CHAPTER 54

MANUAL FOR PHYSICIAN'S SERVICES

Authority

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

Source and Effective Date

R.1991 d.136, effective February 15, 1991.
See: 22 N.J.R. 3711(b), 23 N.J.R. 858(a).

Executive Order No. 66(1978) Expiration Date

Chapter 54, Manual for Physician's Services, expires on February 15, 1996.

Chapter Historical Note

Chapter 54, Manual for Physician's Services, was readopted, pursuant to Executive Order No. 66(1978), by R.1991 d.136. See: Source and Effective Date. See subchapter and section annotations for specific rulemaking activity.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. GENERAL PROVISIONS

10:54-1.1 Definitions
10:54-1.2 Scope of service
10:54-1.3 Record keeping
10:54-1.4 Policies related to inpatient care
10:54-1.5 Prior authorization
10:54-1.6 Basis of payment
10:54-1.7 Physical medicine and rehabilitative services
10:54-1.8 Environmental equipment
10:54-1.9 Policy on shoes
10:54-1.10 Prescription policies
10:54-1.11 Supplies and equipment
10:54-1.12 Drugs and direction for allowable drug items
10:54-1.13 Choice of prescription drugs
10:54-1.14 Quantity of medication
10:54-1.15 Drug services requiring prior authorization
10:54-1.16 Pharmaceutical services not eligible for payment
10:54-1.17 Telephone-ordered original prescription
10:54-1.18 Prescription refill
10:54-1.19 (Reserved)
10:54-1.20 Sterilization
10:54-1.21 (Reserved)
10:54-1.22 (Reserved)
10:54-1.23 Medicaid reimbursement for abortions

SUBCHAPTER 2. BILLING PROCEDURES

10:54-2.1 General billing procedures
10:54-2.2 Timeliness of claim submission and claim inquiry
10:54-2.3 Prior authorization
10:54-2.4 Combination Medicare/Medicaid claims
10:54-2.5 Health Insurance Claim Form
10:54-2.6 Automated Data Exchange

SUBCHAPTER 3. (RESERVED)

SUBCHAPTER 4. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

APPENDIX A NEW JERSEY MEDICAID FORMULARY

SUBCHAPTER 1. GENERAL PROVISIONS

Authority

N.J.S.A. 30:4D-6(a)5, 7 and 7b; 1905(a)(5) of the Social Security Act and 42 CFR 440.50.

Source and Effective Date

R.1984 d.34, eff. February 2, 1984.
See: 15 N.J.R. 2129(a), 16 N.J.R. 371(a).

Historical Note

This subchapter was filed and became effective prior to September 1, 1969. Amendments were filed and became effective July 16, 1971 as R.1971 d.115. See: 3 N.J.R. 109(a), 3 N.J.R. 156(c). Further amendments were filed and became effective April 1, 1972 as R.1972 d.65. See: 4 N.J.R. 46(d), 4 N.J.R. 103(b). Further amendments were filed and became effective May 10, 1972 as R.1972 d.92. See: 4 N.J.R. 67(c), 4 N.J.R. 128(a). Further amendments were filed and became effective August 21, 1972 as R.1972 d.164. See: 4 N.J.R. 125(b), 4 N.J.R. 219(a). Further amendments were filed and became effective September 1, 1973 as R.1973 d.197. See: 5 N.J.R. 44(a), 5 N.J.R. 281(b). New rules were added and filed and became effective March 20, 1974 as R.1974 d.68. See: 6 N.J.R. 66(a), 6 N.J.R. 150(c). Further amendments were filed and became effective July 15, 1974 as R.1975 d.186. See: 6 N.J.R. 242(c), 6 N.J.R. 312(d). Further amendments were filed and became effective November 19, 1974 as R.1974 d.311. See: 6 N.J.R. 398(c), 6 N.J.R. 478(b). Further amendments were filed and became effective March 4, 1975 as R.1975 d.42. See: 7 N.J.R. 7(b), 7 N.J.R. 166(a). Further amendments were filed and became effective July 17, 1975 as R.1975 d.205. See: 7 N.J.R. 212(b), 7 N.J.R. 364(c). Further amendments were filed and became effective August 1, 1975 as R.1975 d.227. See: 7 N.J.R. 315(b), 7 N.J.R. 430(a). Further amendments were filed and became effective November 10, 1975 as R.1975 d.339. See: 7 N.J.R. 316(a), 7 N.J.R. 567(c). Further amendments were filed and became effective December 18, 1975 as R.1975 d.373. See: 7 N.J.R. 506(a), 8 N.J.R. 38(a). Further amendments were filed on July 19, 1976 to become effective August 10, 1976 as R.1976 d.218. See: 8 N.J.R. 229(b), 8 N.J.R. 385(b). Further amendments were filed and became effective October 26, 1976 as R.1976 d.336. See: 7 N.J.R. 505(a), 8 N.J.R. 558(b). Further amendments were filed and became effective November 15, 1977 as R.1977 d.424. See: 9 N.J.R. 582(e). Further amendments were filed and became effective February 15, 1979 as R.1979 d.63. See: 11 N.J.R. 133(b). A new rule was filed and became effective June 15, 1979 as R.1979 d.245. See: 11 N.J.R. 347(a). Further amendments were filed and became effective March 10, 1980 as R.1980 d.91. See: 11 N.J.R. 444(a), 12 N.J.R. 193(c). Further amendments were filed and became effective March 31, 1980 as R.1980 d.130. See: 12 N.J.R. 119(c), 12 N.J.R. 277(a). Further amendments were filed and became effective April 1, 1980 as R.1980 d.138. See: 11 N.J.R. 444(a), 12 N.J.R. 277(c). Further amendments were filed and became effective June 18, 1980 as R.1980 d.264. See: 12 N.J.R. 419(b). Further amendments were filed and became effective November 3, 1980 as R.1980 d.463. See: 12 N.J.R. 319(a), 12 N.J.R. 703(d). Further amendments were filed and became effective May 7, 1981 as R.1981 d.125. See: 13 N.J.R. 94(a), 13 N.J.R. 292(b). Further amendments were filed and became effective July 9, 1981 as R.1981 d.220. See: 12 N.J.R. 413(a), 13 N.J.R. 417(b). Further amendments were filed and became effective July 9, 1981 as R.1981 d.249. See: 13 N.J.R. 293(a), 13 N.J.R. 417(a). Further amendments were filed and became effective October 8, 1981 with an operative date of January 1, 1982, as R.1981 d.374. See: 12 N.J.R. 662(a), 13 N.J.R. 706(d). Further amendments were filed and became effective September 10, 1981 as R.1981 d.329. See: 12 N.J.R. 520(b), 13 N.J.R. 574(b). Further amendments were filed and became effective March 15, 1982 to become operative on April 1, 1982, as R.1982 d.73. See: 13 N.J.R. 292(a), 14 N.J.R. 278(c). Further amendments were filed and became effective December 20, 1982 to become operative February 1, 1983, as R.1982 d.459. See: 14 N.J.R. 1143(a), 14 N.J.R. 1458(c). Further amendments were filed and became effective March 7, 1983 as R.1983 d.55. See: 14 N.J.R. 1337(a), 15 N.J.R. 339(c). Further amendments were filed and became effective December 19, 1983, to become operative January 1, 1984, as R.1983 d.583. See: 15 N.J.R. 782(a), 15 N.J.R. 2168(b). Further amendments were filed and became effective February 21, 1984 as R.1984 d.34. See: 15 N.J.R. 2129(a), 16 N.J.R. 371(a). Further amendments were filed and became effective July 2, 1984 as R.1984 d.271. See: 16 N.J.R. 811(a), 16 N.J.R. 1788(a).

New Jersey State Library

10:54–1.1 Definitions

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

"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 the drug product and ancillary services such as, but not limited to, case management services and laboratory testing.

"Concurrent rate" means that type(s) of service(s) rendered to patients by practitioners under the following conditions:

1. Where the dictates of medical necessity require the services of more than one physician of the same discipline or specialty, in addition to the primary or attending physician, so that appropriate and needed care may be provided to the patient.

   i. Example: A critically ill patient with a multiplicity of diverse medical conditions requiring the services of two or more internists;

2. Where the dictates of medical necessity require the services of more than one physician of different disciplines or specialties in addition to the primary or attending physician so that the appropriate and needed care may be provided to the patient.

   i. Example: A patient requiring an orthopedist for a fractured leg, plus a neurosurgeon for a head injury, plus a general surgeon for a ruptured abdominal viscus, plus an internist for stabilization of an uncontrolled diabetes.

NOTE 1: Whether the practitioner is operating in a group setting or as an individual in solo practice, if concurrent care is requested, it must be clearly demonstrated that significant medical necessity exists both for the primary or attending physician services and the practitioners rendering additional care, and further that retention of care solely by the attending or transfer to the practitioner rendering additional care could have resulted in potential harm to the patient. At such time as the patient's condition permits, the attending would then assume sole responsibility or transfer would be made by the attending to the practitioner supplying additional (concurrent) care.

NOTE 2: Inappropriate admission to the service of an attending physician who is supplying no significant portion of the management of a patient, but acts only as a vehicle for the patient to receive the necessary services of another physician concurrently will result in a denial of payment of the claim submitted by the physician whose services were deemed inappropriate.

"Consultation" means advice or counsel of a qualified specialist as recognized by this program which is requested by the attending physician. This requires a personal examination of the patient with a written report of the history, physical findings, diagnosis, and recommendations of the consultants as noted under procedure codes 9029 and 9030 in N.J.A.C. 10:54-3. When the consultant assumes the continuing care of the patient, any subsequent services rendered by him/her will no longer be considered as consultation. Except where medical necessity dictates or where a hospital policy or state law dictates otherwise, multiple and simultaneous consultations in the same specialty for the same disease, illness or condition, whether in or out of a hospital, are not reimbursable. When consultation services are performed, the name of the referring physician must be included on the claim form and will be listed under the appropriate section of the claim form.

NOTE: For applicable requirements of consultation services see N.J.A.C. 10:54–3.

"HealthStart Maternity (Comprehensive) Care Services Provider" means a physician or a group of physicians who provide either directly or indirectly through linkage with other HealthStart care providers, a comprehensive package of maternity care services which includes two components—"Medical Maternity Care" and "Health Support Services". (See N.J.A.C. 10:49–3 for information about HealthStart Services and provider requirements for participation).

"HealthStart Pediatric (Comprehensive) Care Services Provider" means a physician who provides a comprehensive package of pediatric care services. (See N.J.A.C. 10:49–3 for information about HealthStart Services and provider requirements for participation).

"Physician" means a doctor of medicine or osteopathy 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 practices.

"Physicians services" means those services provided within the scope of practice of his profession as defined by the laws of New Jersey, or if in practice in another state by the laws of that state, and which services are performed by or under the direct personal supervision of the physician. It includes services furnished in the office, the patient's home, a hospital, long-term care facility or elsewhere.

NOTE: Direct personal supervision means that the services must be rendered in the physician's presence. It is not the intent of the program to reimburse a physician for history and/or physical examinations performed by interns, residents, other house staff members or physician's assistants. (Exception: Procedure code 9580 EPSDT, which may permit the use of a nurse practitioner under direct supervision of the physician.)

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

1. Is a diplomate of the appropriate American board, or osteopathic board; or

2. Is a fellow of the appropriate American specialty college, or a member of an osteopathic specialty college; or

3. Has been notified of admissibility to examination by the appropriate American board, or osteopathic board, or has evidence of completion of an appropriate qualifying residency approved by the American Medical Association, or American Osteopathic Association; or

4. Holds an active staff appointment with specialty privileges in a voluntary or governmental hospital which is approved for training in the specialty in which the physician has privileges; or

5. Is recognized in the community as a specialist by his peers.

"Specialist in family practice or general practice", for purposes of the New Jersey Medicaid Program, means a fully licensed physician who is a diplomate of the American Board of Family Practice, or a Diplomate of the American Osteopathic Board of General Practice.

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

Amended by R.1971 d.164, effective September 22, 1971.
See: 3 N.J.R. 153(a), 3 N.J.R. 206(c).
Amended by R.1975 d.86, effective March 31, 1975.
See: 7 N.J.R. 58(a), 7 N.J.R. 226(d).
Amended by R.1975 d.227, effective August 1, 1975.
See: 7 N.J.R. 315(b), 7 N.J.R. 430(a).
Amended by R.1975 d.229, effective August 1, 1975.
See: 7 N.J.R. 318(c), 7 N.J.R. 431(a).
Amended by R.1980 d.463, effective November 3, 1980.
See: 12 N.J.R. 319(a), 12 N.J.R. 703(d).
"Specialist" note amended from denial of reimbursement as a specialist for services outside of field.
Amended by R.1984 d.34, effective February 21, 1984.
See: 15 N.J.R. 2129(a), 16 N.J.R. 371(a).
Nonsexist language added.
Amended by R.1984 d.271, effective July 2, 1984.
See: 16 N.J.R. 811(a), 16 N.J.R. 1788(a).
"Specialist" added.
Amended by R.1988 d.62 effective February 1, 1988.
See: 19 N.J.R. 1978(a), 20 N.J.R. 278(b).
Added definitions "HealthStart Maternity" and "HealthStart Pediatric (Comprehensive) Care Services Provider".
Amended by R.1992 d.98, effective March 2, 1992.
See: 23 N.J.R. 281(a), 24 N.J.R. 845(a).
Added definition for "bundled drug services."

