(b) Diagnostic endoscopy: The following are the qualifiers for HCPCS procedure codes for diagnostic endoscopic procedure codes.

1. Respiratory System (CPT codes 30000-32999)

31520 Laryngoscopy direct, with or without tracheoscopy; diagnostic newborn.
QUALIFIER: When combined with another endoscopic procedure, each procedure may be reimbursed at 100% of the maximum fee allowance.

31525 Laryngoscopy direct, with or without tracheoscopy; diagnostic except newborn.
QUALIFIER: When combined with another endoscopic procedure, each procedure may be reimbursed at 100% of the maximum fee allowance.

31575 Laryngoscopy, flexible fiberoptic; diagnostic
QUALIFIER: When combined with another endoscopic procedure, each procedure may be reimbursed at 100% of the maximum fee allowance.

31615 Tracheobronchoscopy through established tracheostomy incision.
QUALIFIER: When combined with another endoscopic procedure, the procedure may be reimbursed at the rate of the maximum fee allowance of the procedure of the "deepest penetration".

31622 Diagnostic (flexible or rigid) with or without all washing or brushing.
QUALIFIER: When combined with another endoscopic procedure, the procedure may be reimbursed at the rate of the maximum fee allowance of the procedure of the "deepest penetration".

2. Hemic and Lymphatic systems (CPT codes 38100-39599)

39400 22 Mediastinoscopy with biopsy
QUALIFIER: Multiple surgery pricing applies.

3. Digestive system (CPT codes 40490-49999)

i. Upper gastrointestinal system

43200 Esophagoscope, rigid or flexible; diagnostic, with or without removal of foreign body
QUALIFIER: When combined with another endoscopic procedure, the procedure may be reimbursed at the rate of the maximum fee allowance of the procedure of the "deepest penetration".

43234 Upper gastrointestinal endoscopy simple primary examination (e.g. with small diameter flexibile fiberscope)
QUALIFIER: When combined with another endoscopic procedure, the procedure may be reimbursed at the rate of the maximum fee allowance of the procedure of the "deepest penetration".

43235 Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum, as appropriate; complex diagnostic
QUALIFIER: When combined with another endoscopic procedure, the procedure may be reimbursed at the rate of the maximum fee allowance of the procedure of the "deepest penetration".

ii. Lower gastrointestinal

45300 Proctosigmoidoscopy; diagnostic (separate procedure)
QUALIFIER: When combined with another endoscopic procedure, the procedure may be reimbursed at the rate of the maximum fee allowance of the procedure of the "deepest penetration".

45330 Sigmoidoscopy, flexible fiberoptic; diagnostic
QUALIFIER: When combined with another endoscopic procedure, the procedure may be reimbursed at the rate of the maximum fee allowance of the procedure of the "deepest penetration".

46600 Anoscope: diagnostic (separate procedure)
QUALIFIER: This diagnostic endoscopy procedure has the least penetration: (despite the "high" HCPCS number). When combined with another endoscopic procedure in the same body system, the reimbursement is at the rate of the maximum fee allowance of any other procedure code that denotes the "deepest penetration".

iii. Biliary tract;

47550 Biliary endoscopy, intraoperative (kaleidoscope)
QUALIFIER: When combined with another endoscopic procedure, each procedure may be reimbursed at 100% of the maximum fee allowance.

47552 Biliary endoscopy, intraoperative (kaleidoscope)
QUALIFIER: When combined with another endoscopic procedure, each procedure may be reimbursed at 100% of the maximum fee allowance.

iv. Urinary system (CPT codes 50010-53899)

50951 Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
QUALIFIER: When combined with another endoscopic procedure, each procedure may be reimbursed at 100% of the maximum fee allowance.

50970 Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
QUALIFIER: When combined with another endoscopic procedure, each procedure may be reimbursed at 100% of the maximum fee allowance.

52000 Cystourethroscopy (separate procedure)
QUALIFIER: When combined with another endoscopic procedure, each procedure may be reimbursed at 100% of the maximum fee allowance.

v. Female genital system (CPT codes 56000-58999)

57452 Colposcopy (vaginoscopy); (separate procedure)
QUALIFIER: When combined with another endoscopic procedure, each procedure may be reimbursed at 100% of the maximum fee allowance.

