

CHAPTER 57

PODIATRY SERVICES

Authority

N.J.S.A. 30:4D-6b, 30:4D-7, 7a, b, and c, 30:4D-12.

Source and Effective Date

R.1996 d.60, effective February 5, 1996.
See: 27 N.J.R. 4223(a), 28 N.J.R. 1015(a).

Executive Order No. 66(1978) Expiration Date

Chapter 57, Podiatry Services, expires on February 5, 2001.

Chapter Historical Note

Chapter 57, Podiatry Services Manual, became effective June 1, 1971 as R.1971 d.66. See: 3 N.J.R. 43(c), 3 N.J.R. 109(b). The provisions of Subchapter 2, Podiatry Billing Procedures, were adopted by R.1974 d.222, effective September 15, 1974. See: 6 N.J.R. 264(c), 6 N.J.R. 35(c). Subchapter 3, HCFA Common Procedure Coding System (HCPCS), was adopted 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 57 was readopted as R.1991 d.129, effective February 13, 1991. See: 22 N.J.R. 3439(b), 23 N.J.R. 858(b).

Chapter 57, Podiatry Services Manual, was repealed, and Chapter 57, Podiatry Services, was adopted as new rules, by R.1996 d.60, effective February 5, 1996. See: Source and Effective Date.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. GENERAL PROVISIONS

- 10:57-1.1 Introduction
- 10:57-1.2 Scope of services
- 10:57-1.3 Definitions
- 10:57-1.4 Provisions for provider participation
- 10:57-1.5 Prior authorization
- 10:57-1.6 Basis of reimbursement
- 10:57-1.7 Personal contribution to care requirements for NJ KidCare-Plan C
- 10:57-1.8 Record keeping

SUBCHAPTER 2. PROVISION OF SERVICES

- 10:57-2.1 Covered and non-covered services
- 10:57-2.2 General provisions
- 10:57-2.3 Provisions regarding surgery
- 10:57-2.4 Radiology services
- 10:57-2.5 Consultation policies
- 10:57-2.6 Podiatric orthotic services
- 10:57-2.7 Clinical laboratory services
- 10:57-2.8 Hospital outpatient department services
- 10:57-2.9 Diagnostic radiology services
- 10:57-2.10 Multiple visits; out of office
- 10:57-2.11 Pharmaceutical; podiatrist administered drugs
- 10:57-2.12 Pharmaceutical services
- 10:57-2.13 Medical exception process (MEP)

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

- 10:57-3.1 Introduction to the HCPCS procedure code system
- 10:57-3.2 HCPCS Procedure Codes and Maximum Fee Allowance
- 10:57-3.3 Descriptions of Level II Codes
- 10:57-3.4 Descriptions of Level III Codes
- 10:57-3.5 Qualifiers for podiatry services

APPENDIX A

SUBCHAPTER 1. GENERAL PROVISIONS

10:57-1.1 Introduction

(a) This chapter is concerned with the provision of podiatric services by a person licensed to practice podiatry in accordance with the New Jersey Medicaid program policies and procedures and the standards of practice as defined by the laws of the State of New Jersey (N.J.S.A. 45:5) and the American Podiatric Medical Association.

(b) An approved New Jersey Medicaid provider of podiatric services may be reimbursed for medically necessary covered services provided within the scope of the practitioner's license, and the practitioner's approved New Jersey Medicaid Program Provider Agreement.

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

Amended by R.1998 d.248, effective May 18, 1998.
See: 30 N.J.R. 626(a), 30 N.J.R. 1812(b).

10:57-1.2 Scope of services

Podiatry care under the Medicaid program is allowable to covered persons if such services are essential. Essential podiatry care includes those services which require the professional knowledge and skill of a licensed podiatrist. For recipients in the Medically Needy Program, podiatry care is only available to pregnant women, and the aged, the blind or disabled. (For information on how to identify a covered person, please refer to N.J.A.C. 10:49-2.)

10:57-1.3 Definitions

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

"CPT" means that edition of the Current Procedure Terminology most current at the time of reference, as published annually by the American Medical Association, Chicago, Illinois, unless otherwise specified in rule.

"Flat-foot conditions" means the local condition of flattened arches regardless of the underlying etiology. Treatment of flat-foot conditions encompasses all phases of services in connection with flat feet.

"Podiatrist" means a doctor of podiatric medicine licensed to practice podiatry by the New Jersey State Board of Medical Examiners, or similarly licensed by a comparable agency in the state in which he or she practices.

"Podiatry services" means those services performed by a licensed podiatrist within the scope of practice as defined by the laws of the State of New Jersey (N.J.S.A 45:5-7) and which are within the scope of the services covered by the New Jersey Medicaid program.

"Routine foot care" means the cutting or removal of corns or calluses, the trimming of nails, and other hygienic and preventive maintenance care in the realm of self-care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone for both ambulatory and bedfast patients, and any services performed in the absence of localized illnesses, injury or symptoms involving the foot.

"Specialist" for purposes of the New Jersey Medicaid program, means a fully licensed podiatrist who:

1. Is a diplomate of the appropriate specialty board as recognized by the American Podiatric Medical Association; or
2. Has been notified of board eligibility by the appropriate specialty board as recognized by the American Podiatric Medical Association.

"Subluxation" means the structural misalignment of the joints of the feet which do not require surgical methods of treatment and/or correction, with the exception of fractures and complete dislocations.

Amended by R.1998 d.248, effective May 18, 1998.
See: 30 N.J.R. 626(a), 30 N.J.R. 1812(b).
Added "CPT" definition.

10:57-1.4 Provisions for provider participation

(a) In order to participate in the Medicaid program a podiatrist shall apply to and be approved by the New Jersey Medicaid program. Application for approval by the New Jersey Medicaid program requires completion and submission of the "Medicaid Provider Application" (FD-20) and the "Medicaid Provider Agreement" (FD-62).

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

Unisys Corporation
Provider Enrollment
PO Box 4804
Trenton, New Jersey 08650-4804

(b) In order to be approved as a Medicaid participating provider, the podiatrist shall be licensed by the State of New Jersey Board of Medical Examiners (See N.J.A.C. 13:35-3).

1. An out-of-State podiatrist must have comparable documentation under the applicable State requirements of the state in which the services are provided.

(c) In order to be approved as a specialist under the Medicaid program, a licensed podiatrist shall possess either of the following:

1. A specialty certification/permit issued by the specialty board as recognized by the American Podiatric Medical Association; or
2. A copy of the notification of board eligibility by the specialty board as recognized by the American Podiatric Medical Association.

(d) A photocopy of the current license, certification/permit or notification of board eligibility by the specialty shall be provided at the time of the application for enrollment.

10:57-1.5 Prior authorization

(a) Authorization by the Podiatry Services Unit ("Unit"), Division of Medical Assistance and Health Services, PO Box 712, Trenton, New Jersey 08625-0712, shall be obtained prior to the provision of the following services:

1. All orthopedic footwear;
2. Custom molded foot or ankle orthoses;
3. Routine debridement of toenails, more than once every two months.

(b) A written request for authorization (Form FD-356) shall be submitted, identifying the case and containing sufficient information about the problem and plan of treatment to enable the Unit to make a proper evaluation.

10:57-1.6 Basis of reimbursement

(a) Reimbursement for podiatry services covered under the New Jersey Medicaid or NJ KidCare program shall be on the basis of the customary charge, not to exceed a fixed fee schedule determined reasonable by the Commissioner of the Department of Human Services as specified at N.J.A.C. 10:57-3, and further limited by Federal policy relative to payment of practitioners and other individual providers. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

(b) For services rendered on or after February 10, 1995, and prior to July 20, 1998, to beneficiaries eligible for both Medicare Part B and Medicaid or NJ KidCare, reimbursement will be made for the Medicare Part B coinsurance and deductible amounts or the Medicaid or NJ KidCare maximum allowable (less any third party payments including Medicare reimbursement), whichever is greater. Effective on July 20, 1998, payments shall only be made up to the Medicaid or NJ KidCare maximum allowable amount consistent with N.J.A.C. 10:49-7.3(c)1.

