

CHAPTER 52

HOSPITAL SERVICES MANUAL

Authority

N.J.S.A. 30:4D-6a(1), 30:4D-7, 7a, b, c, and e; 30:4D-12, P.L. 1992, c.160; 1902(a)(13) of the Social Security Act; 42 U.S.C. 1396a; 42 447.251, 253.

Source and Effective Date

R.1995 d.123, effective February 3, 1995.
See: 26 N.J.R. 4551(a), 27 N.J.R. 1660(a).

Executive Order No. 66(1978) Expiration Date

Chapter 52, Hospital Services Manual, expires on February 3, 2000.

Chapter Historical Note

Chapter 52, originally Manual for Hospital Services, became effective with Subchapter 1, Coverage, and Subchapter 2, Admission and Billing Procedures, adopted as R.1971 d.30, effective March 5, 1971. See: 3 N.J.R. 24(b), 3 N.J.R. 62(c). Subchapter 3, Teleprocessing Procedures, was adopted as R.1975 d.230, effective August 1, 1975. See: 7 N.J.R. 316(b), 7 N.J.R. 431(b).

Pursuant to Executive Order No. 66(1978), Subchapter 1 was readopted as R.1984 d.47, effective February 9, 1984. See: 15 N.J.R. 2125(a), 16 N.J.R. 424(b). Pursuant to Executive Order No. 66(1978), Subchapter 2 was readopted as R.1985 d.56, effective January 28, 1985. See: 16 N.J.R. 3159(a), 17 N.J.R. 451(a). Pursuant to Executive Order No. 66(1978), Chapter 52 was readopted as R.1990 d.157, effective February 8, 1990. See: 21 N.J.R. 3911(a), 22 N.J.R. 799(b).

Subchapter 4, HCFA Common Procedure Coding System (HCPCS), was adopted as R.1993 d.327, effective August 17, 1992, but operative September 1, 1992. See: 24 N.J.R. 917(a), 24 N.J.R. 2898(a). Pursuant to P.L. 1992, c. 160; 1902(a)(13) of the Social Security Act; 42 U.S.C. 1396a; 42 C.F.R. 447.251, 253 and the authority cited above Subchapter 5, Procedural and Methodological Regulations; Subchapter 6, Financial Reporting Principles and Concepts; Subchapter 7, Diagnosis Related Groups (DRG); Subchapter 8, Basis of Specific Payment for Disproportionate Share Hospitals, and Subchapter 9, Review and Appeal of Rates, were adopted as Emergency New Rules R.1993 d.154, effective March 11, 1993 (to expire May 10, 1993). See: 25 N.J.R. 1582(a). The provisions of R.1993 d.154 were readopted as R.1993 d.263, effective May 10, 1993, with changes effective June 7, 1993. See: 25 N.J.R. 2560(a).

Pursuant to Executive Order No. 66(1978), Chapter 52 was readopted as R.1995 d.123. See: Source and Effective Date. As a part of R.1995 d.123, Chapter 52 was retitled Hospital Services Manual; existing Subchapters 1 through 4 were repealed, and new Subchapters 1 through 4 were adopted, effective April 17, 1995; and Subchapter 10 was adopted as new rules, effective April 17, 1995. See, also, section annotations.

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SUBCHAPTER 1. GENERAL PROVISIONS

10:52-1.1 Purpose and scope

This chapter of the Hospital Services Manual outlines the policies and procedures of the Division for the provision of inpatient and outpatient (including emergency room) hospital services to Medicaid recipients. The hospitals that are included in these policies and procedures are general hospitals, special hospitals, rehabilitation hospitals and private psychiatric hospitals, unless specifically indicated otherwise.

Petition for Rulemaking.

See: 27 N.J.R. 1818(b), 27 N.J.R. 2014(c).

10:52-1.2 Definitions

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

“Adjusted admissions” means inpatient admissions increased to reflect outpatient activity, which is calculated by admissions multiplied by total gross revenue divided by inpatient gross revenue.

“Base year” means the year from which historical cost data are utilized to establish prospective reimbursement in the rate year.

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

“Current Cost Base” means the actual costs and revenue of the hospital as identified in the Financial Elements in the base reporting period for the purposes of rate setting.

“Diagnosis Related Groups (DRGs)” means a patient classification system in which cases are grouped by shared characteristics of principal diagnosis, secondary diagnosis, age, surgical procedure, and other complications, and consumption of a similar amount of resources.

“Division” means the New Jersey Division of Medical Assistance and Health Services within the New Jersey Department of Human Services.

“Early and Periodic Screening, Diagnosis and Treatment (EPSDT)” means a preventive and comprehensive health program for Medicaid recipients under 21 years of age for the purpose of assessing a recipient’s health needs through initial and periodic examinations, health education and guidance, and identification, diagnosis, and treatment of health problems.

“Entity,” as used in N.J.A.C. 10:52-1.2A, means an outpatient department not contiguous to a main inpatient hospital for which that hospital is attempting to seek recognition and reimbursement as an outpatient hospital service.

“Equalization Factor” means the factor that is calculated based on defined Labor Market Areas and multiplied by hospital costs to permit comparability between differing regional salary costs in setting Statewide standard costs per case.

“Financial Elements” means the reasonable cost of items approved as reimbursable under Medicaid (see N.J.A.C. 10:52-5.10).

“Grouper” means the logic that assigns cases into the appropriate Diagnosis Related Groups in accordance with the clinical and statistical information supplied.