(c) HCPCS Code Qualifiers

41872 Gingivoplasty
QUALIFIER: Reimbursement is based upon a dollar amount for each quadrant.

50590 Lithotripsy, extracorporeal shock wave (Professional Component) (PC)
QUALIFIER: For the Professional Component of lithotripsy, extracorporeal shock wave (ESWL), reimbursement includes all professional services (Professional Component pertaining to ESWL performed by the treating physician during this hospitalization, consortium visit or office visit. This code excludes reimbursement of the Technical Component of the ESWL service.

55250 Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)
QUALIFIER: As a primary sterilization (family planning procedure), a completed consent form must be attached to the 1500 N.J. claim form. See N.J.A.C. 10:54-5.16 for regulations on sterilizations and hysterectomy.

55450 Ligation (percutaneous) of vas deferens, unilateral or

New Jersey State Library

bilateral (separate procedure)
QUALIFIER: As a primary sterilization (family planning procedure), a completed consent form must be attached to the 1500 N.J. claim form. See N.J.A.C. 10:54-5.16 for regulations on sterilization and hysterectomy.

58301 WM Removal of intrauterine device by certified nurse midwife.

58611 Ligation or transection of fallopian tube(s) when done at the time of obstetrical delivery (caesarean section) or intra-abdominal surgery (not a separate procedure)
QUALIFIER: This procedure code may be billed separately in addition to the appropriate procedure codes for primary obstetrical or abdominal surgery procedure. This also includes those obstetrical procedure codes used by HealthStart identified providers.

59510 Caesarean delivery only including postpartum care
59514 QUALIFIER: For anesthesia during Caesarean Section,
59515 use Anesthesia reimbursement methodology including the AA modifier and indicating the standard anesthesia formula (time in units of 15 minute intervals) when used in combination with HCPCS 62278 or 62279.

62278 Injection of anesthesia substance (including narcotics), diagnostic or therapeutic; epidural, lumbar or caudal, single
QUALIFIER: Only for use during labor or intractable pain, (including insertion of catheter or cannula—lumbar or caudal—single, regardless of time).

62279 Injection of anesthesia substance (including narcotics), diagnostic or therapeutic; epidural, lumbar or caudal, continuous
QUALIFIER: Only for use during labor or intractable pain, (including insertion of catheter or cannula—lumbar or caudal—continuously, regardless of time). Reimbursement is at a flat fee unless C-Section is necessary; then, separate reimbursement for the C-Section and anesthesia using the anesthesia reimbursement formula is allowed. This procedure code may be used with HCPCS 59515.

66170 Fistula of sclera for glaucoma; trephination with iridectomy; trabeculectomy
QUALIFIER: This procedure code may be billed with the following other procedure codes representing other optical procedure (HCPCS 65850, 66030, 66625, and 67500) and be reimbursed according to the multiple surgical policy.

66920 Discission of secondary membranous cataract
QUALIFIER: This procedure code must not be billed with any other procedure code representing any other optical procedure.

66930 Removal of secondary membranous cataract
QUALIFIER: This procedure code must not be billed with any other procedure code representing any other optical procedure.

66940 Removal of lens material; aspiration techniques, one or more stages.
QUALIFIER: This procedure code must not be billed with any other procedure code representing any other optical procedure.

67221 Photodynamic therapy
QUALIFIER: This procedure code may be billed with 67225. This procedure code must be rendered by ophthalmologists who are retinal specialists, and shall be limited to patients meeting the following criteria:
Best corrected visual acuity equal to or better than 20/200 if the decreased visual acuity is caused by the macular degeneration; and Classic subfoveal choroidal neovascularization (CNV), occupying 50 percent or greater of the entire ocular lesion; and
A reported ICD-9 CM diagnosis of 115.02, 115.92, 362.21 or 362.52 (exudative senile macular degeneration)
NOTE: Report HCPCS procedure code 67225 on the CMS 1500 claim form for procedures performed on a second eye when both eyes are treated on the same date of service. Evaluation and management (E&M) services, fluorescent angiography (FA) and other ocular diagnostic services may also be billed separately when determined medically necessary and provided on the same date of service.
Modifiers LT or RT should be used on all claims for codes 67221 and 67225, whether initial or subsequent treatment.