(c) Any podiatric physician who meets the above cited qualifications listed in N.J.A.C. 10:57-1.3 as a specialist and the requirements specified in N.J.A.C. 10:57-1.4 shall be eligible for specialist reimbursement.

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), inserted a reference to NJ KidCare; and in (b), inserted “, and prior to July 20, 1998,” following “February 10, 1995”, substituted “beneficiaries” for “recipients”, inserted references to NJ KidCare throughout, and added the last sentence.

10:57-1.7 Personal contribution to care requirements for NJ KidCare-Plan C

(a) General policies regarding the collection of personal contribution to care for NJ KidCare-Plan C 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 podiatric services.

1. A podiatric visit is defined as a face-to-face contact with a medical professional, including services provided under the supervision of the podiatrist, which meets the documentation requirements of this chapter and allows the podiatrist to request reimbursement for services.

2. Podiatric visits include podiatric services provided in the office, patient’s home, or any other site, except any site of the hospital, where the child may have been examined by the podiatrist or the podiatric staff.

3. The podiatrist shall collect one personal contribution to care per podiatric visit, regardless of the number of podiatric services provided in the session.

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. 10:57-1.7, Record keeping, recodified to N.J.A.C. 10:57-1.8.

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.

See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

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

10:57-1.8 Record keeping

(a) Podiatrists shall keep such individual records as are necessary to fully disclose the kind and extent of the services provided and shall make such information available as the Division or its agents may request. For the initial examination, the following documentation shall be on the record, regardless of the setting where the examination was performed:

1. Date of service;
2. Chief complaint(s);
3. Pertinent historical and physical data;
4. Reports of diagnostic procedures ordered or performed;
5. Diagnosis;

6. Prescription (including medication) and treatment.

(b) Progress notes may be brief but shall include date(s) of service, changes in patient condition, specific medications and/or other treatments.

Recodified from N.J.A.C. 10:57-1.7 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).

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.

SUBCHAPTER 2. PROVISION OF SERVICES

10:57-2.1 Covered and non-covered services

(a) The following foot care services shall not be covered:

1. Flat-foot conditions:

i. Exceptions:

(1) Treatment which is an integral part of post-fracture or postoperative treatment plan;

(2) Supportive devices (for example, arch supports, specific additions to shoes and the like) which are prescribed to palliate pain and other symptoms associated with the condition.

ii. Treatment where the talo-crural joint is involved;

iii. Treatment where there may be attachment of a supportive device to a brace or bar.

2. Subluxations of the feet in which the normal relationship of the bones, tendons, ligaments and supporting muscles is disturbed and which, regardless of underlying etiology, require treatment by mechanical methods (for example, whirlpool, paraffin baths, casting, strapping, splinting, padding, shortwave or low voltage currents, physical therapy, exercise manipulation, massage, and the like):

i. Exceptions:

(1) Where treatment is an integral part of post-fracture or postoperative treatment plan;

(2) Where the talo-crural joint is involved;

(3) Where there may be attachment of a supportive device to a brace or bar.

3. Routine foot care, routine hygienic care:

i. Exceptions:

(1) Treatment of painful corns, calluses and warts;

(A) When treatments are in excess of one per month, the case must be referred for evaluation to the podiatry unit of the Division of Medical Assis-

tance and Health Services, PO Box 712, Mail Code #15, Trenton, New Jersey 08625-0712.

(2) Treatment of the foot for Medicaid beneficiaries with metabolic, neurological, and peripheral diseases (for examples, diabetes mellitus, arteriosclerosis obliterans, Buerger's disease, chronic thrombo-phlebitis, peripheral neuropathies); and

(3) Treatment of fungal (mycotic) and other infections of the feet and toenails.

(b) The following guidelines limit the provision of (a)3 above.

1. The importance of preventive or hygienic care for patients with a systemic illness, such as peripheral vascular disease, diabetes, or with severe physical disability is recognized. These will be considered on an individual basis by the podiatrist consultant.

2. If services ordinarily considered routine are performed at the same time as and as a necessary integral part of otherwise covered services, such as diagnosis and treatment of diabetic ulcers, wounds and infections, they are covered.

3. Fungal (mycotic) and other infections of the feet and toenails require professional services which are outside the scope of "routine foot services." Diagnostic and treatment services for foot infections are covered in the same manner as services performed for infections occurring elsewhere on the body, and the same type of coverage rules apply.

4. Treatment of plantar warts that are symptomatic and/or cause disability will be considered a covered service.

Amended by R.1998 d.248, effective May 18, 1998.

See: 30 N.J.R. 626(a), 30 N.J.R. 1812(b).

In (a)3i(2), substituted "beneficiaries" for "recipients" after "Medicaid".

10:57-2.2 General provisions

(a) For purposes of reimbursement, a podiatrist and/or physician; podiatrist and/or physicians' group; shared health care facility; or providers sharing a common record are considered a single provider.

(b) When reference is made in the 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.

1. 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 12-month period by a podiatrist, podiatric group, shared health care facility, or practitioner sharing a common record.

2. 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 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.

3. 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, one of the minimum documentation requirements must be met.

i. HCPCS 99201 and 99202 are exceptions to the above requirements outlined in the qualifier for the initial visit. For HCPCS 99201 and 99202, the provider shall follow the qualifier applied to routine visit or follow-up care visit, for reimbursement purposes.

ii. When reference is made, in the CPT, 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 minimum documentation specified in N.J.A.C. 10:57-1.7.

iii. House call procedure codes refer to a podiatrist visit limited to the provision of podiatric care to an individual who would be too ill to go to a podiatrist'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.

10:57-2.3 Provisions regarding surgery

(a) Specific requirements for surgery procedures may be found at N.J.A.C. 10:57-3.2(b).

1. Certain surgical procedures are carried out as an integral part of a total service and, as such, do not warrant a separate charge. When such a procedure is carried out as a separate entity not immediately related to other services, the provider may bill a value for Separate Procedure.

2. Complications or other circumstances requiring additional and unusual services concurrent with the procedure(s) or during the listed period of normal follow-up

care, may warrant additional reimbursement on a fee-for-service basis.

3. When multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed at the same operative session, the total reimbursement shall be the allowance of the primary procedure plus 50 percent of the allowance of the secondary procedure to a total maximum of 200 percent unless otherwise specified in this section.

4. Anesthesia services rendered to his or her patient by the operating podiatrist are considered part of the surgical procedure and will not receive any additional reimbursement.

5. 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 \$142.00. The allowance permitted is a maximum of 15 percent of the listed specialist fee. The minimum payment is \$27.00.

10:57-2.4 Radiology services

(a) Specific requirements for radiology procedures may be found at N.J.A.C. 10:57-3.2(c).

1. Reimbursement will be made for 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.

10:57-2.5 Consultation policies

(a) A consultation is recognized for reimbursement only when performed by a specialist, as the term is defined at N.J.A.C. 10:57-1.3, who is recognized as such by this Program and the request has been made by or through the patient's attending physician or other licensed practitioner 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.

(b) 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 shall not bill for an initial visit if he or she bills for the consultation.

(c) If there is no referring physician, podiatrist or licensed practitioner, then an initial visit code should be billed instead of a consultation code.

(d) If the patient is seen for the same illness on repeated visits by the same consultant, these visits are considered routine visits or follow-up care visits and not consultations.

(e) Consultation codes will be declined in an office or residential health care facility setting if the consultation has been requested by or between members of the same group, shared health care facility or physicians, podiatrists and/or licensed practitioners sharing common records. A routine visit code is applicable under these circumstances.

(f) If a prior claim for comprehensive consultation visit has been made within the preceding 12 months, then a repeat claim for this code will be denied if made by the

same physician/podiatrist, physician/podiatrist group, shared health care facility or physicians/podiatrists using a common record except in those instances where the consultation required the utilization of one hour or more of the podiatrist's personal time. Otherwise, limited consultation codes would be considered the applicable codes to utilize if their criteria are met.

10:57-2.6 Podiatric orthotic services

(a) Payment will be allowed for orthotic services rendered by a podiatrist for his or her own patients with prior authorization (See N.J.A.C. 10:57-1.5).

