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State/Territory Name: **NEW JERSEY**

State Plan Amendment (SPA) #: **13-14 MA**

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
New York Regional Office
26 Federal Plaza, Room 37-100
New York, NY 10278

DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS
DMCHO: JH

Valerie Harr
State Medicaid Director
Department of Human Services
Division of Medical Assistance and Health Services
State of New Jersey
P.O. Box 712
Trenton, NJ 08625-0712

Dear Director Harr:

This is to notify you that New Jersey State Plan Amendment (SPA) #13-14 MA has been approved for adoption into the State Medicaid Plan with an effective date of September 1, 2013. This State Plan Amendment updates the fee schedule for various non-institutional services and provides information on how to locate the fee schedule(s). Enclosed are copies of SPA #13-14 MA and the HCFA- 179 form, as approved.

Enclosed are copies of SPA #13-14 and the HCFA-179 form, as approved. As requested by the state, CMS has entered pen & ink changes to: Blocks 7a and 7b, Federal Budget Impact, to correct the FFYs and the respective budget impact amounts; Block 8, Page Number of the Plan Section or Attachment; and Block 9, Page Number of the Superseded Plan Section or Attachment.

If you have any questions or wish to discuss this SPA further, please contact Shing Jew at (212) 616-2426 or Joanne Hounsell at (212) 616-2446.

Sincerely,

/s/

John Guhl
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosures: HCFA-179 Form
State Plan Pages

cc:
J. Velez
J. Hubbs
G. Lovell
R. Weaver
M. Cieslicki
T. Simananda
J. Guhl
G. Critelli
S. Jew
J. Hounsell
M. Lopez

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER	2. STATE
13-14-MA	New Jersey

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
September 1, 2013

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 U.S.C. 1396a(a)(30)(A)

7. FEDERAL BUDGET IMPACT:
a. FFY ~~2014 $26,000.00~~ 2013 $3,000.00
b. FFY ~~2015 $26,000.00~~ 2014 $36,000.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B Pages 1, 2, 2a
Attachment 4.19-B Pages 3, 4, 4(b)
Attachment 4.19-B Pages 5, 5a, 6(a)
Attachment 4.19-B Page 7
Attachment 4.19-B Page 9, 9(b)
Attachment 4.19-B Page 9(c)7, 9(e)
Attachment 4.19-B Page 9(f).
Attachment 4.19-B Pages 11, 12
Attachment 4.19-B Pages ~~14~~, 15, 16, 16(a)
Attachment 4.19-B Page 19
Attachment 4.19-B Page 21
Attachment 4.19-B Pages 22, 22a, 22b, 22c
Attachment 4.19-B Page 23
Attachment 4.19-B Pages 24.4, 24.5, 24.6, 24.7
Attachment 4.19-B Page 25.3
Attachment 4.19-B Page ~~32~~ 35

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B Pages 1, 2, 2a
Attachment 4.19-B Pages 3, 4, 4(b)
Attachment 4.19-B Pages 5, 5a, 6(a)
Attachment 4.19-B Page 7
Attachment 4.19-B Page 9, 9(b)
Attachment 4.19-B Page 9(c)7, 9(e)
Attachment 4.19-B Page 9(f).
Attachment 4.19-B Pages 11, 12
Attachment 4.19-B Pages ~~14~~, 15, 16, 16(a)
Attachment 4.19-B Page 19
Attachment 4.19-B Page 21
Attachment 4.19-B Pages 22, 22a, 22b, 22c
Attachment 4.19-B Page 23
Attachment 4.19-B Pages 24.4, 24.5, 24.6, 24.7
Attachment 4.19-B Page 25.3
NEW

10. SUBJECT OF AMENDMENT
2013 Fee Schedule

Attachment 4.19B Page 10(h)
Attachment 4.19B Pages 33, 34, 35

Attachment 4.19 B Page 10(h

11. GOVERNOR'S REVIEW *(Check One)*
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
Not required, pursuant to 7.4 of the Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL
/s/

13. TYPED NAME: Jennifer Velez

14. TITLE: Commissioner,
Department of Human Services

15. DATE SUBMITTED: 9/25/13

16. RETURN TO

Valerie Harr, Director
Division of Medical Assistance and Health Services
P.O. Box 712, Mail Code #26
Trenton, NJ 08625-0712

