



State of New Jersey  
Department of Human Services  
Division of Medical Assistance & Health Services

# MONTHLY NEWSLETTER

Volume 15 No. 09

August 2005

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## **PROVIDER MANUALS, NEWSLETTERS AND FISCAL AGENT BILLING SUPPLEMENTS NOW PROVIDED AND UPDATED IN ELECTRONIC FORM**

**IMPORTANT NEWS:** Effective immediately, all provider manuals, newsletters and Fiscal Agent Billing Supplements will be provided in electronic form.

The provider manuals, including both the Administration rules and specific provider rules in the New Jersey Administrative Code, may be downloaded free of charge from the Division of Medical Assistance and Health Services (DMAHS) website. See page 3 of this newsletter for instructions on how to access provider manuals in electronic form.

Provider newsletters, **including this Monthly Newsletter**, may be downloaded free of charge from the Unisys website.

The most recent versions of the Fiscal Agent Billing Supplement and other informational materials are also on the Unisys website. See page 3 of this newsletter for instructions on how to access provider newsletters and Fiscal Agent Billing Supplements in electronic form.

Unless providers specifically request printed copies, providers will access all provider manual information on the Unisys website and on the Division's website. **If you do not have Internet access and wish to receive updates on paper, you must complete the form on page 4 of this newsletter and fax or mail it to DMAHS at the address included on the form.**

**See Table of Contents on Page 2 for information contained in this Monthly Newsletter.**

Also, for your convenience, see pages 7 and 8, which contain a Telephone Directory of important contacts, including the Division's Office of Utilization Management (OUM) (Main Office: 609-588-7151). OUM staff are available to discuss policy matters with providers. Staff in the Division's Medical Assistance Customer Centers (MACCs) are available to discuss access and/or quality of care concerns. Unisys, the State's fiscal agent, may be contacted at 1-800-776-6334 to discuss problems providers may experience with claims processing.

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## **HOW TO ACCESS INFORMATION FOUND ON THE STATE AND UNISYS WEBSITES**

### **New Jersey Medicaid Administrative Services Chapter**

**State Website:**

**[www.state.nj.us/humanservices/dmahs/manuals.html](http://www.state.nj.us/humanservices/dmahs/manuals.html)** Click on Chapter 10-49

**Unisys Website Link:**

**[www.njmmis.com](http://www.njmmis.com)**

**See link at bottom of page: Click on New Jersey Division of Medical Assistance and Health Services-Eligibility and Service Manuals and follow the State Website directions above.**

### **Specific Provider Policy Chapters:**

**State Website:**

**[www.state.nj.us](http://www.state.nj.us)** Click on the chapter you want, for example, Chapter 10-50 for transportation services, Chapter 10-51 for pharmaceutical services or Chapter 10-54 for physician services.

**Unisys Website Link:**

**[www.njmmis.com](http://www.njmmis.com)**

**See link at bottom of page: Click on New Jersey Division of Medical Assistance and Health Services-Eligibility and Service Manuals and follow the State Website directions above.**

### **Fiscal Agent Billing Supplement:**

**[www.njmmis.com](http://www.njmmis.com)**

**Click on Fiscal Agent Billing Supplement**

### **Medicaid Alerts:**

**[www.njmmis.com](http://www.njmmis.com)**

**Click on Newsletters & Alerts**

### **Medicaid/DHSS Newsletters:**

**[www.njmmis.com](http://www.njmmis.com)**

**Click on Newsletters & Alerts**

## REQUEST FOR PAPER UPDATES

DIRECTIONS: Enter the requested information below, sign your name, and send the completed form to the address at the bottom of this form.

Provider Name: \_\_\_\_\_ Provider Number: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

FAX Number: \_\_\_\_\_

Mail To Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I would like to receive printed (paper) copies of updates and distributions.

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Provider/Authorized Representative Signature

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Date

### MAIL THIS COMPLETED FORM TO:

Office of Provider Relations  
New Jersey Division of Medical Assistance and Health Services  
P.O. Box 712 Mail Code 15  
Trenton, NJ 08625-0712

### OR FAX THIS COMPLETED FORM TO:

Fax Number: (609) 588-3889

# **MEDICAID NEWS**

## **NEW BILLING PROCEDURES FOR EPO CLAIMS BILLED BY HOSPITAL-BASED ESRD PROVIDERS**

The Medicaid Newsletter Volume 15, No. 01 (Revised), dated March 2005 announced to Freestanding ESRD Providers new procedures for billing EPO claims using the UB-92 claim form and reported revenue codes 634 and 635.

These changes required Freestanding ESRD Centers to report Revenue Codes 634 (administration of less than 10,000 units) and 635 (administration of 10,000 or more units) on the UB-92 claim form when requesting EPO payments.

ESRD Centers were also required to report:

The HCPCS procedure code Q4055 in Field No. 44 (HCPCS/Rates) on the UB-92 claim form; and

The actual number of EPO units provided, expressed "per 1000" in Field 46. For example, if 10,000 EPO units were

provided, "10" must be reported in Field 46.

Reimbursement is set at \$12.26 per 1000 units.