67225 Photodynamic therapy, second eye, at single session
QUALIFIER: This procedure code must be billed with 67221. This procedure code must be rendered by ophthalmologists who are retinal specialists, and shall be limited to patients meeting the following criteria:
Best corrected visual acuity equal to or better than 20/200 if the decreased visual acuity is caused by the macular degeneration; and
Classic subfoveal choroidal neovascularization (CNV), occupying 50 percent or greater of the entire ocular lesion; and
A reported ICD-9 CM diagnosis of 115.02, 115.92, 362.21 or 362.52 (exudative senile macular degeneration).
NOTE: Report HCPCS procedure code 67225 on the CMS 1500 claim form for procedures performed on a second eye when both eyes are treated on the same date of service.
Evaluation and management (E&M) services, fluorescent angiography (FA) and other ocular diagnostic services may also be billed separately when determined medically necessary and provided on the same date of service.
Modifiers LT or RT should be used on all claims for codes 67221 and 67225, whether initial or subsequent treatment.

69930 Cochlear device implantation, with or without mastoidectomy
QUALIFIER: Reimbursement limited to those cases that meet the current Medicare Selection Criteria.

70470 52 Limited computerized axial tomography, head or body
70482 52 for medical necessary follow-up or monitoring
70488 52 QUALIFIER: For C.A.T. scan guidance (monitoring)
70492 52 performed in conjunction with biopsy, aspiration, punc-
71270 52 ture, injection of contrast material, placement of tube
74170 52 stint, drain, etc. use codes with modifier "52".

(d) Magnetic Resonance Imaging (MRI) Diagnostic Services:

QUALIFIER: An MRI service provided by physicians in an office setting may only be billed to and reimbursed by Medicaid when the recipient is other than a hospital inpatient. The Medicaid Maximum Fee Allowance is the composite rate and must not be split between the technical component and the professional component. These rules apply to the billing of the HCPCS for MRI as follows:

70540	72148
70551	72156
70552	72157
70553	72158
71550	72196
72141	72220
72142	73720
72146	73721
72147	74181

72170 Radiologic examination, pelvis; anteroposterior only
QUALIFIER: Pelvis x-ray is not eligible for separate payment when performed in conjunction with complete lumbarsacral spine x-rays (72100, 72110, 72114, 72120)

76805 Echography, pregnant uterus, B-scan and/or real time with image documentation; complete (complete fetal and maternal evaluation)

QUALIFIER: Limited to one complete study per pregnancy per provider. Any additional medically necessary studies performed by the same provider will be reimbursed as HCPCS 76815 (limited study). Also, only one study (complete or limited or follow-up) can be reimbursed to the same provider on a given day.

76815 Echography, pregnant uterus, B-scan and/or real time with image documentation; limited (gestational age, heart beat, placental location, fetal position, or emergency in the delivery room.)
QUALIFIER: Subsequent to the third study, a statement of medical necessity attesting that the pregnancy is high risk with substantiating reasons is required to be attached to the claim. Only one study (complete or limited or follow-up) can be reimbursed to the same provider on a given day.

76816 Echography, pregnant uterus, B-scan and/or real time with image documentation; follow-up or repeat
QUALIFIER: Subsequent to the third study, a statement of medical necessity attesting that the pregnancy is high risk with substantiating reasons is required to be attached to the claim. Only one study (complete or limited or follow-up) can be reimbursed to the same provider on a given day.

77790 Supervision, handling and loading radioelement
QUALIFIER: Reimbursable only when performed by a Radiologist

78805 Radionuclide localization of abscess: limited area
QUALIFIER: Reimbursable only when performed by a Radiologist.

*** FOR QUALIFIERS FOR PATHOLOGY AND LABORATORY SERVICES PROCEDURE CODES, SEE THE SECTION OF THIS SUBCHAPTER AT N.J.A.C 10:54-9.9.

