HUMAN SERVICES

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Podiatry Services

Proposed Readoption with Amendments: N.J.A.C. 10:57

Authorized By: Carole Johnson, Commissioner, Department of Human Services.

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

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

Agency Control Number: 19-P-09.

Proposal Number: PRN 2020-041.

Submit comments by June 19, 2020, to:

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The agency proposal follows:

Summary

Pursuant to N.J.S.A. 52:14B-5.1.c, the Podiatry Services chapter, N.J.A.C. 10:57, was scheduled to expire on April 4, 2020. As the Department of Human Services (Department) filed this notice of proposal with the Office of Administrative Law (OAL) prior to that date, the expiration date is extended to October 1, 2020, pursuant to N.J.S.A. 52:14B-5.1.c(2). The Department proposes to readopt the chapter with the amendments described below. The proposed amendments contain updated reimbursement code information and minor updates of terms, citations, and procedures.

The updates of the Healthcare Common Procedure Coding System (HCPCS) procedure codes reflect the current codes authorized by the Federal Centers for Medicare and Medicaid Services (CMS) and the reimbursement amounts provided by the Medicaid/NJ FamilyCare fee-for-service program as of the publication date of this proposed rulemaking.

The Department has reviewed the chapter and finds that it should be readopted, as amended, because the rules in it are necessary, adequate, reasonable, efficient, understandable, and responsive to the purposes for which they were originally promulgated. The Podiatry Services rules are necessary to regulate fee-for-service reimbursement to podiatrists by the Medicaid/NJ FamilyCare program.

The chapter proposed for readoption contains three subchapters, described as follows:

Subchapter 1, General Provisions, contains an introduction, information on the scope of services, definitions used in the chapter and rules concerning provider participation, prior authorization, basis of reimbursement, personal contributions and copayments associated with specified NJ FamilyCare plans, and recordkeeping.

Subchapter 2, Provision of Services, contains rules addressing covered and non-covered services, general provisions for service, podiatric surgery, radiology, consultation policies, podiatric orthotic services, clinical laboratory services, hospital outpatient services, diagnostic radiology, multiple visits, podiatrist-administered drugs, pharmaceutical services, and the medical exception process.

Subchapter 3, Healthcare Common Procedure Coding System (HCPCS), contains an introduction to the HCPCS procedure code system, a list of codes and maximum fee allowances, descriptions of Level II codes, and qualifiers related to specified podiatric services.

N.J.A.C. 10:57 Appendix A contains instructions on how to obtain a copy of the Fiscal Agent Billing Supplement.

Summary of General Amendments

Throughout the chapter, the terms "Medicaid and NJ FamilyCare" and "Medicaid or NJ FamilyCare" are being changed to "Medicaid/NJ FamilyCare" to reflect the correct name of the program.

Throughout the chapter, references to the New Jersey "Department of Health and Senior Services" are being changed to "Department of Health" to reflect the correct name of the Department. The acronym "DHSS" is being changed to "DOH" as a result of this change.

Throughout the chapter and N.J.A.C. 10:57 Appendix, references to "Unisys" are being changed to "DXC Technology" to reflect the current name of the Medicaid/NJ FamilyCare fiscal agent.

Summary of Specific Amendments

At N.J.A.C. 10:57-1.2, references to "podiatry" are proposed to be changed to "podiatric" for grammatical correctness.

N.J.A.C. 10:57-1.6(b) is proposed for deletion. The information regarding reimbursement procedures for services between February 10, 1995 and July 20, 1998, is no longer needed as all claims have been processed for that timeframe. The requirement for the payment of claims after July 20, 1998, is standard billing procedure as described at N.J.A.C. 10:57-1.6(a).

At N.J.A.C. 10:57-2.11(a)1i and (a)2, references to the HCPCS code 90799 are being deleted to reflect the deletion of that code from the CMS' nationally issued Healthcare Procedure Coding System (HCPCS). Additionally, a reference to "Level III HCPCS" is being deleted since these codes are no longer used by the program.

At N.J.A.C. 10:57-2.13, proposed amendments define the acronyms "PDUR" and "DUR" and provide a cross-reference for additional information for the New Jersey Prospective Drug Use Review (PDUR) program.

At N.J.A.C. 10:57-2.13(d), a proposed amendment changes the reference from "HSP" number to "identification" number because beneficiary identification numbers are no longer referred to as "HSP" numbers.

N.J.A.C. 10:57-3.1(b)3 is proposed for deletion because Level III HCPCS codes are no longer allowed to be used for billing purposes.

At N.J.A.C. 10:57-3.2(a), the following procedure codes related to injection or infusion services are proposed to be deleted from the chapter to reflect their deletion from the CMS' nationally issued Health Care Procedure Coding System (HCPCS): 90780, 90781, 90799, 99271, 99272, 99273, 99274, 99275, 99301, 99302, 99303, 99311, 99312, 99313, 99321, 99322, 99323, 99331, 99332, and 99333.

