

CHAPTER 66

INDEPENDENT CLINIC SERVICES

**Division of Medical Assistance and Health Services
INDEPENDENT CLINIC SERVICES MANUAL**

**N.J.A.C. 10:66
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SUBCHAPTER 1. GENERAL PROVISIONS

10:66-1.1 Scope of service

(a) This chapter (N.J.A.C. 10:66) describes the policies and procedures of the New Jersey Medicaid and NJ FamilyCare fee-for-service programs pertaining to the provision of, and reimbursement for, medically necessary Medicaid-covered and NJ FamilyCare-covered services in an independent clinic setting. The term independent clinic includes, but is not limited to, clinic types such as: ambulatory care facility, ambulatory surgical center, ambulatory care/family planning clinic, and Federally qualified health center.

(b) Medically necessary services provided in an independent clinic setting shall meet all applicable State and Federal Medicaid and NJ FamilyCare fee-for-service laws, and all applicable policies, rules and regulations as specified in the appropriate provider services manual of the New Jersey Medicaid and NJ FamilyCare fee-for-service programs.

(c) Independent clinic services are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are provided by a facility (freestanding) that is not part of a hospital but is organized and operated to provide medical care to outpatients, including such services provided outside the clinic by clinic personnel to any Medicaid or NJ FamilyCare fee-for-service beneficiary who does not reside in a permanent dwelling or does not have a fixed home or mailing address. Clinic services do not include services provided by hospitals to outpatients.

(d) The chapter is divided into six subchapters, as follows:

1. N.J.A.C. 10:66-1 contains scope of service, definitions, provisions for provider participation, prior authorization, basis for reimbursement, recordkeeping requirements, personal contribution to care requirements for NJ FamilyCare-Plan C and copayments for NJ FamilyCare-Plan D, and the medical exception process.

2. N.J.A.C. 10:66-2 contains policies and procedures pertaining to specific Medicaid-covered and NJ FamilyCare-covered services provided in an independent clinic. Where unique characteristics or requirements exist concerning a particular Medicaid-covered or NJ FamilyCare-covered service, the service is separately identified and discussed.

3. N.J.A.C. 10:66-3 contains information about HealthStart, a program for pregnant women and children.

4. N.J.A.C. 10:66-4 and its Appendices contain information about Federally qualified health centers, including rules governing the provision of services; the Medicaid cost report containing the forms used by Federally qualified health centers to determine Medicaid and NJ FamilyCare fee-for-service reimbursement amounts; and instructions for the proper completion of the forms. The Appendices are: Appendix A, Pre-2001 Cost Report; Appendix B, FQHC Annual Cost Reporting Requirements; Appendix C, New FQHC Medicaid Cost Reports for First and Second Years of Operation; Appendix D,

Change in Scope of Service Application Requirements; and Appendix E, Medicaid Managed Care Wrap-around Reports.

5. N.J.A.C. 10:66-5 contains information about ambulatory surgical centers, including covered services, anesthesia services, facility services, and medical records.

6. N.J.A.C. 10:66-6 pertains to the Healthcare Common Procedure Coding System (HCPCS). The HCPCS contains procedure codes and maximum fee allowances corresponding to Medicaid-reimbursable services.

(e) The Appendix following N.J.A.C. 10:66-6 pertains to the Fiscal Agent Billing Supplement. The Fiscal Agent Billing Supplement contains billing instructions and samples of forms (claim forms, prior authorization forms, and consent forms) used in the billing process.

10:66-1.2 Definitions

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

"Ambulatory care facility" means a health care facility or a distinct part of a health care facility, licensed by the New Jersey State Department of Health and Senior Services, which provides preventive, diagnostic, and treatment services to persons who come to the facility to receive services and depart from the facility on the same day.

"Ambulatory care/family planning facility" means a health care facility or a distinct part of a health care facility, licensed by the New Jersey State Department of Health and Senior Services to provide specified surgical procedures.

"Ambulatory surgical center (ASC)" means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization; has an agreement with the Centers for Medicare & Medicaid Services (CMS) as a Medicare participating provider for ambulatory surgical services; is licensed if required, by the New Jersey State Department of Health and Senior Services; and meets the enrollment requirements of the New Jersey Medicaid/NJ FamilyCare programs as indicated in the Administration chapter at N.J.A.C. 10:49-3.2, and N.J.A.C. 10:66-1.3.

"Audited financial statements" are defined in requirements set forth in N.J.A.C. 10:66-4.3. This section provides a set of guidelines so that FQHC providers will know the criteria for a satisfactory audit.