“Hospital” means an institution which is primarily engaged in providing the following services to inpatients, by or under the supervision of physicians:

1. Diagnostic services and therapeutic services for the prevention, medical diagnosis, treatment, and care of injured, disabled or sick persons, including obstetrical services and services to the normal newborn; or,
2. Rehabilitative services for the rehabilitation of injured, disabled, or sick persons; and that
3. Maintains clinical records on all patients;
4. Has by-laws in effect with respect to its staff of physicians;
5. Requires every patient to be under the care of a physician;

6. Provides 24-hour nursing services rendered or supervised by a registered professional nurse, and has a registered professional nurse or licensed practical nurse on duty at all times;

7. Has in effect a hospital utilization review plan that meets the requirement of the law (Sec. 1861(K) of the Social Security Act); and has in place a discharge planning process that meets the requirements of the law (Sec. 1861(ee)) of the Social Security Act;

8. Is licensed as a hospital in the State of New Jersey, or licensed as a hospital by the appropriate agency under the laws of the respective state in which the hospital is located, or approved by the agency of the state or locality responsible for licensing hospitals meeting the standards established for such licensing;

9. Meets any other requirements that the U.S. Secretary of Health and Human Services finds necessary in the interest of health and safety of individuals who furnished services in the institution; and

10. For the purposes of N.J.A.C. 10:52-1.2A only, is where the main inpatient hospital services are located.

“Hospital (Approved General)” means an institution which is approved to participate as a provider in the Division if it:

1. Is licensed as a general hospital by the State of New Jersey, or licensed as a hospital by the appropriate agency under the laws of the respective state in which the hospital is located; (NOTE: When only a specific identifiable part of a multi-service institution is licensed, only the section licensed is considered a Medicaid provider);

2. Meets the requirements for participation and certification under Medicare (Title XVIII of the Social Security Act);

3. Has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under Medicaid (Title XIX); and,

4. Has signed a provider agreement to participate in and abide by the rules of the Division and applicable Federal regulations.

“Hospital (Approved Private Psychiatric)” means an institution which is approved to participate as a provider in the Division and:

1. Is licensed by the State of New Jersey as a psychiatric (mental-non-governmental) hospital or licensed as a private psychiatric hospital (non-governmental) by the appropriate agency under the laws of the respective state in which the hospital is located;

2. Meets the requirements for participation and certification under Medicare (Title XVIII of the Social Security Act) as a psychiatric hospital;

3. Has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under Medicaid (Title XIX);

4. Meets the special Medicare standards relative to staffing requirements and clinical medical records; and,

5. Has signed a provider agreement to participate in and abide by the rules of the Division and applicable Federal regulations.

“Hospital (Approved Private Psychiatric) facility that provides inpatient services to children under 21 years of age” means an institution that shall meet the requirements of 1., 2., 3., 4. and 5. above, listed in the definition of “Hospital (Approved Private Psychiatric): or in addition to 1. and 5. above, has facility accreditation by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO).

“Hospital (Approved Special)” means an institution which is approved by the New Jersey State Department of Health as a special hospital (for definition of special hospital, see N.J.A.C. 8:43G-1.3(b)2) and which includes any hospital which assures the provision of comprehensive specialized diagnosis, care, treatment and rehabilitation, where applicable, on an inpatient basis for one or more specific categories of patients; and approved to participate as a provider in the Division if it meets the appropriate standards of participation for one of the following classifications:

(a) Special (Acute care or short term) or Comprehensive Rehabilitation Hospital:

1. Licensed as a special or comprehensive rehabilitation hospital by the New Jersey Department of Health;

2. Accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or the Commission on Accreditation as a hospital or rehabilitation facility; and/or

3. Meets the requirements for participation and certification under Medicare (Title XVIII of the Social Security Act) as a hospital;

4. Has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under Medicaid (Title XIX); and,

5. Has signed a provider agreement to participate in and abide by the rules of the Division and all applicable Federal regulations.

“Informed Consent” means the voluntary knowing assent from the individual on whom any sterilization is to be performed after he or she has been given (as evidenced by a document executed by such individual) and has been given:

1. A fair explanation of procedures to be followed;
2. A description of attendant discomforts and risks;
3. A description of benefits to be expected;

10:52-10.14 Adjustment methodology

(a) For a listing adjustment, the charity care write off amount for each account should agree with the reimbursement rate that would have been paid to the hospital by the Medicaid program. To the extent that charity care write off amounts are overstated, the hospital's listing total will be reduced by the amount of the overstatement.

(b) For an alternative documentation adjustment, a ratio shall be developed using sample dollars with alternative documentation as a percentage of total sample dollars. If this ratio is less than or equal to .10, there shall be no adjustment. If this ratio is greater than .10, the ratio shall be reduced by .10 and then multiplied by hospital charity care at the Medicaid rate. This amount shall be subtracted from hospital charity care at the Medicaid rate. The result shall be used in the compliance adjustment calculation in (c) below.

(c) For a compliance adjustment, each file reviewed must pass the compliance steps in N.J.A.C. 10:52-10.4 through 10.10. Failure in any one step fails the file and associated sample dollars. A failure rate (failed dollars divided by the total dollars sampled) that meets or exceeds 10 percent shall require an adjustment to the hospital's charity care listing total, based on unit dollar sampling.

(d) The hospital's charity care total adjusted for (a), (b) and (c) above will constitute the hospital's audited charity care amount.

(e) A hospital which disagrees with the audit findings may request a review of auditor judgment with representatives from the Department of Health within 15 days of the date that the Department of Health staff or the Department of Health's audit subcontractor finishes their review of the hospital's charity care files and provides the hospital with a copy of the audit results.

(f) A hospital which disagrees with the audit findings may request an administrative hearing, which shall be conducted in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

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 (Narratives found in CPT-4)

These codes are adapted from CPT-4 for utilization primarily by Physicians, Podiatrists, Optometrists, Certified Nurse-Midwives, Independent Clinics and Independent Laboratories. CPT-4 is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians.

Copyright restrictions make it impossible to print excerpts from CPT-4 procedure narratives for Level I codes. Thus, in order to determine those narratives it is necessary to refer to CPT-4, which is incorporated herein by reference, as amended and supplemented.

2. LEVEL II CODES (Narratives found at N.J.A.C. 10:52-10.3)

These codes are assigned by HCFA for physicians and non-physician services which are not in CPT-4.

3. LEVEL III CODES (Narratives found at N.J.A.C. 10:52-4.3)

These codes are assigned by the Division to be used for those services not identified by CPT-4 codes or HCFA assigned codes. Level III codes identify services unique to New Jersey.

(b) The responsibility of the provider when rendering specific services and requesting reimbursement is listed in both Subchapter 1 and Subchapter 2 of N.J.A.C. 10:52, Hospital Services.

(c) Regarding specific elements of HCPCS codes which requires attention of provider, the lists of HCPCS code numbers for Pathology and Laboratory are arranged in tabular form with specific information for a code identified under columns with titles such as: "IND", "HCPCS CODE", "MOD", "DESCRIPTION", and "MAXIMUM FEE ALLOWANCE". The information identified under each column is summarized below:

Column Title	Description
IND	(Indicator-Qualifier) Lists alphabetic symbols used to refer provider to information concerning the New Jersey Medicaid program's qualifications and requirements when a procedure or service code is used. Explanation of indicators and qualifiers used in this column are identified below: "A" preceding any procedure code indicates that these tests can be and are frequently done as groups and combinations (profiles) on automated equipment.

