing facility or RBHA '79 facility. The request for prior authorization shall be submitted directly to the appropriate Medicaid District Office that serves that nursing or RBHA '79 facility on the "Authorization of Mental Health Services (FD-07)" form.

3. Services provided by a nurse practitioner in an independent clinic, including a mental health clinic and FQHCS shall only be billed by the clinic, after prior authorization in accordance with the Clinic Services Manual, N.J.A.C. 10:66-1.4.

4. In all other settings: prior authorization shall be required for mental health services rendered to a Medicaid recipient (within a 12-month service year commencing with the patient's initial visit) when those services are provided in a setting other than an inpatient hospital, nursing facility or RBHA '79 facility, and when the reimbursement for those services exceeds \$900.00 to the CNP/CNS, Psychiatric/Mental Health. The request for prior authorization shall be submitted directly to the Psychiatric Consultant, Mental Health Services, Office of the Medical Affairs and Provider Relations, Division of Medical Assistance and Health Services, PO Box 712, Trenton, New Jersey 08625 on the "Authorization of Mental Health Services (FD-07)" form.

(c) Prior authorization for mental health services may be granted by the New Jersey Medicaid program for a maximum period of one year, and additional authorizations may be requested. The request for authorization shall include the diagnosis, as set forth in the ICD-9 CM (latest revision), the treatment plan and the progress report, in detail. When a request for prior authorization is denied or modified, the CNP/CNS shall be notified of the reason, in writing, by the fiscal agent.

1. When a patient's authorized treatment plan is changed because of a change in the patient's treatment needs, which results in an increase in service or change in the kind of service, a new authorization or a modification

of the existing authorization shall be requested by the CNP/CNS.

Ordinarily only one mental health procedure shall be reimbursed per day for the same recipient by the same physician, group of physicians, shared health facility, psychologist or CNP/CNS(P/MH) sharing a common record. When circumstances require more than one mental health procedure, the medical necessity for the services shall be documented in the patient's chart, and a determination regarding reimbursement shall be made by the Division on a case-by-case basis.

(d) CNP/CNS(P/MH)s providing mental health services shall document those services as described above and at N.J.A.C. 10:58A-1.4, Recordkeeping.

Recodified from N.J.A.C. 10:58A-2.8 by R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).

See: 31 N.J.R. 245(a), 31 N.J.R. 1956(a).

Former N.J.A.C. 10:58A-2.9, PASARR, Pre-Admission Screening (PAS) and Annual Resident Review (ARR), recodified to N.J.A.C. 10:58A-2.10.

10:58A-2.10 PASARR, Pre-Admission Screening (PAS) and Annual Resident Review (ARR)

(a) Federal legislation (1919(a)(b) of the Social Security Act, 42 U.S.C. 1396r) established Pre-Admission Screening (PAS) for MI/MR applicants to Medicaid participating nursing facilities (NFs) and an Annual Resident Review (ARR) program for residents of Medicaid participating NFs.

(b) Through PASARR, NF applicants or residents of NFs are evaluated to assess the appropriateness of their admission to the facility or continued residence within the facility, in respect to whether they need specialized services for the treatment of mental illness or mental retardation. Persons in need of specialized services (active treatment) will be directed to an alternate placement.

(c) The initial PAS screening is conducted by a regional staff nurse, to determine whether the individual requires nursing facility level of care.

1. After the RSN has determined that the individual needs NF-level services, an individual identified as meeting the criteria for mental retardation services is referred to the staff of the Division of Developmental Disabilities for a specialized services evaluation.

2. An individual identified as meeting criteria for mental illness is evaluated by a psychiatrist, an attending physician or a certified nurse practitioner/clinical nurse specialist, psychiatric/mental health (CNP/CNS, Psychiatric/Mental Health) to determine the need for specialized services.

(d) Professionals who are qualified to perform psychiatric evaluations for PASARR include psychiatrists, general physicians, both doctors of medicine (M.D.) and of osteopathy (D.O.), and certified nurse practitioners/clinical nurse spe-

cialists who are certified in the advanced practice category of Psychiatric/Mental Health.

(e) The initial Pre-Admission PASARR Screen shall be used for Medicare and/or Medicaid persons residing in the community (currently at home or boarding home) who are applicants to Medicare/Medicaid nursing facilities and are being examined by an attending-physician or CNP/CNS, Psychiatric/Mental Health to determine the need for specialized services for mental illness. Practitioners completing the screen to determine the need for specialized services shall use the 99333 and W9848 HCPCS procedure codes, with a Medicaid maximum fee allowance of \$44.00.

1. If the screening examination reveals the need for a more specialized examination, a psychiatric consultation may be requested by the attending physician or CNP/CNS Psychiatric/Mental Health. Existing consultation codes for limited consultation and for comprehensive consultation may be used for this purpose by the consulting psychiatrist, as appropriate. Applicants with a diagnosis of MI or MR, regardless of the payment source of their care, shall be subject to the PASARR review. For MI individuals funded through other than the New Jersey Medicaid program, the fee for psychiatric evaluations conducted by psychiatrists or in NFs by attending physicians, CNP/CNSs Psychiatric/Mental Health will be paid by Medicare, other third party carriers or by the individual.

2. If the individual has a diagnosis of Alzheimer's disease or related dementias, as described in the 1987 edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), documentation shall be provided to the admitting Medicaid-certified nursing facility, for the individual's clinical record, on the history, physical examination, and diagnostic workup, to support the diagnosis. Dementia-diagnosed individuals shall have psychiatric disorders diagnosed and documented. (Neither a new examination nor a comprehensive neurological evaluation shall be required.) Individuals diagnosed as mentally retarded who are also diagnosed as having organic dementia shall be evaluated in accordance with the DDD Level II screens to determine need for specialized services.

i. The examining attending-physician or CNP/CNS Psychiatric/Mental Health shall obtain the "Division of Mental Health and Hospitals Psychiatric Evaluation" form (DMH&H-1994) from the Medicaid District Office and shall submit the completed form to the Division of Mental Health and Hospitals, PO Box 727, Trenton, New Jersey 08625-0727, Attention: PASARR Coordinator.

ii. The evaluation form shall be mailed no later than 48 hours following the consultation to prevent undue delay in patient placement.

(f) The Annual Resident Review of PASARR, with maximum fee allowance (CNP/CNS Psychiatric/Mental Health) of \$44.00 is used for Medicare and/or Medicaid nursing facility patients who are being evaluated by the attending physician or CNP/CNS Psychiatric/Mental Health for the purposes of an annual resident review to determine the need for specialized services for mental illness.

1. If this examination reveals the need for a more specialized examination, a psychiatric consultation may be requested by the attending physician or CNP/CNS Psychiatric/Mental Health. Existing consultation codes for limited consultation and for comprehensive consultation may be used for this purpose by the consulting psychiatrist as appropriate.

2. If the individual has a diagnosis of Alzheimer's disease or related dementias, as described in the 1987 edition of the Diagnostic and Statistical Manual of Mental Disorders, once the original documentation has been obtained, that documentation supporting the diagnosis shall be kept on the resident's current clinical record. (A new examination does not have to be completed.)

3. The procedure can only be utilized on an annual basis by the same physician or CNP/CNS Psychiatric/Mental Health for the same patient.

i. The provider shall attach a completed Division of Mental Health and Hospitals Psychiatric Evaluation form (DMH&H-1994) to the patient's clinical chart. The Nursing Facility administrator will be responsible for providing these forms to the attending-physician or CNP/CNS Psychiatric/Mental Health.

ii. The attending physician or CNP/CNS Psychiatric/Mental Health will complete the psychiatric evaluation. The NF will submit a copy of the Psychiatric Evaluation to the MDO. The required annual resident review information shall be submitted to MDOs no later than the fifth day of the month in which the reassessments are due.

Recodified from N.J.A.C. 10:58A-2.9 by R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).

See: 31 N.J.R. 245(a), 31 N.J.R. 1956(a).

Former N.J.A.C. 10:58A-2.10, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), recodified to N.J.A.C. 10:58A-2.11.

10:58A-2.11 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

(a) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a Federally mandated comprehensive child health program for Medicaid recipients from birth through 20 years of age. The term "EPSDT Services" means the following:

1. EPSDT Screening Services;
2. Vision Services;
3. Dental Services;

4. Hearing Services; and

5. Such necessary health care diagnostic services, treatment and other measures to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services. (See 42 CFR 441 Subpart B.)

(b) A certified nurse practitioner/clinical nurse specialist, pediatric nurse practitioner, or family nurse practitioner may provide EPSDT screening services.

(c) An EPSDT examination shall include the following:

1. A comprehensive health and developmental history including assessment of both physical and mental health development;

2. A comprehensive unclothed physical exam including vision and hearing screening, dental inspection, and nutritional assessment;

3. Appropriate immunizations according to age and health history;

4. Appropriate laboratory tests, including:

i. Hemoglobin/hematocrit;

ii. Urinalysis;

iii. Tuberculin test (Mantoux), annually;

iv. Lead screening using blood lead level determinations between 6 and 12 months, at 2 years of age, and annually up to six years of age. At all other visits, screening shall consist of verbal risk assessment and additional blood lead level testing, if indicated; and

v. Other appropriate medically necessary procedures.

5. Health education, including anticipatory guidance;

6. Vision services:

i. A newborn examination including general inspection of the eyes, visualization of the red reflex, and evaluation of ocular motility;

ii. An appropriate medical and family history;

iii. An evaluation, by age six months, of eye fixation preference, muscle imbalance, and pupillary light reflex; and

iv. A second examination with visual acuity testing by age three or four years.

v. Periodic vision testing for school aged children:

(1) Kindergarten or first grade (five or six years);

(2) Second grade (seven years);

(3) Fifth grade (10/11 years);

(4) Eighth grade (13/14 years); and

(5) Tenth or eleventh grades (15/17 years).

vi. Referral for vision screening of children who:

(1) Cannot read the majority of the 20/40 line before their fifth birthday;

(2) Have a two-line difference of visual acuity between the eyes;

(3) Have suspected strabismus; or

(4) Have an abnormal light or red reflex.

7. Hearing Services:

i. Newborn hearing screening, including risk assessment;

ii. Individual hearing screening administered annually to all children through age eight and to all children at risk of hearing impairment.

iii. Screening every other year for children age eight and older.

8. Dental Services:

i. Intraoral examination included as an integral part of a general physical examination;

ii. A formal referral to a dentist at one year of age (recommended) and mandatory for children three years of age and older;

iii. Dental inspection and prophylaxis every six months until 17 years of age, then annually.

9. Referral for further diagnosis and treatment or follow up of all correctable abnormalities, uncovered or suspected. Referral may be to the provider conducting the screening examination, or to another provider, as appropriate.

