

**CHAPTER 54  
PHYSICIAN SERVICES**

**Authority**

N.J.S.A. 30:4D-6a(5); 30:4D-7, 7a, b and c;  
30:4D-12; 42 CFR 440.50.

**Source and Effective Date**

R.2001 d.51, effective January 12, 2001.  
See: 32 N.J.R. 3929(a), 33 N.J.R. 555(a).

**Chapter Expiration Date**

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 54, Physician Services, expires on July 11, 2006. See: 38 N.J.R. 907(a).

**Chapter Historical Note**

Chapter 54, Manual for Physician's Services, was adopted and became effective prior to September 1, 1969.

Subchapter 3, Procedure Code Manual, was repealed, and Subchapter 4, HCFA Common Procedure Coding System (HCPCS), was adopted as new rules by R.1986 d.52, effective March 3, 1986. See: 17 N.J.R. 1519(b), 18 N.J.R. 478(a).

Pursuant to Executive Order No. 66(1978), Chapter 54, Manual for Physician's Services, was readopted as R.1991 d.136, effective February 15, 1991. See: 22 N.J.R. 3711(b), 23 N.J.R. 858(a).

Chapter 54, Manual for Physician's Services, was repealed, and Chapter 54, Physicians Services, was adopted as new rules by R.1996 d.66, effective February 5, 1996. See: 27 N.J.R. 4576(a), 28 N.J.R. 902(b).

Pursuant to Executive Order No. 66(1978), Chapter 54, Physician Services, was readopted as R.2001 d.51, effective January 12, 2001. See: Source and Effective Date. See, also, section annotations.

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(c) If authorized, the authorization letter of a medical consultant of the New Jersey Medicaid program will be forwarded to the attending physician. When submitting the claim for service to the Medicaid fiscal agent, the physician shall attach the authorization letter to the claim.

Amended by R.2001 d.51, effective February 5, 2001.  
See: 32 N.J.R. 3929(a), 33 N.J.R. 555(a).

In (a), substituted "Medical Assistance Customer Center (MACC)" for "Medicaid District Office (MDO)" preceding "in the area" and substituted "beneficiary" for "recipient" preceding "resides" in the introductory paragraph; in (a)1, substituted "Utilization Management" for "Health Services Administration" preceding ", Mental Health Services Unit,".

#### 10:54-3.4 Out-of-State elective services

(a) For a beneficiary residing in New Jersey in other than a hospital, who is to be admitted or referred to an out-of-State hospital or physician for elective inpatient or outpatient hospital services, the physician planning such action shall sign a statement that the medically necessary service is not available at a reasonable distance within the State of New Jersey and shall send the signed statement to the MACC.

(b) For a beneficiary traveling outside New Jersey who is to be admitted to an out-of-State hospital for elective surgery, as part of the prior authorization request, the attending physician shall justify the decision by sending to the Medical Assistance Customer Center (MACC), a signed statement that an attempt to return to a New Jersey hospital would create a significant risk to life or health or would create the need for an unreasonable amount of travel for the beneficiary.

Amended by R.2001 d.51, effective February 5, 2001.  
See: 32 N.J.R. 3929(a), 33 N.J.R. 555(a).

Substituted "beneficiary" for "recipient" and references to MACC for references to MDO throughout.

#### 10:54-3.5 Out-of-State emergencies and interstate transfers

(a) Prior authorization shall not be required for emergencies nor for interstate hospital transfers. However, in these instances, the hospital shall attach the attending physician's signed statement to the claim, attesting to the nature of the emergency; or, for a hospital interstate transfer, attesting to the unavailability of the medically necessary service within a reasonable distance within the State of New Jersey; or that the need to obtain prior authorization would result in a delay that could create a significant risk to life or health or unduly prolong hospitalization. The physician shall provide the hospital with a copy of the authorization letter to be attached to the claim from the hospital, when applicable.

(b) For prior authorization and preadmission screening for mental health and psychiatric services, see N.J.A.C. 10:54-7.1 and 7.4 of this Chapter.

## SUBCHAPTER 4. BASIS OF PAYMENT

### 10:54-4.1 General payment methodology

(a) Payment for physician services covered under the New Jersey Medicaid or NJ KidCare program is based upon the customary charge prevailing in the community for the same service but shall not exceed a "Maximum Fee Allowance Schedule" which has been determined reasonable by the Commissioner and set forth in N.J.A.C. 10:54-9 and as limited by Federal policy relative to the payment of physicians and other licensed health care practitioners.

1. In no event shall the charge to the New Jersey Medicaid or NJ KidCare program exceed the charge by the provider for identical services to other governmental agencies or other groups or individuals in the community.

2. Effective July 20, 1998, for services provided to beneficiaries eligible for both Medicare Part B and Medicaid or NJ KidCare, including Qualified Medicare Beneficiaries, Medicaid or NJ KidCare shall reimburse physicians and practitioners the Medicare Part B coinsurance and deductible amount or the Medicaid or NJ KidCare maximum fee allowable (less any third party payments, including Medicare reimbursement), whichever is less.