SUBCHAPTER 11. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS) FOR HOSPITAL OUTPATIENT LABORATORY SERVICES

10:52-11.1 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

Column Title
Description
 "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.
 "L" preceding any procedure code indicates that the complete narrative for the code is located at N.J.A.C. 10:52-10.3.
 "N" preceding any procedure code indicates that qualifiers are applicable to that code. These qualifiers are listed by procedure code number at N.J.A.C. 10:52-10.4.

HPCPS CODE
 Lists the HPCPS procedure code numbers.
MOD
 Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid program's recognized modifier codes are listed at N.J.A.C. 10:52-10.5.

DESCRIPTION
 Lists the code narrative. (Narratives for Level I codes are found in CPT-4. Narratives for Level II and Level III codes are found at N.J.A.C. 10:52-10.3.)

MAXIMUM FEE ALLOWANCE
 Lists New Jersey Medicaid program's maximum reimbursement schedule for Pathology and Laboratory services. If the symbols "S.C.C." (Subject Cost-to-Charge) are listed instead of a dollar amount, it means that service is subject to the cost-to-charge ratio. If the symbols "N.A." (Not Applicable) are listed instead of a dollar amount, it means that service is not reimbursable.

1. The fee listed under "Office Total Fee(s)" represents 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.

2. The fee schedule for all diagnostic Medical, Radiology and Pathology services performed in a hospital setting is indicated in the "Prof. Comp" and represents the professional component for those hospital based physicians whose contract is based on fee-for-service.

(d) Regarding alphabetic and numeric symbols under "IND" and "MOD", these symbols when listed under the "IND" and "MOD" columns are elements of the HPCPS coding system used as qualifiers or indicators (as in the "IND" column) and as modifiers (as in the "MOD" column). They assist the physician 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.

1. These symbols and/or letters must not be ignored because in certain instances requirements are created in addition to the narrative which accompanies the CPT/HPCPS procedure code as written in CPT-4. The provider will then be liable for the additional requirements and not just the CPT/HPCPS procedure code narrative. These requirements must be fulfilled in order to receive reimbursement.

2. If there is no identifying symbol listed, the CPT/HPCPS code narrative prevails.

10:52-11.2 HPCPS Procedure Codes and Maximum Fee Allowance Schedule for Pathology/Laboratory

Ind	HPCPS Code	Mod	Maximum Fee Allowance	
			Office Total Fee	\$ Prof. Comp
N	36415		1.80	
N	80002		5.00	
N	80003		5.90	
N	80004		5.90	
N	80005		5.90	
N	80006		5.90	
N	80007		7.10	
N	80008		7.10	
N	80009		7.10	
N	80010		7.50	
N	80011		7.50	
N	80012		7.50	
N	80016		7.50	
N	80018		11.00	
N	80019		11.00	
N	80050		36.00	
N	80055		15.00	
N	80058		5.90	
N	80059		30.00	
N	80061		15.00	
N	80072		12.00	
N	80090		28.80	
N	80091		12.00	
	80092		37.00	
	80100		5.20	
	80101		5.20	
	80102		15.00	
	80150		15.00	
	80152		15.00	
	80154		21.50	
	80156		20.00	
	80158		20.00	
	80160		15.00	
	80162		15.00	
	80164		10.00	
	80166		15.00	
	80168		24.50	
	80170		12.60	
	80172		1.80	
	80174		15.00	
	80176		18.00	
	80178		9.00	
	80182		12.00	
	80184		12.80	
	80185		19.00	
	80186		19.00	
	80188		20.00	
	80190		15.00	
	80192		15.00	
	80194		15.00	
	80196		7.00	
	80198		15.00	
	80200		12.60	

Maximum Fee Allowance					Maximum Fee Allowance				
Ind	HCPCS Code	Mod	Office Total Fee	\$ Prof. Comp	Ind	HCPCS Code	Mod	Office Total Fee	\$ Prof. Comp
	80202		12.00			82190		S.C.C.	
	80299		10.80			82205		12.00	
	80400		34.00			82232		24.50	
	80402		96.00			82239		20.00	
	80406		98.00			82240		5.69	
	80408		130.00		A	82250		3.00	
	80410		127.00		A	82251		4.50	
	80412		S.C.C.			82252		2.50	
	80414		61.00			82270		1.20	
	80415		50.00			82273		3.70	
	80418		S.C.C.			82286		7.60	
	80420		74.00			82300		30.00	
	80422		45.00			82306		30.00	
	80424		33.00			82307		25.00	
	80426		130.00			82308		34.00	
	80428		60.00		A	82310		3.00	
	80430		73.00			82330		14.70	
	80432		125.00			82331		7.50	
	80434		100.00			82340		3.60	
	80435		95.00			82355		9.00	
	80436		75.00			82360		12.00	
	80438		50.00			82365		9.00	
	80439		100.00			82370		9.00	
	80440		60.00		A	82374		3.30	
	80500		9.00			82375		6.00	
	80502		13.00			82376		3.00	
	81000		1.20			82378		22.40	
	81002		1.00			82380		6.00	
	81003		1.50			82382		12.00	
	81005		1.00			82383		12.00	
	81007		3.82			82384		18.00	
	81015		.40			82387		24.00	
	81025		3.00			82390		6.00	
	81050		3.40			82397		21.00	
	82000		15.00			82415		18.50	
	82003		26.00		A	82435		3.00	
	82009		5.00			82436		3.00	
	82010		10.00			82438		3.00	
	82013		14.00			82441		8.92	
	82024		30.00		A	82465		3.00	
	82030		34.00			82480		4.50	
A	82040		1.80			82482		11.27	
	82042		4.30			82485		30.00	
	82043		4.30			82486		4.40	
	82044		1.00		N	82487		4.00	
	82055		4.50		N	82488		15.00	
	82075		8.80		N	82489		15.00	
	82085		13.75			82491		21.50	
	82088		40.00			82495		30.00	
	82101		16.30			82507		40.00	
	82103		7.80			82520		17.00	
	82104		7.80			82525		9.00	
	82105		10.20			82528		19.70	
	82106		10.20			82530		17.00	
	82108		38.00			82533		17.00	
	82128		12.90			82540		3.00	
	82130		25.00		A	82550		4.80	
	82131		24.00			82552		7.80	
	82135		20.00			82553		7.50	
	82140		6.00			82554		16.00	
	82143		4.20		A	82565		3.00	
	82145		12.00			82570		3.00	
A	82150		4.50			82575		4.50	
	82154		40.00			82585		6.30	
	82157		29.00			82595		1.50	
	82160		38.00			82600		27.50	
	82163		21.00			82607		15.00	
	82164		20.00			82608		15.00	
	82172		20.00			82615		11.50	
	82175		7.20			82626		37.00	
	82180		3.60			82627		33.00	

