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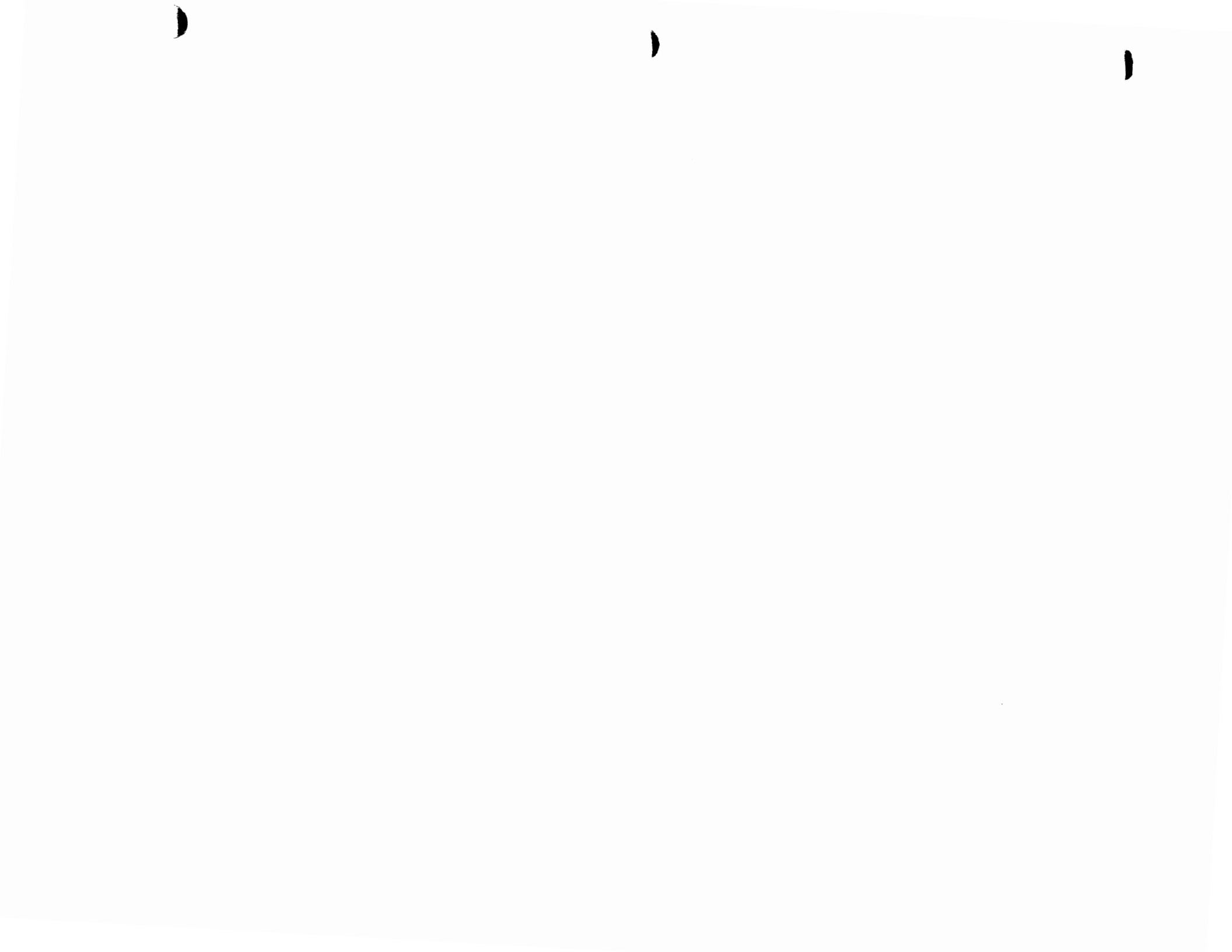
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**NEW JERSEY ADMINISTRATIVE CODE**  
**TITLE 10. DEPARTMENT OF HUMAN**  
**SERVICES**  
**CHAPTER 61. INDEPENDENT CLINICAL**  
**LABORATORIES**

Current through June 2, 1997; 29 N.J. Reg. No. 11

**AUTHORITY**

N.J.S.A. 30:4D-6a(1) through (5), b(3), (4), (8),  
(14), (16) and (18);  
30:4D-7, 7a, b and c; N.J.S.A. 30:4D-12;  
1902(a)(9) of the Social Security  
Act; 42 U.S.C. 1396(a)9; 42 U.S.C. 263(a); 42  
CFR 440.30, 493.

**SOURCE AND EFFECTIVE DATE**

R.1996 d.68, effective February 5, 1996.  
See: 27 N.J.R. 4861(a), 28 N.J.R. 1054(a).

**EXECUTIVE ORDER NO. 66(1978)**

**EXPIRATION DATE**

Chapter 61, Independent Clinical Laboratories,  
expires on February 5, 2001.

**CHAPTER HISTORICAL NOTE**

The provisions of Chapter 61, Independent Laboratory Services, were filed as R.1971 d.57, effective April 21, 1971. See: 3 N.J.R. 43(a), 3 N.J.R. 83(b). Subchapter 3 was repealed and a new Subchapter 3, HCFA Common Procedure Coding System (HCPCS), was adopted effective March 3, 1986, as R.1986 d.52. See: 17 N.J.R. 1519(b), 18 N.J.R. 478(a). Pursuant to Executive Order No. 66(1978), Chapter 61 was readopted as R.1991 d.138, effective February 15, 1991. See: 22 N.J.R. 3713(a), 23 N.J.R. 838(e).

Chapter 61, Independent Laboratory Services, was repealed, and Chapter 61, Independent Clinical Laboratories, was adopted as new rules by R.1996 d.68, effective February 5, 1996. See: Source and Effective Date. See, also, section annotations.

NJ ADC T. 10, Ch. 61, Refs & Annos  
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10:61-1.1 Purpose and scope

This chapter outlines the policies and procedures for coverage of clinical laboratory services that must be met in order to qualify for reimbursement under the New Jersey Medicaid program. The services of a qualified clinical laboratory for which reimbursement may be made relate only to diagnostic tests performed in a laboratory which is independent of a physician's office, a participating hospital, or other facility. Rules for laboratory services provided by other types of providers are included in the Medicaid rules for those particular providers. Diagnostic laboratory tests, for purposes of this chapter, do not include diagnostic radiological studies.

<General Materials (GM) - References,  
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10:61-1.3 Scope of services

Each laboratory shall provide the New Jersey Health Services Program, Office of Medical Affairs, Unit Code 15, CN-712, Trenton, New Jersey 08625-0712, with a listing of tests, including panels and profiles actually performed on its premises (address to be identified) and a current price list, including discounts, with an update of said list as capabilities change.