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
June 09, 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
September 01, 2013

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: John Guhl

22. TITLE: Acting Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS

FORM CMS-179 (07-92)

Instructions on Back

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF NEW JERSEY

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

The reimbursement methodologies for the following services are contained in this attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF NEW JERSEY

Methods and Standards for Establishing Payment Rates for Non-Institutional Services
OUTPATIENT HOSPITAL SERVICES

a) In-state Outpatient Hospital Services

1. Outpatient Hospital (Dental Services): Reimbursement for dental services performed in the outpatient department of the hospital shall be made in accordance with a fee schedule, equal to the fees paid to private practitioners and independent dental clinics. The exception is, reimbursement for Outpatient dental services provided to NJ Medicaid/ FamilyCare fee-for-service beneficiaries with chronic medical conditions and/or developmental disabilities resulting in special healthcare needs. Consideration for the special healthcare needs exclude services from being performed in a private dental office or dental clinic, and require that the service be performed in a hospital operating room. This reimbursement will follow the cost-to-charge reimbursement methodology as described in the State Plan Attachment 4.19-B a) Item number 7. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of dental services and the fee schedule and any annual/periodic adjustments to the fee schedule are published in N.J.A.C. 10:56-3.2 & 3.3. The effective date of the applicable fee schedule as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

2. Outpatient Hospital (HealthStart): Reimbursement for HealthStart Health Support Services and Pediatric Continuity of Care shall be paid in accordance with a fee schedule. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of Health Start services and the fee schedule and any annual/periodic adjustments to the fee schedule are published in N.J.A.C. 10:54-9.10. The effective date of the applicable fee schedule as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

3. Outpatient Hospital (Renal Dialysis): Services for End-Stage Renal Disease (ESRD): Reimbursement for Renal Dialysis Services for ESRD shall be at 100 percent of the Medicare composite rate including any add-on charges.

4. Outpatient Hospital (Medicare Deductible and Co-insurance Amounts): Medicare deductible and co-insurance amounts shall be reimbursed at 100 percent.

5. Outpatient Hospital (Laboratory/Pathology): Most hospital outpatient department laboratory/pathology services are reimbursed using the Medicaid Laboratory/Pathology Fee Schedule. There are some exceptions for blood

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

products and other laboratory services, such as pathology, that are reimbursed on a cost-to-charge ratio. Specimen drawing and collection are reimbursed separately. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of lab/pathology services and the fee schedule and any annual/periodic adjustments to the fee schedule are published in N.J.A.C. 10:52-10.2 & 10.3. The effective date of the applicable fee schedule as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

6. Outpatient Mental Health Services: Most outpatient mental health services are reimbursed utilizing a fee schedule. Exceptions are Revenue code range 900-904 that are reimbursed on a cost-to-charge ratio. State developed fee schedule rates are the same for both governmental and private providers of mental health services and the fee schedule and any annual/periodic adjustments to the fee schedule are published in N.J.A.C. 10:52-4.3. The effective date of the applicable fee schedule as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

7. All other outpatient hospital services shall be reimbursed according to the cost-to-charge reimbursement methodology. The cost-to-charge-ratio is a retrospective cost reimbursement rate and is an interim payment. Payments will be compared to each facility's final settlement. The only exceptions are those listed at 1-6 above. Final settlements shall be reduced for hospital outpatient capital costs by 10 percent and reasonable cost of hospital outpatient services (net of outpatient capital cost) shall be reduced by 5.8 percent as reported in the Medicare Cost Report (HCFA-2552). This reduction shall be calculated when the Medicare Cost Report (HCFA-2552) is finalized and if the report is amended.

8. In no event shall the payment for any service listed above exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

LABORATORY SERVICES

Reimbursement for covered services shall be made in accordance with a fee schedule. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of laboratory services. In no event shall the charge to Title XIX from a laboratory exceed the lowest charge to other providers for the specific service.

The effective date of the applicable fee schedule as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

Reimbursement for laboratory services in outpatient settings conforms with the lower limits set by Medicare as required by section 1903 (i) (7) of the Social Security Act.

Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

PHYSICIAN SERVICES
(Includes Dentists, Osteopaths and Optometrists)

Reimbursement for covered services shall be made in accordance with a fee schedule. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of physician services. 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.