(b) The "Maximum Fee Allowance Schedule" differentiates rates according to whether the physician is a specialist or nonspecialist. (See N.J.A.C. 10:54-1.2 through 1.5 of this manual for regulations for specialist.)

(c) For reimbursement for injections and immunizations, see N.J.A.C. 10:54-4.3(a)6 and N.J.A.C. 10:54-9.8(h).

(d) For reimbursement for services of advanced practice nurses employed by a physician or physician group, see N.J.A.C. 10:58A-4.1 through 4.5, incorporated herein by reference.

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), inserted references to NJ KidCare throughout.

Amended by R.1998 d.382, effective July 20, 1998.

See: 30 N.J.R. 1255(b), 30 N.J.R. 2646(b).

In (a)2, inserted "Effective July 20, 1998," at the beginning, inserted references to NJ KidCare throughout, and substituted "less" for "greater" at the end.

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.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

### 10:54-4.2 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 NJ KidCare-Plan C and copayments for NJ KidCare-Plan D are set forth at 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 when the service is provided for preventive care, prenatal care, family planning services or substance abuse treatment services.

1. An office visit is defined as a face-to-face contact with a medical professional under the supervision of the physician, which meets the documentation requirements codified at N.J.A.C. 10:52-2.6 through 2.12.

2. Office visits include physician services provided in the office, patient's home, or any other site excluding hospital where the child may have been examined by the physician. Generally, these procedure codes are in the 90000 HCPCS series of reimbursable codes codified at N.J.A.C. 10:54-9.3.

3. Physician 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) Physicians 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 primary care and specialist physician 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) Physicians shall collect the copayment specified in (d) above except for those situations outlined in (f) below. Copayments shall not be waived.

(f) Physicians shall not charge a copayment under Plan D for services provided to newborns, who are covered under fee-for-service for Plan D; or for preventive services, including well child visits, lead screening and treatment, or 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).

Former N.J.A.C. 10:54-4.2, Use of physician reimbursement codes, recodified to N.J.A.C. 10:52-4.3.

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.

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).

#### 10:54-4.3 Use of physician reimbursement codes

When the examination of the beneficiary is by the same physician, a practitioner, a shared health facility or group of physicians/practitioners who share a common record, the examination is considered that of a single provider.

Recodified from N.J.A.C. 10:54-4.2 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).

Former N.J.A.C. 10:54-4.3, HCPCS codes for new patients visits, recodified to N.J.A.C. 10:54-4.4.

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.

Amended by R.2001 d.51, effective February 5, 2001.

See: 32 N.J.R. 3929(a), 33 N.J.R. 555(a).

Substituted "beneficiary" for "recipient" preceding "is by the same physician."

#### 10:54-4.4 HCPCS codes for new patients visits

(a) This rule applies to office, and hospital inpatient and outpatient services to new patients (excluding preventive health care for patients through 20 years of age).

(b) When the CPT manual refers to office or hospital inpatient or outpatient services-new patient, Medicaid will consider this service an initial visit.

1. When the setting for an initial visit is an office or residential health care facility, reimbursement shall be limited to a single visit. Future requests for reimbursement which include this category of codes will be denied when the beneficiary is seen by the same physician, practitioner, group of physicians/practitioners, or shared health care facility sharing a common record. Reimbursement for an initial office visit precludes subsequent reimbursement for an initial residential health care facility visit and vice versa.

2. 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 twelve month period by a physician, group, shared health care facility, or practitioner sharing a common record.

(c) If the setting is a nursing facility or hospital, the initial visit concept shall still apply when considered for reimbursement purposes despite CPT reference to the terms initial hospital care as applying to a new or established patient. 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).

(d) Reimbursement for an initial hospital visit shall be disallowed to the same physician, practitioner, group of physicians/practitioners, or shared health care facility sharing a common record who submit a claim for a consultation and transfer the patient to their service. "Consultation" and "Initial Hospital Visit" shall not be billed for the same provider on the same patient on the same day of service.

Amended by R.2001 d.51, effective February 5, 2001.

See: 32 N.J.R. 3929(a), 33 N.J.R. 555(a).

In (c)1, substituted "Utilization Management" for "Health Services Administration"; in (c)2, substituted "Medical Assistance Customer Center" for "Medicaid District Office"; and substituted references to beneficiary and beneficiaries for references to recipient and recipients throughout.

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

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

Rewrote (c)2.

## SUBCHAPTER 8. PHARMACEUTICAL SERVICES

### 10:54-8.1 Pharmaceutical; conditions for participation as provider of pharmaceutical services

(a) All covered pharmaceutical services shall be provided under the New Jersey Medicaid program shall be provided to Medicaid beneficiaries within the scope of N.J.A.C. 10:49, Administration; N.J.A.C. 10:51, Pharmaceutical Services; and N.J.A.C. 10:54-8, Physician Services.

(b) All drugs shall be prescribed.

