CHAPTER 59

MEDICAL SUPPLIER MANUAL

Authority

N.J.S.A. 30:4D–6b(2)(6); 30:4D–7, 7a, b and c; 30:4D–12; 42 CFR 440.70, 120.

Source and Effective Date

R.1991 d.137, effective February 15, 1991.
See: 22 N.J.R. 3712(a), 23 N.J.R. 858(d).

Executive Order No. 66(1978) Expiration Date

Chapter 59, Medical Supplier Manual, expires on February 15, 1996.

Chapter Historical Note

Chapter 59, Medical Supplier Manual, was filed and became effective April 21, 1971, as R.1971 d.55. See: 3 N.J.R. 43(b), 3 N.J.R. 82(e). Pursuant to Executive Order No. 66(1978), Chapter 59 was readopted as R.1991 d.137. See: Source and Effective Date. See subchapter and section annotations for specific rulemaking activity.

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SUBCHAPTER 1. MEDICAL SUPPLIES AND EQUIPMENT

Authority

N.J.S.A 30:4D-b(12), 7 and 7b.

Source and Effective Date

R.1984 d.385, effective August 15, 1984.
See: 16 N.J.R. 1442(a), 16 N.J.R. 2368(a).

Historical Note

This subchapter was filed and became effective April 21, 1971 as R.1971 d.55. See: 3 N.J.R. 43(b), 3 N.J.R. 82(e). Revisions to the original rules were filed December 4, 1973 as R.1973 d.339 to become effective February 1, 1974. Further amendments were filed and became effective February 14, 1975 as R.1975 d.31. See: 7 N.J.R. 7(c), 7 N.J.R. 105(b). Further amendments were filed and became effective January 24, 1977 as R.1977 d.14. See: 8 N.J.R. 467(a), 9 N.J.R. 91(b). Further amendments were filed and became effective February 17, 1977 as R.1977 d.38. See: 8 N.J.R. 551(c), 9 N.J.R. 125(d). Further amendments were filed and became effective August 16, 1979 as R.1979 d.324. See: 11 N.J.R. 246(c), 11 N.J.R. 448(d). Further amendments were filed and became effective December 1, 1980 as R.1980 d.510. See: 12 N.J.R. 25(a), 13 N.J.R. 17(d). Further amendments were filed and became effective September 10, 1981 (operative November 1, 1981) as R.1981 d.328. See: 13 N.J.R. 223(b), 13 N.J.R. 579(b). This subchapter was filed and became effective for readoption with amendments August 15, 1984 as R.1984 d.385. See: 16 N.J.R. 1442(a), 16 N.J.R. 2368(a). See chapter and section level for further amendments.

10:59–1.1 Scope

This chapter is concerned with all medical supplies and equipment excluding prosthetic appliances and orthotic devices (that is braces, artificial limbs, eye aids, dentures, hearing aids, and so forth), except as provided in N.J.A.C. 10:59–1.6 and 1.7.

10:59–1.2 Definitions

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

"Medical equipment" means an item, article or apparatus which has the following characteristics:

1. Is primarily and customarily used to serve a medical purpose;

2. Is generally not useful to a person in the absence of a disease; illness or injury;

3. Is capable of withstanding repeated use (durable) and is nonexpendable (for example hospital bed, oxygen equipment, wheelchair, walker, suction equipment, and the like).

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"Medical supplies" means item(s) which meet the following conditions:

1. Are consumable, expendable, disposable or non durable;

2. Are prescribed by a practitioner;

3. Are medically necessary for use by an eligible recipient (for example, disposable pads).

4. Except:

i. Excluded medicine chest items and personal hygiene items (See N.J.A.C. 10:59–1.6 and 1.7); and

ii. Note: Medical supplies and equipment ordered for patients in a participating medical institution are considered part of the institution's cost and cannot be billed directly to the Program by the supplier.

(1) An exception is when unusual or unique circumstances require the use of medical equipment not usually found in a long term care facility. Such medical equipment may be reimbursable with prior authorization from the Medicaid District Office (MDO) serving the county where the facility is located. See N.J.A.C. 10:59–1.7.

"Recycling" means an item, purchased by the New Jersey Medicaid Program, that is no longer medically needed by the client, that as a minimum, will be sanitized and refurbished and/or repaired, if needed, by the DME provider and supplied to another recipient.

Amended by R.1985 d.376, effective August 5, 1985.
See: 16 N.J.R. 2048(a), 17 N.J.R. 1894(a).
Added definitions "Recycling".

10:59–1.3 Eligible providers

(a) Eligible providers include the following:

1. All pharmacies operating under a valid permit issued by the Board of Pharmacy of the State of New Jersey and all medical-surgical suppliers having an established place of business in New Jersey which is open to the public during normal business hours.

2. All pharmacies outside of New Jersey operating under a valid permit issued by the Board of Pharmacy of the state in which the pharmacy is located and all medical-surgical suppliers outside of New Jersey who qualify as Medicaid providers in the state in which they are located.

10:59–1.4 Provisions for participation

(a) All services and supplies shall be furnished in accordance with the policies, procedures, and payment allowances established by the Division of Medical Assistance and Health Services.

(b) In order to participate in the recycling program, the provider must sign a separate Recycling Provider Agreement (FD–62R) and be approved by the New Jersey Medicaid Program.