At N.J.A.C. 10:57-3.2(a), the following HCPCS procedure codes are proposed to be added to the chapter: 96360, 96361, 96365, 96366, 96367, 96368, 96369, 96370, 96371, 96372, 96373, 96374, 96375, 96376, 96379, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99334, 99335, and 99336. These procedure codes allow providers to more specifically indicate the service provided and have been designated by CMS as replacement codes for the codes proposed for deletion.

At N.J.A.C. 10:57-3.2(a), the maximum allowable fee amounts for the following procedure codes, related to office visits and the evaluation and management of patients, are proposed to be increased to reflect the current rate allowed by the Medicaid/NJ FamilyCare fee-for-service program: 90703, 93923 TC, 93970, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99221, 99222, 99223, 99232, 99233, 99234, 99235, 99236, 99238, 99239, 99283, 99284, 99285, 99315, 99316, 99341, 99342, 99343, 99344, 99345, 99349, and 99350.

At N.J.A.C. 10:57-3.2(a), the maximum allowable fee amount for the following procedure code, related to office visits and the evaluation and management of patients, is proposed to be decreased to reflect the current rate allowed by the Medicaid/NJ FamilyCare fee-for-service program: 93923, with the modifier of 26.

At N.J.A.C. 10:57-3.2(a), the maximum allowable fee amount for a specialist billing the following procedure code, related to office visits and the evaluation and management of patients, is proposed to be decreased to

reflect the current rate allowed by the Medicaid/NJ FamilyCare fee-for-service program: 93970.

At N.J.A.C. 10:57-3.2(a), the reimbursement amount listed under "S," indicating reimbursement for a specialist, for HCPCS code 93971 TC is proposed for deletion because specialists do not perform the technical component of the procedure.

At N.J.A.C. 10:57-3.2(a), the maximum allowable fee amount for a non-specialist billing the following procedure code, related to office visits and the evaluation and management of patients, is proposed to be decreased to reflect the current rate allowed by the Medicaid/NJ FamilyCare fee-for-service program: 99212.

At N.J.A.C. 10:57-3.2(b), the maximum allowable fee amounts for the following procedure codes, related to surgery, are proposed to be increased to reflect the current rate allowed by the Medicaid/NJ FamilyCare fee-for-service program: 11043, 11730, 11732, 15050, 16035, 20670, 20690, 27604, 27605, 27613, 27614, 27618, 27656, 27884, 28001, 28002, 28010, 28024, 28043, 28190, 28192, 28193, 28230, 28272, 28312, 28344, 28470, 28675, 28820, 28820 50, 28825, 28825 50, 29740, 29750, 36470, 36471, and 64774.

At N.J.A.C. 10:57-3.2(b), the maximum allowable fee amount for the procedure code 11730, related to surgery, is proposed to be adjusted to reflect the current rate allowed by the Medicaid/NJ FamilyCare fee-for-service program. The reimbursement amount allowed for a specialist is being increased and the reimbursement amount for a non-specialist is being decreased.

At N.J.A.C. 10:57-3.2(b), the maximum allowable fee amount for the HCPCS procedure code 29899 is proposed to be changed from "B.R." (by report) to reflect the current rate allowed by the Medicaid/NJ FamilyCare fee-for-service program.

At N.J.A.C. 10:57-3.2(b), the maximum allowable fee amount for the following procedure code is proposed to be decreased to reflect the current rate allowed by the Medicaid/NJ FamilyCare fee-for-service program: 20692.

At N.J.A.C. 10:57-3.3, the maximum allowable fee amount for the following procedure code is proposed to be increased to reflect the current rate allowed by the Medicaid/NJ FamilyCare fee-for-service program: J0690.

At N.J.A.C. 10:57-3.3, the maximum allowable fee amounts for the following procedure codes are proposed to be changed from "By Report" to specific maximum allowable fee amounts to reflect the current rate allowed by the Medicaid/NJ FamilyCare fee-for-service program: L3031 and L3649.

At N.J.A.C. 10:57-3.3, the maximum allowable fee amounts for the following procedure codes are proposed to be decreased to reflect the current rate allowed by the Medicaid/NJ FamilyCare fee-for-service program: J0696, J1100, L3170, L3215, L3216, L3217, L3219, L3221, L3222, L3230, L3300, L3310, L3334, and Q0112.

At N.J.A.C. 10:57-3.4(a)1, the qualifier for HCPCS code 36415 is proposed to be amended to indicate that the maximum units allowed per date of service is 10 units of service.

At N.J.A.C. 10:57-3.4(a)3, the HCPCS procedure code 90780 is being replaced with HCPCS procedure code 96360 consistent with the changes made by CMS.

At N.J.A.C. 10:57-3.4(a)4, the HCPCS procedure code 90781 is being replaced with HCPCS procedure code 96361 consistent with the changes made by CMS.