1. "Prescribed drugs" means simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance, that are:

i. Prescribed by a practitioner licensed or authorized by the State of New Jersey, or the state in which he or she practices, to prescribe drugs and medicine within the scope of his or her license and practice:

ii. Dispensed by licensed pharmacists in accordance with regulations promulgated by the New Jersey Board of Pharmacy, N.J.A.C. 13:39; and

iii. Dispensed by licensed pharmacists on the basis of a written prescription that is maintained in the pharmacist's records.

Amended by R.2001 d.51, effective February 5, 2001.

See: 32 N.J.R. 3929(a), 33 N.J.R. 555(a).

In (a), substituted "beneficiaries" for "recipients".

### 10:54-8.2 Pharmaceutical; program restrictions affecting payment for prescribed drugs

(a) The choice of prescribed drugs shall be at the discretion of the prescriber within the limits of applicable laws. However, the prescriber's discretion is limited for certain drugs. Reimbursement may be denied if the requirements of the following rules are not met:

1. Covered and non-covered pharmaceutical services as listed in the Pharmaceutical Services chapter, N.J.A.C. 10:51-1.11 and 1.13, respectively, incorporated herein by reference;

2. Pharmaceutical services requiring prior authorization (see N.J.A.C. 10:51-1.14, incorporated herein by reference);

3. Quantity of medication (see N.J.A.C. 10:51-1.15, incorporated herein by reference);

4. Dosage and directions (see N.J.A.C. 10:51-1.16, incorporated herein by reference);

5. Telephone-rendered original prescriptions (see N.J.A.C. 10:51-1.17, incorporated herein by reference);

6. Changes or additions to the original prescription (see N.J.A.C. 10:51-1.18, incorporated herein by reference);

7. Prescription refill (see N.J.A.C. 10:51-1.19, incorporated herein by reference);

8. Prescription Drug Price and Quality Stabilization Act (N.J.S.A. 24:6E-1 et seq.) (see N.J.A.C. 10:51-1.20, incorporated herein by reference);

i. Products listed in the current New Jersey Drug Utilization Review Council (DURC) Formulary, (hereafter referred to as "the Formulary"), and all subsequent revisions, distributed to all prescribers and pharmacists; and

ii. Non-proprietary or generic dispensing (see N.J.A.C. 10:51-1.9, incorporated herein by reference).

9. Federal regulations (42 CFR 447.301, 331-333) that set the aggregate upper limits on payment for certain multi-source drugs if Federal Financial Participation (FFP) is to be made available. The limit applies to all "maximum allowable cost" drugs (see N.J.A.C. 10:51-1.5, Basis of payment, incorporated herein by reference);

10. Drug Efficacy Study Implementation (DESI): "Less than effective drugs" subject to a Notice of Opportunity for Hearing (NOOH) by the Federal Food and Drug Administration (see N.J.A.C. 10:51-1.21 and listing of DESI drugs in Appendix A of N.J.A.C. 10:51, incorporated herein by reference);

11. Drug Manufacturers' Rebate Agreement with the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services (see N.J.A.C. 10:51-1.22, incorporated herein by reference);

12. Medical exception process (MEP) (see N.J.A.C. 10:54-8.3);

13. In addition, diabetic testing materials, including blood glucose reagent strips, urine monitoring strips, tapes, tablets, and lancets. Electronic blood glucose monitoring devices or other devices used in the monitoring of blood glucose levels are considered medical supplies and are covered services by Medicaid. These services may require prior authorization from the Medicaid District

Office (MDO) (See Medical Supplier Services, N.J.A.C. 10:59);

14. For claims with service dates on or after July 1, 1998, all drugs prescribed for the treatment of impotency shall be limited to male beneficiaries over the age of 18 years and to four treatments per month;

15. For claims with service dates on or after August 1, 1998, prescribers shall write "Diagnosis of Impotency" on the face of any prescription for impotency drugs. Claims for such prescriptions without this written statement shall be subject to recoupment by the State of New Jersey; and

16. For claims with service dates on or after July 1, 1999, the pharmacist shall be reimbursed for the least expensive, therapeutically effective nutritional supplement or specialized infant formula, at the time of dispensing unless the prescriber indicates, in his or her own handwriting on each written prescription, or follow-up written prescription to a telephone rendered prescription, the phrase "Brand Medically Necessary."

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).

In (a), inserted a new 12, and recodified former 12 as 13.

Amended by R.2001 d.51, effective February 5, 2001.

See: 32 N.J.R. 3929(a), 33 N.J.R. 555(a).

In (a)13, substituted "Medical Assistance Customer Center (MACC)" for "Medicaid District Office (MDO)".

Amended by R.2001 d.124, effective April 16, 2001.

See: 32 N.J.R. 4392(a), 33 N.J.R. 1201(a).

In (a), substituted "Quantity" for "Quality" in 3, added 14 through 16, and amended N.J.A.C. references throughout.

### 10:54-8.3 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 shall be administered by a contractor, referred to as the MEP contractor, under a 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 (MEP) 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 justification 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, and drug description. The prescriber shall be requested to provide the reason for the 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 the 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 by the Medicaid/NJ KidCare programs.

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. 10:54-8.3, Pharmaceutical; Physician-administered drugs, recodified to N.J.A.C. 10:54-8.4.

