CHAPTER 54

PHYSICIAN SERVICES

Authority

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

Source and Effective Date

R.1996 d.66, effective February 5, 1996.
See: 27 N.J.R. 4576(a), 28 N.J.R. 902(b).

Executive Order No. 66(1978) Expiration Date

Chapter 54, Physician Services, expires on February 5, 2001.

Chapter Historical Note

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

Chapter 54, Manual for Physician's Services, was readopted, pursuant to Executive Order No. 66(1978), by R.1991 d.136, effective February 15, 1991. See: 22 N.J.R. 3711(b), 23 N.J.R. 858(a). Subchapter 3, Procedure Code Manual, was repealed by R.1986 d.52 and Subchapter 4, HCFA Common Procedure Coding System (HCPCS), was adopted as new rules, effective March 3, 1986. See: 17 N.J.R. 1519(b), 18 N.J.R. 478(a).

Chapter 54, Manual for Physician's Services, was repealed, and Chapter 54, Physicians Services, was adopted as new rules by R.1996 d.66, effective February 5, 1996. See: Source and Effective Date.

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SUBCHAPTER 1. GENERAL PROVISIONS

10:54–1.1 Purpose and scope

(a) The Physician Services chapter outlines the policies and procedures of the New Jersey Medicaid program for a physician who prescribes, provides directly, or personally directs medically necessary health services to Medicaid recipients. The policies and procedures in this chapter foster the delivery of services in the most efficient and cost-effective manner consistent with good medical practice.

(b) As a Medicaid provider, the physician may also participate in special programs, such as the HealthStart (Maternity and Pediatric Services), Garden State Health Plan and managed health care, which is provided to designated recipients in selected counties, in accordance with the provisions of N.J.A.C. 10:49–20 and 10:74, respectively.

(c) Medicaid rules regarding physicians who have a collaborative arrangement with certified nurse practitioners/clinical nurse specialists (CNP/CNS) may be found in the New Jersey Administrative Code at N.J.A.C. 10:58A. Medicaid rules regarding physicians who employ CNP/CNSs may be found in N.J.A.C. 10:54 (this chapter).

(d) Medicaid rules covering independent certified nurse midwives (CNM) may be found in the New Jersey Administrative Code at N.J.A.C. 10:58. Medicaid rules regarding physicians who employ CNMs may be found in N.J.A.C. 10:54 (this chapter).

10:54–1.2 Definitions

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

"Appropriate State agency" means an agency that has a letter of agreement with the New Jersey Medicaid program that includes permission to request medical consultations that are consistent with good medical practice.

"Bundled drug service" means a drug that is marketed or distributed by the manufacturer or distributor as a combined package which includes the cost of the drug product and ancillary services such as, but not limited to, case management services and laboratory testing.

"Concurrent care" means care rendered to a patient by more than one physician/practitioner where the dictates of medical necessity require that services of one or more clinicians in addition to the attending clinician, so that appropriate and needed care may be provided to the patient.

"Consultation" means the professional evaluation of a patient by a qualified specialist recognized as such by this Program, that is requested by the attending physician or an appropriate State agency.

"Certified Nurse Midwife (C.N.M.)" means a registered professional nurse who:

1. Is licensed by the New Jersey State Board of Nursing, in accordance with N.J.A.C. 13:37;

2. Certified by the American College of Nurse Midwives (ACNM) (American College of Nurse Midwives, 818 Connecticut Ave. NW, Washington, DC 20006, 202–728–9860) or the American College of Nurse Midwives Certification Council (ACC) (Certification Council, 8401 Corporate Drive, Landover, MD 20785, 301–459–1321) and evidence of continuing competency as required by the ACNM; and,

3. Maintains current registration as a Certified Nurse Midwife with the New Jersey State Board of Medical Examiners, in accordance with N.J.A.C. 13:35–2A.

"Early and periodic screening, diagnosis and treatment (EPSDT)" means a preventive and comprehensive health program for Medicaid recipients through 20 years of age, including the assessment of an individual's health care needs through initial and periodic examinations (screenings), the provision of health education and guidance, and the assurance that any identified health problems are diagnosed and treated at the earliest possible time.