**DMAHS is expanding use of these procedures to also apply to claims submitted by hospital-based ESRD providers.**

**These changes for hospital-based ESRD providers shall apply to claims processed by Unisys on or after March 7, 2005 with service dates on or after September 1, 2004.**

## **STATE FISCAL YEAR 2006 IMPACT ON PHARMACY REIMBURSEMENT**

**Effective July 1, 2005,** The State Fiscal Year 2006 Appropriations Act required the following changes in pharmacy coverage and reimbursement for all State pharmacy benefit programs:

Reimbursement for physician-administered drugs (Level II HCPCS codes) shall be based on the Average Wholesale Price (AWP) less 12.5% or the practitioner's acquisition cost, whichever is less.

85% of the days supply dispensed for a prescription must be exhausted before that prescription is refillable. The former requirement was 75%.

The 90% requirement for Work First New Jersey (WFNJ)/General Assistance (GA) prescriptions remains the same.

Beneficiaries will no longer be able to receive methadone administered by a Substance Abuse Treatment Centers and narcotic prescriptions dispensed by a pharmacy at the same time.

A new claim processing Error Code has been activated that monitors clinic claims for methadone to determine if this drug is being used by a beneficiary at the same time prescriptions are being dispensed by a pharmacy for narcotics.

Pharmacies may continue to request prior authorization for methadone prescriptions dispensed for pain management purposes.

**CHANGE IN  
MEDICAID  
REIMBURSEMENT  
FOR  
PRACTITIONER-  
ADMINISTERED  
DRUGS**

The State Fiscal Year 2006 Appropriations Act reduces Medicaid reimbursement for practitioner-administered drugs.

This policy change ensures that Medicaid

reimbursement for these drugs will be the same, whether administered by a physician or received as pharmacy service.

Current Medicaid reimbursement for practitioner-administered drugs is the lower of a drug's Average Wholesale Price (AWP) or a practitioner's acquisition cost.

**Effective for claims  
with service dates on  
or after July 1, 2005,**

reimbursement for practitioner-administered drugs (Level II HCPCS codes) shall be based on a drug's AWP less 12.5% or the practitioner's acquisition cost, whichever is less.

**Reimbursement for  
practitioner-  
administered vaccines  
is not affected by this  
policy change.**

## IMPORTANT CONTACT INFORMATION

Providers may contact the offices below, at the numbers listed, to discuss the following matters:

TO DISCUSS:	CONTACT:	TELEPHONE NUMBER:
Policy matters	The DMAHS Office of Provider Relations/Office of Utilization Management	<p>MAIN OFFICE (609) 588-7151</p> <p>DENTAL (609) 588-7137 (609) 588-7140</p> <p>DRUG REBATE (609) 588-8522 (609) 588-8526</p> <p>DURABLE MEDICAL EQUIPMENT (609) 588-4304</p> <p>GENERAL ASSISTANCE &amp; MEDICAL POLICY (WFNJ-GA) (609) 588-2662</p> <p>HOSPICE (609) 588-2739</p> <p>LABORATORY CONSULTANT (609) 588-2730</p> <p>MATERNAL &amp; CHILD HEALTH SERVICES (609) 588-2731</p> <p>MENTAL HEALTH (609) 631-4685</p> <p>ORTHOTICS &amp; PROSTHETICS/ PODIATRY (609) 588-4610</p> <p>PHARMACY/DUR (609) 588-2724 (609) 588-4624</p> <p>TRANSPORTATION (609) 631-4636</p> <p>VISION CARE (609) 588-2745</p>
Problems with claims processing	Unisys	1-800-776-6334

<p>Access or quality of care concerns</p>	<p>The DMAHS Medical Assistance Customer Centers (MACCs)</p>	<p>Burlington, Mercer (856) 787-3855  Camden, Gloucester, Salem (856) 614-2870  Cumberland, Atlantic, Cape May (856) 690-5208  Essex (973) 648-3700  Hudson (201) 217-7100  Middlesex, Union (732) 499-5700  Monmouth (732) 761-3600 (973) 631-6440  Morris, Hunterdon, Somerset, Sussex, Warren (973) 631-6440  Ocean (732) 255-0731  Passaic, Bergen (973) 977-4077</p>
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<b>Physician Services Manual (N.J.A.C. 10:54):</b> <b>2005 Updates to HCPCS procedure codes and maximum fee allowances</b>
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**EFFECTIVE: (1) Additions Effective for Claims with Dates of Service on or after as listed below:**

**ADDITIONS**

<b><u>HCPCS CODE</u></b>	<b><u>MAXIMUM FEE ALLOWANCE</u></b>	<b><u>EFFECTIVE DATE</u></b>
90656	12.30	JANUARY 1, 2005
	<b>NOTE:</b> (COVERED UNDER VFC PROGRAM FOR AGES UNDER 19)	
90714	18.81	APRIL 1, 2005
	<b>NOTE:</b> (COVERED UNDER VFC PROGRAM FOR AGES UNDER 19)	
90734	89.69	JANUARY 1, 2005
	<b>NOTE:</b> (COVERED UNDER VFC PROGRAM FOR AGES 11 AND 15 ONLY FOR SERVICE DATES OF JUNE 13, 2005 AND AFTER)	

**EFFECTIVE: (2) Deletions Effective for Claims with Dates of Service on or after October 31, 2005**

**DELETIONS**

<b><u>CODES DELETED</u></b>	<b><u>TO REPORT, USE CODE</u></b>
50959	NO REPLACEMENT
50959AA	NO REPLACEMENT

**Note:** No Replacement Code means an existing procedure code is no longer available for this service. If a Replacement Code is available, this information is reported above. Providers needing to bill a service with “No Replacement Code” may use “Not Otherwise Classified”.

