N.J.A.C. 10:57

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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Title 10, Chapter 57 -- Chapter Notes

Statutory Authority

CHAPTER AUTHORITY:

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

History

CHAPTER SOURCE AND EFFECTIVE DATE:

R.2021 d.053, effective April 28, 2021.

See: *52 N.J.R. 855(a)*, *53 N.J.R. 1001(b)*.

CHAPTER HISTORICAL NOTE:

Chapter 57, Podiatry Services Manual, was adopted as R.1971 d.66, effective June 1, 1971. See: 3 N.J.R. 43(c), 3 N.J.R. 109(b).

Subchapter 2, Podiatry Billing Procedures, was revised by R.1974 d.222, effective September 15, 1974. See: 6 N.J.R. 264(c), 6 N.J.R. 351(e).

Subchapter 3, HCFA Common Procedure Coding System (HCPCS), was adopted as R.1986 d.52, effective March 3, 1986. See: 17 N.J.R. 1519(b), 18 N.J.R. 478(a).

Pursuant to Executive Order No. 66(1978), Chapter 57, Podiatry Services Manual, was readopted as R.1991 d.129, effective February 13, 1991. See: 22 N.J.R. 3439(b), 23 N.J.R. 858(b).

Chapter 57, Podiatry Services Manual, was repealed, and Chapter 57, Podiatry Services, was adopted as new rules by R.1996 d.60, effective February 5, 1996. See: *27 N.J.R. 4223(a)*, *28 N.J.R. 1015(a)*.

Pursuant to Executive Order No. 66(1978), Chapter 57, Podiatry Services, was readopted as R.2001 d.63, effective January 23, 2001. See: *32 N.J.R. 4096(a)*, *33 N.J.R. 661(b)*.

Chapter 57, Podiatry Services, was readopted as R.2006 d.240, effective May 31, 2006. See: *38 N.J.R. 1126(a)*, *38 N.J.R. 2805(a)*.

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 57, Podiatry Services, was scheduled to expire on May 31, 2013. See: *43 N.J.R. 1203(a)*.

Chapter 57, Podiatry Services, was readopted, effective April 4, 2013. See: *45 N.J.R. 1139(b)*.

In accordance with *N.J.S.A. 52:14B-5.1*, Chapter 57, Podiatry Services, was scheduled to expire on October 1, 2020. Pursuant to Executive Order No. 127 (2020), the expiration date was extended until 90 days after the last day of the public health emergency declared in Executive Order No. 103 (2020).

Chapter 57, Podiatry Services, was readopted as R.2021 d.053, effective April 28, 2021. See: Source and Effective Date. See, also, section annotations.

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Research References & Practice Aids

CHAPTER EXPIRATION DATE:

Chapter 57, Podiatry Services, expires on April 28, 2028.

N.J.A.C. 10:57-1.1

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§ 10:57-1.1 Introduction

(a) This chapter is concerned with the provision of podiatric services by a person licensed to practice podiatry in accordance with the New Jersey Medicaid/NJ FamilyCare programs, policies, and procedures and the standards of practice as defined by the laws of the State of New Jersey (*N.J.S.A. 45:5-1* et seq.) and the American Podiatric Medical Association.

(b) An approved New Jersey Medicaid/NJ FamilyCare provider of podiatric services may be reimbursed for medically necessary covered services provided within the scope of her or his license, and her or his approved New Jersey Medicaid/NJ FamilyCare fee-for-service programs Provider Agreement.

(c) A podiatrist may enroll in the New Jersey Medicaid/NJ FamilyCare fee-for-service programs and provide covered, medically necessary services as an independent practitioner, or may provide such services as part of another entity, such as a hospital or clinic, physician group practice, a mixed practitioner practice, or under the managed care program.

History

HISTORY:

Amended by R.1998 d.248, effective May 18, 1998.

See: *30 N.J.R. 626(a)*, *30 N.J.R. 1812(b)*.

Amended by R.1999 d.292, effective September 7, 1999.

See: *31 N.J.R. 1304(a)*, *31 N.J.R. 2637(a)*.

In (a), inserted a reference to NJ KidCare programs; and in (b) and (c), inserted references to NJ KidCare fee-for-service programs.

Amended by R.2006 d.240, effective July 3, 2006

See: *38 N.J.R. 1126(a)*, *38 N.J.R. 2805(a)*.

Substituted "FamilyCare" for "KidCare" throughout; in (a), inserted "-1 et seq."; and in (b), inserted "/NJ Family Care".

Amended by R.2021 d.053, effective June 7, 2021.

See: *52 N.J.R. 855(a)*, *53 N.J.R. 1001(b)*.

Substituted "Medicaid/NJ" for "Medicaid and NJ" throughout the section; in (a), inserted a comma following "policies"; and in (c), deleted "or" following the first occurrence of "practice," and inserted a comma following the second occurrence of "practice".

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N.J.A.C. 10:57-1.2

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§ 10:57-1.2 Scope of services

Podiatry care under the Medicaid/NJ FamilyCare programs is allowable to covered persons if such services are essential. Essential podiatric care includes those services that require the professional knowledge and skill of a licensed podiatrist. For beneficiaries in the Medically Needy Program, podiatric care is only available to pregnant women, and the aged, the blind, or disabled. (For information on how to identify a covered person, please refer to N.J.A.C. 10:49-2.)

History

HISTORY:

Amended by R.1999 d.292, effective September 7, 1999.

See: *31 N.J.R. 1304(a)*, *31 N.J.R. 2637(a)*.

Inserted a reference to NJ KidCare programs in the first sentence, and substituted a reference to beneficiaries for a reference to recipients in the third sentence.

Amended by R.2006 d.240, effective July 3, 2006.

See: *38 N.J.R. 1126(a)*, *38 N.J.R. 2805(a)*.

Substituted "FamilyCare" for "KidCare".

Amended by R.2021 d.053, effective June 7, 2021.

See: *52 N.J.R. 855(a)*, *53 N.J.R. 1001(b)*.

Substituted "Medicaid/NJ" for "Medicaid and NJ", "podiatric" for "podiatry", and "that" for "which", and inserted a comma following "blind".

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N.J.A.C. 10:57-1.3

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§ 10:57-1.3 Definitions

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

"CPT" means that edition of the Current Procedural Terminology most current at the time of reference, as published annually by the American Medical Association, Chicago, Illinois, unless otherwise specified in rule.

"Flat-foot conditions" means the local condition of flattened arches regardless of the underlying etiology. Treatment of flat-foot conditions encompasses all phases of services in connection with flat feet.

"Podiatrist" means a doctor of podiatric medicine licensed to practice podiatry by the New Jersey State Board of Medical Examiners, or similarly licensed by a comparable agency in the state in which he or she practices.

"Podiatry services" means those services performed by a licensed podiatrist within the scope of practice as defined by the laws of the State of New Jersey (*N.J.S.A. 45:5-7*) and that are within the scope of the services covered by the New Jersey Medicaid/NJ FamilyCare program.

"Routine foot care" means the cutting or removal of corns or calluses, the trimming of nails, and other hygienic and preventive maintenance care in the realm of self-care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone for both ambulatory and bedfast patients, and any services performed in the absence of localized illnesses, injury or symptoms involving the foot.

"Specialist" for purposes of the New Jersey Medicaid/NJ FamilyCare program, means a fully licensed podiatrist who:

1. Is a diplomate of the appropriate specialty board as recognized by the American Podiatric Medical Association; or

2. Has been notified of board eligibility by the appropriate specialty board as recognized by the American Podiatric Medical Association.

"Subluxation" means the structural misalignment of the joints of the feet which do not require surgical methods of treatment and/or correction, with the exception of fractures and complete dislocations.

History

HISTORY:

Amended by R.1998 d.248, effective May 18, 1998.

See: *30 N.J.R. 626(a)*, *30 N.J.R. 1812(b)*.

Added "CPT" definition.

Amended by R.1999 d.292, effective September 7, 1999.

See: *31 N.J.R. 1304(a)*, *31 N.J.R. 2637(a)*.

In "Podiatry services" and "Specialist", inserted references to NJ KidCare programs.

Amended by R.2006 d.240, effective July 3, 2006.

See: *38 N.J.R. 1126(a)*, *38 N.J.R. 2805(a)*.

In definition "CPT", substituted "Procedural" for "Procedure"; and in definitions "Podiatry services" and "Specialist", substituted "FamilyCare" for "KidCare".

Amended by R.2021 d.053, effective June 7, 2021.

See: *52 N.J.R. 855(a)*, *53 N.J.R. 1001(b)*.

In definition "Podiatry services" and the introductory paragraph of definition "Specialist", substituted "Medicaid/NJ" for "Medicaid and NJ" and "program" for "programs"; and in definition "Podiatry services", substituted "that" for "which".

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N.J.A.C. 10:57-1.4

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§ 10:57-1.4 Provisions for provider participation

(a) In order to participate in the Medicaid/NJ FamilyCare programs, a podiatrist shall apply to, and be approved by, the New Jersey Medicaid/NJ FamilyCare program. Application for approval by the New Jersey Medicaid/NJ FamilyCare program requires completion and submission of the "Medicaid Provider Application" (FD-20) and the "Medicaid Provider Agreement" (FD-62).

1. The documents referenced in (a) above are located as Forms #8 and #9 in the Appendix at the end of the Administration Chapter (*N.J.A.C. 10:49*), and may be obtained from, and submitted to:

DXC Technology

Provider Enrollment

PO Box 4804

Trenton, New Jersey 08650-4804

(b) In order to be approved as a Medicaid/NJ FamilyCare participating provider, the podiatrist shall be licensed by the State of New Jersey Board of Medical Examiners (See N.J.A.C. 13:35-3).

1. An out-of-State podiatrist must have comparable documentation under the applicable State requirements of the state in which the services are provided.

(c) In order to be approved as a specialist under the Medicaid/NJ FamilyCare program, a licensed podiatrist shall possess either of the following:

1. A specialty certification/permit issued by the specialty board as recognized by the American Podiatric Medical Association; or

2. A copy of the notification of board eligibility by the specialty board as recognized by the American Podiatric Medical Association.

(d) A photocopy of the current license, certification/permit or notification of board eligibility by the specialty shall be provided at the time of the application for enrollment.

History

HISTORY:

Amended by R.1999 d.292, effective September 7, 1999.

See: *31 N.J.R. 1304(a)*, *31 N.J.R. 2637(a)*.

In (a) and (c), inserted references to NJ KidCare programs in the introductory paragraphs.

Amended by R.2006 d.240, effective July 3, 2006.

See: *38 N.J.R. 1126(a)*, *38 N.J.R. 2805(a)*.

Substituted "FamilyCare" for "KidCare" throughout; and in (b), inserted "/NJ FamilyCare".

Amended by R.2021 d.053, effective June 7, 2021.

See: *52 N.J.R. 855(a)*, *53 N.J.R. 1001(b)*.

Substituted "Medicaid/NJ" for "Medicaid and NJ" and "program" for "programs", and inserted commas, throughout the section; and in (a)1, inserted "in (a)", and substituted "DXC Technology" for "Unisys Corporation".

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N.J.A.C. 10:57-1.5

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§ 10:57-1.5 Prior authorization

(a) Authorization by the Podiatry Services Unit ("Unit"), Division of Medical Assistance and Health Services, PO Box 712, Trenton, New Jersey 08625-0712, shall be obtained prior to the provision of the following services:

1. All orthopedic footwear;
2. Custom molded foot or ankle orthoses;
3. Routine debridement of toenails, more than once every two months.

(b) A written request for authorization (Form FD-356) shall be submitted, identifying the case and containing sufficient information about the problem and plan of treatment to enable the Unit to make a proper evaluation.

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N.J.A.C. 10:57-1.6

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§ 10:57-1.6 Basis of reimbursement

(a) Reimbursement for podiatry services covered under the New Jersey Medicaid/NJ FamilyCare fee-for-service program shall be on the basis of the customary charge, not to exceed a fixed fee schedule determined reasonable by the Commissioner, Department of Human Services (see N.J.A.C. 10:57-3 for fee schedule), and further limited by Federal policy relative to payment of practitioners and other individual providers. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

(b) Any podiatric physician who meets the above cited qualifications listed in *N.J.A.C. 10:57-1.3* as a specialist and the requirements specified in *N.J.A.C. 10:57-1.4* shall be eligible for specialist reimbursement.