**** FOR QUALIFIERS FOR PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASARR), SEE THE SECTION OF THIS SUBCHAPTER AT N.J.A.C. 10:54-9.10.

90741 Immunization, passive; Immune serum globulin, human (ISG)
QUALIFIER: Prior authorization from the Medical Consultant at the Medicaid District Office is required.

90742 Immunization, passive; Specific hyperimmune serum globulin, human (ISG); e.g. hepatitis B, measles, pertussis, rabies, Rho(D), tetanus, vaccinia, varicella zoster
QUALIFIER: Prior authorization from the Medical Consultant at the Medicaid District Office is required.

90780 IV infusion therapy, (excluding allergy, immunizations and chemotherapy) administered by physician exclusive of his/her other duties or under direct supervision of physician by a practitioner; up to one hour
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 physician's presence with the patient to the exclusion of his other duties.

90781 IV infusion therapy, (excluding allergy, immunization and chemotherapy) administered by physician exclusive of his or her other duties or under direct supervision of physician; each addition hour after first hour, up to eight hours
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 physician's presence with the patient to the exclusion of his or her other duties.

90799 Unlisted therapeutic or diagnostic injection (For allergy immunization, see HCPCS 95000 et seq.)
QUALIFIER: This procedure code may be used for intradermal, subcutaneous, or intra arterial injections. Reimbursement is on a flat fee basis and are all inclusive for the cost of the service and the materials. (See also N.J.A.C. 10:54 for reimbursement using "J" codes.) Intravenous and intra-arterial injections are reimbursable only when performed by the physician.

90801 Initial Comprehensive Psychiatric Evaluation
DESCRIPTION: Psychiatric diagnostic interview examination including history, mental status or disposition (may include communication with family or other sources, ordering medical interpretation of laboratory or other medical diagnostic studies. In circumstances other informants will be seen in lieu of the patient.)
QUALIFIER: This code requires for reimbursement purposes a minimum of 50 minutes of direct clinical involvement with the patient or family member. No more that one claim is reimbursable per the same patient, per the same physician, per year.

90830 Psychological testing, by physician, with a written report, per hour
QUALIFIER: One unit is equal to 1 hour of psychological testing.

90843 Individual Psychotherapy—20-30 minute session
QUALIFIER: This code requires for reimbursement purposes a minimum of 25 minutes of direct personal clinical involvement with the patient or family member.

90844 Individual Psychotherapy—45-50 minute session
QUALIFIER: This code requires for reimbursement purposes a minimum of 50 minutes of direct personal clinical involvement with the patient or family member.

90847 Family Therapy—50 minute session
QUALIFIER: This code requires for reimbursement purposes a minimum of 80 minutes of direct personal clinical involvement with the patient or family member.

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

90853 Group medical psychotherapy (other than of a multiple-family group) by a physician, with continuing medical diagnostic evaluation and drug management when indicated
QUALIFIER: Psychotherapy Group (maximum 8 persons per group: 90 minutes, per person, per session.)

90887 Family Conference—25 minute session
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.

92568 Acoustic reflex testing
QUALIFIER: Must include at least two (2) frequencies per ear.

92977 Thrombolysis, coronary; by intravenous infusion
QUALIFIER: Reimbursable only when performed by a physician whose personal involvement would include the exclusion of all other duties and services.

97799 Physical therapy
QUALIFIER: This procedure code may be used for the initial evaluation for physical therapy in the home or for physical therapy in a physicians office or independent clinic. Must not be used for continuing physical therapy in the home or in hospital inpatient or outpatient settings.

99082 Unusual travel (e.g. transportation and escort of patient)
QUALIFIER: This procedure code may be used for travel costs only associated and billed with HOUSE CALL or HOME VISIT. (See procedure codes 99341, 99341WM, 99342, 99342 WM, 99343, 99351, 99351WM, 99352, 99352 WM, 99353.

99190 Assembly and operation of pump with oxygenator or heat exchanger (with or without ECG and/or pressure monitoring); each hour
QUALIFIER: Reimbursable only when personally performed by a physician.