(c) Payment by the Program for a purchase or for rental charges shall constitute full payment for the supplies or equipment furnished and no additional charge shall be made to or on behalf of the eligible recipient.

1. Note: For Medicare/Medicaid eligible recipients, see N.J.A.C. 10:59–2.6 "Combination Medicare/Medicaid claims".

(d) The provider agrees to permit properly identified representatives of the Division of Medical Assistance and Health Services to perform the following:

1. Inspect the original prescription or order on file;

2. Audit records pertaining to costs of medical supplies and equipment provided to eligible recipients;

3. Inspect private sector records, where deemed necessary, to comply with the Federal regulations to determine a provider's "usual and customary charges to the public". Information pertaining to the patient's name, address, and prescriber will remain confidential within the limits of the law. Only the following items may be reviewed:

i. Description of equipment or supplies;

ii. Quantity dispensed;

iii. Price charged (purchase or rental);

iv. Date of service.

Amended by R.1985 d.376, effective August 5, 1985.
See: 16 N.J.R. 2048(a), 17 N.J.R. 1894(a).
(b) added; Old (b)-(c) renumbered (c)-(d).

10:59–1.5 Prescription policies

(a) Medical supplies and equipment require a personally signed, legible, dated order by the prescribing practitioner which must contain the following information;

1. The patient's name, address, Health Services Program (HSP) Number, and Patient Person Number;

2. A description of the supplies and/or equipment prescribed;

(Note: the phrase "wheelchair" or "patient needs wheelchair" is insufficient. The order must describe the type and style of the wheelchair.)

3. The length of time the medical equipment item is required;

4. A diagnosis and a summary of the patient's physical condition, to support the need for the item(s) prescribed;

5. The prescribing practitioner's name, address and Individual Medicaid Practitioner (I.M.P.) Number, if applicable.

(b) The initial request for authorization of "ostomy bags and supplies" must be accompanied by a prescription as described in (a) above. However, the Medicaid Medical Consultant will determine, upon review of the prescription and consultation with the prescriber if necessary, whether the patient will have an indefinite need for such supplies. If it is determined that such need will be indefinite, the MDO will issue the initial authorization notifying the medical surgical supplier that monthly prescriptions for that patient will no longer be required for such supplies; however, prior authorization will be required.

10:59–1.6 Non-covered items

(a) Payment will not be authorized for the following items:

1. Personal incidentals, including items for personal cleanliness, body hygiene, and grooming (for example standard toothbrushes, mouthwashes, dentifrices, deodorants, shampoos, plain and deodorant soaps, cosmetics, sanitary pads, shaving items, and so forth);

2. Supplies administered or directly furnished by practitioners;

3. Items available without charge through programs of other public or voluntary agencies (for example New Jersey State Department of Health, Heart Association, American Cancer Society and so forth);

4. First aid supplies (that is, sterile gauze, adhesive tape, adhesive bandage, cotton), except as noted below:

i. When a covered person requires an unusual or excessive amount of any first aid supplies for use in home care during illness or injury, prior authorization must be requested from the appropriate MDO (see N.J.A.C. 10:59–2.4).

5. Orthopedic mattress;

6. Environmental control equipment and supplies (for examples, air conditioners, humidifiers, dehumidifiers, electrostatic filters and so forth):

i. Exceptions are vaporizers and cool mist humidifiers.

7. Inflatable rubber invalid rings;

8. Stainless steel urinals;

9. Stainless steel bedpans;

10. Water bed;

11. Oxygen and equipment for administration of oxygen for patients in long term care facilities;

12. Oral thermometers;

13. Rectal thermometers;

14. Bathroom scales;

15. Feminine syringes, douche bags;

16. Ice bags;

17. Hot water bottles;

18. Sterile or non-sterile tongue blades;

19. Heating pads;

20. Hydrocollators;

21. Infant syringes, family syringes, enema bags;

22. Nasal aspirators;

23. Eye patches;

24. Plastic gloves;

25. Medical supplies and equipment for patients in LTCF (see N.J.A.C. 10:59–1.7(a));

26. Items not meeting the criteria outlined in N.J.A.C. 10:59–1.2.

Case Notes

Judge's allowance of reimbursement for purchase of HEPA Air Cleaner reversed as electrostatic air filter reimbursement is specifically prohibited by regulation. In the Matter of M.D., 7 N.J.A.R. 254 (1980), reversed 179 N.J.Super. 541, 432 A.2d 943, (App.Div.1981), modified in part and remanded 91 N.J. 1, 449 A.2d 1235 (1982).

10:59–1.7 Prior authorization

(a) Suppliers providing any of the following items must first obtain prior authorization from the appropriate MDO.

1. All durable medical equipment intended for use by a patient in a long term care facility (see N.J.A.C. 10:59–1.2 and 4ii);

2. Rental items regardless of price;

3. Oral hygiene devices. However, standard toothbrushes, dental floss, and so forth, are personal hygiene items and therefore, not reimbursable (see N.J.A.C. 10:59–1.2, and 4i);

4. Orthopedic shoes are covered only under the following conditions:

i. When attached to a brace or bar; and/or

ii. When a part of the normal (customary, usual) post-fracture treatment program; and/or

iii. When used to correct or adapt to gross foot deformities;

iv. For additional information concerning policies and procedures for providers of shoes and shoe appliances, reference is made to N.J.A.C. 10:59–1.12 and 1.13.