**Prosthetic and Orthotic Services Manual (N.J.A.C. 10:55):  
2005 HCPCS procedure codes and maximum fee allowances for prosthetic and  
orthotic services**

**EFFECTIVE: Deletions Effective for Claims with Dates of Service on or after  
October 31, 2005**

**DELETIONS**

<b><u>CODES DELETED</u></b>	<b><u>TO REPORT, USE CODE</u></b>
K0556	L5673
K0557	L5679
K0558	L5681
K0559	L5683

**Note:** No Replacement Code means an existing procedure code is no longer available for this service. If a Replacement Code is available, this information is reported above. Providers needing to bill a service with “No Replacement Code” may use “Not Otherwise Classified”.

**Dental Services Manual (N.J.A.C. 10:56):  
2005 HCPCS procedure codes and maximum fee allowances for dental services**

**EFFECTIVE: (1) Change Effective for Claims with Dates of Service on or after November 1, 2005**

**CHANGE**

<b><u>HCPCS CODE</u></b>	<b><u>PROCEDURE DESCRIPTION</u></b>	<b><u>MAXIMUM FEE ALLOWANCE</u></b>		
		<b><u>\$</u></b>	<b><u>\$</u></b>	<b><u>NS</u></b>
D7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	45.00		41.00

**EFFECTIVE: (2) Additions Effective for Claims with Dates of Service on or after January 1, 2005**

**ADDITIONS**

<b><u>HCPCS CODE</u></b>	<b><u>PROCEDURE DESCRIPTION</u></b>	<b><u>MAXIMUM FEE ALLOWANCE</u></b>		
		<b><u>\$</u></b>	<b><u>\$</u></b>	<b><u>NS</u></b>
D2934	PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN - PRIMARY TOOTH	135.00		124.00
D2971	ADDITIONAL PROCEDURES TO CONSTRUCT NEW CROWN UNDER EXISTING PARTIAL DENTURE FRAMEWORK	50.00		50.00
D7283	PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH	56.00		53.00
D7288	BRUSH BIOPSY - TRANSEPITHELIAL SAMPLE COLLECTION	10.00		10.00
D7511	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE – COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)	BR		BR
D7521	INCISION AND DRAINAGE OF ABSCESS - EXTRAORAL SOFT TISSUE – COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)	BR		BR

**EFFECTIVE: (3) Deletions Effective for Claims with Dates of Service on or after  
October 31, 2005**

**DELETIONS**

<b><u>CODES</u></b>	<b><u>TO REPORT, USE CODE</u></b>
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**DELETED**

D2970	NO REPLACEMENT
D7281	NO REPLACEMENT

**Note:** No Replacement Code means an existing procedure code is no longer available for this service. If a Replacement Code is available, this information is reported above. Providers needing to bill a service with “No Replacement Code” may use “Not Otherwise Classified”.

**Medical Supply Manual (N.J.A.C. 10:59):****Updates to HCPCS procedure codes and maximum fee allowances for medical supplies and durable medical equipment****EFFECTIVE: (1) Change Effective for Claims with Dates of Service on or after January 1, 2005****CHANGE**

<b><u>PA IND</u></b>	<b><u>HCPCS CODE</u></b>	<b><u>PROCEDURE DESCRIPTION</u></b>	<b><u>MAXIMUM FEE ALLOWANCE</u></b>
N	E0972	WHEELCHAIR ACCESSORY, TRANSFER BOARD OR DEVICE, EACH	37.78

**EFFECTIVE: (2) Additions Effective for Claims with Dates of Service on or after January 1, 2005****ADDITIONS**

<b><u>PA IND</u></b>	<b><u>HCPCS CODE</u></b>	<b><u>PROCEDURE DESCRIPTION</u></b>	<b><u>MAXIMUM FEE ALLOWANCE</u></b>
Y	A4605	TRACHIAL SUCTION CATHETER, CLOSED SYSTEM, EACH	13.12
N	A7527	TRACHEOSTOMY/LARYNGECTOMY TUBE PLUG/STOP, EACH	2.86
Y	B4157	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, FOR SPECIAL METABOLIC NEEDS FOR INHERITED DISEASE OF METABOLISM, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	BR
Y	E0463	PRESSURE SUPPORT VENTILATOR WITH VOLUME CONTROL MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH INVASIVE INTERFACE (E.G. TRACHEOSTOMY TUBE)	BR
Y	E0464	PRESSURE SUPPORT VENTILATOR WITH VOLUME CONTROL MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH NON-INVASIVE INTERFACE (E.G. MASK)	BR

