

**HUMAN SERVICES**

**DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES**

**Hospital Services Manual**

**Physician Services**

**Advanced Practice Nurse Services**

**Independent Clinic Services**

**New Jersey Care. . . Special Medicaid Programs**

**Use of International Classification of Diseases 10th Revision**

**Proposed Amendments: N.J.A.C. 10:52-14.16; 10:54-5.33, 5.34, 7.10, and 9.8;  
10:58A-1.2 and 2.9; 10:66-6.4; and 10:72-3.10**

Authorized By: Elizabeth Connolly, Acting Commissioner, Department of Human Services.

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

Calendar Reference: See Summary below for explanation of exception to rulemaking calendar requirements.

Agency Control Number: 14-P-01

Proposal Number: PRN 2015-103.

Submit comments by October 19, 2015, to:

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The agency proposal follows:

### **Summary**

The Department is proposing amendments to N.J.A.C. 10:52, the Hospital Services Manual; 10:54, Physician Services; 10:58A, Advanced Practice Nurse Services; 10:66, Independent Clinic Services; and 10:72, New Jersey Care ... Special Medicaid Programs, in order to comply with Federal requirements at 45 CFR 160.103, 162.100, and 162.1002(c). The proposed amendments would, for Medicaid services provided on or after October 1, 2015, modify existing rules regarding the standard medical data code sets (code sets) used for coding diagnoses and inpatient hospital procedures by requiring use of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) for diagnosis coding, including the Official ICD–10–CM Guidelines for Coding and Reporting, as maintained and distributed by the U.S. Department of Health and Human Services (HHS), and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD–10–PCS) for inpatient hospital procedure coding, including the Official ICD–10–PCS Guidelines for Coding and Reporting, as maintained and distributed by HHS (collectively “ICD-10”). The new

code sets will replace the International Classification of Diseases, 9th Revision, Clinical Modification, Volumes 1 and 2, including the Official ICD–9–CM Guidelines for Coding and Reporting (ICD–9–CM Volumes 1 and 2), and the International Classification of Diseases, 9th Revision, Clinical Modification, Volume 3, including the Official ICD–9–CM Guidelines for Coding and Reporting.

At N.J.A.C. 10:52-14.16; 10:54-5.33, 5.34, and 7.10; and 10:58A-1.2 and 2.9, proposed amendments specify that the ICD-9-CM code set is to be used prior to October 1, 2015, and that on or after October 1, 2015, that the ICD-10-CM code set shall be used. Billing instructions are also provided in the case of a claim that has dates in both timeframes.

At N.J.A.C. 10:54-9.8(c) and 10:66-6.4(a)2i(3), the ICD codes related to the treatment of exudative senile macular degeneration are being updated.

At N.J.A.C. 10:72-3.10(b)1, the ICD codes related to the primary diagnosis qualifying a woman for limited prenatal care are being updated.

Federal regulations at 45 CFR 160.103, 162.100, and 162.1002 require state Medicaid programs and their providers to use the above described ICD-10 standards as of October 1, 2015.

Additionally, new N.J.A.C. 10:52-14.16(a)1 is proposed regarding payment for readmissions to hospitals and would state that, in the event that one claim has a date of service prior to October 1, 2015, and another claim has a date of service on or after October 1, 2015, the principal diagnosis reported on the first claim as an International Classification of Diseases, 9th Revision, with Clinical Modifications (ICD-9-CM) diagnosis code, is compared to the principal diagnosis reported on the other claim as an

International Classification of Diseases, 10th Revision, with Clinical Modifications ICD-10-CM diagnosis code, using the Centers for Medicare and Medicaid Services (CMS) General Equivalency Mapping (GEM) criteria, 2014 Version, which is incorporated by reference, as amended and supplemented. It would also provide a website address at which information regarding the CMS GEM can be found. The GEM is a practical, code-to-code translation reference for the ICD-9-CM and ICD-10 code sets, which contains translation alternatives between those two code sets. For each code set, the GEM takes the complete meaning of a code in the old code set, ICD-9-CM, as a single unit and identifies the most appropriate translation(s) to the correct new code set, ICE-10-CM or ICD-10-PCS, for that specific procedure.

