Department shall determine whether the amount of mitigation completed at the bank site is commensurate with the number of credits already sold. If the Department determines that the amount of mitigation completed is less than the number of credits already sold, the Department shall assert its rights to the financial assurance provided under N.J.A.C. 7:13-13.15(k) and (l).

7:13-13.21 Application for a mitigation bank

(a)-(b) (No change.)

(c) To obtain Department approval of a proposed mitigation bank, an applicant shall submit the information required by the riparian mitigation bank proposal checklist, available from the Department at the address set forth at N.J.A.C. 7:13-1.3. The checklist shall require the following:

1.-8. (No change.)

9. Performance standards to enable the Department to determine when credits may be released under N.J.A.C. 7:13-13.20(e);

10.-12. (No change.)

13. Financial assurance meeting the requirements of N.J.A.C. 7:13-13.15;

14.-18. (No change.)

(d) (No change.)

SUBCHAPTER 20. APPLICATION FEES

7:13-20.1 Application fees

(a)-(d) (No change.)

(e) The fees for applications under this chapter are set forth in Table 20.1 below:

Table 20.1
APPLICATION FEES

…

Additional application fee stormwater review if a project is a “major development” pursuant to Stormwater Management Rules (see N.J.A.C. 7:8-1.2)*[1]* *3*

	Fee
…	
Modification of previously reviewed stormwater calculations	Thirty percent of the original stormwater fee

[1] *3* The additional application fee for stormwater review set forth in this table shall not exceed $20,000.

(a)

SITE REMEDIATION AND WASTE MANAGEMENT PROGRAM

Notice of Readoption

Processing of Damage Claims Pursuant to the Sanitary Landfill Facility Closure and Contingency Fund Act

Readoption: N.J.A.C. 7:1I

Authorized By: Bob Martin, Commissioner, Department of Environmental Protection.

Authority: N.J.S.A. 13:1B-3, 13:1D-9, 13:1E-100 et seq. (particularly 13:1E-106 and 13:1E-114), and 58:10-23.11 et seq.

Effective Date: June 20, 2017.

New Expiration Date: June 20, 2024.

Take notice that pursuant to N.J.S.A. 52:14B-5.1, the Processing of Damage Claims Pursuant to the Sanitary Landfill Facility Closure and Contingency Fund Act rules at N.J.A.C. 7:1I were scheduled to expire on July 20, 2017. The Department of Environmental Protection (Department) has reviewed these rules and has determined that the rules should be readopted because they are necessary, reasonable, and proper for the purpose for which they were originally promulgated. In accordance with N.J.S.A. 52:14B-5.1.c(1), timely filing of this notice extended the expiration date of the chapter seven years from the date of filing.

N.J.A.C. 7:1I, Processing of Damage Claims Pursuant to the Sanitary Landfill Facility Closure and Contingency Fund Act, constitutes the rules of the Department concerning the processing of claims under the Sanitary Landfill Facility Closure and Contingency Fund Act, N.J.S.A. 13:1E-100 et seq., for damages resulting from the improper operation or closure of sanitary landfill facilities. The rules establish the Department’s procedures for review and decision making regarding such claims.

HUMAN SERVICES

(b)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Vision Care Services Manual

Readoption with Amendments: N.J.A.C. 10:62

Adopted Repeals: N.J.A.C. 10:62-1.6, 1.10, and 3.3

Proposed: December 5, 2016, at 48 N.J.R. 2574(a).

Adopted: February 27, 2017, by Elizabeth Connolly, Acting Commissioner, Department of Human Services.

Filed: April 18, 2017, as R.2017 d.096, **with non-substantial changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 30:4D-1 et seq., and 30:4J-8 et seq.

Agency Control Number: 16-A-06.

Effective Dates: April 18, 2017, Readoption;
July 17, 2017, Amendments and Repeals.

Expiration Date: April 18, 2024.

Summary of Public Comments and Agency Responses:

Comments were received from the New Jersey Society of Optometric Physicians, William J. Ference, OD, President.

1. COMMENT: Optometrists should be allowed to be credentialed and enroll as providers by the Medicaid/NJ FamilyCare program so that they can provide procedures and care for conditions discovered during a routine examination. Optometrists frequently complain that they are told by insurers that they are only authorized to provide services when seeing patients through a vision care plan, which often only allows the optometrist to provide a routine examination and not the procedures and care needed to treat a condition identified during the examination.