"Clinical practitioner" means a physician (including doctor of medicine, osteopathy, dentistry, podiatry, optometry, and chiropractic medicine), advanced practice nurse, certified nurse midwife, and clinical psychologist.

"Clinic services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not a part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients:

1. Services furnished at the clinic by or under the direction of a physician or dentist; and
2. Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

"Compensated hours" means, in the case of a Federally-qualified health center only, all hours for which an employee receives compensation, payment or any form of remuneration, including regular time, overtime, vacation time, sick time, personal time, educational time, and all other compensated time.

"Dental clinic" means an independent clinic, whether freestanding, or a distinct component of a multi-service ambulatory care facility, licensed by the New Jersey State Board of Dentistry.

"Dentist" means an individual who is licensed to practice dentistry in the state in which treatment is provided, whose practice is limited solely to dentistry and its specialties, as recognized by the American Dental Association, and who meets the requirements of N.J.A.C. 10:56.

"Drug treatment center" means an independent clinic, whether freestanding, or a distinct part of a facility which is licensed or approved by the New Jersey State Department of Health and Senior Services (DHSS) to provide health care for the prevention and treatment of drug addiction and drug abuse, in accordance with N.J.A.C. 8:43A-26, Drug Abuse Treatment Services.

"End Stage Renal Disease (ESRD) facility" means a freestanding facility approved by the Centers for Medicare & Medicaid Services (CMS) for participation in the Medicare program as an end stage renal disease facility.

"Federally qualified health center (FQHC)" means an entity that is receiving a grant under Section 330 of the Public Health Service Act; or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under Section 330 of the Public Health Service Act; or based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant; or was treated by the Secretary, for purposes of Medicare Part B, as a Federally Funded Health Center as of January 1, 1990; and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) or by an urban Indian organization receiving

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funds under Title V of the Indian Health Care Improvement Act for the provision of primary health services.

"Freestanding facility" means a facility which may not be part of a hospital. However, a clinic may be located in the same building as a hospital, as long as there is no administrative, organizational, financial or other connection between the clinic and the hospital.

"Independent clinic" means a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients.

"Local health department clinic" means an independent clinic which is licensed or approved by the New Jersey State Department of Health and Senior Services (DHSS) to provide medical care to outpatients in accordance with N.J.A.C. 8:52.

"Managed care wraparound payments" means DMAHS payments made to FQHCs for the difference between the Medicaid FQHC encounter rate and amounts paid to FQHCs by managed care organizations for encounters provided to Medicaid and FamilyCare beneficiaries.

"Medical director" means a physician, doctor of medicine (M.D.) or osteopathy (D.O.), who is responsible for the direction, provision and quality of medical services provided to patients and who is qualified in accordance with N.J.A.C. 8:43A-1.14.

"Medicare Economic Index (MEI)" means that factor that adjusts reimbursement rates for annual inflation, which is determined in accordance with section 1842(b)(3) of the Social Security Act, 42 U.S.C. § 1395u(b)(3) and regulation at 42 C.F.R. 405.504.

"Medicare limit" means the Medicare FQHC urban payment limit as provided for in section 1833(a)(3) of the Social Security Act, 42 U.S.C. § 13951(a) and section 1861(v)(1)(A) of the Social Security Act, 42 U.S.C. § 1395(x)(v), and section 1886(d)(2)(D) of the Social Security Act, 42 U.S.C. § 1395ww(d). The Medicare limit is adjusted for inflation annually by the Medicare Economic Index (MEI) applicable to primary care services.

"Mental health clinic" means an independent clinic, whether freestanding, or a distinct component of a multi-service ambulatory care facility, which meets the minimum standards established by the Community Mental Health Services Act implementing rules, including, but not limited to, N.J.A.C. 10:37, and is approved by the Division of Mental Health Services, in accordance with that Division's rules.

"Mental health services worker" means an individual who possesses a bachelor's degree or associate's degree in psychosocial rehabilitation or mental health services, or

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related life or work experience, such as assuming leadership roles during participation in mental health services or mental health consumer initiatives.

"Outpatient" means a patient of an organized medical facility, or a distinct part of that facility who is expected by the facility to receive and who does receive professional services for less than a 24-hour period, regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.

"PA" means prior authorization. See N.J.A.C. 10:66-1.4.

"Patient" means a beneficiary who is receiving needed professional services that are directed by a licensed practitioner of the healing arts towards the maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

"Personal care assistant" means a person who has successfully completed a training program in personal care services and is certified by the New Jersey State Department of Law and Public Safety, Board of Nursing, as a homemaker-home health aide; who successfully completes a minimum of 12 hours in-service education per year offered by the agency; and who is supervised by a registered professional nurse employed by a Division homemaker/personal care assistant provider agency.