5. Cervical collars: Soft, hard, malleable frame;

6. Abdominal belts (fashioned elastic type—not used for incisional hernia);

7. Abdominal corsets (non-elastic type);

8. Abdominal supports (low back-non-elastic type—size to fit patient);

9. Sacro-iliac and lumbo sacral corsets, supports or belts (male or female);

10. Special corset, boned and reinforced with steel stays;

11. Combination corset with inside abdominal belts;

12. Elastic support stockings, and so forth;

13. Surgical weight hose;

14. Trusses;

15. Knee cage (standard);

16. Hand orthosis: Short opponens (C–Bar, Lumbrical Bar);

17. Ostomy bags;

18. Medical supplies and durable medical equipment to be purchased for which the charge to the Program exceeds $30.00;

19. Denis Browne Splints and Fillauer Bar;

20. Parts used for repair of durable medical equipment for which the charge to the program exceeds $30.00.

(b) Suppliers repairing durable medical equipment and requesting reimbursement for labor charges must obtain prior authorization.

As amended, R.1975 d.31, eff. February 14, 1975.
See: 17 N.J.R. 7(c), 7 N.J.R. 105(b).
As amended, R.1977 d.38, eff. February 17, 1977.
See: 8 N.J.R. 551(c), 9 N.J.R. 125(d).
As amended, R.1980 d.510, eff. December 1, 1980.
See: 12 N.J.R. 25(a), 13 N.J.R. 17(d).
(a)4iii "or adapt to" added. (a)20 and (b) added.
Amended by R.1985 d.429, effective August 19, 1985 (operative September 1, 1985).
See: 17 N.J.R. 1522(a), 17 N.J.R. 2045(a).
(a)4iv added.

10:59–1.8 Procedures for requesting prior authorization

(a) Complete the following items on the Medical Supplies and Equipment Claim (MC–11–C4): 1, 2, 3, 4, 5, 6, 7, 8, 9, 14, (B, C, D, E, F), 16 and 17. Mail the claim form and the written prescription (a legible photocopy is acceptable) to the appropriate MDO. For repairs, a written prescription is not required.

(b) If the request is authorized, item 15 will be signed and dated by a Medicaid Medical Consultant and the contractor's and provider's copies will be returned to you. The MDO will retain the MDO copy and the prescriber's written order. You may then proceed to supply the authorized item and/or service to the recipient. (See N.J.A.C. 10:59–2 for billing instructions.)

(c) If the request is denied, you will receive written notification from MDO.

> Note: See N.J.A.C. 10:59–2.8 for prior authorization procedures for Medicare/Medicaid eligible persons.

As amended, R.1980 d.150, eff. December 1, 1980.
See: 12 N.J.R. 25(a), 13 N.J.R. 17(d).
(a) add "For repairs, ... required." (b) and/or service added after "authorized item".

10:59–1.9 Purchase policy

(a) Medical equipment items shall be purchased when, in the judgment of the Medicaid Medical Consultant, the medical need will exist for a period of time long enough to make purchase more economically practical than rental.

(b) When purchase is authorized:

1. The submitted price shall be the provider's usual and customary charge to the general public.

2. Reimbursement shall be based on one of the following standards, whichever is less:

i. The provider's usual and customary charge to the general public; or

ii. An allowance determined reasonable by the Commissioner of Human Services, within the limitations set by Federal policy relative to reimbursement individual providers.

3. In no event shall the Medicaid allowance exceed the lowest charge calculated by the Medicare Carrier, or other government agencies, or the lowest charges to other groups or individuals in the community.

(c) When purchase of a vaporizer or cool mist humidifier is prescribed:

1. Only one vaporizer or cool mist humidifier per household will be eligible for reimbursement.

i. Exceptions:

(1) If medical necessity warrants the need for additional vaporizers or cool mist humidifiers;

(2) In the event such equipment is broken and needs replacement, a statement from the provider and a new prescription must be attached to the claim form.

2. Reimbursement shall be based on one of the following standards, whichever is less:

i. Wholesale cost plus 50 percent of cost. A copy of the invoice must be submitted with the claim; or

ii. The provider's usual and customary charge to the general public.

3. The maximum charge allowed by the N.J. Medicaid Program for a vaporizer or a cool mist humidifier is $30.00.

(d) When durable medical equipment is authorized and purchased on behalf of a Medicaid recipient, ownership of such equipment will best in the Division of Medical Assistant and Health Services. The recipient will be granted a possessory interest for as long as it is medically necessary (as approved by the Division) that the recipient requires use of the equipment.

(e) Whenever the Division of Medical Assistance and Health Services purchases durable medical equipment, actual notice of such purchase will be issued to both the Medicaid recipient and the Medicaid provider. When it is no longer medically necessary that the recipient needs such equipment, possession and control will revert to the Division. The recipient shall sign an agreement to this effect as part of the process of authorizing purchase of the equipment.

1. When the Division has been advised it is no longer medically necessary that the recipient requires the use of the durable medical equipment purchased by the New Jersey Medicaid Program, the equipment shall be recycled, if recycling is economically feasible. See N.J.A.C. 10:59–1.12, Recycling policy.