### 10:54-8.4 Pharmaceutical; Physician-administered drugs

(a) The New Jersey Medicaid program shall reimburse physicians for certain approved drugs administered by inhalation, intradermally, subcutaneously, intramuscularly or intravenously in the office, home, or independent clinic setting according to the following reimbursement methodologies:

1. Physician-administered medications shall be reimbursed directly to the physician under certain situations. (See N.J.A.C. 10:54-9.8 for a listing of HCPCS procedure codes, "J" codes and applicable Level III procedure codes with a few exceptions such as, immunizations). For this methodology, the physician is required to bill the appropriate "J" code, Level III, HCPCS procedure code.

i. A "J" code may be billed in conjunction with an office, home, or independent clinic visit when the criteria for an office or home visit is met and the procedure code for the method of drug administration. The HCPCS 90799 may be billed for intradermal, subcutaneous, intramuscular, or intravenous drug administration. Other HCPCS procedure codes may be billed for the administration of allergy, chemotherapy or inhalation drugs.

ii. The New Jersey Medicaid program has assigned HCPCS procedure codes and Medicaid maximum fee allowances to certain, selected drugs for which reimbursement to the physician is based on the Average Wholesale Price (AWP) of a single dose of an injectable or inhalation drug, or the physician's acquisition cost, whichever is less.

iii. Unless otherwise indicated in Subchapter 8 or under the exception listed in (a)2 and 3 below, the Medicaid maximum fee allowance is determined based on the AWP per unit which equals one cubic centimeter (cc) or milliliter (ml) of drug volume for each unit. For drug vials with a volume equal to one cubic centimeter (cc) or milliliter (ml), the Medicaid maximum fee allowance shall be based on the cost per vial.

iv. When a physician office, home, or independent clinic visit is for the sole purpose of administering a drug, the reimbursement shall include the cost of the drug and administration. In these situations, there is no reimbursement for a physician office, home, or independent clinic visit. If, in addition to the physician administration of a drug, the criteria of an office, home, or independent clinic visit is met, the cost of the drug and administration may, if medically indicated, be reimbursed in addition to the visit.

v. No reimbursement will be made for vitamins, liver or iron injections or combination thereof; except in laboratory-proven deficiency states requiring parenteral therapy.

vi. No reimbursement will be made for placebos or any injections containing amphetamines or derivatives thereof.

vii. No reimbursement will be made for injection given as a preoperative medication or as a local anesthetic which is part of an operative or surgical procedure, since this injection would normally be included in the prescribed fee for such a procedure.

2. The second method of reimbursement shall be limited to situations where a drug required for administration has not been assigned a "J" code, Level III HCPCS procedure code. In these situations, the drug shall be prescribed and obtained from a pharmacy which directly bills the New Jersey Medicaid program. In this situation, the physician shall bill only for the administration of the drug using HCPCS 90799.

3. Separate reimbursement shall be available for the administration of drug(s) in accordance with the appropriate procedure codes listed in the Physician's Current Procedural Terminology (CPT).

(b) The drug administered shall be consistent with the diagnosis and conform to accepted medical and pharmacological principles in respect to dosage frequency and route of administration.

Recodified from N.J.A.C. 10:54-8.3 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).

#### 10:54-8.5 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; E-Inactivated 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) APNs 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. 10:54-9.4.

New Rule, R.2001 d.51, effective February 5, 2001.  
See: 32 N.J.R. 3929(a), 33 N.J.R. 555(a).  
Amended by R.2004 d.334, effective September 7, 2004.  
See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

### SUBCHAPTER 9. HEALTH CARE FINANCING ADMINISTRATION (HCFA) COMMON PROCEDURE CODING SYSTEM (HCPCS)

#### 10:54-9.1 Introduction

(a) The New Jersey Medicaid program utilizes the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physician's Current Procedural Terminology—4th Edition (CPT-4) architecture, employing a five-position code and as many as two 2-position modifiers. Unlike the CPT-4 numeric design, the HCFA assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three-level coding system.

1. Level I Codes: The narratives for these codes are 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.

2. Level II Codes: The narratives for Level II codes are found in N.J.A.C. 10:54-9.10. These codes are not found in the CPT-4 and are assigned by HCFA for use by physicians and other practitioners.

3. Level III Codes: The narratives for Level III codes are found in N.J.A.C. 10:54-9.10. These codes are assigned by the Division of Medical Assistance and Health Services to be used for those services which are unique to the New Jersey Medicaid program.

(b) General policies regarding the use of HCPCS for procedures and services are listed below:

1. The responsibilities of physicians when rendering specific services is located in N.J.A.C. 10:54-1 through N.J.A.C. 10:54-8.

2. When filing a claim, the HCPCS procedure codes, including modifiers and qualifiers, must be used in accordance with the narratives in CPT-4 and the narratives and descriptions listed in this Subchapter 9, whichever is applicable.

3. The use of a procedure code, which describes the service, will be interpreted by the New Jersey Medicaid program, as evidence that the physician or practitioner personally furnished, as a minimum, the stated service. He or she will sign the claim as the servicing provider with the Medicaid Servicing Provider Number (MSPN) as evidence of the validity of the use of the procedure code reflecting the service provided.