The term physician services includes services of the type which an optometrist is also legally authorized to perform and such services are reimbursed whether furnished by a physician or an optometrist under this plan.

Physicians who are HealthStart providers will be reimbursed in accordance with a fee schedule utilizing HCPCS codes developed for HealthStart. Physicians practicing in hospital outpatient departments may be reimbursed in accordance with a fee schedule if they are unbundled, i.e., allowed to bill independently for professional services.

The effective date of the applicable fee schedule as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

Reimbursement for immunizations services will be based on the Wholesale Acquisition Cost (WAC) price of the NDC, less 1% plus $2.50 for the physician's cost of administering the immunization.

Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF NEW JERSEY

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

PODIATRIST, CHIROPRACTOR AND PSYCHOLOGIST SERVICES

Reimbursement for covered services shall be made in accordance with a fee schedule. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of podiatry, chiropractic, and psychology services. 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.

The effective date of the applicable fee schedule as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan. Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF NEW JERSEY

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

ADVANCED PRACTICE NURSE SERVICES

Reimbursement for covered services shall be made in accordance with a fee schedule. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of advanced practice nurse services. 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.

Reimbursement to HealthStart pediatric providers will be based on a fee schedule utilizing HCPCS codes developed for HealthStart.

Advanced practice nurses practicing in hospital outpatient departments may be reimbursed in accordance with a fee schedule if they are unbundled, i.e., allowed to bill independently for professional services.

Reimbursement for immunization services will be based on the Wholesale Acquisition Cost (WAC) price of the NDC, less 1% plus $2.50 for the practitioner's cost of dispensing the immunization.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

HOME HEALTH AGENCIES – HOME CARE SERVICES

Final costs per unit and final payments shall be subject to a final reconciliation performed once the agencies' 1999 audited cost reports are available.

Non Routine medical supplies will be reimbursed using the Medicaid fee schedule.

C. Services rendered on or after January 1, 2001

For calendar year 2001, each home health agency shall be reimbursed its agency-specific rates as calculated for calendar year 2000, plus an adjustment equal to the DRI for 2001.

Final Payments shall be subject to a final reconciliation performed once the agencies' 1999 audited cost reports are available.

The unit of service shall be a 15 minute interval of a skilled nursing visit, a home health aide visit, a speech therapy visit, a physical therapy visit, an occupational therapy visit, or a medical social service visit. The home health agency may bill one unit of service for each full 15 minute interval of face-to-face service in which hands-on medical care was provided to a Medicaid or NJ KidCare fee-for-service beneficiary. Routine supplies shall be considered visit overhead costs and billed as part of a unit of service. Non routine medical supplies are billable and will be reimbursed in accordance with the established Medicaid fee schedule.

2. Out of State Approved Agencies

For services rendered on or after January 1, 1999, out-of state home health services shall be reimbursed using the lesser of either the reasonable and customary charges or service-specific statewide unit rates in effect prior to this amendment, based on a prospective per unit methodology. No cost filing is required and no retroactive settlement shall be made.

3. Fee Schedules

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of home health services. The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

HOME HEALTH SERVICES: MEDICAL SUPPLIES, EQUIPMENT AND APPLIANCES

There are four (4) methods of reimbursement for medical supplies, equipment and appliances, collectively known as durable medical equipment (DME), furnished to Medicaid patients. These methods are purchase, rental, repair, and recycling. The decision on which method is appropriate depends on several factors, including, but not limited to, cost of the DME, the patient's medical need for the DME, and the length of time the patient will need the DME. Except as otherwise noted in the plan, state-developed fee schedule rates for durable medical equipment are the same for both governmental and private providers of these services, and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the DMAHS Durable Medical Equipment Manual. The effective date of the applicable fee schedule as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

1. Purchase Policy
   (a) Medical equipment items shall be purchased when the medical need will exist for a period of time long enough to make purchases more economically practical than rental.
   (b) Payment for purchase is made by one of the following methods:
      i. If there is a Medicaid fee schedule, payment shall be based on the lesser of the provider's usual and customary charge to the general public or the Medicaid fee allowance established by the Medicaid program.
      ii. If there is no Medicaid fee schedule, payment shall be based on the lesser of the provider's usual and customary charge to the general public, or a calculated maximum fee allowance equal to either 130 percent of a supplier's invoice cost or 80 percent of the manufacturer's list price for supplies or equipment.
   (c) When vaporizers or cool mist humidifiers are purchased, they shall be reimbursed based on the payment methods described in (b) above.
   (d) Reimbursement for adult incontinence briefs and oxygen concentrators shall be at 70% of reasonable and customary charges.