As amended, R.1977 d.13, eff. January 24, 1977.
See: 8 N.J.R. 467(a), 9 N.J.R. 91(b).
As amended, R.1981 d.376, eff. October 8, 1981.
See: 13 N.J.R. 430(c), 13 N.J.R. 707(a).
As amended, R.1984 d.385, eff. August 15, 1984.
See: 16 N.J.R. 1442(a), 16 N.J.R. 2368(a).
(c)2.i.: Changed "59" to "50".
Amended by R.1985 d.376, effective August 5, 1985.
See: 16 N.J.R. 2048(a), 17 N.J.R. 1894(a).
(d) amended and (e) added.

10:59–1.10 Rental policy

(a) Medical equipment items may be rented when, in the judgment of the Medicaid Medical Consultant, the medical need for the item will be of such duration that rental will be more economically practical than purchase.

(b) When rental is authorized:

1. Authorization or reauthorization for rental, under the general category of "Medical Supplies and Equipment" shall not exceed three months duration. The duration of authorized rental will be indicated in item 15 of the form MC–11–C4. To obtain reauthorization, the provider must submit a new prescription from the prescribing physician, indicating the continued medical need.

2. If a medical equipment item has an approved purchase price under the Program of $100.00 or more, the monthly rental payment will be the amount billed or 12 percent of the approved purchase price, whichever is less. Ten such payments shall be deemed to be the full purchase price and no further payments shall be made.

3. If a medical equipment item has an approved purchase price under the program of less than $100.00, the monthly rental payment will be the amount billed or 20 percent of the approved purchase price, whichever is less. Six such payments shall be deemed to be the full purchase price and no further payments shall be made.

4. If a used medical equipment item is supplied on a rental, the approved purchase price may not exceed the usual and customary or fair market value for such a used item. The rental payment may not exceed the percentage of the applicable fair market value in (b)2 or 3 above.

5. The monthly rental fee for a new medical equipment item shall include a full service warranty covering the authorized period of rental.

6. The monthly rental fee for a new medical equipment item shall include the manufacturer's guarantee and full service warranty covering the rental period(s) indicated in (b)2 and 3 above.

7. If the purchase of a rental item is authorized before the maximum rental to purchase conversion period (See (b)2 or 3), a final payment will be made equal to the remaining months of a 10–month rental period times either the amount billed or 1/10 of the approved purchase price, whichever is less. On a six-month rental, a final payment will be made equal to the remaining months of the rental period times either the amount billed or 1/6 of the approved purchase price, whichever is less.

8. If death, ineligibility, or other circumstances shall intervene, over which the New Jersey Medicaid Program may have no control, rental fees for any medical equipment item shall terminate at the end of the month such circumstance(s) occur and no further payment will be made. It shall be the provider's responsibility to notify the Program when the medical need has ceased to exist, as soon as such information becomes available.

9. Exceptions include the following:

i. Demurrage (rental) charges for oxygen cylinders not replaced within 30 days do not require a prior authorization, but may be billed to the New Jersey Medicaid Program by submitting the contractor's copy of the claim form to the contractor and the MDO copy to the appropriate MDO.

ii. Respiratory equipment such as, but not limited to, IPPB machines, ventilators and respirators, shall not be considered purchased after rental payments reach

120 percent of the approved purchase price as described in (b)2 and 3 above (purchase of such equipment can be approved at any time). Except:

(1) Note: Rental of ancillary equipment such as regulators and oxygen equipment qualify under (b)2 and 3 above (120 percent = paid).

(2) Note: Rental of IPPB machines will qualify under (b)2 and (b)3 above (120 percent = paid).

(A) Repairs to an IPPB machine may be prior authorized when the item is no longer under rental. (See N.J.A.C. 10:59–1.11 on repair policy.)

(B) An IPPB machine shall be purchased when, in the judgment of the Medicaid Medical Consultant, the medical need will exist for a period of time long enough to make purchase more economically practical than rental.

As amended, R.1980 d.510, eff. December 1, 1980.
See: 12 N.J.R. 25(a), 13 N.J.R. 17(d).
(b) substantially amended.
As amended, R.1981 d.328, eff. September 10, 1981 (to become operative November 1, 1981).
See: 13 N.J.R. 223(b), 13 N.J.R. 579(b).
(b)9ii: delete "IPPB machines" after "but not limited to,"; (b)9ii(2)(A) and (B) added.

10:59–1.11 Repair policy

(a) Medical equipment items may be repaired and suppliers reimbursed for replacement parts and/or labor charges when, in the judgment of the Medicaid Medical Consultant, the medical need for the item will continue to exist for a period of time and repair is more economical than purchase.

(b) When repair is authorized:

1. Reimbursement for replacement parts shall be based on one of the following standards, whichever is less:

i. The provider's usual and customary charge to the general public; or

ii. An allowance determined reasonable by the Commissioner of Human Services, within the limitations set by Federal policy relative to reimbursement to individual providers.

2. Reimbursement for labor charge shall be $20.00 per hour, divided into quarter hour increments of $5.00.

3. Exceptions:

i. Reimbursement for repairs, both parts cost and labor charge, will not be authorized for durable medical equipment under warranty.

ii. When combined parts cost and labor charge exceed 50 percent of replacement value, repair will not be authorized.

iii. Reimbursement for travel time will not be authorized.

(c) When an emergency situation occurs and repairs are made without obtaining prior authorization, the supplier must obtain post authorization within two MDO working days of such repair.