4. Listed in the following sections are specific policies of the New Jersey Medicaid program relevant to HCPCS. This is to specifically call to the attention of physicians and practitioners the uniqueness of the policies in this subchapter and the need to incorporate these instructions when filing a claim for services provided to Medicaid recipients. (See also the Fiscal Agent Billing Supplement.)

5. Additional requirements of the provider when rendering specific services and requesting reimbursement are listed in the subchapters on prior authorization, record-keeping, basis of payment, EPSDT, and other specific services.

**10:54-9.2 Elements of HCPCS procedure codes which require attention**

(a) The lists of HCPCS procedure code for use of physicians and other practitioners are arranged in tabular form with specific information for a code given under columns with titles such as "IND", "HCPCS CODES", "MOD", "DESCRIPTION", "FOLLOW-UP DAYS", "MAXIMUM FEE ALLOWANCE" AND "ANES BASIC UNITS". The information given under each column is summarized below:

Column "IND"	Title (Indicator-Qualifier)
	Lists alphabetic symbols used to refer provider to information concerning the New Jersey Medicaid program's qualifications and requirements when a HCPCS procedure code is used. Explanation of indicators and qualifiers used in this column are given below:
"A"	preceding any procedure code indicates that these tests can be and are frequently done as groups and combinations (profiles) on automated equipment.
"C"	preceding any procedure code indicates that cosmetic surgery is not payable by Medicaid unless prior authorization is received by the provider. (See also N.J.A.C. 10:54-5.3 and 9.10(g).)
"E"	preceding any procedure code indicates that these procedures are excluded from multiple surgery pricing and, as such, should be reimbursed at 100% of the Medicaid maximum fee allowance even if the procedure is done on the same patient by the same surgeon at the same operative 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. 10:54-9.10(f).)
"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.
"I"	preceding any procedure code indicates that certain surgical procedures when performed incidental to other surgical procedures by the operating surgeon or assistant are covered in the reimbursement allowance for the primary procedure. (See N.J.A.C. 10:54-9.10(b).)
"L"	preceding any procedure code indicates that the complete narrative for the code is located in N.J.A.C. 10:54-9.10 of this chapter.
"M"	preceding any procedure code indicates that this service is medically necessary under the Medical Justification Program. (See N.J.A.C. 10:54-3.2.)
"N"	preceding any procedure code means that qualifiers are applicable to that code.
"S"	preceding any procedure code indicates that a second opinion by another physician is required for this procedure. (See N.J.A.C. 10:54-9.10(b).)
"HCPCS CODES"	Lists the HCPCS procedure code numbers.
"MOD"	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 affixed to the procedure code. The New Jersey Medicaid program's recognized modifier codes are listed in N.J.A.C. 10:54-9.3.
"DESCRIPTION"	Lists the code narrative for Level II and III procedure codes. Narratives for Level I are in CPT-4.
"FOLLOW-UP DAYS"	Lists the number of days for follow-up care.
"MAXIMUM FEE ALLOWANCE"	Lists New Jersey Medicaid program's maximum fee allowance schedule. 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 report to the claim form. If the symbol "N.A." (Not Applicable) are listed instead of a dollar amount, it means that service is not reimbursable.
"ANES BASIC UNITS"	B.U.V. (Basic Unit Value) + A.T. (Anesthesia Time per Unit) × \$6.30 (specialist) or \$5.50 (non-specialist) equals reimbursement.

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 (as in the "IND" column) and as modifiers (as in the "MOD" column). They assist the physician or practitioner 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 must not be ignored because in certain instances requirements are created in addition to the narrative which accompanies the HCPCS code as described in the CPT-4. THE PROVIDER WILL THEN BE SUBJECT TO THE ADDITIONAL REQUIREMENTS AND NOT JUST THE CPT/HCPCS CODE NARRATIVE. These requirements must be fulfilled in order to receive reimbursement.

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

(b) The following statements are requirements for billing and for using HCPCS:

1. When filing a claim, the appropriate HCPCS Codes must be used in conjunction with modifiers, when applicable.

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

3. For purposes of reimbursement, a physician, practitioner, physicians' group, shared health care facility or physicians sharing a common record are considered a single provider.

4. When billing, the provider must enter a CPT/HCPCS code into the procedure code column field 24-D of HCFA 1500 claim form.

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

6. When submitting a claim, the physician or practitioner must always use his/her usual and customary fee. The fees designated for the HCPCS procedure codes represent the New Jersey Medicaid program's maximum payment for the given procedure.

7. All references to time parameters shall mean the physician's or practitioner's personal time in reference to the service rendered unless it is otherwise indicated.

i. Reimbursement will be made for an assistant surgeon when the service is medically necessary and when a duly qualified surgical resident or house physician is unavailable, and when the primary procedure performed has a procedure code specialist fee of at least \$142. The allowance permitted is a maximum of 15 percent of the listed specialist fee. The minimum payment is \$27.

ii. When billing for assistant surgery services, affix to the appropriate procedure code the modifier "80" which identifies surgical assistant services.