10:54–1.2 Scope of service

(a) Payment will be made for the medically necessary services, subject to the following limitations:

1. No additional payment will be made for injections and drugs dispensed by the physician except as outlined under specific procedure codes listed in subchapter 3 (Procedure Code Manual) of this chapter.

2. Clinical laboratory services:

i. "Clinical laboratory services", means professional and technical laboratory services provided to a patient by a laboratory that is qualified to participate under Title XVIII of the Social Security Act and is determined currently to meet the requirements of such participation as indicated in section 201.2 of the New Jersey Medicaid Programs Independent Laboratory Manual. Such laboratories include:

(1) Independent clinical laboratories, including physician operated out-of-hospital laboratories which perform primarily diagnostic work referred by other physicians or practitioners, and which meet the above qualifications;

(2) Hospital laboratories holding valid certifications from the New Jersey Department of Health, and which provide laboratory services to ambulatory patients as requested by a practitioner;

ii. Where laboratory service has been provided by a certified laboratory, payment shall be made only to the laboratory;

NOTE 1: A physician cannot include in his claim any charges for laboratory services when the procedures have been performed by an independent clinical laboratory. Exception: A physician may claim reimbursement for laboratory services performed for his own patients in his own office, but these must be standard laboratory procedures. Dip tests, paper tests and tablet tests will be disallowed as reimbursable items. For reimbursement purposes a urinalysis must include a microscopic examination, though the chemical part may be done by dip stick.

NOTE 2: Reimbursement for the sum of any number of the components of cluster of tests may not exceed the total reimbursement for the group offering (profile), whether done by automation or bench testing, whether or not the equipment is available in the facility. Where clusters constitute a profile, they must be billed in that manner. A cluster of tests is considered those components of a test or series of tests which, when combined math-

ematically or otherwise, comprise a finished identifiable laboratory study or studies. Examples:

1. The components of an SMA 12/60 or other automated laboratory study;

2. Inclusive of an MCH, MCV, and so forth, as a component of a C.B.C.;

Inclusive of all ova and parasites in a stool examination.

NOTE 3: Rebates by reference laboratories, service laboratories, physicians or other utilizers or providers of laboratory service are prohibited under the Medicaid program. This refers to rebates in the form of refunds, discounts or kickbacks, whether in the form of money, supplies, equipment, or other thing of value. This provision prohibits laboratories from renting space or providing personnel or other considerations to a physician or other practitioner whether or not a rebate is involved.

3. HealthStart Maternity (Comprehensive) Health Services. (See N.J.A.C. 10:49–3 for information about HealthStart Services and provider requirements for participation.)

4. HealthStart Pediatric (Comprehensive) Care Services. (See N.J.A.C. 10:49–3 for information about HealthStart Services and provider requirements for participation.)

5. Physician services provided in the hospital setting; inpatient:

i. For the hospitalized patient (inpatient), specific physician services for which the physician is customarily reimbursed directly by the hospital under contractual or other arrangements (that is ECG interpretation, laboratory services, and so forth) are considered a reimbursable hospital cost and must be billed by the hospital not by the physician;

ii. Neither the physician nor the hospital will be paid for the following elective surgical procedures unless a second opinion has been rendered by a board certified specialist.

(1) Surgical procedures requiring a second opinion are identified by a plus symbol (+) in the procedure code manual (N.J.A.C. 10:54–3). A code with a double plus symbol (+ +) preceding the code indicates that a second opinion is not required for a child 18 years of age or under.

(A) Hysterectomy. Number Codes: 4614, 4618, 4631, 4632, 4634;

(B) Cholecystectomy. Number Codes: 3515, 3516, 3517;

(C) Hernia Repair. Number Codes: 3631, 3632, 3633, 3634, 3635, 3646, 3651, 3661, 3662, 3663, 3664, 3665, 3666;

(D) Tonsillectomy and/or Adenoidectomy. Number Codes: 2992, 2993, 2994, 3000;

(E) Laminectomy. Number Codes: 5190, 5208, 5209, 5210, 5211, 5225;

(F) Spinal Fusion. Number Codes: 0634, 0635, 0636, 0637, 0638, 0639, 0640, 0641.

(2) Medicare/Medicaid eligible recipients are excluded from the mandatory second opinion requirement.

6. Hospital services provided in the hospital setting; outpatient:

i. All services rendered to a patient registered in the hospital outpatient department as a clinic patient are considered hospital costs, including costs of physician services. Any arrangement, contractual or otherwise, for payment of the physician(s) providing a service(s) to such a registered clinic patient is, therefore, between the hospital and the physician(s);

ii. Hospital based physician services; ambulatory (nonregistered clinic patient):

(1) This type of patient is considered to be the private ambulatory patient of a physician who has referred the patient to the hospital for services provided, in part or whole, by a hospital base physician (for example, radiologist, pathologist, electrocardiographer, and so forth);

(2) Such specific services are considered hospital costs when provided by the physician, who is customarily reimbursed directly by the hospital, contractually or otherwise, and are not reimbursable directly to the referring physician;

7. Services to persons in long-term care facilities:

i. When physician's services are provided to persons in a long-term care facility (skilled nursing facility or intermediate care facility), payment will not be made for any practitioner or therapy services rendered by an owner, partner, administrator, officer, stockholder of the company or corporation or who otherwise has a direct or indirect financial interest in the institution;

ii. A more detailed guideline of physician services performed in long-term care facilities may be found in the long-term care facility manual usually located in the institution or assistance is available to you on a peer basis from the local medical assistance units medical consultant located in your area. (See subchapter 2 of this chapter for a directory of local medical assistance units.);

iii. Exception: A medical director who is neither a owner, partner, official, stockholder of the company or corporation, but who is reimbursed a salary by the facility for administrative purposes, may bill on a fee-for-service basis for medical services rendered by him to patients in that facility;

8. Diagnostic and therapeutic radiology services:

i. Radiological (x-ray) services shall ordinarily be provided only by a physician who is a specialist in radiology. However, a physician other than a radiologist who is a specialist may provide radiological services which are related and limited to his own special field;

ii. Reimbursement for radiological services by physician(s), other than those covered in the preceding paragraph, will be limited to diagnostic x-ray of long bones in emergency situations and/or diagnostic chest x-ray, limited only to his own patients in his own office;

9. Portable x-ray services:

i. Portable radiological (x-ray) services shall be provided only by a physician who is a specialist in radiology under the criteria listed below;

ii. Those radiologic services provided to eligible Medicaid recipients, regardless of setting (home, long-term care facility, hospital institution, and so forth) in which it is not medically practical to provide such services other than by bringing equipment and personnel to the patient for which these services are indicated;

iii. Conformity with Federal, State and local laws and regulations:

(1) Certificate of need, licensed and radiological certification from State Department of Health;

(2) Medicare certification from Social Security Administration;

(3) Medicaid approval from Division of Medical Assistance and Health Services;

(4) Conformity with American Society of Radiology Standards for portable radiological services, including:

(A) Proper use and maintenance of equipment;

(B) Route recheck of equipment;

(C) Written policies and procedures;

(D) Hazards of excessive exposure to radiation;

(E) Time frames for checking radiation monitors of personnel;

(F) Proper maintenance of records;

(G) Indoctrination, orientation and continuing in-service education of personnel.

iv. Ownership of equipment and qualifications of personnel:

(1) Equipment to be owned by licensed radiologist or corporation;

(2) Licensed x-ray technologist in New Jersey;

(3) Board certified or board qualified radiologist to supervise services and interpret films;

v. Availability of services:

(1) Services available around-the-clock 24 hours a day;

(2) Back-up services in event primary equipment or personnel unavailable;

(3) Time limits on taking and reporting film studies:

(A) Emergency: Within three hours of notification to provider;

(B) Urgent: Within six hours of notification to provider;

(C) Routine: Within 36 hours of notification to provider;

NOTE: All reports must be written and forwarded to the appropriate physician and/or facility within two working days of taking of film. This does not preclude telephone reports in emergency or urgent situations or upon request of attending physician, as long as written report follows.

vi. Types of services provided (Film studies must be consistent with stated output of the machine):

(1) Skeletal films (any type);

(2) Chest films;

(3) Abdominal films;

vii. Types of services excluded:

(1) Contrast studies of any type; oral or parenteral;

(2) Nondiagnostic studies;

(3) Procedures involving fluoroscopy;

(4) Procedures requiring special equipment, materials or technical competency;

(5) Procedures requiring special manipulation of the patient;

(6) Procedures requiring the on-site presence of a qualified radiologist;

(7) Routine screening procedures;

viii. Referral standards:

(1) Portable x-ray services are rendered only on the written order of a licensed health professional within the limits of his licensure;

(2) The physician ordering the service must:

(A) Define the body area to be x-rayed;

(B) Provide the diagnosis indicating the reason for the order;

(C) Indicate the current clinical status of the patient;

(D) Indicate dates and types of previous x-ray procedures within past year;

(3) Regardless of who retains the x-ray film after the service has been rendered (attending physician or portable x-ray services):

(A) Retention of such film and written records is consistent with State law;

(B) Release of such film and records is provided to other health professionals and/or facilities, who may subsequently be responsible for the patient's care, with the written consent of the patient (or his surrogate) and the physician who ordered the study;

(4) Portable x-ray service records shall consist of, as a minimum:

(A) Date(s) of examination;

(B) Type of examination with radiologic findings and diagnosis (description of procedures ordered and performed);

(C) Name of patient;

(D) Place of examination;

(E) Technician who performed the examination;

(F) Radiologist who interpreted the film;

(G) Referring physician;

(H) Date report sent to referring physician;

(I) Whether film studies were retained by the service or forwarded to the referring physician with date forwarded;

ix. Claim submission and reimbursement:

(1) Health Insurance Claim Form (HCFA–1500) is to be used with written designation of person authorized to sign form;

(2) Reimbursement in keeping with present Medicaid schedule for radiological services;

NOTE: Reimbursement is all inclusive in accordance with the schedule of allowances and payable to the approved provider. Any arrangement for apportionment is between the provider and personnel consistent with standard practice habits of the medical profession.

(3) In item 24 of the Health Insurance Claim Form (HCFA–1500), the provider in order to receive payment must identify the radiologist who interpreted the film in order to receive payment.

10. Family planning services including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling.

i. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered by the New Jersey Medicaid program.

(1) Exception: When a service is provided that is ordinarily considered an infertility service, but is provided for another purpose, then the physician must submit the claim with supporting documentation for medical review and approval of payment to the Division of Medical Assistance and Health Services, Office of Medical Affairs and Provider Relations, CN 712, (Mail Code # 14), Trenton, New Jersey 08625–0712.

As amended, R.1975 d.42, effective March 4, 1975.
See: 7 N.J.R. 7(b), 7 N.J.R. 166(a).
As amended, R.1975 d.227, effective August 1, 1975.
See: 7 N.J.R. 315(b), 7 N.J.R. 430(a).
As amended, R.1977 d.424, effective November 15, 1977.
See: 9 N.J.R. 582(e).
As amended, R.1981 d.125 effective May 7, 1981.
See: 13 N.J.R. 94(a), 13 N.J.R. 292(b).
(a)6ii: delete "routine diagnostic chest x-ray and/or" and add "and/or diagnostic chest x-ray."
As amended, R.1981 d.249, effective July 9, 1981.
See: 13 N.J.R. 293(a), 13 N.J.R. 417(a).
Incorporated billing procedures using HCFA–1500 claim form.
As amended, R.1982 d.73, effective March 15, 1982 (operative April 1, 1982).
See: 13 N.J.R. 292(a), 14 N.J.R. 278(c).
Added (a)3ii-(a)3ii(6).
As amended, R.1982 d.459, effective December 20, 1982 (operative February 1, 1983).
See: 14 N.J.R. 1143(a), 14 N.J.R. 1458(c).
Second opinion requirement removed from certain surgical procedures.
As amended, R.1984 d.34, effective February 21, 1984.
See: 15 N.J.R. 2129(a), 16 N.J.R. 371(a).
Payment under limited circumstances for injections and drugs, clarified.
Subsection (b) deleted dealing with immunization procedure codes.
Amended by R.1988 d.62, effective February 1, 1988.
See: 19 N.J.R. 1978(a), 20 N.J.R. 278(b).
Added (a)3.–4. and renumbered (a)3.–7. as (a)5.–9.
Amended by R.1994 d.600, effective December 5, 1994.
See: 26 N.J.R. 3345(a), 26 N.J.R. 4762(a).