(b) Services provided by a prosthetic and orthotic (P&O) facility must be billed directly to the program by the P&O facility, and not by the referring practitioner. (See N.J.A.C. 10:55, Prosthetic and Orthotic Services.)

10:57-2.7 Clinical laboratory services

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

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

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

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

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

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

(e) When the clinical laboratory test is performed on site, the venipuncture shall not be reimbursable as a separate

procedure; its cost is included within the reimbursement for the lab procedure.

(f) When a podiatrist refers a laboratory test to an independent clinical reference laboratory:

1. The clinical reference laboratory shall be certified under the CLIA, as described at (a) and (b) above, to perform the required laboratory test(s);
2. The clinical laboratory shall be licensed by the New Jersey State Department of Health and Senior Services, as described above at (b) and (c), or comparable agency in the state in which the laboratory is located;
3. The clinical laboratory shall be approved for participation as an independent laboratory provider by the New Jersey Medicaid program in accordance with (b) above, and
4. Independent clinical laboratories shall bill the New Jersey Medicaid program for all reference laboratory work performed on their premises. The podiatrist will not be reimbursed for laboratory work performed by a reference laboratory.

Amended by R.1998 d.248, effective May 18, 1998.
See: 30 N.J.R. 626(a), 30 N.J.R. 1812(b).

In (c) and (f)2, inserted "and Senior Services" after "Department of Health".

10:57-2.8 Hospital outpatient department services

(a) A hospital-based podiatrist who is salaried and whose services are reimbursed as part of the hospital's cost shall not bill fee-for-service to the New Jersey Medicaid program.

1. A podiatrist practicing in the hospital outpatient department, whose reimbursement is not part of the hospital's cost, may bill fee-for-service independent of the hospital charges for professional service according to Medicare principles of reimbursement, if the arrangement with the hospital permits it.

10:57-2.9 Diagnostic radiology services

Payment will be allowed for necessary radiological services by a podiatrist, subject to the limitations of his or her licensure. Routine X-rays for screening purposes shall not be reimbursed.

10:57-2.10 Multiple visits; out of office

(a) Podiatry services rendered in a residential or medical facility (that is, hospital, nursing home, or extended care facility) shall be based on referral by the attending physician.

(b) Multiple visits to patients in the same health facility or congregate living arrangement will be reimbursed on an out-of-office visit basis for the initial visit to each patient and on an office visit basis for each subsequent visit to each patient receiving services.

10:57-2.11 Pharmaceutical; podiatrist administered drugs

(a) The New Jersey Medicaid program shall reimburse podiatrists for certain approved drugs administered intradermally, subcutaneously, intramuscularly or intravenously in the office, home, or independent clinic setting according to the following reimbursement methodologies, and the requirements of N.J.A.C. 10:51.

1. Podiatrist-administered medications shall be reimbursed directly to the podiatrist under certain situations. (See HCPCS, N.J.A.C. 10:57-3 for a listing of HCPCS procedure codes.)

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 is for the method of drug administration. The HCPCS 90799 may be billed for intradermal, subcutaneous, intramuscular, or intravenous drug administration.

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 podiatrist is based on the Average Wholesale Price (AWP) of a single dose of an injectable or inhalation drug, or the podiatrist's acquisition cost, whichever is less.

iii. Unless otherwise indicated in N.J.A.C. 10:57-2, 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. A visit for the sole purpose of an injection is reimbursable as an injection and not as an office visit plus an injection. On the other hand, if the criteria of an office or home visit are met, an injection may, if medically indicated, be considered as an add-on to the visit. The drug administered must be consistent with the diagnosis and conform to accepted medical and pharmacological principles in respect to dosage frequency and route of administration.

v. No reimbursement will be made for an 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. In situations where a drug required for administration has not been assigned a "J" code or level III HCPCS, the drug shall be prescribed by the podiatrist and obtained from a pharmacy which directly bills the New Jersey Medicaid program. In this situation, the podiatrist shall bill only for the administration of the drug, using HCPCS 90799.

Amended by R.1998 d.248, effective May 18, 1998.
See: 30 N.J.R. 626(a), 30 N.J.R. 1812(b).
In (a)1, changed the N.J.A.C. reference.

10:57-2.12 Pharmaceutical services

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

10:57-2.13 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 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, drug description. The prescriber shall be requested to provide the reason for medical exception, diagnosis, expected duration of therapy, and expiration date for medical exception.

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

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

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

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

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

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

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

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:57-3.1 Introduction to the HCPCS procedure code system

(a) The New Jersey Medicaid program uses the Health Care Financing Administration's (HCFA) Common Procedure Code System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedure Terminology (CPT) (American Medical Association, PO 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 numeric design, the HCFA-assigned codes and modifiers contain alphabetic characters. Because of copyright restrictions, the CPT procedure narratives for Level I codes are not included in this manual, but are hereby incorporated by reference.

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

1. Level I codes: Narratives for these codes are found in CPT, which is incorporated herein by reference, as amended and supplemented. The codes are adapted from CPT for use primarily by physicians, podiatrists, optometrists, certified nurse-midwives, certified nurse practitioners and clinical nurse specialists, independent clinics and independent laboratories. Level I procedure codes, and fees for each, for which podiatrists may bill, can be found at N.J.A.C. 10:57-3.2.

2. Level II codes: These codes are assigned by HCFA for physician and non-physician services which are not in CPT. Narratives for these codes, and the fees for each, can be found at N.J.A.C. 10:57-3.3.

3. Level III codes: Level III codes identify services unique to the New Jersey Medicaid program. These codes are assigned by the Division to be used for those services not identified by CPT codes or HCFA-assigned codes. Narratives for these codes, and the fees paid for each, can be found at N.J.A.C. 10:57-3.4.

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

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

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

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

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

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

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

- A = "A" preceding any procedure code indicates that these tests can be and are frequently done as groups and combinations (profiles) on automated equipment.
- E = "E" preceding any procedure code indicates that these procedures are excluded from multiple surgery pricing and, as such, should be reimbursed at 100 percent of the Medicaid maximum fee allowance, even if the procedure is done on the same patient by the same surgeon at the same operative session. The procedure codes are excluded indicating that office visit codes are not reimbursed in addition to procedure codes for surgical procedures.
- L = "L" preceding any procedure code indicates that the complete narrative for the code is located in N.J.A.C. 10:57-3.3 or 3.4.
- N = "N" preceding any procedure code means that qualifiers are applicable to that code. (See N.J.A.C. 10:57-3.5)
- HCPCS CODE = HCPCS procedure code numbers.
- MOD = Alphabetic and numeric symbols: Under certain circumstances, services and procedures may be modified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid program's modifier codes for podiatry services are:
- 20 = Microsurgery: When the service is performed using the techniques of microsurgery, including the aid of an operating microscope, modifier '20' may be added to the surgical procedure.

- 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.
- 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 the '26' modifier and a manual pricing edit is received, resolve the edit by adding the '26' modifier.
- 50 = Bilateral Procedure: Unless otherwise identified in the listing, bilateral procedures requiring separate incisions that are performed at the same operative session, should be identified by the appropriate five-digit code describing the first procedure. The second (bilateral) procedure is identified by adding modifier '50' to the procedure number.
- 51 = Multiple Procedures: When multiple procedures are performed at the same operative session, the major procedure may be reported as listed. The secondary, additional or lesser procedure(s) may be identified by adding the modifier '51' to the secondary procedure number(s).
- 52 = Reduced Services: Under certain circumstances, a service or procedure is partially reduced or eliminated at the podiatrist'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 skill of two surgeons (usually with different skills) may be required in the management of a specific procedure. Under such circumstances the separate services may be identified by adding the modifier '62' to the procedure number used by each surgeon for reporting his or her services.
- 66 = Surgical Team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or podiatrists, often of different specialties, plus other highly skilled, specially trained personnel and various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician or podiatrist with the addition of the modifier '66' to the basic procedure number used for reporting services.
- 75 = Concurrent Care Services Rendered By More Than One Physician Or Podiatrist: When the patient's condition requires the additional services of more than one physician or podiatrist, each physician or podiatrist may identify his or her services by adding the modifier '75' to the procedure code for the basic service performed.
- 76 = Repeat Procedure By Same Podiatrist: The podiatrist may need to indicate that a procedure or service was repeated subsequent to the original service. This circumstance may be reported by adding the modifier '76' to the repeated service.
- 77 = Repeat Procedure By Another Podiatrist: The podiatrist may need to indicate that a basic procedure performed by another podiatrist had to be repeated. This situation may be reported by adding modifier '77' to be repeated service.
- 80 = Assistant Surgeon: Surgical assistant services are identified by adding this modifier '80' to the usual procedure number(s).
- TC = When applicable, a charge may be made for the technical component alone. Under those circumstances the technical component is identified by adding the modifier 'TC' to the usual procedure code.
- XE = Non-Medicare-Covered Service—to indicate a service provided to a Medicare/Medicaid recipient is not reimbursable by Medicare.