8. Certain listed procedures are commonly carried out as an integral part of a total service, and, as such, do not warrant a separate charge. Concerning the terminology

"separate procedures" when attached to a HCPCS/CPT-4 description, when a procedure is carried out as a separate entity not immediately related to other services, the indicated value for "separate procedure" is applicable.

9. Additional charges on a fee-for-service basis may be reimbursed for complications or other circumstances requiring additional or unusual services concurrent with the procedure(s) or during the listed period of normal follow-up care with a "22" modifier, if so designated with additional documentation accompanying to the claim form.

10:54-9.3 Definitions of modifiers

(a) 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/NJ FamilyCare program's recognized modifier codes are:

Modifier Code	Description
22	Unusual 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 with additional documentation must accompany the claim form to justify the greater services, unusual services or complications.
26	Professional Component: Certain procedures are a combination of a physician 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. If a professional component type service is keyed without a '26' modifier and a manual pricing edit is received, resolve the edit by adding a 26 modifier.
50	Bilateral Procedures: When bilateral procedures are provided at the same operative session, the first major procedure may be reported as listed. The second (bilateral) procedure may be identified by adding the modifier '50' to the usual procedure number(s).
51	Multiple Procedures: When multiple procedures are performed on the same day or at the same session, the major procedure or service may reported as listed. The secondary additional, or lesser procedure(s) or service(s) may be identified by adding the modifier '51' to the secondary procedure or service code(s). This modifier may be used to report multiple medical procedures performed at the same session, as well as a combination of medical and surgical procedures, or several surgical procedures performed at the same operative session.
52	Reduced Services: Under certain circumstances a service or procedure is partially reduced at the physician'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.
62	Two Surgeons: Under certain circumstances the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical procedure. Under such circumstances the services of each may be identified by adding the modifier '62' to the procedure number used by each surgeon for reporting his services.
66	Surgical Team: Under some circumstance, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel and various types of complex equipment) are carried out under the 'surgical

Modifier Code	Description	IND	HCPCS			Maximum Fee Allowance		Anes. Basic Units
			Code	Mod	\$	\$	NS	
75	Concurrent Care: Services Rendered by More than One Physician: When the patient's condition requires the additional services of more than one physician, each physician may identify his or her services by adding the modifier '75' to the basic service performed represented by the procedure code.		90718		3.35		3.35	
			90718	52	2.50		2.50	
			90719		4.88		4.88	
			90720		30.27		30.27	
			90720	52	2.50		2.50	
			90724		6.97		6.97	
			90724	52	2.50		2.50	
			90725		BR		BR	
			90726		BR		BR	
			90727		BR		BR	
76	Repeat Procedure by Same Physician: The physician may need to indicate that a procedure or service was repeated subsequent to the original service. This may be reported by adding the modifier '76' to the procedure code of the repeated service.		90728		BR		BR	
			90732		14.35		14.35	
			90732	52	2.50		2.50	
			90733		17.48		17.48	
			90733	52	2.50		2.50	
77	Repeat Procedure by Another Physician: The physician may need to indicate that a basic procedure performed by another physician had to be repeated. This may be reported by adding the modifier '77' to the procedure code of the repeated service.		90737		25.79		25.79	
			90737	52	2.50		2.50	
			90741		BR		BR	
			90742		BR		BR	
80	Assistant Surgeon: Surgical assistant services may be identified by adding the modifier '80' to the basic procedure code. See N.J.A.C. 10:54-9.2(b).	N	90749		BR		BR	
			90780		45.00		40.00	
			90781		45.00		40.00	
AA	Anesthesia services personally rendered by anesthesiologist.	N						
AP	Determination of refractive state was not performed in course of diagnostic ophthalmological examination.	N						
AV	Advanced Practice Nurse.							
TC	When applicable, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding the modifier 'TC' to the usual procedure code.		90782		2.50		2.50	
			90783		6.00		6.00	
			90784		2.50		2.50	
			90788		2.50		2.50	
			90799		2.50		2.50	
WB	Second surgical session performed on the same day as an earlier surgical session.	N	90801		37.00	26.00		
WF	Family planning.	N	90830		37.00	26.00		
WM	Midwifery.	N	90843		19.00	13.00		
WT	Early and Periodic Screening, Diagnosis and Treatment (EPSDT).	N	90844		37.00	26.00		
			90847		37.00	26.00		
WY	Legal abortion-1st trimester.	N	90847	22	46.00	32.00		
WZ	Legal abortion-2nd trimester.	N	90853		8.00	6.00		
YY	Second surgical opinion consultation.		90862		16.00	14.00		
ZZ	Third surgical opinion consultation.		90870		32.00		26.00	
			90871		38.00		31.00	
			90887		19.00		13.00	
			90899		BR		BR	
			90918		160.00		160.00	
			90919		160.00		160.00	
			90920		160.00		160.00	
			90921		160.00		160.00	
			90922		5.45		5.45	
			90935		37.00		37.00	
90937		56.00		56.00				
90945		30.00		30.00				
90947		61.00		61.00				
90989		400.00		400.00				
90993		39.00		NA				
90993	26	39.00		NA				
90995		160.00		160.00				
90997		180.00		180.00				
90998		5.45		5.45				
91000		17.00		NA				
91000	26	17.00		NA				
91010		54.00		NA				
91010	26	54.00		NA				
91011		58.00		NA				
91011	26	58.00		NA				
91012		58.00		NA				
91012	26	58.00		NA				
91020		54.00		NA				
91020	26	54.00		NA				
91030		20.00		NA				
91030	26	20.00		NA				
91032		20.00		NA				
91032	26	20.00		NA				