"Physician" means a doctor of medicine (M.D.) or osteopathy (D.O.) licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners, or similarly licensed by comparable agencies of the state in which he or she practices.

"Podiatrist" means an individual licensed to practice podiatry in the state in which treatment is provided, and whose practice is limited to podiatry, within the scope of practice for that state.

"Prevocational services" means interventions, strategies and activities within the context of a partial care program that assist individuals to acquire general work behaviors, attitudes and skills needed to take on the role of worker and in other life domains, such as: responding to criticism, decision making, negotiating for needs, dealing with interpersonal issues, managing psychiatric symptoms and adherence to prescribed medication directions/schedules. Examples of interventions not considered prevocational or covered by Medicaid and NJ FamilyCare include: technical occupational skills training, college preparation, student education, including preparation of school assigned classwork or homework and individualized job development.

"Prospective Payment System (PPS)" means a payment rate per encounter which is determined in accordance with 42 U.S.C. § 1396a(a) and adjusted annually by the MEI applicable to primary care services.

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"Psychologist" means an individual who is licensed to practice psychology in the state in which treatment is provided, and who is a Diplomate of the American Board of Professional Psychology (Diplomate Qualified) or has been notified of admissibility to the examination by the American Board of Professional Psychology (Diplomate Eligible).

"Satellite" means an affiliate of a separately enrolled independent clinic. A satellite is located at a site distinct from that of the separately enrolled independent clinic but shares the same governing authority.

"Special minimum wage certificate" means a certificate issued by the U.S. Department of Labor pursuant to 29 C.F.R. § 525, which permits a worker with a disability to be paid at a rate below the rate which would otherwise be required by statute.

"Specialist" means a fully licensed physician who:

1. Is a diplomate of a specialty board approved by the American Board of Medical Specialties or the Advisory Board of the American Osteopathic Association;
2. Is a fellow of the appropriate American specialty college or a member of an osteopathic specialty college;
3. Is currently admissible to take the examination administered by a specialty board approved by the American Board of Medical Specialties or the Advisory Board of the American Osteopathic Association, or has evidence of completion of an appropriate qualifying residency approved by the American Medical Association or American Osteopathic Association;
4. Holds an active staff appointment with specialty privileges in a voluntary or governmental hospital which is approved for training in the specialty in which the physician has privileges; or
5. Is recognized in the community as a specialist by his or her peers.

"Specialist in dentistry" means an individual who is licensed to practice dentistry in the state in which treatment is provided, and whose practice is limited solely to his or her specialty, which is recognized by the American Dental Association. Additional conditions regarding the qualifications for a dental specialist for the New Jersey Medicaid and NJ KidCare fee-for-service programs are located in the New Jersey Medicaid and NJ KidCare fee-for-service programs' Dental Services chapter, N.J.A.C. 10:56.

"Specialist in podiatry" means an individual who is licensed to practice podiatry in the state in which treatment is provided, and who is a Diplomate of the appropriate American Podiatry Association-recognized board or has been notified of admissibility to examination by the appropriate American Podiatry Association recognized board.

"Therapeutic subcontract work activity" means production, assembly and/or packing/collating tasks for which individuals with disabilities performing these tasks are paid less than minimum wage and, pursuant to 29 C.F.R. § 525, a special minimum

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wage certificate has been issued to the organization/program by the U.S. Department of Labor.

"Vocational services" means those interventions, strategies and activities that assist individuals to acquire skills to enter a specific occupation and take on the role of colleague (that is, a member of a profession) and/or assist the individual to directly enter the workforce and take on the role of an employee, working as a member of an occupational group for pay with a specific employer.

10:66-1.3 Provisions for provider participation

(a) Each independent clinic, including each satellite, shall be individually approved by the New Jersey Medicaid and NJ FamilyCare fee-for-service programs and enrolled with the Division's fiscal agent, for approved service(s). If a clinic wishes to add a service(s), approval from the New Jersey Medicaid and NJ FamilyCare fee-for-service programs shall be obtained before reimbursement for the service(s) may be claimed. For additional details, see the Administration chapter, N.J.A.C. 10:49-3.2, Enrollment process, and N.J.A.C. 10:49-3.3, Providers with multi-locations.