(d) Children two years of age and older are provided preventive health care services through the EPSDT program. In addition, Medicaid providers who have not been certified as HealthStart Pediatric Providers use the EPSDT procedure codes for preventive health care services for children from birth through age two when the requirements for the EPSDT examination have been met. The following schedule reflects the ages at which children shall be provided EPSDT screening:

1. Under six weeks;

2. Two months;

3. Four months;

4. Six months;

5. Nine months;

6. 12 months;

7. 15 months;

8. 18 months;

9. 24 months; and

10. Annually through age 20.

(e) Reimbursement policy for EPSDT services:

1. Each periodic EPSDT screening shall be billed only once for the same patient by the same practitioner(s) sharing a common record.

2. Reimbursement for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) examination is contingent upon the submission of a completed "Report and Claim for EPSDT/HealthStart Screening and Related Procedures (MC-19)" within 30 days of the date of service.

3. Laboratory, other diagnostic procedures, and immunizations shall be eligible for separate reimbursement. (See N.J.A.C. 10:58-2.5)

Recodified from N.J.A.C. 10:58A-2.10 by R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).
See: 31 N.J.R. 245(a), 31 N.J.R. 1956(a).

10:58A-2.12 Obstetrical/gynecological (OB/GYN) care

Reimbursement for specified OB/GYN services at N.J.A.C. 10:58A-4.4(h) provided under the Medicaid and New Jersey KidCare fee-for-service programs shall be limited to certified nurse practitioners/clinical nurse specialists who are certified in the advance practice category of "OB/GYN."

New Rule, R.2000 d.144, effective April 3, 2000.
See: 31 N.J.R. 3968(a), 32 N.J.R. 1208(a).

10:58A-2.13 New Jersey Vaccines for Children program

(a) The New Jersey Vaccines for Children (VFC) program provides free vaccines for administration to beneficiaries under 19 years of age who are eligible for New Jersey Medicaid and NJ KidCare Plan A services. Medicaid and NJ KidCare programs shall not provide reimbursement to providers for administering these vaccines exclusive of the VFC program.

1. Vaccines that have been identified as available under the VFC program include, but are not limited to, the following, individually or in combination: Diphtheria, Tetanus, Pertussis; Haemophilus Influenzae Type b (Hib); Rotavirus Vaccine; Hepatitis B (Pediatric/ Adolescent); Hepatitis Type B Immunoglobulin; Hepatitis A (Pediatric); Mumps, Measles, Rubella; Oral Polio Vaccine; Varicella Vaccine; Influenzae Vaccine; and Pneumococcal Vaccine.

2. The Center for Disease Control (CDC) is expected to periodically add vaccines to the approved list for the VFC program. The Medicaid/NJ KidCare program shall not reimburse for any vaccine so added to the VFC list of approved vaccines.

(b) The vaccines listed in (a)1 above may be provided to any child without health insurance and those children who are American Indian or an Alaskan Native.

(c) CNP/CNS's shall bill the HCPCS procedure code W9356 to receive reimbursement for administering vaccines under this program. See N.J.A.C. 10:58A-4.4(b).

(d) Vaccines administered to beneficiaries 19 years of age and older shall be billed with the appropriate procedure code. See N.J.A.C. 10:58A-4.2(j).

New Rule, R.2000 d.144, effective April 3, 2000.
See: 31 N.J.R. 3968(a), 32 N.J.R. 1208(a).

SUBCHAPTER 3. HEALTHSTART

10:58A-3.1 HealthStart service

The New Jersey HealthStart program provides comprehensive maternity services for pregnant women (including those determined to be presumptively eligible) and child health services for children (through two years of age) who are eligible for Medicaid benefits.

10:58A-3.2 Purpose

(a) The purpose of HealthStart is to provide for comprehensive maternity services to pregnant Medicaid recipients, including those determined to be presumptively eligible, and preventive child health services for Medicaid recipients up to the age of two.

1. Pediatric HealthStart services are an expansion of the EPSDT program as described at N.J.A.C. 10:58A-2.10.

(b) This subchapter describes the HealthStart services which have been determined to lie within the scope of practice of the CNP/CNS, as defined by the New Jersey Board of Nursing, and to constitute the services to be provided by the independently practicing CNP/CNS.

10:58A-3.3 Scope of services

(a) HealthStart maternity services provided by a HealthStart-certified CNP/CNS are health support services provided in accordance with the HealthStart guidelines. HealthStart pediatric services include up to nine preventive visits, as recommended by the American Academy of Pediatrics, provided by a HealthStart-certified provider who assumes the primary responsibility for coordination and continuity of care.

(b) HealthStart maternity health support services include:

1. Case coordination services;
2. Health education assessment and counseling services;
3. Nutrition assessment and counseling services;
4. Social-psychological assessment and counseling services.
5. Home visitation; and
6. Outreach, referral and follow-up services.

(c) HealthStart comprehensive pediatric care includes nine preventive child health visits; all the recommended immunizations; case coordination and continuity of care including, but not limited to, the provision or arrangement for sick care, 24 hour telephone access, and referral and follow-up for complex or extensive medical, social, psychological, and nutritional needs.

10:58A-3.4 HealthStart provider participation criteria

(a) The following Medicaid-enrolled provider types are eligible to participate as HealthStart providers: independent clinics, hospital outpatient departments, local health departments meeting the New Jersey State Department of Health's Improved Pregnancy Outcome criteria and/or approved as Child Health Conferences, physicians and physician groups, certified nurse midwives and CNP/CNSs.

(b) In addition to New Jersey Medicaid program rules applicable to provider participation, HealthStart/ CNP/CNS providers shall:

1. Sign an Addendum to the New Jersey Medicaid program's Provider Agreement;
2. Have a valid HealthStart Provider Certificate; and
3. Provide maternity health support services and/or pediatric services in accordance with this subchapter.

(c) In addition to (a) and (b) above, a HealthStart CNP/CNS pediatric care provider shall participate in program evaluation and training activities including, but not limited to, documentation of outreach and follow-up activities in the patient's record.

(d) A site review may be required to ascertain an applicant's ability to meet the standards for a HealthStart Provider Certificate and to provide services in accordance with the New Jersey State Department of Health's Guidelines for HealthStart Providers in the appropriate area.

(e) A HealthStart Provider Certificate shall be reviewed by the New Jersey State Department of Health at least every 18 months from the date of issuance.

(f) An application for a HealthStart Provider Certificate is available from:

HealthStart Program
New Jersey State Department of Health
50 East State Street
CN 364
Trenton, NJ 08625-0364

(g) Guidelines for HealthStart services, when rendered by a CNP/CNS employed by a clinic, physician or hospital, can be found at Independent Clinic Services, N.J.A.C. 10:66; Physician Services, N.J.A.C. 10:54; or Hospital Services, N.J.A.C. 10:52; respectively, and the guidelines for qualifications of HealthStart providers can be found at N.J.A.C. 10:66, Independent Clinic Services.

10:58A-3.5 Termination of HealthStart Provider Certificate

(a) The New Jersey State Department of Health is responsible for enforcement of its requirements for HealthStart Provider Certificates and for evaluation and enforcement of its requirements within the Standards and Guidelines for HealthStart Providers.

(b) Causes for termination of the HealthStart Provider Certificate by the New Jersey State Department of Health are as follows:

1. Failure to comply with HealthStart standards;
2. Failure to complete the recertification process; and/or

3. Voluntary withdrawal from the HealthStart program.

(c) Termination of the HealthStart Provider Certificate shall result in the termination of the HealthStart Provider Agreement with the New Jersey Medicaid program. Providers who are decertified by HealthStart continue to be eligible to provide regular Medicaid services, at regular Medicaid reimbursement rates.

10:58A-3.6 Records: documentation, confidentiality and informed consent for HealthStart maternity care providers

(a) HealthStart CNP/CNS maternity care providers shall have policies which protect patient confidentiality, provide for informed consent, and document health support services in accordance with the New Jersey State Department of Health's Guidelines for HealthStart Maternity Care Providers.

(b) An individual record shall be maintained for each patient throughout the pregnancy.

(c) Each record shall be confidential and shall include at least the following: history and physical examination findings, assessment, a care plan, treatment services, laboratory reports, counseling and health instructions provided, and documentation of referral and follow-up services.

(d) There shall be policies and procedures for informed consent for all HealthStart services.

10:58A-3.7 Health support services

(a) Health support services are a component of comprehensive maternity care. In order to render HealthStart health support services, a CNP/CNS provider must be affiliated with, or have a formal agreement with an obstetrical provider rendering the medical maternity care component. Health support services are provided as follows:

1. Case coordination services shall facilitate the delivery of continuous, coordinated and comprehensive services for each patient in accordance with this subchapter and as follows:

i. A permanent case coordinator shall be assigned to each patient no later than two weeks after the HealthStart enrollment visit;

ii. Prenatal case coordination activities shall include, but not be limited to:

(1) Orienting the patient to all services;

(2) Developing, maintaining and coordinating the care plan in consultation with the patient;

(3) Coordinating and monitoring the delivery of all services and referrals;

(4) Monitoring and facilitating the patient's entry into and continuation with maternity services;

(5) Facilitating and providing advocacy for obtaining referral services;

(6) Reinforcing health teachings and providing support;

(7) Providing vigorous follow up for missed appointments and referrals;

(8) Arranging home visits;

(9) Meeting with the patient and coordinating patient care conferences; and

(10) Reviewing, monitoring and updating the patient's complete record;

iii. Postpartum care coordination activities shall include, but not be limited to:

(1) Arranging and coordinating the postpartum visit and any home visit;

(2) Arranging with the obstetrical care provider to obtain the labor, delivery and postpartum hospital summary record information no later than two weeks after delivery;

(3) Linking the patient to appropriate service agencies including: the Special Supplemental Food Program for Women, Infants and Children (WIC), pediatric care (preferably with a HealthStart pediatric care provider), future family planning, Special Child Health Services County Case Management Unit, and other health and social agencies, if needed;

(4) Arranging for the transfer of pertinent information or records to the pediatric care and/or future family planning service providers;

(5) Coordinating referrals and following up on missed appointments and referrals; and

(6) Reinforcing health instructions for mother and baby.

2. Nutrition assessment and basic guidance services shall be provided to orient and educate all patients to nutritional needs during pregnancy and educate the patient to good dietary practices in accordance with this subchapter. Specialized nutrition assessment and counseling shall be provided to those women with additional needs. Services shall be provided as follows:

i. Initial assessment services, which shall include, but not be limited to:

(1) Review of the patient's chart;

(2) Identification of dental problems which may interfere with nutrition;

(3) Nutritional history;

10:58A-3.10 Preventive care services by HealthStart pediatric care providers

(a) HealthStart pediatric care providers shall provide preventive health visits in accordance with the recommended guidelines of the American Academy of Pediatrics and this chapter. The schedule shall include a two to four week visit, a two month visit, a four month visit, a six month visit, a nine month visit, a 12 month visit, a 15 month visit, an 18 month visit and a 23 to 24 month visit. Each visit shall include, at a minimum, medical, family and social history, unclothed physical examination, developmental and nutritional assessment, vision and hearing screening, dental assessment, assessment of behavior and social environment, anticipatory guidance, age appropriate laboratory examinations and immunizations. Referrals shall be made as appropriate.