R.1980 d.510, eff. December 1, 1980.
See: 12 N.J.R. 25(a), 13 N.J.R. 17(d).
Amended by R.1985 d.671, effective January 21, 1986.
See: 17 N.J.R. 2516(a), 18 N.J.R. 186(a).
Labor charge increased from "$10.00" to "$20.00" per hour.

10:59–1.12 Recycling policy

(a) The New Jersey Medicaid Program shall recycle returned durable medical equipment items when the Program has determined that the cost of pickup, refurbishing and/or repair and delivery is more economical than purchase of a new item.

(b) When the New Jersey Medicaid Program is advised that a durable medical equipment item is available for recycling, the Medicaid District Office shall contact an appropriate DME recycling provider who can service the item and who will recover, refurbish and store the item.

1. When the DME provider examines the item and finds that more than minimal repairs are needed, he must obtain prior authorization from the Medicaid District Office before undertaking any repairs. See: N.J.A.C. 10:59–1.11, Repair policy.

2. When, in the judgment of the New Jersey Medicaid Program, a durable medical equipment item cannot be repaired at reasonable cost, the item may be discarded after a representative of the Program has inspected the item.

(c) Reimbursement for repairs and recycling (i.e. pickup, refurbishing and delivery) shall be made following delivery of the item to the next recipient.

(d) Reimbursement for recycling (i.e. pickup, refurbishing and delivery) shall be based on one of the following standards, whichever is greater:

1. The monthly rental fee for a new item of that type; or

2. $35.00.

(e) Reimbursement for recycling (i.e. pickup, refurbishing and delivery) equipment that is heavy and/or cumbersome and requires two or more persons shall be based on one of the following standards, whichever is greater:

1. Two months rental fee for a new item of that type; or

2. $70.00.

i. Prior authorization must be obtained from the Medicaid District Office in order to claim reimbursement under this subsection (e).

(f) While the recycled equipment is in possession of the DME recycling provider, the DME recycling provider has the responsibility to store, safe-guard and maintain the equipment.

(g) State institutions will have first priority on recycled durable medical equipment when specifically requested.

New Rule, R.1985 d.376, effective August 5, 1985.
See: 16 N.J.R. 2048(a), 17 N.J.R. 1894(a).

10:59–1.13 Policy on shoes

(a) Reimbursement for shoes will be made in the following manner:

1. The provider will attach a copy of the invoice to the claim form (MC–11–C4) that is submitted to the Prudential Insurance Company.

i. If there is more than one line item on an invoice, the provider must clearly identify which item corresponds to the entry on item 14 of the claim form;

ii. The item identified on both the invoice and the claim form must correspond to the item that was dispensed to the Medicaid patient.

2. The provider will complete the claim form in the prescribed manner.

i. Providers will continue to use the same procedure code number and narrative description contained in the listing for shoes that is referenced at N.J.A.C. 10:59–3.2(b).

3. The Prudential Insurance Company will process the claim for payment by taking the invoice cost and adding 50 percent to this cost. The sum total of both figures (invoice cost plus 50 percent) will be the amount of reimbursement to the provider.

i. If the provider's customary charge is lower than the computed amount (invoice cost plus 50 percent) specified in 3 above, then the provider will be reimbursed on the basis of his/her customary charge.

(b) The Prudential Insurance Company may request additional information from the provider where the invoice cost is excessive in comparison to invoice costs submitted by other providers. An adjustment may be made for invoice costs that are deemed excessive.

New Rule, R.1985 d.429, effective August 19, 1985 (operative September 1, 1985).
See: 17 N.J.R. 1522(a), 17 N.J.R. 2045(a).

10:59–1.14 Common procedures for providers of shoes and shoe appliances

(a) Certain procedures may be performed by providers other than certified prosthetists and orthotists, including pedorthists and shoe dealers. These procedures will be identified by an asterisk (*) next to the procedure code which is referenced, but not reproduced, at N.J.A.C. 10:55–3.1, entitled Prosthetic and Orthotic Code lists, which is a subchapter within the Prosthetic and Orthotic Service Manual.

(b) Providers submitting claims using the asterisk (*) procedure codes must follow all applicable Medicaid policies and procedures.

New Rule, R.1985 d.429, effective August 19, 1985 (operative September 1, 1985).
See: 17 N.J.R. 1522(a), 17 N.J.R. 2045(a).

SUBCHAPTER 2. BILLING PROCEDURES

Authority

N.J.S.A. 30:4D–6b(12), 7, 7a, 7b.

Source and Effective Date

R.1985 d.628, effective November 19, 1985.
See: 17 N.J.R. 2326(b), 17 N.J.R. 2977(a).

Historical Note

All provisions of this subchapter became effective April 21, 1971 as R.1971 d.55. See: 3 N.J.R. 43(b), 3 N.J.R. 82(e). Revisions became effective December 4, 1973 as R.1973 d.339. Amendments became effective August 16, 1979 as R.1979 d.324. See: 11 N.J.R. 246(c), 11 N.J.R. 448(d). This subchapter was readopted effective November 19, 1985 with amendments effective December 16, 1985 pursuant to Executive Order 66(1978) as R.1985 d.628. See: 17 N.J.R. 2326(a), 17 N.J.R. 2977(a). See chapter and section levels for further amendments.

10:59–2.1 General billing procedures

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

(b) This subchapter contains basic information necessary for the submission of a claim. Included is a sample of the claim form to be used in submitting bills for covered items or services, and instructions for the proper completion of the form.