99191 Assembly and operation of pump with oxygenator or heat exchanger (with or without ECG and/or pressure monitoring); ¾ hour
QUALIFIER: Reimbursable only when personally performed by a physician.

99192 Assembly and operation of pump with oxygenator or heat exchanger (with or without ECG and/or pressure monitoring); ½ hour
QUALIFIER: Reimbursable only when personally performed by a physician.

(e) The following statements and qualifiers apply to the "Evaluation and Management" procedure codes (HCPCS 99201-99499).

OFFICE OR OTHER OUTPATIENT SERVICES—NEW PATIENT; HOSPITAL INPATIENT SERVICES—INITIAL HOSPITAL CARE; NURSING FACILITY SERVICES—COMPREHENSIVE NURSING FACILITY ASSESSMENTS; AND DOMICILIARY, REST HOME, OR CUSTODIAL CARE SERVICES—NEW PATIENT

(Excludes Preventive Health Care for patients through 20 years of age.)

99201
99202
99203
99204
99205
99221
99222
99223
99301
99302
99303
99321
99322
99323

When reference is made in your CPT manual to Office or Other Outpatient Services—New Patient; Hospital Inpatient Services—Initial Hospital Care; Nursing Facility Services—Comprehensive Nursing Facility Assessments; and Domiciliary, Rest Home, or Custodial Care Services-New Patient; the intent of Medicaid is to consider this service as the Initial Visit.

When the setting for this Initial Visit is an office or residential health care facility, for reimbursement purposes it is limited to a single visit. Future use of this category of codes will be denied when the recipient is seen by the same physician, group of physicians, or involves a shared health care facility which is a group of physicians sharing a common record. Reimbursement for an initial office visit also precludes subsequent reimbursement for an initial residential health care facility visit and vice versa.

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 physician, group, shared health care facility, or practitioner sharing a common record.

If the setting is a nursing facility or hospital, the Initial Visit concept will still apply for reimbursement purposes despite CPT reference to the term Initial Hospital Care or Comprehensive Nursing Facility Assessments. Subsequent readmissions to the same facility may be reimbursed as Initial Visits, if the readmission occurs in more than 30 days from a previous discharge from the same facility by the same provider. In instances when the

readmission occurs within 30 or less days from a previous discharge, the provider shall bill the relevant HCPCS procedure codes specified in the qualifier under the headings Subsequent Hospital Care or Subsequent Nursing Facility Care.

Initial Hospital Visit during a single admission will be disallowed to the same physician, 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.

It is also to be understood that in order to receive reimbursement for an Initial Visit, the following minimal documentation must be on the record regardless of the setting where the examination was performed:

Example:

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

   NOTE: Record and documentation of visits to patients in residential health care facilities should be maintained in the providers' office record.

   EXCEPTIONS: HCPCS procedure codes 99201 and 99202 are exceptions to the above requirements outlined in the qualifier for the initial visit. For codes 99201 and 99202, the provider is expected to follow the qualifier applied to routine visit or follow-up care visit for reimbursement purposes.

OFFICE OR OTHER OUTPATIENT SERVICES—ESTABLISHED PATIENT; HOSPITAL INPATIENT SERVICES—SUBSEQUENT HOSPITAL CARE; NURSING FACILITY SERVICES—SUBSEQUENT NURSING FACILITY CARE; AND DOMICILIARY, REST HOME OR CUSTODIAL CARE SERVICES—ESTABLISHED PATIENT

(Excludes Preventive Health Care for patients through 20 years of age.)

99211
99211WM
99212
99212WM
99213
99213WM
99214
99214WM
99215
99215WM
99231
99232
99233
99311
99312
99313
99331
99332
99333

When reference is made in your CPT manual to Office or Other Outpatient Services—Established Patient; Hospital Inpatient Services—Subsequent Hospital Care; Nursing Facility Services—Subsequent Nursing Facility Care; and Domiciliary, Rest Home or Custodial Care Services—Established Patient; 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.

