N.J.A.C. 10:61

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 61. INDEPENDENT CLINICAL LABORATORIES

Title 10, Chapter 61 -- 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:

Effective: July 6, 2021.

See: 53 N.J.R. 1279(a).

CHAPTER HISTORICAL NOTE:

Chapter 61, Independent Laboratory Services, was adopted as R.1971 d.57, effective April 21, 1971. See: 3 N.J.R. 43(a), 3 N.J.R. 83(b).

Subchapter 3, Laboratory Code List, was repealed and a new Subchapter 3, HCFA Common Procedure Coding System (HCPCS), was adopted effective March 3, 1986, as R.1986 d.52.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

Pursuant to Executive Order No. 66(1978), Chapter 61, Independent Laboratory Services, was readopted as R.1991 d.138, effective February 15, 1991. See: 22 N.J.R. 3713(a), 23 N.J.R. 838(e).

Chapter 61, Independent Laboratory Services, was repealed, and Chapter 61, Independent Clinical Laboratories, was adopted as new rules by R.1996 d.68, effective February 5, 1996. See: 27 N.J.R. 4861(a), 28 N.J.R. 1054(a).

Pursuant to Executive Order No. 66(1978), Chapter 61, Independent Clinical Laboratories, was readopted as R.2001 d.79, effective February 1, 2001. See: 32 N.J.R. 4167(a), 33 N.J.R. 781(c).

Subchapter 3, HCFA Common Procedure Coding System (HCPCS), was renamed Healthcare Common Procedure Coding System (HCPCS) by R.2006 d.37, effective January 17, 2006. See: 37 N.J.R. 3182(a), 38 N.J.R. 807(a).

Chapter 61, Independent Clinical Laboratories, was readopted as R.2006 d.244, effective June 7, 2006. See: 38 N.J.R. 1383(a), 38 N.J.R. 2827(a).

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 61, Independent Clinical Laboratories, was scheduled to expire on June 7, 2013. See: *43 N.J.R. 1203(a)*.

Chapter 61, Independent Clinical Laboratories, was readopted as R.2014 d.003, effective December 2, 2013. See: 45 N.J.R. 2099(a), *46 N.J.R. 77(b)*.

In accordance with *N.J.S.A. 52:14B-5.1*, Chapter 61, Independent Clinical Laboratories, was scheduled to expire on December 2, 2020. Pursuant to Executive Order Nos. 127 (2020) and 244 (2021) and P.L. 2021, c. 104, any chapter of the New Jersey Administrative Code that would otherwise have expired during the Public Health Emergency originally declared in Executive Order No. 103 (2020) is extended through January 1, 2022. Chapter 61, Independent Clinical Laboratories, was readopted with technical changes, effective July 6, 2021. See: Source and Effective Date. See, also, section annotations.

Annotations

Notes

Chapter Notes

Research References & Practice Aids

CHAPTER EXPIRATION DATE:

Chapter 61, Independent Clinical Laboratories, expires on July 6, 2028.

N.J.A.C. 10:61-1.1

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 61. INDEPENDENT CLINICAL LABORATORIES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:61-1.1. Purpose and scope

This chapter outlines the policies and procedures for coverage of clinical laboratory services that must be met in order to qualify for reimbursement under the Medicaid/NJ FamilyCare fee-for-service programs. The services of a qualified clinical laboratory for which reimbursement may be made relate only to diagnostic tests performed in a laboratory which is independent of a physician's office, a participating hospital, or other facility. Rules for laboratory services provided by other types of providers are included in the Medicaid/NJ FamilyCare rules for those particular providers. Diagnostic laboratory tests, for purposes of this chapter, do not include diagnostic radiological studies.

History

HISTORY:

Amended by R.2006 d.37, effective January 17, 2006.

See: *37 New Jersey Register 3182(a)*, *38 New Jersey Register 807(a)*.

Deleted "New Jersey" preceding "Medicaid"; added "NJ FamilyCare fee-for-service" and "NJ FamilyCare."

Annotations

Notes

Chapter Notes

N.J.A.C. 10:61-1.2

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 61. INDEPENDENT CLINICAL LABORATORIES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:61-1.2. Definitions

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

"Automated multichannel tests" means laboratory tests which can be and are frequently performed as groups and combinations (profiles) on automated multichannel equipment.