1. All clinical practitioners directly affiliated with the clinic shall enroll in the New Jersey Medicaid and NJ FamilyCare fee-for-service programs, as indicated in the Administration chapter at N.J.A.C. 10:49-3.4, in order to obtain an individual Medicaid and NJ FamilyCare fee-for-service Provider Number(s).

2. (Reserved)

(b) Each independent clinic seeking enrollment in the New Jersey Medicaid and NJ FamilyCare fee-for-service programs shall possess a certificate of need and/or license, if required, from the New Jersey State Department of Health and Senior Services or the Division of Mental Health Services of the New Jersey Department of Human Services, or from both agencies, if required by law or rule.

1. The facility shall provide only those services for which it is licensed or authorized to provide by the New Jersey State Department of Health and Senior Services or the Division of Mental Health Services of the New Jersey Department of Human Services, or both, if applicable.

2. A photocopy of the license shall be forwarded to the New Jersey Medicaid and New Jersey FamilyCare fee-for-service programs as an attachment to the clinic's initial application for enrollment and when the license is renewed on an annual basis.

(c) In addition to N.J.A.C. 10:66-1.3(a) and (b) above, each independent clinic shall obtain approval from the relevant Federal and State agency(ies), as required by law, rule and/or regulation, including, but not limited to, the following:

1. For an ambulatory surgical center, an agreement with the Centers for Medicare & Medicaid Services (CMS) under Medicare to participate as an ambulatory surgical center and licensure as an ambulatory surgical center, by the New Jersey State Department of Health and Senior Services;

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2. For a Federally qualified health center, approval by the Centers for Medicare & Medicaid Services as a Federally qualified health center and licensure by the New Jersey State Department of Health and Senior Services as an ambulatory care facility;
3. For an ambulatory care/family planning/surgical facility, licensure as an ambulatory care/family planning/surgical facility by the New Jersey State Department of Health and Senior Services;
4. For a dental clinic, a permit to operate shall be obtained from the State Board of Registration and Examination in Dentistry (see N.J.A.C. 13:30-4.2) prior to enrollment as a dental clinic provider, and shall remain in effect;
5. For a mental health clinic, approval by the Division of Mental Health Services of the New Jersey Department of Human Services; and
6. For child health conferences, approval by the New Jersey State Department of Health and Senior Services in accordance with N.J.A.C. 8:52 and as indicated at N.J.A.C. 10:66-3.3.

(d) Each out-of-State clinic seeking reimbursement for services provided to New Jersey Medicaid and NJ FamilyCare fee-for-service beneficiaries shall enroll, if the clinic is approved by Title XIX (Medicaid) in its own state, in the New Jersey Medicaid and NJ FamilyCare fee-for-service programs as indicated in the Administration chapter at N.J.A.C. 10:49-3.2(c).

(e) Each Medicaid or NJ FamilyCare fee-for-service beneficiary's care in an independent clinic shall be under the supervision of a physician directly affiliated with the clinic. The Medical Director or his or her designee shall assume professional responsibility for the services provided and thus assure that the services are medically appropriate.

(f) A physician affiliated with a clinic shall spend as much time in the facility as is necessary to assure that Medicaid and NJ FamilyCare fee-for-service beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of medical and dental practice.

(g) For a physician to be affiliated with a clinic, there shall be a contractual agreement or some other type of formal, written arrangement on file at the facility between the physician and the facility by which the physician is obligated to supervise the care provided to the clinic's Medicaid and NJ FamilyCare fee-for-service beneficiaries.

1. The contractual agreement or formal, written arrangement shall indicate the physician's responsibilities and compensation.

(h) The clinic's medical staff, including physicians, dentists, and other practitioners, shall be appropriately licensed in order to provide the medical care delivered to Medicaid and NJ FamilyCare fee-for-service beneficiaries.

10:66-1.4 Prior authorization (PA)

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(a) In addition to N.J.A.C. 10:49-6.1, this section outlines prior authorization (PA) requirements for dental, mental health, and vision care services, as specified in (b), (c) and (d) below, respectively. Prior authorization as specified in N.J.A.C. 10:49-2.6 shall be required for out-of-State clinics for specified dental, mental health and vision care services in accordance with N.J.A.C. 10:49-6 and in accordance with specific provider chapters. Prior authorization requirements by the Primary Care Provider (PCP) for persons participating in managed health care programs are located at N.J.A.C. 10:49-21.4(c).

(b) Dental services shall be prior authorized as indicated in the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' Dental Services chapter, N.J.A.C. 10:56-1.4.