N.J.A.C. 10:57-3.4(a)5, is proposed for deletion because the code attached to the qualifiers is being deleted as described above.

Recodified N.J.A.C. 10:57-3.4(a)5 is proposed for amendment to delete the following HCPCS codes, consistent with their deletion from N.J.A.C. 10:57-3.2(a): 99301, 99302, 99303, 99321, 99322, and 99323. Also, the following codes are being added to reflect their addition at N.J.A.C. 10:57-3.2(a): 99304, 99305, 99306, 99324, 99325, and 99326.

Recodified N.J.A.C. 10:57-3.4(a)6 is proposed for amendment to delete the following HCPCS codes, consistent with their deletion from N.J.A.C. 10:57-3.2(a): 99311, 99312, 99313, 99331, 99332, and 99333. Also, the following codes are being added to reflect their addition at N.J.A.C. 10:57-3.2(a): 99307, 99308, 99309, 99310, 99318, 99334, 99335, and 99336.

At recodified N.J.A.C. 10:57-3.4(a)7iv, 7iv(1), and 7iv(2), the following HCPCS codes are being deleted, consistent with their deletion from N.J.A.C. 10:57-3.2(a): 99274 and 99275. Additionally, at recodified N.J.A.C. 10:57-3.4(a)7iv(1) the words "is required" are being deleted from the end of the first sentence for grammatical correctness.

At recodified N.J.A.C. 10:57-3.4(a)8, the following HCPCS codes are being deleted, consistent with their deletion from N.J.A.C. 10:57-3.2(a): 99271, 99272, and 99273.

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

Social Impact

In State Fiscal Year 2019, a monthly average of 1,271 Medicaid/NJ FamilyCare beneficiaries received services from approximately 212 providers of podiatry services that were reimbursed on a fee-for-service basis. The rules proposed for readoption with amendments will have a positive impact on Medicaid and NJ FamilyCare fee-for-service beneficiaries because the rules will assure the continued coverage of services for these beneficiaries with no change in scope or duration of services.

There is no expected impact on the providers because the requirements for participating as a Medicaid/NJ FamilyCare provider will not change as a result of these proposed amendments.

Economic Impact

During State Fiscal Year 2019, the Department paid approximately $152,983 (Federal and State share combined) to providers of fee-for-service podiatry services for Medicaid/NJ FamilyCare.

The proposed amendments will not have an economic impact on Medicaid/NJ FamilyCare beneficiaries because beneficiaries are not required to pay for podiatry services. This policy will not change as a result of these proposed amendments.

The proposed amendments are not expected to have a significant impact on future expenditures for the provision of these services because the Department's annual budget allows for the adjustment of the HCPCS reimbursement codes, including additions and deletions to the list of covered services and the corresponding maximum fee allowances, to correspond to the annual amendments to the national coding system.

The economic impact on providers is expected to be positive because the readoption of the chapter will ensure that the providers continue to receive reimbursement for rendering services to Medicaid/NJ FamilyCare beneficiaries. The adjustments to the reimbursement amounts are consistent with community standards and the providers will benefit from the increase in the majority of the rates. The exact economic impact will depend on the volume of the services provided by the individual provider.

Federal Standards Statement

Podiatry services are an optional Medicaid/NJ FamilyCare service consistent with Section 1902(a)(10)(A)(ii) of the Social Security Act, 42 U.S.C. § 1396a(a)(10)(ii), and Section 1905(a)(5) of the Social Security Act, 42 U.S.C. § 1396d(a)(5). New Jersey has elected to provide podiatry services. Podiatry services are regulated by 42 CFR 440.60, and reimbursement for podiatry services is regulated by 42 CFR 440.2(b). Podiatrists are required to render services within the scope of their practice as defined under State law.

Title XXI of the Social Security Act allows states the option of establishing a State Children's Health Insurance Program for targeted low-income children. New Jersey elected this option through implementation of the NJ FamilyCare Children's program. Sections 2103 and 2110, 42 U.S.C. §§ 1397cc and 1397jj, respectively, provide broad coverage guidelines and service definitions for the program. Section 2110(a)3 authorizes physician services, including those physicians specializing in podiatry.

The Department has reviewed the Federal standards and has determined that the rules proposed for readoption with amendments do not exceed Federal standards. Therefore, a Federal standards analysis is not required.

Jobs Impact

The Department does not anticipate that the rules proposed for readoption with amendments will result in the creation or loss of jobs in the State of New Jersey.

Agriculture Industry Impact

Since the rules proposed for readoption with amendments concern the provision of podiatry services to Medicaid/NJ FamilyCare fee-for-service beneficiaries, the Department anticipates that the rules proposed for readoption with amendments will have no impact on the agriculture industry in the State of New Jersey.