The Department has provided a comment period of at least a 60 days on this notice of proposal, therefore, this notice is excepted from the rulemaking calendar requirement pursuant to N.J.A.C. 1:30-3.3(a)5.

### **Social Impact**

The proposed amendments will have no social impact on the Medicaid/NJ FamilyCare beneficiaries. The amendments address only the billing procedures of health care providers and do not affect beneficiary access to services or change eligibility requirements.

Providers will not experience any social impact as a result of this rulemaking because they are required to use the new ICD-10 codes under the Federal regulations that necessitate these proposed amendments.

### **Economic Impact**

The proposed amendments will have no economic impact on Medicaid/NJ FamilyCare beneficiaries. The amendments address only the billing procedures of the providers and do not affect beneficiary access to services or change eligibility requirements.

Providers will not experience any economic impact as a result of this rulemaking because they are required to use the new ICD-10 codes under the Federal regulations that necessitate these proposed amendments.

### **Federal Standards Statement**

42 U.S.C. § 1320d-2(c) authorizes the establishment of Federally required code sets for use in various health care related contexts. Federal regulations at 45 CFR 162.1002 establish those code sets. Federal regulations at 45 CFR 160.103, 162.100, and 162.1002 require state Medicaid programs and their providers to use ICD-10 standards as of October 1, 2015.

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

### **Jobs Impact**

Since the proposed amendments update the medical data code sets used by Medicaid providers, and those code sets will be required under Federal regulations, the

Department anticipates that the proposed rulemaking will have no impact on the creation or loss of jobs in the State of New Jersey.

### **Agriculture Industry Impact**

Since the proposed amendments update the medical data code sets used by Medicaid providers, the Department anticipates that the proposed rulemaking will have no impact on the agriculture industry in the State of New Jersey.

### **Regulatory Flexibility Statement**

The proposed amendments reflect the new diagnosis and procedure classification systems required by the Federal Centers for Medicare and Medicaid Services (CMS). The proposed amendments will apply to any healthcare providers who provide services to Medicaid/NJ FamilyCare beneficiaries. Some of these providers may be considered small businesses under the terms of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

The proposed amendments do not impose any recordkeeping, compliance, or reporting requirements on providers, beyond those already imposed by Federal regulations, as described above in the Federal standards statement and Summary above. Providers are currently required to use the International Classification of Diseases, 9th Revision in order to comply with the Federal requirements related to health care services provided to beneficiaries. Those Federal regulations require those same providers to use the ICD-10 as of October 1, 2015.

Although providers can anticipate no fiscal impact from actually using the ICD-10, the ICD-10-CM/PCS, as new classification systems, are more complex and comprehensive than ICD-9-CM/PCS and providers may experience one-time investment costs related to re-credentialing of medical coders, the purchase of translation/transition tools, and technical changes to existing software to update their systems to accept the new ICD-10 format and clinical nomenclature, in order to comply with the Federal regulations. The State rule amendments will not impose any reporting or recordkeeping requirements, or impose any initial capital costs or annual compliance costs, beyond what the providers will already spend in order to comply with the Federal mandate. The proposed amendments must be equally applicable to all providers regardless of business size, because all providers must comply with the Federal requirements in order to report the appropriate identifying information for billing purposes.

### **Housing Affordability Impact Analysis**

Since the proposed amendments update the medical data code sets used by Medicaid providers, the Department anticipates that the proposed rulemaking will have no impact on the development of the affordability of housing in New Jersey and there is no likelihood that the amendments would evoke a change in the average costs associated with housing.