(c) In addition to the other requirements of this section, mental health services provided to each Medicaid or NJ FamilyCare fee-for-service beneficiary require prior authorization when payment to an independent clinic exceeds \$ 6,000 for that Medicaid or NJ FamilyCare fee-for-service beneficiary in any 12-month period, commencing with the beneficiary's initial visit.

1. The maximum period of authorization shall not exceed 12 months for all mental health services. Additional authorizations may be requested.

i. The maximum period of authorization for partial care shall not exceed six months.

2. When requesting prior authorization, Forms FD-07 and FD-07A, "Request for Authorization of Mental Health Services and/or Mental Health Rehabilitation Services" and "Request for Prior Authorization: Supplemental Information," shall be completed and forwarded to: the Medical Assistance Customer Center (MACC) that serves the county in which the services are rendered. See the Fiscal Agent Billing Supplement, N.J.A.C. 10:66--Appendix, for instructions on the completion of the prior authorization forms.

3. The "Brief Clinical History" and "Present Clinical Status" sections of the FD-07A "Request for Prior Authorization: Supplemental Information" form are particularly important and must provide sufficient medical information to justify and support the proposed treatment request. Failure to comply may result in a reduction or denial of requested services.

4. A departure from the plan of care requires a new request for prior authorization when a change in the beneficiary's clinical condition necessitates an increase in the frequency and intensity of services, or change in the type of services which exceeds the cost of the services authorized.

5. Similarly, a new request for authorization is required for a medical/remedial therapy session or encounter that departs from the plan of care in terms of increased need, scheduling, frequency, or duration of services furnished (for example, unscheduled emergency services furnished during an acute psychotic episode).

6. If the request for prior authorization is approved, the Division's fiscal agent shall notify the provider in writing regarding the Division's decision; authorized date or time

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frame; and activation of the prior authorization number. If the request is modified, denied, or if the Division requires additional information, the provider is so notified in writing by the fiscal agent.

(d) Vision care services require prior authorization as indicated in the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' Vision Care Services chapter, N.J.A.C. 10:62-1.16 and 2.5.

(e) Transportation services to and from a drug treatment center shall be prior authorized after 60 days of treatment at the drug treatment center. The provider shall request prior authorization by completing and forwarding Form MC-12(A), Transportation Prior Authorization Form, to: Unisys Corporation, Transportation Unit, PO Box 4813, Trenton, NJ 08650, or fax to 1-609-588-0816. See the Fiscal Agent Billing Supplement, N.J.A.C. 10:66 Appendix, for instructions on the completion of the prior authorization form.

10:66-1.5 Basis for reimbursement

(a) Except as indicated at (c) through (e) below, reimbursement to independent clinics is in accordance with the maximum fee schedule indicated at N.J.A.C. 10:66-6.2 and is based on the same fees, conditions, and definitions for corresponding services governing the reimbursement of Medicaid-participating and NJ FamilyCare fee-for-service-participating practitioners in "private" (independent) practice. Reimbursement is made directly to the clinic.

1. An independent clinic shall charge for services to all patients, except as provided by legislation. No charge will be made directly to the Medicaid or NJ FamilyCare fee-for-service beneficiary, and the charge to the New Jersey Medicaid and NJ FamilyCare fee-for-service programs may not exceed the charge by the clinic for identical services to other groups or individuals in the community.

(b) The HCPCS procedure code system, N.J.A.C. 10:66-6, contains procedure codes and maximum fee allowances corresponding to Medicaid-reimbursable and NJ FamilyCare fee-for-service-reimbursable services. An independent clinic may claim reimbursement for only those HCPCS procedure codes that correspond to the allowable services included in the clinic's provider enrollment approval letter, as indicated at N.J.A.C. 10:66-1.3(a).

1. If a HCPCS procedure code(s), approved for use by a specific clinic, is assigned both a specialist and non-specialist maximum fee allowance, the amount of the reimbursement will be based upon the status (specialist or non-specialist) of the individual practitioner who actually provided the billed service. To identify this practitioner, enter the Medicaid and NJ FamilyCare fee-for-service Provider Services Number in the appropriate section of the claim, as indicated in the Fiscal Agent Billing Supplement, N.J.A.C. 10:66 Appendix.

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(c) The basis for reimbursement of services provided in an ambulatory surgical center (ASC) is as follows:

1. Reimbursement shall be made for services rendered by both the ASC facility and the attending physician, if the physician is not reimbursed for surgical/medical services by the facility.