Note: In no event shall the purchase prices, described above, exceed the lowest payment allowed by Medicare.

2. Rental Policy

Payment is calculated at one hundred twenty (120) percent of the approved purchase price. The following policies also apply:

   (a) If the approved purchase is $100.00 or over, monthly rental is twelve (12) percent of this price. After ten(10) monthly payments, equipment is considered purchased and paid in full.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

INDEPENDENT CLINIC SERVICES

Payment for Independent Clinic Services shall be as follows:

(1) Independent Clinic Services Generally

(a) Reimbursement for covered services shall be made in accordance with a fee schedule. Except where a set fee schedule exists, reimbursement to independent clinics shall be based on the same fees, conditions and definitions, for corresponding services, utilized for the reimbursement of the individual Title XIX participating practitioners and providers in "private" practice.

Except as otherwise noted in the plan, state-developed fee schedule rates for services provided in Independent Clinics are the same for both governmental and private providers of these services, and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the DMAHS Independent Clinic Manual.

(b) In no event shall the charge to the Title XIX programs exceed the charge by the provider for identical services to other governmental agencies or other groups or individuals in the community.

The effective date of the applicable fee schedule as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

(c) Payment for Part B co-insurance and deductible shall be paid only to the Title XIX maximum allowable (less any third party payments).

(2) Adult Day Health Services (ADHS) and Pediatric Day Health Services (PDHS)

Reimbursement for rehabilitation services for Medical Day Care Services (Adult Day Health Services (ADHS) and Pediatric Day Health Services (PDHS) Services) shall be made in accordance with a per diem rate established yearly by the State for each ADHS or PDHS clinic. All adult Medical Day Care providers, regardless of the setting, shall receive a per diem reimbursement rate equal to $78.50, effective July 1, 2009. A per diem unit of service shall be equal to at least five continuous hours of service for adults or at least six continuous hours of service for children on-site at the clinic.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

INDEPENDENT CLINIC SERVICES

Immunizations:

Reimbursement for immunization services will be based on the Wholesale Acquisition Cost (WAC) price of the NDC, less 1% plus $2.50 for the physician's cost of dispensing the immunization.

Reimbursement for all injectables and inhalation drugs to Federally Qualified Health Centers (FQHCs) is at the encounter rate.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

(4) Effective for service dates on or after July 11, 2008 for Medicaid/NJ FamilyCare fee-for-service beneficiaries, FQHCs shall receive reimbursement for deliveries and Ob/Gyn surgeries, at the higher of the Medicaid fee schedule rate for the particular code or the FQHC's PPS encounter rate. Reimbursement for surgical assistants will be at the Medicaid fee schedule rate for the particular code. 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. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of these services.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

a) Antepartum and Postpartum encounters provided to Medicaid/NJ FamilyCare fee-for-service beneficiaries that are not included in the delivery code reimbursement, will be reimbursed to the FQHC at the PPS encounter rate.

b) Post-surgical encounters provided to Medicaid/NJ FamilyCare fee-for-service beneficiaries that are not included in the Ob/Gyn surgical code reimbursement, will be reimbursed to the FQHC at the PPS encounter rate.

c) FQHCs shall receive reimbursement for deliveries and Ob/Gyn surgeries specified on the fiscal agent's website at www.njmmis.com, from the managed care organization(s). FQHCs shall receive reimbursement for surgical assistants related to these deliveries and Ob/Gyn surgeries from the managed care organization(s).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON INSTITUTIONAL SERVICES

INDEPENDENT CLINIC SERVICES

Reimbursement for ambulatory surgical services provided by an ambulatory care/ family planning/ surgical facility licensed and authorized by the New Jersey Department of Health shall be as follows:

Reimbursement for ambulatory surgical procedures shall be made in accordance with a fee schedule. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of ambulatory surgical services. If more than one surgical procedure is performed on a patient in a single operative session, payment is limited to two procedures, provided that the second procedure is at a separate operative site on the patient. Full payment will be made for the procedure with the highest reimbursement rate. Payment for the other procedure will be at 50 percent of the applicable reimbursement rate for that procedure. 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. The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