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

1. In an office, or residential health care facility.
   (a) Purpose of visit;
   (b) Pertinent history obtained;
   (c) Pertinent physical findings including pertinent negative findings based on the above;
   (e) Lab, X-ray, EKG, etc., ordered with results; and
   (f) Diagnosis.
2. In a hospital or nursing facility setting.
   (a) Update of symptoms;
   (b) Update of physical findings;
   (c) Resume of findings of procedures, if any done;
   (d) Pertinent positive and negative findings of lab, X-ray;
   (e) Additional planned studies, if any, and why; and
   (f) Treatment changes, if any.

HOME SERVICES AND HOUSE CALLS

99343
99353

House Call

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 physician visit limited to the provision of medical care to an individual who would be too ill to go to a physician'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
99341WM
99342
99342WM
99351
99351WM
99352
99352WM

Home Visit

For purposes of Medicaid reimbursement, these codes apply when the provider visits Medicaid recipients in the home setting and the visit does not meet the criteria specified House Call listed above.

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. Purpose of visit;
2. Pertinent history obtained;
3. Pertinent physical findings, including pertinent negative physical findings based on 1. and 2.;
4. 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.

CONSULTATIONS

A consultation is recognized for reimbursement only when performed by a specialist recognized as such by this Program and the request has been made by or through the patient's attending physician and the need for such a request would be consistent with good medical practice. Two types of consultation are recognized for reimbursement—comprehensive consultation and limited consultation.

COMPREHENSIVE CONSULTATION

99244
99245
99254
99255
99274
99275

In order to receive reimbursement for HCPCS codes 99244, 99245, 99254, 99255, 99274 and 99275, the performance of a total systems evaluation by history and physical examination, including a total systems review and total system physical examination, are required. An alternative to that would be the utilization of one or more hours of the consulting physician's personal time in the performance of the consultation.

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

Examples:

1. I personally performed a total (all) systems evaluation by history and physical examination, or
2. This consultation utilized 60 or more minutes of my personal time.

The following rules regarding consultations should also be recognized:

1. If a consultation is performed in an inpatient or outpatient setting and the patient is then transferred to the consultant's service during that course of illness, then the provider may not bill for an Initial Visit if he/she bills for the consultation.

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

New Patient		Established Patient	
15783	15822	19325 50	30430
15786	15823	19325	30435
15787	15824		30450
15788	15826	21120	30460
15789	15831	through	30462
15792		21198	30520
15793			

(h) Physician Administered Drugs

1. The New Jersey Division of Medical Assistance and Health Services provides physician reimbursement for the administration of medications. Reimbursement will continue to be available for the administration of the drug. The procedure code 90799 may be billed for intradermal, subcutaneous, intramuscular, or intravenous drug administration.

2. However, reimbursement for the drug administered by a physician, other than immunizations, was only available if a prescription was issued and the drug was obtained from a pharmacy which directly billed the New Jersey Medicaid program.

3. Unless otherwise indicated, the Medicaid maximum fee allowance shall be based on the AWP per unit which equals one cubic centimeter (CC) or milliliter (ml). For drug vials with a volume equal to one cc or ml, the Medicaid maximum fee allowance shall be based on the cost per vial. For further information on physician administered drugs, see N.J.A.C. 10:54-8.6.

HCPCS Code	Description	Maximum Fee Allowance
J0690	Cefazolin 500 mg	$ 1.92
J0696	Ceftriaxone 250 mg	10.24
J1100	Dexamethasone 4 mg	0.80
J1200	Diphenhydramine 50 mg	0.55
J2550	Promethazine 50 mg	0.42
J2680	Fluphenazine Decanoate 25 mg	9.50
J2790	RhoGAM, Rho (D) Immune Globulin (Human) Single dose (Micro-Dose)	20.40
J2790 22	RhoGAM, Rho (D) Immune Globulin (Human) Single dose (Full dose) (22—Services greater than usual)	72.07
J9000	Doxorubicin 10 mg	42.00
J9010	Doxorubicin 50 mg	195.50
J9020	Asparaginase 10,000 Units	50.36
J9031	BCG Live Vaccine 27 mg	152.13
J9040	Bleomycin Sulfate 15 units	255.08
J9045	Carboplatin 50 mg	72.01
J9060	Cisplatin Powder or Solution 10 mg	30.33
J9070	Cyclophosphamide 100 mg	4.91
J9100	Cytarabine 100 mg	6.72
J9130	Decarbazine 100 mg	12.00
J9190	Fluorouracil 50 mg	0.18
J9217	Lupron 7.5 mg	451.25
J9230	Mechlorethamine HCl 10 mg	10.10
J9240	Medroxyprogesterone 100 mg	9.05
J9240 22	Medroxyprogesterone 400 mg	31.50
J9260	Methotrexate Sodium 50 mg	4.75
J9280	Mitomycin 5 mg	119.08
J9360	Vinblastine Sulfate 1 mg	3.25
J9370	Vincristine 1 mg	27.50
W9095	Immunization—Tetanus antitoxin	6.60