"CLIA" means the Clinical Laboratory Improvement Amendments of 1988, which extends the scope of Federal governmental regulation of laboratories to all laboratory sites where laboratory tests are performed, including physicians' offices. The purpose of this legislation is to uniformly ensure the quality and reliability of medical tests performed by all laboratories that test human specimens.

"CLIA Identification Number" means a 10 digit identification number issued by the Centers for Medicare & Medicaid Services (CMS) to independent clinical laboratories and other entities which perform laboratory testing. A CLIA Identification Number must be on file with the New Jersey Medicaid/NJ FamilyCare program before payment is made for any laboratory testing.

"Clinical laboratory services" means professional and technical laboratory services provided by an independent clinical laboratory when ordered by a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by the laws of the state in which he or she practices.

"Panel" means laboratory tests that are associated with organ or disease oriented areas, such as organ "panels" (for example, hepatic function panel). The tests listed with each panel identify the defined components of that panel.

"Profile" means a combination of laboratory tests that can be and are frequently done as groups and in combinations on automated multi-channel equipment (for example, SMA6, SMA).

"Reference laboratory" means a laboratory meeting the requirements stipulated in *N.J.A.C. 10:61-1.4* which performs specific tests at the request of another approved certified laboratory.

"Service laboratory" means a laboratory meeting the requirements stipulated in *N.J.A.C. 10:61-1.4* which performs specific tests on the laboratory's own premises.

History

HISTORY:

Amended by R.2006 d.37, effective January 17, 2006.

See: *37 New Jersey Register 3182(a)*, *38 New Jersey Register 807(a)*.

Rewrote definition "CLIA Identification Number".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:61-1.3

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 61. INDEPENDENT CLINICAL LABORATORIES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:61-1.3. Scope of services

Each laboratory shall provide the New Jersey Health Services Program, Office of Utilization Management, Mail Code #33, PO Box 712, Trenton, New Jersey 08625-0712, with a listing of tests, including panels and profiles actually performed on its premises (address to be identified) and a current lab price list, including discounts, with an update of said list on a semiannual basis; beginning with the first listing due six months from the date of the last report filed by providers enrolled as of January 17, 2006.

History

HISTORY:

Amended by R.2001 d.79, effective March 5, 2001.

See: *32 New Jersey Register 4167(a)*, *33 New Jersey Register 781(c)*.

Amended by R.2006 d.37, effective January 17, 2006.

See: *37 New Jersey Register 3182(a)*, *38 New Jersey Register 807(a)*.

Rewrote the section.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:61-1.4

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 61. INDEPENDENT CLINICAL LABORATORIES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:61-1.4 Requirements for provider participation; general

(a) To qualify for participation as a clinical laboratory under the Medicaid/NJ Family Care program, the following requirements must be met:

1. Licensure and/or approval by the New Jersey State Department of Health or comparable agency in the state in which the facility is located. This includes meeting certificate of need and licensure requirements, when required, and all applicable laboratory provisions of the New Jersey State Sanitary Code (see *N.J.A.C. 8:45*);

2. Enrollment as an independent laboratory under the Title XVIII Medicare program (see *42 CFR 493.1*);

3. Meet the requirements of an independent clinical laboratory under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) (see *42 USC 1396(a)(9)*). (See *N.J.A.C. 10:61-2.1(a)*5.)

(b) In order to participate in the Medicaid/NJ FamilyCare program as an independent laboratory provider, the following documents shall be submitted to Gainwell Technologies, Provider Enrollment, PO Box 4804, Trenton, NJ 08650-4804:

1. Form FD-20, Medicaid Provider Application Form;

2. Form FD-62, Medicaid Provider Agreement;

3. A copy of CMS 1513, Disclosure of Ownership, Control and Interest Statement;

4. A copy of the Medicare certification; and

5. A copy of the documents to certify the lab meets the CLIA requirements.

(c) The provider will be notified by Gainwell Technologies as to whether their application for participation was approved or disapproved by the Medicaid/NJ FamilyCare Program.

History

HISTORY:

Amended by R.2006 d.37, effective January 17, 2006.

See: *37 N.J.R. 3182(a)*, *38 N.J.R. 807(a)*.