REIMBURSEMENT FOR PHARMACEUTICAL SERVICES

1.25 Maximum Allowable Cost – Physician/ Practitioner Administered Drugs.

Reimbursement of Level II and Level III HCPCS codes for practitioner-administered drugs shall be based on the Wholesale Acquisition Cost (WAC) price less 1% of a single dose of an injectable or inhalation drug or the physician or practitioner's acquisition cost, whichever is less, when the drug is administered in a physician or practitioner's office. The Title XIX maximum fee allowance for these drugs will be adjusted periodically by the program to accommodate changes in the market cost.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON INSTITUTIONAL SERVICES

PROSTHETIC AND ORTHOTIC APPLIANCES

The reimbursement policy for the purchase or repair of any appliance or orthopedic footwear is in accordance with the lower of the Title XIX maximum fee allowance or the provider's usual and customary charge. 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. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of prosthetic and orthotic appliance services.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

An additional labor charge is available only for repair-related activities after expiration of the warranty or as a result of a change of the prescription. Labor is not reimbursable for a new item or appliance.

Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON INSTITUTIONAL SERVICES

VISION CARE SERVICES

Reimbursement for covered services shall be made in accordance with a fee schedule. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of vision care services.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

In no event shall the charge to the Title XIX programs exceed the charge by the provider for identical services and/or items to other governmental agencies, private non-profit agencies, trade unions, or other individuals in the community.

Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON INSTITUTIONAL SERVICES

PERSONAL CARE SERVICES

Reimbursement for personal care services shall be made in accordance with a fee schedule, differentiated according to the respective training levels of individuals who qualify as personal care assistants. There is a rate for individual patients and a group rate for two to eight persons receiving care in the same residential setting at the same time.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of Personal Care services. 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.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON INSTITUTIONAL SERVICES

NURSE MIDWIFERY SERVICES

Reimbursement for nurse midwifery services shall be made in accordance with a fee schedule using the HCPCS procedure code system and is based on payment of 70 percent of the physician's specialist fee for the same procedure.

Reimbursement for nurse midwives who participate as HealthStart providers shall be made in accordance with a fee schedule utilizing the HCPCS codes developed for HealthStart.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of Nurse Midwifery services. 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.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NON-INSTITUTIONAL SERVICES

FREESTANDING BIRTH CENTER SERVICES

Medicaid providers of freestanding birth centers are reimbursed as follows:

Facility payments for birth center services provided by a freestanding birth center are limited to the lower of the facility's usual and customary charge or the Medicaid maximum fee schedule for services provided by the center. The fee schedule for freestanding birth center services shall be based on the level of services rendered by the center. A higher facility rate is established for prenatal, intrapartum and limited postpartum care provided to low-risk, uncomplicated maternity patients provided by the center and a lower facility rate is established for antepartum and intrapartum care provided to a maternity patient who is transferred to a hospital due to an emergent or complicated delivery. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of birth center services. The effective date of the applicable fee schedule as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

Physicians (OB/GYN), Pediatricians, Advanced Practice Nurses and Certified Nurse Midwives, as well as other licensed practitioners, clinical laboratory and pharmaceutical services shall be reimbursed based on the Medicaid fee schedule. The fee schedule may also be found at http://www.njmmis.com. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The effective date of the applicable fee schedule as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

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OTHER SERVICES

Payment for all other services provided under this plan shall be based on a fixed fee schedule. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of all other non-institutional services. 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.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

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CASE MANAGEMENT SERVICES

1. Reimbursement for clinical case management services and liaison case management services under the case management program/mental health (CMP/MH) program shall be made in accordance with a fee schedule.

2. Reimbursement for early intervention case management services for EPSDT eligible infants and toddlers shall be made in accordance with a fee schedule.

3. Reimbursement for case management organization services under the Children's System of Care Initiative shall be made in accordance with a fee schedule.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of all case management services. 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.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

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REIMBURSEMENT FOR EPSDT SERVICES

Except as noted below, EPSDT screening and diagnosis and follow up treatment are already covered by existing reimbursement methodology in the State Plan.