<General Materials (GM) - References,  
Annotations, or Tables >

NJ ADC 10:61-1.3  
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10:61-1.4 Requirements for provider participation;  
general

(a) To qualify for participation as a clinical laboratory under the New Jersey Medicaid program, the following requirements must be met:

1. Licensure and/or approval by the New Jersey State Department of Health or comparable agency in the state in which the facility is located. This includes meeting certificate of need and licensure requirements, when required, and all applicable laboratory provisions of the New Jersey State Sanitary Code (see N.J.A.C. 8:45);

2. Enrollment as an independent laboratory under the Title XVIII Medicare program (see 42 CFR 493.1);

3. Meet the requirements of an independent clinical laboratory under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) (see 42 USC 1396(a)(9)). (See N.J.A.C. 10:61-2.1(a)5.)

(b) In order to participate in the Medicaid program as an independent laboratory provider, the following documents shall be submitted to Unisys Corporation, Provider Enrollment, P.O. Box 4804, Trenton, N.J. 08650-4804:

1. Form FD-20, Medicaid Provider Application Form;

2. Form FD-62, Medicaid Provider Agreement;

3. A copy of HCFA 1513, Disclosure of Ownership, Control and Interest Statement;

4. A copy of the Medicare certification; and

5. A copy of the documents to certify the lab meets the CLIA requirements.

(c) The provider will be notified by Unisys as to whether their application for participation was approved or disapproved by the New Jersey Medicaid Program.

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Annotations, or Tables>

NJ ADC 10:61-1.4  
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10:61-1.5 Medicare-Medicaid relationship

(a) Upon approval as an independent laboratory provider for Title XIX Medicaid participation and reimbursement, the requirements for independent laboratory services under the Title XVIII Medicare program shall be followed.

(b) A laboratory approved for Medicaid participation shall only provide services and be reimbursed for the specialties and subspecialties specifically approved for Medicare participation.

(c) State, county and municipal laboratories located in New Jersey may qualify for Medicaid reimbursement provided they meet the criteria in N.J.A.C. 10:61-1.4 and 1.5.

(d) Any entity that performs diagnostic tests in connection with its provider practice shall comply with this chapter and shall have a CLIA Identification Number to perform clinical laboratory testing reimbursable by the New Jersey Medicaid program. (See N.J.A.C. 10:49-24). A CLIA Identification Number must be on file with the New Jersey Medicaid program before payment is made for any laboratory testing.

<General Materials (GM) - References,  
Annotations, or Tables >

NJ ADC 10:61-1.5  
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NJ ADC 10:61-1.6  
END OF DOCUMENT

**SUBCHAPTER 1. GENERAL PROVISIONS**

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10:61-1.6 Recordkeeping

(a) All requests for clinical laboratory services shall require an explicit order personally signed by the physician or other licensed practitioner requesting the services. The written order shall contain the specific test requested, and shall be on file with the billing laboratory and available for review by Medicaid representatives, along with the results of the tests billed.

(b) The written order shall contain the specific clinical laboratory test(s) requested and shall be supported by documentation in the referring physician's/practitioner's medical records.

(c) Standing orders shall be:

1. Patient specific, and not blanket requests from the physician or licensed practitioner;

2. Medically necessary and related to the diagnosis of the recipient; and

3. Effective for no longer than a 12 month period from the date of the physician's/practitioner's signature.

(d) Telephone laboratory orders shall be followed up with a written request and shall be on file with the clinical laboratory.

(e) The results of the tests billed shall be on file with the billing laboratory performing tests. The results shall be available for review by Medicaid representatives.

(f) The New Jersey Medicaid Program shall have the right to inspect all records, files and documents of in-State and out-of-State service and reference clinical laboratories which provide laboratory tests and services for New Jersey Medicaid recipients.



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10:61-1.7 Basis of reimbursement

Reimbursement shall be on the basis of the lowest professional charge, not to exceed an allowance determined reasonable by the Commissioner of Human Services, and further limited by Federal policy relative to payment of clinical laboratory services. The maximum fee schedule (allowance) is set forth at N.J.A.C. 10:61-3. In no event shall the charge to the New Jersey Medicaid program exceed the provider's charge for identical services to other groups or individuals.

<General Materials (GM) - References,  
Annotations, or Tables >

NJ ADC 10:61-1.7  
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10:61-2.1 Clinical Laboratory Improvement  
Amendments (CLIA) requirements

(a) All independent clinical laboratories and other entities providing clinical laboratory services to Medicaid beneficiaries must meet the requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988. These requirements include that the provider must have one of the following:

1. A certificate of waiver;
2. A certificate of compliance;
3. A registration certificate;
4. A certificate for provider-performed microscopy (PPM) procedures;
5. A certificate of accreditation, and a registration certificate or a certificate of compliance; or
6. Be deemed CLIA exempt due to accreditation by a private, nonprofit accreditation organization or exempted under an approved state laboratory program. (See code of Federal Regulations 42 CFR 493)

<General Materials (GM) - References,  
Annotations, or Tables >

NJ ADC 10:61-2.1  
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10:61-2.2 Specific services

(a) The sum of any number of the components of a battery of tests shall not exceed the total charged for the group offering (panel or profile), whether done by automation or bench testing, whether or not the equipment is available in the facility. Where batteries constitute a profile, they shall be billed in that manner. A battery of tests is considered to be those components of a test or series of tests which, when combined, mathematically or otherwise, comprise a finished identifiable laboratory study or studies. Examples are:

1. The components of a chemistry profile or other automated laboratory study;
2. An MCH, MCV, or other test, as a component of a C.B.C.;
3. Inclusive of all ova and parasites in a stool examination.

(b) If the components of a profile or panel are billed separately, total reimbursement for the components of the panel or profile shall not exceed the Medicaid fee allowance for the profile itself.

(c) In no instance shall reimbursement exceed the Medicare Fee Schedule.

(d) Where tests are referred by an approved service laboratory to an approved reference laboratory, the approved reference laboratory shall be a Medicaid provider and shall directly bill the Medicaid program for the service.

1. The initiating laboratory shall only refer clinical laboratory tests to laboratories which have a valid CLIA Identification Number and are New Jersey Medicaid approved providers.

(e) The policy on reimbursement for visits to the

nursing home, residential health care facility, or to the beneficiary's home by an independent lab for the purposes of obtaining blood by venous or arterial puncture is as follows:

1. Utilize HCPCS code W8900 for visits to homebound beneficiaries in their own home or living in a residential health care facility, group home, or boarding home. This code may be used only once per trip regardless of the number of patients seen and requires a distance in excess of 20 miles per round trip.

2. Utilize HCPCS code W8920 for a visit to the first beneficiary in a nursing facility, or Intermediate Care Facility/Mental Retardation (ICF/MR). For each additional beneficiary visited, utilize HCPCS code W8925.

3. Reimbursement will not be made for travel to other sites including, but not limited to, hospitals, physician offices, or clinics.

<General Materials (GM) - References,  
Annotations, or Tables >

NJ ADC 10:61-2.2  
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10:61-2.3 Limitations on laboratory services

(a) Tests performed by a non-approved laboratory are not reimbursable. The referring laboratory shall verify approved status.

(b) Additional payment will not be made to a laboratory for obtaining specimens, except when performed in a long-term care facility, boarding home, or home.