Added "NJ FamilyCare" following "Medicaid/" throughout; in introductory paragraphs (a) and (c), deleted "New Jersey" preceding "Medicaid"; in (b)3, substituted "CMS" for "HCFA".

Notice of readoption with technical change, effective August 2, 2021.

See: *53 N.J.R. 1279(a)*.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:61-1.5

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 61. INDEPENDENT CLINICAL LABORATORIES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:61-1.5. Medicare-Medicaid relationship

(a) Upon approval as an independent laboratory provider for Title XIX Medicaid participation and reimbursement, the requirements for independent laboratory services under the Title XVIII Medicare program shall be followed.

(b) A laboratory approved for Medicaid/NJ FamilyCare participation shall only provide services and be reimbursed for the specialties and subspecialties specifically approved for Medicare participation.

(c) State, county and municipal laboratories located in New Jersey may qualify for Medicaid/NJ FamilyCare reimbursement provided they meet the criteria in *N.J.A.C. 10:61-1.4* and *1.5*.

(d) Any entity that performs diagnostic tests in connection with its provider practice shall comply with this chapter and shall have a CLIA Identification Number to perform clinical laboratory testing reimbursable by the Medicaid/NJ FamilyCare program. A CLIA Identification Number must be on file with the Medicaid/NJ FamilyCare program before payment is made for any laboratory testing.

History

HISTORY:

Amended by R.2006 d.37, effective January 17, 2006.

See: *37 New Jersey Register 3182(a)*, *38 New Jersey Register 807(a)*.

Added "NJ FamilyCare" following "Medicaid/" throughout; in (d), deleted "New Jersey" preceding "Medicaid" throughout and deleted reference to N.J.A.C. 10:49-24.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:61-1.6

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 61. INDEPENDENT CLINICAL LABORATORIES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:61-1.6 Orders for laboratory tests; recordkeeping

(a) All orders for clinical laboratory services shall be in the form of an explicit order personally signed by the physician or other licensed practitioner requesting the services, or be in an alternative form of order specifically authorized in (b)1 through 3 below. The written order shall contain the specific clinical laboratory test(s) requested, shall be on file with the billing laboratory and shall be available for review by Medicaid/NJ FamilyCare representatives upon request.

(b) If a signed order is not utilized, then clinical laboratory services shall be ordered in one of the following ways:

1. In the absence of a written order, the patient's chart or medical record may be used as the test requisition or authorization, but must be physically present at the laboratory at the time of testing and available to Federal or State representatives upon request;

2. A test request also may be submitted to the laboratory electronically, if the system used to generate and transmit the electronic order has adequate security and system safeguards to prevent and detect fraud and abuse and to protect patient confidentiality. The system shall be designed to prevent and detect unauthorized access and modification or manipulation of records, and shall include, at a minimum, electronic encryption; or

3. Telephoned or other oral laboratory orders are also permissible, but shall be followed up with a written or electronic request within 30 days of the telephone or other oral request, which shall be maintained on file with the clinical laboratory. If the laboratory is unable to obtain the written or electronic request, it must maintain documentation of its efforts to obtain them.

(c) Standing orders shall be:

1. Patient specific, and not blanket requests from the physician or licensed practitioner;

2. Medically necessary and related to the diagnosis of the recipient; and

3. Effective for no longer than a 12-month period from the date of the physician's/practitioner's order.

(d) The laboratory must ensure that all orders described in (a) through (c) above contain the following information:

1. The name and address or other suitable identifiers of the authorized person requesting the test and, if appropriate, the individual responsible for using the test results, or the name and address of the laboratory submitting the specimen, including, as applicable, a contact person to enable the reporting of imminently life-threatening laboratory results or panic or alert values;

2. The patient's name or unique patient identifier;

3. The sex and the age (or date of birth) of the patient;

4. The test(s) to be performed;

5. The source of the specimen, when appropriate;

6. The date and, if appropriate, time of specimen collection;

7. For Pap smears, the patient's last menstrual period, and indication of whether the patient had a previous abnormal report, treatment or biopsy; and

8. Any additional information relevant and necessary for a specific test to ensure accurate and timely testing and reporting of results, including interpretation, if applicable.

(e) The results of the tests billed shall be on file with the billing laboratory performing tests. The results shall be available for review by Medicaid/NJ FamilyCare representatives.

