4. An opportunity for a fair hearing may be granted to any provider requesting a hearing on any complaint or issue arising out of the claims payment process, in accordance with N.J.A.C. 10:49–10, Notices, Appeals and Fair Hearings.

Amended by R.1998 d.89, effective February 17, 1998.
See: 29 N.J.R. 4615(a), 30 N.J.R. 734(a).

In (d)2, updated the address.

SUBCHAPTER 3. HEALTH CARE FINANCING ADMINISTRATION (HCFA) COMMON PROCEDURE CODING SYSTEM (HCPCS) CODE AND MAXIMUM FEE SCHEDULE FOR PSYCHOLOGICAL SERVICES

10:67–3.1 Introduction

(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—4th Edition (CPT–4) (CPT) architecture, employing a five-position code and as many as 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. Copies may be obtained from the American Medical Association, PO Box 10950, Chicago, Illinois 60610, attention: Order Department. The HCPCS codes are relevant to Medicaid psychological services and must be used when filing a claim. Listed below are some of the general policies of the New Jersey Medicaid program regarding HCPCS.

1. The use of a procedure code will be interpreted by the New Jersey Medicaid program as a representation that the psychologist personally furnished, as a minimum, the service for which it stands.

(b) When submitting a claim, the psychologist must always use his/her usual and customary fee. The MEDICAID MAXIMUM FEE ALLOWANCE designated for any HCPCS code represents the New Jersey Medicaid program's maximum payment for the given procedure.

1. All references to time parameters shall mean the psychologist's personal time in reference to the service rendered unless it is otherwise indicated.

2. The information under the "QUALIFIER" refers the provider to information concerning the New Jersey Medicaid's program qualifications and requirements when a procedure or services code is used.

(c) The psychological services use exclusively Level I HCPCS codes of 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 the psychologist. Level I procedure codes, and fees for each, for which the psychologist may bill, can be found at N.J.A.C. 10:67–3.2.

(d) Specific elements of HCPCS codes require the attention of providers. The lists of HCPCS code numbers for psychologist 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" & "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:

"P" = preceding any procedure code indicates that prior authorization shall be required. The appropriate form that must be used to request prior authorization is indicated in the Fiscal Agent Billing Supplement.

"N" = preceding any procedure code means that qualifiers are applicable to that code. (See also N.J.A.C. 10:67–2.3 for the specific limitations of the total dollar amounts for services within a specific timeframe for a specific Medicaid beneficiary.)

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.

"22" = Unusual Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding the modifier "22" to the usual procedure number. A report with additional documentation must accompany the claim form to justify the greater services, unusual services or complications.

(e) Listed below are general policies of the New Jersey Medicaid program that pertain to HCPCS. Specific information concerning the responsibilities of a psychologist when rendering Medicaid-covered services and requesting reimbursement are located at N.J.A.C. 10:67–1.4, Recordkeeping; N.J.A.C. 10:67–1.5, Basis of reimbursement; and N.J.A.C. 10:67–2, General provisions.

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 N.J.A.C. 10:67–3.2.

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 psychologist and psychologist specialist. When submitting a claim, the psychologist must always use her or his usual and customary fee.

v. 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.89, effective February 17, 1998.
See: 29 N.J.R. 4615(a), 30 N.J.R. 734(a).
Substituted references to CPT for references to CPT–4 throughout; and in (a), rewrote the first sentence, and inserted a third sentence.

10:67–3.2 HCPCS Codes and reimbursement rates for psychological services (Level I)

IND	HCPCS Code	Maximum Fee Allowance $ S	$	NS
N	90801	$37.00		$26.00
N	90843	$19.00		$13.00
N	90844	$37.00		$26.00
N	90847	$37.00		$26.00
N	90847–22	$46.00		$32.00
N	90853	$ 8.00		$ 6.00
N	90887	$19.00		$13.00
N	96100	$37.00		$26.00
N	96105	$37.00		$26.00
N	96111	$37.00		$26.00
N	96115	$37.00		$26.00
N	96117	$37.00		$26.00

Amended by R.1998 d.89, effective February 17, 1998.
See: 29 N.J.R. 4615(a), 30 N.J.R. 734(a).

Deleted descriptions from existing codes and added new codes and fees.

10:67–3.3 HCPCS Code qualifiers for psychological services

Code	Narrative
90801	Initial Comprehensive Psychiatric Evaluation QUALIFIER: A Medicaid provider who is a psychologist may bill this physician procedure code for parallel psychological services. This code requires for reimbursement purposes a minimum of 50 minutes of direct clinical involvement with the patient or family member. No more than one claim is reimbursable per the same patient, per the same physician, per year.
90843	Individual Psychotherapy—25 minute session QUALIFIER: This code requires for reimbursement purposes a minimum of 25 minutes of direct personal clinical involvement with the patient or family member.
90844	Individual Psychotherapy—50 minute session QUALIFIER: This code requires for reimbursement purposes a minimum of 50 minutes of direct personal clinical involvement with the patient.
90847	Family Therapy—50 minute session QUALIFIER: A Medicaid provider who is a psychologist may bill this physician procedure code for parallel psychological services. This code requires for reimbursement purposes a minimum of 50 minutes of direct personal clinical involvement with the patient or family member.
90847–22	Family Therapy—80 minute session QUALIFIER: A Medicaid provider who is a psychologist may bill this physician procedure code for parallel psychological services. This code requires for reimbursement purposes a minimum of 80 minutes of direct personal clinical involvement with the patient or family member.
90853	Group psychotherapy by a psychologist (other than of a multiple family group). QUALIFIER: A Medicaid provider who is a psychologist may bill this physician procedure code for parallel psychological services. This code requires for reimbursement purposes a minimum of 90 minutes per session. One unit equals 90 minutes for each person in the group with the maximum of eight persons in the group.
90887	Family Conference—25 minute session QUALIFIER: A Medicaid provider who is a psychologist may bill this physician procedure code for parallel psychological services. This procedure code must be used in conjunction with the treatment of the patient. This code requires for reimbursement purposes a minimum of 25 minutes of direct personal clinical involvement with the patient or family member. The CPT narrative otherwise remains applicable.
96100	Psychological testing with a written report per hour. QUALIFIER: The rate per hour includes time for interpretation and reporting the results of the psychological testing, including the cost of administration of the test and the scoring.
96105	Assessment of aphasia with a written report per hour. QUALIFIER: The rate per hour includes time for interpretation and reporting the results of the psychological testing, including the cost of administration of the test and the scoring.
96111	Extended developmental testing with a written report per hour. QUALIFIER: The rate per hour includes time for interpretation and reporting the results of the psychological testing, including the cost of administration of the test and the scoring.
96115	Neurobehavioral status exam with a written report per hour. QUALIFIER: The rate per hour includes time for interpretation and reporting the results of the psychological testing, including the cost of administration of the test and the scoring.
96117	Neuropsychological testing battery with a written report per hour. QUALIFIER: The rate per hour includes time for interpretation and reporting the results of the psychological testing, including the cost of administration of the test and the scoring.

New Rule, R.1998 d.89, effective February 17, 1998.
See: 29 N.J.R. 4615(a), 30 N.J.R. 734(a).

APPENDIX

FISCAL AGENT BILLING SUPPLEMENT

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

Unisys Provider Services Unit
P.O. Box 4804
Trenton, New Jersey 08650–4804

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
CN 049
Trenton, New Jersey 08625–0049