Regulatory Flexibility Analysis

The rules proposed for readoption with amendments will affect providers of podiatry services to Medicaid/NJ FamilyCare fee-for-service beneficiaries. Many of these providers are classified as small businesses, as that term is defined at N.J.S.A. 52:14B-17 of the Regulatory Flexibility Act. The rules proposed for readoption continue the existing reporting, recordkeeping, and compliance requirements and do not impose any additional recordkeeping, compliance, or reporting requirements on small businesses.

State and Federal laws provide for certification and approval of the provider category and specify that the provider of health services maintain records of services provided to individuals. Providers are required by law and rule to maintain sufficient records to fully document the name of the patient being treated, and other details, including: dates and the nature of services, plan of diagnosis, treatment, and medications. These requirements, which are set forth in State law (N.J.S.A. 30:4D-12 and 45:5-1 et seq.) and rules (N.J.A.C. 10:49 and in the rules of the State Board of Medical Examiners), must apply equally to all providers participating in the New Jersey Medicaid/NJ FamilyCare program. Podiatric providers must also comply with the American Podiatric Medical Association standards. Consequently, the Department is not authorized to exempt a provider, whether or not the provider is a small business, from the documentation of, and reporting to, the Medicaid/NJ FamilyCare program of any services rendered to Medicaid/NJ FamilyCare beneficiaries.

There are no capital costs associated with the rules proposed for readoption or with the proposed amendments. The amendments simply add newly authorized codes to the existing list, delete codes no longer in use, revise fees, and correct errors in the text. These rule changes do not impose any new reporting or recordkeeping requirements. Providers must use the Federally updated codes and may not use deleted codes when requesting reimbursement. While the use of the updated HCPCS codes may be considered compliance requirements, the codes are an industry standard and providers use the same updated codes when requesting reimbursement from other payers.

In addition to existing recordkeeping requirements, providers are required to bill in the manner prescribed in the Fiscal Agent Billing Supplement referenced at N.J.A.C. 10:57 Appendix A, and to bill only for those services described in Subchapter 3, which must be delivered in the manner described in Subchapters 1 and 2. Providers cannot be excused from the requirements contained in this chapter because a uniform quality of care must be provided to all beneficiaries, and because the Division must assure that all reimbursements made conform to New Jersey statute and to applicable Federal law and regulation.

Housing Affordability Impact Analysis

Since the rules proposed for readoption with amendments concern the provision of podiatry services to Medicaid/NJ FamilyCare fee-for-service beneficiaries, the Department anticipates that the proposed rulemaking will have no impact on the affordability of housing nor will it have an impact on average costs associated with housing.

Smart Growth Development Impact Analysis

Since the rules proposed for readoption with amendments concern the provision of podiatry services to Medicaid/NJ FamilyCare fee-for-service beneficiaries, the proposed rulemaking will have no impact on housing production within Planning Areas 1 and 2, or within designated centers, under the State Development and Redevelopment Plan and will have no impact on smart growth.

Racial and Ethnic Community Criminal Justice and Public Safety Impact

The Department has evaluated this rulemaking and determined that it will not have an impact on pretrial detention, sentencing, probation, or parole policies concerning adults and juveniles in the State. Accordingly, no further analysis is required.

Full text of the rules proposed for readoption may be found in the New Jersey Administrative Code at N.J.A.C. 10:57.

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

SUBCHAPTER 1. GENERAL PROVISIONS

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 and NJ] **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 and NJ] **Medicaid/NJ** FamilyCare fee-for-service programs Provider Agreement.

(c) A podiatrist may enroll in the New Jersey [Medicaid and NJ] **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, [or] a mixed practitioner practice**,** or under the managed care program.

10:57-1.2 Scope of services

Podiatry care under the [Medicaid and NJ] **Medicaid/NJ** FamilyCare programs is allowable to covered persons if such services are essential. Essential [podiatry] **podiatric** care includes those services [which] **that** require the professional knowledge and skill of a licensed podiatrist. For beneficiaries in the Medically Needy Program, [podiatry] **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.)

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.

…

"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 [which] **that** are within the scope of the services covered by the New Jersey [Medicaid and NJ] **Medicaid/NJ** FamilyCare program[s].

…

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

1.-2. (No change.)

…

10:57-1.4 Provisions for provider participation

(a) In order to participate in the [Medicaid and NJ] **Medicaid/NJ** FamilyCare programs**,** a podiatrist shall apply to**,** and be approved by**,** the New Jersey [Medicaid and NJ] **Medicaid/NJ** FamilyCare program[s]. Application for approval by the New Jersey [Medicaid and NJ] **Medicaid/NJ** FamilyCare program[s] 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:

[Unisys Corporation] **DXC Technology**
Provider Enrollment

PO Box 4804
Trenton, New Jersey 08650-4804

(b) (No change.)

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

1.-2. (No change.)

(d) (No change.)