### **Smart Growth Development Impact Analysis**

Since the proposed amendments update the medical data code sets used by Medicaid providers, the Department anticipates that there is no likelihood that the

amendments would evoke a change in housing production within Planning Areas 1 or 2, or within designated centers, under the State Development and Redevelopment Plan.

**Full text** of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

## . CHAPTER 52

### HOSPITAL SERVICES MANUAL

#### SUBCHAPTER 14. METHODOLOGY FOR ESTABLISHING DRG PAYMENT RATES FOR INPATIENT SERVICES AT GENERAL ACUTE CARE HOSPITALS BASED ON DRG WEIGHTS AND A STATEWIDE BASE RATE

##### 10:52-14.16 Payment for readmissions

(a) For New Jersey hospitals, [where] **if** a patient is readmitted to the same hospital for the same or similar diagnosis within seven days, the second claim submitted for payment will be denied. [The] **For dates of service before October 1, 2015, the same or similar principal diagnosis is defined as principal diagnoses with the same first three digits in accordance with the International Classification of Diseases, 9th Edition, Clinical Modification published by Practice Management Information Corporation. For dates of service on or after October 1, 2015, the same or similar principal diagnosis is defined as principal diagnoses in the same diagnosis category, as defined by the first three characters, in accordance with the International Classification of Diseases, 10th Revision, with Clinical Modifications (ICD-10-CM).** For these readmissions, **requests for payment of services related to the two**

hospital inpatient stays shall be combined on the same claim form for reimbursement purposes.

**1. In the event that one claim has a date of service prior to October 1, 2015, and another claim has a date of service on or after October 1, 2015, the principal diagnosis reported on the first claim as an International Classification of Diseases, 9th Revision, with Clinical Modifications (ICD-9-CM) diagnosis code, is compared to the principal diagnosis reported on the other claim as an International Classification of Diseases, 10th Revision, with Clinical Modifications (ICD-10-CM) diagnosis code, using the Centers for Medicare and Medicaid Services (CMS) General Equivalency Mapping (GEM) criteria, 2014 Version, which is incorporated herein by reference, as amended and supplemented. Information regarding the CMS GEM can be found at <https://www.cms.gov/Medicare/Coding/ICD10/2014-ICD-10-CM-and-GEMs.html>.**

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

## CHAPTER 54

### PHYSICIAN SERVICES

#### SUBCHAPTER 5. POLICIES AND PROCEDURES FOR PROVISION OF SERVICES PRESCRIBED OR RENDERED BY A PHYSICIAN

##### 10:54-5.33 Orthopedic footwear services

(a)-(c) (No change.)

(d) Orthopedic footwear and foot orthotics require a personally signed and dated order (prescription) by the prescribing physician for prosthetic and orthotic appliances, repair

and replacement of parts for custom-made prosthetic and orthotic appliances, and orthopedic footwear. The prescription shall include the following:

1. (No change.)

2. Relevant diagnosis(es) (including the ICD-9-**CM** code(s) **for dates of service before October 1, 2015, and the ICD-10-CM code(s) for dates of service on or after October 1, 2015**) supporting the need for the orthopedic footwear and/or foot orthotics;  
and

3. (No change.)

(e) (No change.)

10:54-5.34 Prosthetic and orthotic services (P & O)

(a) (No change.)

(b) Prosthetic and orthotic appliances shall require a personally signed and dated order (prescription) by the prescribing physician, which includes the following:

1. (No change.)

2. Relevant diagnosis(es) (including **the ICD-9-CM code(s) for dates of service before October 1, 2015, and the ICD-10-CM code(s) for dates of service on or after October 1, 2015**) supporting need for custom-made prosthetic and orthotic appliances;  
and

3. (No change.)

(c) (No change.)

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

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

(c) The request for authorization shall include the diagnosis, as set forth in the ICD-9 [(latest revision)] **for dates of service before October 1, 2015, or the ICD-10 for dates of service on or after October 1, 2015**, and also must include the treatment plan and progress report in detail. No post facto authorization will be granted.