(b) Each provider shall provide or arrange for sick care and 24 hour telephone physician/CNP/CNS access during non-office hours. If not directly provided by the HealthStart provider, sick care and 24 hour telephone access shall be provided for each child by a single designated provider via a documented agreement. Information on care given shall be communicated to the primary HealthStart pediatric care provider. Telephone access provided exclusively via emergency room staff is not permitted. Referral to the emergency room should occur only for emergency medical care or urgent care.

(c) Case coordination, outreach and follow-up services shall include letter and/or telephone call reminders to the child's parent or guardian for preventive well-child visits and letters and/or telephone follow-up of missed appointments. Referrals for home visit services for follow-up shall be made when appropriate. For all referrals and follow-up visits, the provider shall document the completion of such referrals and/or visits. If the referral is not completed, a letter or phone call to the child's parent or guardian and/or to the referred agency shall be sent or made. All of the activity shall be recorded on the patient's chart.

10:58A-3.11 Referral services by HealthStart pediatric care providers

(a) All HealthStart CPS/CNS pediatric care providers shall make provision for consultation for specialized health and other pediatric services. Services shall include medical services, as well as social, psychological, educational and nutritional services.

1. This may include, but is not limited to: the Special Supplemental Food Program for Women, Infants and Children (WIC); Division of Youth and Family Services, Special Child Health Services Case Management Units and Child Evaluation Centers; early intervention programs; county welfare agencies/boards of social services; certified home health agencies; community mental health centers; and local and county health departments.

10:58A-3.12 Records: documentation, confidentiality and informed consent for HealthStart pediatric care providers

(a) HealthStart pediatric care providers shall have policies which protect patient confidentiality, as defined at N.J.A.C. 10:49-9.4, and provide for informed consent and document comprehensive care services in accordance with this Chapter.

(b) An individual record shall be maintained for each patient.

(c) Each record shall be confidential and shall include at least the following: history and physical examination, results of required assessments, care plan, treatment services, laboratory reports, counseling and health instruction provided and documentation of referral and follow-up services.

(d) There shall be policies and procedures for appropriate informed consent for all HealthStart pediatric services.

10:58A-3.13 HealthStart services

(a) This section applies to CNP/CNS services provided by a CNP/CNS who has a HealthStart certificate.

(b) HealthStart pediatric care provides for up to nine preventive child health visits for a child under two years of age.

1. All preventive child health visits shall be billed using the HealthStart Preventive Child Health Visit codes appropriate to the child's age at the time of visit.

2. Claims shall be submitted using Form MC-19, EPSDT/HealthStart Screening and Related Procedures.

(c) A HealthStart pediatric preventive care visit includes the following elements:

1. A comprehensive health and developmental history including assessment of both physical and mental health development;

2. A comprehensive unclothed physical exam including vision and hearing screening, dental inspection, and nutritional assessment;

3. Appropriate immunizations according to age and health history;

4. Appropriate laboratory tests, including:

- i. Hemoglobin/hematocrit;

- ii. Urinalysis;

- iii. Tuberculin test (Mantoux), annually;

- iv. Lead screening using blood lead level determinations between six and 12 months, at two years of age, and annually up to six years of age. At all other visits, screening shall consist of verbal risk assessment and additional blood lead level testing, if indicated; and

v. Other appropriate medically necessary procedures.

5. Health education, including anticipatory guidance; and

6. Referral for further diagnosis and treatment or follow up of all correctable abnormalities, uncovered or suspected. Referral may be to the provider conducting the screening examination, or to another provider, as appropriate.

(d) The HealthStart CNP/CNS pediatric providers shall provide case coordination, including referral for nutritional, psychological, social and other community services, as appropriate; provision or arrangement for 24-hour telephone physician/CNP/CNS access and sick care; and outreach and follow-up activities in accordance with this chapter.

SUBCHAPTER 4. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:58A-4.1 Introduction to the HCPCS procedure code system

(a) The New Jersey Medicaid program uses the Health Care Financing Administration's (HCFA) Common Procedure Code System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedure Terminology-4th Edition (CPT-4), American Medical Association, P.O. Box 10950, Chicago, IL 60610 Attention: Order Department, architecture, employing a five-position code and as many as two two-position modifiers. Unlike the CPT-4 numeric design, the HCFA-assigned codes and modifiers contain alphabetic characters. Because of copyright restrictions, the CPT-4 procedure narratives for Level I codes are not included in this manual, but are hereby incorporated by reference.

(b) HCPCS has been developed as a three-level coding system, as follows.

1. Level I codes: Narratives for these codes are found in CPT-4, which is incorporated herein by reference, as amended and supplemented. The codes are adapted from CPT-4 for use primarily by physicians, podiatrists, optometrists, certified nurse-midwives, certified nurse practitioners and clinical nurse specialists, independent clinics and independent laboratories. Level I procedure codes and fees for each, which CNP/CNSs may bill, can be found at N.J.A.C. 10:58A-4.2.

2. Level II codes: These codes are assigned by HCFA for physician and non-physician services which are not in CPT-4. Narratives for these codes, and the fees for each, can be found at N.J.A.C. 10:58A-4.3.

3. Level III codes: Level III codes identify services unique to the New Jersey Medicaid program. These codes are assigned by the Division to be used for those services not identified by CPT-4 codes or HCFA-assigned codes. Narratives for these codes, and the fees paid for each, can be found at N.J.A.C. 10:58A-4.4.

(c) Specific elements of HCPCS codes require the attention of providers. The lists of HCPCS code numbers for independent clinic services are arranged in tabular form with specific information for a code given under columns with titles such as: "IND" "HCPCS CODE" "MOD," "DESCRIPTION," "FOLLOW-UP DAYS" and "MAXIMUM FEE ALLOWANCE." The information given under each column is summarized below:

1. Alphabetic and numeric symbols under "IND" & "MOD":

These symbols, when listed under the "IND" and "MOD" columns, are elements of the HCPCS coding system used as qualifiers or indicators ("IND" column) and as modifiers ("MOD" column). They assist the provider in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

i. These symbols and/or letters shall not be ignored because they reflect requirements, in addition to the narrative which accompanies the CPT/HCPCS procedure code as written in the CPT, for which the provider is liable. These additional requirements shall be fulfilled before reimbursement is requested.

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

IND lists alphabetic symbols used to refer the provider to information concerning the New Jersey Medicaid and NJ KidCare program's qualifications and requirements when a procedure or service code is used.

An explanation of the indicators and qualifiers used in this column is located below and in paragraph 1, "Alphabetic and numeric symbols," as follows:

E = "E" preceding any procedure code indicates that these procedures are excluded from multiple surgery pricing and, as such, should be reimbursed at 100 percent of the program maximum fee allowance, even if the procedure is done on the same patient, by the same provider, at the same session and also that the procedure codes are excluded from the policy indicating that office visit codes are not reimbursed in addition to procedure codes for surgical procedures. (See N.J.A.C. 10:58A-4.6(a)).

L = "L" preceding any procedure code indicates that the complete narrative for the code is located at N.J.A.C. 10:58A-4.4(b) and 4.5(c).

N = "N" preceding any procedure code means that qualifiers are applicable to that code. These qualifiers are listed by procedure code number at N.J.A.C. 10:58A-4.5.

- P = "P" preceding any procedure code indicates that prior authorization is required. The appropriate form that must be used to request prior authorization is indicated in the Fiscal Agent Billing Supplement.
- HCPCS CODE = HCPCS procedure code numbers.
- MOD = Alphabetic and numeric symbols: Under certain circumstances, services and procedures may be modified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid program's modifier codes for certified nurse practitioner/certified clinical nurse specialist services are:
 - AV = Certified Nurse Practitioner.
 - WT = Services provided to Medicaid recipients under 21 years of age under Early Periodic Screening, Diagnosis and Treatment Program (EPSDT) as set forth at N.J.A.C. 10:58A-2.10. The "WT" modifier is used by providers who are not certified as HealthStart providers, when billing for services to children up to the age of two years. Providers certified for HealthStart should consult N.J.A.C. 10:58A-3.1 through 3.18.
 - 22 = Unusual services: When the service provided is greater than that usually required for the listed procedure, it may be identified by adding the modifier "22" to the usual procedure number.
 - 50 = Bilateral procedures: Unless otherwise identified in the listings, bilateral procedures requiring a separate incision which are performed during the same operative session should be identified by the appropriate five-digit code describing the first procedure. The second (bilateral) procedure is identified by adding modifier "50" to the procedure number.
 - 52 = Reduced services: Under certain circumstances, a service or procedure is partially reduced or eliminated at the practitioner's election. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of the modifier "52," signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

DESCRIPTION = Code narrative:

Narratives for Level I codes are found in CPT-4.

Narratives for Level II and III codes are found at N.J.A.C. 10:58A-4.3 and 4.4, respectively.

FOLLOW-UP DAYS = Number of days for follow-up care which are considered as included as part of the procedure code for which no additional reimbursement is available.

MAXIMUM FEE ALLOWANCE = New Jersey Medicaid program's maximum reimbursement allowance. If the symbols "B.R." (By Report) are listed instead of a dollar amount, it means that additional information will be required in order to evaluate and price the service. Attach a copy of any additional information to the claim form.

(d) Listed below are general policies of the New Jersey Medicaid program that pertain to HCPCS. Specific informa-

tion concerning the responsibilities of a CNP/CNS when rendering Medicaid-covered services and requesting reimbursement are located at N.J.A.C. 10:58A-1.4, Recordkeeping; 10:58A-1.5, Basis of Reimbursement; and 10:58A-2.6, Policies for the Use of Evaluation and Management Services HCPCS Codes.

1. General requirements are as follows:

i. When filing a claim, the appropriate HCPCS procedure codes must be used, in conjunction with modifiers when applicable.

ii. When billing, the provider must enter on the claim form a CPT/HCPCS procedure code as listed in this subchapter (N.J.A.C. 10:58A-4.2, 4.3, 4.4.)

iii. Date(s) of service(s) must be indicated on the claim form and in the provider's own record for each service billed.

iv. The "MAXIMUM FEE ALLOWANCE" as noted with these procedure codes represents the maximum payment for the given procedure for the CNP/CNS. When submitting a claim, the CNP/CNS must always use her or his usual and customary fee.

(1) Listed values for all surgical procedures include the surgery and the follow-up care included in the maximum fee allowance for the period (indicated in days) in the column titled "Follow-Up Days."

v. The HCPCS procedure codes that are billable in conjunction with office visit codes are listed at N.J.A.C. 10:58A-4.5, Qualifiers. (See the "N" designation in the "Indicator" column.)

vi. The use of a procedure code will be interpreted by the New Jersey Medicaid program as evidence that the practitioner personally furnished, as a minimum, the services for which it stands.

vii. For reimbursement purposes, those services with the modifier "AV" must be personally performed by the CNP/CNS who is submitting the claim.

Amended by R.2000 d.144, effective April 3, 2000.
See: 31 N.J.R. 3968(a), 32 N.J.R. 1208(a).