"HealthStart" means a program of health services provided to pregnant women, infants and small children, as defined in N.J.A.C. 10:49–1.4.

"HealthStart Maternity Care Services" means a comprehensive package of maternity care services which includes two components, Medical Maternity Care and Health Support Services, and is provided in accordance with N.J.A.C. 10:54–6.

"HealthStart Maternity (Comprehensive) Care Services Provider" means a physician, a certified nurse midwife, a group of physicians, a group of certified nurse midwives (or mixed group of physicians and CNMs), a hospital, an independent clinic approved by the New Jersey State Department of Health and the New Jersey Medicaid program which provides HealthStart Maternity (Comprehensive) Care services either directly, or indirectly through linkage with other practitioners, in independent clinics, in hospital outpatient departments, or in physicians' offices.

"HealthStart Pediatric Care Provider" means a physician/practitioner or group of physicians/practitioners, an outpatient hospital department, or an independent clinic (including a local health department), meeting the New Jersey State Department of Health Improved Program Outcomes and/or the Child Health Conference Criteria, and approved by the New Jersey State Department of Health and the New Jersey Medicaid program to provide a comprehensive package of pediatric care services.

"Nurse midwifery services" means those services provided by certified nurse midwives (C.N.M.) within the scope of practice of certified nurse midwifery in the rules and regulations of the Board of Medical Examiners of the State of New Jersey in N.J.A.C. 10:35–2A which are:

1. To manage the care of essentially normal women during the maternity cycle;

2. To provide care to essentially normal newborns at the time of delivery; and

3. To provide well-woman health care (see definition in N.J.A.C. 10:54–1.2).

"Personal direction" means the supervision by a physician of a service performed by another licensed physician or licensed practitioner. The use of this term does not apply to the supervision of other health care personnel unless otherwise specified.

"Physician" means a doctor of medicine (M.D.) or osteopathy (D.O.) licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners, or similarly licensed by comparable agencies of the state in which he or she practices.

"Physician services" means those services provided within the scope of practice of a doctor of medicine (M.D.) or osteopathy (D.O.) as defined by the laws of the State of New Jersey, or if in practice in another state by the laws of that state, and the services which are performed by or under the personal direction of the physician. It includes physician services furnished in the office, the patient's home, a hospital, a nursing facility and/or other settings. (For rules regarding personal direction, see N.J.A.C. 10:54–2.2.)

"Practitioner" refers to a licensed certified nurse practitioner/clinical nurse specialist (CNP/CNS), a certified nurse midwife, a dentist, a chiropractor, a podiatrist, or a psychologist, as defined by this rule. Practitioners are responsible for examining, diagnosing, treating and counseling patients, and ordering medications, within the specific scope of their practice, as defined by their specific Board. On occasion, this chapter defines rules and procedures which are provided by physicians and other practitioners; in these instances, the term "physician/ practitioner" is used. The term practitioner does not refer to and is not inclusive of physicians (who are defined only as M.D. and DOs).

"Prior authorization" means the approval by the New Jersey Medicaid program before a service is rendered or an item provided. Services which require prior authorization are specified in this chapter (also see N.J.A.C. 10:49–6).

"Transfer" means the relinquishing of responsibility for the continuing care of the patient by one physician or practitioner and the assumption of such responsibility by another physician or practitioner.

"Well–woman health care" means those preventive and referral services which may include family planning, reproductive health care counseling, and reproductive system's health care screening.

10:54–1.3 Provider participation criteria

(a) All physicians, licensed doctors of medicine or surgery (M.D.) or doctors of osteopathy (D.O.), pursuant to N.J.A.C. 13:35 (incorporated herein by reference), authorized to provide medical and surgical services by the State of New Jersey, who are an approved Medicaid participating provider in accordance with (b) below, and who comply with all the rules of the New Jersey Medicaid program, are eligible to provide medical and surgical services for Medicaid recipients.

1. Any out-of-State physician may provide medical and surgical services under this Program if he or she meets the comparable documentation and licensing requirements in the State in which he or she is practicing, and is a New Jersey Medicaid participating provider.