Amended by R.2004 d.334, effective September 7, 2004.  
See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

**10:54-9.4 HCPCS procedure codes and maximum fee schedule for medicine**

IND	HCPCS Code	Mod	Maximum Fee Allowance			Anes. Basic Units
			\$	\$	NS	
	90701		16.34		16.34	
	90701	52	2.50		2.50	
	90702		3.29		3.29	
	90702	52	2.50		2.50	
	90703		3.40		3.40	
	90703	52	2.50		2.50	
	90704		23.60		23.60	
	90704	52	2.50		2.50	
	90705		18.39		18.39	
	90705	52	2.50		2.50	
	90706		22.04		22.04	
	90706	52	2.50		2.50	
	90707		39.87		39.87	
	90707	52	2.50		2.50	
	90712		14.44		14.44	
	90712	52	2.50		2.50	
	90713		22.80		22.80	
	90713	52	2.50		2.50	
	90714		3.03		3.03	
	90714	52	2.50		2.50	
	90717		BR		BR	

63001	63045	63086	63196	31720	50690	64400-64530
63003	63046	63087	63197	36010	50951	W2650
63005	63047	63088	63198	36100	50970	W2655
63011	63048	63090	63199	36120	51600	W3600
63012	63055	63091	63200	36140	51605	W5930
63015	63056	63170	63250	36160	51610	
63016	63057	63172	63251	36200	51725	
63017	63064	63173	63252	36215	51726	
63020	63066	63180	63265	36245	51736	
63020 50	63075	63182	63266	36400	51741	
63030	63076	63185	63267	36405	51772	
63030 50	63077*	63190	63268	36406	51785	
63035	63078*	63191	63270	36410	51592	
63040	63081	63191 50	63271			
63042	63082	63194	63272			
	63085	63195	63273			

\*NOTE: HCPCS codes identified with an asterisk (\*) do not require a Second Surgical Opinion if the recipient is under 19 years of age with a diagnosis of scoliosis.

4. Hernia Repair (Unilateral or Bilateral including umbilical hernia—for recipients 19 years of age or older):

- 49505
- 49520
- 49525
- 49550
- 49555
- 49560
- 49565
- 49570
- 49585
- 49590
- 56316
- 56317

(e) Multiple surgical pricing: The following HCPCS procedure codes are excluded from multiple surgical pricing and as such shall be reimbursed like the primary procedure at 100 percent of the Medicaid Maximum Fee Allowance even when the procedure is done on the same patient, by the same surgeon, at the same operative session.

11700	36415	52000
11701	36430	53670
11710	35488	53675
11711	36489	54150
11901	36520	54160
19030	36522	54200
20500	36600	54220
20501	36620	54230
21079	38790	54235
21080	43200	54240
21081	43234	54250
21082	43235	56300
21083	43259	56350
21084	43260	57150
21085	44360	57170
21086	45300	57410
21087	45330	57450
21088	45335	57452
29000-29799	45378	58301
31520	46600	58340
31525	47500	58611
31575	47550	59020
31615	47552	59025
31622	50320	59030
31700	50394	59414
31708	50396	62270-62291
31710	50684	63690
31719	50686	63691

(f) Surgery and office visit (New and Established Patient) Conflicts: The following procedure codes are excluded from the policy indicating that office visit codes are not reimbursed in addition to procedure codes for other conditions. Thus, the following Office Visit (New and Established Patient) procedure codes, listed below, may be billed with the procedure codes listed identified with the titles, Surgery Values and Excluded Codes. (If the surgical procedure code reimburses less than an Office Visit, reimbursement will be the higher of the office visit rate or the surgical procedure code rate, not both.)

1. The policy is applicable to these surgical procedure codes:

- 10000-69999
- T1000-T9999
- W0000-W6999
- W9027
- W9029
- W9030
- W9031

2. The policy is also applicable to office visit (new and established patient) procedure codes:

- 99211
- 99212
- 99213
- 99214
- 99215
- 99311
- 99312
- 99313
- 99331
- 99332
- 99333

3. The following procedure codes are excluded from this policy:

W2650	36010	38790	53670	59025
W2655	36100	47500	53675	59030
W3600	36120	50320	54150	59414
W3650	36140	50394	54160	59430
W5930	36160	50396	54200	62270
11900	36200	50684	54220	62272-62291
11901	36215	50686	54230	63690
19030	36245	50690	54235	63691
20500	36400	51600	54240	64400-64530
20501	36405	51605	54250	99381
20550	36406	51610	51725	
20600-20610		36410	51726	
21079-21088		36415	51736	
29000-29799		36430	57150	

31700 36488 51739 57170  
 31708 36489 51741 57410  
 31710 36520 51772 58301  
 31719 36522 51785 58340  
 31720 36600 51792 59020

H5300

(h) Mental health services: When requesting reimbursement for the following HCPCS procedure code, a separate service line shall be completed for each day that the service is provided. Providers shall not "span bill" for services.