Maximum Fee Allowance					Maximum Fee Allowance				
Ind	HCPCS Code	Mod	Office Total Fee	\$ Prof. Comp	Ind	HCPCS Code	Mod	Office Total Fee	\$ Prof. Comp
	82633		43.50			83018		25.00	
	82634		39.00			83020		6.00	
	82638		18.00			83026		2.00	
	82646		25.30			83030		12.00	
	82649		31.00			83033		7.00	
	82651		33.00			83036		6.60	
	82652		55.00			83045		1.50	
	82654		13.60			83050		3.00	
	82664		13.60			83051		1.20	
	82666		22.00			83055		1.50	
	82668		17.50			83060		3.00	
	82670		25.00			83065		3.00	
	82671		41.00			83068		3.00	
	82672		25.00			83069		3.00	
	82677		28.00			83070		6.00	
	82679		25.00			83071		10.00	
	82690		25.00			83088		40.00	
	82693		12.50			83150		12.00	
	82696		22.00			83491		12.60	
	82705		.60			83497		6.00	
	82710		7.80			83498		30.50	
	82715		7.80			83499		30.50	
	82725		15.50			83500		34.00	
N	82728		16.00			83505		40.00	
	82735		24.00			83518		8.00	
	82742		29.50			83519		15.00	
	82746		10.50			83520	S.C.C.		
	82747		18.00			83525		12.00	
	82757		25.00			83527		22.00	
	82759		11.50			83528		20.00	
	82760		15.00		A	83540		4.50	
	82775		30.00		A	83550		7.20	
	82776		8.90			83570		6.00	
	82784		11.30			83582		6.00	
	82785		16.00			83586		7.50	
	82787		49.00			83593		6.00	
	82800		5.20			83605		15.00	
	82803		16.50		A	83615		4.20	
	82805		8.00			83625		9.00	
	82810		10.00			83632		16.00	
	82820		14.92			83633		6.30	
	82926		6.00			83634		14.00	
	82928		6.00		N	83655		9.00	
	82938		26.00			83661		10.50	
	82941		16.00			83662		5.00	
	82943		20.00			83670		2.10	
	82946		13.00			83690		4.50	
A	82947		3.00			83715		7.50	
	82948		1.50			83717		22.00	
	82950		3.00		A	83718		8.00	
	82951		5.00			83719		17.00	
	82952		1.00			83721		10.00	
	82953		10.00			83727		17.00	
	82955		6.00		A	83735		4.50	
	82960		7.00			83775		5.90	
	82962		2.60			83785		35.00	
	82963		26.50			83805		26.00	
	82965		6.30			83825		8.40	
	82975		22.00			83835		10.20	
A	82977		4.80			83840		4.50	
	82978		12.00			83857		12.00	
	82979		10.00			83858		22.00	
	82980		20.00			83864		13.00	
	82985		6.60			83866		15.00	
	83001		17.00			83872		3.20	
	83002		17.00			83873		25.00	
	83003		16.00			83874		12.00	
	83008		24.00			83883	S.C.C.		
	83010		12.00			83885		19.00	
	83012		12.00			83887		20.00	
	83015		10.20			83890		5.71	

Maximum Fee Allowance					Maximum Fee Allowance				
Ind	HCPSC Code	Mod	Office Total Fee	\$ Prof. Comp	Ind	HCPSC Code	Mod	Office Total Fee	\$ Prof. Comp
	83892		5.71			84300		3.90	
	83894		5.71			84305		16.00	
	83896		5.71			84307		16.00	
	83898		30.00			84311		7.50	
	83912		31.39			84315		3.00	
	83915		6.00			84375		29.00	
	83916		20.00			84392		7.00	
	83918		19.00			84402		38.00	
	83925		22.00			84403		32.00	
	83930		9.50			84425		32.00	
	83935		9.90			84430		3.60	
	83957		65.00			84432		13.00	
	83945		17.00			84436		6.00	
	83970		54.00			84437		6.00	
	83986		4.30			84439		10.00	
	83992		18.00			84442		12.00	
	84022		20.00			84443		24.00	
	84030		6.00			84445		27.80	
	84035		4.90			84446		19.00	
	84060		3.60			84449		30.00	
	84061		3.60		A	84450		3.00	
	84066		14.00		A	84460		3.00	
A	84075		3.60			84466		19.00	
	84078		3.60		A	84478		8.30	
	84080		3.60			84479		6.00	
N	84081		24.00			84480		15.00	
	84085		7.90			84481		15.00	
	84087		15.00			84482		15.00	
A	84100		3.00			84485		3.30	
	84105		3.00			84488		3.30	
	84106		1.80			84490		3.30	
	84110		7.50			84510		12.70	
	84119		3.00		A	84520		3.00	
	84120		7.50			84525		3.00	
	84126		37.00			84540		3.00	
	84127		15.00			84545		6.00	
A	84132		3.90		A	84550		3.00	
	84133		3.90			84560		3.00	
	84134		20.00			84577		6.00	
	84135		12.00			84578		.40	
	84138		12.00			84580		2.10	
	84140		50.00			84583		2.10	
	84143		60.00			84585		12.00	
	84144		20.00			84586		50.00	
	84146		20.00			84588		49.50	
	84150		30.00			84590		6.00	
	84153		26.00			84597		20.00	
A	84155		1.80			84600		18.00	
	84160		1.80		N	84620		16.00	
	84165		6.00			84630		16.00	
	84181		25.00			84681		22.00	
	84182		26.00			84702		11.39	
N	84202		10.40			84703		3.00	
N	84203		3.00			84830		3.00	
	84206		19.00			84999		S.C.C.	
	84207		40.00			85002		1.20	
	84210		16.00		N	85007		2.40	
	84220		13.00			85008		1.20	
	84228		17.00			85009		1.20	
	84233		16.00			85013		1.50	
	84234		20.00		N	85014		1.50	
	84235		63.20		N	85018		1.20	
	84238		43.00		N	85021		1.80	
	84244		25.00		N	85022		3.00	
	84252		30.00		N	85023		S.C.C.	
	84255		37.00		N	85024		4.80	
	84260		44.00		N	85025		S.C.C.	
	84270		25.00		N	85027		4.80	
	84275		16.00			85029		2.75	
	84285		28.80			85030		3.25	
A	84295		3.90			85031		3.00	