<u>PA IND</u>	<u>HCPCS CODE</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>
Y	E1039	TRANSPORT CHAIR, ADULT SIZE, HEAVY DUTY, PATIENT WEIGHT CAPACITY 250 POUNDS OR GREATER	BR
Y	E2368	POWER WHEELCHAIR COMPONENT, MOTOR, REPLACEMENT ONLY	413.26
Y	E2369	POWER WHEELCHAIR COMPONENT, GEAR BOX, REPLACEMENT ONLY	359.95
Y	E2370	POWER WHEELCHAIR COMPONENT, MOTOR AND GEAR BOX COMBINATION, REPLACEMENT ONLY	642.27
Y	E2605	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	257.35
Y	E2606	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	348.86
Y	E2611	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	249.88
Y	E2612	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	338.03
Y	E2613	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	314.43
Y	E2614	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	435.14
Y	E2615	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	361.86
Y	E2616	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	486.86
Y	E2618	WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT), FOR USE WITH MANUAL WHEELCHAIR OR LIGHTWEIGHT POWER WHEELCHAIR, INCLUDES ANY TYPE MOUNTING HARDWARE	BR

<u>PA IND</u>	<u>HCPCS CODE</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>
Y	E2619	REPLACEMENT COVER FOR WHEELCHAIR SEAT CUSHION OR BACK CUSHION, EACH	41.06
Y	E2620	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	459.81
Y	E2621	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	438.16
Y	E8000	GAIT TRAINER, PEDIATRIC SIZE, POSTERIOR SUPPORT, INCLUDES ALL ACCESSORIES AND COMPONENTS	BR
Y	E8001	GAIT TRAINER, PEDIATRIC SIZE, UPRIGHT SUPPORT, INCLUDES ALL ACCESSORIES AND COMPONENTS	BR
Y	E8002	GAIT TRAINER, PEDIATRIC SIZE, ANTERIOR SUPPORT, INCLUDES ALL ACCESSORIES AND COMPONENTS	BR

**NOTE:** Effective for claims with service dates on or after **July 1, 2005**, reimbursement for practitioner-administered drugs shall be based on a drug's AWP less 12.5% or the practitioner's acquisition cost, whichever is less for the following J-codes only.

N	J7611	ALBUTEROL, INHALATION SOLUTION, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1MG	0.17
N	J7612	LEVALBUTEROL, INHALATION SOLUTION, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 0.5 MG	0.17
N	J7613	ALBUTEROL, INHALATION SOLUTION, ADMINISTERED THROUGH DME, UNIT DOSE, 1 MG	0.51
N	J7614	LEVALBUTEROL, INHALATION SOLUTION, ADMINISTERED THROUGH DME, UNIT DOSE, 0.5 MG	0.51
N	J7616	ALBUTEROL, UP TO 5 MG AND IPRATROPIUM BROMIDE, UP TO 1 MG, COMPOUNDED INHALATION SOLUTION, ADMINISTERED THROUGH DME	0.69
N	J7617	LEVALBUTEROL, UP TO 2.5 MG AND IPRATROPIUM BROMIDE, UP TO 1 MG, COMPOUNDED INHALATION SOLUTION, ADMINISTERED THROUGH DME	0.69

<u>PA IND</u>	<u>HCPCS CODE</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>
N	J7674	METHACHOLINE CHLORIDE ADMINISTERED AS INHALATION SOLUTION THROUGH A NEBULIZER, PER 1 MG	0.48
N	K0628	FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, DIRECT FORMED, MOLDED TO FOOT AFTER EXTERNAL HEAT SOURCE OF 230 DEGREES FAHRENHEIT OR HIGHER, TOTAL CONTACT WITH PATIENT'S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 1/4 INCH MATERIAL OF SHORE A 35 DUROMETER OR 3/16 INCH MATERIAL OF SHORE A 40 DUROMETER (OR HIGHER), PREFABRICATED, EACH	19.38
N	K0630	SACROILIAC ORTHOSIS, FLEXIBLE, PROVIDES PELVIC-SACRAL SUPPORT, REDUCES MOTION ABOUT THE SACROILIAC JOINT, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	58.25
Y	K0632	SACROILIAC ORTHOSIS, PROVIDES PELVIC-SACRAL SUPPORT, WITH RIGID OR SEMI-RIGID PANELS OVER THE SACRUM AND ABDOMEN, REDUCES MOTION ABOUT THE SACROILIAC JOINT, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	BR
N	K0634	LUMBAR ORTHOSIS, FLEXIBLE, PROVIDES LUMBAR SUPPORT, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, SHOULDER STRAPS, STAYS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	34.62
N	K0635	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	49.00

<u>PA IND</u>	<u>HCPCS CODE</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>
N	K0636	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	258.38
N	K0637	LUMBAR-SACRAL ORTHOSIS, FLEXIBLE, PROVIDES LUMBO-SACRAL SUPPORT, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	52.73
N	K0639	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, LOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	101.81
Y	K0640	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	645.31
N	K0642	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	180.25

<u>PA IND</u>	<u>HCPCS CODE</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>
Y	K0644	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, LUMBAR FLEXION, RIGID POSTERIOR FRAME/PANELS, LATERAL ARTICULATING DESIGN TO FLEX THE LUMBAR SPINE, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, ANTERIOR PANEL, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	612.78
Y	K0646	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR FRAME/PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	675.30
Y	K0648	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/PANEL(S) POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XYPHOID, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, OVERALL STRENGTH IS PROVIDED BY OVERLAPPING RIGID MATERIAL AND STABILIZING CLOSURES, INCLUDES STRAPS, CLOSURES, MAY INCLUDE SOFT INTERFACE, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	675.04