10:54–1.3 Record keeping

(a) All physicians are to keep legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services. Minimum requirements for services performed in the office, home, sheltered boarding home, long-term care facility and the hospital setting shall include a progress note in the clinical record for each visit, except where specified otherwise, which supports the procedure code or codes claimed. This information must be made available upon the request of the Division of Medical Assistance and Health Services' New Jersey Medicaid Program or its agents.

(b) Mental Health Services (excluding partial hospitalization and personal care) shall keep the following records:

1. For each patient contact made by a mental health therapist the following are required ingredients of a psychotherapy progress note:

i. Date and duration of service (hour, half-hour etc.)

ii. Signature of provider (if a member of a group).

iii. Name of the modality used, that is, individual, group, family therapy, etc. (a psychiatrist should record current medication and dose; new or changed medications.)

iv. Notations of progress, impediments, or treatment complications.

v. Other—this may include dates or information not included in above, but yet important to clinical picture and prognosis.

vi. One or more of the following components must be recorded to delineate the visit and establish its uniqueness. All of these components need not be included.

(1) Symptoms and complaints;

(2) Affect;

(3) Behavior;

(4) Focus topics;

(5) Significant incidents or historical events.

As amended, R.1981 d.329, eff. September 10, 1981.
See: 12 N.J.R. 520(b), 13 N.J.R. 574(b).
Substantially amended.
Amended by R.1985 d.52, effective February 19, 1985 (operative March 1, 1985).
See: 16 N.J.R. 2333(a), 17 N.J.R. 452(a).
(b) added.

10:54–1.4 Policies related to inpatient care

(a) If the patient is admitted to a hospital and does not have a private physician nor chooses one, then a physician may, in accordance with regulations of the hospital's medical and governing boards, be assigned as the private physician and be reimbursed as such, provided:

1. The patient is allowed free choice of physician;

2. The physician chosen accepts the professional responsibility for the patient and provides for any required aftercare by himself or appropriate referral.

(b) The New Jersey Medicaid Program recognized as a covered service medically necessary inpatient services which are provided in an approved private psychiatric hospital or psychiatric section of an approved general hospital with the following limitations (see N.J.A.C. 10:49–1.4(b) for the Medically Needy Program):

1. Reimbursement for inpatient care is based upon the medical necessity of the admission and may not exceed 20 days unless supported by a medical recertification (Form MC–2);

2. Whenever the span of inpatient days exceeds 20, the attending physician is required to certify the necessity of continued hospitalization on or before the expiration of the 20th day. The maximum number of days allowed on the recertification is 20 days. Only one recertification is allowable for each admission;

i. In extremely unusual situations where more than 40 days inpatient care is deemed necessary by the attending physician, a special request for continued stay may be submitted no later than the 30th hospital day. The request must specify, in detail, why continued hospitalization is necessary for the patient and is to be submitted to:

Chief, Mental Health Services
Division of Medical Assistance and Health Services
P.O. Box 2486
Trenton, New Jersey 08625

3. The request must specify the actual number of days for which authorization is requested;

4. Failure to obtain prior authorization will result in nonpayment of the hospital's claim for all days beyond the 40th day and all physicians claims for the corresponding period will be denied for payment;

5. The regulations of the New Jersey Medicaid Program require that the attending physician sign a statement on or before the expiration of AID days (recertification form) certifying the medical necessity of continued hospitalization beyond the AID days.

(c) When an inpatient is to be discharged from the hospital and continuing medical care is required either in another medical facility (that is, I.C.F., skilled nursing facility, and so forth), or by a community health agency (for example, home health agency), a legible abstract or summary must be prepared by either the attending physician or the hospital and signed by the attending physician, covering

the pertinent findings on the history, physical examination, x-rays, laboratory services, ECG and consultations with reference to the patient's care in the hospital, with recommendations for further medical care, and forwarded to the institution or agency to which the patient has been referred.

As amended, R.1984 d.34, eff. February 21, 1984.
See: 15 N.J.R. 2129(a), 16 N.J.R. 371(a).
References to the AID program deleted.
Amended by R.1986 d.236, effective June 16, 1986 (operative July 1, 1986).
See: 18 N.J.R. 803(a).
Added text to (b) "(see 10:49–1.4(b) for the Medically Needy Program):".

10:54–1.5 Prior authorization

(a) Prior authorization means approval by a medical consultant with the New Jersey Medicaid Program before a service is rendered or an item provided.

(b) Prior authorization for certain services rendered by physicians are required as follows:

1. Cosmetic surgery:

i. For purposes of the New Jersey Medicaid Program, cosmetic surgery is considered to be that modality which is performed solely for the purpose of beautifying an individual and which has no significant redeeming medical need. In these cases, this surgery is not a reimbursable service. However, if a significant redeeming medical need can be demonstrated, a request for prior authorization granting permission for such surgery will be considered by the medical consultant of the Medicaid district office serving the area (see N.J.A.C. 10:54–2);

ii. Repair or reconstruction of changes due to trauma or infection which demonstrates significant medical necessity within the intent of the New Jersey Medicaid Program would not require prior authorization;

2. Psychiatric services:

i. Prior authorization is required for psychiatric services exceeding $300.00 in payments to the physician in any 12–month period, commencing with the patient's initial visit, when provided in other than inpatient or outpatient hospital setting. When approved by New Jersey Medicaid, each authorization may be granted for a maximum period of one year. Additional authorizations may be requested.

(1) Exception: After an initial evaluation, prior authorization is required under all circumstances for psychiatric services rendered to Medicaid eligible recipients in long-term care facilities and sheltered boarding homes.

ii. Exception: Psychiatric services rendered in an approved hospital outpatient department, to a registered clinic patient, shall not require prior authorization but, in accordance with the Hospital Manual, shall require a physician's certification and plan of treatment after the first 30 days. Certification and/or recertification and plan of treatment shall consist of a typewritten statement, signed by the attending physician, which shall indicate the type, amount, frequency and duration of the services that are to be furnished, and must include the diagnosis and anticipated goals. The certification must be completed on a timely basis and the dates on the report must be applicable to the billing dates on the claim submitted by the hospital.

iii. In general hospital outpatient departments, prior authorization is required for Partial Hospitalization (P.H.) services after 30 calendar days.

iv. When prior authorization is required for psychiatric services in other than an inpatient or outpatient hospital setting, the request is to be submitted on a "Request for Authorization of Psychiatric Services" form (FD–07) to the Chief, Bureau of Mental Health Services, P.O. Box 2486, Trenton, New Jersey 08625. Items 1 through 17 must be completed.

v. When a request for prior authorization is approved, the Chief of Mental Health Services shall provide the practitioner with written confirmation for continued care by signing form FD–07 (Request for authorization of psychiatric services) and return two copies to the practitioner. The original copy of the authorization (FD–07) must be attached to the Health Insurance Claim Form (HCFA–1500) when submitting the claim for payment. The other copy is retained by the physician for his records. When a request for prior authorization is denied, the practitioner shall be notified in writing by the Chief of Mental Health Services of the reason.

vi. The request must include the diagnosis, as set forth in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (latest edition), and also must include the treatment plan and progress report in detail. No post facto authorization will be granted.

vii. If request for authorization is approved, both the provider copy and the contractor copy will be returned to the provider, who is responsible for submitting the contractor copy along with the HCFA–1500 to the Prudential Insurance Company for payment.

viii. If request for authorization is denied, the provider shall be notified of the reason, in writing, by the Chief of Mental Health Services.

As amended, R.1971 d.115, eff. July 16, 1971.
See: 3 N.J.R. 109(a), 3 N.J.R. 156(c).
As amended, R.1972 d.92, eff. May 10, 1972.
See: 4 N.J.R. 67(c), 4 N.J.R. 128(a).

As amended, R.1980 d.138, eff. April 1, 1980.
See: 11 N.J.R. 444(a), 12 N.J.R. 277(c).
As amended, R.1981 d.220, eff. July 9, 1981.
See: 12 N.J.R. 413(a), 13 N.J.R. 417(b).
Note 6 added.
As amended, R.1981 d.249, eff. July 9, 1981.
See: 13 N.J.R. 293(a), 13 N.J.R. 417(a).
(b)2iv is added. Renumber (b)2iv.-vi. as v.-vii.
As amended, R.1981 d.374, eff. October 8, 1981 (operative January 1, 1982).
See: 12 N.J.R. 662(a), 13 N.J.R. 706(d).
As amended, R.1984 d.34, eff. February 21, 1984.
See: 15 N.J.R. 2129(a), 16 N.J.R. 371(a).
Prior authorization requirement added for partial hospitalization services after 30 days.

10:54–1.6 Basis of payment

(a) Reimbursement for covered services furnished under the New Jersey Medicaid Program shall be on the basis of the customary charge prevailing in the community for the same service, not to exceed an allowance determined reasonable by the Commissioner (Institutions and Agencies), and further limited by Federal policy relative to payment of practitioners and other individual providers. In no event shall the charge to the New Jersey Medicaid Program exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community. If a patient receives care from more than one member of a partnership or corporation in the same discipline, the maximum payment allowance would be the same as that of a single attending physician.

NOTE 1: Allowances for surgical procedures are all-inclusive and include consultation services performed within two days prior to day of operation and include anesthesia services when rendered by the operating surgeon.

NOTE 2: Reimbursement for services will be made only for periods when eligibility is current.

NOTE 3: Payment for a psychiatric consultation or shock therapy shall be considered as inclusive for all psychiatric services performed on that day.

NOTE 4: Reimbursement is not made for, and recipients may not be asked to pay for, broken appointments.

NOTE 5: Reimbursement will not be made by the New Jersey Medicaid Program for refractions for optical appliances (for example, eyeglasses, contact lenses, and so forth) or for visual training unless it is performed by:

1. A physician recognized by the New Jersey Medicaid Program as a specialist in ophthalmology (in accordance with the specialist definition in section 1 of this subchapter or section 200.1 of the Vision Care Manual);

2. An optometrist licensed by the State of New Jersey;

3. An independent outpatient health facility approved by the New Jersey Medicaid Program or render eye care services, and/or visual training services;

4. Hospitals meeting the definition of "approved hospital" as described in section 200.1 of the New Jersey Medicaid Program Hospital Manual.

NOTE 6: Reimbursement for anesthesia time is defined as that period which includes:

1. Those professional activities of the anesthesiologist directly related to the pre-operative preparation of the patient in the operating room or pre-induction room preceding the proposed surgery;

2. Introduction of the anesthetic agent;

3. Continuous supervision during the surgery;

4. Continuous supervision during the immediate post-operative period until release of the patient in a satisfactory psychological state to a competent recovery room staff;

5. Anesthesia time is reported in the time element of 15 minutes (1 unit). Should the time element of 15 minutes (1 unit) in # 1 or # 4 above be exceeded, the reason(s) must be documented on the anesthesia record and the Practitioner Claim Form.

As amended, R.1973 d.197, eff. September 1, 1973.
See: 5 N.J.R. 44(a), 5 N.J.R. 281(b).
As amended, R.1975 d.229, eff. August 1, 1975.
See: 7 N.J.R. 318(c), 7 N.J.R. 431(a).
As amended, R.1981 d.220, eff. July 9, 1981.
See: 12 N.J.R. 413(a), 13 N.J.R. 417(b).
Note 6 added.

10:54–1.7 Physical medicine and rehabilitative services

(a) This section is concerned with rehabilitation services which includes physical therapy, occupational therapy, speech therapy, and other restorative services provided for the purpose of attaining maximum reduction of physical or mental disability and restoration of the patient to his best possible functional level. It does not include restorative/nursing procedures or physical therapy which is purely palliative, such as, the application of heat per se, in any form, massage, routine calisthenics or group exercises, assistance in any activity or use of a simple mechanical device not requiring the special skill of a qualified physical therapist. Rehabilitation services shall be made available to covered persons as an integral part of a comprehensive medical program. (See 10:49–1.4(b) for the Medically Needy Program.) Such services include not only intermittent or part-time service to the patient, but also instructions to responsible members of the family in follow-up procedures necessary for the care of the patient.

(b) Definitions include the following:

1. "Rehabilitation services" means physical therapy, occupational therapy, speech therapy and hearing services and the use of such supplies and equipment as are necessary in the provision of such services;

2. "A qualified physical therapist" is one who for program payment purposes is an individual who is licensed as a physical therapist by the state in which practicing and meets one of the following requirements:

i. Has graduated from a physical therapy curriculum approved by the American Physical Therapy Association, or by the Council on Medical Education and Hospitals of the American Medical Association, or jointly by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association; or

ii. Prior to January 1, 1966, was admitted to membership by the American Physical Therapy Association, or was admitted to registration by the American Registry of Physical Therapists, or has graduated from a physical therapy curriculum in a four-year college or university approved by a State department of education; or

iii. Has two years of appropriate experience as a physical therapist and has achieved a satisfactory grade on proficiency examination approved by the secretary except that such determinations of proficiency will not apply with respect to persons initially licensed by a state as a physical therapist after December 31, 1977, or seeking qualification as a physical therapist after that date; or

iv. Was licensed or registered prior to January 1, 1966, and prior to January 1, 1970, has 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring physicians; or

v. If trained outside the United States, was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy, meets the requirements for membership in a member organization of the World Confederation for Physical Therapy, has one year of experience under the supervision of an active member of the American Physical Therapy Association, and has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association;

3. A "speech therapist" is certified by the American Speech and Hearing Association, or has completed the academic requirements and is in the process of accumulating the necessary supervised work experience required for certification;

4. A "qualified occupational therapist" is registered by the American Occupational Therapy Association or is a graduate of a program in occupational therapy approved by the Council of Medical Education of the American Medical Association and is engaged in obtaining the required supplemental clinical experience prerequisite to registration by the American Occupational Therapy Association.