Private duty nursing will be reimbursed in accordance with a fee schedule to Medicaid-approved agencies.

Religious nonmedical nursing services will be reimbursed utilizing a fee schedule. Hospice room and board will be reimbursed according to existing methodology. Hospice services will be reimbursed according to Medicare principles of reimbursement as required by Federal statute.

Organ transplants will be reimbursed using existing DRG methodology. This methodology can be found in Attachment 4.19-A, SECTION I, pages I-1 through I-47 of the State Plan.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of all EPSDT services. 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.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

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REIMBURSEMENT FOR EPSDT SERVICES: School-Based Rehabilitative Services

Reimbursement for School-Based Rehabilitative Services shall be made in accordance with a fee schedule. The evaluation services will be reimbursed by means of one fee, and the rehabilitative services will be reimbursed through a separate fee.

The fee for rehabilitative services is for the provision of covered components of rehabilitative service(s) included in the treatment plan and will reimburse one day of service.

The reimbursement for School-Based Rehabilitative Services will vary according to the placement in which the rehabilitative services are provided. Settings in which rehabilitative services can be provided are:

In-District
Out-of-District
Non-Public School
State Operated School for the Handicapped.

The fee for evaluation covers the activities necessary to determine a recipient's need for services and the development of a treatment plan; and the periodic review and, when necessary, modification of a treatment plan previously developed.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of all EPSDT services. 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.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

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REIMBURSEMENT FOR EPSDT SERVICES:
Special Rehabilitative Services, Day Training Centers

Special Rehabilitative Services at Day Training Centers will be reimbursed in accordance with a fee schedule. The unit of service is one "day".

The fee is for providing covered components of rehabilitative service(s) included in the treatment plan. Reimbursement for this rehabilitative service is not intended to cover medical or health services, except for those specified in the child's treatment plan.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of all EPSDT services. 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.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

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REIMBURSEMENT FOR EPSDT SERVICES:
Multi-disciplinary Rehabilitative Services, Early Intervention

Reimbursement for Multi-disciplinary Rehabilitative Services for Early Intervention, including evaluation shall be made in accordance with a fee schedule. The fee will be for one day of services. Reimbursement for evaluation will be one fee. Reimbursement for Multi-disciplinary Rehabilitative Services for Early Intervention will be at another fee.

The fee constitutes reimbursement for providing the covered components of the rehabilitative service(s) included in the IFSP. Reimbursement for this rehabilitative service is not intended to cover medical services, other than those rendered by the Early Intervention provider and contained in the IFSP.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of all EPSDT services. 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.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

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REHABILITATION SERVICES

Environmental Lead Inspection Services

Reimbursement for rehabilitation services – environmental lead inspection services shall be made in accordance with a fee schedule or the provider's usual and customary charge, whichever is less. 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.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of all Environmental Lead Inspection services.

The effective date of the applicable fee schedules as well as a link to their electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

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Reimbursement for Mental Health Rehabilitation Services

13(d).7 Mobile Response Services

Reimbursement for Mobile Response under the Children's System of Care Initiative shall be made in accordance with a fee schedule. For the first 72 hours of service, a flat fee per episode is established for all the services provided during this time period.

The per crisis episode fee (for the first 72 hours) and the weekly fee for crisis stabilization management are established using a market-basket rate setting methodology employing the following primary indicators of reasonable and appropriate behavioral healthcare cost in New Jersey's regional healthcare markets:

1. Regional median salary data obtained from three industry-sponsored proprietary surveys of compensation standards for positions selected for comparability and clinical appropriateness according to title, minimum education, licensure and supervisory requirements and description of duties.

2. Staffing patterns derived from service-specific clinical guidelines establishing minimum, industry accepted standards for direct care staffing, consumer access and service frequency and clinical and administrative supervision.

Crisis Stabilization management, after the first 72 hours, is also reimbursed in accordance with a fee schedule based on the mobile response agency's responsibilities to develop, coordinate, secure authorization for, and implement a crisis stabilization plan. The fee is defined as a 15 minute unit. The provider can bill for a maximum of 4 hours (16 units) per week. The provider can only bill for the amount of time actually provided for stabilization management. The provider can bill for a maximum of 32 hours (128 units) over an 8-week period, for stabilization management actually provided.