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

90870

92507

Amended by R.2003 d.69, effective February 3, 2003.  
 Sec: 34 N.J.R. 3183(a), 35 N.J.R. 888(a).  
 Added (g) and (h).

97799

APPENDIX A

STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES		Form #17
<u>Medicaid District Office</u>	<u>Director &amp; Phone Number</u>	<u>Address</u>
(01) Atlantic Fax #1-609-344-2268	William Underland, Director Tel. 609-441-3620	1601 Atlantic Avenue, 7th Floor Atlantic City, NJ 08401
(02) Bergen Fax #1-201-996-8084	Kate Buckley, Director Tel. 201-996-8060	171-173 Main Street Hackensack, NJ 07601
(03) Burlington Fax #1-609-265-0095	Eileen Calabro, Acting Director Tel. 609-261-0448	50 Rancocas Road Mt. Holly, NJ 08060
(04) Camden Fax #1-609-757-4626	Daniel Cooperson, Director Ronald Coppola, Regional Director Tel. 609-757-2870	101 Haddon Avenue, 5th Floor Camden, NJ 08103
(05) Cape May (06) Cumberland Fax #1-609-794-2586	Barbara Dils, Director Tel. 609-696-6560	108 Landis Avenue Vineland, NJ 08360
(07) Essex Fax #1-201-642-6468	Diane West, Director Tel. 201-648-2470; 201-648-3700	153 Halsey Street, 4th Floor Newark, NJ 07102
(08) Gloucester (17) Salem Fax #1-609-845-0444	Joan Suleskey, Acting Director Tel. 609-853-4177	251 N. Delsea Drive Deptwood Center Deptford, NJ 08096-1930
(09) Hudson Fax #1-201-433-7544	William Underland, Director Tel. 201-433-8011	2815 Kennedy Boulevard, 2nd Floor Jersey City, NJ 07306
(10) Hunterdon (18) Somerset Fax #1-908-782-7899	Caroline Krajewski, Director Tel. 908-782-1130	84 Park Avenue, 2nd Floor Flemington, NJ 08822
(11) Mercer Fax #1-609-599-4627	Eileen Calabro, Acting Director Tel. 609-292-7315	314-316 E. State Street Trenton, NJ 08608
(12) Middlesex Fax #1-908-906-8275	Colleen DeMarks, Director John Russell, Regional Director Tel. 908-549-3541	Bldg. B, Suite 5 & 6 25 S. Main Street Edison, NJ 08837
(13) Monmouth Fax #1-908-409-6446	Frances Garrett, Director Tel. 908-308-1159	1003 Route 9 North—Suite 200 Howell, NJ 07731-1113
(14) Morris (19) Sussex (21) Warren Fax #1-201-631-6448	Marie Grubin, Director Tel. 201-631-6440	10 Park Place, 4th Floor Morristown, NJ 07960
(15) Ocean Fax #1-908-255-0743	Gail Dempsey, Acting Director Tel. 908-255-0731	1510 Hooper Avenue Toms River, NJ 08753
(16) Passaic Fax #1-201-684-8182	Kathleen Lohrey, Acting Director Tel. 201-977-4077	66 Hamilton Street Paterson, NJ 07505
(20) Union Fax #1-908-353-5340	Director Tel. 908-820-3135	24-52 Rahway Avenue, 3rd Floor United Jersey Bank Bldg. Elizabeth, NJ 07201

Northern Regional  
Medicaid Office  
Fax #1-201-684-7769

Thomas Rafferty  
Acting Regional Director  
Tel. 201-977-4541

100 Hamilton Plaza  
Room 601, Box 2  
Paterson, NJ 07505

Rev. 7/92

**APPENDIX B**

**FISCAL AGENT BILLING SUPPLEMENT**

**AGENCY NOTE:** The Fiscal Agent Billing Supplement is filed as an incorporated Appendix of this chapter/manual but is not reproduced in the New Jersey Administrative Code. When revisions are made to the fiscal agent billing supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agent Billing Supplement, write to:

Paramax/Unisys  
PO Box 4801  
Trenton, New Jersey 08650-4801

or contact:

Office of Administrative  
Quakerbridge Plaza, Build  
PO Box 049  
Trenton, New Jersey 08625-0049

**APPENDIX C**

**EMC MANUAL**

**AGENCY NOTE:** The Electronic Media Claims (EMC) Manual is filed as an incorporated Appendix of this chapter/manual, but is not reproduced in the New Jersey Administrative Code. When revisions are made to the EMC Manual, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the EMC Manual, write to:

Paramax/Unisys  
PO Box 4801  
Trenton, N.J. 08650-4801