RESPONSE: This chapter addresses services reimbursed on a fee–for-service basis and optometrists are credentialed and can be separately reimbursed by the Medicaid/NJ FamilyCare program for services provided on a fee-for-service basis. Regarding the limitations faced by optometrists when providing services on other than a fee-for-service basis, the Department is aware that managed care organizations routinely contract with third-party organizations, such as vision care plans to provide full coordination of vision care services. However, these rules only address vision care services that are provided on a fee-for-service basis and not those services provided by a managed care organization. Therefore, no changes will be made upon adoption.

2. COMMENT: N.J.A.C. 10:62-1.2 and 1.16. Current regulations do not define low vision, while the New Jersey Commission for the Blind and Visually Impaired (CBVI) does have a definition for low vision. It may be helpful if we work from the same definition, which would then make the prior authorizations for some services unnecessary.

RESPONSE: The Department agrees that the Division of Medical Assistance and Health Services (DMAHS) should clarify that the same definition and criteria for low vision is used by both the DMAHS and

the CBVI. The definitions listed below are being added to N.J.A.C. 10:62-1.2 as part of the adoption. These definitions are consistent with how the term "low vision" is used by the eye care provider community and the definitions codified by CBVI at N.J.A.C. 10:94-1.2. DMAHS is using the same definitions as CBVI for the terms associated with low vision, that is, "low vision client, low vision follow-up examination, and low vision service," because the CBVI definitions accurately describe the clients and the services that are available. DMAHS agrees with the commenter that it would be helpful to them if both agencies used the same definition. Since both CBVI and DMAHS are agencies within the Department, the inclusion of the CBVI definitions in N.J.A.C. 10:62 are not considered so substantive as to require additional public notice and comment in accordance with N.J.A.C. 1:30-6.3. The Department considers the use of prior authorization is an important utilization management tool used by the Medicaid/NJ FamilyCare program, therefore, the requirements concerning prior authorization at N.J.A.C. 10:62-1.16 will remain in effect.

"Low vision" means reduced visual acuity and/or abnormal visual fields from a disorder in the visual system.

"Low vision client" means an individual with an eye disorder, which reduces visual performance and cannot be corrected by conventional methods.

"Low vision follow-up examination" means examinations provided to clients with aids, to monitor progress and problems.

"Low vision service" means a series of comprehensive tests, evaluations and multidisciplinary referrals provided for the low vision patient, which has as its objective a prescription of low vision aids and instruction/training programs to enhance the low vision patient's performance."

3. COMMENT: N.J.A.C. 10:62-3. The fee schedules between Medicaid services and services provided by the CBVI are not equal and may be in need of review.

RESPONSE: The fee schedule of the DMAHS was compared to the fee schedule of the CBVI and the DMAHS has determined that no adjustments will be made to the DMAHS fee schedule upon adoption.

4. COMMENT: N.J.A.C. 10:62-1.19. N.J.A.C. 10:62-1.19(d) limits clinical reimbursement for clinical laboratory services to an ophthalmologist. Optometrists can and do provide clinical laboratory tests/services and follow the same rules as other practitioners as required by the Department of Health. We request that the language be changed to include optometrists as part of the fee for services for independent clinical laboratory services.

RESPONSE: Clinical laboratory services rendered to Medicaid/NJ FamilyCare beneficiaries must be performed by independent clinical laboratories in accordance with N.J.A.C. 10:61, which, among other standards, requires that the facility meet the requirements of an independent clinical laboratory under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), or that the facility be deemed CLIA-exempt by a private, nonprofit accreditation organization or under an approved State laboratory program. In addition, the DMAHS reviewed N.J.A.C. 13:38, the New Jersey State Board of Optometrists rules, under which optometrists are licensed, and did not find any State rules that allow the provision of clinical laboratory services or CLIA-waived testing by State-licensed optometrists. Since the performance of laboratory services is not part of the scope of licensure for an optometrist under New Jersey licensing rules, DMAHS rules will not be amended to include CLIA-waived laboratory services performed by optometrists.

Federal Standards Statement

Federal law (sections 1902(a)10 and 1905(a) of the Social Security Act (the Act), 42 U.S.C. §§ 1396a(a)10 and 1396d(a) respectively), governing the Medicaid and NJ FamilyCare programs authorize a State Medicaid program, under Title XIX of the Act, to provide specific types of medical assistance, including physicians' services, eyeglasses, and prosthetic devices. Regulations at 42 CFR 440.50 and 440.120 also provide Federal requirements regarding physicians' services, eyeglasses, and prosthetics. Regulations at 42 CFR 441.30 provide Federal requirements regarding optometric services. The State Medicaid fee-for-service program covers vision care services and appliances to the extent described in N.J.A.C. 10:62.