(c) A laboratory shall be reimbursed only those tests that are within the specialty/subspecialty categories indicated in its CLIA approval.

(d) Laboratory services provided primarily for the diagnosis or treatment of infertility shall not be covered by the New Jersey Medicaid program.

1. For those HCPCS procedure codes which are determined to be primarily for the diagnosis of infertility, refer to the HCPCS subchapter and the Indicator "F."

<General Materials (GM) - References,  
Annotations, or Tables >

NJ ADC 10:61-2.3  
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10:61-2.4 Laboratory rebates

(a) Rebates by reference laboratories, service laboratories, physicians or other utilizers or providers of laboratory service are prohibited under the Medicaid program. Rebates shall include refunds, discounts or kickbacks, whether in the form of money, supplies, equipment, or other things of value. Laboratories shall not rent space or provide personnel or other considerations to a physician or other practitioner, whether or not a rebate is involved.

<General Materials (GM) - References,  
Annotations, or Tables >

NJ ADC 10:61-2.4  
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**SUBCHAPTER 3. HCFA COMMON**  
**PROCEDURE CODING SYSTEM (HCPCS)**

summarized below:

Current through June 2, 1997; 29 N.J. Reg. No. 11

10:61-3.1 Purpose, scope and general provisions

(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.

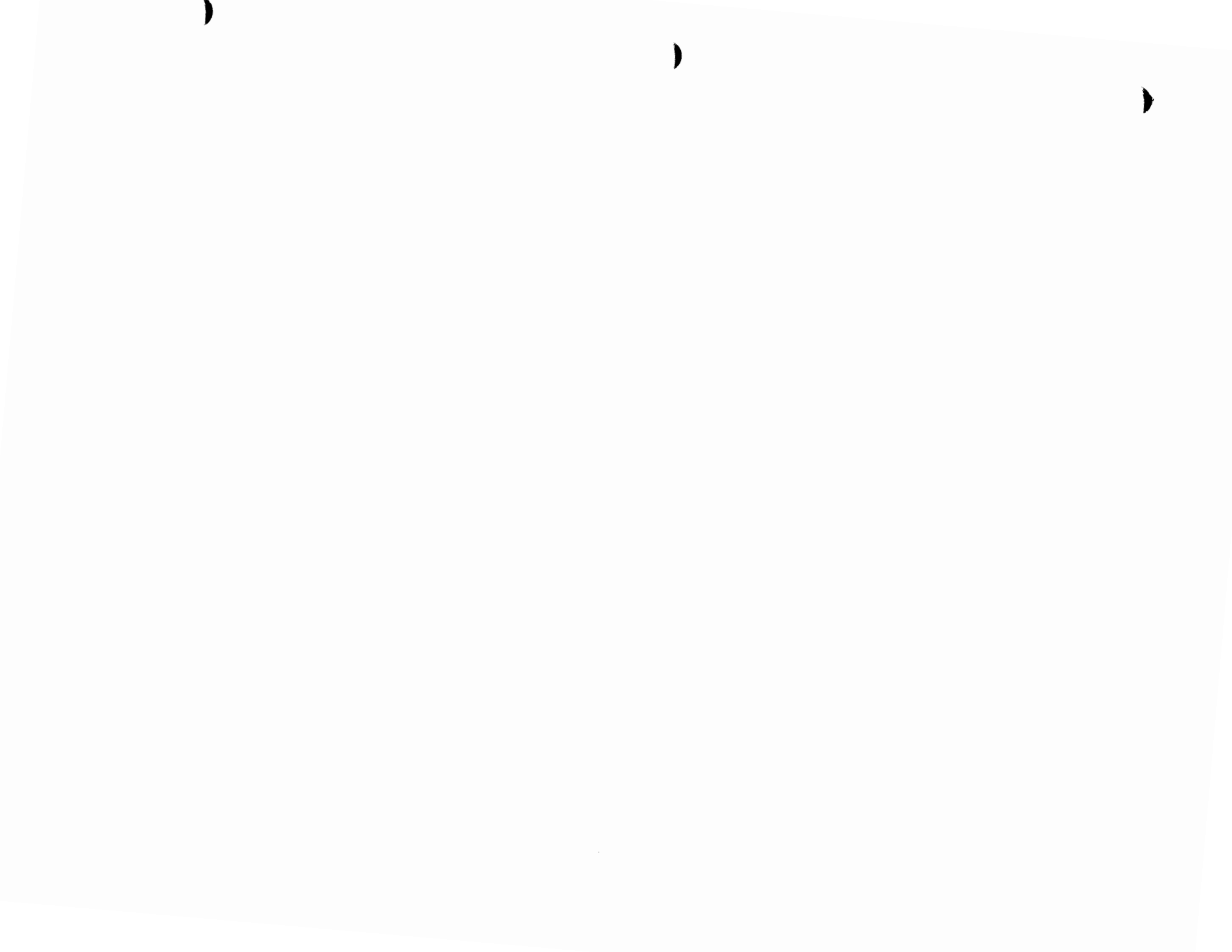
(b) HCPCS has been developed as a three-level coding system. The CPT-4 procedure narratives for Level I codes are incorporated herein by reference.

1. Level I codes: (Narratives found in CPT-4). CPT-4 is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians. (See N.J.A.C. 10:61-3.2.)

2. Level II codes are assigned by HCFA for physician and non-physician services which are not in CPT-4. (See N.J.A.C. 10:61-3.3.)

3. 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. (See N.J.A.C. 10:61-3.4.)

(c) The lists of HCPCS code numbers for Pathology and Laboratory are arranged in tabular form with specific information for a code identified under columns with titles such as: "IND", "HCPCS CODE", "MOD", "DESCRIPTION", and "MAXIMUM FEE ALLOWANCE". The information identified under each column is



Column Title	Description								
IND	<p>(Indicator-Qualifier) Lists alphabetic symbols used to refer provider to information concerning the New Jersey Medicaid program's qualifications and requirements when a procedure or service code is used.</p> <p>Explanation of indicators and qualifiers used in this column are identified below:</p> <p>"A" preceding any procedure code indicates that these tests can be and are frequently done as groups and combinations (profiles) on automated equipment.</p> <p>"F" preceding any procedure code indicates that this code, when used primarily for the diagnosis and treatment of infertility, is not covered by the New Jersey Medicaid program.</p> <p>"L" preceding any procedure code indicates that the complete narrative for the code is located at N.J.A.C. 10:61-3.3 or 3.4.</p> <p>"N" preceding any procedure code indicates that qualifiers are applicable to that code. These qualifiers are listed by procedure code number at N.J.A.C. 10:61-3.5.</p>								
HCPCS CODE	Lists the HCPCS procedure code numbers.								
MOD	<p>Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid program's recognized modifier codes are listed below:</p> <table border="0" style="width: 100%;"> <thead> <tr> <th style="text-align: left;">Modifier Code</th> <th style="text-align: left;">Description</th> </tr> </thead> <tbody> <tr> <td style="vertical-align: top;">22</td> <td>Unusual Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '22' to the usual procedure number. A report may also be appropriate.</td> </tr> <tr> <td style="vertical-align: top;">26</td> <td>Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier '26' to the usual procedure number.</td> </tr> <tr> <td style="vertical-align: top;">52</td> <td>Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's or ordering 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.</td> </tr> </tbody> </table>	Modifier Code	Description	22	Unusual Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '22' to the usual procedure number. A report may also be appropriate.	26	Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier '26' to the usual procedure number.	52	Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's or ordering 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.
Modifier Code	Description								
22	Unusual Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '22' to the usual procedure number. A report may also be appropriate.								
26	Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier '26' to the usual procedure number.								
52	Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's or ordering 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	Lists the code narrative. (Narratives for Level I codes are found in CPT-4. Narratives for Level II and Level III codes are found at N.J.A.C. 10:61-3.3 and 3.4, respectively.)								
MAXIMUM FEE ALLOWANCE	Lists New Jersey Medicaid program's maximum reimbursement schedule for Pathology and Laboratory services. If the symbols "B.R." (By Report) are listed instead of a dollar amount, it means that additional information will be								