(c) Requirements include the following:

1. The physician, in communication with the physical therapist, must prescribe (authorize in writing) the specific means or methods to be used by the therapist and the frequency of therapy services;

2. Physical therapy must be related to the active treatment regimen designed by the physician to elevate the patient to his maximum level of function which has been lost or reduced by reason of injury or illness;

3. "Physical therapy as needed" or a similarly worded blanketed request by the physician does not suffice as an accepted prescription since no specific treatment is named and the physical therapist is in effect prescribing the patient's regimen.

(d) Restorative nursing is an active program of restorative care, which is an integral part of all nursing service directed toward assisting each patient to achieve and maintain an optimal level of independence in self-care and to assist him to achieve his maximum possible physical, mental, and social efficiency. As a minimum the functions of restorative nursing shall include:

1. Developing a plan for restorative nursing care services based upon a nursing assessment of patient needs;

2. Providing direct nursing care services that will maintain optimum physical and mental health for the patient or resident to meet his medical treatment needs;

3. Applying nursing measures that prevent crippling and superimposed infections and insure the safety and comfort of the patient in his environment;

4. Establishing a sustained, supporting relationship with the patient or resident;

5. Participating in retraining of the patient or resident in selfcare activities;

6. Providing health teaching and training that will meet the needs of the individual patient or resident and his family;

7. Recording and reporting nursing observations of the patient's condition, progress, and personal needs, and the action taken to meet the patient or resident's needs;

8. Assisting with the patient or resident's discharge plans and providing for the nursing referral of the patient or resident for continued nursing services where needed;

9. Evaluating the nursing care in terms of overall goals in patient or resident care;

10. Carrying out specific restorative nursing techniques such as:

i. The prevention of physical deformities through positioning, change of position, range of motion exercises, and so forth;

ii. Teaching ambulatory techniques of brace and crutch walking, and so forth;

iii. The prevention and care of decubitus ulcers;

iv. Teaching self-care activities including the utilization of self-help devices;

v. Controlling incontinency rehabilitation of bladder and bowel;

vi. Assisting with the problems of communication;

vii. Motivational and emotional support and the application of reality orientation, remotivation, and behavior modification techniques.

(e) Procedures when prescribing all rehabilitation services are:

1. The Physician shall place detailed orders on the patient's chart prior to the treatment being initiated, specifying goals or potentials;

2. The physician shall instruct the physical therapist, or others of the allied health professions, to file notes in the patient's chart similar to nursing notes at least weekly, reflecting the patient's response to treatment;

3. The physician shall review the patient's record at least every 30 days, when in a skilled nursing home, to determine if treatment is being provided according to his orders and indicate by signing the treatment records. Treatment that is being provided but which has not been prescribed or authorized by the physician should be discontinued immediately;

4. Formal physical and occupational therapy is not indicated when evidence indicates that similar types of care could be provided on the nursing unit by restorative nursing or other techniques.

(f) Rehabilitation services may be provided by the following:

1. By home health agency in the patient's home or other place of residence;

2. To a patient in the long-term care facility;

3. In a hospital outpatient department;

4. In an approved clinic (independent outpatient health facility not part of the hospital);

5. In the physician's office setting, which is limited to physical therapy only:

i. Physical therapy performed in a physician's office is a reimbursable service under the following conditions:

(1) The service is delivered personally in the physician's office by a registered physical therapist (see subsection (b) of this section for qualifications);

(2) Except for the initial evaluation visit, all subsequent therapy visits have been prior authorized by the Medicaid medical consultant;

(3) All treatments must be individual and consist of a minimum of 30 minutes and not more than three patients can be treated simultaneously by the same therapist;

(4) Treatment progress notes must be in the patient's record folder and signed by the physical therapist rendering treatment.

NOTE 1: Maintenance therapy will be disallowed.

NOTE 2: Authorization if given will not exceed a period of 60 days, but may be again reauthorized on submission of request (Form FD–06) which contains a progress report and demonstrates medical justification for reauthorization.

NOTE 3: No portion of the time spent on a physical therapy treatment may be considered as part of the time parameter of an office visit. Office visits billed during the same day must have clearly and separately met the time and other parameters described in the procedure codes in subchapter 3 of this chapter.

NOTE 4: The physical therapist is not a direct provider to the program and therefore reimbursement will be made only to the physician. Billing for physical therapy services performed in the physician's office must be listed on the Health Insurance Claim Form (HCFA–1500) in section 24D under procedure code 9090 with a statement, "physical therapy session". A copy of the approved prior authorization form (FD–06) must accompany the claim form when sent to the Prudential Insurance Company for reimbursement. (See FD–06 exhibit 1.)

(g) If the attending physician orders an evaluation for physical therapy, an appropriate qualified physical therapist may make an initial visit to evaluate the need for physical therapy without prior authorization. The reimbursement fee paid to the physician for the initial visit will be the same as the allowance for the subsequent treatment visits. All subsequent therapy visits require prior authorization which is granted by the Medicaid Medical Consultant of the Medicaid District Office. Prior authorization, which is required in all settings except the hospital, shall not exceed 60 calendar days and shall be granted only when the following conditions are met:

1. All rehabilitation services of any type shall be supported by a written recommendation of a licensed physician, including a statement covering the medical necessity for therapy, the objective of treatment, a therapy prescription and the estimated number of treatments;

2. Therapy prescriptions must be definitive as to type and scope of procedures to be rendered. Prescriptions such as "physical therapy 3X a week" will not be accepted;

3. Exception: While an authorization for home health services is in effect and the condition of the recipient changes, indicating a need for additional services, the home health agency, after consultation with the attending physician, may request authorization for these additional services. A new plan of treatment and plan of care shall be submitted for approval. However, if the need is urgent, the request may be made and granted by telephone for no more than three additional visits and/or treatments which will then be followed by written authorization from the local medical assistance unit to the home health agency;

4. Prior authorization is obtained by submission to the local medical assistance unit of a written treatment plan by the requesting physician, including the diagnosis, modalities and specific course of treatment plan, objectives to be gained and specific frequency of treatment. This information is submitted on Form FD–06. This form may be obtained from the Prudential Insurance Company.

As amended, R.1981 d.249, eff. July 9, 1981.
See: 13 N.J.R. 293(a), 13 N.J.R. 419(a).
Incorporated billing procedures using HCFA–1500 Claim Form.
As amended, R.1983 d.583, eff. December 19, 1983 (operative January 1, 1984).
See: 15 N.J.R. 782(a), 15 N.J.R. 2168(b).
Language added concerning initial evaluative visits.
Amended by R.1986 d.236, effective June 16, 1986 (operative July 1, 1986).
See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a).
Added text "(See 10:49–1.4(b) for the Medically Needy Program.)"

10:54–1.8 Environmental equipment

(a) Under the program, no reimbursement concerning environmental equipment is allowed.

(b) Environmental equipment is considered to be equipment which:

1. Can withstand repeated uses; and

2. Is primarily and customarily not used to serve a medical purpose; and

3. Generally is not medically useful to a person in the absence of an illness or injury.

Case Notes

Reimbursement for purchase of HEPA Air Cleaner prohibited as device is environmental equipment; judge's allowance of reimbursement by analogy to vaporizer reversed as N.J.A.C. 10:59–1.6 specifically prohibits electrostatic air filter reimbursement (Director's Final Decision). In the Matter of M.D., 7 N.J.A.R. 254 (1980), reversed 179 N.J.Super. 541, 432 A.2d 943, (App.Div.1981), modified in part and remanded 91 N.J. 1, 449 A.2d 1235 (1982).

Determination whether easy chair lift constitutes environmental equipment. M.M. v. Division of Medical Assistance and Health Services, 2 N.J.A.R. 145 (1979).

10:54–1.9 Policy on shoes

(a) Shoes with or without accompanying appliances, used to prevent or correct gross deformities of the feet and consisting of the following basic parts:

1. Correct straight last lines;

2. Heels with sufficient bearing surfaces;

3. Toe with ample room for function;

4. Sole with sufficient weight for foot protection;

5. A rigid shank;

6. Properly fitting upper;

7. Smooth and protective lining;

8. Snug fitting heel counter;

9. Properly fitted as to length and width.

(b) In the New Jersey Medicaid Program, orthopedic shoes are reimbursable under the following conditions (see 10:49–1.4(b) for the Medically Needy Program):

1. When attached to a brace or bar;

2. When part of the normal post-operative or post-fracture treatment program;

3. When used to correct or adapt to gross foot deformities.

As amended, R.1975 d.227, eff. August 1, 1975.
See: 7 N.J.R. 315(b), 7 N.J.R. 430(a).
As amended, R.1980 d.91, eff. March 10, 1980.
See: 11 N.J.R. 444(a), 12 N.J.R. 193(c).
Amended by R.1986 d.236, effective June 16, 1986 (operative July 1, 1986).
See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a).
Added text "(see 10:49–1.4(b) for the Medically Needy Program):".

10:54–1.10 Prescription policies

(a) This section is intended to describe the physician's responsibility in writing of prescriptions in order to maintain the traditional patient-prescriber-provider relationship and to insure the recipient free choice of provider. Physicians are urged to familiarize themselves with all aspects of this section in order to effect economics consistent with good medical practices and to facilitate prompt payment to the provider. (See 10:49–1.4(b) for the Medically Needy Program service limitations.)

1. The New Jersey Medicaid Program allows the choice of prescribed drugs to the prescriber, within the limits of applicable laws, rules and regulations of the program. The Prescription Drug Price and Quality Stabilization Act applies to the New Jersey Medicaid Program, and the formulary published by the Drug Utilization Review Council shall be used for all drugs listed therein.

2. The practitioner's Individual Medicaid Practitioner number must appear on all written prescriptions and must be given to the pharmacist with all telephone orders. This number must be transposed onto the prescription claim form submitted by the pharmacy and serves to expedite the processing of these claims.

3. All practitioners licensed or authorized to prescribe by the State of New Jersey, and who comply with all rules and regulations of the New Jersey Health Services (Medicaid) Program, are eligible to prescribe for eligible Medicaid recipients. Out–of–State practitioners may prescribe under this program, as herein outlined, if they meet the same requirements in their state.

(b) Medical supplies and equipment, prosthetics and orthotics, and other assistive devices that are essential for the patient's medical condition are allowed unless otherwise available at no charge from community resources (that is, the American Cancer Society, service organizations, and so forth).

1. Prior authorization must be obtained by the supplier of prosthetic and orthotic appliances, certain medical supplies, and equipment and hearing aids. Prosthetic and orthotic appliances provided only by certified prosthetists and/or orthotists. (For purposes of the New Jersey Medicaid Program, a prosthetic and orthotic appliance is one which has been fabricated in an approved certified prosthetic and orthotic facility under the specific direction of a licensed prescribing physician and designed to fit that specific individual to perform the function for which it was fabricated.)

2. Prosthetic and orthotic appliances require a personally signed and dated order (prescription) by the prescribing physician which must include the following:

i. Patient's name, age, address, H.S.P. number, patient person number; and

ii. Relevant diagnosis supporting need for custom-made prosthetic and orthotic appliances; and

iii. Detailed (meaningful) description of the prosthetic and orthotic appliance order (that is, "back brace", "leg brace", "artificial limbs", "orthopedic shoe", and so forth, on a prescription is unacceptable).

3. The approved prosthetic and orthotic provider upon receipt of an acceptable prescription will submit, with the prescription attached, his detailed breakdown of the appliance ordered, according to the accepted New Jersey prosthetic and orthotic nomenclature, to the appropriate local medical assistance unit, on a prosthetic and orthotic claim form. Upon receipt of this information at the local medical assistance unit, the local medical consultant will review the medical (prosthetic or orthotic) data and sign the claim form in the appropriate space, if approved. In the event that a physician's prescription does not conform to the prosthetic and orthotic nomenclature accepted by this division and the approved New Jersey prosthetic and orthotic facilities, it shall be incumbent upon the facility to transform the original prescription to conform to the accepted nomenclature. This does not imply that the physician's prescription will in any way be altered.

4. In case of a claim submitted by an out-of-State facility which may be unfamiliar with New Jersey nomenclature, the division's prosthetic or orthotic consultant will assume the responsibility of clarifying the claim to conform to the accepted nomenclature.

5. Contact local medical assistance unit to ascertain which prosthetic and orthotic providers are eligible under the program.