**EFFECTIVE: (3) Additions Effective for Claims with Dates of Service on or after November 1, 2005**

**ADDITIONS**

<b><u>PA IND</u></b>	<b><u>HCPCS CODE</u></b>	<b><u>PROCEDURE DESCRIPTION</u></b>	<b><u>MAXIMUM FEE ALLOWANCE</u></b>
N	A4216	STERILE WATER/SALINE, 10 ML	0.36
Y	A7520	TRACHEOSTOMY/LARYNGECTOMY TUBE, NON-CUFFED, POLYVINYLCHLORIDE (PVC), SILICONE OR EQUAL, EACH	37.98
Y	A7521	TRACHEOSTOMY/LARYNGECTOMY TUBE, CUFFED, POLYVINYLCHLORIDE (PVC), SILICONE OR EQUAL, EACH	37.64
Y	A7522	TRACHEOSTOMY/LARYNGECTOMY TUBE, STAINLESS STEEL OR EQUAL (STERILIZABLE AND REUSABLE), EACH	36.13
Y	A7525	TRACHEOSTOMY MASK, EACH	1.66
Y	A7526	TRACHEOSTOMY TUBE COLLAR/HOLDER, EACH	2.70
N	E0197	AIR PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH	150.67
N	E0198	WATER PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH	150.67
N	E0199	DRY PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH	25.64
Y	E0561	HUMIDIFIER, NON-HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	85.60
Y	E0562	HUMIDIFIER, HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE	240.98
N	E0981	WHEELCHAIR ACCESSORY, SEAT UPHOLSTERY, REPLACEMENT ONLY, EACH	37.72
N	E0982	WHEELCHAIR ACCESSORY, BACK UPHOLSTERY, REPLACEMENT ONLY, EACH	41.22

<u>PA IND</u>	<u>HCPCS CODE</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>
Y	E0983	MANUAL WHEELCHAIR ACCESSORY, POWER ADD-ON TO CONVERT MANUAL WHEELCHAIR TO MOTORIZED WHEELCHAIR, JOYSTICK CONTROL	BR
Y	E0984	MANUAL WHEELCHAIR ACCESSORY, POWER ADD-ON TO CONVERT MANUAL WHEELCHAIR TO MOTORIZED WHEELCHAIR, TILLER CONTROL	BR
N	E2205	MANUAL WHEELCHAIR ACCESSORY, HAND RIM WITHOUT PROJECTIONS, ANY TYPE, REPLACEMENT ONLY, EACH	26.14
N	E2206	MANUAL WHEELCHAIR ACCESSORY, WHEEL LOCK ASSEMBLY, COMPLETE, EACH	32.54
N	E2360	POWER WHEELCHAIR ACCESSORY, 22 NF NON-SEALED LEAD ACID BATTERY, EACH	89.87
N	E2361	POWER WHEELCHAIR ACCESSORY, 22 NF SEALED LEAD ACID BATTERY, EACH, (E.G. GEL CELL, ABSORBED GLASSMAT)	111.58
N	E2362	POWER WHEELCHAIR ACCESSORY, GROUP 24 NON-SEALED LEAD ACID BATTERY, EACH	73.58
N	E2363	POWER WHEELCHAIR ACCESSORY, GROUP 24 SEALED LEAD ACID BATTERY, EACH (E.G. GEL CELL, ABSORBED GLASSMAT)	148.80
N	E2364	POWER WHEELCHAIR ACCESSORY, U-1 NON-SEALED LEAD ACID BATTERY, EACH	89.87
N	E2365	POWER WHEELCHAIR ACCESSORY, U-1 SEALED LEAD LEAD BATTERY, EACH (E.G. GEL CELL, ABSORBED GLASSMAT)	89.74
N	E2366	POWER WHEELCHAIR ACCESSORY, BATTERY CHARGER, SINGLE MODE, FOR USE WITH ONLY ONE BATTERY TYPE, SEALED OR NON-SEALED, EACH	210.90
N	E2367	POWER WHEELCHAIR ACCESSORY, BATTERY CHARGER, DUAL MODE, FOR USE WITH EITHER BATTERY TYPE, SEALED OR NON-SEALED, EACH	335.26
N	E2601	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	BR

<u>PA IND</u>	<u>HCPCS CODE</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>
N	E2602	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	BR
N	E2603	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	BR
N	E2604	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	BR
Y	E2607	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	236.48
Y	E2608	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	283.20
N	T4521	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, SMALL, EACH	0.70
N	T4522	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, MEDIUM, EACH	0.70
N	T4523	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, LARGE, EACH	0.70
N	T4524	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EXTRA LARGE, EACH	0.90
N	T4525	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, SMALL SIZE, EACH	0.70
N	T4526	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, MEDIUM SIZE, EACH	0.70
N	T4527	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, LARGE SIZE, EACH	0.90
N	T4528	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, EXTRA LARGE SIZE, EACH	0.90

<u>PA IND</u>	<u>HCPCS CODE</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>
N	T4529	PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, SMALL/MEDIUM SIZE, EACH	0.50
N	T4530	PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, LARGE SIZE, EACH	0.50
N	T4531	PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, SMALL/MEDIUM SIZE, EACH	0.50
N	T4532	PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, LARGE SIZE, EACH	0.50
N	T4533	YOUTH SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EACH	0.70
N	T4535	DISPOSABLE LINER/SHIELD/GUARD/PAD/UNDERGARMENT, FOR INCONTINENCE, EACH	BR