In (c)1, substituted a reference to CPT for a reference to CPT-4 in i. inserted a reference to NJ KidCare programs in IND description, and inserted a reference to "E".

10:58A-4.2 HCPCS procedure code numbers and maximum fee allowance schedule (Level I)

IND	HCPCS CODES	MOD	FOLLOW-UP DAYS	MAXIMUM FEE ALLOWANCE \$
(a) Surgical services:				
	10060	AV		10.50
	10120	AV		15.20
	10140	AV		15.20
	10160	AV		10.50
	11055	AV		10.45

	11056 AV		13.30
	11057 AV		13.30
	11719 AV		4.75
 (b) Family planning procedures:			
N	11975 AV	30	80.70
N L†	11975 AV 22		Direct Package Price,‡ Plus
		30	80.70
N	11976 AV	90	80.70
N	11977 AV	90	161.50
N L†	11977 AV 22	90	Direct Package Price‡, Plus 161.50
			161.50

† Level III code. Included here for convenience in preparing billings.
‡ Direct Package Price is the price paid by the purchaser directly to the manufacturer without going through the wholesaler.

			MAXIMUM FEE ALLOWANCE
IND	HCPCS CODES	MOD	\$

 (c) Non-complex repairs:			
Wounds	12001 AV		15.20
	12002 AV		20.00
Burns	16000 AV		13.30
	16020 AV		13.30

 (d) Strapping (Any age):			
N	29105 AV		20.00
N	29125 AV		20.00
N	29130 AV		15.20
N	29200 AV		15.20
N	29220 AV		20.00
N	29240 AV		20.00
N	29260 AV		15.20
N	29280 AV		15.20

 (e) Splints:			
N	29505 AV		39.90
N	29515 AV		35.20
N	29520 AV		20.00
N	29530 AV		15.20
N	29540 AV		15.20
N	29550 AV		13.30
N	29580 AV		15.20
N	29590 AV		9.50

 (f) Casts, removal or repair:			
N	29700 AV		11.40
N	29705 AV		11.40
N	29710 AV		15.20
N	29715 AV		15.20
N	29720 AV		20.00
N	29730 AV		7.60
N	29740 AV		7.60

 (g) Other procedures, by system:			
1. Respiratory:			
	30300 AV		13.30
	30901 AV		20.00
	30901 AV 50		50.40
	31720 AV		19.00

2. Vascular injection procedures:			
	36000 AV		30.00
N	36415 AV		1.80
 3. Urinary System:			
	51010 AV		35.20
	51700 AV		17.10
	51705 AV		17.10
N	53670 AV		13.30
 4. Obstetric/Gynecologic:			
N	57150 AV		13.30
	57160 AV		13.30
E	58301 AV		16.40
	59025 AV		18.00
	59025 AV 26		16.00
	59430 AV		17.10

5. Auditory System:			
	69200 AV		10.50

 (h) Laboratory Services:			
	81002		1.00
	81025		3.00
	82270		1.20
	82962		2.60
	83026		2.00
	84830		3.00
	85013		1.50
	85651		1.50

 (i) Tuberculin Testing:			
	86580		4.00
	86585		4.00

 (j) Immunizations:			
	90701		16.34
L	90701 52	Administration of serum only	2.50
	90702		3.29
L	90702 52	Administration of serum only	2.50
	90703		3.40
L	90703 52	Administration of serum only	2.50
	90704		23.60
L	90704 52	Administration of serum only	2.50
	90705		18.39
L	90705 52	Administration of serum only	2.50
	90706		22.04
L	90706 52	Administration of serum only	2.50
	90707		39.87
L	90707 52	Administration of serum only	2.50
	90712		14.44
L	90712 52	Administration of serum only	2.50
	90713		22.80
L	90713 52	Administration of serum only	2.50
	90716		48.00
L	90716 52		2.50
	90717		BR
L	90717 52	Administration of serum only	2.50
	90718		3.35
L	90718 52	Administration of serum only	2.50
	90720		30.27
L	90720 52	Administration of serum only	2.50
	90725		BR
	90727		BR

L	90732		14.35				
	90732 52	Administration of serum only	2.50			1. Office and Other Outpatient Services:	
	90733		17.48			New patient:	
L	90733 52	Administration of serum only	2.50				
	90746		63.57	N	99201 AV		13.30
L	90746 52		2.50	N	99202 AV		13.30
	90748		56.20	N	99203 AV		16.20
	90749		BR	N	99204 AV		16.20
L	90749 52		2.50			Established patient:	
		(k) Infusion Therapy (Excluding Allergy, Immunization and Chemotherapy):		N	99211 AV		13.30
N	90780 AV		\$38 per hour	N	99212 AV		13.30
N	90781 AV		\$38 per hour	N	99213 AV		13.30
		(l) Therapeutic or Diagnostic Injections:		N	99214 AV		13.30
	90782 AV		2.50			2. Hospital inpatient services:	
	90784 AV		2.50			Initial hospital care, new or established patient	
	90788 AV		2.50	N	99221 AV		16.20
		(m) Psychiatry:				Subsequent hospital care:	
N P	90801 AV		24.70	N	99231 AV		13.30
N P	90804 AV		12.40	N	99232 AV		13.30
N P	90805 AV		12.40			3. Hospital emergency department:	
N P	90806 AV		24.70			Emergency department services, new or established patient	
N P	90807 AV		24.70				
N P	90830 AV		24.70				
N P	90843 AV		12.40				
N P	90844 AV		24.70				
N P	90847 AV		24.70				
N P	†90847 AV 22		30.40	N	99281 AV		6.70
	90862 AV		13.30	N	99282 AV		6.70
N P	90887 AV		12.40	N	99283 AV		6.70
LNP	†H5025 AV		5.70	N	99284 AV		6.70
		† Level III code, listed here for practitioner's convenience. (For narrative description of this procedure, see N.J.A.C. 10:58A-4.5(f).)				4. Nursing home visit:	
		(n) Audiological function tests:				Comprehensive nursing facility assessments, new or established patient:	
	92552 AV		11.00				
	92553 AV		14.00	N	99301 AV		16.20
	92567 AV		5.00	N	99302 AV		16.20
		(o) Cardiovascular services:		N	99303 AV		16.20
	92950 AV		30.40			Subsequent nursing facility care, new or established patient:	
	93005		11.00				
		(p) Pulmonary services:		N	99311 AV		13.30
	94010		18.00	N	99312 AV		13.30
		(q) Chemotherapy:				Pre-Admission Screening and Annual Resident Review:	
	96400 AV		3.80		99313 AV		14.00
	96408 AV		13.30		99333 AV		14.00
	96410 AV		29.90	N L	†W9848 AV		30.00
	96412 AV		29.90	N L	†W9849 AV		30.00
	96414 AV		13.30			† Level III code; included here for convenience in billing.	
	96420 AV		13.30			5. Nursing facility discharge services:	
	96422 AV		26.60				
	96423 AV		13.30		99315 AV		13.30
	96425 AV		13.30		99316 AV		19.00
	96520 AV		13.30			6. Domiciliary, rest home (for example, boarding home), or custodial care services:	
	96530 AV		13.30				
		(r) Evaluation and Management Services:					

J0550	Injection, penicillin G benzathine and penicillin G procaine, (Bicillin C-R) up to 2,400,000 units	11.70	J0810	Injection, cortisone, 50 mg	0.95
J0560	Injection, penicillin G benzathine, (Bicillin long acting), up to 600,000 units	6.55	J0835	Injection, cosyntropin, per 0.25 mg	14.15
J0570	Injection, penicillin G benzathine, (Bicillin long acting), up to 1,200,000 units	6.55	J0850	Injection, cytomegalovirus immune globulin intravenous (human), per vial	421.31
J0580	Injection, penicillin G benzathine, (Bicillin long acting), up to 2,400,000 units	6.55	J0895	Injection, deferoxamine mesylate, (Desferal), 100 mg	10.35
J0585	Botulinum toxin type A per unit	3.99	J0945	Injection, brompheniramine maleate, per 10 mg	0.68
J0590	Injection, ethylnorepinephrine HCl, (Bronkheprine Sodium), 1 ml	2.42	J0970	Injection, estradiol valerate, up to 40 mg	0.42
J0600	Injection, edetate calcium disodium, 200 mg	6.33	J1000	Injection, depo-estradiol cypionate, 5 mg	0.90
J0610	Injection, calcium gluconate, per 10 ml	1.50	J1020	Injection, methylprednisolone acetate, 20 mg	0.75
J0630	Injection, calcitonin salmon, up to 400 units	15.54	J1030	Injection, methylprednisolone acetate, 40 mg	2.10
J0635	Injection, calcitriol, (Calcijex), 1 mcg amp.	12.74	J1040	Injection, methylprednisolone acetate, 80 mg	3.14
J0640	Injection, leucovorine calcium, 50 mg	21.53	J1050	Injection, medroxyprogesterone acetate, (Depo-Provera, Prempro), 100 mg	9.05
J0670	Injection, mepivacaine HCl, (Carbocaine), per 10 ml	3.80	J1055	Injection, medroxyprogesterone acetate, for contraceptive use, 150 mg	44.54
J0690	Injection, cefazolin sodium, (Ancef, Kefzol), up to 500 mg	1.92	J1060	Injection, testosterone cypionate and estradiol cypionate, up to 1 ml	0.38
J0694	Injection, cefoxitin sodium, (Mefoxin), 1 gm	8.53	J1070	Injection, testosterone cypionate, up to 100 mg	0.28
J0695	Injection, cefonocid sodium, (Monocid), 1 gm	21.87	J1080	Injection, testosterone cypionate, 1 cc/200 mg	0.63
J0696	Injection, ceftriaxone sodium, (Rocephin), per 250 mg	10.24	J1095	Injection, dexamethasone acetate, per 8 mg	9.56
J0697	Injection, sterile cefuroxime sodium, 750 mg	6.76	J1100	Injection, dexamethasone sodium phosphate, up to 4 mg/ml	0.80
J0698	Cefotaxime sodium, (Claforan), per gm	11.45	J1110	Dihydroergotamine Mesylate, 1 mg	10.80
J0702	Injection, betamethasone acetate and betamethasone sodium phosphate, per 3 mg	2.27	J1160	Injection, digoxin, up to 0.5 mg	0.38
J0704	Injection, betamethasone sodium phosphate, per 4 mg	1.78	J1165	Injection, phenytoin sodium, (Dilantin), per 50 mg	1.10
J0710	Injection, cephalixin sodium (Cefadyl), up to 1 gram	1.64	J1170	Injection, hydromorphone, 2 mg	1.50
J0713	Injection, ceftazidime, per 500 mg	131.88	J1180	Injection, dyphylline, (Dilor, Lufyllin), up to 500 mg	0.13
J0715	Injection, ceftizoxime sodium, per 500 mg	6.75	J1190	Injection, dexrazoxane hydrochloride, per 250 mg	152.39
J0720	Injection, chloramphenicol sodium succinate, (Chloromycetin Sodium Succinate), up to 1 gram	4.15	J1200	Injection, diphenhydramine HCl, (Benadryl), up to 50 mg	0.55
J0730	Injection, chlorpheniramine maleate, (ClorTrimeton), per 10 mg	0.15	J1205	Injection, chlorothiazide sodium, (Diuril), per 500 mg	9.54
J0735	Injection, clonidine hydrochloride, 1 mg	51.00	J1212	Injection, DMSO, dimethyl sulfoxide, 50%, 50 ml	0.98
J0740	Injection, cidofovir, 375 mg	727.09	J1230	Injection, methadone HCl, (Dolophine HCl), up to 10 mg	1.60
J0743	Injection, cilastatin sodium/meropenem (Primaxin), 250 mg	14.32	J1240	Injection, demenhydrinate, (Dramamine), up to 50 mg	0.57
J0760	Injection, colchicine, per 1 mg	3.26	J1245	Injection, dipyridamole, per 10 mg	28.80
J0770	Injection, colistimethate sodium, (Coly-Mycin), up to 150 mg	35.56	J1250	Injection, dobutamine hydrochloride, per 250 mg	12.00
J0780	Injection, prochlorperazine, (Compazine), up to 10 mg	1.30	J1260	Injection, dolasetron mesylate, 1 mg	1.56
J0800	Injection, corticotropin, up to 40 units	17.38	J1320	Injection, amitriptyline HCl, (Elavil HCl), up to 20 mg	0.19
			J1325	Injection, epoprostenol, 0.5 mg	16.58
			J1330	Injection, ergonovine maleate, up to 0.2 mg	1.60