(c) Dosage and directions for use must be indicated on all original prescriptions. Prescriptions written and dispensed with nonspecific directions such as "PRN", "as directed", or "ad lib", and so forth, are not eligible for payment.

1. Exceptions are:

i. Topical applications;

ii. Aerosol inhalers;

iii. Nitroglycerin; or

iv. Pharmacy items in which specific directions for use are seldom possible.

(d) The choice of prescription drugs remains at the discretion of the prescribing physician subject to the observation of the following tenets:

1. Oral medication should be prescribed when as effective as injectable preparations;

2. Nonproprietary or generic named drugs of equal therapeutic effectiveness should be prescribed if available at a lower cost than proprietary or brand named drugs;

3. The practitioner should note the specific conditions listed under subsections (f) and (g) of this section regarding restriction of payment to pharmacies for certain prescription drugs.

(e) The quantity of medication prescribed should provide a sufficient amount of medication necessary for the duration of the illness or an amount sufficient to cover the interval between visits, but may not exceed a 60–day supply or 100 unit doses, whichever is greater. Any drug used continuously (that is, daily, three times daily, every other day, and so forth)—for 14 days or more is considered to be a sustaining drug or maintenance medication and should be prescribed in sufficient quantities to treat the patient for up to 60 days. In long-term medical care facilities (that is, skilled nursing facilities, infirmary section of home for aged, or public medical institution), if the quantity of sustaining drug or medication is not indicated in writing by the prescriber, the

pharmacy provider may dispense up to a maximum of 30 days' supply.

1. Exceptions include the following:

i. Patients authorized as Level IV B in a long-term care facility, where the interval between physician visits may be 60 days, may have one refill, one time only, if a 60–day supply was authorized on the original prescription.

ii. Oral contraceptives may be prescribed up to a supply for three ovulatory cycles;

iii. Vitamins and vitamin/mineral combinations may be prescribed and dispensed in quantities up to a 100–day supply.

iv. Hypodermic syringes and/or needles may be prescribed and dispensed in quantities to a 100–day supply.

(f) The following therapeutic classes and dosage forms require prior authorization obtained by the prescribing practitioner from the Medicaid District Office. If the request is approved, an authorization number will be provided and must appear on the prescriber's original prescription. The pharmacist cannot be reimbursed unless he has the authorization number to insert on the pharmacy claim form.

1. Protein replacement products;

2. Preventive drugs, for example, isoniazid (INH), para aminosalicylic acid (PAS), when not available through the Department of Health distributing stations or provided without charge through programs of public or voluntary agencies (that is, New Jersey Heart Association, and so forth);

3. Injectable drugs as follows:

i. Gammaglobulin when not available from the Department of Health or other agencies;

ii. Measles, mumps, rubella as a combined vaccine when not available from the Department of Health or other agencies;

iii. Drugs to be administered to a patient by other than the prescriber or an employee of the prescriber. Written prescription must include the statement, "Medicaid authorized";

4. Methadone:

i. Exception: Not reimbursable for use in drug detoxification or for addiction.

(g) The following classes of prescription drugs will not be honored for payment:

1. Drugs for which adequate literature, that is, package inserts, and so forth and price catalogues are not readily available;

2. Experimental drugs;

3. Telephone ordered refills;

4. Drugs directly furnished by practitioner:

i. Exception: Injection policy as outlined in subchapter 3 of this chapter;

5. Oral preventive drugs and biologicals provided without charge through programs of other public or voluntary agencies (that is, New Jersey State Department of Health, New Jersey Heart Association, and so forth);

6. Medications prescribed for use by hospital inpatients;

7. Medication prescribed for a Title XIX (Medicaid) covered person who is receiving benefits under part A of Title XVIII (Medicare) as a patient in a long-term care facility (LTC);

8. Prescriptions written and dispensed with nonspecific directions;

9. Food supplements, milk modifiers, infant formula and therapeutic diets;

i. Exceptions: Protein replacements in life sustaining situations;

10. Methadone when used for drug detoxification or addiction;

11. Drugs for which final orders have been published by the Food and Drug Administration, withdrawing the approval of their new drug application (NDA).

12. Antiobesics and anorexiants;

13. Drugs considered less than effective under the Drug Efficacy Study Implementation Program.

(h) Telephone orders from the prescriber for original prescriptions, in accordance with all applicable Federal and State laws and regulations, will be permitted.

NOTE 1: Telephone orders for refills are not permitted.

NOTE 2: For drugs listed in the Drug Utilization Review Council (DURC) formulary, the prescriber must initial the statement "Substitution Permissible" or "Substitution Not Permissible." If neither statement is initialed, the pharmacist shall substitute from the formulary and bill Medicaid accordingly. For telephone prescriptions, this information must be put in writing immediately.

(i) The pharmacist must initial, complete and submit prescription claim form (MC–6) to Blue Cross of New Jersey for payment of an allowable refill. The following instructions apply for allowable refills:

1. Refill instructions must be indicated by the prescriber on the original prescription. Prescriptions without such instructions are not refillable and are not eligible for payment;

2. Prescription refills will be limited to two times within a six-month period if so indicated by the prescriber on the original prescription.

i. Exceptions include:

(1) Oral contraceptives originally prescribed for a three ovulatory cycle supply may be refilled two times within a nine-month period;

(2) Vitamins and vitamin-mineral combinations originally prescribed for a 100–day supply may be refilled two times within one year;

3. Refill instructions indicating "refill prn" or indicating more than two refills will be honored for payment only up to the limits imposed in paragraph 2 of this subsection;

4. Payments will not be allowed for telephone authorized refills.

As amended, R.1975 d.227, eff. August 1, 1975.
See: 7 N.J.R. 315(b), 7 N.J.R. 430(a).
As amended, R.1984 d.34, eff. February 21, 1984.
See: 15 N.J.R. 2129(a), 16 N.J.R. 371(a).
(a)1. Substantially amended, further exceptions for payments added.
Amended by R.1986 d.236, effective June 16, 1986 (operative July 1, 1986).
See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a).
Added text "(See 10:49–1.4(b) for the Medically Needy Program service limitations.)"

EDITOR'S NOTE: Take notice that an Exhibit 1, Request for Authorization or Reauthorization for Prescribed Rehabilitation Treatment Program form, was also adopted with the text above but is not reproduced herein. Further information concerning this exhibit may be obtained from the Division of Medical Assistance and Health Services, Department of Institutions and Agencies, P.O. Box 2486, Trenton, New Jersey 08625.

10:54–1.11 Supplies and equipment

(a) Medical supplies and equipment, prefabricated prosthetics and orthotics, and other assistive devices that are essential for the patient's medical condition are allowable unless otherwise available at no charge from community resources (that is, American Cancer Society, service organizations, and so forth).

(b) Prior authorization must be obtained by the provider for custom-made prosthetic and orthotic appliances (required to support or strengthen the body or replace parts thereof), certain medical supplies and hearing aids. Custom-made appliances may be provided only by certified prosthetists and/or orthotists. (For purpose of the New Jersey Health Services Program, a custom-made appliance is one which has been fabricated in an approved facility under the specific direction of a prescribing practitioner and designed to fit the specific individual to perform the function for which it was fabricated.)

(c) Contact local medical assistance unit to ascertain which prosthetic and orthotic providers are eligible under the program.

As amended, R.1975 d.227, eff. August 1, 1975.
See: 7 N.J.R. 315(b), 7 N.J.R. 430(a).

10:54–1.12 Drugs and direction for allowable drug items

The practitioner must include specific directions on all drug prescriptions or the prescription will not be eligible for payment. Examples of nonacceptable directions are: "prn", "as directed" and "ad lib", and so forth. This ruling does not apply for prescriptions such as topical preparations, aerosol inhalers and nitroglycerin tablets since specific directions are seldom possible in these instances.

As amended, R.1975 d.227, eff. August 1, 1975.
See: 7 N.J.R. 315(b), 7 N.J.R. 430(a).

10:54–1.13 Choice of prescription drugs

(a) The choice of prescribed drugs shall be at the discretion of the prescriber within the limits of applicable law and as listed herein. However, no payment shall be made for certain drugs under specific conditions.

1. Exceptions:

i. Covered pharmaceutical services requiring prior authorization (see N.J.A.C. 10:54–1.10(f));

ii. Pharmaceutical services not eligible for payment (see N.J.A.C. 10:54–1.10(g));

iii. Non-legend drugs (see N.J.A.C. 10:54–1.16).

(b) The New Jersey Drug Utilization Review Council Formulary (hereafter referred to as the Formulary) dated July 9, 1979, and all subsequent revisions, distributed to all prescribers and pharmacists, supersedes the New Jersey Medicaid Formulary dated November 11, 1975.

(c) The Prescription Drug Price and Quality Stabilization Act (N.J.S.A. 24:6E–1) shall apply to the New Jersey Health Services (Medicaid) Program. This law requires that every prescription blank contain the statements "Substitution Permissible" and "Do Not Substitute." The prescriber must initial one of the statements in addition to signing the prescription blank.

1. When the prescriber does not initial either statement on a prescription for a drug product listed in the Formulary, the pharmacist shall substitute from the list of interchangeable products.

2. When the prescriber initials "Substitution Permissible", the pharmacist shall dispense and bill Medicaid for one of the less expensive products listed as interchangeable with the brand name prescribed. The Medicaid client must accept the interchangeable product unless the client is willing to pay the pharmacy's full usual and customary price.

3. When the prescriber initials "Do Not Substitute," the pharmacist shall dispense and bill Medicaid for the prescribed product.

4. When the prescriber orders by generic name, the Formulary does not apply. The pharmacist shall dispense the least expensive, therapeutically effective product available to him/her at the time of dispensing. The product need not necessarily be from the list of interchangeable products.

(d) The Federal Maximum Allowable Cost (MAC) regulations prescribe the upper limit Medicaid may reimburse for certain multi-source drugs. The limit shall apply to all MAC drugs, unless the prescriber indicates in his/her own handwriting on each written or telephoned prescription "Brand Necessary" or "Medically Necessary". The Department of Health and Human Services requires a handwritten statement and does not permit the use of alternatives, such as a check box, initials, or prescriber's signature next to a preprinted statement "Do Not Substitute". For purposes of reimbursement, the physicians override capability under N.J.S.A. 24:6E-1 does not apply to drugs which have a federal MAC limit.

(e) Blanket authorization denying substitutions will not be permitted. Each prescription order must state "Brand Necessary" or "Brand Medically Necessary" in the prescriber's own handwriting or his/her initials, if a printed statement or rubber stamp is used. (See N.J.A.C. 10:54-1.13(d)).

As amended, R.1975 d.227, eff. August 1, 1975.
See: 7 N.J.R. 315(b), 7 N.J.R. 430(a).
As amended, R.1975 d.339, effective November 10, 1975.
See: 7 N.J.R. 316(a), 7 N.J.R. 567(c).
As amended, R.1984 d.34, eff. February 21, 1984.
See: 15 N.J.R. 2129(a), 16 N.J.R. 371(a).
Entire text deleted and replaced.

10:54-1.14 Quantity of medication

(a) The quantity prescribed should provide a sufficient amount of medication necessary for the duration of the illness or an amount sufficient to cover the interval between visits, but may not exceed a 60 day supply or 100 unit doses, whichever is greater.

(b) Any drug used continuously (that is daily, three times daily, every other day and so forth) for 14 days or more is considered to be a sustaining drug or maintenance medication and should be prescribed in sufficient quantities to treat the patient for up to 60 days or 100 unit doses, whichever is greater.

(c) In long-term care facilities (that is, skilled nursing home, infirmary section of home for the aged, a public medical institution), if the quantity of sustaining drug or maintenance medication is not indicated in writing by the prescriber, the pharmacy provider must dispense an appropriate quantity of medication not to exceed a one month supply.

As amended, R.1975 d.227, eff. August 1, 1975.
See: 7 N.J.R. 315(b), 7 N.J.R. 430(a).
As amended, R.1984 d.34, eff. February 21, 1984.
See: 15 N.J.R. 2129(a), 16 N.J.R. 371(a).
Language added delineating supply to 60 days or 100 unit doses whichever is less.

10:54-1.15 Drug services requiring prior authorization

(a) The following therapeutic classes and dosage forms require prior authorization obtained by the prescribing practitioner from the Medicaid District Office. If the request is approved, an authorization number will be provided and must appear on the prescriber's original prescription. The pharmacist must check the box in the space provided on the prescription claim form (MC-6) identifying a prior authorized item, and enter the authorization number in the proper space in this area.

1. Protein replacement products, such as (but not limited to) Probana, Protagen, Nutramigen, Neo-Mullsoy.

2. Preventive drugs and biologicals listed in Appendix A when not available through listed distributing stations.

3. Injectable medication to be administered to a patient by other than the prescriber or prescriber's employee.

4. Hymenoptera venom.

5. Methadone (not eligible when used for detoxification drug maintenance).

6. Non-legend medication not listed in Appendix B or C.

As amended, R.1975 d.227, effective August 1, 1975.
See: 7 N.J.R. 315(b), 7 N.J.R. 430(a).
As amended, R.1984 d.34, effective February 21, 1984.
See: 15 N.J.R. 2129(a), 16 N.J.R. 371(a).
Increased list of drug services requiring prior authorization.