(f) The Medicaid/NJ FamilyCare program shall have the right to inspect all records, files and documents of in-State and out-of-State service and reference clinical laboratories which provide laboratory tests and services for Medicaid/NJ FamilyCare beneficiaries.

(g) All laboratory test orders shall be supported by documentation in the referring physician's/practitioner's medical records.

(h) If the laboratory transcribes or enters test requisition or authorization information into a record system or a laboratory information system, the laboratory must ensure that the information is transcribed or entered accurately.

History

HISTORY:

Amended by R.2006 d.37, effective January 17, 2006.

See: *37 N.J.R. 3182(a)*, *38 N.J.R. 807(a)*.

In (a), (e) and (f), added "NJ FamilyCare" following "Medicaid/" throughout; in (f), deleted "New Jersey" preceding "Medicaid" throughout, substituted "Program" for "program" and "beneficiaries" for "recipients".

Amended by R.2011 d.069, effective February 22, 2011.

See: *42 N.J.R. 1670(a)*, *43 N.J.R. 423(a)*.

Section was "Recordkeeping". Rewrote (a), (b) and (d); in (c)3, substituted "12-month" for "12 month" and "order" for "signature"; and added (g) and (h).

Annotations

Notes

Chapter Notes

N.J.A.C. 10:61-1.7

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 61. INDEPENDENT CLINICAL LABORATORIES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:61-1.7. Basis of reimbursement

Reimbursement shall be on the basis of the lowest professional charge, not to exceed an allowance determined reasonable by the Commissioner of Human Services, and further limited by Federal policy relative to payment of clinical laboratory services. The maximum fee schedule (allowance) is set forth at N.J.A.C. 10:61-3. In no event shall the charge to the Medicaid/NJ FamilyCare program exceed the provider's charge for identical services to other groups or individuals.

History

HISTORY:

Amended by R.2006 d.37, effective January 17, 2006.

See: *37 New Jersey Register 3182(a)*, *38 New Jersey Register 807(a)*.

Added "NJ FamilyCare" following "Medicaid/" and deleted "New Jersey" preceding "Medicaid".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:61-2.1

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 61. INDEPENDENT CLINICAL LABORATORIES > SUBCHAPTER 2. PROVISION OF SERVICE

§ 10:61-2.1. Clinical Laboratory Improvement Amendments (CLIA) requirements

(a) All independent clinical laboratories and other entities providing clinical laboratory services to Medicaid/NJ FamilyCare beneficiaries must meet the requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988. These requirements include that the provider must have one of the following:

1. A certificate of waiver;

2. A certificate of compliance;

3. A registration certificate;

4. A certificate for provider-performed microscopy (PPM) procedures;

5. A certificate of accreditation, and a registration certificate or a certificate of compliance; or

6. Be deemed CLIA exempt due to accreditation by a private, nonprofit accreditation organization or exempted under an approved state laboratory program. (See code of Federal Regulations 42 CFR 493)

History

HISTORY:

Amended by R.2006 d.37, effective January 17, 2006.

See: *37 New Jersey Register 3182(a)*, *38 New Jersey Register 807(a)*.

In introductory paragraph (a), added "NJ FamilyCare" following "Medicaid/".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:61-2.2

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 61. INDEPENDENT CLINICAL LABORATORIES > SUBCHAPTER 2. PROVISION OF SERVICE

§ 10:61-2.2. Specific services

(a) The sum of any number of the components of a battery of tests shall not exceed the total charged for the group offering (panel or profile), whether done by automation or bench testing, whether or not the equipment is available in the facility. A battery of tests is considered to be those components of a panel or series of tests which, when combined, mathematically or otherwise, comprise a finished identifiable laboratory study or studies. Examples are:

1. The components of a metabolic profile or other automated laboratory study;

2. An MCH, MCV, or other test, as a component of a C.B.C.;

3. Inclusive of all ova and parasites in a stool examination.

(b) If the components of a profile or panel are billed separately, total reimbursement for the components of the panel or profile shall not exceed the Medicaid/NJ FamilyCare fee allowance for the panel or profile itself.

(c) In no instance shall reimbursement exceed the Medicare Fee Schedule.

(d) Where tests are referred by an approved service laboratory to an approved reference laboratory, the approved reference laboratory shall be a Medicaid/NJ FamilyCare provider and shall directly bill the Medicaid/NJ FamilyCare program for the service.