required in order to properly evaluate the service. Attach a copy of the additional information report to the claim form. If the symbols "N.A." (Not Applicable) are listed instead of a dollar amount, it means that service is not reimbursable.

1. The fee listed under "Total Fee(s)" represents the combined technical and professional component of the reimbursement for the procedure code notwithstanding any statement to the contrary in the narrative. It will be paid only to one provider and will not be broken down into its component parts.

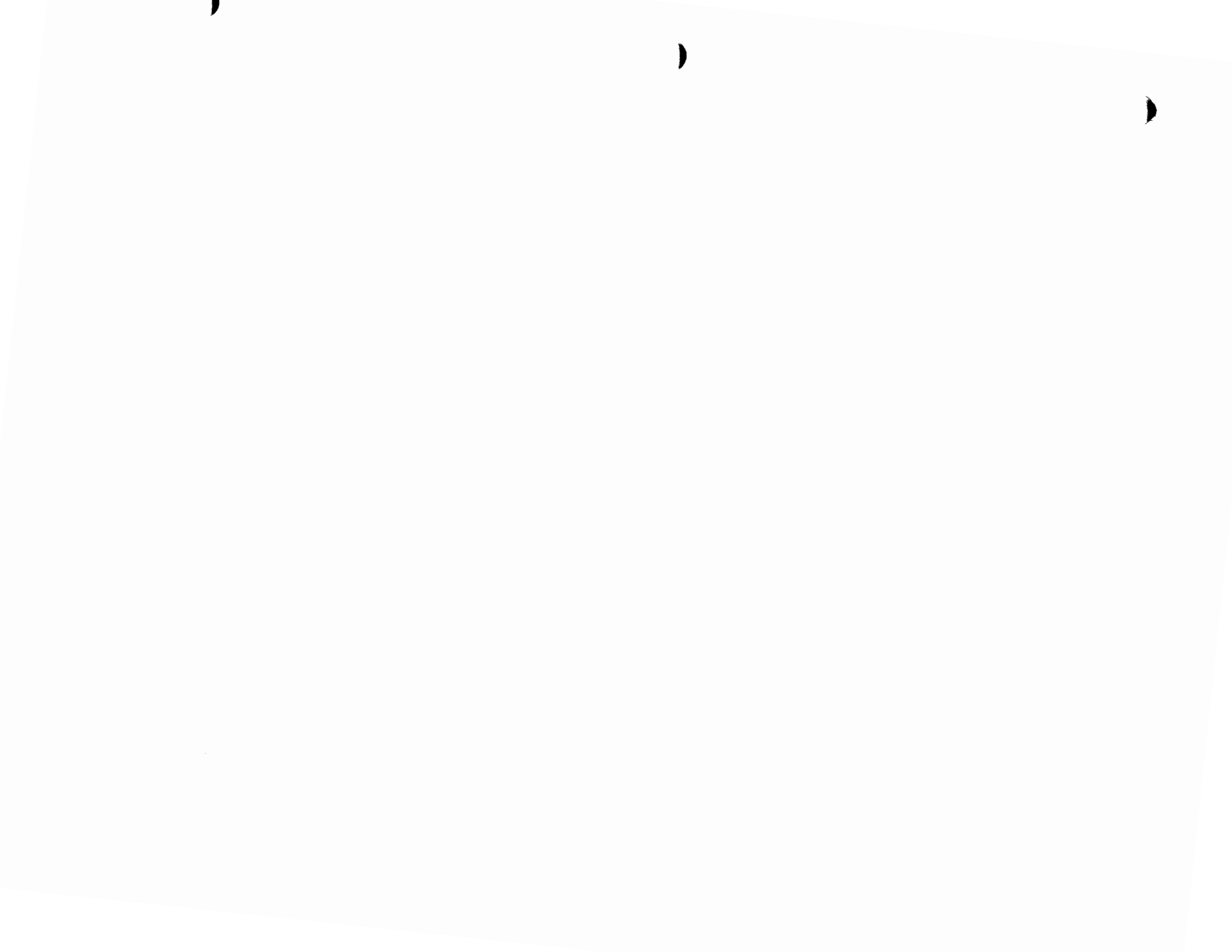
(d) When alphabetic and numeric symbols are listed under the "IND" and "MOD" columns, they are qualifiers or indicators (in the "IND" column) and as modifiers (in the "MOD" column). The symbols assist the provider in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

1. These symbols and/or letters must not be ignored because in certain instances requirements are created in addition to the narrative which accompanies the CPT/HCPCS procedure code as written in CPT-4. The provider will then be liable for the additional requirements and not just the CPT/HCPCS procedure code narrative. These requirements must be fulfilled in order to receive reimbursement.

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

<General Materials (GM) - References,  
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**SUBCHAPTER 3. HCFA COMMON**  
**PROCEDURE CODING SYSTEM (HCPCS)**

Current through June 2, 1997; 29 N.J. Reg. No. 11

10:61-3.2 HCPCS procedure codes and maximum  
fee allowance schedule for Level 1

IND	HCPCS Code	MOD	Maximum Fee Allowance	
			Total Fee	\$ Prof. Comp
N	36415		1.80	
N	80002		5.00	
N	80003		5.90	
N	80004		5.90	
N	80005		5.90	
N	80006		5.90	
N	80007		7.10	
N	80008		7.10	
N	80009		7.10	
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**NEW JERSEY ADMINISTRATIVE CODE**  
**TITLE 10. DEPARTMENT OF HUMAN**  
**SERVICES**  
**CHAPTER 61. INDEPENDENT CLINICAL**  
**LABORATORIES**

**SUBCHAPTER 1. GENERAL PROVISIONS**  
Current through June 2, 1997; 29 N.J. Reg. No. 11

10:61-1.2 Definitions

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

"Automated multichannel tests" means laboratory tests which can be and are frequently performed as groups and combinations (profiles) on automated multichannel equipment.