10:54-1.16 Pharmaceutical services not eligible for payment

(a) The following classes of prescription drugs will not be honored for payment:

1. Drugs for which adequate literature, that is, package inserts, and so forth, and price catalogues are not readily available;

2. Experimental drugs;

3. Telephone ordered refills;

4. Medication furnished by a prescriber or an employee of a prescriber;

5. Preventive drugs and biologicals provided without charge through programs of other public or voluntary agencies (that is, New Jersey State Department of Health, New Jersey Heart Association, and so forth):

i. Exceptions: Instances where preventive drugs and biologicals are not available at the listed distributing stations and prior authorization to provide these items is obtained from the local medical assistance unit.

6. Medications prescribed for use by hospital inpatients;

7. Prescribed non-legend (OTC) drugs for patients in long-term medical facilities (that is, skilled nursing facilities, infirmary sections of a home for the aged or public medical institutions);

8. Medication prescribed for a Title XIX (Medicaid) covered person who is receiving benefits under Part A of Title XVIII (Medicare) as a patient in a skilled nursing facility (SNF);

9. Prescribed nonlegend drugs unless specifically listed in Appendix B or C (Allowable Nonlegend Drugs). (Appendixes B and C are furnished separately as a loose-leaf section of the New Jersey Medicaid Manual.) See N.J.A.C. 10:54–1.15, Drug services requiring prior authorization.

10. Prescriptions written and dispensed with nonspecific directions;

11. Food supplements, milk modifiers, infant formula and therapeutic diets.

i. Exceptions: Protein replacements.

12. Methadone or any prescription containing Methadone; that is tablets, capsules, liquid, injectable or powder, when used for drug detoxification or addiction maintenance. See N.J.A.C. 10:54–1.15.

13. Drugs for which final orders have been published by the Food and Drug Administration, withdrawing the approval of their new drug application (NDS).

14. Antiobesics and anorexiants;

15. Drugs considered less than effective under the Drug Efficacy Study Implementation Program;

16. Drugs or drug products not approved by the Federal Food and Drug Administration, when such approval is required by Federal law and/or regulation;

17. Injectable drug products;

i. Exceptions:

(1) Food and Drug Administration approved antineoplastic drugs;

(2) Gamma-globulin when not available from the Department of Health or other agencies. Prior authorization must be obtained by the prescriber;

(3) Medication to be administered to a patient by other than the prescriber or an employee of the prescriber. Prior authorization must be obtained by the prescriber and the written prescription must include the statement, "Medicaid authorized", and the assigned prior authorization number;

(4) Insulin;

(5) Hymenoptera venom preparations when prior authorized;

18. Radiopaque contrast materials. (Telepaque);

19. Any bundled drug service shall not be eligible for reimbursement by the New Jersey Medicaid Program.

i. This provision may be waived at the discretion of the Commissioner if he or she determines that a bundled drug service is less than or equal to the total cost of the unbundled components if reimbursed separately; or

ii. The Commissioner may waive the provisions for reasons of medical necessity for a bundled drug or in accordance with terms approved by the Department as follows:

(1) Those instances where discontinuation, withdrawal, or elimination of the use of the bundled drug in someone who has been receiving bundled drug would result in deprivation of life saving or life prolonging benefits of the drug or would cause potential harm or serious exacerbation of the illness being treated; or

(2) Those instances where use of the bundled drug has shown marked improvement in the recipients clinical status reflected in alleviation of symptoms, and elevation of level of function and independence.

iii. In order to determine eligibility for reimbursement, manufacturers or distributors of a bundled drug service shall submit complete product information, including the cost to the Program of the total bundled drug service, discrete costs of each component of the bundled drug service, cost benefit analyses, and other information as requested by the Department, to the Chief Pharmaceutical Consultant, Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625–0712.

iv. If the Commissioner determines that a bundled drug is eligible for reimbursement under this section, New Jersey Medicaid recipients who were already receiving a bundled drug service prior to March 2, 1992, shall continue to be eligible for this treatment if prior authorization is requested and approved. Prior authorization shall be obtained by completing the appropriate "Request for Authorization Form" requesting medication management authorization and providing sufficient documentation to support the need for treatment, and mailing the completed form and documentation to:

Medical Director
Division of Medical Assistance and Health Services
CN 712
Trenton, NJ 08625–0712

Amended by R.1972 d.164, effective August 21, 1972.
See: 4 N.J.R. 125(b), 4 N.J.R. 219(a).
Amended by R.1975 d.227, effective August 1, 1975.

See: 7 N.J.R. 315(b), 7 N.J.R. 430(a).
Amended by R.1984 d.34, effective February 21, 1984.
See: 15 N.J.R. 2129(a), 16 N.J.R. 371(a).
List of noneligible drugs and drug services increased.
Amended by R.1992 d.98, effective March 2, 1992.
See: 23 N.J.R. 281(a), 23 N.J.R. 1310(a), 24 N.J.R. 845(a).
In (a): added 19 for bundled drug services.

10:54-1.17 Telephone-ordered original prescription

(a) Telephone orders from the prescriber for original prescriptions, in accordance with all applicable Federal and State laws and regulations, will be permitted.

(b) When a prescriber chooses not to allow product interchange on a telephone order, the statement "Substitution not permitted by prescriber-telephoned Rx", plus the pharmacist's full signature next to or below the statement, must appear on the prescription order. A rubber stamp bearing the statement is acceptable.

(c) When a prescriber chooses to certify "Brand Necessary" or "Brand Medically Necessary" on a telephoned prescription for a product included on the Federal MAC list, a written signed prescription order containing the certification must be sent to the pharmacist within seven days of the date of the telephone order. The written prescription must be retained by the pharmacist as the original prescription. Failure to comply will result in the payment for the prescription being reduced to the MAC reimbursement level.

(d) For purposes of reimbursement, telephone authorization to refill an original prescription is considered a new order and requires a new written prescription number. Stamping or writing a new number on the original prescription order does not constitute a new prescription under the Medicaid Program.

As amended, R.1975 d.227, effective August 1, 1975.
See: 7 N.J.R. 315(b), 7 N.J.R. 430(a).
As amended, R.1975 d.339, effective November 10, 1975.
See: 7 N.J.R. 316(a), 7 N.J.R. 567(c).
As amended, R.1984 d.34, effective February 21, 1984.
See: 15 N.J.R. 2129(a), 16 N.J.R. 371(a).
(b) deleted and replaced; (c) and (d) new.

10:54-1.18 Prescription refill

(a) The pharmacist must initiate, complete and submit Prescription Claim Form (MC-6) to Blue Cross of New Jersey for payment of an allowable refill. The following instructions apply for allowable refills:

1. Refill instructions must be indicated by the prescriber on the original prescription. Prescriptions without such instructions are not refillable and are not eligible for payment.

2. Prescription refills will be limited to a maximum of five times within a six-month period if so indicated by the prescriber on the original prescriptions.

i. Exceptions:

(1) Oral contraceptives originally prescribed for a three ovulatory cycle supply may be refilled up to three times within one year if so indicated on the original prescription;

(2) Vitamins and vitamin-mineral combinations originally prescribed for a 100 day supply may be refilled two times within one year if so indicated by the prescriber.

3. Refill instructions indicating "refill prn" or indicating more than five refills will be honored for payment only up to the limits imposed in (a)2 above and will be reimbursed up to these limits only.

4. Payments will not be allowed for telephone authorized refills. A new prescription is required.

5. Prescription refills shall not be dispensed until a reasonable quantity (approximately 75 percent) of the medication originally dispensed or refilled could have been consumed in accordance with the prescriber's written directions for use.

i. Exception: When medication has been lost or destroyed (for example, broken container), the pharmacist may refill the prescription. A note of explanation for the early refill must be stapled to the Medicaid Prescription Claim Form (MC-6), in order to be eligible for reimbursement.

As amended, R.1975 d.227, eff. August 1, 1975.
See: 7 N.J.R. 315(b), 7 N.J.R. 430(a).
As amended, R.1984 d.34, eff. February 21, 1984.
See: 15 N.J.R. 2129(a), 16 N.J.R. 371(a).
Refill changed to three times in a year if so indicated.

10:54-1.19 (Reserved)

R.1974 d.68, eff. March 30, 1974.
See: 6 N.J.R. 66(a), 6 N.J.R. 150(c).
As amended, R.1974 d.186, eff. July 15, 1974.
See: 6 N.J.R. 242(c), 6 N.J.R. 312(d).
As amended, R.1974 d.311, eff. November 19, 1974.
See: 6 N.J.R. 398(c), 6 N.J.R. 478(b).
As amended, R.1980, d.463, eff. November 3, 1980.
See: 12 N.J.R. 319(a), 12 N.J.R. 703(d).
"Specialist" note amended from denial of reimbursement as a specialist for services outside of field.
R.1984 d.271, eff. July 2, 1984.
See: 16 N.J.R. 811(a), 16 N.J.R. 1788(a).
Section repealed.

10:54-1.20 Sterilization

(a) Definitions include the following:

1. Sterilization means any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

2. Institutionalized individual means an individual who is involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or confined under voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.

3. Mentally incompetent individual means an individual who has been declared mentally incompetent by a Federal, State, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

(b) Payments will be made for sterilization procedures and hysterectomies only if the following requirements were met (for hysterectomies, there are exceptions and additions to the following requirements, see (d) below):

1. The individual is at least 21 years old at the time consent is obtained;

2. The individual is not mentally incompetent or institutionalized;

3. The individual has voluntarily given informed consent;

4. At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery;

5. The Medicaid agency obtained documentation showing that all these requirements were met. This documentation must include a consent form or an acknowledgement of receipt of hysterectomy information.

(c) Informed consent is considered to be given only if:

1. The person who obtained consent for the sterilization procedure offered to answer any questions the individual may have concerning the procedure, provided a copy of the consent form, and provided orally all of the following information or advice to the individual to be sterilized:

i. Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled;

ii. A description of available alternative methods of family planning and birth control;

iii. Advice that the sterilization procedure is considered to be irreversible;

iv. A thorough explanation of the specific sterilization procedure to be performed;

v. A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;

vi. A full description of the benefits or advantages that may be expected as a result of the sterilization;

vii. Advice that the sterilization will not be performed for at least 30 days;

2. Suitable arrangements were made to insure that the information specified in paragraph 1 above was effectively communicated to any individual who is blind, deaf, or otherwise handicapped;

3. An interpreter was provided if the individual to be sterilized did not understand the language used on the approved consent form or the language used by the person obtaining consent;

4. The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained;

5. The consent form requirements were met.

i. Content of the consent form. The consent form must be an exact replica of the federal form.

ii. Required signatures. The consent form must be signed and dated by:

(1) The individual to be sterilized;

(2) The interpreter, if one was provided;

(3) The person who obtained the consent; and

(4) The physician who performed the sterilization procedure.

NOTE: A copy of the consent form must be given to the individual.

6. Any additional requirement of State or local law for obtaining consent, except a requirement for spousal consent, was followed.

i. Informed consent may not be obtained while the individual to be sterilized is:

(1) In labor or childbirth;

(2) Seeking to obtain or obtaining an abortion; or

(3) Under the influence of alcohol or other substances that affect the individual's state of awareness.

(d) Payments will be made for a hysterectomy when the completed Receipt of Hysterectomy Information Form (FD–189) is received by the Medicaid Contractor and the following requirements have been met:

1. A hysterectomy may not be performed solely for the purpose of rendering an individual permanently incapable of reproducing; or if there was more than one purpose to the procedure, would not be performed but

for the purpose of rendering the individual permanently incapable of reproducing.

2. A hysterectomy on a female of any age may be performed when medically necessary, provided that the person who secured authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will render the individual permanently incapable of reproducing; and the individual or a representative must have signed a written acknowledgement of receipt of that information.

3. In the event a Receipt of Hysterectomy Information Form (FD-189) was not obtained, it is possible to submit, with the claim form, a written certification signed by the physician who performed the hysterectomy. This written certification is applicable if, and only, one or more of the following conditions existed:

i. The patient was sterile before the hysterectomy and the physician lists the cause of sterility;

ii. The patient required a hysterectomy because of a life threatening emergency in which the physician determined that prior acknowledgement was not possible and the physician describes, in the certification, the nature of the emergency;

iii. The hysterectomy was performed during a period of the patient's retroactive New Jersey Medicaid coverage and the patient was informed, before the operation, that the hysterectomy would make her permanently incapable of reproducing or that one of the conditions described in (d)3i or ii above was applicable and the physician includes in the certification a statement that the patient was informed or describes which condition applied.

(1) Although a physician certification is acceptable for situations described in (d)3 of this section, the New Jersey Medicaid Program recommends that the Hysterectomy Receipt of Information Form be used whenever possible.