10:57-1.6 Basis of reimbursement

(a) Reimbursement for podiatry services covered under the New Jersey [Medicaid and NJ] **Medicaid/NJ** FamilyCare **fee-for-service** program[s] 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) For services rendered on or after February 10, 1995, and prior to July 20, 1998, to beneficiaries eligible for both Medicare Part B and Medicaid or NJ FamilyCare, reimbursement will be made for the Medicare Part B coinsurance and deductible amounts or the Medicaid or NJ FamilyCare maximum allowable (less any third party payments including Medicare reimbursement), whichever is greater. Effective on July 20, 1998, payments shall only be made up to the Medicaid or NJ FamilyCare maximum allowable amount consistent with N.J.A.C. 10:49-7.3(c)1.]

[(c)] **(b)** (No change in text.)

SUBCHAPTER 2. PROVISION OF SERVICES

10:57-2.1 Covered and non-covered services

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

1.-2. (No change.)

3. Routine foot care, routine hygienic care:

i. Exceptions:

(1) (No change.)

(2) Treatment of the foot for [Medicaid or NJ] **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) (No change.)

(b) (No change.)

10:57-2.7 Clinical laboratory services

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

(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 [and Senior Services] rules found at N.J.A.C. 8:44 and 8:45.

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

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

1. (No change.)

2. The clinical laboratory shall be licensed by the New Jersey State Department of Health [and Senior Services], as described [above] 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 and NJ] **Medicaid/NJ** FamilyCare program[s] in accordance with (b) above; and

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

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 or NJ] **Medicaid/NJ** FamilyCare program[s].

1. (No change.)

10:57-2.11 Pharmaceutical; podiatrist administered drugs

(a) The New Jersey [Medicaid and NJ] **Medicaid/NJ** FamilyCare fee-for-service program[s] 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. [The HCPCS 90799 may be billed for intradermal, subcutaneous, intramuscular, or intravenous drug administration.]

ii.-iv. (No change.)

v. No reimbursement will be made for an injection given as a preoperative medication or as a local anesthetic [which] **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 [or level III HCPCS], the drug shall be prescribed by the podiatrist and obtained from a pharmacy [which] **that** directly bills the New Jersey Medicaid/NJ FamilyCare program. In this situation, the podiatrist shall bill only for the administration of the drug[, using HCPCS 90799].

10:57-2.12 Pharmaceutical services

All covered pharmaceutical services provided under the New Jersey [Medicaid and NJ] **Medicaid/NJ** FamilyCare fee-for-service programs shall be provided to [Medicaid and NJ] **New Jersey Medicaid/NJ** FamilyCare fee-for-service beneficiaries within the scope of N.J.A.C. 10:49, Administration, and [N.J.A.C.] 10:51, Pharmaceutical 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 [DUR] **Drug Utilization Review** Board **(NJ DURB)** and approved by the Commissioners of DHS and [DHSS] **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) (No change.)

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

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

1.-2. (No change.)

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, [HSP] **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.-5. (No change.)

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) (No change.)

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

1.-2. (No change.)

[3. Level III codes: Level III codes identify services unique to the New Jersey Medicaid and NJ FamilyCare programs. These codes are assigned

by the Division to be used for those services not identified by CPT codes or CMS-assigned codes.]

(c) (No change.)

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

1. General requirements are as follows:

i.-v. (No change.)

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

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

(a) MEDICINE

IND	HCPCS Code	Mod	Maximum Fee Allowance S	$	NS	Anes Basic Units
	90703		[3.40] **17.72**	3.40		
[N	90780		45.00	40.00		
N	90781		45.00	40.00		
N	90799		2.50	2.50]		
…						
	93923	26	[23.00] **18.10**	[20.00] **15.10**		
	93923	TC	[22.00] **26.90**	22.00		
…						
	93970		[62.40]**62.00**	58.00		
…						
	93971	TC	[18.00] **NA**	18.00		
	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**		
N	99201		[23.50] **24.78**	[20.60] **21.06**		
N	99202		[23.50] **41.08**	[20.60] **34.92**		
N	99203		[32.30] **58.02**	[25.00] **49.31**		
N	99204		[32.30] **87.59**	[25.00] **74.45**		
N	99205		[32.30] **109.89**	[25.00] **93.40**		
…						
N	99212		[23.50] **24.41**	[20.60] **20.22**		
N	99213		[23.50] **39.85**	[20.60] **33.87**		
N	99214		[23.50] **58.21**	[20.60] **49.48**		
N	99215		[23.50] **77.76**	[20.60] **66.10**		
N	99217		[23.50] **38.64**	[20.60] **32.84**		
N	99221		[32.30] **53.17**	[25.00] **45.19**		
N	99222		[32.30] **71.88**	[25.00] **61.10**		
N	99223		[32.30] **106.24**	[25.00] **90.30**		
…						
N	99232		[23.50] **38.20**	[20.60] **32.47**		
N	99233		[23.50] **54.59**	[20.60] **46.40**		
N	99234		[55.90] **69.80**	[47.00] **59.33**		
N	99235		[55.90] **88.90**	[47.00] **75.56**		
N	99236		[55.90] **114.23**	[47.00] **97.10**		
	99238		[23.50] **38.64**	[20.60] **32.84**		
N	99239		[23.50] **56.64**	[20.60] **48.14**		
…						
[N	99271		44.00	37.00		
N	99272		64.70	54.40		
N	99273		64.70	54.40		
N	99274		91.10	77.90		
N	99275		91.10	77.90]		