Rates have been established based on a survey of current market rates and reflect reasonable and customary community rates paid to providers of similar service.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of Mobile Response services. 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.

The effective date of the applicable fee schedules as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

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Reimbursement for Mental Health Rehabilitation Services

13(d).8 EPSDT Behavioral Health Assistance Rehabilitation Services

Reimbursement for Behavioral Health Assistance Rehabilitation Services under the Children's System of Care Initiative provided under the treatment component of EPSDT will be made in accordance with a fee schedule consistent with an approved plan of care, with a minimum service unit defined as 15 minutes.

The fees are established using a market-based rate setting methodology employing the following primary indicators of reasonable and appropriate behavioral healthcare costs in New Jersey's regional healthcare markets:

1. Regional median salary data obtained from three industry-sponsored proprietary surveys of compensation standards for positions selected for comparability and clinical appropriateness according to title, minimum education, licensure and supervisory requirements and descriptions of duties.

2. Staffing patterns derived from service-specific clinical guidelines establishing minimum, industry accepted standards for direct care staffing, consumer access and service frequency and clinical and administrative supervision.

Rates have been established based on a survey of current market rates and reflect reasonable and customary community rates paid to providers of similar services. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of EPSDT Behavioral Health Assistance Rehabilitation Services. 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.

The effective date of the applicable fee schedules as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

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Reimbursement for Community Mental Health Rehabilitation Services in/by Community Residences Licensed by the Division of Mental Health Services

Reimbursement for community mental health rehabilitation services for eligible Medicaid and NJ FamilyCare-Plan A individuals is based on site-specific levels of care delivered by each provider. Licensed residences include group homes of 15 beds or less, supervised apartments and private residences serving up to five individuals. Reimbursement will be made at a per diem rate or made in accordance with a fee schedule at a ¼ hour rate, depending on the level of care provided.

1. Level A+ means community mental health rehabilitation services available in the community residence or in a community setting 24 hours per day delivered by the provider.

2. Level A means community mental health rehabilitation services available in the community residence or in a community setting at least 12 hours per day, but less than 24 hours per day, delivered by the provider.

3. Level B means community mental health rehabilitation services provided in the community residence or in a community setting at least 4 hours per day, but less than 12 hours per day, delivered by the provider.

4. Level C means community mental health rehabilitation services provided in the community residence or in a community setting a minimum of 1 hour per week, delivered by the provider.

5. Level D means community mental health rehabilitation services available in the community residence, in residences not to exceed five residents, or in a community setting, 24 hours per day, delivered by the provider.

Levels A+, A, and D are reimbursed on a per diem rate. Level B services provided to supervised apartment residents and Level C services are reimbursed on a ¼ hour basis. Level B services provided to group home residents are reimbursed on a per diem rate.

Except as otherwise noted in the plan, state developed fee schedule rates used for the reimbursement of Level B services provided to supervised apartment residents and Level C services are the same for both governmental and private 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.

The effective date of the applicable fee schedules as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

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Reimbursement for each level of care shall be made in accordance with a fee schedule. Rates specific to each level of care are developed based on the average cost per billable unit. The fees are all-inclusive and are based on the range of services included within the service definition.

The average costs were developed from actual cost information from providers for each level of care. A one-month sample of actual allowable costs incurred during CY 2002 was used to allocate the final annual costs as reflected in the final Reports of Expenditure for contract years ending in CY 00 or 01, as adjusted by the providers' independent audits. Unallowable costs such as room, board, and other non-treatment/rehabilitation costs were deducted from the actual sample period costs to arrive at the allowable costs that were used in the allocation. Those costs that were determined to be reasonable by the Department were allowed. The allowable cost information from CY 00 or CY 01 contracts was then adjusted to rate year (SFY 02 and 03) dollars to assure comparability and applicability to the rate year.
The total gross adjusted allowable costs were then divided by the average volume of eligible service units to arrive at an average allowable daily or, as applicable, ¼ hour rate per unit of service.

Medicaid/NJ FamilyCare – Plan A reimbursement will not include payment for costs related to room and board related to 24 hour stays.

Governmental and non-governmental providers are reimbursed at the same rates.

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.

The effective date of the applicable fee schedules as well as a link to its electronic publication can be found on page 36 of Attachment 4.19-B of the State Plan.