J1362	Injection, erythromycin gluceptate, 1 gram	24.34	J1670	Injection, tetanus immune globulin, human, up to 250 units	24.13
J1364	Injection, erythromycin lactobionate, 500 mg	11.26	J1690	Injection, prednisone tebutate, (Hydrelta-T.B.A.), up to 20 mg	0.32
J1380	Injection, estradiol valerate, up to 10 mg	0.15	J1700	Injection, hydrocortisone acetate, (Analpram HC, Hydrocortone Acetate), up to 25 mg	0.70
J1390	Injection, estradiol valerate, up to 20 mg	0.24	J1710	Injection, hydrocortisone sodium phosphate, (Hydrocortone Phosphate), up to 50 mg	5.24
J1410	Injection, estrogen conjugated, per 25 mg	30.65	J1720	Injection, hydrocortisone sodium succinate, (Solu-Cortef), up to 100 mg	3.34
J1435	Injection, estrone, per 1 mg	0.06	J1730	Injection, diazoxide, (Hypertat), up to 300 mg	4.67
J1436	Injection, etidronate disodium, per 300 mg	10.60	J1739	Injection, hydroxyprogesterone caproate, 125 mg/ml	0.52
J1440	Injection, filgrastim, (G-CSF), 300 mcg	156.10	J1741	Injection, hydroxyprogesterone caproate, 250 mg/ml	0.96
J1441	Injection, filgrastim, (G-CSF), 480 mcg	248.60	J1760	Injection, iron dextran, (Imferon), 2 cc	9.43
J1455	Injection, foscarnet sodium, (Foscavir), per 1000 ml	73.28	J1780	Injection, iron dextran, (Imferon), 10 cc	3.25
J1460	Injection, gamma globulin I.M., 1 cc	2.40	J1785	Injection, imiglucerase, per unit	740.00
J1470	Injection, gamma globulin I.M., 2 cc	2.40	J1790	Injection, droperidol, (Inapsine), up to 5 mg	1.29
J1480	Injection, gamma globulin I.M., 3 cc	2.40	J1800	Injection, propranolol HCl, (Inderal), up to 1 mg	3.34
J1490	Injection, gamma globulin I.M., 4 cc	2.40	J1810	Injection, droperidol and fentanyl citrate, (Innovar), up to 2 ml ampule	4.97
J1500	Injection, gamma globulin I.M., 5 cc	2.40	J1820	Injection, insulin, up to 100 units	1.30
J1510	Injection, gamma globulin I.M., 6 cc	2.40	J1825	Injection, interferon beta-1a, 33 mcg administered under direct supervision of a physician, excludes self administration	852.00
J1520	Injection, gamma globulin I.M., 7 cc	2.40	J1830	Injection, interferon beta-1B, 0.25 mg	60.00
J1530	Injection, gamma globulin I.M., 8 cc	2.40	J1840	Injection, kanamycin sulfate, (Kantrex), up to 500 mg	1.68
J1540	Injection, gamma globulin I.M., 9 cc	2.40	J1850	Injection, kanamycin sulfate, (Kantrex), up to 75 mg	1.52
J1550	Injection, gamma globulin I.M., 10 cc	2.40	J1885	Injection, ketorolac tromethamine, (Toradol I.M.), per 15 mg	7.05
J1560	Injection, gamma globulin I.M., 11 cc or greater	2.40	J1890	Injection, cephalothin sodium, (Keflin), up to 1 gram	3.42
J1561	Injection, immune globulin, intravenous per 500 mg	43.56	J1910	Injection, kutapressin, up to 2 ml	126.84
J1562	Injection, immune globulin, intravenous, 5 grams	377.17	J1930	Injection, propiomazine HCl, up to 20 mg	4.15
J1565	Injection, respiratory syncytial virus, immune globulin, intravenous, 50 mg	14.35	J1940	Injection, furosemide, (Lasix), up to 20 mg	0.53
J1570	Injection, ganciclovir sodium, (Cytovene), 500 mg	34.80	J1950	Injection, leuprolide acetate, (Depot Suspension), 3.75 mg	455.43
J1580	Injection, garamycin, gentamicin, up to 80 mg	1.26	J1956	Injection, levofloxacin, 250 mg	39.60
J1600	Injection, gold sodium thiomalate, 50 mg	10.36	J1960	Injection, levorphanol tartrate, up to 2 mg	2.91
J1610	Injection, glucagon hydrochloride, 1 mg	30.81	J1970	Injection, methotrimeprazine, (Levoprome), up to 20 mg	22.69
J1620	Injection, gonadorelin hydrochloride, per 100 mcg	65.95	J1980	Injection, hyoscyamine sulfate, (Levsin), up to 0.25 mg	9.22
J1626	Injection, granisetron hydrochloride, 100 mcg	186.10	J1990	Injection, chlordiazepoxide HCl, (Librium), up to 100 mg	7.04
J1630	Injection, haloperidol, up to 5 mg	6.02	J2000	Injection, lidocaine HCl, 50 cc	0.08
J1631	Injection, haloperidol decanoate, 50 mg	27.94	J2010	Injection, lincomycin HCl, up to 300 mg	1.61
J1642	Injection, heparin sodium, (Heparin Lock Flush), 10 units	0.59	J2060	Injection, lorazepam (Ativan), 2 mg	9.78
J1644	Injection, heparin sodium, 1,000 units	0.14			
J1645	Injection, dalteparin sodium, per 2,500 IU	15.35			
J1650	Injection, enoxaparin sodium, 10 mg	16.80			

J2150	Injection, mannitol, 25% in 50 ml	0.06	J2640	Injection, prednisolone sodium phosphate, up to 20 mg	1.20
J2175	Injection, meperidine HCl, 100 mg	0.64	J2650	Injection, prednisolone acetate, up to 1 ml	0.19
J2180	Injection, meperidine/promethazine HCl, (Mepergan), up to 50 mg	1.48	J2670	Injection, tolazoline HCl, (Priscoline HCl), up to 25 mg	3.37
J2210	Injection, methylergonovine maleate, (Metherqine Maleate), up to 0.2 mg	1.14	J2675	Injection, progesterone, per 50 mg	0.12
J2240	Injection, metocurine iodide, (Metubine Iodine), up to 2 mg	0.82	J2680	Injection, fluphenazine decanoate, (Prolixin DeConoate), up to 25 mg	9.50
J2250	Injection, midazolam hydrochloride, per 1 mg	2.61	J2690	Injection, procainamide HCl, (Proenstyl), up to 1 gram	5.81
J2260	Injection, milrinone lactate, per 5 ml	7.02	J2700	Injection, oxacillin sodium, (Prostaphlin), up to 250 mg	3.05
J2270	Injection, morphine sulfate, up to 10 mg	0.64	J2710	Injection, neostigmine methylsulfate, (Prostigmin Methylsulfate), up to 0.5 mg	1.83
J2271	Injection, morphine sulfate, 100 mg	4.49	J2720	Injection, protamine sulfate, 10 mg	0.68
J2275	Injection, morphine sulfate, 10 mg (Preservative Free)	0.92	J2725	Injection, protirelin, per 250 mcg	24.38
J2300	Injection, nalbuphine HCl, per 10 mg	1.71	J2730	Injection, pralidoxime chloride, (Protopam Chloride), up to 1 gm	119.63
J2310	Injection, naloxone hydrochloride, per 1 mg	3.41	J2760	Injection, phentolamine mesylate, (Regitine), up to 5 mg	10.29
J2320	Injection, nandrolone decanoate, up to 50 mg	1.38	J2765	Injection, metoclopramide HCl, (Reglan), up to 10 mg	1.11
J2321	Injection, nandrolone decanoate, up to 100 mg	0.92	J2790	Injection, Rho (D) Immune Globulin, (Human), (Rhogam), Single dose package: Micro-Dose	26.00
J2322	Injection, nandrolone decanoate, up to 200 mg	5.00	J2790 22	Injection, Rho (D) Immune Globulin, (Human), (22-services greater than usual) (Rhogam), Single dose package, Full dose	45.00
J2330	Injection, thiothixene, (Navane), up to 4 mg	0.97	J2800	Injection, methocarbamol, (Robaxin), up to 10 ml	0.13
J2350	Injection, niacinamide, niacin, up to 100 mg	0.03	J2820	Injection, sarqramostim, (GM-CSF), 50 mcg	13.08
J2355	Injection, orpelvekin, 5 mg	225.60	J2860	Injection, secobarbital sodium, (Seconal Sodium), up to 250 mg	0.29
J2360	Injection, orphenadrine citrate, (Norflex, Norgestic), up to 60 mg	0.18	J2910	Injection, aurothioglucose, (Solqanal), up to 50 mg	13.30
J2370	Injection, phenylephrine HCl, (Neo-Synephrine), up to 1 ml	8.19	J2912	Injection, sodium chloride, 0.9%, per 2 ml	0.85
J2400	Injection, chlorprocaine HCl, (Nesacaine and Nesacaine MPF), per 30 ml	17.85	J2920	Injection, methylprednisolone sodium succinate, (Solu Medrol), up to 40 mg	2.00
J2405	Injection, ondansetron HCl, 1 mg	12.22	J2930	Injection, methylprednisolone sodium succinate, (Solu Medrol), up to 125 mg	5.32
J2410	Injection, oxymorphone HCl, (Numorphan), up to 1 mg	3.88	J2950	Injection, promazine HCl, (Prozine, Sparine), up to 25 mg	0.25
J2430	Injection, pamidronate disodium, per 30 mg	207.26	J2970	Injection, methicillin sodium, (Staphcillin), up to 1 gram	5.55
J2440	Injection, papaverine HCl, up to 60 mg	0.33	J2994	Injection, reteplase, 37.6 mg (two single use vials)	2,750.00
J2460	Injection, oxytetracycline HCl, up to 50 mg	0.72	J2995	Injection, streptokinase, per 250,000 IU	18.82
J2510	Injection, penicillin G procaine, aqueous, up to 600,000 units	2.57	J2996	Injection, alteplase recombinant, per 10 mg	550.00
J2512	Injection, pentagastrin, per 2 ml	14.30	J3000	Injection, streptomycin, up to 1 gram	3.95
J2515	Injection, pentobarbital sodium, per 50 mg	0.26	J3010	Injection, fentanyl citrate, (Sublimaze), up to 2 ml	1.03
J2545	Pentamidine isethionate, 300 mg, solution for inhalation	98.75	J3030	Injection, sumatriptan succinate, 6 mg	36.29
J2550	Injection, promethazine HCl, (Phenergan), up to 50 mg	0.42	J3070	Injection, pentazocine HCl, (Talwin), up to 30 mg	4.19
J2560	Phenobarbital Sodium, up to 120 mg	3.28			
J2590	Injection, oxytocin, (Pitocin), up to 10 units	0.50			
J2597	Injection, desmopressin acetate, per 1 mcg	26.67			