"CLIA" means the Clinical Laboratory Improvement Amendments of 1988, which extends the scope of Federal governmental regulation of laboratories to all laboratory sites where laboratory tests are performed, including physicians' offices. The purpose of this legislation is to uniformly ensure the quality and reliability of medical tests performed by all laboratories that test human specimens.

"CLIA Identification Number" means a 10 digit identification number issued by the Health Care Financing Administration (HCFA) to independent clinical laboratories and other entities which perform laboratory testing. A CLIA Identification Number must be on file with the New Jersey Medicaid program before payment is made for any laboratory testing.

"Clinical laboratory services" means professional and technical laboratory services provided by an independent clinical laboratory when ordered by a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by the laws of the state in which he or she practices.

"Panel" means laboratory tests that are associated with organ or disease oriented areas, such as organ "panels" (for example, hepatic function panel). The tests listed with each panel identify the defined components of that panel.

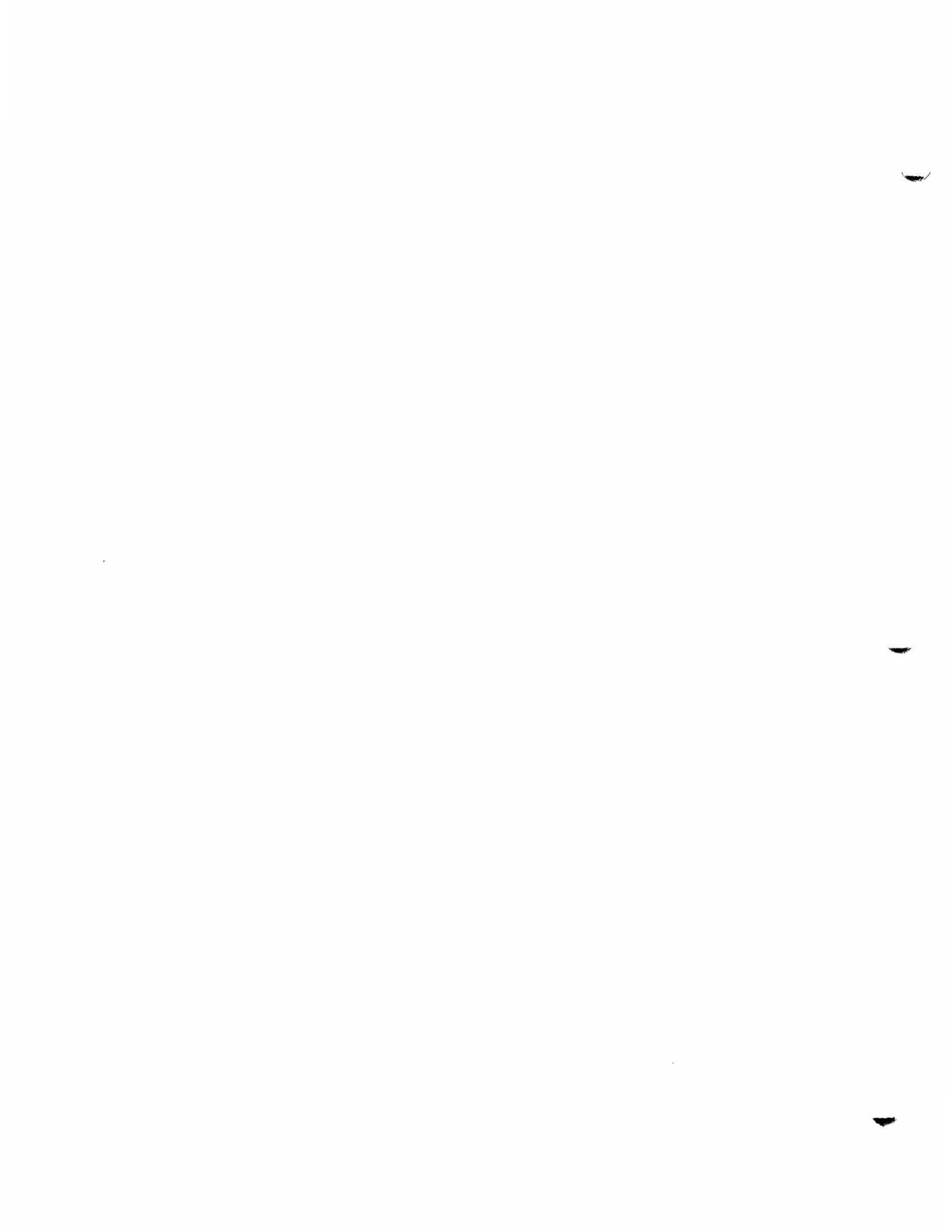
"Profile" means a combination of laboratory tests that can be and are frequently done as groups and in combinations on automated multi-channel equipment (for example, SMA6, SMA).

"Reference laboratory" means a laboratory meeting the requirements stipulated in N.J.A.C. 10:61-1.4 which performs specific tests at the request of another approved certified laboratory.

"Service laboratory" means a laboratory meeting the requirements stipulated in N.J.A.C. 10:61-1.4 which performs specific tests on the laboratory's own premises.

<General Materials (GM) - References,  
Annotations, or Tables >

NJ ADC 10:61-1.2  
END OF DOCUMENT



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	87186	13.00
	87187	13.00
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	87190	.60
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	87205	4.20
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	88104	12.00	7.00
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**CHAPTER 61. INDEPENDENT CLINICAL**  
**LABORATORIES**  
**SUBCHAPTER 3. HCFA COMMON**  
**PROCEDURE CODING SYSTEM (HCPCS)**

Current through June 2, 1997; 29 N.J. Reg. No. 11

10:61-3.3 HCPCS procedure codes, procedure  
description and maximum fee allowance schedule for  
Level 2

	HCPCS			Maximum Fee Allowance
IND	Code	MOD	Procedure Description	
N	G0001		Routine Venipuncture	\$ 1.80
	Q0111		Wet mount, including preparations of vaginal, cervical or skin specimens	2.40
	Q0112		All potassium hydroxide (KOH) preparations	2.40
	Q0113		Pinworm examination	5.10
	Q0114		Fern test	9.60
	Q0115		Post-coital direct, qualitative examinations of vaginal or cervical mucous	12.33
	Q0116		Hemoglobin by single analyte instruments with self-contained or component features to perform specimen/reagent interaction, providing direct measurements and read-out	2.00

<General Materials (GM) - References,  
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NJ ADC 10:61-3.3  
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**NEW JERSEY ADMINISTRATIVE CODE**  
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**PROCEDURE CODING SYSTEM (HCPCS)**

Current through June 2, 1997; 29 N.J. Reg. No. 11

10:61-3.4 HCPCS procedure codes, procedure description and maximum fee allowance schedule for Level 3