IND	HCPCS Code	Mod	Maximum Fee Allowance S	$	NS	Anes Basic Units
…						
	99283		[23.50] **32.23**	[20.60] **27.40**		
	99284		[32.30] **61.11**	[25.00] **51.94**		
	99285		[32.30] **89.92**	[25.00] **76.43**		
[N	99301		32.30	25.00		
N	99302		32.30	25.00		
N	99303		32.30	25.00		
N	99311		23.50	20.60		
N	99312		23.50	20.60		
N	99313		23.50	20.60]		
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		[23.50] **38.83**	[20.60] **33.01**		
N	99316		[32.30] **55.80**	[29.40] **47.43**		
[N	99321		32.30	25.00		
N	99322		32.30	25.00		
	99323		32.30	25.00		
N	99331		23.50	20.60		
N	99332		23.50	20.60		
N	99333		23.50	20.60]		
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		[23.50] **29.18**	[20.60] **24.81**		
N	99342		[23.50] **41.94**	[20.60] **35.65**		
N	99343		[51.50] **63.82**	[51.50] **58.07**		
	99344		[51.50] **96.05**	[51.50] **81.64**		
	99345		[51.50] **116.83**	[51.50] **99.30**		
…						
	99349		[51.50] **68.14**	[51.50] **57.92**		
	99350		[51.50] **94.43**	[51.50] **80.26**		

(b) SURGERY

IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee$ Allowance S	$	NS	Anes Basic Units
…							
	11043		0	[16.00] **23.93**	[14.00] **20.34**		3
…							
	11730		0	[10.00] **11.58**	[10.00] **9.84**		3
	11732		0	[3.00] **3.91**	[3.00] **3.32**		3
…							
	15050		30	[30.00] **62.87**	[26.00] **53.44**		4
…							
	16035		0	[16.00] **21.07**	[14.00] **17.91**		3
…							
	20670		0	[24.00] **42.82**	[21.00] **36.40**		3
…							
	20690		0	[61.00] **65.48**	[53.00] **55.66**		5
	20692		21	[221.75] **211.75**	180.00		3
…							
	27604		0	[16.00] **54.65**	[14.00] **46.45**		3
	27605		15	[29.00] **38.34**	[25.00] **32.59**		0
…							
	27613		0	[16.00] **28.18**	[14.00] **23.95**		3
	27614		0	[29.00] **64.45**	[25.00] **54.78**		3

IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee$ Allowance S	$ NS	Anes Basic Units
…						
	27618		0	[29.00] **50.28**	[25.00] **42.74**	3
…						
	27656		90	[114.00] **911.18**	[97.00] **774.50**	3
…						
	27884		0	[24.00] **63.93**	[21.00] **54.34**	4
	28001		0	[18.00] **31.48**	[16.00] **26.76**	3
	28002		0	[36.00] **49.26**	[32.00] **41.87**	3
…						
	28010		0	[24.00] **25.77**	[21.00] **21.90**	3
…						
	28024		60	[37.00] **52.18**	[32.00] **44.35**	3
…						
	28043		0	[29.00] **45.16**	[25.00] **38.39**	3
…						
	28190		0	[18.00] **29.14**	[16.00] **24.77**	3
	28192		30	[34.00] **52.85**	[29.00] **44.92**	4
	28193		30	[34.00] **59.81**	[29.00] **50.84**	4
…						
	28230		30	[42.00] **49.26**	[37.00] **41.87**	3
…						
	28272		30	[29.00] **44.48**	[25.00] **37.80**	3
…						
	28312		30	[46.00] **58.55**	[40.00] **49.77**	3
…						
	28344		45	[42.00] **63.12**	[37.00] **53.65**	3
…						
	28470		30	[18.00] **24.58**	[16.00] **20.72**	3
…						
	28675		60	[47.00] **65.73**	[40.00] **55.87**	3
…						
	28820		45	[42.00] **63.67**	[37.00] **54.12**	3
	28820	50	45	[63.00] **94.96**	[56.00] **80.71**	3
	28825		45	[42.00] **60.94**	[37.00] **51.80**	3
	28825	50	45	[63.00] **90.89**	[56.00] **77.25**	3
…						
E D	29740		0	[9.00] **11.05**	[8.00] **9.39**	3
E D	29750		0	[9.00] **11.32**	[8.00] **9.62**	3
…						
	29899		90	[B.R.] **225.00**	[B.R.] **191.00**	3
…						
	36470		0	[10.00] **16.70**	[8.00] **14.19**	0
	36471		0	[18.00] **20.03**	[16.00] **17.02**	0
…						
	64774		30	[42.00] **45.96**	[37.00] **39.06**	3
…						