Title XXI of the Act allows states to establish a State Children's Health Insurance Program for targeted low-income children. New Jersey elected this option through implementation of the NJ FamilyCare program. Section 2103 (42 U.S.C. § 1397cc) provides broad coverage guidelines for such programs. Section 2110 (42 U.S.C. § 1397jj) provides definitions of services for such programs. Within the general Federal guidelines, Title XXI anticipates that a state will implement policies and procedures to establish such a program.

The Department has reviewed the Federal statutory and regulatory requirements and has determined that the readopted rules, the adopted amendments, and the repeals do not exceed Federal standards. Therefore, a Federal standards analysis is not required.

Full text of the readopted rules can be found in the New Jersey Administrative Code at N.J.A.C. 10:62.

Full text of the adopted amendments follows (additions to proposal indicated in boldface with asterisks ***thus***):

SUBCHAPTER 1. EYE CARE: PROFESSIONAL SERVICES

10:62-1.1 Scope

This subchapter delineates the New Jersey Medicaid/NJ FamilyCare fee-for-service programs' standards for examinations and care for vision defects and/or eye diseases for the purpose of maintaining or improving the health of New Jersey Medicaid/NJ FamilyCare fee-for-service beneficiaries.

10:62-1.2 Definitions

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

"Clinical laboratory services" means professional and technical laboratory services performed by a clinical laboratory certified by CMS in accordance with the Federal Clinical Laboratory Improvement Act (CLIA), 42 U.S.C. § 263a and ordered by a physician or other licensed practitioner, within the scope of his or her practice, as defined by the laws of the State of New Jersey and/or of the state in which the practitioner practices.

"CMS" means the Federal Centers for Medicare and Medicaid Services.

***"Low vision" means reduced visual acuity and/or abnormal visual fields from a disorder in the visual system.**

"Low vision client" means an individual with an eye disorder, which reduces visual performance and cannot be corrected by conventional methods.

"Low vision follow-up examination" means examinations provided to clients with aids, to monitor progress and problems.

"Low vision service" means a series of comprehensive tests, evaluations, and multidisciplinary referrals provided for the low vision patient, which has as its objective a prescription of low vision aids and instruction/training programs to enhance the low vision patient's performance.*

"Ophthalmologist" means a fully licensed medical doctor who has been recognized by the New Jersey Medicaid/NJ FamilyCare fee-for-service programs as a specialist in ophthalmology.

. . .

10:62-1.3 Providers of professional services

(a) Within the restrictions of their respective licensure, the following are eligible providers of eye care upon fulfilling the Enrollment Process requirements in N.J.A.C. 10:49-3.2:

1.-2. (No change.)

3. Independent clinics approved by the New Jersey Medicaid/NJ FamilyCare fee-for-service programs to render eye care services; and

4. Hospitals meeting the definition of "hospital" at N.J.A.C. 10:52-1.2.

10:62-1.4 Covered services

Professional services include office visits for evaluation and management, comprehensive eye examinations, low vision examinations, low vision work-ups, vision training work-ups, vision

training program visits as well as other specific procedures as listed at N.J.A.C. 10:62-3.2. Payment is made subject to the limitations specified under each type of service. In order to determine whether a service requires prior authorization, and for details regarding such prior authorization of services, see N.J.A.C. 10:62-1.16.

10:62-1.5 Comprehensive eye examination

(a) A comprehensive eye examination may include cycloplegics and a post cycloplegic visit. All findings and data, including positive and negative, shall be clearly recorded. A comprehensive eye examination shall include the following, as a minimum, where possible unless contraindicated:

1.-3. (No change.)

4. Refraction, objective and subjective;

5. Extra-ocular measurement;

6. Gross visual fields, central and peripheral;

7. Tonometry when indicated for patients under 35; tonometry is mandatory for all patients over 35. The specific method used should be identified and recorded; the finger palpation test is not acceptable;

8. (No change.)

9. The diagnosis, including, but not limited to, ocular deficiency or deformity, visual or muscular anomaly; and

10. (No change.)

(b) (No change.)