2. For facility reimbursement, surgical procedures performed in an ASC are separated into a classification system as specified by CMS and published in the Federal Register in accordance with 42 CFR 416.65(c), the Federal regulations governing ASC services.

i. A single payment is made to an ASC which encompasses all facility services furnished by the ASC in connection with a covered procedure performed on a patient in a single operative session.

ii. If more than one covered surgical procedure is performed on a patient during a single operative session, payment is limited to two procedures, provided that the two procedures are performed at separate operative body sites.

(1) Full payment shall be made for the procedure with the highest Medicaid or NJ FamilyCare fee-for-service reimbursement allowance. Payment for the other procedure shall be at 50 percent of the applicable reimbursement allowance for that procedure. Total reimbursement may not exceed 150 percent of the primary procedure allowance.

iii. The ASC facility payment for all procedures in each group is established at a single rate, as follows:

Group	Maximum Fee Allowance
1	\$ 195.00
2	\$ 261.00
3	\$ 300.00
4	\$ 369.00
5	\$ 421.00
6	\$ 541.00
7	\$ 585.00
8	\$ 627.00
9	\$ 794.00

Note: Should the Centers for Medicare & Medicaid Services (CMS) amend the group designation for any procedure(s), the maximum fee allowance for the newly designated group shall apply and shall not be construed as a fee increase/decrease to the affected procedure(s).

3. Physician reimbursement shall be in accordance with the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' Physician Maximum Fee Allowance for specialist and non-specialist, N.J.A.C. 10:54, and the following:

i. When submitting a claim, the physician performing the surgical procedure shall use the applicable claim form, billing the New Jersey Medicaid or NJ FamilyCare fee-for-service program either as an individual provider or as a member of a physician's group.

ii. A physician on salary for administrative duties (such as a medical director) shall be permitted to submit claims for surgical/medical services performed. Administrative duties shall be considered a direct cost of the facility and shall be included in the clinic payment.

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(d) The basis for reimbursement for services provided in a Federally qualified health center (FQHC) for periods prior to January 1, 2001 shall be as follows:

1. For cost reporting periods beginning prior to January 1, 1994, FQHC reimbursement shall be made at an interim encounter rate as described in (d)3 below. The interim encounter rate includes an add-on for the cost expended by a FQHC for the outstationing of county welfare agency (CWA) staff to determine Medicaid eligibility. An FQHC's financial responsibility for outstationing activities is equivalent to the non-Federal share (currently 50 percent) of estimated CWA costs for the calendar year.

i. Estimated outstationing charges for each FQHC shall be used to determine the amount to be withheld from Medicaid payments and disbursed to CWAs each calendar quarter.

ii. Withholdings (see (d)1i above) shall be made at the beginning of each calendar quarter in an amount equal to one-fourth of the estimated annual outstation charge for each FQHC.

2. For cost reporting periods beginning on and after January 1, 1994, FQHC reimbursement shall be based on the same HCPCS procedure code fees, conditions and definitions for corresponding services governing the reimbursement of Medicaid-participating and NJ KidCare-participating practitioners in "private" (independent) practice, in accordance with N.J.A.C. 10:54-9 and 10:56-3 and reimbursement of independent clinics in accordance with this chapter.

i. FQHC reimbursement shall include an interim encounter rate as described in (d)3 below to be billed once for each Medicaid fee-for-service FQHC encounter. FQHCs shall bill HCPCS fees excluding the encounter procedure codes. The interim encounter rate shall be based upon all reasonable costs not reimbursed by the HCPCS procedure code fees, and shall include an add-on for the cost expended by a FQHC for the outstationing of county welfare agency staff to determine Medicaid or NJ KidCare eligibility. An FQHC's financial responsibility for outstationing activities is equivalent to the non-Federal share (currently 50 percent) of estimated CWA costs for the calendar year.

ii. Estimated outstationing charges for each FQHC shall be used to determine the amount to be withheld from Medicaid and NJ KidCare-Plan A fee-for-service payments and disbursed to CWAs each calendar quarter.

iii. Withholdings (see (d)2ii above) shall be made at the beginning of each calendar quarter in an amount equal to one fourth of the estimated annual outstation charge for each FQHC.

3. The interim encounter rate shall be determined as follows:

i. For cost reporting periods beginning prior to January 1, 1992:

(1) For those FQHCs that have filed a Medicare cost report, the interim encounter rate shall be the current Medicare interim encounter rate.

(2) For those FQHCs that have not filed a Medicare cost report, the interim encounter rate shall be an average of the interim encounter rates described in (d)3i(1) above.

ii. For cost reporting periods beginning on and after January 1, 1992 and prior to January 1, 1994:

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(1) The interim encounter rate shall be the prior year's actual encounter rate as calculated from the Medicaid cost report which shall be incremented by the medical care component of the Consumer Price Index. The interim encounter rate may be adjusted to approximate the reimbursable cost the FQHC is currently incurring to provide covered services to Medicaid beneficiaries.