1. The initiating laboratory shall only refer clinical laboratory tests to laboratories which have a valid CLIA Identification Number and are Medicaid/NJ FamilyCare approved providers.

(e) The policy on reimbursement for visits to the nursing home, residential health care facility, or to the beneficiary's home by an independent lab for the purposes of obtaining blood by venous or arterial puncture is as follows:

1. Utilize HCPCS code W8900 for visits to homebound beneficiaries in their own home or living in a residential health care facility, group home, or boarding home. This code may be used only once per trip regardless of the number of patients seen and requires a distance in excess of 20 miles per round trip.

2. Utilize HCPCS code 36415 for a visit to a beneficiary in a nursing facility, or Intermediate Care Facility/Mental Retardation (ICF/MR).

3. Reimbursement will not be made for travel to other sites including, but not limited to, hospitals, physician offices, or clinics.

History

HISTORY:

Amended by R.2001 d.79, effective March 5, 2001.

See: *32 New Jersey Register 4167(a)*, *33 New Jersey Register 781(c)*.

In (a)1, substituted "metabolic" for "chemistry".

Amended by R.2006 d.37, effective January 17, 2006.

See: *37 New Jersey Register 3182(a)*, *38 New Jersey Register 807(a)*.

In introductory paragraph (a), deleted "Where batteries constitute a profile, they shall be billed in that manner." and substituted "panel" for "test"; in (b) and introductory paragraph (d), added "NJ FamilyCare" following "Medicaid/" throughout; in (b), added "panel or" preceding "profile"; in (d)1, deleted "New Jersey"; and rewrote (e)2.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:61-2.3

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 61. INDEPENDENT CLINICAL LABORATORIES > SUBCHAPTER 2. PROVISION OF SERVICE

§ 10:61-2.3. Limitations on laboratory services

(a) Tests performed by a non-approved laboratory are not reimbursable. The referring laboratory shall verify approved status.

(b) Additional payment will not be made to a laboratory for obtaining specimens, except when performed in a long-term care facility, boarding home, or home.

(c) A laboratory shall be reimbursed only those tests that are within the specialty/subspecialty categories indicated in its CLIA approval.

(d) Laboratory services provided primarily for the diagnosis or treatment of infertility shall not be covered by the Medicaid/NJ FamilyCare program.

1. For those HCPCS procedure codes which are determined to be primarily for the diagnosis of infertility, refer to the HCPCS subchapter and the Indicator "F."

History

HISTORY:

Amended by R.2006 d.37, effective January 17, 2006.

See: *37 New Jersey Register 3182(a)*, *38 New Jersey Register 807(a)*.

In (d), added "NJ FamilyCare" following "Medicaid/" and deleted "New Jersey".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:61-2.4

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 61. INDEPENDENT CLINICAL LABORATORIES > SUBCHAPTER 2. PROVISION OF SERVICE

§ 10:61-2.4. Laboratory rebates

Rebates by reference laboratories, service laboratories, physicians or other utilizers or providers of laboratory service are prohibited under the Medicaid/NJ FamilyCare program. Rebates shall include refunds, discounts or kickbacks, whether in the form of money, supplies, equipment, or other things of value. Laboratories shall not rent space or provide personnel or other considerations to a physician or other practitioner, whether or not a rebate is involved.

History

HISTORY:

Amended by R.2006 d.37, effective January 17, 2006.

See: *37 New Jersey Register 3182(a)*, *38 New Jersey Register 807(a)*.

Deleted designation "(a)" and added "NJ FamilyCare" following "Medicaid/".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:61-3.1

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 61. INDEPENDENT CLINICAL LABORATORIES > SUBCHAPTER 3. HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

§ 10:61-3.1. Purpose, scope and general provisions

(a) The Medicaid/NJ FamilyCare program uses the Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS), for 2006, established and maintained by CMS in accordance with the Health Insurance Portability and Accountability Act, of 1996, *42 U.S.C. §§ 1320d* et seq., and the American Medical Association (AMA) Current Procedural Terminology (CPT) codes published by PMIC, 4727 Wilshire Blvd., Suite 300, Los Angeles, CA 90010. The HCPCS and CPT codes are incorporated herein by reference, as amended and supplemented. AMA and CMS revisions to the CPT codes and the Healthcare Common Procedure Coding System (code additions, code deletions and replacement codes) will be reflected in this chapter through publication of a notice of administrative change in the New Jersey Register. Revisions to existing and new reimbursement amounts codes specified by the Department and specification of new reimbursement amounts for new codes will be made through rulemaking in accordance with the Administrative Procedure Act, *N.J.S.A. 52:14B-1* et seq. HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology (CPT) (American Medical Association, P.O. Box 10950, Chicago, IL 60610.) 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.