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Reimbursement for Rehabilitation Services – Mental Health Community Support Services

10. The average cost/available service hour/band was adjusted to account for the proportion of time that services will be delivered as face-to-face contact. Much of the ancillary activity supporting face-to-face encounters is not face-to-face, i.e., substantive phone contact, staff travel time to and from face-to-face encounters with recipients, service planning and documentation, etc. The proportion of time assumed to be available for face-to-face contact is 50%.

11. The unit of service for community support services is a 15 minute individual and 15 minute group unit period of face-to-face time. Group size is limited to 6.

12. The average cost/available hour/band for face-to-face time was divided by 4 to yield the cost/individual unit of service (15 minute period). The cost per individual unit was divided by 4 which is the average group size, (a group being between 2 and 6 individuals) to yield rate per group unit of service.

13. Except as otherwise noted in the plan, state fee schedule rates established pursuant to this section are the same for both governmental and private providers of mental health community support services. 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.

    The effective date of the applicable fee schedules as well as a link to its electronic publication can be found on page 36 of this Section of the plan.

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Reimbursement Template – Physician Services

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☐ The rates reflect all Medicare site of service and locality adjustments.

☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☐ The rates reflect all Medicare geographic/locality adjustments.

☒ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code: **NJ will use the March 28, 2013 Deloitte fee schedule rates. Rates will be set at the beginning of CY 2013 and CY 2014 The fee schedule rates will remain the same throughout the calendar year.**

Method of Payment

☒ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☐ quarterly

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Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes). 90461; 99218; 99219; 99220; 99224; 99225; 99226; 99288; 99339; 99340; 99358; 99359; 99360; 99363; 99364; 99366; 99367; 99368; 99374; 99375; 99377; 99378; 99379; 99380; 99401; 99402; 99403; 99404; 99411; 99412; 99420;99429; 99441; 99442; 99443; 99444; 99450; 99455; 99456; 99485; 99486 and 99487

☒ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

90460; 99488; 99489 99495; and 99496 added January 1, 2013

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program

☐ Rate using the CY 2009 conversion factor

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Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☒ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: $16.18.

☐ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is:_____.

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:_____

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014, but not prior to December 31, 2014. All rates are published at www.njmmis.com.

Vaccine Administration
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014, but not prior to December 31, 2014. All rates are published at www.njmmis.com.

PRA Disclosure Statement

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FEE SCHEDULE EFFECTIVE DATES AND LINKS

The fees in the State's fee schedules referenced in Attachment 4.19-B were set on September 1, 2013, and are effective for services provided on or after that date. All applicable procedure code listings and/or rates are published on the State's website and can be located using the following links:

- **Medicaid Fee Schedules:**
  - **Location**: https://www.njmmis.com/downloadDocuments/CPTHCPCSCODES.pdf
  - **Description**: Main file of procedure codes billable to Medicaid for all services outlined in the Table of Contents on Page 1 of this Section, except as listed below.

- **Children's Rates**:
  - **Location**: https://www.njmmis.com/downloadDocuments/childrensrates.pdf
  - **Description**: File contains procedure codes billable to Medicaid for services outlined in the Table of Contents on Page 1 of this Section provided to beneficiaries under the age of 21.

- **Outpatient Laboratory Billing Only:**
  - **Location:** https://www.njmmis.com/downloadDocuments/Outpatientlabonly.pdf
  - **Description:** File contains procedure codes billable to Medicaid for laboratory services conducted in an outpatient hospital setting as described beginning on Page 2 of this Section.

- **ACA Enhanced Rates:**
  - **Location:** https://www.njmmis.com/downloadDocuments/CPTCodesACA.pdf
  - **Description:** File containing the procedure codes with ACA enhanced rates for physician services. Any Evaluation and Management/Vaccine Administration codes with enhanced rates per the ACA are also available at this location.

- **Outpatient Mental Health Services Only:**
  - **Location:** https://www.njmmis.com/ps_revCodes.aspx
  - **Description:** File containing Revenue Codes and rates for Outpatient Psychiatric Services provided to adults and children, as described under Outpatient Mental Health Services on Page 2a of this Section.

- **Home Health Rates Only:**
  - **Location:** https://www.njmmis.com/hh_revCodes.aspx
  - **Description:** File containing Revenue Codes and rates for statewide Home Health services as described on Page 6a of this Section.