DESCRIPTION = Code narrative:

Narratives for Level I codes are found in CPT. Narratives for Level II and III codes are found at N.J.A.C. 10:57-3.3 and 3.4, respectively.

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

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

(d) Listed in this subsection are general policies of the New Jersey Medicaid program that pertain to HCPCS. Specific information concerning the responsibilities of a podiatrist when rendering Medicaid-covered services and requesting reimbursement are located at N.J.A.C. 10:57-1.7, Recordkeeping and 10:57-1.6, Basis of Reimbursement.

1. General requirements are as follows:

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

ii. When billing, the provider must enter on the claim form a CPT/HCPCS procedure code as listed in this subchapter (N.J.A.C. 10:57-3.2, 3.3, 3.4).

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

iv. The "Maximum Fee Allowance" as noted with these procedure codes represents the maximum payment for the given procedure for the podiatrist. When submitting a claim, the podiatrist must always use her or his usual and customary fee.

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

v. The HCPCS procedure codes that are billable in conjunction with office visit codes are listed at N.J.A.C. 10:57-3.5, Qualifiers. (See the "N" designation in the "Indicator" column.)

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

Amended by R.1998 d.248, effective May 18, 1998.
See: 30 N.J.R. 626(a), 30 N.J.R. 1812(b).
Updated HCPCS codes throughout.

10:57-3.2 HCPCS Procedure Codes and Maximum Fee Allowance

(a) MEDICINE



IND	HCPCS Code	Mod	Maximum Fee Allowance			IND	HCPCS Code	Mod	Maximum Fee Allowance		
			S	\$	NS				S	\$	NS
	90703		3.40		3.40	E N	99333		16.00		14.00
N	90780		45.00		40.00	N	99341		16.00		14.00
N	90781		45.00		40.00	N	99342		16.00		14.00
N	90799		2.50		2.50	N	99343		35.00		35.00
	93922		22.00		NA	N	99351		16.00		14.00
	93922	26	9.00		NA	N	99352		16.00		14.00
	93922	TC	9.00		NA	N	99353		35.00		35.00
	93923		45.00		NA		99499		B.R.		B.R.
	93923	26	23.00		NA						
	93923	TC	22.00		22.00						
	93965		30.00		NA						
	93965	26	12.00		NA						
	93965	TC	18.00		18.00						
	93970		62.40		NA						
	93970	26	24.70		NA						
	93970	TC	37.70		37.70						
	93971		30.00		NA						
	93971	26	12.00		NA						
	93971	TC	18.00		18.00						
	99025		22.00		17.00						
	99199		B.R.		B.R.						
N	99201		16.00		14.00						
N	99202		16.00		14.00						
N	99203		22.00		7.00						
N	99204		22.00		17.00						
N	99205		22.00		17.00						
E N	99211		16.00		14.00						
E N	99212		16.00		14.00						
E N	99213		16.00		14.00						
E N	99214		16.00		14.00						
E N	99215		16.00		14.00						
N	99221		22.00		17.00						
N	99222		22.00		17.00						
N	99223		22.00		17.00						
N	99231		16.00		14.00						
N	99232		16.00		14.00						
N	99233		16.00		14.00						
N	99238		16.00		14.00						
N	99241		44.00		N.A.						
N	99242		44.00		N.A.						
N	99243		44.00		N.A.						
N	99244		62.00		N.A.						
N	99245		62.00		N.A.						
N	99251		44.00		N.A.						
N	99252		44.00		N.A.						
N	99253		44.00		N.A.						
N	99254		62.00		N.A.						
N	99255		62.00		N.A.						
	99261		16.00		14.00						
	99262		16.00		14.00						
	99263		16.00		14.00						
N	99271		44.00		N.A.						
N	99272		44.00		N.A.						
N	99273		44.00		N.A.						
N	99274		62.00		N.A.						
N	99275		62.00		N.A.						
	99281		9.00		7.00						
	99282		9.00		7.00						
	99283		9.00		7.00						
	99284		9.00		7.00						
	99285		9.00		7.00						
N	99301		22.00		17.00						
N	99302		22.00		17.00						
N	99303		22.00		17.00						
E N	99311		16.00		14.00						
E N	99312		16.00		14.00						
E N	99313		16.00		14.00						
N	99321		22.00		17.00	E	11721	0	21.00		18.00
N	99322		22.00		17.00		11730	0	10.00		10.00
N	99323		22.00		17.00		11731	0	5.00		5.00
E N	99331		16.00		14.00		11732	0	3.00		3.00
E N	99332		16.00		14.00		11740	0	16.00		14.00

(b) SURGERY

IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes Basic Units
				S	\$	NS	
	10060		0	13.00		11.00	3
	10061		30	48.00		42.00	4
	10120		0	18.00		16.00	3
	10121		30	34.00		29.00	4
	10140		0	18.00		16.00	3
	10141		30	48.00		42.00	3
	10160		0	13.00		11.00	3
	10180		14	100.00		85.00	3
	11000		0	13.00		11.00	4
	11001		0	6.00		5.00	3
	11040		0	13.00		11.00	3
	11041		0	13.00		11.00	3
	11042		0	16.00		14.00	3
	11043		0	16.00		14.00	3
	11044		0	48.00		42.00	3
	11050		0	13.00		11.00	3
	11051		0	18.00		15.00	3
	11052		0	23.00		20.00	3
	11100		0	13.00		11.00	4
	11101		0	5.00		4.00	3
	11300		15	18.00		16.00	3
	11301		15	22.00		20.00	3
	11302		15	27.00		24.00	3
	11303		30	32.00		27.00	3
	11305		15	18.00		16.00	3
	11306		15	22.00		20.00	3
	11307		15	27.00		24.00	3
	11308		15	32.00		27.00	3
	11400		15	18.00		16.00	3
	11401		15	22.00		20.00	3
	11402		15	27.00		24.00	3
	11403		15	32.00		27.00	3
	11404		15	32.00		27.00	3
	11406		15	32.00		27.00	3
	11420		15	18.00		16.00	3
	11421		15	22.00		20.00	3
	11422		15	27.00		24.00	3
	11423		15	32.00		27.00	3
	11424		15	32.00		27.00	3
	11426		15	32.00		27.00	3
	11470		15	91.00		78.00	5
	11600		90	37.00		32.00	3
	11601		90	47.00		42.00	3
	11602		90	61.00		53.00	3
	11604		90	80.00		70.00	3
	11606		90	92.00		80.00	3
	11620		90	61.00		53.00	4
	11621		90	90.00		79.00	4
	11622		90	121.00		105.00	4
	11623		90	140.00		121.00	4
	11624		90	162.00		139.00	4
	11626		90	186.00		160.00	4
	11720		0	13.00		11.00	3

IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes Basic Units	IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes Basic Units
				S	\$	NS						S	\$	NS	
	11750		30	42.00		37.00	3	17110		0	16.00		14.00	0	
	11752		30	59.00		50.00	3	17200		0	16.00		14.00	0	
	11755		0	25.00		20.00	3	17201		0	8.00		7.00	3	
	11760		60	42.00		37.00	3	17250		0	16.00		14.00	3	
	11762		90	69.00		59.00	3	17270		15	29.20		24.81	3	
	11765		60	21.00		18.00	3	17271		15	43.74		37.20	3	
	11900		0	16.00		14.00	3	17272		15	52.20		44.36	3	
	11901		0	16.00		14.00	3	17273		15	61.48		52.26	3	
	12001		0	18.00		16.00	3	17274		15	76.81		65.30	3	
	12002		0	24.00		21.00	3	17276		15	94.27		80.15	3	
	12004		0	30.00		26.00	3	17304		0	100.00		85.00	3	
	12005		7	46.00		39.00	3	17305		0	25.00		21.00	3	
	12006		7	57.00		48.00	3	17306		0	25.00		21.00	3	
	12007		7	82.50		70.00	3	17307		0	25.00		21.00	3	
	12020		7	57.00		48.00	5	17310		0	15.00		13.00	0	
	12021		7	57.00		48.00	5	17340		0	18.00		15.00	3	
	12041		30	30.00		26.00	3	20000		0	18.00		16.00	3	
	12042		30	67.00		59.00	4	20005		0	45.00		40.00	4	
	12044		30	82.50		70.00	4	20206		0	29.00		25.00	3	
	12045		30	99.00		84.00	4	20520		7	51.00		45.00	3	
	12046		30	110.00		94.00	4	20525		7	102.00		90.00	4	
	12047		30	143.00		120.00	4	E 20550		0	13.00		11.00	0	
	13131		30	67.00		59.00	4	E 20600		0	13.00		11.00	3	
	13132		30	145.00		126.00	4	E 20605		0	13.00		11.00	3	
	13160		30	121.00		103.00	3	20615		0	80.00		68.00	3	
	13300		30	242.00		210.00	4	20650		0	55.00		47.00	4	
	14040		60	193.00		168.00	4	20670		0	24.00		21.00	3	
	14041		60	242.00		210.00	4	20680		21	121.00		105.00	4	
	14300		60	242.00		210.00	4	20690		0	61.00		53.00	5	
	14350		60	193.00		168.00	3	20692		21	221.75		180.00	3	
	15000		60	70.50		60.00	3	20693		21	136.15		115.00	3	
	15150		30	30.00		26.00	4	20694		21	60.50		51.00	3	
	15100		45	121.00		105.00	3	20838		90	400.00		NA	4	
	15101		45	61.00		53.00	4	20900		30	113.00		96.00	3	
	15120		45	182.00		158.00	4	20957		60	616.00		524.00	6	
	15121		45	61.00		53.00	4	27530		30	74.00		65.00	3	
	15220		45	151.00		131.00	4	27532		90	121.00		105.00	3	
	15221		30	76.00		65.00	3	27534		90	145.00		126.00	3	
	15240		45	151.00		131.00	4	27535		90	242.00		210.00	3	
	15241		30	76.00		65.00	3	27536		90	242.00		210.00	3	
	15350		45	68.00		54.00	3	27603		30	114.00		97.00	3	
	15400		45	68.00		54.00	3	27604		0	16.00		14.00	3	
	15572		45	217.00		185.00	3	27605		15	29.00		25.00	0	
	15574		45	217.00		185.00	5	27606		30	63.00		54.00	3	
	15610		45	89.00		77.00	4	27607		30	228.00		194.00	3	
	15620		45	121.00		105.00	4	27610		60	182.00		158.00	3	
	15850		0	35.00		35.00	3	27612		30	182.00		158.00	3	
	15851		0	35.00		35.00	3	27613		0	16.00		14.00	3	
	15852		0	35.00		35.00	3	27614		0	29.00		25.00	3	
	16000		0	16.00		14.00	5	27615		60	228.00		194.00	3	
	16010		0	35.00		35.00	3	27618		0	29.00		25.00	3	
	16015		0	100.00		85.00	3	27619		30	57.00		49.00	3	
	16020		0	16.00		14.00	0	27620		60	182.00		158.00	3	
	16025		0	24.00		20.00	0	27625		90	211.00		184.00	3	
	16030		0	32.00		27.00	0	27626		60	228.00		194.00	3	
	16035		0	16.00		14.00	3	27630		30	90.00		79.00	3	
	16040		0	21.00		18.00	3	27635		60	228.00		194.00	4	
	16041		0	38.00		30.00	3	27637		60	285.00		243.00	4	
	16042		0	54.00		45.00	3	27638		60	285.00		243.00	4	
	17000		0	16.00		14.00	3	27640		60	211.00		184.00	4	
	17001		0	8.00		7.00	3	27641		60	211.00		184.00	4	
	17002		0	4.00		3.00	3	27645		90	342.00		291.00	4	
	17010		0	42.00		36.00	0	27646		90	342.00		291.00	4	
	17100		0	18.00		15.00	0	27647		90	371.00		316.00	4	
	17101		0	6.00		5.00	3	27648		0	61.00		53.00	3	
	17102		0	4.00		3.00	3	27650		90	227.00		197.00	4	
	17104		0	76.00		59.00	3	27652		90	314.00		267.00	4	
	17105		0	100.00		85.00	0	27654		90	314.00		267.00	4	
	17106		0	111.75		95.00	3	27656		90	114.00		97.00	3	
	17107		0	212.80		180.90	3	27658		90	121.00		105.00	3	
	17108		0	322.85		274.50	3	27659		90	121.00		105.00	3	

IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes Basic Units	IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance		Anes Basic Units
				S	\$ NS						S	\$ NS	
	27664		90	90.00	79.00	3	27886		90	242.00	210.00	3	
	27665		90	90.00	79.00	3	27888		90	242.00	210.00	3	
	27675		30	171.00	146.00	3	27889		60	242.00	210.00	3	
	27676		30	200.00	170.00	3	27892		90	127.00	108.00	3	
	27680		30	143.00	122.00	3	27893		90	127.00	108.00	3	
	27681		30	171.00	146.00	3	27894		90	147.00	125.00	3	
	27685		90	151.00	131.00	4	28001		0	18.00	16.00	3	
	27686		90	202.00	175.00	3	28002		0	36.00	32.00	3	
	27687		30	171.00	146.00	3	28003		30	100.00	85.00	3	
	27690		90	182.00	158.00	3	28005		30	150.00	128.00	3	
	27691		90	342.00	291.00	3	28008		60	61.00	53.00	3	
	27692		30	29.00	25.00	3	28010		0	24.00	21.00	3	
	27695		90	302.00	263.00	3	28011		0	37.00	32.00	3	
	27696		90	342.00	291.00	3	28020		60	109.00	95.00	3	
	27698		90	227.00	197.00	3	28022		60	109.00	95.00	3	
	27700		90	249.00	216.00	3	28024		60	37.00	32.00	3	
	27705		90	272.00	236.00	3	28030		30	143.00	122.00	3	
	27707		90	113.00	100.00	3	28035		30	171.00	146.00	3	
	27709		90	350.00	298.00	3	28043		0	29.00	25.00	3	
	27712		90	288.00	251.00	3	28045		0	57.00	49.00	3	
	27715		90	570.00	485.00	4	28046		60	228.00	194.00	3	
	27720		90	399.00	340.00	3	28050		30	171.00	146.00	3	
	27722		90	428.00	364.00	3	28052		30	103.00	88.00	3	
	27725		90	570.00	485.00	4	28054		30	86.00	74.00	3	
	27727		90	570.00	485.00	4	28060		30	143.00	122.00	3	
	27730		90	257.00	219.00	3	28062		60	228.00	194.00	3	
	27732		30	143.00	122.00	3	28070		30	171.00	146.00	3	
	27734		90	314.00	267.00	3	28072		30	103.00	88.00	3	
	27740		90	302.00	263.00	3	28080		30	121.00	105.00	3	
	27742		90	439.00	382.00	3	28086		30	160.00	136.00	3	
	27745		60	200.00	170.00	3	28088		30	114.00	97.00	3	
	27750		30	114.00	97.00	3	28090		30	90.00	79.00	3	
	27752		90	121.00	105.00	3	28092		30	61.00	53.00	3	
	27756		90	211.00	184.00	3	28100		60	121.00	105.00	4	
	27758		90	314.00	267.00	3	28102		60	200.00	170.00	3	
	27760		90	79.00	68.00	3	28103		60	200.00	170.00	3	
	27762		90	79.00	68.00	3	28104		30	143.00	122.00	4	
	27766		90	151.00	131.00	3	28106		60	200.00	170.00	3	
	27780		7	45.00	39.00	3	28107		60	200.00	170.00	3	
	27781		30	45.00	39.00	3	28108		60	121.00	105.00	4	
	27784		90	121.00	105.00	3	28110		30	69.00	59.00	3	
	27786		90	72.00	63.00	3	28111		30	171.00	146.00	3	
	27788		90	79.00	68.00	3	28112		30	103.00	88.00	3	
	27792		90	151.00	131.00	3	28113		30	103.00	88.00	3	
	27808		30	100.00	85.00	3	28114		90	242.00	210.00	3	
	27810		90	121.00	105.00	3	28116		30	171.00	146.00	3	
	27814		90	211.00	184.00	3	28118		30	143.00	122.00	3	
	27816		30	100.00	85.00	3	28119		30	143.00	122.00	3	
	27818		90	121.00	105.00	3	28120		60	90.00	79.00	4	
	27822		90	242.00	210.00	3	28122		60	90.00	79.00	4	
	27823		90	242.00	210.00	3	28124		60	90.00	79.00	4	
	27824		30	100.00	85.00	3	28126		30	143.00	122.00	3	
	27825		90	121.00	105.00	3	28130		90	211.00	184.00	3	
	27826		90	242.00	210.00	3	28140		60	121.00	105.00	3	
	27827		90	242.00	210.00	3	28150		90	90.00	79.00	3	
	27828		90	242.00	210.00	3	28153		30	69.00	59.00	3	
	27829		90	305.00	263.00	3	28160		90	90.00	79.00	3	
	27830		30	60.00	51.00	3	28171		90	371.00	316.00	3	
	27831		30	80.00	68.00	3	28173		90	371.00	316.00	3	
	27832		90	164.00	142.00	3	28175		90	371.00	316.00	3	
	27840		45	61.00	53.00	0	28190		0	18.00	16.00	3	
	27842		45	61.00	53.00	3	28192		30	34.00	29.00	4	
	27846		90	305.00	263.00	3	28193		30	34.00	29.00	4	
	27848		60	275.00	233.00	3	28200		90	121.00	105.00	3	
	27860		0	61.00	53.00	3	28202		30	161.00	137.00	3	
	27870		90	302.00	263.00	3	28208		90	61.00	53.00	3	
	27871		90	302.00	263.00	3	28210		30	103.00	88.00	3	
	27880		90	242.00	210.00	3	28220		60	113.00	99.00	3	
	27881		60	266.00	226.00	3	28222		60	139.00	119.00	3	
	27882		90	155.00	137.00	4	28225		60	113.00	99.00	3	
	27884		0	24.00	21.00	4	28226		60	139.00	119.00	3	

IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes Basic Units	IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes Basic Units
				\$	\$	NS						\$	\$	NS	
	28230		30	42.00		37.00	3		28605		45	61.00		53.00	3
	28232		60	139.00		119.00	3		28606		30	69.00		59.00	3
	28234		60	139.00		119.00	3		28615		30	143.00		122.00	3
	28238		30	171.00		146.00	3		28630		45	61.00		53.00	0
	28240		30	61.00		53.00	3		28635		7	65.00		55.00	3
	28250		30	143.00		122.00	3		28636		7	85.00		72.00	3
	28260		30	171.00		146.00	3		28645		90	121.00		105.00	3
	28261		60	200.00		170.00	3		28660		0	16.00		14.00	0
	28262		60	212.00		184.00	3		28665		0	35.00		30.00	3
	28264		60	285.00		243.00	3		28666		45	80.00		68.00	3
	28270		30	69.00		59.00	3		28675		60	47.00		40.00	3
	28272		30	29.00		25.00	3		28705		90	361.00		307.00	3
	28280		45	61.00		53.00	3		28715		90	272.00		236.00	3
	28285		90	90.00		79.00	3		28725		90	182.00		158.00	3
	28286		30	68.00		57.00	3		28730		60	203.00		173.00	3
	28288		21	72.00		63.00	3		28735		60	226.00		192.00	3
	28290		60	90.00		70.00	3		28737		60	200.00		170.00	3
	28292		90	139.00		121.00	3		28740		90	166.00		126.00	3
	28293		90	242.00		210.00	3		28750		90	90.00		79.00	3
	28294		90	141.00		123.00	3		28755		90	90.00		79.00	3
	28296		60	200.00		170.00	3		28760		90	200.00		173.00	3
	28305		60	217.00		185.00	3		28800		90	211.00		184.00	3
	28306		90	113.00		100.00	3		28805		90	211.00		184.00	3
	28307		60	217.00		185.00	3		28810		90	121.00		105.00	3
	28308		90	113.00		100.00	3		28820		45	42.00		37.00	3
	28309		60	257.00		219.00	3		28820	50	45	63.00		56.00	3
	28310		30	69.00		59.00	3		28825		45	42.00		37.00	3
	28312		30	46.00		40.00	3		28825	50	45	63.00		56.00	3
	28313		90	90.00		79.00	3		28899		0	B.R.		B.R.	0
	28315		60	55.00		47.00	3		29345		0	53.00		42.00	3
	28320		60	200.00		170.00	3		29355		0	47.00		42.00	3
	28322		30	143.00		122.00	3		29358		2	41.00		34.85	3
	28340		90	90.00		79.00	3		29365		0	53.00		42.00	3
	28341		90	90.00		79.00	3	E	29405		0	42.00		37.00	3
	28344		45	42.00		37.00	3	E	29425		0	47.00		42.00	3
	28345		90	90.00		79.00	3	E	29435		0	66.00		53.00	3
	28400		30	68.00		59.00	3	E	29440		0	12.00		10.00	3
	28405		90	90.00		79.00	3	E	29450		0	24.00		21.00	3
	28406		60	228.00		194.00	3	E	29450	50	0	37.00		32.00	3
	28415		90	151.00		131.00	3	E	29505		0	48.00		42.00	3
	28420		90	300.00		255.00	3	E	29515		0	42.00		37.00	3
	28430		30	82.00		72.00	3	E	29540		0	18.00		16.00	0
	28435		90	90.00		79.00	3	E	29550		0	16.00		14.00	0
	28436		30	175.00		149.00	3	E	29580		0	18.00		16.00	3
	28445		60	275.00		234.00	3	E	29590		0	12.00		10.00	0
	28450		30	41.00		36.00	3	E	29700		0	14.00		12.00	3
	28455		90	61.00		53.00	3	E	29705		0	14.00		12.00	3
	28456		30	121.00		103.00	3	E	29730		0	9.00		8.00	3
	28465		90	121.00		105.00	3	E	29740		0	9.00		8.00	3
	28470		30	18.00		16.00	3	E	29750		0	9.00		8.00	3
	28475		90	42.00		37.00	3	E	29750	50	0	15.00		13.00	3
	28476		30	82.00		70.00	3	E	29799		0	B.R.		B.R.	0
	28485		90	90.00		79.00	3		29894		0	100.00		85.00	3
	28490		30	18.00		16.00	3		29895		90	200.00		170.00	4
	28495		30	30.00		26.00	3		29897		60	100.00		85.00	3
	28496		30	60.00		51.00	3		29898		60	150.00		128.00	3
	28505		30	120.00		102.00	3		29909		0	BR		BR	0
	28510		30	18.00		16.00	3	E	36410		0	18.00		16.00	0
	28515		30	30.00		26.00	3	E N	36415		0	1.80		1.80	0
	28525		30	90.00		77.00	3		36470		0	10.00		8.00	0
	28530		30	18.00		16.00	3		36471		0	18.00		16.00	0
	28531		30	59.00		50.00	3	E	64450		0	18.00		16.00	0
	28540		45	61.00		53.00	0		64702		90	79.00		68.00	3
	28545		45	61.00		53.00	3		64704		90	105.00		91.00	3
	28546		30	69.00		59.00	3		64708		90	242.00		210.00	3
	28555		90	211.00		184.00	3		64726		90	90.00		77.00	3
	28570		45	61.00		53.00	0		64774		30	42.00		37.00	3
	28575		45	61.00		53.00	3		64776		30	53.00		45.00	3
	28576		45	118.00		100.00	3		64778		30	30.00		26.00	3
	28585		90	211.00		184.00	3		64782		30	79.00		68.00	3
	28600		45	61.00		53.00	0		64783		30	70.00		60.00	3

IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes Basic Units	IND	HCPCS Code	Mod	Description	Maximum Fee Allowance		
				\$	\$	NS						\$	\$	NS
	64784		30	131.00		114.00					imburseable when billed by the independent clinical laboratory. It is considered all inclusive as part of the laboratory test.			
	64830		0	46.00		39.00								
	64831		90	79.00		68.00								
	64832		30	43.00		37.00		J0690			Injection, cefazolin sodium, up to 500 mg	1.92		1.92
	64834		90	105.00		91.00								
	64856		90	210.00		183.00		J0696			Injection, ceftriaxone sodium, per 250 mg	10.24		10.24
	64857		90	158.00		137.00		J1100			Injection, dexamethasone sodium phosphate, up to 4 mg/ml	0.80		0.80
								J1200			Injection, diphenhydramineHCl, up to 50 mg	0.55		0.55

(c) RADIOLOGY

IND	HCPCS Code	Mod	Maximum Fee Allowance			IND	HCPCS Code	Mod	Description	Maximum Fee Allowance				
			\$	\$	NS					\$	\$	NS		
	73600			10.00					L1902		AFO, ankle gauntlet, custom fitted	48.81		48.81
	73600	26		3.60					L1906		AFO, multiligaments ankle support	75.00		75.00
	73600	TC		6.40					L1930		AFO, custom fitted, plastic	156.80		156.80
	73610			13.00					L1940		AFO, molded to patient model, plastic	387.94		387.94
	73610	26		5.40					L2102		Ankle-foot-orthosis (AFO), fracture orthosis, tibial fracture cast orthosis, plaster type casting material molded to patient	162.40		162.40
	73610	TC		7.60					L2104		AFO, fracture orthosis, tibial fracture cast orthosis, synthetic type casting material, molded to patient	203.20		203.20
	73615			28.80					L2108		AFO, fracture orthosis, tibial fracture cast orthosis, molded to patient model	569.60		569.60
	73615	26		10.80					L2112		AFO, fracture orthosis, tibial fracture orthosis, custom fitted	244.00		244.00
	73615	TC		18.00					L2114		AFO, fracture orthosis, tibial fracture orthosis, semi-rigid custom fitted	321.37		321.37
	73620			10.00					L2116		AFO, fracture orthosis, tibial fracture orthosis, rigid custom fitted	366.40		366.40
	73620	26		3.60					L3000		Foot insert, removable, molded to patient model "UCB" type, Berkeley shell, each	140.00		140.00
	73620	TC		6.40					L3001		Foot insert, removable, molded to patient model, Spenco, each	76.00		76.00
	73630			13.00					L3002		Foot insert, removable, molded to patient model, Plastazote or equal, each	76.00		76.00
	73630	26		5.40					L3003		Foot insert, removable, molded to patient model, silicone gel, each	76.00		76.00
	73630	TC		7.60					L3010		Foot insert, removable, molded to patient model, longitudinal arch support, each	76.00		76.00
	73650			10.00					L3020		Foot insert, removable, molded to patient model, longitudinal/metatarsal support, each	88.00		88.00
	73650	26		3.60					L3030		Foot insert, removable, formed to patient foot, each	48.00		48.00
	73650	TC		6.40					L3040		Foot, arch support, removable, premolded, longitudinal, each	29.60		29.60
	73660			5.00					L3050		Foot, arch support, removable, premolded, metatarsal, each	32.00		32.00
	73660	26		3.60					L3060		Foot, arch support, removable, premolded, longitudinal/metatarsal, each	48.00		48.00
	73660	TC		1.40					L3070		Foot, arch support, nonremovable, attached to shoe, longitudinal, each	16.00		16.00

(d) PATHOLOGY & LABORATORY SERVICES

IND	HCPCS Code	Mod	Maximum Fee Allowance			IND	HCPCS Code	Mod	Description	Maximum Fee Allowance				
			\$	\$	NS					\$	\$	NS		
	81000			1.20					L3090		Foot, arch support, nonremovable, attached to shoe, longitudinal/metatarsal, each	24.00		24.00
	82948			1.50					L3100		Hallus-Valgus night dynamic splint	20.00		20.00
	85002			1.20					L3140		Foot, rotation positioning device, including shoe(s)	56.00		56.00
	85008			1.20					L3150		Foot, rotation positioning device, without shoe(s)	60.00		60.00
	86671			15.00					L3170		Foot, plastic heel stabilizer	112.00		112.00
	87070			9.00										
	87076			6.00										
N	87081			9.00										
	87081			9.00										
	87084			3.00										
	87101			8.00										
	87102			8.00										
	87103			8.00										
	87106			8.00										
	87210			2.40										
	87220			2.40										

Amended by R.1998 d.248, effective May 18, 1998.
 See: 30 N.J.R. 626(a), 30 N.J.R. 1812(a).
 Updated HCPCS codes throughout.

10:57-3.3 Descriptions of Level II Codes

IND	HCPCS Code	Mod	Description	Maximum Fee Allowance		
				\$	\$	NS
	G0001		Routine venipuncture QUALIFIER: This service is reimburseable in the provider office laboratory (POL) when the specimen is referred out to an independent clinical laboratory for testing. Venipuncture is not re-	1.80		1.80

IND	HCPCS Code	Mod	Description	Maximum Fee Allowance		
				\$	\$	NS
	L3201		Orthopedic shoe, oxford with supinator or pronator, infant	48.00		48.00
	L3202		Orthopedic shoe, oxford with supinator or pronator, child	48.00		48.00
	L3203		Orthopedic shoe, oxford with supinator or pronator, junior	48.00		48.00
	L3204		Orthopedic shoe, hightop with supinator or pronator, infant	48.00		48.00
	L3206		Orthopedic shoe, hightop with supinator or pronator, child	48.00		48.00
	L3207		Orthopedic shoe, hightop with supinator or pronator, junior	48.00		48.00
	L3208		Surgical boot, each, infant	24.00		24.00
	L3209		Surgical boot, each, child	24.00		24.00
	L3211		Surgical boot, each, junior	24.00		24.00
	L3212		Benesch boot, pair, infant	48.00		48.00
	L3213		Benesch boot, pair, child	48.00		48.00
	L3214		Benesch boot, pair, junior	48.00		48.00
	L3215		Orthopedic footwear, woman's shoes, oxford	76.00		76.00
	L3216		Orthopedic footwear, woman's shoes, depth inlay	100.00		100.00
	L3217		Orthopedic footwear, woman's shoes, hightop, depth inlay	116.00		116.00
	L3218		Orthopedic footwear, woman's surgical boot, each	64.00		64.00
	L3219		Orthopedic footwear, man's shoes, oxford	76.00		76.00
	L3221		Orthopedic footwear, man's shoes, depth inlay	100.00		100.00
	L3222		Orthopedic footwear, man's shoes, hightop, depth inlay	116.00		116.00
	L3223		Orthopedic footwear, man's surgical boot, each	64.00		64.00
	L3230		Orthopedic footwear, custom shoes, depth inlay	380.00		380.00
	L3250		Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each	250.00		250.00
	L3251		Foot, shoe molded to patient model, silicone shoe, each	280.00		280.00
	L3252		Foot, shoe molded to patient model, Plastozote (or similar), custom fabricated, each	256.00		256.00
	L3253		Foot, molded shoe Plastazote (or similar), custom fitted, each	112.00		112.00
	L3254		Nonstandard size or width	20.00		20.00
	L3255		Nonstandard size or length	20.00		20.00
	L3257		Orthopedic footwear, additional charge for split size	50.00		50.00
	L3260		Ambulatory surgical boot, each	88.00		88.00
	L3265		Plastazote sandal, each	56.00		56.00
	L3300		Lift, elevation, heel, tapered to metatarsals, per inch	64.00		64.00
	L3310		Lift, elevation, heel and sole, neoprene, per inch	64.00		64.00
	L3320		Lift, elevation, heel and sole, cork, per inch	100.00		100.00
	L3332		Lift, elevation, inside shoe, tapered, up to one-half inch	44.00		44.00
	L3334		Lift, elevation, heel, per inch	36.00		36.00
	L3340		Heel wedge, Sach	10.40		10.40
	L3350		Heel wedge	12.00		12.00
	L3360		Sole wedge, outside sole	12.00		12.00
	L3370		Sole wedge, between sole	14.40		14.40
	L3380		Club foot wedge	12.00		12.00
	L3390		Outflare wedge	16.00		16.00
	L3400		Metatarsal bar wedge, rocker	16.00		16.00
	L3410		Metatarsal bar wedge, between sole	16.00		16.00
	L3420		Full sole and heel wedge, between sole	24.00		24.00
	L3430		Heel, counter, plastic reinforced	24.00		24.00
	L3440		Heel, counter, leather reinforced	24.00		24.00
	L3450		Heel, Sach cushion type	64.00		64.00
	L3455		Heel, new leather, standard	8.00		8.00
	L3460		Heel, new rubber, standard	8.00		8.00
	L3465		Heel, Thomas with wedge	20.00		20.00
	L3470		Heel, Thomas extended to ball	24.00		24.00