Maximum Fee Allowance					Maximum Fee Allowance				
Ind	HCPCS Code	Mod	Office Total Fee	\$ Prof. Comp	Ind	HCPCS Code	Mod	Office Total Fee	\$ Prof. Comp
N	85041		1.20			85612		13.00	
N	85044		3.00			85613		10.00	
	85045		4.00			85635		8.40	
N	85048		1.20			85651		1.50	
	85060		S.C.C.			85660		3.00	
	85095		S.C.C.			85670		6.60	
	85097		S.C.C.			85675		6.42	
	85102		S.C.C.			85705		7.90	
	85130		S.C.C.			85730		3.00	
	85170		.60			85732		3.00	
	85175		3.90			85810		15.00	
	85210		3.00			85999		S.C.C.	
	85220		25.00			86000		.90	
	85230		25.00			86003		20.00	
	85240		25.00			86005		5.00	
	85244		29.00			86021		9.00	
	85246		10.00			86022		9.00	
	85247		10.00			86023		15.00	
	85250		27.00			86038		7.80	
	85260		26.00			86039		15.00	
	85270		26.00			86060		3.60	
	85280		26.00			86063		1.20	
	85290		8.00			86077		S.C.C.	
	85291		7.00			86078		S.C.C.	
	85292		28.00			86079		S.C.C.	
	85293		28.00			86140		3.00	
	85300		15.00			86147		38.00	
	85301		16.00			86155		14.00	
	85302		17.00			86156		3.00	
	85303		18.00			86157		9.00	
	85305		17.00			86160		9.00	
	85306		18.00			86161		9.00	
	85335		10.00			86162		15.60	
	85337		10.00			86171		4.50	
	85345		1.80			86185		7.90	
	85347		3.00			86215		18.50	
	85348		1.20			86225		13.00	
	85360		12.00			86226		15.00	
	85362		3.00			86235		25.00	
	85366		8.00			86243		15.90	
	85370		5.00			86255		7.80	
	85378		5.00			86256		12.50	
	85379		5.00			86277		16.00	
	85384		9.60			86280		5.40	
	85385		9.60			86287		10.00	
	85390		7.00			86289		15.00	
	85400		9.00			86290		18.00	
	85410		9.00			86291		15.00	
	85415		10.00			86293		12.00	
	85420		9.00			86295		12.00	
	85421		15.00			86296		10.00	
	85441		6.00			86299		12.60	
	85445		5.00			86302		19.00	
	85460		9.40			86306		20.00	
	85475		10.00			86308		3.00	
	85520		19.00			86309		5.00	
	85525		17.00			86310		4.50	
	85530		16.00			86311		26.00	
	85535		3.00			86316		30.00	
	85540		8.90			86317		8.00	
	85547		10.50			86318		7.00	
	85549		28.00			86320		10.50	
	85555		4.80			86325		25.00	
	85557		4.80			86327		25.00	
	85576		10.00			86329		20.00	
	85585		1.00			86331		4.50	
N	85590		3.00			86332		33.00	
N	85595		3.00			86334		31.20	
	85597		20.00			86337		13.71	
	85610		3.00			86340		20.00	
	85611		4.50			86341		25.00	

Maximum Fee Allowance					Maximum Fee Allowance				
Ind	HCP	Mod	Office	\$ Prof. Comp	Ind	HCP	Mod	Office	\$ Prof. Comp
	Code		Total Fee			Code		Total Fee	
	86343		6.00			86729		12.00	
	86344		10.86			86732		15.00	
	86353		32.00	EACH MITOGEN		86735		15.00	
	86359		40.00			86738		12.00	
	86360		55.00			86741		12.00	
	86376		6.60			86744		12.00	
	86378		26.00			86747		12.00	
	86382		20.00			86750		12.00	
	86384		10.86			86753		12.00	
	86403		8.00			86756		12.00	
	86430		1.80			86759		12.00	
	86431		4.50			86762		12.00	
	86485		S.C.C.			86765		10.00	
	86490		S.C.C.			86768		12.00	
	86510		S.C.C.			86771		12.00	
	86580		S.C.C.			86774		5.40	
	86585		S.C.C.			86777		12.00	
	86586		S.C.C.			86778		15.00	
	86588		13.20			86781		12.00	
	86590		8.00			86784		8.00	
	86592		1.50			86787		12.60	
	86593		3.00			86790		S.C.C.	
	86602		10.00			86793		8.00	
	86603		10.00			86800		13.00	
	86606		10.00			86805		22.00	
	86609		10.00			86806		22.00	
	86612		10.00			86807		55.00	
	86615		10.00			86808		39.00	
	86618		25.00			86812		12.60	
	86619		10.00			86813		19.00	
	86622		8.00			86816		19.00	
	86625		10.00			86817		19.00	
	86628		10.00			86821		68.00	
	86631		10.00			86822		50.00	
	86632		15.00			86849		S.C.C.	
	86635		10.00			86850		4.20	
	86638		12.50			86860		4.20	
	86641		12.50			86870		9.00	
	86644		23.00			86880		5.00	
	86645		12.00			86885		6.80	
	86648		18.00			86886		5.00	
	86651		12.00			86890		75.00	
	86652		12.00			86891		75.00	
	86653		12.00			86900		2.00	
	86654		12.00			86901		2.00	
	86658		12.00			86903		11.70	
	86663		12.00			86904		11.70	
	86664		23.00			86905		3.00	
	86665		25.00			86906		2.00	
	86668		12.00			86910		12.60	
	86671		15.00			86911		5.00	
	86674		S.C.C.			86915		67.50	
	86677		12.00			86920		12.00	
	86682		12.00			86921		12.00	
	86684		15.00			86922		12.00	
	86687		12.00			86940		9.50	
	86688		13.00			86941		12.50	
	86689		21.20			86945		S.C.C.	
	86692		20.00			86950		S.C.C.	
	86694		12.80			86965		S.C.C.	
	86695		12.80			86970		S.C.C.	
	86698		15.00			86971		S.C.C.	
	86701		13.00			86972		S.C.C.	
	86702		13.00			86975		S.C.C.	
	86703		21.00			86976		S.C.C.	
	86710		12.00			86977		S.C.C.	
	86713		20.00			86978		S.C.C.	
	86717		S.C.C.			86985		S.C.C.	
	86720		15.00			86999		S.C.C.	
	86723		15.00			87001		9.00	
	86727		15.00			87003		15.00	