History

HISTORY:

Amended by R.1998 d.382, effective July 20, 1998.

See: *30 N.J.R. 1255(b)*, *30 N.J.R. 2646(b)*.

In (a), inserted a reference to NJ KidCare; and in (b), inserted ", and prior to July 20, 1998," following "February 10, 1995", substituted "beneficiaries" for "recipients", inserted references to NJ KidCare throughout, and added the last sentence.

Amended by R.1999 d.292, effective September 7, 1999.

See: *31 N.J.R. 1304(a)*, *31 N.J.R. 2637(a)*.

In (a), inserted a reference to NJ KidCare programs.

Amended by R.2006 d.240, effective July 3, 2006.

See: *38 N.J.R. 1126(a)*, *38 N.J.R. 2805(a)*.

Substituted "FamilyCare" for "KidCare" throughout.

Amended by R.2021 d.053, effective June 7, 2021.

See: *52 N.J.R. 855(a)*, *53 N.J.R. 1001(b)*.

In (a), substituted "Medicaid/NJ" for "Medicaid and NJ" and "fee-for-service program" for "programs"; deleted former (b); and recodified former (c) as (b).

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N.J.A.C. 10:57-1.7

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§ 10:57-1.7 Personal contribution to care requirements for NJ FamilyCare-Plan C and copayments for NJ FamilyCare-Plan D

(a) General policies regarding the collection of personal contribution to care for NJ FamilyCare-Plan C and copayments for NJ FamilyCare-Plan D are set forth at N.J.A.C. 10:49-9.

(b) Personal contribution to care for NJ FamilyCare-Plan C services is $5.00 per visit for podiatric services.

1. A podiatric visit is defined as a face-to-face contact with a medical professional, including services provided under the supervision of the podiatrist, which meets the documentation requirements of this chapter and allows the podiatrist to request reimbursement for services.

2. Podiatric visits include podiatric services provided in the office, patient's home, or any other site, except any site of the hospital, where the child may have been examined by the podiatrist or the podiatric staff.

3. The podiatrist shall collect one personal contribution to care per podiatric visit, regardless of the number of podiatric services provided in the session.

(c) The copayment for podiatric services under NJ FamilyCare-Plan D shall be $5.00 per visit.

(d) Podiatrists shall collect the copayment specified in (c) above. Copayments shall not be waived.

History

HISTORY:

New Rule, R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

See: *30 N.J.R. 1060(a)*.

Former *N.J.A.C. 10:57-1.7*, Record keeping, recodified to *N.J.A.C. 10:57-1.8*.

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.

See: *30 N.J.R. 1060(a)*, *30 N.J.R. 3519(a)*.

Readopted the provisions of R.1998 d.154 without change.

Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).

See: *31 N.J.R. 998(a)*, *31 N.J.R. 1806(a)*, *31 N.J.R. 2879(b)*.

In (a), added reference to copayments for NJ KidCare-Plan D; added (c) and (d).

Amended by R.2006 d.240, effective July 3, 2006.

See: *38 N.J.R. 1126(a)*, *38 N.J.R. 2805(a)*.

Section was "Personal contribution to care requirements for NJ KidCare-Plan C and copayments for NJ KidCare-Plan D". Substituted "FamilyCare" for "KidCare" throughout; and in (b), substituted "per" for "a".

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N.J.A.C. 10:57-1.8

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§ 10:57-1.8 Record keeping

(a) Podiatrists shall keep such individual records as are necessary to fully disclose the kind and extent of the services provided and shall make such information available as the Division or its agents may request. For the initial examination, the following documentation shall be on the record, regardless of the setting where the examination was performed:

1. Date of service;
2. Chief complaint(s);
3. Pertinent historical and physical data;
4. Reports of diagnostic procedures ordered or performed;
5. Diagnosis;
6. Prescription (including medication) and treatment.

(b) Progress notes may be brief but shall include date(s) of service, changes in patient condition, specific medications and/or other treatments.

History

HISTORY:

Recodified from *N.J.A.C. 10:57-1.7* by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

See: *30 New Jersey Register 1060(a)*.

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.

See: *30 New Jersey Register 1060(a)*, *30 New Jersey Register 3519(a)*.

Readopted the provisions of R.1998 d.154 without change.

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N.J.A.C. 10:57-2.1

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§ 10:57-2.1 Covered and non-covered services

(a) The following foot care services shall not be covered:

1. Flat-foot conditions:

i. Exceptions:

(1) Treatment which is an integral part of post-fracture or postoperative treatment plan;

(2) Supportive devices (for example, arch supports, specific additions to shoes and the like) which are prescribed to palliate pain and other symptoms associated with the condition.

ii. Treatment where the talo-crural joint is involved;

iii. Treatment where there may be attachment of a supportive device to a brace or bar.

2. Subluxations of the feet in which the normal relationship of the bones, tendons, ligaments and supporting muscles is disturbed and which, regardless of underlying etiology, require treatment by mechanical methods (for example, whirlpool, paraffin baths, casting, strapping, splinting, padding, shortwave or low voltage currents, physical therapy, exercise manipulation, massage, and the like):

i. Exceptions:

(1) Where treatment is an integral part of post-fracture or postoperative treatment plan;

(2) Where the talo-crural joint is involved;

(3) Where there may be attachment of a supportive device to a brace or bar.

3. Routine foot care, routine hygienic care:

i. Exceptions:

(1) Treatment of painful corns, calluses and warts;

(A) When treatments are in excess of one per month, the case must be referred for evaluation to the podiatry unit of the Division of Medical Assistance and Health Services, PO Box 712, Mail Code #15, Trenton, New Jersey 08625-0712.

(2) Treatment of the foot for Medicaid/NJ FamilyCare beneficiaries with metabolic, neurological, and peripheral diseases (for examples, diabetes mellitus, arteriosclerosis obliterans, Buerger's disease, chronic thrombo-phlebitis, peripheral neuropathies); and

(3) Treatment of fungal (mycotic) and other infections of the feet and toenails.

(b) The following guidelines limit the provision of (a)3 above.

1. The importance of preventive or hygienic care for patients with a systemic illness, such as peripheral vascular disease, diabetes, or with severe physical disability is recognized. These will be considered on an individual basis by the podiatry consultant.

2. If services ordinarily considered routine are performed at the same time as and as a necessary integral part of otherwise covered services, such as diagnosis and treatment of diabetic ulcers, wounds and infections, they are covered.

3. Fungal (mycotic) and other infections of the feet and toenails require professional services which are outside the scope of "routine foot services." Diagnostic and treatment services for foot infections are covered in the same manner as services performed for infections occurring elsewhere on the body, and the same type of coverage rules apply.

4. Treatment of plantar warts that are symptomatic and/or cause disability will be considered a covered service.

History

HISTORY:

Amended by R.1998 d.248, effective May 18, 1998.

See: *30 N.J.R. 626(a)*, *30 N.J.R. 1812(b)*.

In (a)3i(2), substituted "beneficiaries" for "recipients" after "Medicaid".

Amended by R.2006 d.240, effective July 3, 2006.

See: *38 N.J.R. 1126(a)*, *38 N.J.R. 2805(a)*.

In (a)3i(2), inserted "or NJ FamilyCare".

Amended by R.2021 d.053, effective June 7, 2021.

See: *52 N.J.R. 855(a)*, *53 N.J.R. 1001(b)*.

In (a)3i(2), substituted "Medicaid/NJ" for "Medicaid and NJ".

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N.J.A.C. 10:57-2.2

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§ 10:57-2.2 General provisions

(a) For purposes of reimbursement, a podiatrist and/or physician; podiatrist and/or physicians' group; shared health care facility; or providers sharing a common record are considered a single provider.

(b) When reference is made in the CPT manual to Office or other outpatient services--new patient; Hospital inpatient services--initial hospital care; Nursing facility services--comprehensive nursing facility assessments; and Domiciliary, Rest home, or Custodial care services--new patient; the intent of Medicaid/NJ FamilyCare is to consider this service as the initial visit. When the setting for this 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 will be denied when the recipient is seen by the same physician, group of physicians, or involves a shared health care facility which is a group of physicians sharing a common record. Reimbursement for an initial office visit also precludes subsequent reimbursement for an initial residential health care facility visit and vice versa.

1. Reimbursement for an initial office visit or initial residential health care facility visit will be disallowed, if a preventive medicine service, EPSDT examination or office consultation were billed within a 12-month period by a podiatrist, podiatric group, shared health care facility, or practitioner sharing a common record.

2. If the setting is a nursing facility or hospital, the initial visit concept will still apply for reimbursement purposes despite CPT reference to the term initial hospital care or comprehensive nursing facility assessments. Subsequent readmissions to the same facility may be reimbursed as initial visits, if the readmission occurs more than 30 days from a previous discharge from the same facility by the same provider. In instances when the readmission occurs within 30 or less days from a previous discharge, the provider shall bill the relevant HCPCS procedure codes specified in the qualifier under the headings Subsequent hospital care or Subsequent nursing facility care.

3. Initial hospital visit during a single admission will be disallowed to the same physician, group, shared health care facility, or practitioners sharing a common record who submit a claim for a consultation and transfer the patient to their service. It is also to be understood that in order to receive reimbursement for an initial visit, one of the minimum documentation requirements must be met.

i. HCPCS 99201 and 99202 are exceptions to the above requirements outlined in the qualifier for the initial visit. For HCPCS 99201 and 99202, the provider shall follow the qualifier applied to routine visit or follow-up care visit, for reimbursement purposes.

ii. When reference is made, in the CPT, to Office or other outpatient services--established patient; Hospital inpatient services--subsequent hospital care; Nursing facility services--subsequent nursing facility care; and Domiciliary, Rest home or Custodial care services--established patient; the intent of Medicaid/NJ FamilyCare is to consider this service as the Routine Visit or Follow-Up Care visit. The setting could be office, hospital, nursing facility or residential health care facility. In order to document the record for reimbursement purposes, a progress note for the noted visits should include the minimum documentation specified in *N.J.A.C. 10:57-1.8*.

iii. House call procedure codes refer to a podiatrist visit limited to the provision of podiatric care to an individual who would be too ill to go to a podiatrist's office and/or is "home bound" due to his/her physical condition. When billing for a second or subsequent patient treated during the same visit, the visit should be billed as a home visit.

History

HISTORY:

Amended by R.2006 d.240, effective July 3, 2006.

See: *38 N.J.R. 1126(a)*, *38 N.J.R. 2805(a)*.

In introductory paragraph of (b) and in (b)3ii, inserted "/NJ FamilyCare"; and in (b)3ii, substituted "*N.J.A.C. 10:57-1.8*" for "*N.J.A.C. 10:57-1.7*".

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N.J.A.C. 10:57-2.3

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§ 10:57-2.3 Provisions regarding surgery

(a) Specific requirements for surgery procedures may be found at *N.J.A.C. 10:57-3.2(b)*.

1. Certain surgical procedures are carried out as an integral part of a total service and, as such, do not warrant a separate charge. When such a procedure is carried out as a separate entity not immediately related to other services, the provider may bill a value for Separate Procedure.

2. Complications or other circumstances requiring additional and unusual services concurrent with the procedure(s) or during the listed period of normal follow-up care, may warrant additional reimbursement on a fee-for-service basis.

3. When multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed at the same operative session, the total reimbursement shall be the allowance of the primary procedure plus 50 percent of the allowance of the secondary procedures to a total maximum of 200 percent of the primary procedure unless otherwise specified in this section.

4. Anesthesia services rendered to his or her patient by the operating podiatrist are considered part of the surgical procedure and will not receive any additional reimbursement.

5. Reimbursement will be made for an assistant surgeon when the service is medically necessary and when a duly qualified surgical resident or house physician is unavailable, and when the primary procedure performed has a procedure code specialist fee of at least $ 142.00. The allowance permitted is a maximum of 15 percent of the listed specialist fee. The minimum payment is $ 27.00.

History

HISTORY:

Amended by R.2001 d.63, effective February 20, 2001.

See: *32 New Jersey Register 4096(a)*, *33 New Jersey Register 661(b)*.

In (a)3, inserted "of the primary procedure" following "of 200 percent".