(c) If billing on a monthly basis for an authorized three-month rental, insert in item 15 of the claim form the statement "see previous claim form" for the second and third month. Reauthorization from the Medicaid District Office (MDO) is required for continued rental beyond the third month.

R.1987 d.408, effective October 5, 1987.
See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).
(a) added; old text became (b).

10:59–2.2 Timeliness of claim submission and claim inquiry

For timeliness of claim submission and claim inquiry, see N.J.A.C. 10:49–1.12.

Amended by R.1985 d.628, effective December 16, 1985.
See: 17 N.J.R. 2326(b), 17 N.J.R. 2977(a).
Substantially amended.
New Rule, R.1987 d.408, effective October 5, 1987.
See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).
Rule repealed was general policy.

10:59–2.3 Patient identification

Verify that the patient is a covered person on the first visit and each visit thereafter, by viewing the patient's validation form which is issued monthly. Individuals under the jurisdiction of the Division of Youth and Family Services (DYFS) are issued quarterly validation cards. It is especially important to review a patient's validation form prior to billing when rentals have been authorized. Prior authorization is no guarantee that an individual is covered.

Amended by R.1986 d.236, effective June 16, 1986 (operative July 1, 1986).
See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a).
Deleted text ", except for Supplemental .... see N.J.A.C. 10:59–1." and substituted "monthly. Individuals under . quarterly validation cards."

10:59–2.4 Prior authorization

Items or services requiring prior authorization should not be provided until the authorization is received. Following receipt of authorization for the MDO and dispensing of the item, complete item 14A, have the patient sign the claim (item 18) and forward the contractor's copy to Prudential for reimbursement. Retain the provider's copy for your records. It is not necessary to submit the practitioner's written order together with a prior authorized claim, except for combination Medicare/Medicaid claims.

10:59–2.5 Claims not requiring authorization

Submit a completed contractor's copy (MC–11–C4) to Prudential together with the other (prescription) from the prescribing practitioner. (See N.J.A.C. 10:59–1.5.) All items on the MC–11–C4 must be completed except item 15.

10:59–2.6 Combination, Medicare/Medicaid claims

All services allowable under Medicare which are provided to an individual eligible for both Medicare and Medicaid benefits should be billed on the Health Insurance Claim Form (HCFA–1500), and the claims are to be sent directly to the Medicare Intermediary Prudential Medicare Claims Division IV, P.O. Box 4000, Linwood, NJ 08221. Providers should understand that they are agreeing to accept assignment when billing in this manner. In order to obtain Medicaid consideration, the provider must record the correct New Jersey Health Services Program Case and Patient Person Number in item 8 in addition to the Health Insurance Claim form in item 2 of form HCFA–1500 (A sample HCFA–1500 is shown as Exhibit 1). Medicare will process the claim and forward it to the Medicaid Program.

As amended, R.1981 d.249, eff. July 9, 1981.
See: 13 N.J.R. 293(a), 13 N.J.R. 417(a).
Deleted reference to HCFA–1490 on important billing procedures using HCFA–1500 claim form.
Amended by R.1985 d.628, effective December 16, 1985.
See: 17 N.J.R. 2326(b), 17 N.J.R. 2977(a).
"1500" substituted for "1490".

10:59–2.7 Combination claim for DME not requiring prior authorization

(a) For covered items for a Medicare/Medicaid eligible person not requiring prior authorization under the New Jersey Medicaid Program, the provider is to submit the original and one copy of the fully completed Health Insurance Claim form (HCFA–1500) directly to Prudential, Medicare Claim Division III, P.O. Box 3000, Linwood, NJ 08221.

As amended, R.1981 d.249, eff. July 9, 1981.
See: 13 N.J.R. 293(a), 13 N.J.R. 417(a).
(a): Incorporated billing procedures using HCFA–1500 claim form and deleted reference to form HCFA–1490.

10:59–2.8 Combination claims for DME requiring prior authorization

(a) For items requiring prior authorization under the New Jersey Medicaid Program, the provider is to submit the physician's prescription complete with patient's name, diagnosis and a specified period of necessity and four copies (use two claim forms with a carbon in between) of the completed Health Insurance Claim Form (HCFA–1500) to the appropriate MDO. The item(s) must be fully described in item 24D on form HCFA–1500.

(b) The MDO will review the prescription and item(s) requested and render a decision. If authorized, the Medicaid Medical Consultant will describe the terms of the authorization, insert the date of authorization and affix his signature in Item 34 of the HCFA–1500. The MDO will retain the one copy of form HCFA–1500 and will return the original, and two copies together with the prescription to the provider.

(c) When billing, the provider is to submit two authorization copies of the form HCFA–1500 and the prescription to Prudential, Medicare Claim Division III, P.O. Box 3000, Linwood, NJ 08221.

(d) Reimbursement to the provider will be made initially by Medicare and be followed by an additional fee allowable from the Medicaid Program. If a purchase has been authorized, the provider will receive a lump sum payment for Medicare's fee. This will be complimented with a separate reimbursement from Medicaid based on any deductible and coinsurance, not to exceed Medicaid's Maximum Allowance. If rental or rental purchase has been authorized, the monthly payments will be made by Medicare with Medicaid making additional payments as allowed.