Maximum Fee Allowance				Maximum Fee Allowance					
Ind	HCPCS Code	Mod	Office Total Fee	\$ Prof. Comp	Ind	HCPCS Code	Mod	Office Total Fee	\$ Prof. Comp
	87015		5.10			88156		6.00	
N	87040		9.00			88157		6.00	
N	87045		9.00			88160		S.C.C.	
N	87060		9.00			88161		S.C.C.	7.00
N	87070		9.00			88162		S.C.C.	
	87072		6.00			88170		S.C.C.	
	87075		9.00			88171		S.C.C.	
	87076		6.00			88172		S.C.C.	
	87081		9.00			88173		S.C.C.	
	87082		4.00			88180		S.C.C.	
	87083		4.00			88182		300.00	
	87084		3.00			88199		S.C.C.	
	87085		4.00			88230		90.00	
	87086		6.00			88233		90.00	
	87087		2.70			88235		90.00	
	87088		2.70			88237		90.00	
	87101		8.00			88239		90.00	
	87102		8.00			88245		184.00	
	87103		8.00			88248		230.00	
	87106		8.00			88250		184.00	
	87109		14.00			88262		184.00	
	87110		15.00			88263		184.00	
	87116		6.00			88267		230.00	
	87117		9.00			88280		37.00	
	87118		12.00			88283		46.00	
	87140		3.00			88285		2.00	
	87143		3.00			88289		40.00	
	87145		3.00			88300		S.C.C.	7.00
	87147		3.00			88302		S.C.C.	15.00
	87151		3.00			88304		S.C.C.	19.00
	87155		3.00			88305		S.C.C.	30.00
	87158		3.00			88307		S.C.C.	44.00
	87163		12.00			88309		S.C.C.	66.00
	87164		6.00			88311		S.C.C.	
	87166		6.00			88312		S.C.C.	8.00
	87174		10.00			88313		S.C.C.	5.00
	87175		15.00			88314		S.C.C.	7.00
	87176		6.40			88318		S.C.C.	
	87177		5.10			88319		S.C.C.	
	87178		24.00			88321		S.C.C.	
	87179		24.00			88323		S.C.C.	
	87181		5.80			88325		S.C.C.	
N	87184		9.00			88329		S.C.C.	
	87186		13.00			88331		S.C.C.	41.00
	87187		13.00			88332		S.C.C.	
	87188		6.00			88342		S.C.C.	7.00
	87190		.60			88346		40.00	7.00
	87192		.60			88347		45.00	7.00
	87197		15.00		N	88348		184.00	151.00
	87205		4.20		N	88349		S.C.C.	151.00
	87206		4.20			88355		S.C.C.	31.50
	87207		3.00			88356		S.C.C.	31.50
	87208		5.10			88358		S.C.C.	31.50
	87210		2.40			88362		S.C.C.	31.50
	87211		5.10			88365		47.25	15.75
	87220		2.40			88371		S.C.C.	
	87230		27.00			88372		S.C.C.	
	87250		28.00			88399		S.C.C.	
	87252		29.50			89050		0.90	
	87253		6.00			89051		0.90	
	87999		S.C.C.			89060		8.50	
	88104		S.C.C.	7.00		89100		S.C.C.	
	88106		S.C.C.	7.00		89105		S.C.C.	
	88107		S.C.C.	7.00		89125		0.60	
	88108		S.C.C.	7.00		89130		S.C.C.	
	88125		S.C.C.			89132		S.C.C.	
	88130		9.65	7.00		89135		S.C.C.	
	88140		4.20	3.00		89136		S.C.C.	
	88150		6.00			89140		S.C.C.	
	88151		6.00			89141		S.C.C.	
N	88155		6.00			89160		2.10	

HCPCS		Maximum Fee Allowance		HCPCS		Maximum Fee Allowance		
Ind	Code	Mod	Office Total Fee	\$ Prof. Comp	Ind	Code Mod	Procedure Description	Maximum Fee Allowance
	89190		2.20		Q0112		All potassium hydroxide (KOH) preparations	2.40
	89300		2.40		Q0113		Pinworm examination	5.10
	89310		4.80		Q0114		Fern test	9.60
	89320		3.00		Q0115		Post-coital direct, qualitative examinations of vaginal or cervical mucous	12.33
F	89325		13.00		Q0116		Hemoglobin by single analyte instruments with self-contained or component features to perform specimen/reagent interaction, providing direct measurements and read-out	2.00
F	89329		31.00		N W8200		Glucose, serum (separate tube, grey top)	2.00
F	89330		8.00				QUALIFIER: Submitted on same claim, and performed on same date as chemistry profiles	
	89350		S.C.C.		W8260		Haldol (haloperidol) serum, confirmation test	33.00
N	89355		S.C.C.		W8265		Serentil, serum mesoridazine, quantitative, confirmation test	33.00
	89360		S.C.C.		W8730		Gonozyme, Gonococcal antigen	11.00
	89399		S.C.C.		W8900		House call to home bound patient in home or sheltered boarding home for purpose of obtaining blood by venous or arterial puncture	10.00
L	G0001		1.80				QUALIFIER: Reimbursement limited to once per trip regardless of number of patients	
L	P9610		1.80		W8920		Visit to obtain blood specimens by venous or arterial puncture "first person in nursing home"	1.80
L	P9615		1.80		W8925		Each additional person in nursing home	.60
L	Q0111		2.40					
L	Q0112		2.40					
L	Q0113		5.10					
L	Q0114		9.60					
L	Q0115		12.33					
L	Q0116		2.00					
LN	W8200		2.00					
L	W8260		33.00					
L	W8265		33.00					
L	W8730		11.00					
L	W8900		10.00					
L	W8920		1.80					
L	W8925		.60					