(2) If there is no prior year actual encounter rate available, the interim encounter rate shall be the Medicare state limit for FQHCs. In this case, the Medicare state limit may be adjusted for Medicaid-only costs which are not included in the Medicare state limit.

iii. For cost reporting periods beginning on and after January 1, 1994 and prior to January 1, 1995:

(1) For those FQHCs that have filed a Medicaid cost report, the interim encounter rate shall be calculated from data on prior years' cost reports.

(2) For those FQHCs that have not filed a Medicaid cost report, the interim encounter rate shall be an average of the interim encounter rates of all FQHCs that have filed a Medicaid cost report.

iv. For cost reporting periods beginning on and after January 1, 1995 and prior to July 15, 1996:

(1) For those FQHCs that have filed a Medicaid cost report, the interim encounter rate shall be the prior year's actual encounter rate as calculated from the Medicaid cost report which shall be incremented by the medical care component of the Consumer Price Index. The interim encounter rate may be adjusted to approximate the reimbursable cost the FQHC is currently incurring in providing covered services to Medicaid recipients.

(2) The FQHCs that have not filed a Medicaid cost report, the interim encounter rate shall be an average of the interim encounter rates described in (d)3iv(1) above.

v. For services rendered on and after July 15, 1996:

(1) For those FQHCs that have filed a Medicaid cost report, the interim encounter rate shall be based on the lower of:

(A) Allowable costs incurred by the facility based on the prior year's cost report inflated by the Medicare Economic Index (MEI), adjusted to reflect amounts reimbursed through the billing of HCPCS codes; or

(B) The Medicaid limit (described in (d)3v(1)(B)(I) through (IV) below), adjusted to reflect amounts reimbursed through the billing of HCPCS codes.

(I) 120 percent of the Medicare Limit for FQHCs for the service period from July 1, 1996 through June 30, 1997;

(II) 115 percent of the Medicare Limit for FQHCs for the service period from July 1, 1997 through June 30, 1998;

(III) 110 percent of the Medicare Limit for FQHCs for service periods beginning July 1, 1998 and thereafter;

(IV) If an FQHC is to receive less Medicaid reimbursement per encounter as a result of this methodology, the reduction will be limited to 20 percent of the prior year's actual encounter rate adjusted for HCPCS reimbursement (actual encounter rate, as defined in (d)4(i) below). This limitation will apply until the FQHC's rate reductions are within the parameters described in (d)3i(1)(B)(I) through (III) above.

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(2) For those FQHCs that have not filed a Medicaid cost report, the interim encounter rate shall be an average of the interim encounter rates described in (d)3v(1) above.

vi. The interim encounter rate may be adjusted during an accounting period. Such adjustment may be made either upon request of the facility, or if there is evidence available to the Medicaid and NJ KidCare-Plan A programs showing that actual costs will be significantly higher or lower than the computed rate. When a facility requests an adjustment of the interim encounter rate, the request shall be supported by a schedule showing that actual costs incurred to date plus estimated costs to be incurred will be significantly higher or lower than the computed rate.

4. The actual encounter rate shall be calculated from the facility's Medicaid cost report, in accordance with N.J.A.C. 10:66-4.2.

i. For services rendered to Medicaid beneficiaries prior to July 15, 1996, the actual encounter rate shall be calculated based upon reasonable costs of Medicaid services provided to Medicaid beneficiaries.

ii. For services rendered to Medicaid beneficiaries on and after July 15, 1996, the actual encounter rate shall be based upon:

(1) The lower of actual allowable costs per encounter; or

(2) The Medicaid limit per encounter.

iii. FQHCs are subject to screening requirements to test the reasonableness of the productivity of the staff employed by a FQHC, as follows:

(1) At least 2.1 encounters per compensated hour, per physician; with the exception of the FQHC's Medical Director for which reported hours shall be the greater of:

(A) 50 percent of compensated hours; or

(B) Actual hours providing direct care.

(2) At least 1.1 encounters per compensated hour, per advanced practice nurse or nurse midwife;

(3) At least 1.25 encounters per compensated hour, per dentist or dental hygienist; and

(4) Each hour a physician, advanced practice nurse, nurse midwife, dentist, or dental hygienist is compensated, shall represent one hour to be reported for screening purposes, except as provided in (d)4ii(1) above.

iv. The actual encounter rate shall be subject to adjustment based upon any audits of the Medicaid cost report.