2. An applicant shall provide the Division with a photocopy of the current license and current certification at the time of the application for enrollment.

(b) In order to participate in the Medicaid program as a physician, the physician shall apply to, and be approved by, the New Jersey Medicaid program. An applicant for approval by the New Jersey Medicaid program as a physician provider shall complete and submit the "Medicaid Provider Application" (FD–20) and the "Medicaid Provider Agreement" (FD–62). The FD–20 and FD–62 can be found 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
P.O. Box 4804
Trenton, New Jersey 08650–4804

(c) Upon signing and returning the Medicaid Provider Application, the Provider Agreement and other enrollment documents to the fiscal agent for the New Jersey Medicaid program, the physician will receive written notification of approval or disapproval. If approved, the physician will be assigned a Medicaid Provider Billing Number, a Medicaid Provider Service Number, and will be provided with an initial supply of pre-printed claim forms.

1. Each physician, or each Certified Nurse Midwife or CNP/CNS, who is the provider of the service or member of the group practice, shall place a Medicaid Provider Service Number (MPSN) on all written prescriptions and shall provide the MPSN with all telephone orders. The MPSN shall be entered on all claims submitted by the provider, to expedite the processing of claims. The Medicaid Provider Billing Number is also required on all Medicaid claim forms as a condition of payment. (See also N.J.A.C. 10:49–3.4.) In the case of a physician/practitioner group, the group number is the Medicaid Provider Billing Number.

(d) In order to participate as a provider of HealthStart services, the physician practicing independently or as part of a group shall be a Medicaid provider and shall meet the requirements as specified at N.J.A.C. 10:54–6, including the provider participating criteria specified in N.J.A.C. 10:54–6.3. The physician shall also possess a valid HealthStart Certificate, issued by the New Jersey State Department of Health. An application for a HealthStart Provider Certificate is available from:

New Jersey Department of Health
Division of Family Health Services
50 East State Street, CN 364
Trenton, New Jersey 08625–0364

10:54–1.4 Reimbursement based on specialist designation

(a) Reimbursement rates for physician services are differentiated as specialist or non-specialist according to the criteria for specialist designation listed in (b) below.

i. The diagnosis, as set forth in the Diagnostic and Statistical Manual of the American Psychiatric Association (Latest edition);

ii. A brief history and present clinical status;

iii. A treatment proposal;

iv. A summary of previous treatment and hospitalizations;

v. The anticipated length of hospitalization; and

vi. Evidence that suitable placement within New Jersey and/or within a reasonable distance of the patient's home is not available.

3. A request for retroactive authorization will be considered only when the request has been delayed by circumstances beyond the control of the hospital.

4. When the request for authorization is approved, both the request letter and the provider's claim form will be returned to the provider. When a claim is submitted for reimbursement, the provider must attach the request for approval and the approval to the UB–92 (HCFA–1450), the hospital claim form.

5. If request for prior authorization is denied, the physician and/or hospital shall be notified of the reason, in writing, by the Central Office, Mental Health Services Unit, Office of Health Services Administration, Division of Medical Assistance and Health Services, CN–712, Trenton, New Jersey 08625.

10:54–7.10 Psychiatric services (including prior authorization); Hospital outpatient and other settings

(a) The following policies and procedures were developed to help ensure the appropriate utilization of hospital outpatient psychiatric services. These include the role of the evaluation team in relation to the patient's treatment regimen, with emphasis placed on intake evaluation, development of a Plan of Care (PoC), performance of periodic review for evaluation purposes, and supportive documentation for services rendered. (See N.J.A.C. 10:52–2.3 Recordkeeping and N.J.A.C. 10:66–2.5 for more specific policies and procedures for psychiatric (mental health services).

(b) Psychiatric services which are medically necessary rendered in an approved hospital outpatient department or in other settings, to a registered patient who is a Medicaid recipient, shall not require prior authorization, except in the following situations:

1. Prior authorization is required for partial hospitalization after the first 90 calendar days. Each authorization for this service may be granted for a maximum period of six months. Additional authorization may be requested. A new prior authorization request for partial hospitalization is required when a departure from the Plan of Care (PoC) is made because a change in the patient's clinical condition may necessitate an increase in the frequency and intensity of services, or a change which exceeds the type of services authorized.