	HCPCS			Maximum Fee Allowance
IND	Code	MOD	Procedure Description	
N	W8200		Glucose, serum (separate tube, grey top)	\$ 2.00
	W8260		Haldol (haloperidol) serum, confirmation test	33.00
	W8265		Serentil, serum mesoridazine, quantitative, confirmation test	33.00
	W8730		Gonozyne, Gonococcal antigen	11.00
N	W8900		Visits to homebound beneficiaries, residential health care facility, group home, or boarding home for purpose of obtaining blood by venous or arterial puncture	10.00
	W8920		Visit to obtain blood specimens by venous or arterial puncture for the first person in a nursing facility or Intermediate Care Facility/Mental Retardation (ICF/MR)	1.80
	W8925		Each additional person in nursing facility or Intermediate Care Facility/Mental Retardation (ICF/MR)	.60

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NJ ADC 10:61-3.4  
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**PROCEDURE CODING SYSTEM (HCPCS)**

Current through June 2, 1997; 29 N.J. Reg. No. 11

10:61-3.5 Pathology and Laboratory HCPCS Codes-  
-Qualifiers

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

1. Chemistry Automated, Multichannel Tests

Applies to CPT Codes: 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018, and 80019. The following list contains those tests which can be and are frequently performed as groups and combinations (profiles) on automated multichannel equipment: Apply this methodology to the above CPT Codes. For reporting one test, regardless of method of testing, use appropriate single test code number. For any combination of tests among those listed below use the appropriate number 80002-80019. Groups of the tests listed here are distinguished from multiple tests performed individually for immediate or "stat" reporting. Laboratory chemistry tests performed on your automated equipment in addition to laboratory chemistry tests listed must be billed as 80002-80019 as part of the automated multichannel test listing.

Acid--Phosphatase

Albumin

Alkaline Phosphatase

(ALT, SGPT) Aspartate

Aminotransferase

(AST, SGOT) Aspartate

Aminotransferase

Amylase

Bilirubin, Total

Bilirubin, Direct

Blood Urea Nitrogen (BUN)

Calcium

Carbon Dioxide (CO sub2 )

Chlorides (Cl)

Cholesterol

Creatinine

Gamma Glutamyl Transpeptidase  
(GGTP)

Glucose (Sugar)

Iron

Iron Binding Capacity

Lactic Dehydrogenase (LD)

Lipoprotein (HDL Cholesterol)

Magnesium

Phosphorus

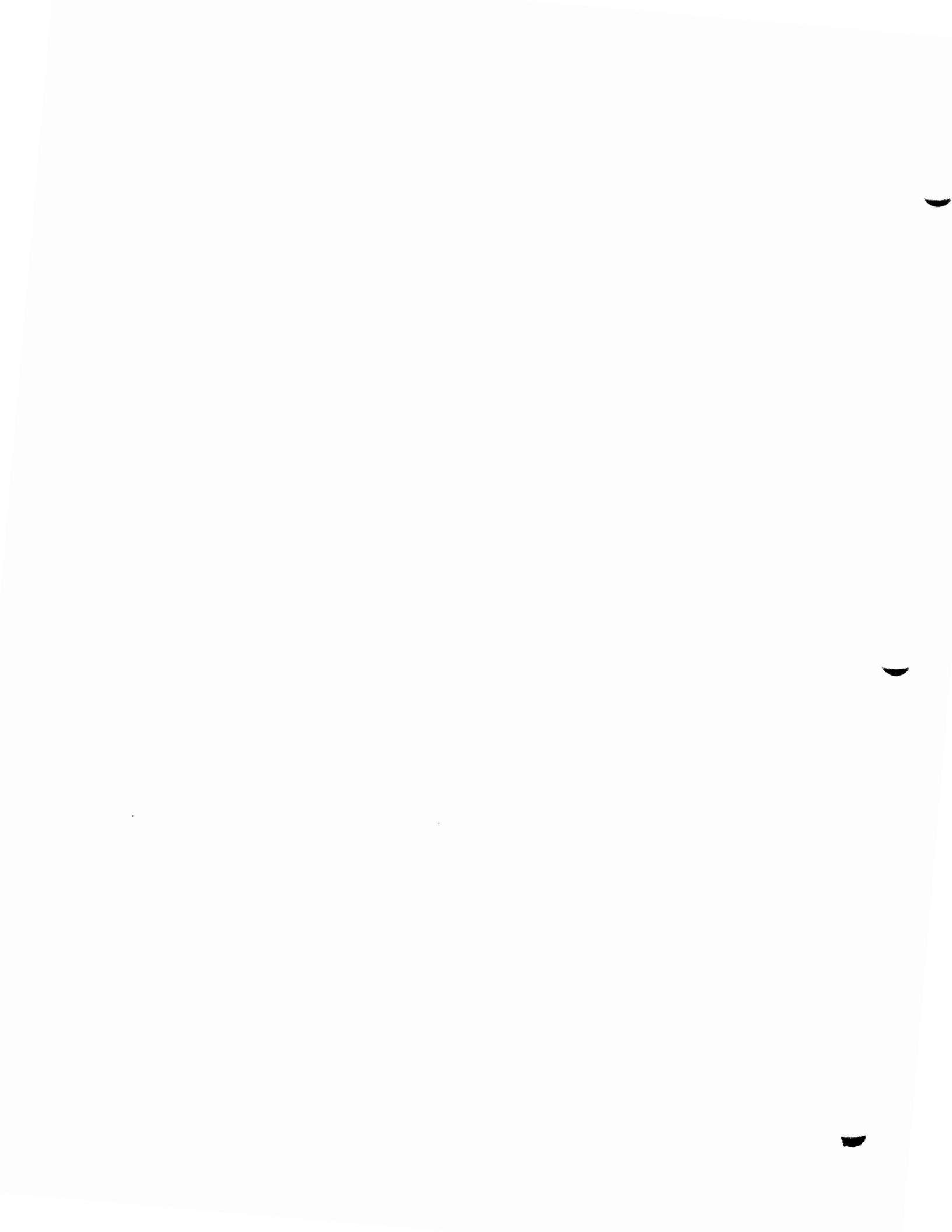
Potassium (K)

Protein, Total

Sodium (NA)

Triglycerides

Uric Acid



Creatine Kinase (CK, CPK)

Note 1: If any two of the following HCPCS procedure codes are performed on the same day by automated equipment and the total reimbursement of the two chemistry tests would have exceeded \$5.00, the maximum reimbursement will not be more than \$5.00: 82040, 82150, 82250, 82251, 82310, 82374, 82435, 82465, 82550, 82565, 82947, 82977, 83540, 83550, 83615, 83718, 83735, 84060, 84075, 84100, 84132, 84155, 84295, 84450, 84460, 84478, 84520, 84550.

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

A/G Ratio  
 BUN/Creatinine Ratio  
 Free Calcium

Globulin  
 FTI (T7)  
 Free Thyroxine

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

Note 4: Code (W8200)--Glucose (separate tube, gray top) performed on the same date as the following chemistry profiles 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018 and 80019 will be paid an additional \$2.00.