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

10:57-3.3 Descriptions of Level II Codes

IND	HCPCS Code	Mod	Description	Maximum Fee Allowance S	$ NS
…					
	J0690		Injection, cefazolin sodium, (ancef, kefzol) up to 500 mg	[1.92] **2.83**	[1.92] **2.83**
	J0696		Injection, ceftriaxone sodium, (rocephin) per 250 mg	[14.81] **12.97**	[14.81] **12.97**
	J1100		Injection, dexamethasone sodium phosphate, up to 4 mg/ml	[0.80] **0.13**	[0.80] **0.13**
…					
	L3031		Foot, Insert/plate, removable, addition to lower extremity orthosis, high strength, lightweight material,	[B.R.] **80.34**	[B.R.] **80.34**

IND	HCPCS Code	Mod	Description	Maximum Fee Allowance S	$	NS
			all hybrid lamination/prepreg composite, each			
…						
	L3170		Foot, plastic heel stabilizer	[112.00] **31.99**		[112.00] **31.99**
…						
	L3215		Orthopedic footwear, woman's shoes, oxford	[76.00] **38.00**		[76.00] **38.00**
	L3216		Orthopedic footwear, woman's shoes, depth inlay	[100.00] **50.00**		[100.00] **50.00**
	L3217		Orthopedic footwear, woman's shoes, hightop, depth inlay	[116.00] **58.00**		[116.00] **58.00**
	L3219		Orthopedic footwear, man's shoes, oxford	[76.00] **38.00**		[76.00] **38.00**
	L3221		Orthopedic footwear, man's shoes, depth inlay	[100.00] **50.00**		[100.00] **50.00**
	L3222		Orthopedic footwear, man's shoes, hightop, depth inlay	[116.00] **58.00**		[116.00] **58.00**
	L3230		Orthopedic footwear, custom shoes, depth inlay	[380.00] **190.00**		[380.00] **190.00**
…						
	L3300		Lift, elevation, heel, tapered to metatarsals, per inch	[64.00] **32.78**		[64.00] **32.78**
	L3310		Lift, elevation, heel and sole, neoprene, per inch	[64.00] **51.17**		[64.00] **51.17**
…						
	L3334		Lift, elevation, heel, per inch	[36.00] **23.98**		[36.00] **23.98**
…						
	L3649		Orthopedic shoe, modification, addition or transfer, NOS	[B.R.] **28.00**		[B.R.] **28.00**
…						
	Q0112		All potassium hydroxide(KOH) preparations	[2.40] **0.10**		[2.40] **0.10**

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—Once per visit per patient.] **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. (No change.)

3. HCPCS [90780—IV] **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 [90781—IV] **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 90799—Unlisted therapeutic or diagnostic injection. May be used for intradermal, subcutaneous, or intra-arterial injections. Reimbursement is on a flat fee basis and is all inclusive for the cost of the service and the materials. Intravenous and intra-arterial injections are reimbursable only when performed by the podiatrist.]

[6.] **5.** HCPCS 99201, 99202, 99203, 99204, 99205, 99221, 99222, 99223, [99301, 99302, 99303, 99321, 99322, 99323-Office] **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. (No change.)

[7.] **6.** HCPCS 99211, 99212, 99213, 99214, 99215, 99231, 99232, 99233, [99311, 99312, 99313, 99331, 99332, 99333—Office] **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. (No change.)

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

i.-iii. (No change.)

iv. The HCPCS codes 99244, 99245, 99254, **and** 99255[, 99274 and 99275] shall be utilized for Comprehensive consultation.

(1) HCPCS 99244, 99245, 99254, **and** 99255, [99274 and 99275,] require a comprehensive evaluation by history and physical examination within the scope of a podiatric specialist's practice [is required]. 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, [99274 and 99275,] 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."

[9.] **8.** The HCPCS codes 99241, 99242, 99243, 99251, 99252, **and** 99253, [99271, 99272 and 99273] 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.

Recodify existing 10.-12. as **9.-11.** (No change in text.)

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:

[UNISYS] **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

LABOR AND WORK FORCE DEVELOPMENT

(a)

DIVISION OF WAGE AND HOUR COMPLIANCE

Pre-Tax Transportation Fringe Benefit

Proposed New Rules: N.J.A.C. 12:55-3

Authorized By: Robert Asaro-Angelo, Commissioner, Department of Labor and Workforce Development.

Authority: N.J.S.A. 27:26A-19.

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

Proposal Number: PRN 2020-047.