**EFFECTIVE: (4) Deletions Effective for Claims with Dates of Service on or after October 31, 2005**

### DELETIONS

<u>CODES DELETED</u>	<u>TO REPORT, USE CODE</u>
A4214	A4216
A4347	NO REPLACEMENT
A4521	T4521
A4522	T4522
A4523	T4523
A4524	T4524
A4525	T4525
A4526	T4526
A4527	T4527
A4528	T4528
A4529	T4529
A4530	T4530
A4531	T4531
A4532	T4532
A4533	T4533
A4535	T4535
A4621	A7525 OR A7526
A4622	A7520 OR A7521 OR A7522

**CODES DELETED****TO REPORT, USE CODE**

A4631	E2360 OR E2361 OR E2362 OR E2363 OR E2364 OR E2365
A4712	A4216
B4151	NO REPLACEMENT
B4156	NO REPLACEMENT
E0142	NO REPLACEMENT
E0145	NO REPLACEMENT
E0146	NO REPLACEMENT
E0176	E0197
E0177	E0198
E0178	E0185
E0179	E0199
E0192	E2607 OR E2608
E0943	A4649
E0962	E2601 OR E2602 OR E2603 OR E2604
E0963	E2601 OR E2602 OR E2603 OR E2604
E0964	E2601 OR E2602 OR E2603 OR E2604
E0965	E2601 OR E2602 OR E2603 OR E2604
E0975	E0981
E0976	E0982
E0979	NO REPLACEMENT
E0991	E0981
E0993	E0982
E1065	E0983 OR E0984
E1066	NO REPLACEMENT
E1069	NO REPLACEMENT
J7508	J7507
J7618	J7611
J7619	J7613
J7621	J7616 OR J7617
K0016	E0973
K0022	E0982
K0023	E1399
K0024	E1399
K0025	E0966
K0026	E0982
K0027	E0982
K0028	E1226
K0029	E0981
K0030	E0992
K0031	NO REPLACEMENT
K0032	E0981
K0033	E0981
K0035	E0951
K0036	E0952
K0048	E0990
K0049	E0995
K0054	NO REPLACEMENT

**CODES DELETED****TO REPORT, USE CODE**

K0055	NO REPLACEMENT
K0057	NO REPLACEMENT
K0058	NO REPLACEMENT
K0059	E2205
K0060	E2205
K0061	E2205
K0062	E0967
K0063	E0967
K0079	E0961
K0080	E0974
K0081	E2206
K0082	E2360
K0083	E2361
K0084	E2362
K0085	E2363
K0086	E2364
K0087	E2365
K0088	E2366
K0089	E2367
K0100	E0959
K0103	E0972
K0107	E0950
K0112	NO REPLACEMENT
K0113	NO REPLACEMENT
K0114	NO REPLACEMENT
K0115	NO REPLACEMENT
K0116	NO REPLACEMENT
K0268	E0561 OR E0562
K0460	E0983
K0461	E0984
L0476	NO REPLACEMENT
L0500	NO REPLACEMENT
L0515	NO REPLACEMENT
L0561	NO REPLACEMENT
L0600	NO REPLACEMENT

**Note:** No Replacement Code means an existing procedure code is no longer available for this service. If a Replacement Code is available, this information is reported above. Providers needing to bill a service with “No Replacement Code” may use “Not Otherwise Classified”.

<b>Vision Care Services Manual (N.J.A.C. 10:62):</b> <b>2005 HCPCS procedure codes and maximum fee allowances for vision care services</b>
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**EFFECTIVE: (1) Additions Effective for Claims with Dates of Service on or after November 1, 2005**

**ADDITIONS**

<b><u>HCPCS CODE</u></b>	<b><u>PROCEDURE DESCRIPTION</u></b>	<b><u>MAXIMUM FEE ALLOWANCE</u></b>
V2121	LENTICULAR LENS, PER LENS, SINGLE	40.00
V2221	LENTICULAR LENS, PER LENS, BIFOCAL	60.00
V2321	LENTICULAR LENS, PER LENS, TRIFOCAL	BR
V2745	ADDITION TO LENS; TINT, ANY COLOR, SOLID, GRADIENT OR EQUAL, EXCLUDES PHOTOCHROMATIC, ANY LENS MATERIAL, PER LENS	3.50
V2784	LENS, POLYCARBONATE OR EQUAL, ANY INDEX, PER LENS	20.00

**EFFECTIVE: (2) Deletions Effective for Claims with Dates of Service on or after October 31, 2005**

**DELETIONS**

<b><u>CODES DELETED</u></b>	<b><u>TO REPORT, USE CODE</u></b>
S0580	V2784
V2116	V2121
V2117	V2121
V2216	V2221
V2217	V2221
V2316	V2321
V2317	V2321
V2740	V2745
V2741	V2745
V2742	V2745
V2743	V2745

**Note:** No Replacement Code means an existing procedure code is no longer available for this service. If a Replacement Code is available, this information is reported above. Providers needing to bill a service with “No Replacement Code” may use “Not Otherwise Classified” procedure codes.