Annotations

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N.J.A.C. 10:57-2.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 57. PODIATRY SERVICES > SUBCHAPTER 2. PROVISION OF SERVICES

§ 10:57-2.4 Radiology services

(a) Specific requirements for radiology procedures may be found at *N.J.A.C. 10:57-3.2(c)*.

1. Reimbursement will be made for the combined technical and professional component of the reimbursement for the procedure code notwithstanding any statement to the contrary in the narrative. It will be paid only to one provider and will not be broken down into its component parts.

Annotations

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N.J.A.C. 10:57-2.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

§ 10:57-2.5 Consultation policies

(a) A consultation is recognized for reimbursement only when performed by a specialist, as the term is defined at *N.J.A.C. 10:57-1.3*, who is recognized as such by this Program and the request has been made by or through the patient's attending physician or other licensed practitioner and the need for such a request would be consistent with good medical practice. Two types of consultation are recognized for reimbursement--comprehensive consultation and limited consultation.

(b) 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, then the provider shall not bill for an initial visit if he or she bills for the consultation.

(c) If there is no referring physician, podiatrist or licensed practitioner, then an initial visit code should be billed instead of a consultation code.

(d) If the patient is seen for the same illness on repeated visits by the same consultant, these visits are considered routine visits or follow-up care visits and not consultations.

(e) Consultation codes will be declined in an office or residential health care facility setting if the consultation has been requested by or between members of the same group, shared health care facility or physicians, podiatrists and/or licensed practitioners sharing common records. A routine visit code is applicable under these circumstances.

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

Annotations

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N.J.A.C. 10:57-2.6

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:57-2.6 Podiatric orthotic services

(a) Payment will be allowed for orthotic services rendered by a podiatrist for his or her own patients with prior authorization (See *N.J.A.C. 10:57-1.5*).

(b) Services provided by a prosthetic and orthotic (P&O) facility must be billed directly to the program by the P&O facility, and not by the referring practitioner. (See *N.J.A.C. 10:55*, Prosthetic and Orthotic Services.)

Annotations

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N.J.A.C. 10:57-2.7

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:57-2.7 Clinical laboratory services

(a) "Clinical laboratory services" means professional and technical laboratory services performed by a clinical laboratory certified by the Centers for Medicare & Medicaid Services (CMS) in accordance with the Clinical Laboratory Improvement Act (CLIA) 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.

(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 Act (CLIA) of 1988; 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 Medicaid/NJ FamilyCare program's Independent Clinical Laboratory Services chapter.

(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 at *N.J.A.C. 8:44* and 8:45.

(d) A podiatrist may claim reimbursement for clinical laboratory services performed for his or her own patients within his or her own office, subject to the following:

1. A podiatrist shall meet the conditions of the CLIA regulations before she or he may perform clinical laboratory testing for Medicaid recipients; and

2. The clinical laboratory tests shall be standard clinical laboratory procedures consistent with the podiatrist's CLIA certification, certificate of waiver or certificate of registration as an independent clinical laboratory.

(e) When the clinical laboratory test is performed on site, the venipuncture shall not be reimbursable as a separate procedure; its cost is included within the reimbursement for the lab procedure.

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

1. The clinical reference laboratory shall be certified under the CLIA, as described at (a) and (b) above, to perform the required laboratory test(s);

2. The clinical laboratory shall be licensed by the New Jersey State Department of Health, as described at (b) and (c) above, or 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 program in accordance with (b) above; and

4. Independent clinical laboratories shall bill the New Jersey Medicaid/NJ FamilyCare program for all reference laboratory work performed on their premises. The podiatrist will not be reimbursed for laboratory work performed by a reference laboratory.

History

HISTORY:

Amended by R.1998 d.248, effective May 18, 1998.

See: *30 N.J.R. 626(a)*, *30 N.J.R. 1812(b)*.

In (c) and (f)2, inserted "and Senior Services" after "Department of Health".

Amended by R.1999 d.292, effective September 7, 1999.

See: *31 N.J.R. 1304(a)*, *31 N.J.R. 2637(a)*.

In (f), inserted references to NJ KidCare programs in 3 and 4.

Amended by R.2006 d.240, effective July 3, 2006.

See: *38 N.J.R. 1126(a)*, *38 N.J.R. 2805(a)*.

Substituted "FamilyCare" for "KidCare" throughout; in (a), substituted "the Centers for Medicare & Medicaid Services (CMS)" for "HCFA"; and in (b), substituted "CMS" for "Health Care Financing Administration (HCFA)" and inserted "/NJ FamilyCare".

Amended by R.2021 d.053, effective June 7, 2021.

See: *52 N.J.R. 855(a)*, *53 N.J.R. 1001(b)*.

In (c) and (f)2, deleted "and Senior Services" following "Health"; and in (f)3 and (f)4, substituted "Medicaid/NJ" for "Medicaid and NJ" and "program" for "programs".

Annotations

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N.J.A.C. 10:57-2.8

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:57-2.8 Hospital outpatient department services

(a) A hospital-based podiatrist who is salaried and whose services are reimbursed as part of the hospital's cost shall not bill fee-for-service to the New Jersey Medicaid/NJ FamilyCare program.

1. A podiatrist practicing in the hospital outpatient department, whose reimbursement is not part of the hospital's cost, may bill fee-for-service independent of the hospital charges for professional service according to Medicare principles of reimbursement, if the arrangement with the hospital permits it.

History

HISTORY:

Amended by R.1999 d.292, effective September 7, 1999.

See: *31 N.J.R. 1304(a)*, *31 N.J.R. 2637(a)*.

In (a), inserted a reference to NJ KidCare programs in the introductory paragraph.

Amended by R.2006 d.240, effective July 3, 2006.

See: *38 N.J.R. 1126(a)*, *38 N.J.R. 2805(a)*.

Substituted "NJ FamilyCare" for "NJ KidCare".

Amended by R.2021 d.053, effective June 7, 2021.

See: *52 N.J.R. 855(a)*, *53 N.J.R. 1001(b)*.

In the introductory paragraph of (a), substituted "Medicaid/NJ" for "Medicaid and NJ" and "program" for "programs".

Annotations

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N.J.A.C. 10:57-2.9

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 57. PODIATRY SERVICES > SUBCHAPTER 2. PROVISION OF SERVICES

§ 10:57-2.9 Diagnostic radiology services

Payment will be allowed for necessary radiological services by a podiatrist, subject to the limitations of his or her licensure. Routine X-rays for screening purposes shall not be reimbursed.

Annotations

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N.J.A.C. 10:57-2.10

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§ 10:57-2.10 Multiple visits; out of office

(a) Podiatry services rendered in a residential or medical facility (that is, hospital, nursing home, or extended care facility) shall be based on referral by the attending physician.

(b) Multiple visits to patients in the same health facility or congregate living arrangement will be reimbursed on an out-of-office visit basis for the initial visit to each patient and on an office visit basis for each subsequent visit to each patient receiving services.

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N.J.A.C. 10:57-2.11

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 57. PODIATRY SERVICES > SUBCHAPTER 2. PROVISION OF SERVICES

§ 10:57-2.11 Pharmaceutical; podiatrist administered drugs

(a) The New Jersey Medicaid/NJ FamilyCare fee-for-service program shall reimburse podiatrists for certain approved drugs administered intradermally, subcutaneously, intra-muscularly, or intravenously in the office, home, or independent clinic setting according to the following reimbursement methodologies and the requirements of *N.J.A.C. 10:51*.

1. Podiatrist-administered medications shall be reimbursed directly to the podiatrist under certain situations. (See HCPCS, N.J.A.C. 10:57-3 for a listing of HCPCS procedure codes.)

i. A "J" code may be billed in conjunction with an office, home, or independent clinic visit when the criteria for an office or home visit is met and the procedure code is for the method of drug administration.

ii. The Division has assigned HCPCS procedure codes and Medicaid/NJ FamilyCare maximum fee allowances to certain, selected drugs for which reimbursement to the podiatrist is based on the Average Wholesale Price (AWP) of a single dose of an injectable drug, or the podiatrist's acquisition cost, whichever is less.

iii. Unless otherwise indicated in N.J.A.C. 10:57-2, the Medicaid/NJ FamilyCare maximum fee allowance is determined based on the AWP per unit which equals one cubic centimeter (cc) or milliliter (ml) of drug volume for each unit. For drug vials with a volume equal to one cubic centimeter (cc) or milliliter (ml), the Medicaid/NJ FamilyCare maximum fee allowance shall be based on the cost per vial.

iv. A visit for the sole purpose of an injection is reimbursable as an injection and not as an office visit plus an injection. On the other hand, if the criteria of an office or home visit are met, an injection may, if medically indicated, be considered as an add-on to the visit. The drug administered must be consistent with the diagnosis and conform to accepted medical and pharmacological principles in respect to dosage frequency and route of administration.

v. No reimbursement will be made for an injection given as a preoperative medication or as a local anesthetic that is part of an operative or surgical procedure, since this injection would normally be included in the prescribed fee for such a procedure.

2. In situations where a drug required for administration has not been assigned a "J" code, the drug shall be prescribed by the podiatrist and obtained from a pharmacy that directly bills the New Jersey Medicaid/NJ FamilyCare program. In this situation, the podiatrist shall bill only for the administration of the drug.

History

HISTORY:

Amended by R.1998 d.248, effective May 18, 1998.

See: *30 N.J.R. 626(a)*, *30 N.J.R. 1812(b)*.

In (a)1, changed the N.J.A.C. reference.

Amended by R.1999 d.292, effective September 7, 1999.

See: *31 N.J.R. 1304(a)*, *31 N.J.R. 2637(a)*.

In (a), inserted a reference to NJ KidCare fee-for-service programs in the introductory paragraph, and substituted a reference to the Division for a reference to the New Jersey Medicaid program and inserted a reference to NJ KidCare maximum fee allowances in 1ii.

Amended by R.2006 d.240, effective July 3, 2006.

See: *38 N.J.R. 1126(a)*, *38 N.J.R. 2805(a)*.

Substituted "FamilyCare" for "KidCare" throughout; and inserted "/NJ FamilyCare" in (a)1iii and in (a)2.

Amended by R.2021 d.053, effective June 7, 2021.

See: *52 N.J.R. 855(a)*, *53 N.J.R. 1001(b)*.

In the introductory paragraph of (a), substituted "Medicaid/NJ" for "Medicaid and NJ" and "program" for "programs", inserted a comma following "intra-muscularly" and deleted a comma following 'methodologies"; in (a)1i, deleted the former second sentence; in (a)1v and (a)2, substituted "that" for "which"; and in (a)2, deleted "or level III HCPCS" following ""code" and deleted ", using HCPCS 90799" from the end.

Annotations

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N.J.A.C. 10:57-2.12

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:57-2.12 Pharmaceutical services

All covered pharmaceutical services provided under the New Jersey Medicaid/NJ FamilyCare fee-for-service programs shall be provided to New Jersey Medicaid/NJ FamilyCare fee-for-service beneficiaries within the scope of *N.J.A.C. 10:49*, Administration, and 10:51, Pharmaceutical Services.

History

HISTORY:

Amended by R.1999 d.292, effective September 7, 1999.

See: *31 N.J.R. 1304(a)*, *31 N.J.R. 2637(a)*.

Deleted (a) designation, inserted a reference to NJ KidCare fee-for service programs, and substituted a reference to Medicaid and NJ KidCare fee-for-service beneficiaries for a reference to Medicaid recipients.

Amended by R.2006 d.240, effective July 3, 2006.

See: *38 N.J.R. 1126(a)*, *38 N.J.R. 2805(a)*.

Substituted "FamilyCare" for "KidCare" two times.

Amended by R.2021 d.053, effective June 7, 2021.

See: *52 N.J.R. 855(a)*, *53 N.J.R. 1001(b)*.

Substituted "Medicaid/NJ" for "Medicaid and NJ", inserted the second occurrence of "New Jersey" and deleted "N.J.A.C." preceding "10:51".

Annotations

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N.J.A.C. 10:57-2.13

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 57. PODIATRY SERVICES > SUBCHAPTER 2. PROVISION OF SERVICES

§ 10:57-2.13 Medical exception process (MEP)

(a) For pharmacy claims with service dates on or after September 1, 1999, which exceed Prospective Drug Use Review (PDUR) standards recommended by the New Jersey Drug Utilization Review Board (NJ DURB) and approved by the Commissioners of DHS and DOH, the Division of Medical Assistance and Health Services has established a Medical Exception Process (MEP). See *N.J.A.C. 10:51-2.23* for more information on the PDUR program.