Submit written comments by June 19, 2020, to:

David Fish, Executive Director
Legal and Regulatory Services
New Jersey Department of Labor and Workforce Development
PO Box 110—13th Floor
Trenton, New Jersey 08625-0110
Fax to: (609) 292-8246
Email: david.fish@dol.nj.gov

The agency proposal follows:

Summary

The Department of Labor and Work Force Development (Department) is proposing new rules at N.J.A.C. 12:55-3, in order to implement P.L. 2019, c. 38, which requires every employer in the State of New Jersey that employs at least 20 persons to provide each employee a pre-tax transportation fringe benefit. The pre-tax transportation fringe benefit required by P.L. 2019, c. 38 (the Act), is the same pre-tax transportation fringe benefit that would otherwise be discretionary for commuter highway vehicle, transit benefits, and qualified parking under 26 U.S.C. § 132(f)(1). The maximum benefit levels allowable under Federal law, which may be deducted for such programs from an employee's gross income, are set forth at 26 U.S.C. § 132(f)(2).

Proposed new N.J.A.C. 12:55-3.1 would describe the purpose and scope of the subchapter.

Proposed new N.J.A.C. 12:55-3.2 would include definitions of words and terms used throughout the subchapter, including a definition for the term "pre-tax transportation fringe benefit." That proposed regulatory definition is taken verbatim from P.L. 2019, c. 38, which defines the term to mean, "a pre-tax election transportation fringe benefit that provides commuter highway vehicle and transit benefits, consistent with the provisions and limits of 26 U.S.C. § 132(f)(1) at the maximum benefit levels allowable under Federal law, to be deducted for those programs from an employee's gross income pursuant to 26 U.S.C. § 132(f)(2)." Currently included among the qualified transportation fringe benefits enumerated at 26 U.S.C. § 132(f)(1) are transportation in a commuter highway vehicle if such transportation is in connection with travel between the employee's residence and place of employment, transit passes, and qualified parking.

Proposed new N.J.A.C. 12:55-3.3 would describe the pre-tax transportation fringe benefit requirement for affected employers (that is, employers who are affected by the requirements of P.L. 2019, c. 38, and, therefore, must offer employees a pre-tax transportation fringe benefit).

Proposed new N.J.A.C. 12:55-3.4 would permit affected employers to use a payroll deduction as a means of providing a pre-tax transportation fringe benefit, provided that the payroll deduction has been authorized by the employee in writing or is included in a collective bargaining agreement.

Proposed new N.J.A.C. 12:55-3.5 would require each affected employer to retain records for six years sufficient to demonstrate that each employee eligible for a pre-tax transportation fringe benefit was offered the opportunity to use pre-tax earnings (gross income) for a pre-tax transportation fringe benefit.

Proposed new N.J.A.C. 12:55-3.6 would concern violations and penalties.

Proposed new N.J.A.C. 12:55-3.7 would address the violator's right to a hearing in the event the violator wishes to contest a penalty levied by the Commissioner for violation of the Act or the subchapter.

As the Department has provided a 60-day comment period for this notice of proposal, this notice is excepted from the rulemaking calendar requirement of N.J.A.C. 1:30-3.3(a)5.

Social Impact

The proposed new rules would have a positive social impact in that they would encourage socially and environmentally conscious methods of commuting to work that relieve congestion on the highways and improve society as a whole. P.L. 2019, c. 38, and the proposed new subchapter require affected employers to offer all of their employees the opportunity to utilize a pre-tax transportation fringe benefit that provides commuter highway vehicle and transit benefits, consistent with the provisions and limits of 26 U.S.C. § 132(f)(1) at the maximum benefit levels allowable under Federal law, to be deducted for those programs from an employee's gross income pursuant to 26 U.S.C. § 132(f)(2). Included among the qualified transportation fringe benefits enumerated at 26 U.S.C. § 132(f)(1) are transportation in a commuter highway vehicle if such transportation is in connection with travel between the employee's residence and place of employment, transit passes, and qualified parking. Transit passes encourage the use of mass transit and transportation services designed to move multiple people at one time. Commuter highway vehicles are designed to hold at least six adults (not including the driver) commuting at one time. Qualified parking reduces the cost of fuel and the congestion of employees commuting without predesignated parking. From a social standpoint, the proposed new rules would encourage methods of commuting that benefit the individual commuters involved and the community at large.

Economic Impact

The proposed new rules would have a positive economic impact in that employees qualifying for the gross income exclusion under any of the approved commuting methods would save money funding their commute to work. Employees availing themselves of qualified commuter highway vehicle transportation, transit passes, or qualified parking are permitted under Federal law to exclude up to $270.00 per month from gross income. That amounts to $3,240 per year in pre-tax dollars per year available for an employee to spend toward commuting expenses that qualify for the pre-tax exclusion, an economic benefit to employees utilizing the pre-tax transportation benefit and to vendors and those providing the commuting services.

Federal Standards Statement

The proposed new rules are subject to, but do not exceed, Federal standards. The requirements of the proposed new rules referring to a "pre-tax transportation fringe benefit" are the same as those imposed by 26 U.S.C. § 132(f), which makes reference to a "qualified transportation fringe." *Ibid.*