NOTE: There is no 30 day waiting period required before a medically necessary hysterectomy may be performed.

R.1975 d.205, eff. July 17, 1975.
See: 7 N.J.R. 212(b), 7 N.J.R. 364(c).
As amended, R.1975 d.373, eff. December 18, 1975.
See: 7 N.J.R. 506(a), 8 N.J.R. 38(a).
As amended, R.1979 d.63, eff. February 15, 1979.
See: 11 N.J.R. 133(b).
As amended, R.1983 d.55, eff. March 7, 1983.
See: 14 N.J.R. 1337(a), 15 N.J.R. 339(c).
Exceptions and additions for payments for hysterectomies.

10:54-1.21 (Reserved)

R.1975 d.228, eff. August 1, 1975.
See: 7 N.J.R. 315(c), 7 N.J.R. 430(b).
As amended, R.1976 d.336, eff. October 26, 1976.
See: 7 N.J.R. 505(a), 8 N.J.R. 558(b).
As amended, R.1981 d.249, eff. July 9, 1981.
See: 13 N.J.R. 293(a), 13 N.J.R. 417(a).
Incorporated billing procedures using HCFA-1500 claim form.
Repealed, R.1984 d.34, eff. February 21, 1984.
See: 15 N.J.R. 2129(a), 16 N.J.R. 371(a).

10:54-1.22 (Reserved)

R.1975 d.227 eff. August 1, 1975.
See: 7 N.J.R. 315(b), 7 N.J.R. 430(a).
As amended, R.1981 d.125, eff. May 7, 1981.
See: 13 N.J.R. 94(a), 13 N.J.R. 292(b).
(a) added: "who is a specialist".
(b) deleted: "routine diagnostic chest X-ray" and added "diagnostic chest X-ray".
As amended, R.1981 d.249, eff. July 9, 1981.
See: 13 N.J.R. 293(a), 13 N.J.R. 417(a).
Incorporated billing procedures using HCFA-1500 Claim Form.
Repealed R.1984 d.34, eff. February 21, 1984.
See: 15 N.J.R. 2129(a), 16 N.J.R. 371(a).

10:54-1.23 Medicaid reimbursement for abortions

(a) Effective May 1, 1980, Medicaid will pay for all medically necessary abortions.

(b) A physician may take the following factors into consideration in determining whether an abortion is medically necessary.

1. Physical, emotional, and psychological factors;

2. Family reasons;

3. Age.

(c) The determinations of medical necessity are subject to review by Medicaid in accordance with existing rules and regulations of the Medicaid Program. Effective May 1, 1980, reimbursement will be made to Medicaid participating providers for medically necessary abortions within the following guidelines:

1. Medically necessary abortions may be performed up to and during the 12th week of pregnancy in a licensed hospital, licensed physician's office or licensed independent abortion clinic.

2. Medically necessary abortions performed after the 12th week of pregnancy must be performed in a licensed hospital.

i. Exception: Termination of pregnancy using the dilation and evacuation procedure, within a period of gestation not exceeding 16 menstrual weeks and/or 14 gestational weeks size as determined by a physician, may be performed in a licensed independent abortion clinic approved for participation in the Medicaid Program.

3. A Physician Certification (Form FD-179, Rev. 4/80) must be attached to the physician's Medicaid claim form.

i. A copy of the completed FD-179 must also be attached to:

(1) The hospital's or independent clinic's Medicaid claim form as appropriate;

(2) The anesthesiologist's Medicaid claim form.

R.1979 d.245, effective June 15, 1979.
See: 11 N.J.R. 347(a).
As amended, R.1980 d.130, effective March 31, 1980.
See: 12 N.J.R. 119(c), 12 N.J.R. 277(a).
As amended, R.1980 d.264, effective June 18, 1980.
See: 12 N.J.R. 419(b).

SUBCHAPTER 2. BILLING PROCEDURES

10:54–2.1 General billing procedures

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

(b) This subchapter contains basic information necessary for the proper completion and submission of a claim.

As amended, R.1972 d.65, effective April 1, 1972.
See: 4 N.J.R. 46(d), 4 N.J.R. 103(b).
As amended, R.1981 d.250, effective July 9, 1981.
See: 13 N.J.R. 296(a), 13 N.J.R. 418(a).
(c): "on a . . . Exchange" added.
New Rule, R.1987 d.408, effective October 5, 1987.
See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).

10:54–2.2 Timeliness of claim submission and claim inquiry

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

As amended, R.1972 d.65, effective April 1, 1972.
See: 4 N.J.R. 46(d), 4 N.J.R. 103(b).
New Rule, R.1987 d.408, effective October 5, 1987.
See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).

10:54–2.3 Prior authorization

(a) Items or services requiring prior authorization should not be provided until the authorization is received. When submitting claims for payment make certain all authorizations have been properly signed and are attached.

(b) Prior authorization is no guarantee that an individual is eligible for services.

Amended by R.1987 d.408, effective October 5, 1987.
See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).
(b) added.

10:54–2.4 Combination Medicare/Medicaid claims

(a) There will be many patients who also have Medicare Supplementary Medical Insurance Benefits (Part B). In such cases the Health Insurance Claim Form (HCFA–1500) should be submitted to Medicare with the patient's Health Services Program Case/Person Number noted in item 8.

(b) In cases where prior authorization is required for the Health Services Program, it must be obtained and submitted with the Medicare claim.

As amended, R.1981 d.249, effective July 9, 1981.
See: 13 N.J.R. 293(a), 13 N.J.R. 417(a).
(a): Old text deleted, new text incorporating billing procedures using HCFA–1500 Claim Form substituted therefor.

10:54–2.5 Health Insurance Claim Form

(a) The physician must use the "Health Insurance Claim Form" (1500 N.J.) when submitting a claim for services provided.

(b) Any laboratory services provided by the physician or practitioner to his/her own patient in his/her own office should be billed on the Health Insurance Claim Form (1500 N.J.). However, every laboratory service provided by an independent laboratory must be billed directly to the Program by the laboratory and not by the physician or practitioner.

As amended, R.1981 d.249, eff. July 9, 1981.
See: 13 N.J.R. 293(a), 13 N.J.R. 417(a).
(a) and (b): Incorporated billing procedures using HCFA–1500 claim form.
Amended by R.1987 d.408, effective October 5, 1987.
See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).
Substituted new (a) for old.

10:54–2.6 Automated Data Exchange

(a) Any approved provider may request approval to submit claims for reimbursement via an approved method of Automated Data Exchange. All costs of rental/purchase of a terminal, installation, maintenance, and usage of telephone lines are the responsibility of the provider.

(b) Requests for approval must be submitted to the appropriate Contractor:

The Prudential Insurance Co.
P.O. Box 471
Millville, New Jersey 08332

OR

Blue Cross of New Jersey
33 Washington Street
Newark, New Jersey 07102

(c) Any provider approved for an Automated Data Exchange claim submission system must comply with all regulations and restrictions set forth by The New Jersey Medicaid Program.

(d) A random billing sample will be audited after a three month period. The review to compare data received via the Automated Data Exchange against the medical records will consist primarily of statement of charges, nature of services rendered, employment or accident related, other coverage, patient/provider signature, and verification that charges and procedure codes match services performed.

1. Subsequent audits will be scheduled at six-month intervals if the error rate is acceptable.

R.1981 d.250, eff. July 9, 1981.
See: 13 N.J.R. 296(a), 13 N.J.R. 418(a).

SUBCHAPTER 3. (RESERVED)

Historical Note

All provisions of this subchapter were filed on March 30, 1972, as R.1972 d.65 to become effective on April 1, 1972. See: 4 N.J.R. 46(d), 4 N.J.R. 103(b). Amendments were filed on July 19, 1976, as R.1976 d.218 to become effective on August 10, 1976. See: 8 N.J.R. 229(b), 8 N.J.R. 385(d). Further amendments which adopted a revised Procedure Code Manual were filed and became effective on June 4, 1979 as R.1979 d.218. See: 11 N.J.R. 17(a), 11 N.J.R. 346(a). Further amendments were adopted as R.1980 d.511, effective November 4, 1980. See: 12 N.J.R. 520(c), 13 N.J.R. 17(e). Amendments were further adopted as R.1981 d.475, effective December 21, 1981. See: 13 N.J.R. 578(d), 13 N.J.R. 946(b). Further amendments were adopted as R.1981 d.111, effective May 7, 1981. See: 13 N.J.R. 95(a), 13 N.J.R. 299(a). Further amendments were adopted as R.1981 d.211, effective July 9, 1981. See: 13 N.J.R. 223(a), 13 N.J.R. 418(c). Further amendments were adopted as R.1981 d.251, effective July 9, 1981. See: 13 N.J.R. 297(a), 13 N.J.R. 430(a). Further revisions to the Procedure Code Manual were filed as R.1981 d.305, effective September 10, 1981 (to become operative October 1, 1981). See: 13 N.J.R. 298(a), 13 N.J.R. 578(b). Further revisions were filed as R.1982 d.73, effective March 15, 1982 (operative April 1, 1982). See: 13 N.J.R. 292(a), 14 N.J.R. 278(c). Further revisions were filed as R.1981 d.314, eff. September 10, 1981, operative October 1, 1981. See: 13 N.J.R. 298(b), 13 N.J.R. 578(c). Further revisions were filed as R.1982 d.419, effective December 6, 1982. See: 14 N.J.R. 891(a), 14 N.J.R. 1394(a). Further revisions were filed as R.1982 d.459, effective December 20, 1982 (operative February 1, 1983). See: 14 N.J.R. 1143(a), 14 N.J.R. 1458(c). Further revisions were filed and became effective January 17, 1984 as R.1984 d.614. See: 15 N.J.R. 1730(a), 16 N.J.R. 144(a). This subchapter was readopted effective May 14, 1984 as R.1984 d.206. See: 16 N.J.R. 485(a), 16 N.J.R. 1349(a). Further amendments were filed and became effective October 17, 1984 as R.1984 d.457. See: 16 N.J.R. 1685(b), 16 N.J.R. 2813(a). Further revisions to the fee schedule became effective May 6, 1985 as R.1985 d.211. See: 17 N.J.R. 546(a), 17 N.J.R. 1094(a). Further revisions to the fee schedules became effective October 21, 1985 as R.1985 d.531. See: 17 N.J.R. 1371(a), 17 N.J.R. 2560(a). This subchapter "Procedure Code Manual" was repealed effective March 3, 1986 as R.1986 d.52. See: 17 N.J.R. 1519(b), 18 N.J.R. 478(a).

SUBCHAPTER 4. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

Authority

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

Source and Effective Date

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

Executive Order 66(1978) Expiration Date

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

Editor's Note: The Division of Medical Assistance and Health Services has adopted the HCPCS coding system for the majority of fee-for-service providers participating in the New Jersey Medicaid Program. The HCPCS will not be reproduced in the Code but may be obtained by contacting:

Administrative Practice Officer
Division of Medical Assistance & Health Services
Quakerbridge Plaza, Building No. 7
CN 712
Trenton, New Jersey 08625

or

Office of Administrative Law
Rules and Publications
Quakerbridge Plaza, Building No. 9
CN 301
Trenton, New Jersey 08625

Historical Note

Unless otherwise expressly noted, all provisions of this subchapter were adopted pursuant to authority of N.J.S.A. 30:4D–1 et seq. and were filed and became effective on August 1, 1975, as R.1975 d.231. See: 7 N.J.R. 327(a), 7 N.J.R. 431(c). Amendments which deleted this subchapter and incorporated the rules in this subchapter into the new Procedure Code Manual in N.J.A.C. 10:54–3.1 et seq. were filed and became effective on June 4, 1979, as R.1979 d.218. See: 11 N.J.R. 17(a), 11 N.J.R. 346(a). This subchapter was adopted effective March 3, 1986 as R.1986 d.52. See: 17 N.J.R. 1519(b), 18 N.J.R. 478(b). The procedure codes have been amended effective August 4, 1986 as R.1986 d.320. See: 18 N.J.R. 927(a), 18 N.J.R. 1593(b).

Public Notice: Pursuant to N.J.S.A. 30:4D–2, 3, 5, 6 and 7 and the New Jersey Appropriations Act (P.L. 1988 c.47), the maximum fee allowance increased for routine visit effective August 1, 1988 and May 1, 1989; Cytopathology smears, cervical or vaginal effective August 1, 1988 and May 1, 1989; house call, prolonged detention, newborn care (routine newborn care), newborn care (high risk vaginal delivery), newborn care (Caesarean section) effective August 1, 1988; Obstetrical services, consultation (limited and comprehensive) fees effective October 1, 1988, January 1, 1989 and April 1, 1989. See: 20 N.J.R. 2101(a). Administrative correction: Obstetrical Services should be $284.70 under NS not $284.00. See: 20 N.J.R. 2400(f). Procedure code added for Cytopathology, smears (88151), effective March 20, 1989 as R.1989 d.135. See 20 N.J.R. 2558(a), 21 N.J.R. 760(a). The procedure codes have been amended to change the references to the postpartum period from six weeks to 60 days, effective March 20, 1989 as R.1989 d.162. See: 20 N.J.R. 1052(a), 21 N.J.R. 761(a).