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

Note 1: Code 80091--Thyroid panel

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

Note 2: Code 80092--Thyroid panel with TSH

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

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

4. Code 82728--Ferritin

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

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

6. Code 84202--Protoporphyrin, RBC; quantitative--Utilize only for testing of anemia. Utilize code 84203--Protoporphyrin, RBC; screen when testing for anemia. Code 84203 will not be reimbursed when billed in conjunction with code





83655--Blood lead determination (quantitative).

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

8. Codes 85023 and 85025--Hematology

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

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

The code for manual differential WBC count (85007) will not be reimbursed in conjunction with codes 85021, 85022, 85023, 85024, 85025, and 85027.

Codes for platelet count (85590 and 85595) will not be reimbursed in conjunction with codes 85023-85027.

Code 85044 may be reimbursed in conjunction with codes 85023 and 85025, when a complete hemogram is ordered.

9. Codes 87040, 87045, 87060, 87070, 87184--Cultures

Note: These codes may only be billed when a pathogenic microorganism is reported. A culture that indicates no growth or normal flora must be billed as a presumptive culture, 87081 or 87082.

10. Code 88155--Pap smear

Note: Obtaining specimen is not a separate eligible service.

11. Codes 88348 and 88349--Electron microscopy; diagnostic and scanning are not reimbursable when used as a research tool.

Note: For reimbursement purposes, Medicaid will pay for the above diagnostic scanning procedure when it pertains to x-ray microanalysis for

identification of asbestos particles and heavy metals, that is, gold, mercury, etc. and also when examining tissue specimens in occasional cases of malabsorption.

12. Code 89360--Sweat (without iontophoresis) test

Note: Reimbursement not eligible for qualitative tests. For reimbursement purposes, 84295 will not be reimbursed at any additional charge. Do not bill 84295 in conjunction 89360.

13. Code 36415--Utilize this code only for finger/heel/ear stick for collection of specimen(s). This service is reimbursable in the physician office laboratory (POL) when the specimen is not referred out to an independent clinical laboratory for testing. Finger/heel/ear stick is not reimbursable when billed by the independent clinical laboratory.

14. Code G0001--This service is reimbursable in the physician office laboratory (POL) when the specimen is not referred out to an independent clinical laboratory for testing. Venipuncture is not reimbursable when billed by the independent clinical laboratory. It is considered all inclusive as part of the laboratory test.

15. Code W8200--This code is reimbursable when submitted on same claim, and performed on same date as chemistry profiles.

16. Code W8900--This code may be used only once per trip regardless of the number of beneficiaries seen and requires a distance in excess of 20 miles per round trip.

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NJ ADC 10:61-3.5  
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**NEW JERSEY ADMINISTRATIVE CODE**  
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**CHAPTER 61. INDEPENDENT CLINICAL**  
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**APPENDIX A**