(b) HCPCS has been developed as a three-level coding system. The CPT procedure narratives for Level I codes are incorporated herein by reference.

1. Level 1 codes (Narratives found in CPT). CPT is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians. (See *N.J.A.C. 10:61-3.2*.)

2. Level II codes are assigned by CMS for physician and non-physician services which are not in CPT. (See *N.J.A.C. 10:61-3.3*.)

3. Level III codes identify services unique to the Medicaid/NJ FamilyCare program. These codes are assigned by the Division to be used for those services not identified by CPT codes or CMS-assigned codes. (See *N.J.A.C. 10:61-3.4*.)

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

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(d) When alphabetic and numeric symbols are listed under the "IND" and "MOD" columns they are qualifiers or indicators (in the "IND" column) and as modifiers (in the "MOD" column). The symbols assist the provider in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

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

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

History

HISTORY:

Amended by R.2001 d.79, effective March 5, 2001.

See: *32 New Jersey Register 4167(a)*, *33 New Jersey Register 781(c)*.

Rewrote the section.

Amended by R.2006 d.37, effective January 17, 2006.

See: *37 New Jersey Register 3182(a)*, *38 New Jersey Register 807(a)*.

Rewrote the section.

Amended by R.2006 d.244, effective July 3, 2006.

See: *38 N.J.R. 1383(a)*, *38 N.J.R. 2827(a)*.

Rewrote (a).

Annotations

Notes

Chapter Notes

N.J.A.C. 10:61-3.2

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 61. INDEPENDENT CLINICAL LABORATORIES > SUBCHAPTER 3. HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

§ 10:61-3.2. HCPCS procedure codes and maximum fee allowance schedule for Level 1

Click here to view image.

History

HISTORY:

Amended by R.2001 d.79, effective March 5, 2001.

See: *32 New Jersey Register 4167(a)*, *33 New Jersey Register 781(c)*.

Rewrote the section.

Amended by R.2002 d.323, effective October 7, 2002.

See: *34 New Jersey Register 959(a)*, *34 New Jersey Register 3524(a)*.

In HCPCS Code 82731, increased the Total Fee from 6.60 to 71.20.

Amended by R.2003 d.15, effective January 6, 2003.

See: *34 New Jersey Register 2676(a)*, *35 New Jersey Register 230(c)*.

Updated the table of HCPCS procedure codes.

Amended by R.2006 d.37, effective January 17, 2006.

See: *37 New Jersey Register 3182(a)*, *38 New Jersey Register 807(a)*.

Rewrote the section.

Administrative correction.

See: *38 New Jersey Register 1456(b)*.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:61-3.3

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 61. INDEPENDENT CLINICAL LABORATORIES > SUBCHAPTER 3. HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

§ 10:61-3.3. HCPCS procedure codes, procedure description and maximum fee allowance schedule for Level 2

Click here to view image.

History

HISTORY:

Amended by R.2001 d.79, effective March 5, 2001.

See: *32 New Jersey Register 4167(a)*, *33 New Jersey Register 781(c)*.

Rewrote the section.

Amended by R.2003 d.15, effective January 6, 2003.

See: *34 New Jersey Register 2676(a)*, *35 New Jersey Register 230(c)*.

Inserted HCPCS codes Q0111 WF and Q0116 WF.

Amended by R.2006 d.37, effective January 17, 2006.

See: *37 New Jersey Register 3182(a)*, *38 New Jersey Register 807(a)*.

Rewrote the section.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:61-3.4

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 61. INDEPENDENT CLINICAL LABORATORIES > SUBCHAPTER 3. HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

§ 10:61-3.4. HCPCS procedure codes, procedure description and maximum fee allowance schedule for Level 3

Click here to view image.

History

HISTORY:

Amended by R.2006 d.37, effective January 17, 2006.