10:62-1.6 (Reserved)

10:62-1.7 Low vision work-up

For purposes of the New Jersey Medicaid/NJ FamilyCare fee-for-service programs, a low vision work-up consists of certain testing techniques and procedures to determine what optical aids and devices can be prescribed for an individual to increase range of vision. A low vision work-up requires a written report and is much more detailed than the low vision examination that follows a complete comprehensive examination.

10:62-1.8 Vision training program

(a) For purposes of the New Jersey Medicaid/NJ FamilyCare fee-for-service programs, vision training is the use of certain procedures and modalities for the development of and/or increase in the vision capacity of the eye(s) with poor and/or inconsistent or distorted vision localization.

(b) (No change.)

(c) If vision training is required following the initial comprehensive eye examination, the practitioner shall submit a written request (form FD-358) to the Vision Care Unit for prior authorization pursuant to N.J.A.C. 10:62-1.16 for a vision training work-up. This request shall include the preliminary findings, detailed reason(s) why it is believed a further evaluation is needed, and any history of previous vision training with the dates and the results. Upon receiving approval for a vision training work-up, the practitioner shall then submit, within 30 days of receipt of authorization, the work-up report to the Vision Care Unit. The vision training work-up report shall consist of, but not be limited to:

1.-6. (No change.)

(d)-(e) (No change.)

(f) Vision training may be provided by a practitioner when found medically necessary. This service can be performed in the office or in an independent clinic approved by the New Jersey Medicaid/NJ FamilyCare fee-for-service programs.

10:62-1.9 Office visits

(a) (No change.)

(b) When multiple special ophthalmological services or ophthalmoscopic services are billed on the same day for the same patient in an office setting, reimbursement shall be limited to the highest valued procedure.

(c) When the setting for the initial visit is an office or residential health care facility, for reimbursement purposes it is limited to a single visit. Future use of this category of codes shall be denied when the beneficiary is seen by the same physician, group of physicians, or shared health care facility as defined at N.J.A.C. 10:49-4.1.

(d) (No change in text.)

10:62-1.10 (Reserved)

10:62-1.11 Emergency room visits

(a) When a physician sees the patient in the emergency room instead of the practitioner's office, the physician shall use the same HCPCS for the visit that would have been used if seen in the physician's office: 99211, 99212, 99213, 99214 or 99215 only. Records of that visit shall become part of the notes in the office chart.

(b) When patients are seen by hospital-based emergency room physicians who are eligible to bill the New Jersey Medicaid/NJ FamilyCare fee-for-service programs, then the appropriate HCPCS shall be used. The "Visit" codes are limited to 99281, 99282, 99283, 99284, and 99285.

10:62-1.12 Inpatient hospital services

(a) To qualify as documentation that the service was rendered by the practitioner during an inpatient stay, the beneficiary's medical record must contain the practitioner's notes indicating that the practitioner personally:

1.-3. (No change.)

4. Visited and examined the beneficiary on each date of service for which a claim for reimbursement is made.

(b)-(c) (No change.)

10:62-1.13 Consultations

(a) A consultation shall be eligible for reimbursement only when the consultation has been performed by a specialist recognized as such by the Medicaid/NJ FamilyCare programs, the request has been made by or through the patient's attending physician, and the need for such a request would be consistent with good medical practice. Two types of consultation shall be eligible for reimbursement: comprehensive consultation and limited consultation.

(b) (No change.)

(c) In addition to the recordkeeping requirements of N.J.A.C. 10:62-1.21, reimbursement for HCPCS 99244, 99245, 99274, and 99275, related to the provision of a comprehensive consultation, requires that the applicable statements listed below, or language essentially similar to those statements, be inserted in the "remarks" section of the claim form. The claim form shall be signed by the provider who performed the consultation.

1. (No change.)

(d) The following provisions regarding consultations shall also apply:

1. If a consultation is performed in an inpatient or outpatient setting and the patient is then transferred to the consultant's service during that course of illness, the provider shall not bill for an Initial Visit in addition to billing for the consultation.

2.-4. (No change.)

5. If a prior claim for a comprehensive consultation visit has been made within the preceding 12 months, then a repeat claim for this code shall be denied if made by the same physician, physician group, shared health care facility or physicians using a common record except in those instances where the consultation required the utilization of one hour or more of the physician's personal time. Otherwise, applicable codes would be Limited Consultation codes if their criteria are met.