(b) The medical exception process shall be administered by a contractor, referred to as the MEP contractor, under contract with the Department of Human Services.

(c) The medical exception process shall apply to all pharmacy claims, regardless of claim media, unless there is a recommended exemption by the NJ DURB that has been approved by the Commissioners of DHS and DOH, in accordance with the rules of those Departments.

(d) The medical exception process (MEP) is as follows:

1. The MEP contractor shall contact prescribers of conflicting drug therapies, or drug therapies which exceed established PDUR standards, to request written justification to determine medical necessity for continued drug utilization.

i. The MEP contractor shall send a Prescriber Notification Letter which includes, but may not be limited to, the beneficiary name, HSP identification number, dispense date, drug quantity, drug description. The prescriber shall be requested to provide the reason for medical exception, diagnosis, expected duration of therapy, and expiration date for medical exception.

ii. The prescriber shall provide information requested on the Prescriber Notification to the MEP contractor.

2. Following review and approval of a prescriber's written justification, if appropriate, the MEP contractor shall override existing PDUR edits through the issuance of a prior authorization number.

3. The MEP contractor shall notify the pharmacy and prescriber of the results of their review and include, at a minimum, the beneficiary's name, mailing address, identification number, the reviewer, service description, service date, and prior authorization number, if approved, the length of the approval, and the appeals process if the pharmacist does not agree with the results of the review.

4. Prescribers may request a fair hearing to appeal decisions rendered by the MEP contractor concerning denied claims (see N.J.A.C. 10:49-10, Notices, Appeals and Fair Hearings).

5. Claims subject to the medical exception process which have not been justified by the prescriber within 30 calendar days shall not be authorized by the MEP contractor and shall not be covered.

History

HISTORY:

§ 10:57-2.13 Medical exception process (MEP)

New Rule, R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).

See: *31 N.J.R. 245(a)*, *31 N.J.R. 1956(a)*.

Amended by R.2021 d.053, effective June 7, 2021.

See: *52 N.J.R. 855(a)*, *53 N.J.R. 1001(b)*.

Rewrote (a); in (c), substituted "NJ DURB that" for "New Jersey DUR Board which" and "DOH" for "DHSS"; and in (d)3, inserted a comma following 'include" and "approval", and substituted "identification" for "HSP".

Annotations

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N.J.A.C. 10:57-3.1

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 57. PODIATRY SERVICES > SUBCHAPTER 3. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

§ 10:57-3.1 Introduction to the HCPCS procedure coding system

(a) The New Jersey Medicaid and NJ FamilyCare programs use the Federal Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) codes for 2006, established and maintained by CMS in accordance with the Health Insurance Portability and Accountability Act, of 1996, *42 USC § 1320d* et seq., and incorporated herein by reference, as amended and supplemented, and as published by PMIC, 4727 Wilshire Blvd., Suite 300, Los Angeles, CA 90010. Revisions to the Healthcare Common Procedure Coding System made by CMS (code additions, code deletions, and replacement codes) will be reflected in this subchapter through publication of a notice of administrative change in the New Jersey Register. Revisions to existing reimbursement amounts specified by the Department and specification of new reimbursement amounts for new codes will be made by rulemaking in accordance with the Administrative Procedure Act, *N.J.S.A. 52:14B-1* et seq. HCPCS follows the American Medical Association's Physician's Current Procedural Terminology CPT architecture, employing a five-position code and as many as two two-position modifiers. Unlike the CPT numeric design, the CMS-assigned codes and modifiers contain alphabetic characters. Because of copyright restrictions, the CPT procedure narratives for Level I codes are not included in this manual, but are incorporated herein by reference, as amended and supplemented. An updated copy of the CPT (Level I) codes may be obtained from the American Medical Association, P.O. Box 10950, Chicago, IL 60610, or by accessing *www.ama-assn.org*. An updated copy of the HCPCS (Level II) codes may be obtained by accessing the HCPCS website at *www.cms.hhs.gov/medicare/hcpcs* or by contacting PMIC, 4727 Wilshire Blvd., Suite 300, Los Angeles, CA 90010.

(b) HCPCS has been developed as a two-level coding system, as follows:

1. Level I codes: Narratives for these codes are found in CPT, which is incorporated herein by reference, as amended and supplemented. The codes are adapted from CPT for use primarily by physicians, podiatrists, optometrists, certified nurse-midwives, certified nurse practitioners and clinical nurse specialists, independent clinics and independent laboratories. Level I procedure codes, and fees for each, for which podiatrists may bill, can be found at *N.J.A.C. 10:57-3.2*.

2. Level II codes: These codes are assigned by CMS for physician and non-physician services which are not in CPT. Narratives for these codes, and the fees for each, can be found at *N.J.A.C. 10:57-3.3*.

(c) Specific elements of HCPCS codes require the attention of providers. The lists of HCPCS code numbers for podiatric services are arranged in tabular form with specific information for a code given under columns with titles such as: "IND," "HCPCS CODE," "MOD," "DESCRIPTION," "FOLLOW-UP DAYS," "MAXIMUM FEE ALLOWANCE" and "ANES BASIC UNITS." The information given under each column is summarized below:

1. 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 ("IND" column) and as modified ("MOD" column). They assist

the provider in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

i. These symbols and/or letters shall not be ignored because they reflect requirements, in addition to the narrative which accompanies the CPT/HCPCS procedure code as written in the CPT, for which the provider is liable. These additional requirements shall be fulfilled before reimbursement is requested.

ii. If there is no identifying symbol listed, the CPT/HCPCS procedure code narrative prevails.

IND =	lists alphabetic symbols used to refer the provider to information concerning the New Jersey Medicaid or NJ FamilyCare programs' qualifications and requirements when a procedure or service code is used. An explanation of the indicators and qualifiers used in this column is located below and in paragraph 1, "Alphabetic and numeric symbols," as follows:
A =	"A" preceding any procedure code indicates that these tests can be and are frequently done as groups and combinations (profiles) on automated equipment.
D =	"D" preceding any procedure code indicates that the procedure code is excluded from the requirement that office visit codes not be reimbursed in addition to procedure codes for surgical procedures performed in the office.
E =	"E" preceding any procedure code indicates that these procedures are excluded from multiple surgery pricing and, as such, should be reimbursed at 100 percent of the Medicaid/NJ FamilyCare maximum fee allowance, even if the procedure is done on the same patient by the same surgeon at the same operative session.
L =	"L" preceding any procedure code indicates that the complete narrative for the code is located in N.J.A.C. 10:57-3.3.
N =	"N" preceding any procedure code means that qualifiers are applicable to that code. (See N.J.A.C. 10:57-3.4.)
HCPCS	
CODE =	HCPCS procedure code numbers.
MOD =	Alphabetic and numeric symbols: Under certain circumstances, services and procedures may be modified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid and NJ FamilyCare programs' modifier codes for podiatry services are:
22 =	Unusual Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '22' to the usual procedure number.
26 =	Professional Component: Certain procedures are a combination of a physician and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier '26' to the usual procedure number. If a professional component type service is keyed without the '26' modifier and a manual pricing edit is received, resolve the edit by adding the '26' modifier.
50 =	Bilateral Procedure: Unless otherwise identified in the

listing, bilateral procedures requiring separate incisions that are performed at the same operative session, should be identified by the appropriate five-digit code describing the first procedure. The second (bilateral) procedure is identified by adding modifier '50' to the procedure number.

51 = Multiple Procedures: When multiple procedures are performed at the same operative session, the major procedure may be reported as listed. The secondary, additional or lesser procedure(s) may be identified by adding the modifier '51' to the secondary procedure number(s).

52 = Reduced Services: Under certain circumstances, a service or procedure is partially reduced or eliminated at the podiatrist's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '52' signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

62 = Two Surgeons: Under certain circumstances, the skill of two surgeons (usually with different skills) may be required in the management of a specific procedure. Under such circumstances the separate services may be identified by adding the modifier '62' to the procedure number used by each surgeon for reporting his or her services.

66 = Surgical Team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or podiatrists, often of different specialties, plus other highly skilled, specially trained personnel and various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician or podiatrist with the addition of the modifier '66' to the basic procedure number used for reporting services.

76 = Repeat Procedure By Same Podiatrist: The podiatrist may need to indicate that a procedure or service was repeated subsequent to the original service. This circumstance may be reported by adding the modifier '76' to the repeated service.

77 = Repeat Procedure By Another Podiatrist: The podiatrist may need to indicate that a basic procedure performed by another podiatrist had to be repeated. This situation may be reported by adding modifier '77' to be repeated service.

80 = Assistant Surgeon: Surgical assistant services are identified by adding this modifier '80' to the usual procedure number(s).

81 = Minimum Assistant Surgeon.

82 = Assistant Surgeon (when a qualified resident surgeon is not available).

TC = When applicable, a charge may be made for the technical component alone. Under those circumstances the technical component is identified by adding the modifier 'TC' to the usual procedure code.

DESCRIPTION =	Code narrative: Narratives for Level I codes are found in CPT. Narratives for Level II Codes are found at N.J.A.C. 10:57-3.3.
FOLLOW-UP DAYS =	Number of days for follow-up care which are considered as included as part of the procedure code for which no additional reimbursement is available.
MAXIMUM FEE ALLOWANCE =	New Jersey Medicaid/NJ FamilyCare program's maximum reimbursement allowance. If the symbols "B.R." (By Report) are listed instead of a dollar amount, it means that additional information will be required in order to evaluate and price the service. Attach a copy of any additional information to the claim form.
ANES BASIC UNITS =	B.U.V. (Basic Unit Value) + A.T. (Anesthesia Time Per Unit) x $ 9.30 (Specialist) or $ 8.10 (non-specialist) equals reimbursement. Anesthesia Time per Unit is 15 minutes = 1 unit.

(d) Listed in this subsection are general policies of the New Jersey Medicaid/NJ FamilyCare program that pertain to HCPCS. Specific information concerning the responsibilities of a podiatrist when rendering Medicaid/NJ FamilyCare fee-for-service covered services and requesting reimbursement are located at *N.J.A.C. 10:57-1.8*, Recordkeeping, and 1.6, Basis of reimbursement.

1. General requirements are as follows:

i. When filing a claim, the appropriate HCPCS procedure codes must be used, in conjunction with modifiers when applicable.

ii. When billing, the provider must enter on the claim form a CPT/HCPCS procedure code as listed in this subchapter.

iii. Date(s) of service(s) must be indicated on the claim form and in the provider's own record for each service billed.

iv. The "Maximum Fee Allowance" as noted with these procedure codes represents the maximum payment for the given procedure for the podiatrist. When submitting a claim, the podiatrist must always use her or his usual and customary fee.

(1) Listed values for all surgical procedures include the surgery and the follow-up care included in the maximum fee allowance for the period (indicated in days) in the column titled "Follow-Up Days."

v. The HCPCS procedure codes that are billable in conjunction with office visit codes are listed at *N.J.A.C. 10:57-3.4*, Qualifiers. (See the "N" designation in the "Indicator" column.)

vi. The use of a procedure code will be interpreted by the New Jersey Medicaid/NJ FamilyCare program as evidence that the practitioner personally furnished, as a minimum, the services for which it stands.

History

HISTORY:

Amended by R.1998 d.248, effective May 18, 1998.

See: *30 N.J.R. 626(a)*, *30 N.J.R. 1812(b)*.

Updated HCPCS codes throughout.

Amended by R.1999 d.292, effective September 7, 1999.

See: *31 N.J.R. 1304(a)*, *31 N.J.R. 2637(a)*.

Inserted references to NJ KidCare programs throughout; in (c)1, inserted a reference to Medicare/NJ KidCare beneficiaries; and in (d), inserted a reference to NJ KidCare fee-for-service covered services.

Amended by R.2001 d.186, effective June 4, 2001.

See: *33 N.J.R. 972(a)*, *33 N.J.R. 1915(b)*.

Rewrote (c).

Amended by R.2004 d.2, effective January 5, 2004.

See: *35 N.J.R. 3799(a)*, *36 N.J.R. 188(a)*.

Rewrote the section.

Amended by R.2006 d.240, effective July 3, 2006.