1.-4. (No change.)

10:54-9.8 HCPCS Procedure Codes with Qualifiers (except for Pathology/Laboratory)

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

(c) HCPCS Code Qualifiers

...

67221 Photodynamic therapy

QUALIFIER: This procedure code may be

billed with 67225. This procedure code must be rendered by ophthalmologists who are retinal specialists, and shall be

limited to patients meeting the following criteria:

Best corrected visual acuity equal to or better than 20/200 if the decreased visual acuity is caused by the macular degeneration; and Classic subfoveal choroidal neovascularization (CNV),

occupying 50 percent or greater of the entire ocular lesion; and

**[A] for dates of service before October 1, 2015, a reported ICD-9-CM**

diagnosis of 115.02, 115.92, 362.21, or 362.52 (exudative senile macular degeneration) **or for dates of service on or after October 1, 2015, a reported ICD-10-CM diagnosis of H35.32 or B39.9 w/H32.**

NOTE: Report HCPCS procedure code 67225 on the CMS 1500 claim form for procedures performed on a second eye when both eyes are treated on the same date of service. Evaluation and management (E&M) services, fluorescent angiography (FA) and other ocular diagnostic services may also be billed separately when determined medically necessary and provided on the same date of service. Modifiers LT or RT should be used on all claims for codes 67221 and 67225, whether initial or subsequent treatment.

67225

Photodynamic therapy, second eye, at single session

QUALIFIER: This procedure code must be billed with 67221. This procedure code must be rendered by ophthalmologists who are retinal specialists, and shall be limited to patients meeting the following criteria:

Best corrected visual acuity equal to or better than 20/200 if the decreased visual acuity is caused by the macular degeneration; and

Classic subfoveal choroidal neovascularization (CNV), occupying 50 percent or greater of the entire ocular lesion; and

[A] **for dates of service before October 1, 2015, a reported ICD-9-CM diagnosis of 115.02, 115.92, 362.21, or 362.52 (exudative senile macular degeneration) or for dates of service on or after October 1, 2015, a reported ICD-10-CM diagnosis of H35.32 or B39.9 w/H32.**

...

(d) –(i) (No change.)

## CHAPTER 58A

### ADVANCED PRACTICE NURSES

#### SUBCHAPTER 1. GENERAL PROVISIONS

##### 10:58A-1.2 Definitions

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

...

"Mental illness," for purposes of the PASRR, refers to a condition, which can be disabling and/or chronic, such as schizophrenia, mood disorder, paranoia, panic, or other severe anxiety disorder, as described, **for dates of service before October 1, 2015, in the International Classification of Diseases, Ninth Revision (ICD-9(M)), or for dates of service on or after October 1, 2015, as described in the International Classification of Diseases, 10th Revision (ICD-10 (F00 – F99))**, and which can lead to a chronic disability. (See PASRR requirements at N.J.A.C. 10:58A-2.10.)

...

## SUBCHAPTER 2. PROVISION OF SERVICES

### 10:58A-2.9 Mental health services

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

(c) Prior authorization for mental health services may be granted by the New Jersey Medicaid/NJ FamilyCare fee-for-service program for a maximum period of one year, and additional authorizations may be requested. The request for authorization shall include the diagnosis, as set forth, **for dates of service before October 1, 2015**, in the [ICD-9 CM (latest revision)] **ICD-9-CM, or for dates of service on or after October 1, 2015, in the ICD-10-CM**, the treatment plan and the progress report, in detail. When a request for prior authorization is denied or modified, the APN shall be notified of the reason, in writing, by the fiscal agent.

1. -2. (No change.)

(d)-(f) (No change.)