2. Prior authorization is required for mental health services exceeding $900.00 in reimbursement to the physician rendered to a Medicaid recipient in any 12–month service year, commencing with the patient's initial visit, when provided in other than an inpatient hospital setting. Reimbursement shall not be paid by the program for physician psychiatric services rendered to a registered hospital outpatient.

3. Prior authorization shall be required for mental health services exceeding $400.00 in payments in any 12–month service year rendered to a Medicaid recipient residing in either a nursing facility or a residential health care facility.

(c) The request for authorization shall include the diagnosis, as set forth in the ICD–9 (latest revision), and also must include the treatment plan and progress report in detail. No post facto authorization will be granted.

1. For those Medicaid recipients who do not reside in a nursing facility and live in a community setting, including a residential health care facility, or for those receiving mental health services in the outpatient department of a hospital, an independent clinic or a physicians office, the request for prior authorization shall be submitted directly to Office of Health Services Administration, Mental Services Unit, Division of Medical Assistance and Health Services, CN–712, Mail Code #18, Trenton, New Jersey 08635–0712 on the "Authorization of Mental Health Services (FD–07)" form.

2. For a Medicaid recipient residing in a nursing facility, the request for prior authorization shall be submitted directly to the appropriate Medicaid District Office that serves that nursing facility on the "Authorization of Mental Health Services (FD–07)" form.

3. When approved by the New Jersey Medicaid program, each authorization may be granted for a maximum period of one year except as listed in (c)3i and ii below. Additional authorizations may be requested.

i. Authorization for partial care and partial hospitalization shall be limited to a maximum period of six months.

ii. Prior authorization shall be required for partial hospitalization after the first 90 calendar days. (See N.J.A.C. 10:52–2.9—Hospital Services Chapter, for further policies and procedures.)

4. The Division shall not reimburse the physician and/or hospital for both mental health services provided in the office and/or hospital or any other setting and medical day care center services provided to the same recipient on the same day. The Division shall also not reimburse the physician and/or hospital for both mental

health services and partial hospitalization services provided to the same patient on the same day.

SUBCHAPTER 8. PHARMACEUTICAL SERVICES

10:54–8.1 Pharmaceutical; Conditions for participation as provider of pharmaceutical services

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

(b) All drugs shall be prescribed.

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

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

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

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

10:54–8.2 Pharmaceutical; Program restrictions affecting payment for prescribed drugs

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

1. Covered and non-covered pharmaceutical services as listed in the Pharmaceutical Services Chapter, N.J.A.C. 10:51–1.11 and 10:51–1.12, respectively, incorporated herein by reference;

2. Pharmaceutical services requiring prior authorization, (see N.J.A.C. 10:51–1.13, incorporated herein by reference);

3. Quality of medication (see N.J.A.C. 10:51–1.14, incorporated herein by reference);

4. Dosage and directions (see N.J.A.C. 10:51–1.15, incorporated herein by reference);

5. Telephone-rendered original prescriptions (see N.J.A.C. 10:51–1.16, incorporated herein by reference);

6. Changes or additions to the original prescription (see N.J.A.C. 10:51–1.17, incorporated herein by reference);

7. Prescription refill (see N.J.A.C. 10:51–1.18, incorporated herein by reference);

8. Prescription Drug Price and Quality Stabilization Act (N.J.S.A. 24:6E–1 et seq.) (see N.J.A.C. 10:51–1.19 incorporated herein by reference);

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

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

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

10. Drug Efficacy Study Implementation (DESI): "Less than effective drugs" subject to a Notice of Opportunity for Hearing (NOOH) by the Federal Food and Drug Administration (see N.J.A.C. 10:51–1.20 and listing of DESI drugs in Appendix A of N.J.A.C. 10:51, incorporated herein by reference);

11. Drug Manufacturers' Rebate Agreement with the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services (see N.J.A.C. 10:51–1.21, incorporated herein by reference); and

12. In addition, diabetic testing materials, including blood glucose reagent strips, urine monitoring strips, tapes, tablets, and lancets. Electronic blood glucose monitoring devices or other devices used in the monitoring of blood glucose levels are considered medical supplies and are covered services by Medicaid. These services may require prior authorization from the Medicaid District Office (MDO). (See Medical Supplier Services, N.J.A.C. 10:59.)