(e) For reimbursement purposes, HCPCS 99241, 99242, 99243, 99251, 99252, 99253, 99271, 99272, and 99273 are considered "limited" because the consultation requires less than the requirements designated as "comprehensive" as noted in (c) above.

(f) (No change.)

10:62-1.14 Home services

(a) The home visit HCPCS 99343 and 99353 shall not apply to residential health care facility or nursing facility settings. These HCPCS refer to a physician visit limited to the provision of medical care to an individual who would be too ill to go to a physician's office and/or is "home bound" due to his or her physical condition. When billing for a second or subsequent patient treated during the same visit, the visit shall be billed as a home visit.

(b) For purposes of New Jersey Medicaid/NJ FamilyCare fee-for-service reimbursement, HCPCS 99341, 99342, 99351, and 99352 apply when the provider visits a New Jersey Medicaid/NJ FamilyCare fee-for-

service beneficiary in the home setting and the visit does not meet the criteria specified for a home visit in (a) above.

(c) In addition to the recordkeeping requirements indicated in N.J.A.C. 10:62-1.21, the record and documentation of a home visit shall become part of the office progress notes and shall include, as appropriate, the following information:

1.-6. (No change.)

10:62-1.16 Professional services requiring prior authorization

(a) (No change.)

(b) Items requiring prior authorization should not be provided to the New Jersey Medicaid/NJ FamilyCare fee-for-service beneficiary until the authorization is received by the provider from the fiscal agent.

(c) (No change.)

(d) Vision care provider services rendered to New Jersey Medicaid/NJ FamilyCare fee-for-service beneficiaries who are enrolled in a managed care organization (MCO) that includes these services in its benefits package must be prior authorized by the MCO/primary care provider. The Fiscal Agent Billing Supplement contains details regarding obtaining prior authorization.

(e) (No change.)

10:62-1.17 Prescription policies

(a) Upon request, a beneficiary must be provided with his or her prescription for an optical appliance. The following information shall be indicated on the prescription: name, address, New Jersey Medicaid/NJ FamilyCare fee-for-service Identification Number, date of examination, and diagnosis code(s).

(b) (No change.)

10:62-1.18 Prescribing medications

(a) All covered pharmaceutical services provided by licensed professionals of vision care services under the New Jersey Medicaid/NJ FamilyCare fee-for-service programs shall be prescribed in accordance with the scope of their practice.

(b) (No change.)

10:62-1.19 Clinical laboratory services

(a) (Reserved)

(b) Clinical laboratory services are furnished by clinical laboratories and by physician office laboratories (POLs) that meet the CMS regulations pertaining to clinical laboratory services defined in the Clinical Laboratory Improvement Amendments (CLIA) of 1988, section 1902(a)(9) of the Social Security Act, 42 U.S.C. § 1396a(a)(9), and as indicated at N.J.A.C. 10:61-1.2, the New Jersey Medicaid/NJ FamilyCare fee-for-service programs' Independent Clinical Laboratory Services manual and N.J.A.C. 8:44 and 8:45.

(c) All independent clinical laboratories and other entities performing clinical laboratory testing shall possess certification as required by CLIA 1988, and the New Jersey Department of Health rules found in N.J.A.C. 8:44 and 8:45.

(d) An ophthalmologist may claim reimbursement for clinical laboratory services performed for the practitioner's own patients within the practitioner's office, subject to the following:

1. An ophthalmologist shall meet the conditions of the CLIA regulations before he or she may perform clinical laboratory testing for New Jersey Medicaid/NJ FamilyCare fee-for-service beneficiaries; and

2. (No change.)

(e) (No change.)

(f) When the ophthalmologist refers a laboratory test to an independent clinical reference laboratory:

1. (No change.)

2. The clinical laboratory shall be licensed by the New Jersey Department of Health as described above at (b) and (c), or by the comparable agency in the state in which the laboratory is located;

3. The clinical laboratory shall be approved for participation as an independent laboratory provider by the New Jersey Medicaid/NJ FamilyCare fee-for-service programs in accordance with (b) above; and

4. Independent clinical laboratories shall bill the New Jersey Medicaid/NJ FamilyCare fee-for-service programs for all reference laboratory work performed on their premises. The ophthalmologist shall not be reimbursed for laboratory work performed by a reference laboratory.

10:62-1.20 Personal contribution to care requirements for NJ FamilyCare–Plan C and copayments for NJ FamilyCare–Plan D

(a) (No change.)