IND	HCPCS Code	Mod	Description	Maximum Fee Allowance		
				\$	\$	NS
	L3480		Heel, pad and depression for spur	16.00		16.00
	L3485		Heel, pad, removable for spur	32.00		32.00
	L3500		Miscellaneous shoe addition, insole, leather	4.00		4.00
	L3510		Miscellaneous shoe addition, insole, rubber	8.00		8.00
	L3520		Miscellaneous shoe additions, insole, felt covered with leather	8.00		8.00
	L3530		Miscellaneous shoe addition, sole, half	12.00		12.00
	L3540		Miscellaneous shoe addition, sole, full	36.00		36.00
	L3550		Miscellaneous shoe addition, toe tap, standard	4.00		4.00
	L3560		Miscellaneous shoe addition, toe tap, horseshoe	6.40		6.40
	L3580		Miscellaneous shoe addition, convert instep to Velcro closure	13.60		13.60
	M0101		Cutting or removal of corns, calluses and/or trimming of nails, application of skin creams and other hygienic and preventive maintenance care (excludes debridement of nail(s))	16.00		4.00
	Q0112		All potassium hydroxide(KOH) preparations	2.40		2.40

Amended by R.1998 d.248, effective May 18, 1998.
See: 30 N.J.R. 626(a), 30 N.J.R. 1812(b).
Updated HCPCS codes throughout.

10:57-3.4 Descriptions of Level III Codes

IND	HCPCS Code	Mod	Description	Maximum Fee Allowance		
				\$	\$	NS
	W2650		Casting for molded shoes. Prior authorization is required.	21.00		21.00
	W2655		Casting for arch support. Prior authorization is required.	5.00		5.00
	X4290		Filler for amputee toes	16.00		16.00
	X4800		Arch support foot plate: (plaster cast taken by vendor) leather whitman ordinary	50.00		50.00
	X4801		Arch support foot plate: (plaster cast taken by vendor) leather, mayer	45.00		45.00
	X4802		Arch support foot plate: (plaster cast taken by vendor) leather schaffer	45.00		45.00
	X4803		Arch support foot plate: (plaster cast taken by vendor) leather schaffer with metatarsal pad	75.00		75.00
	X4804		Arch support foot plate (plaster cast taken by vendor) leather whitman combination	75.00		75.00
	X4805		Arch support foot plate (plaster cast taken by vendor) leather-rohadur plastic	75.00		75.00
	X4810		Velcro straps, attached to a pair of shoes, per pair	14.00		14.00
	X4890		Foot	50.00		50.00
	X4891		Foot, ankle	65.00		65.00
	X4892		Foot, ankle, shin	70.00		70.00
	X4894		Orthopedic shoe articulated	72.00		72.00

Amended by R.1998 d.248, effective May 18, 1998.
See: 30 N.J.R. 626(a), 30 N.J.R. 1812(b).
Updated HCPCS codes throughout.

10:57-3.5 Qualifiers for podiatry services

(a) The following is a list of HCPCS procedure codes with their associated qualifiers. Providers shall use the following procedure codes in billing each of the procedures.

1. HCPCS 36415—Once per visit per patient. Not applicable if the laboratory study, in any part, is performed by the office staff or by the provider.

2. HCPCS 87070, 87081—Culture 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.

3. HCPCS 90780—IV infusion therapy. Not to be used for routine IV drug injection or infusion. Reimbursement is contingent upon the required medical necessity, handwritten chart documentation including time and indication of physician's presence with the patient to the exclusion of his other duties.

4. HCPCS 90781—IV infusion therapy. Not to be used for routine IV drug injection or infusion. Reimbursement is contingent upon the required medical necessity, handwritten chart documentation including time and indication of podiatrist's presence with the patient to the exclusion of his or her other duties.

5. HCPCS 90799—Unlisted therapeutic or diagnostic injection. May be used for intradermal, subcutaneous, or intra-arterial injections. Reimbursement is on a flat fee basis and is all inclusive for the cost of the service and the materials. Intravenous and intra-arterial injections are reimbursable only when performed by the podiatrist.

6. HCPCS 99201, 99202, 99203, 99204, 99205, 99221, 99222, 99223, 99301, 99302, 99303, 99321, 99322, 99323—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.

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

7. HCPCS 99211, 99212, 99213, 99214, 99215, 99231, 99232, 99233, 99311, 99312, 99313, 99331, 99332, 99333—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.

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

8. HCPCS 99341, 99342, 99343, 99351, 99352 and 99353—Home services and House calls.

i. Do not distinguish between specialist and non-specialist.

ii. These codes do not apply to residential health care facility or nursing facility setting.

iii. HCPCS 99341, 99342, 99351 and 99352 apply when the provider visits the Medicaid recipients in their

home setting and the visit does not meet the criteria specified under House call listed above.

iv. The HCPCS codes 99244, 99245, 99254, 99255, 99274 and 99275 shall be utilized for Comprehensive consultation.

(1) HCPCS 99244, 99245, 99254, 99255, 99274 and 99275, require a comprehensive evaluation by history and physical examination within the scope of a podiatric specialist's practice is required. An alternative to that would be the utilization of one or more hours of the consulting podiatrist's personal time in the performance of the consultation.

(2) HCPCS 99244, 99245, 99254, 99255, 99274 and 99275 require 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 podiatrist who performed the consultation.

Examples:

"I personally performed a comprehensive evaluation by history and physical examination within the scope of my podiatric practice as a specialist." or

"This consultation utilized 60 or more minutes of my personal time."

9. The HCPCS codes 99241, 99242, 99243, 99251, 99252, 99253, 99271, 99272 and 99273 shall be utilized for Limited consultation. The area being covered for reimbursement purposes is "limited" in the sense that it requires less than the requirements designated as comprehensive consultation as noted above.

Amended by R.1998 d.248, effective May 18, 1998.

See: 30 N.J.R. 626(a), 30 N.J.R. 1812(b).

Updated HCPCS code references throughout; in (a), deleted 6 and 11 and recodified former 7 through 10 as 6 through 9.

APPENDIX A

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as a part of this chapter but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages 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:

UNISYS
PO Box 4801
Trenton, New Jersey 08619-4801

or contact

Office of Administrative Law
Quakerbridge Plaza, Building 9
PO Box 049
Trenton, New Jersey 08625-0049

Amended by R.1998 d.248, effective May 18, 1998.
Sec: 30 N.J.R. 626(a), 30 N.J.R. 1812(b).
Updated address.