10:54–8.3 Pharmaceutical; Physician-administered drugs

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

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

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

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

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

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

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

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

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

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

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

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

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

10:54–9.1 Introduction

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

1. Level I Codes: The narratives for these codes are found in CPT–4. CPT–4 is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians.

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

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

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

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

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

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

He or she will sign the claim as the servicing provider with the Medicaid Servicing Provider Number (MSPN) as evidence of the validity of the use of the procedure code reflecting the service provided.

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

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

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

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

Column Title

"IND" (Indicator-Qualifier) Lists alphabetic symbols used to refer provider to information concerning the New Jersey Medicaid program's qualifications and requirements when a HCPCS procedure code is used. Explanation of indicators and qualifiers used in this column are given below:

"A" preceding any procedure code indicates that these tests can be and are frequently done as groups and combinations (profiles) on automated equipment.

"C" preceding any procedure code indicates that cosmetic surgery is not payable by Medicaid unless prior authorization is received by the provider. (See also N.J.A.C. 10:54-5.3 and 9.10(g).)

"E" preceding any procedure code indicates that these procedures are excluded from multiple surgery pricing and, as such, should be reimbursed at 100% of the Medicaid maximum fee allowance even if the procedure is done on the same patient by the same surgeon at the same operative session and also that the procedure codes are excluded from the policy indicating that office visit codes are not reimbursed in addition to procedure codes for surgical procedures. (See N.J.A.C. 10:54-9.10(f).)

"F" preceding any procedure code indicates that this code, when used primarily for the diagnosis and treatment of infertility, is not covered by the New Jersey Medicaid program.

"I" preceding any procedure code indicates that certain surgical procedures when performed incidental to other surgical procedures by the operating surgeon or assistant are covered in the reimbursement allowance for the primary procedure. (See N.J.A.C. 10:54-9.10(b).)

"L" preceding any procedure code indicates that the complete narrative for the code is located in N.J.A.C. 10:54-9.10 of this chapter.

"M" preceding any procedure code indicates that this service is medically necessary under the Medical Justification Program. (See N.J.A.C. 10:54-3.2.)

"N" preceding any procedure code means that qualifiers are applicable to that code.

"S" preceding any procedure code indicates that a second opinion by another physician is required for this procedure. (See N.J.A.C. 10:54-9.10(b).)

"HCPCS CODES"—Lists the HCPCS procedure code numbers.

"MOD" Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of alphabetic and/or numeric characters affixed to the procedure code. The New Jersey Medicaid program's recognized modifier codes are listed in N.J.A.C. 10:54-9.3.

"DESCRIPTION"—Lists the code narrative for Level II and III procedure codes. Narratives for Level I are in CPT–4.

"FOLLOW-UP DAYS"—Lists the number of days for follow-up care.

"MAXIMUM FEE ALLOWANCE"—Lists New Jersey Medicaid program's maximum fee allowance schedule. If the symbols "B.R." (By Report) are listed instead of a dollar amount, it means that additional information will be required in order to properly evaluate the service. Attach a copy of the report to the claim form. If the symbol "N.A." (Not Applicable) are listed instead of a dollar amount, it means that service is not reimbursable.

"ANES BASIC UNITS"—B.U.V. (Basic Unit Value) + A.T. (Anesthesia Time per Unit) × $6.30 (specialist) or $5.50 (non–specialist) equals reimbursement.

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

i. These symbols and/or letters must not be ignored because in certain instances requirements are created in addition to the narrative which accompanies the HCPCS code as described in the CPT–4. THE PROVIDER WILL THEN BE SUBJECT TO THE ADDITIONAL REQUIREMENTS AND NOT JUST THE CPT/HCPCS CODE NARRATIVE. These requirements must be fulfilled in order to receive reimbursement.

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

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

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

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