<b>Independent Clinic Services Manual (N.J.A.C. 10:66):                  2005 HCPCS procedure codes and maximum fee allowances for independent clinic services</b>
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**EFFECTIVE: (1) Additions Effective for Claims with Dates of Service on or after as listed below:**

**ADDITIONS**

**(a) Vaccine for children (VFC) administration codes for children under 8 years of age when the physician counsels the patient/family.**

<b><u>HCPCS CODE</u></b>	<b><u>MAXIMUM FEE ALLOWANCE</u></b>	<b><u>EFFECTIVE DATE</u></b>
90465	11.50	January 1, 2005
90466	11.50	January 1, 2005
90467	5.00	January 1, 2005
90468	5.00	January 1, 2005

**NOTE:** Continue to use VFC administration codes 90471 – 90474 when there is no counseling by the physician.

**Vaccines:**

90656	12.30	January 1, 2005
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**NOTE:** (COVERED UNDER VFC PROGRAM FOR AGES UNDER 19)

90714	18.81	April 1, 2005
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**NOTE:** (COVERED UNDER VFC PROGRAM FOR AGES UNDER 19)

90734	89.69	January 1, 2005
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**NOTE:** (COVERED UNDER VFC PROGRAM FOR AGES 11 AND 15 ONLY FOR SERVICE DATES OF JUNE 13, 2005 AND AFTER)

**(b) DRUG ADMINISTRATION CODES EFFECTIVE January 1, 2005:**

**NOTE:** Continue using the old code when a new G code is not provided.

**HYDRATION:**

<b>OLD CODE</b>	cross walked to	<b>NEW CODE</b>
90780		G0345 IV infusion, hydration, initial, up to one hour
90781		G0346 each additional hour, up to 8 hours

## INJECTIONS AND INFUSIONS (NON –CHEMOTHERAPY, OTHER THAN HYDRATION):

<b>OLD CODE</b> cross walked to	<b>NEW CODE</b>
90780	G0347 IV infusion, for therapy/diagnosis,initial, up to one hour
90781	G0348 each additional hour, up to 8 hours
90781	G0349 additional sequential infusion, up to one hour
N/A	G0350 Concurrent infusion
90782	G0351 Therapeutic or diagnostic injection
90783	N/A intra-arterial
90784	G0353 IV push, single or initial substance/drug
N/A	G0354 each additional sequential IV push
90788	N/A IM injection of antibiotic
90799	N/A Unlisted injection or infusion

## CHEMOTHERAPY ADMINISTRATION:

<b>OLD CODE</b> cross walked to	<b>NEW CODE</b>
96400	G0355 Chemotherapy administration, SQ or IM; non-hormonal anti-neoplastic
96400	G0356 hormonal anti-neoplastic
96405	N/A Chemotherapy administration; intraleisional, up to and including 7 lesions
96406	N/A intralesional, more than 7 lesions
96408	G0357 IV push technique, single or initial substance/drug
96408	G0358 IV push technique, each additional substance/drug
96410	G0359 Chemotherapy administration, IV push technique; up to one hour
96412	G0360 each additional hour, up to 8 hours
96414	G0361 initiation of prolonged chemotherapy infusion
96412	G0362 each additional sequential infusion, up to one hour
96420	N/A Chemotherapy administration, intra arterial; push technique
96422	N/A infusion technique, up to one hour
96423	N/A infusion technique, each additional hour, one to 8 hours

<b>OLD CODE</b> cross walked to	<b>NEW CODE</b>
96425	N/A infusion technique, initiation of prolonged infusion ( more than 8 hours)
96440	N/A Chemotherapy administration into pleural cavity
96445	N/A Chemotherapy administration into peritoneal cavity
96450	N/A Chemotherapy administration into CNS
96420	N/A Refilling and maintenance of portable pump
N/A	G0363 Irrigation of implanted venous access device for

96530	N/A	drug delivery systems
96542	N/A	Refilling and maintenance of implantable pump Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents

**Note:** No Replacement Code means an existing procedure code is no longer available for this service. If a Replacement Code is available, this information is reported above. Providers needing to bill a service with “No Replacement Code” may use “Not Otherwise Classified”.

**(c) The list of approved Practitioner-Administered Drugs Effective January 1, 2005.**

The fee allowances for the following HCPCS codes will be based at the cost of common dosages of approved drugs, based on each drug’s Average Wholesale Price (AWP) per unit. A unit represents the dosage indicated in the description for each drug listed.

**NOTE:** Effective for claims with service dates on or after **July 1, 2005**, reimbursement for practitioner-administered drugs shall be based on a drug’s AWP less 12.5% or the practitioner’s acquisition cost, whichever is less.

<u>HCPCS CODE</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>
J0128	INJECTION, ABARELIX, 10 MG	80.92
J0135	INJECTION, ADALIMUMAB, 20 MG	359.45
J0180	INJECTION, AGALSIDASE BETA, 1 MG	142.75
J0878	INJECTION, DAPTOMYCIN, 1 MG	0.36
J1457	INJECTION, GALLIUM NITRATE, 1 MG	1.50
J1931	INJECTION, LARONIDASE, 0.1 MG	268.10
J2357	INJECTION, OMALIZUMAB, 5 MG	18.94
J2469	INJECTION, PALONOSETRON HCl, 25 MCG	340.20
J2794	INJECTION, RISPERIDONE, LONG ACTING, 0.5 MG	5.69
J3246	INJECTION, TIROFIBAN HCl, 0.25MG	9.92
J3396	INJECTION, VERTEPORFIN, 0.1 MG	11.25