See: *37 New Jersey Register 3182(a)*, *38 New Jersey Register 807(a)*.

Rewrote the section.

Annotations

Notes

Chapter Notes

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N.J.A.C. 10:61-3.5

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 61. INDEPENDENT CLINICAL LABORATORIES > SUBCHAPTER 3. HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

§ 10:61-3.5. Pathology and Laboratory HCPCS Codes--Qualifiers

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

1. Codes 80048, 80050, 80051, 80053, 80055, 80061, 80069, 80074, 80076. The panels listed must include the laboratory tests assigned by the CPT as the components of the panel. The tests listed with each of the panels identify the defined components of that panel. If any three laboratory tests included in the panel are billed a la carte, the tests must be billed as the panel. The laboratory provider may not charge Medicaid/NJ FamilyCare more than the lowest charge level offered to another provider. The lowest charges for the laboratory test comprising the panel must aggregate as equivalent to or greater than the listed panel fee.

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

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

4. Code 84202--Protoporphyrin, RBC; quantitative--Utilize only for testing of anemia. Utilize code 84203--Protoporphyrin, RBC; screen when testing for anemia. Code 84203 will not be reimbursed when billed in conjunction with code 83655--Blood lead determination (quantitative).

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

6. Codes 85025 and 85027 Hematology

i. For purpose of reimbursement based on this schedule, a complete blood count (CBC) includes a hematocrit, hemoglobin determination, RBC count, RBC indices, WBC count and differential WBC count.

ii. Hematology codes 85014, 85018, 85041 and 85048 will not be reimbursed in conjunction with codes for blood count with hemogram (85025 and 85027).

iii. The code for manual differential WBC count (85007) will not be reimbursed in conjunction with codes 85025 and 85027.

iv. Codes for platelet count 85049 will not be reimbursed in conjunction with codes 85025 and 85027.

7. Codes 87040, 87045, 87046, 87070, 87184--Cultures

Note: These codes may only be billed when a pathogenic microorganism is reported. A culture that indicates no growth or normal flora must be billed as a presumptive culture, 87081.

8. Code 88155--Pap smear

Note: Obtaining specimen is not a separate eligible service.

9. Codes 88348 and 88349--Electron microscopy; diagnostic and scanning are not reimbursable when used as a research tool.

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

10. Code W8900--This code may be used only once per trip regardless of the number of beneficiaries seen and requires a distance in excess of 20 miles per round trip.

11. Codes 87901, 87903, 87904 and 87999--These codes for Antiretroviral Resistance Testing (ART) shall be limited to three tests per 12-month period.

i. Genotype testing has one code: 87901. Code 87999 is a temporary procedure code for virtual phenotype that must be ordered in conjunction with 87901. The temporary HCPCS code for 87999 is 0023T.

ii. Phenotype testing has two codes. The primary code, 87903, covers the first 10 drugs that are tested. The second code, 87904, shall be used for each additional drug, up to five drugs. The CPT manual specifies that code 87904 must be used in conjunction with 87903. In addition, each drug tested shall be listed separately in conjunction with billing for 87904.

History

HISTORY:

Amended by R.2001 d.79, effective March 5, 2001.

See: *32 N.J.R. 4167(a)*, *33 N.J.R. 781(c)*.

Rewrote the section.

Amended by R.2006 d.37, effective January 17, 2006.

See: *37 N.J.R. 3182(a)*, *38 N.J.R. 807(a)*.

Rewrote the section.

Annotations

Notes

Chapter Notes

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 61. INDEPENDENT CLINICAL LABORATORIES

Appendix

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, access www.njmmis.com or write to:

Gainwell Technologies

PO Box 4801

Trenton, New Jersey 08650-4801

or contact:

Office of Administrative Law

Quakerbridge Plaza, Building 9

PO Box 049

Trenton, New Jersey 08625-0049

History

HISTORY:

Amended by R.2001 d.79, effective March 5, 2001.

See: 32 N.J.R. 4167(a), 33 N.J.R. 781(c).

Amended by R.2006 d.37, effective January 17, 2006.

See: 37 N.J.R. 3182(a), 38 N.J.R. 807(a).

Notice of readoption with technical change, effective August 2, 2021.

See: 53 N.J.R. 1279(a).

Annotations

Notes

Chapter Notes

Appendix

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