See: *38 N.J.R. 1126(a)*, *38 N.J.R. 2805(a)*.

Section was "Introduction to the HCPCS procedure code system". Rewrote section.

Amended by R.2021 d.053, effective June 7, 2021.

See: *52 N.J.R. 855(a)*, *53 N.J.R. 1001(b)*.

In the introductory paragraph of (b), substituted "two-level" for "three-level"; deleted former (b)3; in the introductory paragraph of (d), substituted the first occurrence of "Medicaid/NJ" for "Medicaid and NJ", "program" for "programs", and the second occurrence of "Medicaid/NJ" for "Medicaid-covered or NJ", and updated the second N.J.A.C. cite; and in (d)1vi, substituted "Medicaid/NJ" for "Medicaid and NJ" and "program" for "programs".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:57-3.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 57. PODIATRY SERVICES > SUBCHAPTER 3. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

§ 10:57-3.2 HCPCS procedure codes and maximum fee allowance

(a) MEDICINE

				Maximum Fee		
	HCPCS			Allowance		Anes Basic
IND	Code	Mod	S	$	NS	Units
	90703		17.72		3.40	
	93922		22.00		21.00	
	93922	26	9.00		8.00	
	93922	TC	13.00		13.00	
	93923		45.00		42.00	
	93923	26	18.10		15.10	
	93923	TC	26.90		22.00	
	93965		30.00		28.00	
	93965	26	12.00		10.00	
	93965	TC	18.00		18.00	
	93970		62.00		58.00	
	93970	26	24.00		20.00	
	93970	TC	38.00		38.00	
	93971		30.00		28.00	
	93971	26	12.00		10.00	
	93971	TC	NA		18.00	

§ 10:57-3.2 HCPCS procedure codes and maximum fee allowance

	HCPCS		Maximum Fee Allowance			Anes Basic Units
IND	Code	Mod	S	$	NS	
	96360		20.22		17.19	
	96361		7.12		6.05	
	96365		38.35		32.60	
	96366		11.39		9.68	
	96367		16.53		14.05	
	96368		11.03		9.37	
	96369		89.74		76.28	
	96370		8.13		6.91	
	96371		35.38		30.97	
	96372		8.72		7.41	
	96373		9.87		8.39	
	96374		20.78		17.66	
	96375		8.84		7.51	
	96376		14.14		12.01	
	96379		2.50		2.50	
	99025		22.00		17.00	
	99199		B.R.		B.R.	
N	99201		24.78		21.06	
N	99202		41.08		34.92	
N	99203		58.02		49.31	
N	99204		87.59		74.45	
N	99205		109.89		93.40	
N	99211		16.00		14.00	
N	99212		24.41		20.22	
N	99213		39.85		33.87	
N	99214		58.21		49.48	
N	99215		77.76		66.10	

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	HCPCS		Maximum Fee Allowance			Anes Basic Units
IND	Code	Mod	S	$	NS	
N	99217		38.64		32.84	
N	99221		53.17		45.19	
N	99222		71.88		61.10	
N	99223		106.24		90.30	
N	99231		23.50		20.60	
N	99232		38.20		32.47	
N	99233		54.59		46.40	
N	99234		69.80		59.33	
N	99235		88.90		75.56	
N	99236		114.23		97.10	
	99238		38.64		32.84	
N	99239		56.64		48.14	
N	99241		44.00		37.00	
N	99242		64.70		54.40	
N	99243		64.70		54.40	
N	99244		91.10		77.90	
N	99245		91.10		77.90	
N	99251		34.50		29.30	
N	99252		64.70		54.40	
N	99253		64.70		54.40	
N	99254		91.10		77.90	
N	99255		91.10		77.90	
N	99261		16.00		14.00	
	99262		23.50		20.60	
	99263		23.50		20.60	
	99281		16.00		14.00	
	99282		23.50		20.60	

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	HCPCS		Maximum Fee Allowance			Anes Basic Units
IND	Code	Mod	S	$	NS	
	99283		32.23		27.40	
	99284		61.11		51.94	
	99285		89.92		76.43	
N	99304		45.67		38.82	
N	99305		66.07		56.16	
N	99306		84.57		71.88	
N	99307		22.39		19.03	
N	99308		35.08		29.81	
N	99309		46.62		39.63	
N	99310		68.95		58.60	
N	99315		38.83		33.01	
N	99316		55.80		47.43	
N	99318		48.66		41.36	
N	99324		28.06		23.85	
N	99325		40.56		34.47	
N	99326		70.36		59.81	
N	99334		30.65		26.05	
N	99335		48.26		41.02	
N	99336		68.73		58.42	
N	99341		29.18		24.81	
N	99342		41.94		35.65	
N	99343		63.82		58.07	
	99344		96.05		81.64	
	99345		116.83		99.30	
N	99347		35.00		35.00	
	99348		51.50		51.50	
	99349		68.14		57.92	

			Maximum Fee			Anes
	HCPCS		Allowance			Basic
IND	Code	Mod	S	$	NS	Units
	99350		94.43		80.26	
N	99499		B.R.		B.R.	
N	99600		B.R.		B.R.	

(b) SURGERY

			Follow	Maximum Fee			Anes
	HCPCS		Up	Allowance			Basic
IND	Code	Mod	Days	S	$	NS	Units
	10021		0	49.00		45.00	3
	10021	TC	0	19.00		19.00	0
	10021	26	0	30.00		26.00	0
	10022		0	87.00		78.00	3
	10022	TC	0	26.00		26.00	0
	10022	26	0	61.00		52.00	0
	10060		0	13.00		11.00	3
	10061		10	48.00		42.00	3
	10120		0	18.00		16.00	3
	10121		30	34.00		29.00	3
	10140		0	18.00		16.00	3

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IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes Basic Units
	10160		0	13.00		11.00	3
	10180		14	100.00		85.00	3
	11000		0	13.00		11.00	3
	11001		0	6.00		5.00	3
	11040		0	13.00		11.00	3
	11041		0	13.00		11.00	3
	11042		0	16.00		14.00	3
	11043		0	23.93		20.34	3
	11044		0	48.00		42.00	3
	11055		0	13.00		11.00	3
	11056		0	18.00		15.00	3
	11057		0	23.00		20.00	3
	11100		7	13.00		11.00	3
	11101		0	5.00		4.00	3
	11300		0	18.00		16.00	3
	11301		0	22.00		20.00	3
	11302		0	27.00		24.00	3
	11303		0	32.00		27.00	3
	11305		0	18.00		16.00	3
	11306		0	22.00		20.00	3
	11307		0	27.00		24.00	3
	11308		0	32.00		27.00	3
	11400		15	18.00		16.00	3
	11401		15	22.00		20.00	3
	11402		15	27.00		24.00	3

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IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes Basic Units
	11403		15	32.00		27.00	3
	11404		15	32.00		27.00	3
	11406		15	32.00		27.00	3
	11420		15	18.00		16.00	3
	11421		15	22.00		20.00	3
	11422		15	27.00		24.00	3
	11423		15	32.00		27.00	3
	11424		15	32.00		27.00	3
	11426		15	32.00		27.00	3
	11470		15	91.00		78.00	5
	11600		90	37.00		32.00	3
	11601		90	47.00		42.00	3
	11602		90	61.00		53.00	3
	11604		90	80.00		70.00	3
	11606		90	92.00		80.00	3
	11620		90	61.00		53.00	3
	11621		90	90.00		79.00	3
	11622		9	121.00		105.00	3

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IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes Basic Units
			0				
	11623		90	140.00		121.00	3
	11624		90	162.00		139.00	3
	11626		90	186.00		160.00	3
	11719		0	5.00		5.00	3
	11720		0	13.00		11.00	3
E	11721		0	21.00		18.00	3
	11730		0	11.58		9.84	3
	11732		0	3.91		3.32	3
	11740		0	16.00		14.00	3
	11750		30	42.00		37.00	3
	11752		30	59.00		50.00	3
	11755		0	25.00		20.00	3
	11760		60	42.00		37.00	3
	11762		90	69.00		59.00	3
	11765		60	21.00		18.00	3
	11900		0	16.00		14.00	3
	11901		0	16.00		14.00	3
	11981		0	100.00		85.00	3
	11982		0	100.00		85.00	3
	11983		0	180.00		153.00	3
	12001		0	18.00		16.00	3
	12002		0	24.00		21.00	3

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IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes Basic Units
	12004		0	30.00		26.00	3
	12005		7	46.00		39.00	3
	12006		7	57.00		48.00	3
	12007		7	82.50		70.00	3
	12020		7	57.00		48.00	5
	12021		7	57.00		48.00	5
	12041		30	30.00		26.00	3
	12042		30	67.00		59.00	4
	12044		30	82.50		70.00	4
	12045		30	99.00		84.00	4
	12046		30	110.00		94.00	4
	12047		30	143.00		120.00	4
	13131		30	67.00		59.00	4
	13132		30	145.00		126.00	4
	13160		30	121.00		103.00	3
	13300		30	242.00		210.00	4
	14040		60	193.00		168.00	4
	14041		60	242.00		210.00	4
	14300		60	242.00		210.00	4
	14350		60	193.00		168.00	3

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IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes Basic Units
	15000		10	70.50		60.00	3
	15001		0	40.00		34.00	0
	15050		30	62.87		53.44	4
	15100		45	121.00		105.00	3
	15101		45	61.00		53.00	4
	15120		45	182.00		158.00	4
	15121		45	61.00		53.00	4
	15220		45	151.00		131.00	4
	15221		30	76.00		65.00	3
	15240		45	151.00		131.00	4
	15241		30	76.00		65.00	3
	15342		0	36.00		31.00	0
+	15343		0	12.00		10.00	0
	15350		45	68.00		54.00	3
	15351		0	54.00		46.00	0
	15400		45	68.00		54.00	3
	15401		0	50.00		43.00	0
	15572		45	217.00		185.00	3
	15574		45	217.00		185.00	5
	15610		4	89.00		77.00	4

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IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes Basic Units
			5				
	15620		45	121.00		105.00	4
	15850		0	35.00		35.00	3
	15851		0	35.00		35.00	3
	15852		0	35.00		35.00	3
	16000		0	16.00		14.00	5
	16010		0	35.00		35.00	3
	16015		0	100.00		85.00	3
	16020		0	16.00		14.00	0
	16025		0	24.00		20.00	0
	16030		0	32.00		27.00	0
	16035		0	21.07		17.91	3
+	16036		0	40.00		34.00	0
	17000		0	16.00		14.00	3
	17003		0	5.00		4.00	3
	17004		0	52.00		46.00	3
	17106		0	111.75		95.00	3
	17107		0	212.80		180.90	3
	17108		0	322.85		274.40	3
	17110		0	16.00		14.00	3
	17111		0	23.00		20.00	3
	17250		0	16.00		14.00	3
	17270		15	29.20		24.81	3
	17271		15	43.74		37.20	3
	17272		15	52.20		44.36	3
	17273		1	61.48		52.26	3

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			Follow Up	Maximum Fee Allowance			Anes Basic
IND	HCPCS Code	Mod	Days	S	$	NS	Units
			5				
	17274		15	76.81		65.30	3
	17276		15	94.27		80.15	3
	17304		0	100.00		85.00	3
	17305		0	25.00		21.00	3
	17306		0	25.00		21.00	3
	17307		0	25.00		21.00	3
	17310		0	15.00		13.00	3
	17340		0	18.00		15.00	3
	20000		0	18.00		16.00	3
	20005		0	45.00		40.00	4
	20206		0	29.00		25.00	3
	20520		7	51.00		45.00	3
	20525		7	102.00		90.00	4
D	20550		0	13.00		11.00	5
E	20551		0	13.00		11.00	3
E	20552		0	13.00		11.00	3
E	20553		0	13.00		11.00	3
D	20600		0	13.00		11.00	3
D	20605		0	13.00		11.00	3
	20615		0	80.00		68.00	3
	20650		0	55.00		47.00	4
	20670		0	42.82		36.40	3
	20680		21	121.00		105.00	4
	20690		0	65.48		55.66	5
	20692		21	211.75		180.00	3