Current through June 2, 1997; 29 N.J. Reg. No. 11

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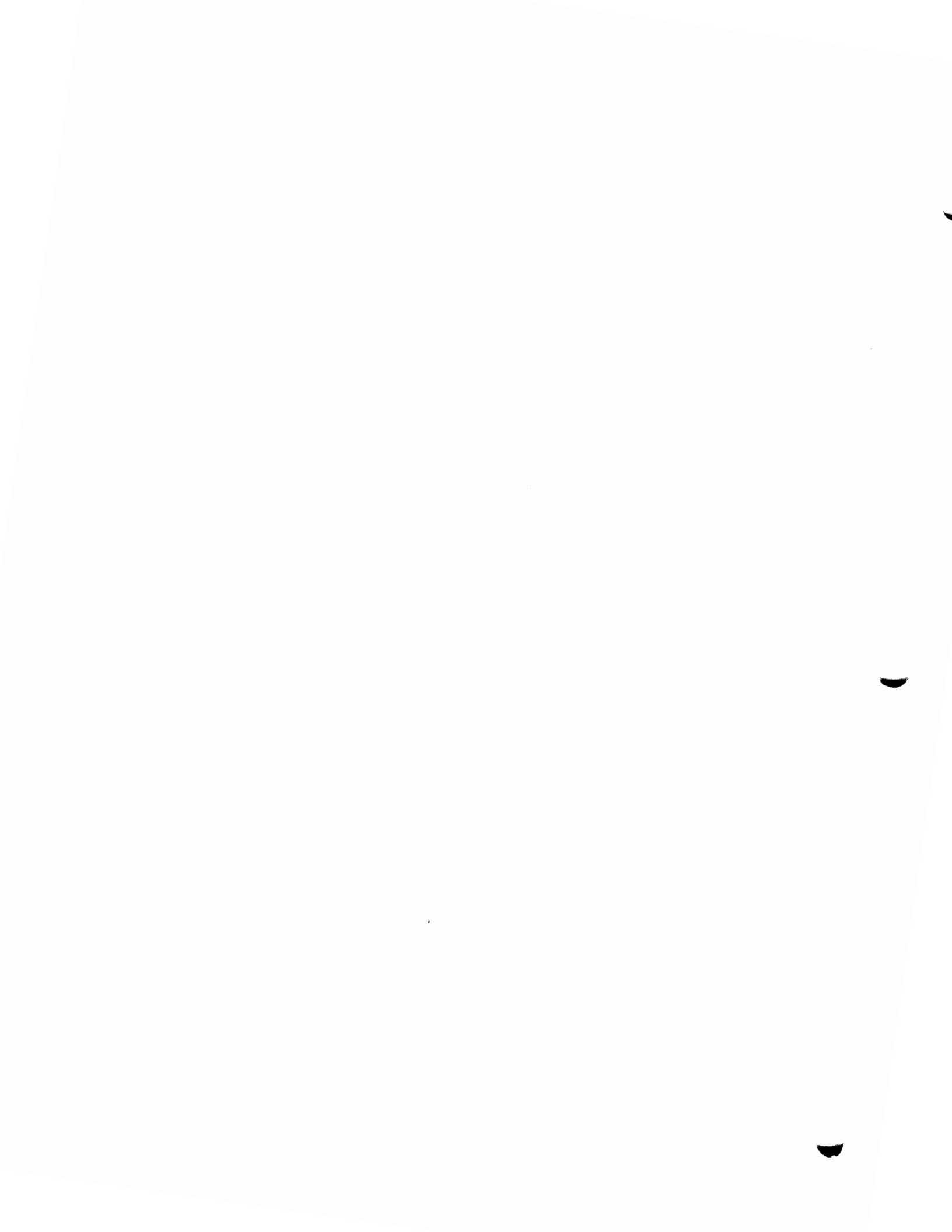
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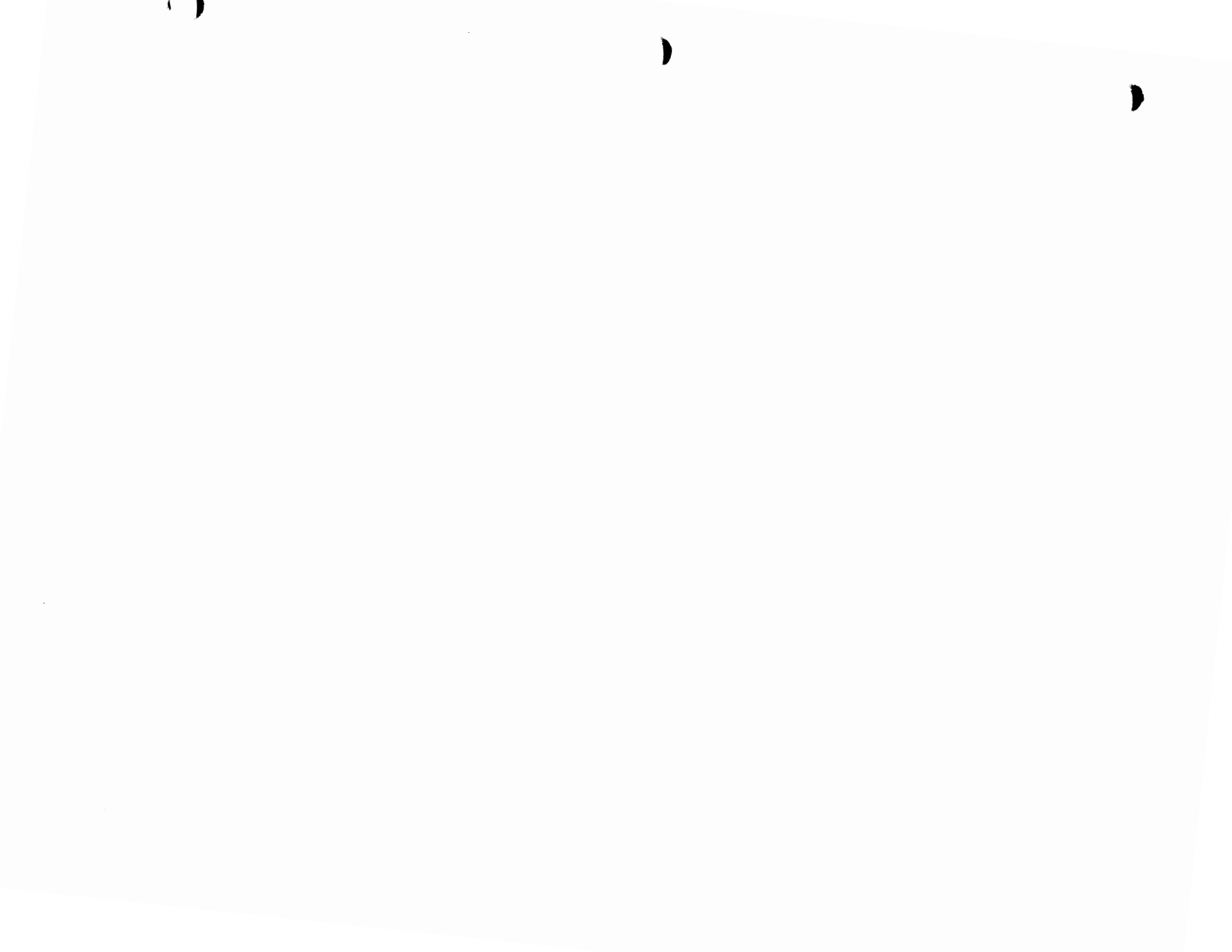
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1. N.J.A.C. T. 10, Ch. 62, Refs & Annos NEW JERSEY ADMINISTRATIVE CODE  
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MANUAL
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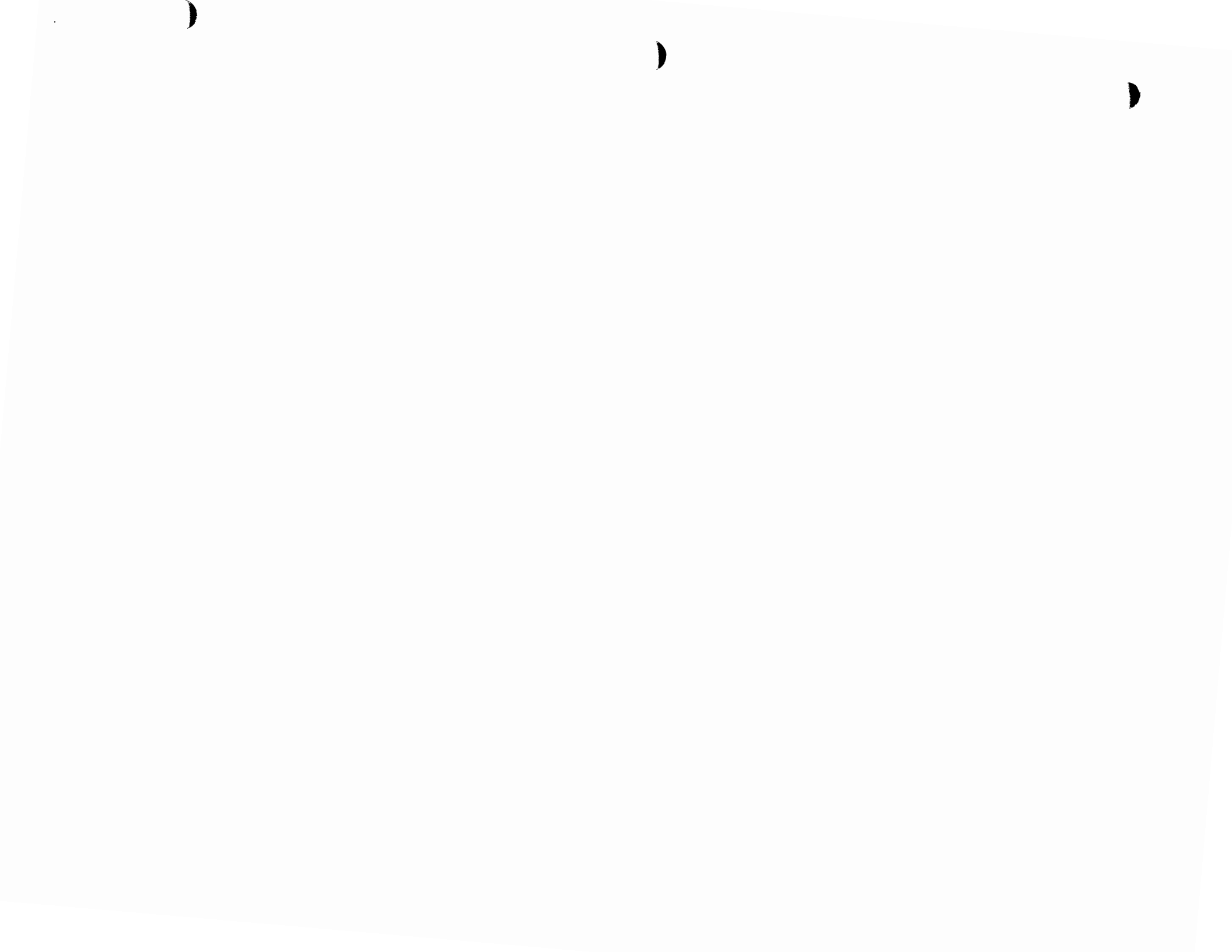
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