J3105	Terbutaline sulfate, up to 1 mg	1.93	J7051	Sterile saline or water, up to 5 ml	0.08
J3120	Injection, testosterone enanthate, up to 100 mg	0.44	J7060	5% dextrose/water solution, 500 ml = 1 unit	9.79
J3130	Injection, testosterone enanthate, up to 200 mg	0.54	J7070	Infusion, D5W, 1,000 cc	10.81
J3150	Injection, testosterone propionate, up to 100 mg	0.38	J7100	Infusion, dextran 40, 500 ml	136.68
J3230	Injection, chlorpromazine HCl, (Thorazine), up to 50 mg	0.12	J7110	Infusion, dextran 75, 500 ml	86.70
J3240	Injection, thyrotropin, up to 10 IU	200.19	J7120	Ringer's Lactate Infusion, up to 1,000 ml = 1 unit	11.30
J3250	Injection, trimethobenzamide HCl, up to 200 mg	0.45	J7192	Factor VIII (antihemophilic factor, recombinant), per IU	1.28
J3260	Injection, tobramycin sulfate, (Nebcin), up to 80 mg	3.41	J7310	Ganciclovir, 4.5 mg, long-acting implant	5,000.00
J3265	Injection, torsemide, 10 mg/ml	1.99	J7315	Sodium hyaluronate, 20 mg for intra articular injection	132.20
J3270	Injection, imipramine HCl, up to 25 mg	1.21	J7320	Hylan, G-F 20, 16 mg, for intra articular injection	206.56
J3280	Injection, thiethylperazine maleate, up to 10 mg	4.48	J7501	Azathioprine; parenteral, vial, 100 mg, 20 ml each	81.60
J3301	Injection, triamcinolone acetate, (Kenalog), 10 mg	1.45	J7503	Cyclosporin, parenteral, 50 mg	5.50
J3302	Injection, triamcinolone diacetate, (Aristocort), per 5 mg	2.21	J7504	Lymphocyte immune globulin, antithymocyte globulin, parenteral, amp, 50 mg/ml, 5 ml each	262.45
J3303	Injection, triamcinolone hexacetonide, (Aristospan), per 5 mg	2.49	J7513	Daclizumab, parenteral, 25 mg	418.20
J3305	Injection, trimetrexate glucuronate, per 25 mg	63.36	J7620	Albuterol sulfate, 0.083% per ml solution for inhalation	0.41
J3310	Injection, perphenazine, (Trilafon), up to 5 mg	6.20	J7625	Albuterol sulfate, 0.5% per ml solution for inhalation	0.75
J3320	Injection, spectinomycin hydrochloride, (Trobicin), up to 2 gm	19.25	J7660	Isoproterenol hydrochloride, 0.5% per ml solution for inhalation	2.34
J3350	Injection, urea, (Ureaphil), up to 40 mg	77.46	J7665	Isoproterenol hydrochloride, 1.0% per ml solution for inhalation	2.47
J3360	Injection, diazepam, (Valium), up to 5 mg	1.22	J7670	Metaproterenol Sulfate, 0.4% (2.5 cc) for inhalation	1.23
J3364	Injection, urokinase, 5,000 IU vial	50.96	J7672	Metaproterenol Sulfate, 0.6% (2.5 cc) for inhalation	1.38
J3365	Injection, IV, urokinase, 250,000 IU vial	427.70	J7675	Metaproterenol Sulfate, 5% per ml solution for inhalation	1.92
J3370	Injection, vancomycin HCl, up to 500 mg	8.28	J9000	Doxorubicin HCl, (Adriamycin), 10 mg	42.00
J3390	Injection, methoxamine HCl, (Vasoxyl), up to 20 mg	24.42	J9015	Aldesleukin, per single use vial	557.35
J3400	Injection, triflupromazine HCl, (Vesprin), up to 20 mg	13.00	J9020	Asparaginase, 10,000 units	50.36
J3410	Injection, hydroxyzine HCl, (Vistaril), 25 mg	0.48	J9031	BCG (intravesical) per installation	152.13
J3420	Injection, vitamin B-12 cyanocobalamin, up to 1,000 mcg	0.51	J9040	Bleomycin sulfate, (Blenoxane) 15 units	255.08
J3430	Injection, phytonadione, (Vitamin K), 1 mg	4.90	J9045	Carboplatin (Paraplatin), 50 mg	96.12
J3450	Injection, mephentermine sulfate, (Wyamine), up to 30 mg	1.87	J9050	Carmustine, (BiCNU), 100 mg	948.93
J3470	Injection, hyaluronidase, (Wydase), up to 150 units	6.46	J9060	Cisplatin, (Platinol), powder or solution, 10 mg	30.33
J3475	Injection, magnesium sulfate, per 500 mg	0.75	J9062	Cisplatin, 50 mg	155.53
J3480	Injection, potassium chloride, per 2 mEq	1.48	J9065	Injection, cladribine, (Leustatin), per 1 mg	51.60
J7030	Infusion, normal saline solution, 1,000 ml = 1 unit	9.86	J9070	Cyclophosphamide, (Cytosan), 100 mg	4.91
J7040	Infusion, normal saline solution, sterile, 500 ml = 1 unit	9.11	J9080	Cyclophosphamide, (Cytosan), 200 mg	9.71
J7042	5% dextrose/normal saline solution, 500 ml = 1 unit	10.77	J9090	Cyclophosphamide, (Cytosan), 500 mg	20.39
J7050	Infusion, normal saline solution, 250 ml = 1 unit	9.86	J9091	Cyclophosphamide, (Cytosan), 1 gram	40.79
			J9092	Cyclophosphamide, (Cytosan), 2 grams	86.00
			J9093	Cyclophosphamide, lyophilized, (Lyophilized Cytosan), 100 mg	6.19

J9094	Cyclophosphamide, lyophilized, (Lyophilized Cytoxan), 200 mg	11.76
J9095	Cyclophosphamide, lyophilized, (Lyophilized Cytoxan), 500 mg	24.69
J9096	Cyclophosphamide, lyophilized, (Lyophilized Cytoxan), 1 gram	49.38
J9097	Cyclophosphamide, lyophilized, (Lyophilized Cytoxan), 2 grams	98.79
J9100	Cytarabine, (Cytarabine Hydrochloride), 100 mg	6.72
J9110	Cytarabine, (Cytarabine Hydrochloride), 500 mg	25.00
J9120	Dactinomycin, 0.5 mg	12.98
J9130	Dacarbazine, 100 mg	13.89
J9140	Dacarbazine, 200 mg	22.23
J9150	Daunorubicin, 10 mg	155.04
J9165	Injection, diethylstilbestrol diphosphate, (Stilphostrol), 250 mg	15.17
J9170	Docetaxel, 20 mg	284.36
J9181	Etoposide, (VePesid), 10 mg	25.55
J9182	Etoposide, (VePesid), 100 mg	25.55
J9185	Fludarabine Phosphate, 50 mg	179.55
J9190	Fluorouracil, 500 mg	0.18
J9200	Floxuridine, 500 mg	136.38
J9201	Gemcitabine HCl, (Gemzar), 200 mg	85.43
J9202	Goserelin acetate implant, (Zoladex), 3.6 mg	439.24
J9206	Irinotecan, 20 mg	110.39
J9208	Ifosfomide, 1 gram	103.57
J9209	Mesna, (Mesnex), 200 mg	7.41
J9211	Idarubicin hydrochloride, 5 mg	261.25
J9213	Interferon alfa-2A, Recombinant, 3 million units	31.51
J9216	Interferon gamma-1B, 3 million units	254.33
J9217	Leuprolide acetate, (Lupron Depot), 7.5 mg	594.65
J9218	Leuprolide acetate, (Lupron), 1 mg	58.38
J9230	Mechlorethamide HCl, (nitrogen mustard), Mustargen®E, 10 mg	10.10
J9245	Injection, melphalan HCl, 50 mg	319.94
J9260	Methotrexate sodium, 50 mg	4.75
J9265	Paclitaxel, 30 mg	175.35
J9266	Pegaspargase, per single dose vial	278.24
J9268	Pentostatin, per 10 mg	1,645.00
J9270	Plicamycin, (Mithracin), 2.5 mg	94.94
J9280	Mitomycin, 5 mg	119.08
J9290	Injection, mitoxantrone HCl, per 5 mg	434.87
J9291	Mitomycin, 40 mg	878.63
J9293	Injection, mitoxantrone HCl, per 5 mg	67.93
J9310	Rituximab, 100 mg	421.35
J9320	Streptozocin, 1 gram	96.51
J9340	Thiotepa, 15 mg	633.44
J9350	Topotecan, 4 mg	548.35
J9360	Vinblastine sulfate, (Velban), 1 mg	3.25
J9370	Vincristine sulfate, (Oncovin), 1 mg	31.24

J9375	Vincristine sulfate, (Oncovin), 2 mg	31.24
J9380	Vincristine sulfate, (Oncovin), 5 mg	31.24
J9390	Vinorelbine tartrate, per 10 mg	63.70
J9600	Porfimer sodium, (Photofrin), 75 mg	2,573.43
Q0136	Injection, epoetin alpha, per 1,000 units (Non-ESRD Use)	12.00

Amended by R.2000 d.144, effective April 3, 2000.
See: 31 N.J.R. 3968(a), 32 N.J.R. 1208(a).
Rewrote the section.