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IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes Basic Units
	20693		21	136.15		115.00	3
	20694		21	60.50		51.00	3
	20838		90	400.00		340.00	4
	20900		30	113.00		96.00	3
	20957		60	616.00		524.00	6
	27530		30	74.00		65.00	3
	27532		90	121.00		105.00	3
	27535		90	242.00		210.00	3
	27536		90	242.00		210.00	3
	27603		30	114.00		97.00	3
	27604		0	54.65		46.45	3
	27605		15	38.34		32.59	0
	27606		30	63.00		54.00	3
	27607		30	228.00		194.00	3
	27610		60	182.00		158.00	3
	27612		30	182.00		158.00	3
	27613		0	28.18		23.95	3
	27614		0	64.45		54.78	3
	27615		60	228.00		194.00	3

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IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance $	Maximum Fee Allowance NS	Anes Basic Units
	27618		0	50.28	42.74	3
	27619		30	57.00	49.00	3
	27620		60	182.00	158.00	3
	27625		90	211.00	184.00	3
	27626		60	228.00	194.00	3
	27630		30	90.00	79.00	3
	27635		60	228.00	194.00	4
	27637		60	285.00	243.00	4
	27638		60	285.00	243.00	4
	27640		60	211.00	184.00	4
	27641		60	211.00	184.00	4
	27645		90	342.00	291.00	4
	27646		90	342.00	291.00	4
	27647		90	371.00	316.00	4
	27648		0	18.00	16.00	3
	27650		90	227.00	197.00	4
	27652		90	314.00	267.00	4
	27654		90	314.00	267.00	4
	27656		9	911.18	774.50	3

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IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes Basic Units
			0				
	27658		90	121.00		105.00	3
	27659		90	121.00		105.00	3
	27664		90	90.00		79.00	3
	27665		90	90.00		79.00	3
	27675		30	171.00		146.00	3
	27676		30	200.00		170.00	3
	27680		30	143.00		122.00	3
	27681		30	171.00		146.00	3
	27685		90	151.00		131.00	4
	27686		90	202.00		175.00	3
	27687		30	171.00		146.00	3
	27690		90	182.00		158.00	3
	27691		90	342.00		291.00	3
E	27692		30	29.00		25.00	3
	27695		90	302.00		263.00	3
	27696		90	342.00		291.00	3
	27698		90	227.00		197.00	3

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IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes Basic Units
	27700		90	249.00		216.00	3
	27705		90	272.00		236.00	3
	27707		90	113.00		100.00	3
	27709		90	350.00		298.00	3
	27712		90	288.00		251.00	3
	27715		90	570.00		485.00	4
	27720		90	399.00		340.00	3
	27722		90	428.00		364.00	3
	27725		90	570.00		485.00	4
	27727		90	570.00		485.00	4
	27730		90	257.00		219.00	3
	27732		30	143.00		122.00	3
	27734		90	314.00		267.00	3
	27740		90	302.00		263.00	3
	27742		90	439.00		382.00	3
	27745		60	200.00		170.00	3
	27750		30	114.00		97.00	3
	27752		9	121.00		105.00	3

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IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes Basic Units
			0				
	27756		90	211.00		184.00	3
	27758		90	314.00		267.00	3
	27760		90	79.00		68.00	3
	27762		90	79.00		68.00	3
	27766		90	151.00		131.00	3
	27780		7	45.00		39.00	3
	27781		30	45.00		39.00	3
	27784		90	121.00		105.00	3
	27786		90	72.00		63.00	3
	27788		90	79.00		68.00	3
	27792		90	151.00		131.00	3
	27808		30	100.00		85.00	3
	27810		90	121.00		105.00	3
	27814		90	211.00		184.00	3
	27816		30	100.00		85.00	3
	27818		90	121.00		105.00	3
	27822		90	242.00		210.00	3
	27823		9	242.00		210.00	3

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IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes Basic Units
			0				
	27824		30	100.00		85.00	3
	27825		90	121.00		105.00	3
	27826		90	242.00		210.00	3
	27827		90	242.00		210.00	3
	27828		90	242.00		210.00	3
	27829		90	305.00		263.00	3
	27830		30	60.00		51.00	3
	27831		30	80.00		68.00	3
	27832		90	164.00		142.00	3
	27840		45	61.00		53.00	0
	27842		45	61.00		53.00	3
	27846		90	305.00		263.00	3
	27848		60	275.00		233.00	3
	27860		0	61.00		53.00	3
	27870		90	302.00		263.00	3
	27871		90	302.00		263.00	3
	27880		90	242.00		210.00	3
	27881		6	266.00		226.00	3

§ 10:57-3.2 HCPCS procedure codes and maximum fee allowance

IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes Basic Units
	27882		90	155.00		137.00	4
	27884		0	63.93		54.34	4
	27886		90	242.00		210.00	3
	27888		90	242.00		210.00	3
	27889		60	242.00		210.00	3
	27892		90	127.00		108.00	3
	27893		90	127.00		108.00	3
	27894		90	147.00		125.00	3
	28001		0	31.48		26.76	3
	28002		0	49.26		41.87	3
	28003		30	100.00		85.00	3
	28005		30	150.00		128.00	3
	28008		60	61.00		53.00	3
	28010		0	25.77		21.90	3
	28011		0	37.00		32.00	3
	28020		60	109.00		95.00	3
	28022		60	109.00		95.00	3
	28024		60	52.18		44.35	3
	28030		30	143.00		122.00	3

§ 10:57-3.2 HCPCS procedure codes and maximum fee allowance

IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes Basic Units
	28035		30	171.00		146.00	3
	28043		0	45.16		38.39	3
	28045		0	57.00		49.00	3
	28046		60	228.00		194.00	3
	28050		30	171.00		146.00	3
	28052		30	103.00		88.00	3
	28054		30	86.00		74.00	3
	28060		30	143.00		122.00	3
	28062		60	228.00		194.00	3
	28070		30	171.00		146.00	3
	28072		30	103.00		88.00	3
	28080		30	121.00		105.00	3
	28086		30	160.00		136.00	3
	28088		30	114.00		97.00	3
	28090		30	90.00		79.00	3
	28092		30	61.00		53.00	3
	28100		60	121.00		105.00	4
	28102		60	200.00		170.00	3
	28103		6	200.00		170.00	3

§ 10:57-3.2 HCPCS procedure codes and maximum fee allowance

IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes Basic Units
	28104		30	143.00		122.00	4
	28106		60	200.00		170.00	3
	28107		60	200.00		170.00	3
	28108		60	121.00		105.00	4
	28110		30	69.00		59.00	3
	28111		30	171.00		146.00	3
	28112		30	103.00		88.00	3
	28113		30	103.00		88.00	3
	28114		90	242.00		210.00	3
	28116		30	171.00		146.00	3
	28118		30	143.00		122.00	3
	28119		30	143.00		122.00	3
	28120		60	90.00		79.00	4
	28122		60	90.00		79.00	4
	28124		60	90.00		79.00	4
	28126		30	143.00		122.00	3
	28130		90	211.00		184.00	3

§ 10:57-3.2 HCPCS procedure codes and maximum fee allowance

IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance $	NS	Anes Basic Units
	28140		60	121.00	105.00	3
	28150		90	90.00	79.00	3
	28153		30	69.00	59.00	3
	28160		90	90.00	79.00	3
	28171		90	371.00	316.00	3
	28173		90	371.00	316.00	3
	28175		90	371.00	316.00	3
	28190		0	29.14	24.77	3
	28192		30	52.85	44.92	4
	28193		30	59.81	50.84	4
	28200		90	121.00	105.00	3
	28202		30	161.00	137.00	3
	28208		90	61.00	53.00	3
	28210		30	103.00	88.00	3
	28220		60	113.00	99.00	3
	28222		60	139.00	119.00	3
	28225		60	113.00	99.00	3
	28226		60	139.00	119.00	3

§ 10:57-3.2 HCPCS procedure codes and maximum fee allowance

IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance $	NS	Anes Basic Units
	28230		30	49.26	41.87	3
	28232		60	139.00	119.00	3
	28234		60	139.00	119.00	3
	28238		30	171.00	146.00	3
	28240		30	61.00	53.00	3
	28250		30	143.00	122.00	3
	28260		30	171.00	146.00	3
	28261		60	200.00	170.00	3
	28262		60	212.00	184.00	3
	28264		60	285.00	243.00	3
	28270		30	69.00	59.00	3
	28272		30	44.48	37.80	3
	28280		45	61.00	53.00	3
	28285		90	90.00	79.00	3
	28286		30	68.00	57.00	3
	28288		21	72.00	63.00	3
	28289		90	228.00	194.00	3
	28290		6	90.00	79.00	3

§ 10:57-3.2 HCPCS procedure codes and maximum fee allowance

IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes Basic Units
	28292		90	139.00		121.00	3
	28293		90	242.00		210.00	3
	28294		90	141.00		123.00	3
	28296		60	200.00		170.00	3
	28305		60	217.00		185.00	3
	28306		90	113.00		100.00	3
	28307		60	217.00		185.00	3
	28308		90	113.00		100.00	3
	28309		60	257.00		219.00	3
	28310		30	69.00		59.00	3
	28312		30	58.55		49.77	3
	28313		90	90.00		79.00	3
	28315		60	55.00		47.00	3
	28320		60	200.00		170.00	3
	28322		30	143.00		122.00	3
	28340		90	90.00		79.00	3
	28341		90	90.00		79.00	3

§ 10:57-3.2 HCPCS procedure codes and maximum fee allowance

IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance $	Maximum Fee Allowance NS	Anes Basic Units
	28344		45	63.12	53.65	3
	28345		90	90.00	79.00	3
	28400		30	68.00	59.00	3
	28405		90	90.00	79.00	3
	28406		60	228.00	194.00	3
	28415		90	151.00	131.00	3
	28420		90	300.00	255.00	3
	28430		30	82.00	72.00	3
	28435		90	90.00	79.00	3
	28436		30	175.00	149.00	3
	28445		60	275.00	234.00	3
	28450		30	41.00	36.00	3
	28455		90	61.00	53.00	3
	28456		30	121.00	103.00	3
	28465		90	121.00	105.00	3
	28470		30	24.58	20.72	3
	28475		90	42.00	37.00	3
	28476		3	82.00	70.00	3

§ 10:57-3.2 HCPCS procedure codes and maximum fee allowance

IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes Basic Units
	28485		90	90.00		79.00	3
	28490		30	18.00		16.00	3
	28495		30	30.00		26.00	3
	28496		30	60.00		51.00	3
	28505		30	120.00		102.00	3
	28510		30	18.00		16.00	3
	28515		30	30.00		26.00	3
	28525		30	90.00		77.00	3
	28530		30	18.00		16.00	3
	28531		30	59.00		50.00	3
	28540		45	61.00		53.00	0
	28545		45	61.00		53.00	3
	28546		30	69.00		59.00	3
	28555		90	211.00		184.00	3
	28570		45	61.00		53.00	0
	28575		45	61.00		53.00	3
	28576		45	118.00		100.00	3

§ 10:57-3.2 HCPCS procedure codes and maximum fee allowance

IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes Basic Units
	28585		90	211.00		184.00	3
	28600		45	61.00		53.00	0
	28605		45	61.00		53.00	3
	28606		30	69.00		59.00	3
	28615		30	143.00		122.00	3
	28630		45	61.00		53.00	0
	28635		7	65.00		55.00	3
	28636		7	85.00		72.00	3
	28645		90	121.00		105.00	3
	28660		0	16.00		14.00	0
	28665		0	35.00		30.00	3
	28666		45	80.00		68.00	3
	28675		60	65.73		55.87	3
	28705		90	361.00		307.00	3
	28715		90	272.00		236.00	3
	28725		90	182.00		158.00	3
	28730		60	203.00		173.00	3
	28735		60	226.00		192.00	3
	28737		60	200.00		170.00	3

§ 10:57-3.2 HCPCS procedure codes and maximum fee allowance

			Follow Up	Maximum Fee Allowance			Anes Basic
IND	HCPCS Code	Mod	Days	S	$	NS	Units
	28740		90	166.00		126.00	3
	28750		90	90.00		79.00	3
	28755		90	90.00		79.00	3
	28760		90	200.00		173.00	3
	28800		90	211.00		184.00	3
	28805		90	211.00		184.00	3
	28810		90	121.00		105.00	3
	28820		45	63.67		54.12	3
	28820	50	45	94.96		80.71	3
	28825		45	60.94		51.80	3
	28825	50	45	90.89		77.25	3
	28899		0	B.R.		B.R.	0
	29345		0	53.00		42.00	3
	29355		0	47.00		42.00	3
	29358		2	41.00		34.85	3
	29365		0	53.00		42.00	3
ED	29405		0	42.00		37.00	3
ED	29425		0	47.00		42.00	3
ED	29435		0	66.00		53.00	3
E	29440		0	12.00		10.00	3