Subchapter 4, HCFA Common Procedure Coding System (HCPCS), expired on March 3, 1991, pursuant to Executive Order 66 (1978).

APPENDIX A

NEW JERSEY MEDICAID FORMULARY

SECTION I

TRADE NAME AND COMPANY	DESIGNATED CHEMICALLY EQUIVALENT NAME
ACHROMYCIN-V (LEDERLE)	TETRACYCLINE
ALPEN (LEDERLE)	AMPICILLIN
AMCILL (PARKE-DAVIS)	AMPICILLIN
AMNESTROGEN (SQUIBB)	ESTROGENS, ESTERIFIED
BENADRYL (PARKE-DAVIS)	DEPHENHYDRAMINE
BETAPEN VK (BRISTOL)	PENICILLIN-V POT.
BRISTACYCLINE (BRISTOL)	TETRACYCLINE
BRISTAMYCIN (BRISTOL)	ERYTHROMYCIN
CHLOR-PZ (USV)	CHLORPROMAZINE
CHLOR-TRIMETON (SCHERING)	CHLORPHENIRAMINE
COMPOCILLIN-VK (ABBOTT-ROSS)	PENICILLIN-V POT.
CONESTRON (WYETH)	ESTROGENS, CONJUGATED
COSEA (ALCON)	CHLORPHENIRAMINE
CYCLOPAR (PARKE-DAVIS)	TETRACYCLINE
DARVON (LILLY)	PROPOXYPHENE
DARVON COMPOUND-65 (LILLY)	PROPOXYPHENE COMPOUND-65
DOLENE (LEDERLE)	PROPOXYPHENE
DOLENE COMPOUND-65 (LEDERLE)	PROPOXYPHENE COMPOUND-65
DOWMYCIN-E (DOW)	ERYTHROMYCIN
DOXY-II (USV)	DOXYCYCLINE
EQUANIL (WYETH)	MEPROBAMATE
ERYPAR (PARKE-DAVIS)	ERYTHROMYCIN
ERYTHROCIN (ABBOTT)	ERYTHROMYCIN
ESIDRIX (CIBA)	HYDROCHLOROTHIAZIDE
ETHRIL (SQUIBB)	ERYTHROMYCIN
EVEX (SYNTEX)	ESTROGENS, ESTERIFIED
GANTRISIN (ROCHE)	SULFISOXAZOLE
HISTASPAN (USV)	CHLORPHENIRAMINE
HYDRODIURIL (MS&D)	HYDROCHLOROTHIAZINE
ILOSONE (DISTA)	ERYTHROMYCIN
IMAVATE (ROBINS)	IMIPRAMINE
JANIMINE (ABBOTT)	IMIPRAMINE
LEDERCILLIN VK (LEDERLE)	PENICILLIN-V POT.
MENEST (BEECHAM)	ESTROGENS, ESTERIFIED
MILTOWN (WALLACE)	MEPROBAMATE
OMNIPEN (WYETH)	AMPICILLIN
ORETIC (ABBOTT)	HYDROCHLOROTHIAZINE
OXLOPAR (PARKE-DAVIS)	OXYTETRACYCLINE
PANMYCIN (UPJOHN)	TETRACYCLINE
PEN-A (PFIZER)	AMPICILLIN
PENAPAR VK (PARKE-DAVIS)	PENICILLIN-V POT.
PENBRITIN (AYERST)	AMPICILLIN
PENSYN (UPJOHN)	AMPICILLIN
PENTIDS (SQUIBB)	PENICILLIN-G
PEN VEE K (WYETH)	PENICILLIN-V POT.
PFIZER-E (PFIZER)	ERYTHROMYCIN
PFIZERPEN (PFIZER)	PENICILLIN-G
PFIZERPEN VK (PFIZER)	PENICILLIN-V POT.
POLYCILLIN (BRISTOL)	AMPICILLIN
PREMARIN (AYERST)	ESTROGENS, CONJUGATED
PRESAMINE (USV)	IMIPRAMINE
PRINCIPEN (SQUIBB)	AMPICILLIN
PROMAPAR (PARKE-DAVIS)	CHLORPROMAZINE

TRADE NAME AND COMPANY	DESIGNATED CHEMICALLY EQUIVALENT NAME
QIDAMP (MALLINCRODT)	AMPICILLIN
QIDMYCIN (MALLINCRODT)	ERYTHROMYCIN
QIDPEN VK (MALLINCRODT)	PENICILLIN–V POT.
QIDTET (MALLINCRODT)	TETRACYCLINE
ROBICILLIN VK (ROBINS)	PENICILLIN–V POT.
ROBIMYCIN (ROBINS)	ERYTHROMYCIN
ROBITET (ROBINS)	TETRACYCLINE
SK–AMPICILLIN (SKF)	AMPICILLIN
SK–BAMATE (SKF)	MEPROBAMATE
SK–ERYTHROMYCIN (SKF)	ERYTHROMYCIN
SK–ESTROGENS (SKF)	ESTROGENS, ESTERIFIED
SK–PENICILLIN VK (SKF)	PENICILLIN–V POT.
SK–PRAMINE (SKF)	IMIPRAMINE
SK–SOXAZOLE (SKF)	SULFISOXAZOLE
SK–TETRACYCLINE (SKF)	TETRACYCLINE
SK–65 (SKF)	PROPOXYPHENE
SK–65 COMPOUND (SKF)	PROPOXYPHENE COMPOUND–65
SOXOMIDE (UPJOHN)	SULFISOXAZOLE
SULFALAR (PARKE–DAVIS)	SULFISOXAZOLE
SUMYCIN (SQUIBB)	TETRACYCLINE
TELDRIN (SKF)	CHLORPHENIRAMINE
TERRAMYCIN (PFIZER)	OXYTETRACYCLINE
TETRACYN (ROERIG)	TETRACYCLINE
TETREX (BRISTOL)	TETRACYCLINE
TETREX BID (BRISTOL)	TETRACYCLINE
TETREX–S (BRISTOL)	TETRACYCLINE
THIURETIC (PARKE–DAVIS)	HYDROCHLOROTHIAZIDE
THORAZINE (SKF)	CHLORPROMAZINE
TOFRANIL (GEIGY)	IMIPRAMINE
TOTACILLIN (BEECHAM)	AMPICILLIN
UTICILLIN VK (UPJOHN)	PENICILLIN–V POT.
V CILLIN–K (LILLY)	PENICILLIN–V POT.
VEETIDS (SQUIBB)	PENICILLIN–V POT.
VIBRAMYCIN (PFIZER)	DOXYCYCLINE

NEW JERSEY MEDICAID FORMULARY
SECTION II

DESIGNATED CHEMICAL EQUIVALENT DOSAGE FORM AND STRENGTH	ACCEPTED ALTERNATE PRODUCT NAME AND COMPANY
AMPICILLIN, CAPS 250MG	PEN–A (PFIZER)
AMPICILLIN, CAPS 500MG	PEN–A (PFIZER)
AMPICILLIN, SUSP 125MG 100CC	PEN–A (PFIZER)
AMPICILLIN, SUSP 125MG 200CC	PEN–A (PFIZER)
AMPICILLIN, SUSP 250MG 100CC	PEN–A (PFIZER)
AMPICILLIN, SUSP 250MG 200CC	PEN–A (PFIZER)
CHLORPHENIRAMINE SUST TABS/CAPS 8MG	CHLORPHENIRAMINE (LEDERLE)
CHLORPHENIRAMINE SUST TABS/CAPS 12MG	CHLORPHENIRAMINE (LEDERLE)
CHLORPROMAZINE TABS 10MG	CHLOR–PZ (USV) CHLORPROMAZINE (LEDERLE)
CHLORPROMAZINE TABS 25MG	CHLOR–PZ (USV) CHLORPROMAZINE (LEDERLE) CHLORPROMAZINE (ABBOTT)
CHLORPROMAZINE TABS 50MG	CHLOR–PZ (USV) CHLORPROMAZINE (LEDERLE) CHLORPROMAZINE (ABBOTT)
CHLORPROMAZINE TABS 100MG	CHLOR–PZ (USV) CHLORPROMAZINE (LEDERLE) CHLORPROMAZINE (ABBOTT)
CHLORPROMAZINE TABS 200MG	CHLOR–PZ (USV) CHLORPROMAZINE (LEDERLE) CHLORPROMAZINE (ABBOTT)
DIPHENHYDRAMINE CAPS 25MG	DIPHENHYDRAMINE (LEDERLE)
DIPHENHYDRAMINE CAPS 50MG	DIPHENHYDRAMINE (LEDERLE)

DOXYCYCLINE CAPS 50MG	DOXY-II (USV)
DOXYCYCLINE CAPS 100MG	DOXY-II (USV)
DOXYCYCLINE ORAL SUSP 25MG/5CC	DOXY-II (USV)
ERYTHROMYCIN TABS/CAPS 250MG	PFIZER-E (PFIZER)
ERYTHROMYCIN TABS/CAPS 500MG	PFIZER-E (PFIZER)
ESTROGENS, CONJ TABS 0.625MG	ESTROGENS, CONJUGATED (LEDERLE)
ESTROGENS, CONJ TABS 1.25MG	ESTROGENS, CONJUGATED (LEDERLE)
ESTROGENS, ESTERIFIED TABS 0.625MG	SK-ESTROGENS (SKF)
ESTROGENS, ESTERIFIED TABS 1.25MG	SK-ESTROGENS (SKF)
ESTROGENS, ESTERIFIED TABS 2.5MG	SK-ESTROGENS (SKF)
HYDROCHLOROTHIAZIDE TABS 50MG	ORETIC (ABBOTT) THIURETIC (PARKE-DAVIS)
IMIPRAMINE TABS 10MG	IMIPRAMINE (LEDERLE) SK-PRAMINE (SKF)
IMIPRAMINE TABS 25MG	IMIPRAMINE (LEDERLE) SK-PRAMINE (SKF)
IMIPRAMINE TABS 50MG	IMIPRAMINE (LEDERLE) JANIMINE (ABBOTT) SK-PRAMINE (SKF)
MEPROBAMATE TABS 200MG	SK-BAMATE (SKF)
MEPROBAMATE TABS 400MG	SK-BAMATE (SKF) MEPROBAMATE (LEDERLE)
OXYTETRACYCLINE CAPS 250MG	OXLOPAR (PARKE-DAVIS)
PENICILLIN-G TABS 200,000U	PFIZERPEN (PFIZER) PENICILLIN-G (WYETH)
PENICILLIN-G TABS 250,000U	PFIZERPEN (PFIZER) PENICILLIN-G (WYETH)
PENICILLIN-G TABS 400,000U	PFIZERPEN (PFIZER) PENICILLIN-G (WYETH)
PENICILLIN-G LIQ. 250MG 100CC	PFIZERPEN (PFIZER)
PENICILLIN-G LIQ. 250MG 200CC	PFIZERPEN (PFIZER)
PENICILLIN-V POT. TABS 125MG	COMPOCILLIN VK (ABBOTT-ROSS) V CILLIN-K (LILLY)
PENICILLIN-V POT. TABS 250MG	PFIZERPEN VK (PFIZER) QIDPEN K (MALLINCRODT) SK-PENICILLIN VK (SKF)
PENICILLIN-V POT. TABS 500MG	PFIZERPEN VK (PFIZER)
PENICILLIN-V POT. LIQ. 125MG 100CC	PFIZERPEN VK (PFIZER) QIDPEN VK (MALLINCRODT)
PENICILLIN-V POT. LIQ. 125MG 200CC	PFIZERPEN VK (PFIZER) QIDPEN VK (MALLINCRODT)
PENICILLIN-V POT. LIQ. 250MG 100CC	PFIZERPEN VK (PFIZER) QIDPEN VK (MALLINCRODT)
PENICILLIN-V POT. LIQ. 250MG 200CC	PFIZERPEN VK (PFIZER)
PROPOXYPHENE CAPS 65MG	SK-65 (SKF)
PROPOXYPHENE COMPD-65 CAPS	SK-65 COMPOUND (SKF)
SULFISOXAZOLE TABS	SK-SOXAZOLE (SKF) SULFISOXAZOLE (LEDERLE)
TETRACYCLINE CAPS/TABS 250MG	ROBITET (ROBINS) SK-TETRACYCLINE (SKF) TETRACYN (ROERIG) TETRACYCLINE (WYETH)
TETRACYCLINE CAPS/TABS 500MG	ROBITET (ROBINS) SK-TETRACYCLINE (SKF) TETRACYN (ROERIG) TETRACYCLINE (WYETH)
TETRACYCLINE SUSP 125MG 5CC	PANMYCIN (UPJOHN) ROBITET (ROBINS) SK-TETRACYCLINE (SKF)

R.1975 d.339, effective November 10, 1975.
See: 7 N.J.R. 316(a), 7 N.J.R. 567(c).