10:58A-4.4 HCPCS procedure codes and maximum fee allowance schedule for Level III codes and narratives

(a) CNP/CNS Administered Drugs:

IND	HCPCS CODES	FOLLOW-UP MOD DAYS	MAXIMUM FEE ALLOWANCE \$
	W9336	Medroxy progesterone Acetate, 150 mg	36.90
	W9337	Cephhradine, 250 mg	2.34
	W9338	Tetramunc, (Diphtheria, Tetanus Toxoids, and Pertussis (DTP) Vaccine)	30.27
	W9339	Lupron, 3.75 mg	60.63
	W9343	Lupron Depot Pediatric, 7.5 mg	594.65
	W9344	Lupron Depot Pediatric, 11.25 mg	1,079.81
	W9345	Lupron Depot Pediatric, 15 mg	1,189.30
	W9357	Herceptin (Transtuzumab), 1 mg	5.15

(b) Immunizations: See N.J.A.C. 10:58A-4.5(c).

N W9096	Hepatitis B immunoprophylaxis with Recombivax HB, 0.25 ml dose.	17.46
N W9096 22	Hepatitis B immunoprophylaxis with Recombivax HB, 0.5 ml dose.	32.79
W9096 52 22	Administration of vaccine only.	2.50
N W9097	Hepatitis B immunoprophylaxis with Recombivax HB, 0.25 ml dose.	17.46
W9097 52	Administration of vaccine only.	2.50
N W9098	Hepatitis B immunoprophylaxis with Recombivax HB, 0.5 ml dose.	32.79
W9098 52	Administration of vaccine only.	2.50
N W9099	Hepatitis B immunoprophylaxis with Recombivax HB, 1.0 ml dose.	63.57
W9099 52	Administration of vaccine only.	2.50
N W9333	Hepatitis B immunoprophylaxis with Energix-B, 0.5 ml dose.	27.88
W9333 52	Administration of vaccine only.	2.50
N W9334	Hepatitis B immunoprophylaxis with Energix-B, 0.5 ml dose.	27.88
W9334 52	Administration of vaccine only.	2.50
N W9335	Hepatitis B immunoprophylaxis with Energix-B, 0.5 ml dose.	62.09
W9335 52	Administration of vaccine only.	2.50
W9338	Immunization, active; Tetramune	30.27
W9338 52	Administration of vaccine only.	2.50
W9356	VFC Vaccine Administration Fee	11.50
†L 90701 52	Diphtheria, Tetanus toxoids and pertussis vaccine. Administration of vaccine only.	2.50
†L 90702 52	Diphtheria and Tetanus toxoids. Administration of vaccine only.	2.50

†L 90703 52	Tetanus toxoid. Administration of vaccine only.	2.50
†L 90704 52	Mumps virus vaccine, live. Administration of vaccine only.	2.50
†L 90705 52	Measles virus vaccine, live, attenuated. Administration of vaccine only.	2.50
†L 90706 52	Rubella virus vaccine, live. Administration of vaccine only.	2.50
†L 90707 52	Measles, mumps and rubella virus vaccine, live. Administration of vaccine only.	2.50
†L 90712 52	Poliovirus vaccine, live, oral. Administration of vaccine only.	2.50
†L 90713 52	Poliomyelitis vaccine. Administration of vaccine only.	2.50
†L 90714 52	Typhoid vaccine. Administration of vaccine only.	2.50
†L 90717 52	Yellow fever vaccine. Administration of vaccine only.	2.50
†L 90718 52	Tetanus and diphtheria toxoids absorbed, for adult use. Administration of vaccine only.	2.50
†L 90720 52	Diphtheria, tetanus and pertussis and Hemophilus influenza B vaccine. Administration of vaccine only.	2.50
†L 90724 52	Influenza virus vaccine. Administration of vaccine only.	2.50
†L 90731 52	Hepatitis B vaccine. Administration of vaccine only.	2.50
†L 90732 52	Pneumococcal vaccine, polyvalent. Administration of vaccine only.	2.50
†L 90733 52	Meningococcal polysaccharide vaccine. Administration of vaccine only.	2.50
†L 90737 52	Hemophilus influenza B. Administration of vaccine only.	2.50
†L 90741 52	Immunization, passive; immune serum globulin, human. administration of vaccine only.	2.50
†L 90742 52	Specific hyperimmune serum globulin (hepatitis B, measles, pertussis, rabies, Rho(D), tetanus, vaccinia, varicella-zoster). Administration of vaccine only.	2.50

† Administration of serum only. These "52" injection codes are Level III codes but are given here for the convenience of the individual preparing billings.

(c) Intra-uterine devices:

W0001 AV 30	Supplying and inserting the intrauterine device "Paragard" by a CNP/CNS, including the post insertion visit.	304.00
W0002 AV 30	Supplying and inserting the intrauterine device "Progestasert" by a CNP/CNS, including post insertion visit.	137.00
W0004 AV 30	Removal of an IUD by a CNP/CNS, followed at the same visit by the insertion of the IUD "Paragard" and including the post insertion visit.	317.00
W0008 AV 30	Removal of an IUD by a CNP/ CNS, followed at the same visit by the insertion of the IUD "Progestasert" and including the post insertion visit.	150.00

(d) Norplant System: See N.J.A.C. 10:58A-4.5(a).

	Direct package price
11975 AV 22	plus \$80.70
11977 AV 22	plus \$161.50

NOTE: The Level I procedure codes for Norplant System are found at N.J.A.C. 10:58A-3.2(b).

(e) EPSDT Screening Examinations (See N.J.A.C. 10:58A-2.10 for EPSDT requirements.) (See N.J.A.C. 10:58A-4.5(m)).

W9820 AV Early and Periodic Screening, Diagnosis and Treatment (EPSDT) through age 20. \$ 18.00

The following age-specific HCPCS procedure codes apply to EPSDT screening services:

W9060 WT AV	EPSDT-under six weeks	\$ 18.00
W9061 WT AV	EPSDT-six weeks to three months	18.00
W9062 WT AV	EPSDT-three months to five months	18.00
W9063 WT AV	EPSDT-five months to 8 months	18.00
W9064 WT AV	EPSDT-8-11 months	18.00
W9065 WT AV	EPSDT-11-14 months	18.00
W9066 WT AV	EPSDT-14-17 months	18.00
W9067 WT AV	EPSDT-17-20 months	18.00
W9068 WT AV	EPSDT-20-24 months	18.00

For explanation of EPSDT requirements, refer to W9820 above, and to N.J.A.C. 10:58A-2.6.

(f) HealthStart Pediatric Preventive Care:

1. HealthStart Pediatric Preventive Care codes represent visits based on an infant's age according to the following schedule:

HCPCS CODE	DESCRIPTION	MAXIMUM FEE ALLOWANCE
W9060 AV	Under six weeks	26.00
W9061 AV	Six weeks to three months	26.00
W9062 AV	Three months to five months	26.00
W9063 AV	Five months to eight months	26.00
W9064 AV	Eight months to 11 months	26.00
W9065 AV	11 months to 14 months	26.00
W9066 AV	14 months to 17 months	26.00
W9067 AV	17 months to 20 months	26.00
W9068 AV	20 months to 24 months	26.00

2. Claims for HealthStart Preventive Care visits shall include a completed Health Insurance Claim Form, 1500 N.J., and a completed "Report and Claim for EPSDT/HealthStart Screening and Related Procedures (MC-19)" form.

(g) Psychiatry:

N P	†90847 AV 22	30.40
	90862 AV	13.30
N P	90887 AV	11.70
L N P	†H5025 AV	5.70

† See N.J.A.C. 10:58A-4.5(f).

(h) OB/GYN

W9855 AV	Initial Antepartum Visit	16.15
W9856 AV	Subsequent Antepartum Visit	13.30

Amended by R.2000 d.144, effective April 3, 2000. See: 31 N.J.R. 3968(a), 32 N.J.R. 1208(a).

Rewrote (a); in (b), inserted W9356 reference; in (c), changed procedure code references and fee allowances throughout; and added (h).

10:58A-4.5 HCPCS procedure codes—qualifiers

HCPCS MOD DESCRIPTIONS

(a) Surgical Services:

11975 AV QUALIFIER: Reimbursed for the insertion or reinsertion of the “Norplant System” (six levonorgestrel implants) and the post insertion visit when provided in a hospital setting, when the CNP/CNS bills for the service. When using this procedure code, the CNP/CNS will not be reimbursed for the cost of the kit. The supplier of the kit to the CNP/CNS will be reimbursed directly for the cost of the kit.

11975 AV 22 QUALIFIER: The maximum fee allowance includes the cost of the kit supplied to the CNP/CNS, the insertion of the “Norplant System” (six levonorgestrel implants) and the post insertion visit. NOTE: The “22” modifier indicates the inclusion of the cost of the kit.

11976 AV QUALIFIER: The maximum fee allowance is reimbursed for the removal of the “Norplant System” (six levonorgestrel implants) and for the post removal visit.

11977 AV QUALIFIER: The maximum fee allowance is reimbursed for the removal and reinsertion of the “Norplant System” (six levonorgestrel implants) and for the post-removal/reinsertion visit.

11977 AV 22 QUALIFIER: The maximum fee allowance is reimbursed for the removal and reinsertion of the “Norplant System” (six levonorgestrel implants) and for the post-removal/reinsertion visit.

E29105AV, E29125AV, E29130AV, E29200AV, E29220AV, E29240AV, E29260AV, E29280AV, E29505AV, E29515AV, E29520AV, E29530AV, E29540AV, E29550AV, E29580AV, E29590AV, E29700AV, E29705AV, E29710AV, E29715AV, E29720AV, E29730AV, E29740AV, E31720AV, E36415AV, E57150AV, E59025AV

QUALIFIER: These HCPCS are excluded from multiple surgical pricing and as such shall be reimbursed like the primary procedure at 100 percent of the program maximum fee allowance even when the procedure is performed on the same beneficiary, by the same provider, at the same session.

NOTE: Modifier “22” indicates that the billing includes the cost of the NPS kit.

(b) Laboratory services:

36415 QUALIFIER: Once per visit, per patient. Not applicable if laboratory study, in any part, is performed by the office staff of the CNP/CNS or by him or herself. When the clinical laboratory test is performed on site, the venipuncture is not reimbursable as a separate procedure; its cost is included within the reimbursement for the lab procedure.

(c) Immunizations:

N W9096 QUALIFIER: This code applies only to newborns of HBsAg negative mothers.

N W9096 22 QUALIFIER: This code applies only to newborns of HBsAg positive mothers.

N W9097 QUALIFIER: This code applies only to high risk recipients under 11 years of age (exclusive of newborns).

N W9098 QUALIFIER: This code applies only to high risk recipients 11-19 years of age.

N W9099 QUALIFIER: This code applies only to high risk recipients over 19 years of age.

N W9333 QUALIFIER: This applies only when immunizing newborns.

N W9334 QUALIFIER: This applies only to high risk recipients under 11 years of age (exclusive of newborns).

N W9335 QUALIFIER: This applies only to high risk recipients over 11 years of age.

W9356 QUALIFIER: This code applies only to the administration of vaccines to beneficiaries under (19) years of age who qualify for the Vaccine for Children (VFC) program. See N.J.A.C. 10:58A-2.13.