§ 10:57-3.2 HCPCS procedure codes and maximum fee allowance

			Follow Up	Maximum Fee Allowance			Anes Basic
IND	HCPCS Code	Mod	Days	S	$	NS	Units
D							
ED	29450		0	24.00		21.00	3
ED	29450	50	0	37.00		32.00	3
ED	29505		0	48.00		42.00	3
ED	29515		0	42.00		37.00	3
ED	29540		0	18.00		16.00	3
ED	29550		0	16.00		14.00	3
ED	29580		0	18.00		16.00	3
ED	29590		0	12.00		10.00	3
ED	29700		0	14.00		12.00	3
ED	29705		0	14.00		12.00	3
ED	29730		0	9.00		8.00	3
ED	29740		0	11.05		9.39	3
ED	29750		0	11.32		9.62	3
ED	29750	50	0	15.00		13.00	3
ED	29799		0	B.R.		B.R.	0
	29891		90	236.00		201.00	3
	29892		90	243.00		206.00	3

§ 10:57-3.2 HCPCS procedure codes and maximum fee allowance

IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes Basic Units
	29893		90	137.00		116.00	3
	29894		30	100.00		85.00	3
	29895		90	200.00		170.00	4
	29897		60	100.00		85.00	3
	29898		60	150.00		128.00	3
	29899		90	225.00		191.00	3
	29909		0	BR		BR	0
	29999		90	BR		BR	3
ED	36410		0	18.00		16.00	0
END	36415		0	1.80		1.80	0
	36470		0	16.70		14.19	0
	36471		0	20.03		17.02	0
E	64450		0	18.00		16.00	0
	64614		10	77.00		65.00	0
	64702		90	79.00		68.00	3
	64704		90	105.00		91.00	3
	64708		90	242.00		210.00	3
	64726		90	90.00		77.00	3
	64774		30	45.96		39.06	3

			Follow Up	Maximum Fee Allowance			Anes Basic
IND	HCPCS Code	Mod	Days	S	$	NS	Units
	64776		30	53.00		45.00	3
	64778		30	30.00		26.00	3
	64782		30	79.00		68.00	3
	64783		30	70.00		60.00	3
	64784		30	131.00		114.00	4
	64831		90	79.00		68.00	3
	64832		30	43.00		37.00	3
	64834		90	105.00		91.00	3
	64856		90	210.00		183.00	3
	64857		90	158.00		137.00	3
	97601		0	35.00		30.00	0

NOTE: "+" means that these add-on codes are always performed in addition to the primary procedure only, by the same practitioner. These add-on codes are exempt from multiple surgical pricing methodologies.

(c) RADIOLOGY

			Maximum Fee Allowance			Anes Basic
IND	HCPCS Code	Mod	S	$	NS	Units

§ 10:57-3.2 HCPCS procedure codes and maximum fee allowance

IND	HCPCS Code	Mod	S	Maximum Fee Allowance $	NS	Anes Basic Units
	73600			10.00		3
	73600	26		3.60		
	73600	TC		6.40		
	73610			13.00		3
	73610	26		5.40		
	73610	TC		7.60		
	73615			28.80		3
	73615	26		10.80		
	73615	TC		18.00		
	73620			10.00		3
	73620	26		3.60		
	73620	TC		6.40		
	73630			13.00		3
	73630	26		5.40		
	73630	TC		7.60		
	73650			10.0		3

IND	HCPCS Code	Mod	S	Maximum Fee Allowance $	NS	Anes Basic Units
				0		
	73650	26		3.60		
	73650	TC		6.40		
	73660			5.00		3
	73660	26		3.60		
	73660	TC		1.40		

(d) PATHOLOGY & LABORATORY SERVICES

IND	HCPCS Code	Mod	Maximum Fee Allowance
	81000		1.20
	82948		1.50
	85002		1.20
	85008		1.20
	86671		15.00
	87070		9.00
	87076		6.00
	87084		3.00
	87101		8.00
	87102		8.00
	87103		8.00
	87106		8.00
	87210		2.40
	87220		2.40

History

HISTORY:

Amended by R.1998 d.248, effective May 18, 1998.

See: *30 N.J.R. 626(a)*, *30 N.J.R. 1812(a)*.

Updated HCPCS codes throughout.

Amended by R.1999 d.292, effective September 7, 1999.

See: *31 N.J.R. 1304(a)*, *31 N.J.R. 2637(a)*.

In (a), inserted references to HCPCS Codes 99344, 99345, 99347, 99348, 99349 and 99350, and deleted references to HCPCS Codes 99351, 99352 and 99353; and in (b), inserted references to HCPCS Codes 11055, 11056, 11057, 11719, 17003, 17004, 17111, 29891, 29892 and 29893, and deleted references to HCPCS Codes 11050, 11051, 11052, 17001, 17002, 17010, 17100, 17101, 17102, 17104 and 17105.

Amended by R.2000 d.419, effective October 16, 2000.

See: *32 N.J.R. 2197(a)*, *32 N.J.R. 3843(a)*.

In (b), inserted references to HCPCS Codes 15001, 15351, 15401 and 28289, and deleted references to HCPCS Codes 11731, 16040, 16042 and 64830.

Amended by R.2001 d.186, effective June 4, 2001.

See: *33 N.J.R. 972(a)*, *33 N.J.R. 1915(b)*.

Rewrote the section.

Amended by R.2004 d.2, effective January 5, 2004.

See: *35 N.J.R. 3799(a)*, *36 N.J.R. 188(a)*.

In (a), added HCPCS Code 99600; in (b), added HCPCS Code 29899.

Amended by R.2006 d.240, effective July 3, 2006.

See: *38 N.J.R. 1126(a)*, *38 N.J.R. 2805(a)*.

Updated tables in (a) and (b).

Amended by R.2021 d.053, effective June 7, 2021.

See: *52 N.J.R. 855(a)*, *53 N.J.R. 1001(b)*.

Rewrote (a) and (b).

Annotations

Notes

Chapter Notes

N.J.A.C. 10:57-3.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 57. PODIATRY SERVICES > SUBCHAPTER 3. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

§ 10:57-3.3 Descriptions of Level II Codes

IND	HCPCS Code	Mod	Description	Maximum Fee Allowance S	$	NS
	G0001		Routine venipuncture QUALIFIER: This service is reimbursable in the provider office laboratory (POL) when the specimen is referred out to an independent clinical laboratory for testing. Venipuncture is not reimbursable when billed by the independent clinical laboratory. It is considered all inclusive as part of the laboratory test.	1.80		1.80
	G0127		Trimming dystrophic nails, 1-10	7.00		7.00
	J0690		Injection, cefazolin sodium, (ancef, kefzol) up to 500 mg	2.83		2.83
	J0696		Injection, ceftriaxone sodium, (rocephin) per 250 mg	12.97		12.97
	J1100		Injection, dexamethasone sodium phosphate, up to 4 mg/ml	0.13		0.13
	J1200		Injection, diphenhydramine HCl (benedryl), up to 50 mg	0.55		0.55
	L1902		AFO, ankle gauntlet, custom fitted	48.81		48.81
	L1906		AFO, multiligaments ankle support	75.00		75.00
	L1907		Ankle-foot-orthosis(AFO) Supramalleolar with straps, with or			

IND	HCPCS Code	Mod	Description	Maximum Fee Allowance S	$	NS
			without interface/pads, custom fabricated	353.71		353.71
	L1930		AFO, custom fitted, plastic	156.80		156.80
	L1940		AFO, molded to patient model, plastic	387.94		387.94
	L1951		AFO, Spiral, Institute of Rehabilitative Medicine type, Plastic or other material, prefabricated, includes fitting and adjustment	527.61		527.61
	L1971		AFO, Plastic or other material with ankle joint, prefabricated, includes fitting and adjustment	294.64		294.64
	L2108		AFO, fracture orthosis, tibial fracture cast orthosis, molded to patient model	569.60		569.60
	L2112		AFO, fracture orthosis, tibial fracture orthosis, custom fitted	244.08		244.08
	L2114		AFO, fracture orthosis, tibial fracture orthosis, semi-rigid custom fitted	321.37		321.37
	L2116		AFO, fracture orthosis, tibial fracture orthosis, rigid custom fitted	366.00		366.00
	L3000		Foot insert, removable, molded to patient model "UCB" type, Berkeley shell, each	140.00		140.00
	L3001		Foot insert, removable, molded to patient model, Spenco, each QUALIFIER: Custom Spenco Device	76.00		76.00
	L3002		Foot insert, removable, molded to patient model, Plastazote or equal, each	76.00		76.00

IND	HCPCS Code	Mod	Description	Maximum Fee Allowance S	$	NS
	L3003		Foot insert, removable, molded to patient model, silicone gel, each	76.00		76.00
	L3010		Foot insert, removable, molded to patient model, longitudinal arch support, each QUALIFIER: Any Custom Leather/Metal Device (Example: Schaeffer, Whitman)	76.00		76.00
	L3020		Foot insert, removable, molded to patient model, longitudinal/ metatarsal support, each QUALIFIER: Any Custom Leather/Plastic Device, Full Foot Only	88.00		88.00
	L3030		Foot insert, removable, formed to patient foot, each QUALIFIER: Only Off-The Shelf Spenco	48.00		48.00
	L3031		Foot, Insert/plate, removable, addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, each	80.34		80.34
	L3040		Foot, arch support, removable, premolded, longitudinal, each QUALIFIER: Only Off-The Shelf Plastazote	29.60		29.60
	L3050		Foot, arch support, removable, premolded, metatarsal, each	32.00		32.00
	L3060		Foot, arch support, removable, premolded, longitudinal/metatarsal, each	48.00		48.00
	L3070		Foot, arch support, nonremovable, attached to shoe, longitudinal, each	16.00		16.00
	L3080		Foot, arch support, nonremovable, attached to shoe, metatarsal, each	20.00		20.00

§ 10:57-3.3 Descriptions of Level II Codes

IND	HCPCS Code	Mod	Description	Maximum Fee Allowance S	$	NS
	L3090		Foot, arch support, nonremovable, attached to shoe, longitudinal/ metatarsal, each	24.00		24.00
	L3100		Hallus-Valgus night dynamic splint	20.00		20.00
	L3140		Foot, rotation positioning device, including shoe(s)	56.00		56.00
	L3150		Foot, rotation positioning device, without shoe(s)	60.00		60.00
	L3170		Foot, plastic heel stabilizer	31.99		31.99
	L3201		Orthopedic shoe, oxford with supinator or pronator, infant	48.00		48.00
	L3202		Orthopedic shoe, oxford with supinator or pronator, child	48.00		48.00
	L3203		Orthopedic shoe, oxford with supinator or pronator, junior	48.00		48.00
	L3204		Orthopedic shoe, hightop with supinator or pronator, infant	48.00		48.00
	L3206		Orthopedic shoe, hightop with supinator or pronator, child	48.00		48.00
	L3207		Orthopedic shoe, hightop with supinator or pronator, junior	48.00		48.00
	L3208		Surgical boot, each, infant	24.00		24.00
	L3209		Surgical boot, each, child	24.00		24.00
	L3211		Surgical boot, each, junior	24.00		24.00
	L3212		Benesch boot, pair, infant	48.00		48.00
	L3213		Benesch boot, pair, child	48.00		48.00
	L3214		Benesch boot, pair, junior	48.00		48.00
	L3215		Orthopedic footwear, woman's shoes, oxford	38.00		38.00
	L3216		Orthopedic footwear, woman's shoes, depth inlay	50.00		50.00
	L3217		Orthopedic footwear, woman's shoes, hightop, depth inlay	58.00		58.00