(e) If the authorization is not granted, the MDO will notify the provider of the reason(s) and will write "Authorization Denied" on the bottom line of item 24 on the form HCFA–1500. If the item(s) are reimbursable under Medicare, the claim should be submitted to Medicare. Any reimbursable under Medicare, the claim should be submitted to Medicare.[1] Any reimbursement will be made by Medicare; Medicaid will not reimburse the provider for any deductible or coinsurance for items for which prior authorization has been denied.

As amended, R.1981 d.249, eff. July 9, 1981.
See: 13 N.J.R. 293(a), 13 N.J.R. 417(a).
(a)-(e): Incorporated billing procedures using HCFA–1500 claim form and deleted references to HCFA–1490.

[1] So in original.

10:59–2.9 Jurisdiction for authorization of services; directory of Medicaid District Offices (MDO)

(a) As a rule, requests for prior authorization are to be made to the MDO serving the county(ies) identified by the first two digits of the eligible person's Health Services Program Case Number. A list of MDO's and the counties which they serve is listed below.

(b) Exceptions include the following:

1. Patients in institutions, (for example, skilled nursing facilities, sheltered boarding homes, special hospitals):

i. Requests for authorization are to be referred to the MDO serving the county wherein the institution is located.

2. Children identified by a code 60 as the third and fourth digits of the Health Services Program Case Number, (for example, 1260001234):

i. These children are under the jurisdiction of the New Jersey Division of Youth and Family Services (formerly Bureau of Children Services). Requests for authorization are to be referred to the MDO serving the county wherein the child is residing.

3. Adult(s) (blind, disabled, elderly) identified by Code 10, 20, or 50 as the third and fourth digits of the Health Services Program Case Number, (for example, 1210004365, 1320501867 or 1450900101): These adults are eligible for Supplemental Security Income (SSI) and receive quarterly validation stubs. Requests for authorization are to be referred to the MDO serving the county wherein the adult is residing.

4. Patient from State institutions: For eligible Medicaid recipients from State institutions the first two digits of the Health Services Program Identification Number identify the institution. Specific Medicaid District Offices, which are identified at N.J.A.C. 10:49–1, Appendix A, have been assigned to handle prior authorization requests for patients from each institution:

IF PATIENT'S HSP IDENTIFICATION NUMBER BEGINS WITH	RESIDENCE IS IN:	CONTACT THE MEDICAID DISTRICT OFFICE BELOW:
31	Greystone Park Psychiatric Hospital	Morris
32	Trenton Psychiatric Hospital	Mercer
33	Marlboro Psychiatric Hospital	Monmouth
34	Ancora Psychiatric Hospital	Camden
35	N.J. Neuro-psychiatric Institute	Hunterdon
36	Arthur Brisbane Child Center	Monmouth
37	Bergen Pines	Bergen
38	Essex County Psychiatric Geriatric Center	Essex
41	Vineland State School	Cumberland
42	North Jersey Training School, Totowa	Passaic
44	Woodbine State School	Atlantic
45	New Lisbon State School Research Center	Burlington
47	Woodbridge State School	Middlesex
48	Hunterdon State School	Hunterdon
90	Family Care	Mercer

Amended by R.1985 d.628, effective December 16, 1985.
See: 17 N.J.R. 2326(b), 17 N.J.R. 2977(a).
Deleted Directory of Medicaid District Offices from Code.

10:59–2.10 Eligibility of patients from state institutions

(a) Medicaid eligibility for patients/residents of state institutions is determined by the New Jersey Division of Public Welfare's Bureau of Local Operations Area Offices. There are four area offices servicing the entire State. Eligibility problems should be referred to the appropriate office as designated below:

	AREA OFFICE	INSTITUTION NO. (See N.J.A.C. 10:59–2.9(b)4.)
Area 1	Bureau of Local Operations Institutional Services Section Broadway Bank Bldg., 8th Floor 100 Hamilton Plaza Paterson, NJ 07505 201–345–1400	31 42
Area 2	Bureau of Local Operations Institutional Services Section P.O. Box 118 Marlboro, NJ 07746 201–946–9770	33 36 47
Area 3	Bureau of Local Operations Institutional Services Section 1478 Prospect Street P.O. Box 1627 Trenton, NJ 08625 609–984–7960	32 35 46 48 90
Area 4	Bureau of Local Operations Institutional Services Section 251–257 Bellevue Avenue Hammonton, NJ 08037 609–561–7300	34 41 44 45

10:59–2.11 Medical Supplies and Equipment Claim (MC–11–C4)

(a) The form MC–11–C4 is to be used for the purpose of billing for medical supplies and equipment and repairs to durable medical equipment. For services requiring prior authorization, item 15 must be signed and dated by a Medicaid Medical Consultant, before the claim may be considered for payment. Instructions for completion of form MC–11–C4 (Exhibit II) follow:

1. Item 1 through 4: Copy the patient's name, address, Health Services Program (HSP) Case Number, and Person Number exactly as it appears on the Validation Form or Medicaid Eligibility Identification Card.

i. For additional information, see N.J.A.C. 10:59–1.

2. Item 5: Indicate the patient's age.

3. Item 6: Check the appropriate block, to identify the patient's sex.

4. Item 7:

i. Check the appropriate block to indicate whether the patient has other health insurance, liability coverage, or No Fault Auto Coverage.

ii. If yes, attach a copy of the decline notice or a copy of the explanation of payment from the carrier.

iii. When the recipient is covered by both Medicare and Medicaid, see section 6 of this subchapter.