10:52-11.3 HCPCS Code Numbers, Procedure Description and Maximum Fee Schedule; Pathology/Laboratory (Codes and Narratives Not Found in CPT-4)

PATHOLOGY/LABORATORY

HCPCS Ind Code Mod	Procedure Description	Maximum Fee Allowance
G0001	Routine Venipuncture QUALIFIER: This service is reimbursable at a fixed rate or at the amount of the hospital charge (whichever is less) per specimen type, per patient encounter, regardless of the number of patient encounters per day.	\$ 1.80
P9610	Catheterization for collection of (urine) specimen(s), single home bound, nursing home, or SNF patient QUALIFIER: This service is reimbursable at a fixed rate or at the amount of the hospital charge (whichever is less) per specimen type, per patient encounter, regardless of the number of patient encounters per day.	1.80
P9615	Catheterization for collection of (urine) specimen(s), (multiple) patients QUALIFIER: This service is reimbursable at a fixed rate or at the amount of the hospital charge (whichever is less) per specimen type, per patient encounter, regardless of the number of patient encounters per day.	1.80
Q0111	Wet mount, including preparations of vaginal, cervical or skin specimens	2.40

10:52-11.4 Pathology and Laboratory HCPCS Codes—Qualifiers

(a) Qualifiers for pathology and laboratory services are summarized below:

1. Chemistry Automated, Multichannel Tests

Applies to CPT Codes: 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018, and 80019. The following list contains those tests which can be and are frequently performed as groups and combinations (profiles) on automated multichannel equipment: Apply this methodology to the above CPT Codes. For reporting one test, regardless of method of testing, use appropriate single test code number. For any combination of tests among those listed below use the appropriate number 80002-80019. Groups of the tests listed here are distinguished from multiple tests performed individually for immediate or "stat" reporting. Laboratory chemistry tests performed on your automated equipment in addition to laboratory chemistry tests listed must be billed as 80002-80019 as part of the automated multichannel test listing.

- Acid—Phosphatase
- Albumin
- Alkaline Phosphatase
- (ALT, SGPT) Aspartate Aminotranferase
- (AST, SGOT) Aspartate Aminotranferase

Amylase
 Bilirubin, Total
 Bilirubin, Direct
 Blood Urea Nitrogen (BUN)
 Calcium
 Carbon Dioxide (CO₂)
 Chlorides (Cl)
 Cholesterol
 Creatine Kinase (CK, CPK)
 Creatinine
 Gamma Glutamyl Transpeptidase (GGTP)
 Glucose (Sugar)
 Iron
 Iron Binding Capacity
 Lactic Dehydrogenase (LD)
 Lipoprotein (HDL Cholesterol)
 Magnesium
 Phosphorus
 Potassium (K)
 Protein, Total
 Sodium (NA)
 Triglycerides
 Uric Acid

NOTE 1: If any two of the following HCPCS procedure codes are performed on the same day by automated equipment and the total reimbursement of the two chemistry tests would have exceeded \$5.00, the maximum reimbursement will not be more than \$5.00: 82040, 82150, 82250, 82251, 82310, 82374, 82435, 82465, 82550, 82565, 82947, 82977, 83540, 83550, 83615, 83718, 83735, 84060, 84075, 84100, 84132, 84155, 84295, 84450, 84460, 84478, 84520, 84550.

NOTE 2: The following calculations and ratios are not eligible for separate or additional reimbursement. Mathematical calculations listed below are not reimbursable:

A/G Ratio	Globulin
BUN/Creatinine Ratio	FTI (T7)
Free Calcium	Free Thyroxine

NOTE 3: Any additional automated multichannel chemistry tests performed on same date as Codes 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018, and 80019 will not be reimbursed at the current allowable fee for each added test when performed on automated multichannel equipment.

NOTE 4: Code (W8200)—Glucose (separate tube, gray top) performed on the same date as the following chemistry profiles 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018 and 80019 will be paid an additional \$2.00.

2. Codes 80050, 80055, 80058, 80059, 80061, 80072, 80090, 80091, 80092—The panels listed must include the laboratory tests assigned by the CPT-4 as the components of the panel. The tests listed with each of the panels identify the defined components of that panel. If any laboratory tests included in the panel are billed a la carte, the tests must be billed as the panel. The laboratory provider may not charge Medicaid more than the lowest charge level offered to another provider. The lowest charges for the laboratory test comprising the panel must aggregate as equivalent to or greater than the listed panel fee.

NOTE 1: Code 80091—Thyroid panel

Reimbursement not eligible for 84439 when billed in conjunction with 80091 on same day.

NOTE 2: Code 80092—Thyroid panel with TSH

Code 8443—TSH will not be paid a separate reimbursement when performed in conjunction with 80091 or 80092.

3. Codes 82487, 82488, and 82489—Chromatography—must list substance (compound) tested for in block 34 (REMARKS) of the claim form.

4. Code 82728—Ferritin

When the procedure for ferritin is performed in combination with Vitamin B12 or Folate or any of the chemistry analytes listed on codes 80002–80019 the maximum reimbursable fee for code 82728 is \$5.00.

5. Code 84081—Phosphatidylglycerol—test done on newborn or amniotic fluid to determine fetal lung maturity.

6. Code 84202—Protoporphyrin, RBC; quantitative—Utilize only for testing of anemia. Utilize code 84203—Protoporphyrin, RBC; screen when testing for anemia. Code 84203 will no longer be reimbursed when billed in conjunction with code 83655—Blood lead determination (quantitative).

7. Code 84620—Xylose absorption tests, blood and/or urine (D-xylose tolerance test), includes serum & urine levels, up to 5 hourly specimens.

8. Codes 85023 and 85025—Hematology

NOTE: For purpose of reimbursement based on this schedule, a complete blood count (CBC) includes a hematocrit, hemoglobin determination, RBC count, RBC indices, WBC count and differential WBC count (See codes 85021 and 85022), for a platelet count with a CBC (see codes 85023–85025).