## CHAPTER 66

### INDEPENDENT CLINICAL SERVICES

## SUBCHAPTER 6. CENTERS FOR MEDICARE & MEDICAID SERVICES

### HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

#### 10:66-6.4 HCPCS procedure codes--qualifiers

(a) Evaluation and management and other procedures:

1. (No change.)

2. Photodynamic therapy: 67221 (one eye) and 67225 (second eye at single session).

i. Procedure code 67221 may be billed with 67225. This procedure must be rendered by ophthalmologists who are retinal specialists, and shall be limited to patients meeting the following criteria:

(1)–(2) (No change.)

(3) [A] **For dates of service before October 1, 2015, a reported [ICD-9 CM] ICD-9-CM diagnosis of 115.02, 115.92, 362.21, or 362.52 (exudative senile macular degeneration), or for dates of service on or after October 1, 2015, a reported ICD-10-CM diagnosis of H35.32 or B39.9 w/H32.**

ii. Procedure code 67225 must be billed with 67221. This procedure must be rendered by ophthalmologists who are retinal specialists, and shall be limited to patients meeting the following criteria: best corrected visual acuity equal to or better than 20/200, if the decreased visual acuity is caused by macular degeneration; classic subfoveal choroidal neovascularization (CNV), occupying 50 percent or greater of the entire ocular lesion; and **for dates of service before October 1, 2015, a reported [ICD-9 CM] ICD-9-CM diagnosis of 115.02, 115.92, 362.21, or 362.52 (exudative senile macular degeneration) or for dates of service on or after October 1, 2015, a reported ICD-10-CM diagnosis of H35.32 or B39.9 w/H32.** Report HCPCS procedure code 67225 on the CMS 1500 claim form for procedures performed on a second eye when both eyes are treated on the same date of service. Evaluation and management (E&M) services, fluorescent angiography (FA) and other ocular diagnostic services may also be billed separately when determined medically necessary and provided on the

same date of service. Modifiers LT or RT should be used on all claims for codes 67221 and 67225 whether initial or subsequent treatment.

3.-11. (No change.)

(b)-(n) (No change.)

## CHAPTER 72

### NEW JERSEY CARE ... SPECIAL MEDICAID PROGRAMS MANUAL

#### SUBCHAPTER 3. NONFINANCIAL ELIGIBILITY FACTORS

##### 10:72-3.10 Emergency services for aliens and limited prenatal care for aliens

(a) (No change.)

(b) Limited prenatal care shall be provided by the Division to alien pregnant women who would be eligible for New Jersey Care ... Special Medicaid Programs or NJ FamilyCare services but for their immigration status. Services available through NJSPCP shall be limited to pregnancy-related services provided at a clinic or at a hospital, and shall include primary care, radiology, and clinical laboratory services or, in the case of radiology and clinical laboratory services, ordered by a clinic. In addition, pregnancy-related pharmaceuticals dispensed at a clinic or a hospital are covered. No other services shall be provided.

1. Services available through NJSPCP shall be limited to pregnancy-related services provided at a clinic or at a hospital, including primary care, radiology, and clinical laboratory services, or, in the case of radiology and clinical laboratory services, ordered by a clinic. In addition, pregnancy-related pharmaceuticals dispensed at a clinic or a hospital shall be covered. No other services shall be provided. Services eligible for

reimbursement shall be directly related to the beneficiary's primary diagnosis. [The] **For dates of service before October 1, 2015, the** eligible beneficiary's primary diagnosis shall be one or more of the pregnancy-related diagnostic codes: 640 through 648.9 or V22 through V23.89, as found in the ICD-9-CM (International Classification of Diseases). **For dates of service on or after October 1, 2015, the eligible beneficiary's primary diagnosis for limited prenatal care shall be one or more of the pregnancy-related diagnostic codes: O09 through O16, O20 through O21, O23 through O26, O28 through O31, O36, O44 through O48, or Z33 through Z34, as found in the ICD-10-CM (International Classification of Diseases).**

i. (No change.)

2.-3. (No change.)