(b) Personal contribution to care for NJ FamilyCare–Plan C services is $5.00 per visit for office visits, except when the service is provided for preventive care.

1. An office visit is defined as a face-to-face contact with a vision care professional that meets the documentation requirements in this subchapter and N.J.A.C. 10:62-3.

2. Office visits include eye care professional services provided in the office, patient's home, or any other site, excluding hospital, where the child may have been examined by the vision care professional. Generally, these procedure codes are set forth in N.J.A.C. 10:62-3.2.

(c) Vision care professionals shall not charge a personal contribution to care for services provided to newborns who are covered under fee-for-service for Plan C; or for preventive services.

(d)-(e) (No change.)

(f) Vision care professionals shall not charge a copayment for services provided to newborns who are covered under fee-for-service for Plan D.

10:62-1.21 Recordkeeping policies

(a) Providers shall keep such 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. Data shall include such quantitative positive and negative findings as will be meaningful in a subsequent review. Check marks are not acceptable. The information shall be readily available to representatives of the New Jersey Medicaid/NJ FamilyCare fee-for-service programs, or their agents, as required.

(b) (No change.)

10:62-1.22 Reimbursement policies

(a) (No change.)

(b) Vision care services shall be identified by means of procedure codes, utilizing the CMS Healthcare Common Procedure Coding System (HCPCS). The codes and maximum fee allowance schedule are listed in N.J.A.C. 10:62-3.

(c) The provider shall use the practitioner's usual and customary charge when submitting a claim for vision care services. Reimbursement for covered services furnished under the New Jersey Medicaid/NJ FamilyCare fee-for-service programs shall be made on the basis of the provider's customary charge, not to exceed an allowance determined to be reasonable by the Commissioner of the Department of Human Services, and further limited by Federal policy (42 CFR 447 Subpart B) relative to payment of practitioners and other individual providers.

1. In no event shall the charge to the New Jersey Medicaid/NJ FamilyCare fee-for-service programs exceed the charge by the provider for identical services to other governmental agencies, private nonprofit agencies, trade unions or other individuals in the community.

2.-3. (No change.)

(d) (No change.)

SUBCHAPTER 2. OPTICAL APPLIANCES AND SERVICES

10:62-2.3 Providers of optical appliances and other services

(a) Within the restrictions of their respective licensure, the following are eligible providers upon fulfilling the Enrollment Process requirements in N.J.A.C. 10:49-3.2:

1.-4. (No change.)

5. Independent clinics approved by the New Jersey Medicaid/NJ FamilyCare fee-for-service programs to render eye care services;

6. Hospitals approved by the New Jersey Medicaid/NJ FamilyCare fee-for-service programs for participation; and

7. (No change.)

10:62-2.4 Covered optical appliances and related services

(a) The following optical appliances and related services are covered under the New Jersey Medicaid/NJ FamilyCare fee-for-service programs. In order to determine whether an optical appliance or related service requires prior authorization, and for details regarding such prior authorization, see N.J.A.C. 10:62-2.5.

1.-2. (No change.)

3. Repairs of optical appliances;

4. Artificial eyes may be provided once every three years when prescribed by an ophthalmologist or an optometrist;

5. Low vision devices;

6. Vision training devices;

7. Replacement of optical appliances:

i.-iv. (No change.)

v. Contact lenses will be provided once every two years for persons age 19 through and including 59 years of age, and once a year for persons up to age 19 or 60 years of age and older.

(1) Replacement of a contact lens in less than the timeframes in this subparagraph is allowed only if there is a need for a change in the fit or design of the lens or if there has been a prescription change of 0.50 diopter in spherical or astigmatic power. The need for a replacement due to a change in the fit or design of the lens shall be determined by the vision care professional based on an examination of the patient.

8. Dual pairs of glasses instead of multifocal;

9. Contact lenses;

10. Polycarbonated or ultraviolet filter lenses, when recommended by the prescribing practitioner as medically necessary;

11. Intraocular lenses; and

12. Protective prescription eyewear that is needed by a specific child beneficiary because it is required pursuant to N.J.S.A. 5:18-1 while the child participates in sports.

10:62-2.5 Optical appliances and related services requiring prior authorization

(a)-(b) (No change.)

(c) Authorization becomes invalid upon termination of eligibility for the New Jersey Medicaid/NJ FamilyCare fee-for-service programs, except when the termination occurs between the time the optical appliance is ordered and the time the optical appliance is dispensed. (Note: The provider shall use the date the optical appliance is ordered as the date of service when this situation occurs.)