90731 QUALIFIER: This code applies only to the treatment of newborns with a history of perinatal exposure to hepatitis B virus.

90741 QUALIFIER: Prior authorization from the Medical Consultant at the Medicaid District Office is required.

90742 QUALIFIER: Prior authorization from the Medical Consultant at the Medicaid District Office is required.

(d) Infusion therapy (excluding allergy, immunizations and chemotherapy):

90780 AV QUALIFIER: Not to be used for routine IV drug injection or infusion. Reimbursement is contingent upon the required medical necessity, hand written chart documentation including time and indication of the physician’s presence with the patient to the exclusion of his or her other duties.

90781 AV QUALIFIER: Not to be used for routine IV drug injection or infusion. Reimbursement is contingent upon the required medical necessity, hand written chart documentation including time and indication of the physician’s presence with the patient to the exclusion of his or her other duties.

(e) Therapeutic or diagnostic injections:

There are no qualifiers for therapeutic or diagnostic injections.

(f) Mental health services:

QUALIFIER: Only under exceptional circumstances will more than one mental health procedure be reimbursed per day for the same recipient by the same CNP/CNS, group of CNP/CNSs, shared health facility, or providers sharing a common record. When circumstances require more than one mental health procedure, the medical necessity for the services shall be documented in the patient’s chart.

H5025 AV Psychotherapy, group-90 minute session 5.70

QUALIFIER: Maximum of eight (8) persons per group, including the recipient for whom the service is billed. This code requires the direct professional participation of the practitioner for a minimum of 90 minutes, of which 10 minutes can be used for documentation.

90801 AV 24.70

QUALIFIER: This code requires for reimbursement purposes a minimum of 50 minutes of direct personal clinical involvement with the patient or family member. No more than one claim

is reimbursable per the same patient, per the same physician or practitioner, per year.

90804 AV Individual Psychotherapy—25 minute session 12.40
 QUALIFIER: This code requires for reimbursement purposes a minimum of 25 minutes of direct personal clinical involvement with the patient or family member.

90806 AV Individual Psychotherapy—50 minute session 24.70
 QUALIFIER: This code requires for reimbursement purposes a minimum of 50 minutes of direct personal clinical involvement with the patient or family member.

90847 AV Family Therapy -50 minute session 24.70
 QUALIFIER: This code requires, for reimbursement purposes, a minimum of 50 minutes of direct personal clinical involvement with the patient or family member.

90847 AV 22 Family Therapy -80 minute session 30.40
 QUALIFIER: This code requires, for reimbursement purposes, a minimum of 80 minutes of direct personal clinical involvement with the patient or family member.

90887 AV Family Conference -25 minute session 12.40
 QUALIFIER: This code requires, for reimbursement purposes, a minimum of 25 minutes of direct personal clinical involvement with the patient or family member. The CPT narrative otherwise remains applicable.

(g) Pre-Admission Screening/Annual Resident Review (PAS/ARR)

W9848 \$ 30.00
 W9849 30.00

(h) Evaluation and management services:

99201 AV, 99202 AV—Initial Visit

- i. QUALIFIER: An Initial Office Visit, or an Initial Residential Health Care Visit, is limited to a single visit. Future use of this category of codes will be denied when the beneficiary is seen by the same practitioner, group of practitioners, or member of the same shared health care facility.
- ii. QUALIFIER: HCPCS procedure codes 99201AV and 99202AV are exceptions to the requirements outlined in the qualifier for the initial visit. For the codes 99201AV and 99202AV, the provider is expected to follow the qualifier applied to routine visit or follow-up care visit for reimbursement purposes.
- iii. QUALIFIER: As described at N.J.A.C. 10:58A-1.4, Evaluation and Management services pertain to patients presenting with symptoms, and as such, exclude Preventive Health Care. Preventive services for patients including newborns through persons 20 years of age are billed under EPSDT, when the procedure requirements are met, as described at N.J.A.C. 10:58A-2.10. Preventive Health Care for adults is described below, at Section (j) of this Chapter.

99203 AV, 99204 AV Office or other outpatient services: new patient

99221 AV Hospital inpatient services: initial hospital care

- iv. QUALIFIER: When reference is made in the CPT manual to the procedures listed above, the intent of the Medicaid and NJ KidCare fee-for-service programs is to consider this service as the Initial Visit.
- v. QUALIFIER: Reimbursement for an initial office visit or initial residential health care facility visit will be disallowed, if a preventive medicine service, EPSDT examination or office consultation were billed within a twelve month period by a practitioner, group, shared health care facility, or practitioners sharing a common record.
- vi. QUALIFIER: In reference to a nursing facility or hospital, the Initial Visit concept will still apply for reimbursement purposes. Subsequent readmissions to the same facility may be reimbursed as Initial Visits, if the readmission occurs more than 30 days from a previous discharge from the same facility by the same provider. When the readmission occurs within 30 days from a previous discharge, the provider shall bill the relevant HCPCS procedure codes specified under the headings Subsequent Hospital Care or Subsequent Nursing Facility Care.
- vii. QUALIFIER: Initial Hospital Visit during a single admission will be disallowed to the same practitioner, group, shared health care facility, or practitioners sharing a common record who submit a claim for a consultation and transfer the patient to their service.

2. Follow-up visit:

99212 AV, 99213 AV, Office or other outpatient services: established patient;
 99214 AV Hospital inpatient services: subsequent hospital care;
 99231 AV, 99232 AV Nursing facility services: subsequent nursing facility care;
 99313 AV Domiciliary, rest home or custodial care services: established patient; and
 99333 AV Home visit.
 99351, 99352

- i. QUALIFIER: When reference is made in the CPT manual to the services specified above, the intent of Medicaid is to consider this service as the Routine Visit or Follow-Up Care visit. The setting could be office, hospital, nursing facility or residential health care facility.

(i) Preventive Medicine Services: Annual Health Maintenance Examination

<u>New Patient</u>	<u>Established Patient</u>
99382 AV	99392 AV
99383 AV	99393 AV
99384 AV	99394 AV
99385 AV	99395 AV
99386 AV	99396 AV
99387 AV	99397 AV

QUALIFIER: Preventive medicine services codes (new patient) 99382, 99383, 99384, 99385, 99386, and 99387 may only be billed once within 12 months when the recipient is seen by the same practitioner, group of practitioners sharing a common record, or member(s) of a shared health care facility. These codes will also be automatically denied for payment when used following an EPSDT examination (procedure code W9820) performed within the preceding 12 months.

QUALIFIER: Preventive medicine services codes (established patient) 99392, 99393, 99394, 99395, 99396 and 99397 may be used only once in a 12-month period for any individual over 2 years of age. For well-child care provided to children under the age of two, it is suggested that the provider bill for an EPSDT examination.

QUALIFIER: Preventive medicine services code 99392 may be used up to 5 times during the patient's first year of life and up to 3 times during the patient's second year of life, respectively, in accordance with the periodicity schedule of preventive visits recommended by the American Academy of Pediatrics. This code does not apply to children under 2 years of age participating in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) or Pediatric HealthStart program. EPSDT and the Pediatric HealthStart providers bill for these services using the program appropriate codes W9060-W9068 or W9060WT-W9068WT.

2. Preventive medicine services codes (established patient) 99392, 99393, 99394, 99395, 99396 and 99397 may be used only once in a 12-month period for any individual over 2 years of age. For well-child care provided to children under the age of two, it is suggested that the provider bill for an EPSDT examination.

3. Preventive medicine services code 99391 and 99392 may be used up to five times during the patient's first year of life and up to three times during the patient's second year of life respectively, in accordance with the periodicity schedule of preventive visits recommended by the American Academy of Pediatrics. These codes do not apply to children under two years of age participating in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) or Pediatric HealthStart program. EPSDT and the Pediatric HealthStart providers bill for these services using the program appropriate codes W9060-W9068 or W9060WT-W9068WT.

(j) Home Services and House Calls:

The "House Call" code does not distinguish between specialist and non-specialist. These codes do not apply to residential health care facility or nursing facility setting.

These codes refer to a practitioner visit limited to the provision of medical care to an individual who would be too ill to go a practitioner's office and/or is "home bound" due to his/her physical condition. When billing for a second or subsequent patient treated during the same visit, the visit should be billed as a home visit.

99341 AV, 99342 AV	13.30	13.30
99344 AV, 99345 AV	30.00	30.00
99347 AV, 99348 AV, 99349 AV, 99350 AV	30.00	30.00

For purposes of Medicaid/NJ KidCare fee-for-service reimbursement, these codes apply when the provider visits Medicaid/NJ KidCare fee-for-service beneficiaries in the home setting and the visit does not meet the criteria specified under House Call listed above.

(k) Emergency room services:

Practitioner's Use of Emergency Room Instead of Office:

99211 AV, 99212 AV, 99213 AV, 99214 AV

—When a practitioner sees his or her patient in the emergency room instead of his or her office, the practitioner shall use the same codes for the visit that would have been used if seen in the practitioner's office (99211, 99212, 99213, 99214 or 99215 only). Records of that visit should become part of the notes in the office chart.

99281 AV, 99282 AV, 99283 AV, 99284 AV

—Emergency room visits (Refer to the CPT.) Hospital-based emergency room practitioners:

—When hospital-based emergency room practitioners who are eligible to bill the Medicaid or NJ KidCare fee-for-service program see patients, the appropriate HCPCS code is used. The "Visit" codes are limited to 99281 AV, 99282 AV, 99283 AV, 99284 AV and 99285 AV.

(l) Newborn care:

99431 AV Routine hospital newborn care—"Well" baby 21.90

QUALIFIER: For reimbursement purposes, code 99431 AV requires as a minimum routine newborn care by a physician other than the physician's rendering maternity service, including complete initial and complete discharge physical examination, conference(s) with the patient(s). This must be documented in the newborn's medical record.

	Newborn care—"Sick" baby	
99221 AV	Initial hospital care	16.20
99231 AV,	Subsequent hospital care	13.30
99232 AV	(For sick babies, use appropriate hospital care code.)	

- (m) W9820 AV Early and Periodic Screening, Diagnosis and Treatment (EPSDT) through age 20. \$18.00

QUALIFIER: Procedure code W9820 shall be used only once for the same patient during any 12 month period by the same practitioner(s) sharing a common record.

QUALIFIER: 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 to the level of an annual health maintenance examination, that is \$16.00.

Amended by R.2000 d.144, effective April 3, 2000.
See: 31 N.J.R. 3968(a), 32 N.J.R. 1208(a).

Rewrote (a), (h) and (j); in (c), inserted a reference to W9356; in (f), (g), (k) and (l), changed procedure code references throughout; and in (k), substituted references to practitioners for references to physicians throughout, and substituted a reference to CPT for a reference to CPT-4.

APPENDIX

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as a part of this chapter but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages shall be distributed to providers and filed with the Office of Administrative Law.

For a copy of the Fiscal Agent Billing Supplement, write to:

Unisys Corporation
PO Box 4801
Trenton, New Jersey 08650-4801

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
PO Box 049
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