(i) Hepatitis B Vaccine: Coverage is available for post exposure prophylaxis and for vaccination of individuals in selected high risk groups, regardless of age, in accordance with the criteria defined by the CDC. In all such cases, the need for this vaccination must be fully documented in the recipient's medical record. In order to facilitate reimbursement for Hepatitis B immunoprophylaxis for high risk individuals, manufacturer, age, and dose specific procedure codes have been developed for use by physicians and independent clinics providing this service.

EXCEPTION: The New Jersey Medicaid program will reimburse for the universal vaccination of infants born on and after January 1, 1992, whose immunization was delayed beyond the newborn period because this policy was not yet in effect. However, the immunization schedule must be completed before the infant's second birthday.

W9096	Hepatitis B immunoprophylaxis with Recombivax 1 HB, 0.25 ml dose. This code applies only to newborns of HBsAg negative mothers.	17.46
W9096 22	Hepatitis B immunoprophylaxis with Recombivax HB, 0.5 ml dose. This code applies only to newborns of HBsAg positive mothers.	32.79
W9097	Hepatitis B immunoprophylaxis with Recombivax HB, 0.25 ml dose. This code applies only to high risk recipients under 11 years of age (exclusive of newborns).	17.46
W9098	Hepatitis B immunoprophylaxis with Recombivax HB, 0.5 ml dose. This code applies only to high risk recipients 11-19 years of age.	32.79
W9099	Hepatitis B immunoprophylaxis with Recombivax HB, 1.0 ml dose. This code applies only to high risk recipients over 19 years of age.	63.57
W9333	Hepatitis B immunoprophylaxis with Engerix-B, 0.5 ml dose. This code applies only when immunizing newborns.	27.88
W9334	Hepatitis B immunoprophylaxis with Engerix-B, 0.5 ml dose. This code applies only to high risk recipients under 11 years of age (exclusive of newborns)	27.88
W9335	Hepatitis B immunoprophylaxis with Engerix-B, 1.0 ml dose. This code applies only to high risk recipients over 11 years of age.	62.09
W9336	Medroxyprogesterone Acetate 150 mg	36.90
W9337	Cephradine 250 mg	2.34
W9338	TETRAMUNE, a biological combining Diphtheria, Tetanus Toxoids and Pertussis Vaccine (DTP) with Hemophilus B Conjugate Vaccine	30.27
	QUALIFIER: Not to be billed separately with HCPCS 90701 or 90731.	
W9339	Lupron 3.75 mg	360.63
W9343	Lupron Depot Pediatric 7.5 mg	451.25
W9344	Lupron Depot Pediatric 11.25 mg	811.25
W9345	Lupron Depot Pediatric 15 mg	902.50

Amended by R.2006 d.26, effective February 6, 2006.
See: 37 N.J.R. 3538(a), 38 N.J.R. 966(a).
In (c), corrected the placement of HCPCS code 66170 and added the qualifiers for the new HCPCS procedure codes 67221 and 67225.

10:54-9.9 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 (C02)
Clorides (C1)
Cholesterol
Creatine Kinase (CK, CPK)
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

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 & urine levels, up to 5 hourly specimens.

8. Codes 85023 and 85025—Hematology

NOTE: For purpose of reimbursement based on this schedule, a complete blood count (CBC) includes a

Next Page is 54-122.1

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).