(d) The following optical appliances require prior authorization:

1.-3. (No change.)

4. Replacement of optical appliances;

i. In circumstances not covered in N.J.A.C. 10:62-2.4, the replacement of an optical appliance requires prior authorization. For example: If lost, broken and irreparable, stolen or a prescription change is less than 0.50 diopter or five degrees in axis.

5. (No change.)

6. Optical tints;

7.-9. (No change.)

10. Intraocular lenses implantations if for more than two implantation procedures per beneficiary per lifetime;

11. Replacement of a contact lens within two years;

12. Protective prescription eyewear; and

13. All other optical appliance items requiring additional charges or not identified in N.J.A.C. 10:62-3.4.

(e) Optical appliance services rendered to New Jersey Medicaid/NJ FamilyCare fee-for-service beneficiaries who are enrolled in an MCO that includes these services in its benefits package must be prior authorized by the MCO/primary care provider. The Fiscal Agent Billing Supplement contains details regarding obtaining prior authorization.

10:62-2.6 Standards and policies regarding lenses

(a) Lenses shall be first quality ophthalmic lenses meeting the requirements published by American National Standard Institute (available from the American National Standards Institute, 25 W. 43rd St, 4th floor, New York, NY 10036, tel. 212-642-4900, website https://www.ansi.org/.

(b) Lenses shall meet impact resistant standards as set forth in the United States Food and Drug Administration regulations at 21 CFR 801.410.

(c)-(d) (No change.)

(e) (Reserved)

(f) Contact lenses may be provided for:

1. Specific ocular pathological conditions including, but not limited to, Keratoconus, monocular surgical aphakia to effect binocular vision, anisometropia of 3.0 diopters or more; and

2. Patients whose vision cannot be improved to at least 20/70 with regular lenses but improvement of vision can be accomplished to 20/70 or better.

(g) (No change.)

(h) (Reserved)

(i) (Reserved)

(j)-(k) (No change.)

(l) The following are not covered under the New Jersey Medicaid/NJ FamilyCare fee-for-service programs:

1. (No change.)

Recodify existing 3-4. as 2.-3. (No change in text.)

4. Rimless lenses; and

5. Temporary glasses.

10:62-2.7 Standards and policies regarding frames

(a) Plastic, nonflammable frames acceptable to the New Jersey Medicaid/NJ FamilyCare fee-for-service programs shall meet the following minimum criteria:

1.-6. (No change.)

(b) Wire-metal frames are not covered under the New Jersey Medicaid/NJ FamilyCare fee-for-service programs.

10:62-2.8 Standards regarding guarantee/warranty

All rights, benefits, and services applicable to a private paying patient shall apply to the same extent to the New Jersey Medicaid/NJ FamilyCare fee-for-service beneficiary.

10:62-2.10 Approved fabricating laboratory

(a) For purposes of the New Jersey Medicaid/NJ FamilyCare fee-for-service programs, an approved fabricating laboratory shall have the necessary equipment, licensed personnel and capability to completely surface and finish new optical glass or plastic lenses or partially finished lenses.

(b) The laboratory shall be able to provide all services necessary to completely furnish eyeglasses as may be requested by an optical dispenser and is subject to approval by the New Jersey Medicaid/NJ FamilyCare fee-for-service programs. A provider may call the Provider Services hotline at 1-800-776-6334 to ascertain if a laboratory is New Jersey Medicaid/NJ FamilyCare fee-for-service-approved.

10:62-2.11 Recordkeeping policies

(a) Providers shall keep such 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, which are subject to post audit review. Such information shall be readily available to the representatives of the New Jersey Medicaid/NJ FamilyCare fee-for-service programs or their agents as required.

(b) The records as required by (a) above shall include the following:

1.-2. (No change.)

3. New Jersey Medicaid/NJ FamilyCare fee-for-service identification number;

4.-8. (No change.)

(c) (No change.)

10:62-2.12 Reimbursement policy

(a) (No change.)

(b) Optical appliances must be identified by means of procedure codes, utilizing the CMS Healthcare Common Procedure Coding System (HCPCS). The codes and maximum fee allowance schedule are listed in N.J.A.C. 10:62-3.