<u>HCPCS CODE</u>	<u>PROCEDURE DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>
J7304	CONTRACEPTIVE SUPPLY, HORMONE CONTAINING PATCH, EACH	14.31
J7343	DERMAL AND EPIDERMAL, TISSUE OF NON-HUMAN ORIGIN, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, WITHOUT METABOLICALLY ACTIVE ELEMENTS, PER SQUARE CENTIMETER	BR
J7344	DERMAL TISSUE, OF HUMAN ORIGIN, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, WITHOUT METABOLICALLY ACTIVE ELEMENTS, PER SQUARE CENTIMETER	BR
J7611	ALBUTEROL, INHALATION SOLUTION, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1 MG	0.17
J7612	LEVALBUTEROL, INHALATION SOLUTION, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 0.5 MG	0.17
J7613	ALBUTEROL, INHALATION SOLUTION, ADMINISTERED THROUGH DME, UNIT DOSE, 1 MG	0.51
J7614	LEVALBUTEROL, INHALATION SOLUTION, ADMINISTERED THROUGH DME, UNIT DOSE, 0.5 MG	0.51
J7616	ALBUTEROL, UP TO 5 MG AND IPRATROPIUM BROMIDE, UP TO 1 MG, COMPOUNDED INHALATION SOLUTION, ADMINISTERED THROUGH DME	0.69
J7617	LEVALBUTEROL, UP TO 2.5 MG AND IPRATROPIUM BROMIDE, UP TO 1 MG, COMPOUNDED INHALATION SOLUTION, ADMINISTERED THROUGH DME	0.69
J7674	METHACHOLINE CHLORIDE ADMINISTERED AS INHALATION SOLUTION THROUGH A NEBULIZER, PER 1 MG	0.48
J9035	INJECTION, BEVACIZUMAB, 10 MG	68.75
J9041	INJECTION, BORTEZOMIB, 0.1 MG	34.18
J9055	INJECTION, CETUXIMAB, 10 MG	60.00
J9305	INJECTION, PEMETREXED, 10 MG	48.75

**EFFECTIVE: (2) Deletions Effective for Claims with Dates of Service on or after October 31, 2005**

**DELETIONS**

<b><u>CODES DELETED</u></b>	<b><u>TO REPORT, USE CODE</u></b>
G0001FP	36415FP
G0001UD	36415UD

**Note:** No Replacement Code means an existing procedure code is no longer available for this service. If a Replacement Code is available, this information is reported above. Providers needing to bill a service with “No Replacement Code” may use “Not Otherwise Classified” procedure codes.

**Pharmaceutical Services Manual (N.J.A.C. 10:51):**

**Additions and deletions; Medicaid and NJ FamilyCare drug rebate programs  
“Manufacturers’ Labeler Code List (APPENDIX F)”;** CMS Release # 137

**ADDITIONS:** The Manufacturers’ Labeler Codes listed below were **added** to the New Jersey Medicaid and the NJ FamilyCare fee-for-service programs as of the indicated effective date:

<b><u>MANUFACTURER</u></b>	<b><u>LABELER</u></b>	<b><u>EFFECTIVE DATE</u></b>
Cornerstone Biopharma, Inc.	10122	04/26/2005
Cotherix, Inc.	10148	04/14/2005
GTx, Inc.	11399	03/18/2005
Gemini Phatrmaceuticals, Inc.	51645	02/12/2005
OHM Laboratories, Inc.	51660	07/01/2005
Richmond Pharmaceuticals, Inc.	54738	02/14/2005
Viro Pharma, Inc.	66593	04/18/2005
Varsity Laboratories	67537	04/06/2005
Dava Pharmaceuticals, Inc.	68774	03/14/2005

**DELETIONS:** The Manufacturers’ Labeler Code listed below will be **deleted** from the New Jersey Medicaid and the NJ FamilyCare fee-for-service programs. Drugs manufactured by the manufacturer **will not be reimbursed** by Medicaid or NJ FamilyCare fee-for-service as of the indicated date:

<b><u>MANUFACTURER</u></b>	<b><u>LABELER</u></b>	<b><u>EFFECTIVE DATE</u></b>
Steris Laboratories	00402	07/01/2005
Ranbaxy Laboratories, Inc.	10631	04/01/2005
Berlex Laboratories	11994	07/01/2005
Jerome Stevens Pharmaceuticals, Inc.	50564	07/01/2005
Speywood Pharmaceuticals, Inc.	55688	07/01/2005
Elge, Inc.	58298	07/01/2005
Niche Pharmaceuticals	59016	07/01/2005
Kiel Laboratories, Inc.	59063	07/01/2005
AM2PAT, Inc.	64054	07/01/2005
Aslung Pharmaceutical, L.P.	65271	07/01/2005
Morepen Max, Inc.	67836	07/01/2005

**NOTE:** The Medicaid, PAAD and Senior Gold Prescription Discount programs **are not related**. Unlike Medicaid, the PAAD program and the Senior Gold Prescription Discount program cover only legend drugs, diabetic testing supplies and insulin. Medicaid, PAAD and Senior Gold program coverage of specific drug products may be different, based on drug-manufacturer participation in the Medicaid, PAAD and Senior Gold Drug Rebate programs.

**RETAIN THIS NEWSLETTER NUMERICALLY BEHIND THE NEWSLETTER TAB  
(BLUE TAB MARKED "5")**