5. Item 8:

i. Check the appropriate box.

ii. If patient's illness or injury is work related, enter the name and address of the employer.

6. Item 9:

i. This information is usually preprinted.

ii. If not preprinted, enter the provider's name, address, and provider number.

iii. Enter the telephone number.

7. Item 10: Indicate whether the injury resulted from an automobile accident.

8. Item 11:

i. Indicate whether a prescription accompanies the claim when submitting it for payment.

ii. Attach the prescription when submitting claims for payment which do not require prior authorization.

9. Item 12: Enter the diagnosis.

10. Item 13:

i. Complete this item for recipients under 21 years of age.

ii. Ask the patient and/or referring physician or clinic if this visit is a result of an EPSDT screening.

iii. Indicate if this patient is such a referral by checking the appropriate block.

iv. Check "No" if unable to obtain the information.

11. Item 14.A: Enter date(s) item and/or repair service was provided.

12. Item 14.B: Enter appropriate code(s): For medical supply and equipment codes see N.J.A.C. 10:59–3.1; for orthotic appliance codes, see N.J.A.C. 10:59–3.2; for labor charge code see N.J.A.C. 10:59–3.3.

13. Item 14.C:

i. Describe item(s) provided, including name of manufacturer and model number. Indicate whether item is new or used by checking appropriate box.

ii. Indicate in quarter hour increments actual time spent repairing equipment.

14. Item 14.D: Enter quantity of item provided.

15. Item 14.E:

i. Rental used item—Enter usual and customary charge or 12 percent of usual and customary charge for purchase of used item, whichever is less.

ii. Enter usual and customary purchase price for used item under "Sale Amount."

iii. Rental new item—Enter usual and customary rental charge or 12 percent of usual and customary purchase price whichever is less.

iv. Enter usual and customary purchase price for new item under "Sale Amount."

v. If billing for more than one month on one claim form, items A, B, C, D, E and F must be completed for each month.

vi. If purchase, insert usual and customary charge requested.

16. Item 14.F: Enter total charges for each line; for example, if requesting two similar $20.00 items, enter $40.00 in column F. Enter the sum of line charges opposite "Total Charges".

17. Item 15:

i. Do not write in this space; for Division use only.

ii. When prior authorization is required obtain authorizing signature from LMAU.

18. Item 16:

i. Enter the name and Individual Medicaid Practitioner (IMP) Number of the practitioner who prescribed the medical supply(ies) and/or equipment.

ii. If the prescribing practitioner does not have an IMP Number, insert only the practitioner's name and write "NON-PAR" next to it. Please print.

19. Item 17:

i. Indicate whether the patient is currently in a long term care facility.

ii. If yes, give the name and address of long term care facility.

20. Item 18: Patient certification, see N.J.A.C. 10:49–1.26.

21. Item 19:

i. Read the Provider Certification carefully.

ii. The provider must sign item 19 before the claim can be considered for payment.

iii. Indicate the billing date which is the date the claim is mailed.

(b) Mailing instructions include:

1. Mail the original copy (contractor's copy) to:

The Prudential Insurance Company of America

P.O. Box 1900
Millville, New Jersey 08332

2. Retain the second copy (provider copy) for your records.

3. The third copy (MDO copy) is retained by the Medicaid District Office for all authorized claims. For claims not requiring prior authorization the provider may destroy the third copy, except on demurrage charges for oxygen cylinders where the third copy is sent to the appropriate MDO. See N.J.A.C. 10:59–1.10(b)7.

As amended, R.1981 d.331, eff. September 10, 1981.
See: 13 N.J.R. 413(a), 13 N.J.R. 575(a).
(a)20: delete i through vi.

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

Authority

N.J.S.A. 30:4D–6a(3)(4)b(5); 6b(1)(3)(5)(6)(7)(8)(10)(12)(15)(16); 7, 7a, 7b, 7c.

Source and Effective Date

R.1986 d.52, effective March 3, 1986.
See: 17 N.J.R. 1519(b), 18 N.J.R. 478(a).

Executive Order 66(1978) Expiration Date

Pursuant to the requirements and criteria of Executive Order 66(1978), this subchapter expires on March 3, 1991.

Historical Note

All provisions of this subchapter "Durable Medical Supply and Equipment Codes" became effective April 21, 1971 as R.1971 d.55. See: 3 N.J.R. 43(b), 3 N.J.R. 82(e). Amendments became effective August 19, 1985 (operative September 1, 1985) as R.1985 d.429. See: 17 N.J.R. 1522(a), 17 N.J.R. 2045(a). This subchapter was repealed and the new subchapter adopted effective March 3, 1986 as R.1986 d.52. See: 17 N.J.R. 1519(b), 18 N.J.R. 478(a).

Editor's Note: The Division of Medical Assistance and Health Services utilizes the HCPCS (Health Care Financing Administration's Common Procedure Coding System) as the basis of reimbursement for providers of medical supplies and equipment that participate in the New Jersey Medicaid Program. The HCPCS coding system utilizes procedure codes and narrative descriptions as the basis of reimbursement.

The HCPCS coding system is not published in the New Jersey Administrative Code but may be obtained from the Administrative Practice Officer, Division of Medical Assistance and Health Services, CN–712, Trenton, New Jersey 08625.