(c) The reimbursement policy of the New Jersey Medicaid/NJ FamilyCare fee-for-service programs provides for payment to the provider of the actual invoice cost of the optical appliance plus a

dispensing fee. Providers are requested to indicate the actual invoice cost of the material when submitting a claim. Actual invoice cost is defined as the net amount paid by the provider, reflecting all discounts or special purchase agreements. The service (dispensing) fee, to which the provider is entitled, should be indicated as a separate item.

(d) The maximum allowable reimbursement for frames is not to exceed an allowance determined to be reasonable by the Commissioner, Department of Human Services. However, providers shall only bill the New Jersey Medicaid/NJ FamilyCare fee-for-service programs for the actual invoice cost of the frame when submitting a claim for payment. Actual invoice cost is defined as the net amount paid by the provider, reflecting all discounts or special purchase agreements. Frames are reimbursable only if they meet the criteria listed in N.J.A.C. 10:62-2.7.

(e) Optical appliances are reimbursable under the New Jersey Medicaid/NJ FamilyCare fee-for-service programs only when prescribed by a provider of professional eye services described in N.J.A.C. 10:62-1.3.

(f) Non-physician services and equipment/supplies furnished to hospital inpatients by outside providers shall not be billed directly to the New Jersey Medicaid/NJ FamilyCare fee-for-service programs. Providers shall submit a bill/invoice to the hospital for payment.

(g) (No change.)

(h) Reimbursement by the New Jersey Medicaid/NJ FamilyCare fee-for-service programs shall be made for covered services provided to eligible beneficiaries only.

SUBCHAPTER 3. HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:62-3.1 Introduction

(a) The New Jersey Medicaid/NJ FamilyCare fee-for-service programs utilize the CMS Healthcare Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology (CPT) architecture, employing a five-position code and as many as two 2-position modifiers. Unlike the CPT numeric design, the CMS assigned codes and modifiers contain alphabetic characters. HCPCS is a two-level coding system.

1.-2. (No change.)

(b) (No change.)

(c) The responsibility of the provider when rendering professional services and requesting reimbursement is listed in N.J.A.C. 10:62-1, Reimbursement Policies; for optical appliances, N.J.A.C. 10:62-2, Reimbursement Policies.

1. (No change.)

2. The use of a HCPCS procedure code will be interpreted by the New Jersey Medicaid/NJ FamilyCare fee-for-service programs as evidence that the practitioner personally furnished, at a minimum, the service which the code represents.

3.-4. (No change.)

5. When submitting a claim, the practitioner shall always use the practitioner's usual and customary fee. The New Jersey Medicaid/NJ FamilyCare fee-for-service dollar value designated for the HCPCS procedure codes represents the New Jersey Medicaid/NJ FamilyCare fee-for-service programs' maximum payment for the given procedure.

i. (No change.)

(d) (No change.)

(e) Regarding alphabetic and numeric symbols under "IND" and "MOD", these symbols when listed under the "IND" and "MOD" columns are elements of the HCPCS coding system used as qualifiers or indicators (as in the "IND" column) and as modifiers (as in the "MOD" column). They assist the provider in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

1. These symbols and letters must not be ignored because, in certain instances, requirements are created in addition to the narrative that accompanies the HCPCS procedure code as written in CPT. The provider must be careful to enter the additional requirements, and not just the HCPCS procedure code narrative. These requirements must be fulfilled in order to receive reimbursement.

2. (No change.)

(f) (No change.)

10:62-3.3 (Reserved)

10:62-3.4 Qualifier for professional vision care services

(a) Qualifiers for professional vision care services are summarized below:

HCPCS Codes	Procedure
1.-2. (No change.)	
3. INDEPENDENT OFFICE PROCEDURES	
92020	Independent Office Procedures—HCPCS
92065	92020, 92065, 92081, 92082, 92083, 92100,
92081	92120, 92130, 92140, 92260,
92082	shall not be reimbursable
92083	when performed on the same day as HCPCS
92100	92002, 92004, 92012 or 92014.
92120	
92130	
92140	
92260	
4.-9. (No change.)	

APPENDIX A

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is filed as an incorporated Appendix of this chapter/manual but is not reproduced in the New Jersey Administrative Code. The Fiscal Agent Billing Supplement can be downloaded free of charge at www.njmmis.com. When revisions are made to the Fiscal Agent Billing Supplement, a revised version will be placed on the website and copies will be filed with the Office of Administrative Law. If you do not have access to the internet and require a copy of the Fiscal Agent Billing Supplement, write to:

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