IND	HCPCS Code	Mod	Description	Maximum Fee Allowance S	$	NS
	L3219		Orthopedic footwear, man's shoes, oxford	38.00		38.00
	L3221		Orthopedic footwear, man's shoes, depth inlay	50.00		50.00
	L3222		Orthopedic footwear, man's shoes, hightop, depth inlay	58.00		58.00
	L3230		Orthopedic footwear, custom shoes, depth inlay	190.00		190.00
	L3250		Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each	250.00		250.00
	L3251		Foot, shoe molded to patient model, silicone shoe, each	280.00		280.00
	L3252		Foot, shoe molded to patient model, Plastozote (or similar), custom fabricated, each	256.00		256.00
	L3253		Foot, molded shoe Plastazote (or similar), custom fitted, each	112.00		112.00
	L3254		Nonstandard size or width	20.00		20.00
	L3255		Nonstandard size or length	20.00		20.00
	L3257		Orthopedic footwear, additional charge for split size	50.00		50.00
	L3260		Ambulatory surgical boot, each	88.00		88.00
	L3265		Plastazote sandal, each	56.00		56.00
	L3300		Lift, elevation, heel, tapered to metatarsals, per inch	32.78		32.78
	L3310		Lift, elevation, heel and sole, neoprene, per inch	51.17		51.17
	L3320		Lift, elevation, heel and sole, cork, per inch	100.00		100.00
	L3332		Lift, elevation, inside shoe, tapered, up to one-half inch	44.00		44.00
	L3334		Lift, elevation, heel, per inch	23.98		23.98

L3340		Heel wedge, Sach	10.40	10.40
L3350		Heel wedge	12.00	12.00
L3360		Sole wedge, outside sole	12.00	12.00
L3370		Sole wedge, between sole	14.40	14.40
L3380		Club foot wedge	12.00	12.00
L3390		Outflare wedge	16.00	16.00
L3400		Metatarsal bar wedge, rocker	16.00	16.00
L3410		Metatarsal bar wedge, between sole	16.00	16.00
L3420		Full sole and heel wedge, between sole	24.00	24.00
L3430		Heel, counter, plastic reinforced	24.00	24.00
L3440		Heel, counter, leather reinforced	24.00	24.00
L3450		Heel, Sach cushion type	64.00	64.00
L3455		Heel, new leather, standard	8.00	8.00
L3460		Heel, new rubber, standard	8.00	8.00
L3465		Heel, Thomas with wedge	20.00	20.00
L3470		Heel, Thomas extended to ball	24.00	24.00
L3480		Heel, pad and depression for spur	16.00	16.00
L3485		Heel, pad, removable for spur	32.00	32.00
L3500		Miscellaneous shoe addition, insole, leather	4.00	4.00
L3510		Miscellaneous shoe addition, insole, rubber	8.00	8.00
L3520		Miscellaneous shoe additions, insole, felt covered with leather	8.00	8.00
L3530		Miscellaneous shoe addition, sole, half	12.00	12.00
L3540		Miscellaneous shoe addition, sole, full	36.00	36.00
L3550		Miscellaneous shoe addition, toe tap, standard	4.00	4.00
L3560		Miscellaneous shoe addition, toe tap, horseshoe	6.40	6.40
L3580		Miscellaneous shoe addition, convert instep to Velcro closure	13.60	13.60
L3580	52	Velcro straps, attached to a pair of shoes, per pair	14.00	14.00

L3649	52	Foot Casting	50.00	50.00
L3649	22	Foot, ankle casting	65.00	65.00
L3649		Orthopedic shoe, modification, addition or transfer, NOS	28.00	28.00
L4205		Repair of orthotic device, quarter-hour rate	10.60	10.60
L5673		Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated socket insert, silicone gel, elastomeric or equal, for use with locking mechanism	506.15	506.15
L5679		Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism	421.77	421.77
L5681		Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel elastomeric or equal, for use with or without locking mechanism, initial only. (For other than initial, use L5673 or L5679)	828.47	828.47
L5683		Addition to lower extremity, below knee/above knee, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel elastomeric or equal, for use with or without locking mechanism, initial only. (For other than initial, use L5673 or L5679)	828.47	828.47
Q0112		All potassium hydroxide(KOH)	0.10	0.10

preparations

History

HISTORY:

Amended by R.1998 d.248, effective May 18, 1998.

See: *30 N.J.R. 626(a)*, *30 N.J.R. 1812(b)*.

Updated HCPCS codes throughout.

Amended by R.1999 d.292, effective September 7, 1999.

See: *31 N.J.R. 1304(a)*, *31 N.J.R. 2637(a)*.

Inserted a reference to HCPCS Code G0127, and in HCPCS Codes L3001, L3010, L3020, L3030 and L3040, added references to Qualifiers.

Amended by R.2001 d.63, effective February 20, 2001.

See: *32 N.J.R. 4096(a)*, *33 N.J.R. 661(b)*.

Deleted a HCPCS Code M0101.

Amended by R.2001 d.186, effective June 4, 2001.

See: *33 N.J.R. 972(a)*, *33 N.J.R. 1915(b)*.

Rewrote the section.

Amended by R.2006 d.240, effective July 3, 2006.

See: *38 N.J.R. 1126(a)*, *38 N.J.R. 2805(a)*.

Updated table.

Amended by R.2021 d.053, effective June 7, 2021.

See: *52 N.J.R. 855(a)*, *53 N.J.R. 1001(b)*.

Rewrote the section.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:57-3.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 57. PODIATRY SERVICES > SUBCHAPTER 3. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

§ 10:57-3.4 Qualifiers for podiatry services

(a) The following is a list of HCPCS codes with their associated qualifiers. Providers shall use the following procedure codes in billing each of the procedures.

1. HCPCS 36415--Maximum units per date of service is 10. Not applicable if the laboratory study, in any part, is performed by the office staff or by the provider.

2. HCPCS 87070, 87081--Culture codes. May only be billed when a pathogenic microorganism is reported. A culture that indicates no growth or normal flora must be billed as a presumptive culture, 87081.

3. HCPCS 96360--IV infusion therapy. Not to be used for routine IV drug injection or infusion. Reimbursement is contingent upon the required medical necessity, handwritten chart documentation, including time and indication of physician's presence with the patient to the exclusion of his other duties.

4. HCPCS 96361--IV infusion therapy. Not be used for routine IV drug injection or infusion. Reimbursement is contingent upon the required medical necessity, handwritten chart documentation, including time and indication of podiatrist's presence with the patient to the exclusion of his or her other duties.

5. HCPCS 99201, 99202, 99203, 99204, 99205, 99221, 99222, 99223, 99304, 99305, 99306, 99324, 99325, 99326--Office or other outpatient services--new patient; Hospital inpatient services--initial hospital care; Nursing facility services--comprehensive nursing facility assessments; and Domiciliary, Rest home, or Custodial care services--new patient.

i. Excludes Preventive Health Care for patients through 20 years of age.

6. HCPCS 99211, 99212, 99213, 99214, 99215, 99231, 99232, 99233, 99307, 99308, 99309, 99310, 99318, 99334, 99335, 99336--Office or other outpatient services--established patient; Hospital inpatient services--subsequent hospital care; Nursing facility services--subsequent nursing facility care; and Domiciliary, Rest home or Custodial care services--established patient.

i. Excludes Preventive Health Care for patients through 20 years of age.

7. HCPCS 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, and 99600 Home services and House calls.

i. Do not distinguish between specialist and nonspecialist.

ii. These codes do not apply to residential health care facility or nursing facility setting.

iii. HCPCS 99341, 99342, 99344, 99345, 99347, 99348, 99349 and 99350 apply when the provider visits the Medicaid or NJ FamilyCare fee-for-service beneficiary in their home setting and the visit does not meet the criteria specified under House Call listed above.

iv. The HCPCS codes 99244, 99245, 99254, and 99255 shall be utilized for Comprehensive consultation.

(1) HCPCS 99244, 99245, 99254, and 99255, require a comprehensive evaluation by history and physical examination within the scope of a podiatric specialist's practice. An alternative to that would be the utilization of one or more hours of the consulting podiatrist's personal time in the performance of the consultation.

(2) HCPCS 99244, 99245, 99254, and 99255, require the following applicable statements, or language essentially similar to those statements, to be inserted in the "remarks" section of the claim form. The form is to be signed by the podiatrist who performed the consultation.

Examples:

"I personally performed a comprehensive evaluation by history and physical examination within the scope of my podiatric practice as a specialist." or

"This consultation utilized 60 or more minutes of my personal time."

8. The HCPCS codes 99241, 99242, 99243, 99251, 99252, and 99253, shall be utilized for Limited consultation. The area being covered for reimbursement purposes is "limited" in the sense that it requires less than the requirements designated as comprehensive consultation as noted above.

9. For procedure codes L3000 through L3003; L3010, L3020, L3030, L3040, L3050, L3060, L3070, L3080 and L3090, up to four units of orthotics may be provided by the same provider to the same beneficiary during a 12-month period.

10. For procedure codes L3201 through L3207; L3215 through L3217; L3219, L3221 and L3222, up to two units may be provided by the same provider to the same beneficiary during a 12-month period.

11. HCPCS procedure codes L3001, L3002, L3003, L3010, L3020, L3030, L3040, L3050, L3060, L3070, L3080, L3090, L3215 through L3223, and L3201 through L3207 do not require prior authorization for the following diagnosis codes: 343.0 to 343.9, 707.0 to 707.9, 711.0 to 712.9, 715.0 to 722.9, 724.0 to 728.9, 730.0 to 737.9, 754.2 to 754.79, 755.0 to 755.39, 755.6 to 755.69, 756.1 to 756.19, 756.8 to 756.89, and 892.0 to 897.7.

History

HISTORY:

Amended by R.1998 d.248, effective May 18, 1998.

See: *30 N.J.R. 626(a)*, *30 N.J.R. 1812(b)*.

Updated HCPCS code references throughout; in (a), deleted 6 and 11 and recodified former 7 through 10 as 6 through 9.

Amended by R.1999 d.292, effective September 7, 1999.

See: *31 N.J.R. 1304(a)*, *31 N.J.R. 2637(a)*.

In (a)8, substituted a reference to HCPCS Codes 99344, 99345, 99347, 99348, 99349 and 99350 for a reference to HCPCS Codes 99351, 99352 and 99353 in the introductory paragraph, and substituted a reference to HCPCS Codes 99344, 99345, 99347, 99348, 99349 and 99350 for a reference to HCPCS Codes 99351 and 99352 and inserted a reference to NJ KidCare fee-for-service beneficiaries in iii.

Amended by R.2004 d.2, effective January 5, 2004.

See: *35 N.J.R. 3799(a)*, *36 N.J.R. 188(a)*.

In (a)8, added HCPCS Code 99600.

§ 10:57-3.4 Qualifiers for podiatry services

Recodified from *N.J.A.C. 10:57-3.5* by R.2006 d.240, effective July 3, 2006.

See: *38 N.J.R. 1126(a)*, *38 N.J.R. 2805(a)*.

Former 10:57-3.4 "Descriptions of Level III Codes" was repealed. Added (a)10 through (a)12.

Amended by R.2021 d.053, effective June 7, 2021.

See: *52 N.J.R. 855(a)*, *53 N.J.R. 1001(b)*.

Rewrote the section.

Annotations

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End of Document

N.J.A.C. 10:57-3.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 57. PODIATRY SERVICES > SUBCHAPTER 3. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

§ 10:57-3.5 (Reserved)

History

HISTORY:

Recodified to *N.J.A.C. 10:57-3.4* by R.2006 d.240, effective July 3, 2006.

See: *38 N.J.R. 1126(a)*, *38 N.J.R. 2805(a)*.

Section was "Qualifiers for podiatry services".

Annotations

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N.J.A.C. 10:57, Appx. A

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APPENDIX A

FISCAL AGENT BILLING SUPPLEMENT

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

DXC Technology

PO Box 4801

Trenton, New Jersey 08619-4801

or contact

Office of Administrative Law

Quakerbridge Plaza, Building 9

PO Box 049

Trenton, New Jersey 08625-0049

History

HISTORY:

Amended by R.1998 d.248, effective May 18, 1998.

See: *30 N.J.R. 626(a)*, *30 N.J.R. 1812(b)*.

Updated address.

Amended by R.2021 d.053, effective June 7, 2021.

See: *52 N.J.R. 855(a)*, *53 N.J.R. 1001(b)*.

Substituted "DXC Technology" for "UNISYS".

Annotations

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APPENDIX A

NEW JERSEY ADMINISTRATIVE CODE

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