Hematology codes 85014, 85018, 85041 and 85048 may not be billed in conjunction with codes for blood count with hemogram (85021, 85022, 85023, 85024, 85025, and 85027).

The code for manual differential WBC count (85007) may not be billed in conjunction with codes 85021, 85022, 85023, 85024, 85025, and 85027.

Codes for platelet count (85590 and 85595) may not be billed in conjunction with codes 985023-85027.

Code 85044 may be billed in conjunction with codes 85023 and 85025, when a complete hemogram is ordered.

9. Codes 87040, 87045, 87060, 87070, 87184—Cultures

NOTE: These 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 and 87082).

10. Code 88155—pap smear

NOTE: Obtaining specimen not a separate eligible service.

11. Code 88348 and 89349—Electron microscopy; diagnostic and scanning are not reimbursable when used as a research tool.

NOTE: For reimbursement purposes, Medicaid will pay for the above diagnostic scanning procedure when it pertains to x-ray microanalysis for identification of asbestos particles and heavy metals, i.e., gold, mercury, etc. and also when examining tissue specimens in occasional cases of malabsorption.

12. Code 89360—Sweat (without iontophoresis) test

NOTE: Reimbursement not eligible for qualitative tests. For reimbursement purposes, 84295 will not be reimbursed at any additional charge. Do not bill 84295 in conjunction 89360.

13. Code 36415—Utilize this code only for finger/heel/ear stick for collection of specimen(s). This service is reimbursable in the physician office laboratory (POL) when the specimen is referred out to an independent clinical laboratory for testing. Finger/heel/ear stick is not reimbursable when billed by the independent clinical laboratory.

NOTE: This service is reimbursable at a fixed rate or at the amount of the hospital charge (whichever is less) per specimen type, per patient encounter, regardless of the number of patient encounters per day.

**10:52-11.5 Pathology and Laboratory HCPCS Codes—
Modifiers**

(a) Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid program's recognized modifier codes are:

Modifier Code	Description
22	Unusual Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '22' to the usual procedure number. A report may also be appropriate.
26	Professional Component: Certain procedures are a combination of a physician component 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.
52	Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '52', signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.
90	Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding the modifier '90' to the usual procedure number.

**SUBCHAPTER 12. GRADUATE MEDICAL
EDUCATION AND INDIRECT MEDICAL
EDUCATION**

Authority

N.J.S.A. 30:4D-6a(1); 7, 7a, b, and c, 30:4D-12; 42 C.F.R. 447.200 through 205, 250 and 252; and P.L. 1996, c.42.

Source and Effective Date

R.1997 d.43, effective January 21, 1997.
See: 28 N.J.R. 4022(a), 29 N.J.R. 350(b).

10:52-12.1 Calculation of the amount of Graduate Medical Education (GME) and Indirect Medical Education (IME) reimbursement to be distributed

(a) Effective for services on or after October 1, 1996, the amount of hospital reimbursement for GME and IME to be distributed shall be calculated based on Medicare principles of reimbursement to major teaching hospitals. Major teaching hospitals are defined as those hospitals which had a minimum of 45 intern and resident full-time equivalents (FTEs) in all approved and accredited residencies from the 1993 Medicare first finalized audited cost report.

(b) Medicare principles of reimbursement for GME and IME are as follows:

1. Direct GME is calculated based on Medicaid's share of the major teaching hospitals' intern and resident FTEs multiplied by their specific per resident amounts as reported on the Medicare audited cost report (including subsequent amendments) in Worksheet E-3 Part IV for the year in which payment is being made.

2. IME is calculated based on Medicare's IME formula, at 42 C.F.R. 412.105, incorporated herein by reference. The major teaching hospitals' IME factor, as calculated by the Medicare IME formula, is multiplied by their hospital specific Medicaid inpatient DRG payments (net of GME and IME) to arrive at the Medicaid IME payment. The components of Medicare's IME formula, IME intern and resident FTEs and maintained beds, are from the audited Medicare cost report (including subsequent amendments) in Worksheet S-3 for the year in which payment is being made.

10:52-12.2 Distribution of Graduate Medical Education (GME) and Indirect Medical Education (IME) reimbursement

Effective for services on or after October 1, 1996, hospital reimbursement for GME and IME as calculated in N.J.A.C. 10:52-12.1 shall be distributed to all teaching hospitals based on the hospital-specific percentage of total weighted GME FTEs, where weighted GME FTEs equals the hospital-specific current GME FTEs times the hospital-specific Medicaid fee-for-service days divided by the total Medicaid fee-for-services days for all teaching hospitals. The source for the GME FTEs and the Medicaid fee-for-service days is the Medicare audited cost report including subsequent amendments for the year in which payment is being made.

10:52-12.3 Establishment of GME and IME interim method of reimbursement

Effective for services provided on or after January 21, 1997, all teaching hospitals are required to submit, for the year in which payment shall be made, their estimated average intern and resident GME and IME FTE count and maintained beds by November 1 of the preceding year to Blue Cross and Blue Shield of New Jersey (BCBSNJ), the Division's settlement agent. BCBSNJ shall review the submitted information for reasonableness and consistency and forward the information to the Division. Effective for services on or after October 1, 1996, the Division shall calculate Medicaid's GME and IME payment based on the major teaching hospitals' submitted data and their Medicaid inpatient DRG payments (net of IME and GME) from their most current fiscal year Unisys settlement data report with 24 months of paid data. Once the Medicaid GME and IME payment is calculated, it shall be distributed to all teaching hospitals in accordance with N.J.A.C. 10:52-12.2 utilizing the submitted FTE count and the Medicaid days from the teaching hospitals' most current fiscal year Unisys settlement data report with 24 months of paid data. The payment shall be made in equal monthly installments and reconciled in accordance with N.J.A.C. 10:52-12.4.

10:52-12.4 Establishment of GME and IME final method of reimbursement

Effective for services on or after October 1, 1996, the Medicaid GME and IME final payment shall be calculated in accordance with N.J.A.C. 10:52-12.1 and distributed to all teaching hospitals in accordance with N.J.A.C. 10:52-12.2. A reconciliation of the final GME and IME distribution of payment to the interim GME and IME distribution of payment shall be made and additional disbursement or recoupment shall be made in accordance with N.J.A.C. 10:52-4.71(a)1 through 5.