5. If a provider wishes to appeal the final rate determination, a written request shall be filed with the Director, Administrative and Financial Services, Division of Medical Assistance and Health Services, Mail Code #23, PO Box 712, Trenton, New Jersey 08625-0712, or the Director's designee, no later than the 180th day following the date of the provider's receipt of the Notification of Final Settlement. See N.J.A.C. 10:49-10.

i. The appeal shall identify the specific items of disagreement and the amount(s) in question, and provide reasons and documentation to support the provider's position.

6. Reimbursement costs shall be determined by multiplying the actual encounter rate times the number of paid Medicaid and NJ KidCare-Plan A encounters for the cost reporting period. Should there be a discrepancy between the FQHC's reported encounters and the fiscal agent's reported encounters, the fiscal agent's encounters

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shall be used for determination of reimbursable costs. Final Settlement shall be determined as the difference between reimbursable costs and all payments made on behalf of Medicaid or NJ KidCare-Plan A beneficiaries, which includes managed care organization payments.

i. If the final settlement results in an underpayment, a lump sum payment shall be made to the FQHC.

ii. If the final settlement results in an overpayment made to the FQHC, the Division of Medical Assistance and Health Services (DMAHS) shall arrange repayment from the FQHC through a lump-sum refund or through an offset against subsequent payments, or a combination of both.

7. A Medicaid cost report including the FQHC's audited financial statements in accordance with N.J.A.C. 10:66-4 and N.J.A.C. 10:66-4 Appendix A shall be submitted to the Director, Administrative and Financial Services, Division of Medical Assistance and Health Services, Mail Code #23, PO Box 712, Trenton, New Jersey 08625-0712, or the Director's designee. The cost report shall be legible and complete in order to be considered acceptable. See N.J.A.C. 10:66-4 Appendix A, incorporated herein by reference.

i. The Medicaid cost report and audited financial statements shall be filed following the close of a provider's reporting period. Cost reports and audited financial statements are due on or before the last day of the fifth month following the close of the period covered by the report.

ii. A 30-day extension of the due date of a cost report may, for good cause, be granted by the DMAHS. Good cause means a valid reason or justifiable purpose in seeking an extension; it is one that supplies a substantial reason, affords a legal excuse for delay, or is the result of an intervening action beyond one's control. Acts of omission and/or negligence by the FQHC, its employees, or its agent, shall not constitute "good cause."

iii. To be granted this extension the provider must submit a written request to, and obtain written approval from, the Director, Administrative and Financial Services, Division of Medical Assistance and Health Services, Mail Code #23, PO Box 712, Trenton, New Jersey 08625-0712, or the Director's designee.

iv. A request for an extension must be received by the Director, Administrative and Financial Services, Division of Medical Assistance and Health Services, or the Director's designee, at least 30 days before the due date of the Medicaid cost report and audited financial statements.

v. If a provider's agreement to participate in the Medicaid or NJ KidCare program terminates or the provider experiences a change of ownership, the cost report is due no later than 45 days following the effective date of the termination of the provider agreement or change of ownership. An extension of the cost report due date cannot be granted when the provider agreement is terminated or a change in ownership occurs.

vi. Failure to submit an acceptable cost report on a timely basis may result in suspension of interim payments. Payments for claims received on or after the date of suspension may be withheld until an acceptable cost report is received.

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(e) The basis for reimbursement for services provided in an FQHC for periods beginning January 1, 2001 shall be as follows:

1. Effective with services performed on or after January 1, 2001 and for each year thereafter, Medicaid payments to the FQHCs shall be based on prospective payment rates, as determined in accordance with this rule, and shall be used solely to reimburse for encounters.

i. PPS encounter rates effective January 1, 2001 through June 30, 2001 shall be calculated based on the FY 1999 and FY 2000 cost reports. The FY 1999 cost reports shall include individual FQHC fiscal year cost reports with individual year-end dates ranging from June 1, 1999 to May 31, 2000. The FY 2000 cost reports shall include individual FQHC fiscal year cost reports with individual year-end dates ranging from June 1, 2000 to May 31, 2001. The calculation of the PPS encounter payment rates to be used to reimburse FQHC services performed on or after January 1, 2001 shall be based on the following:

(1) Interim PPS encounter rates for services provided from January 1, 2001 to June 30, 2001 shall be calculated using the encounter rate from the most recent final cost report settlement, derived by dividing the final Medicaid settled costs by the number of final settled encounters, adjusted for a change in scope of services (in accordance with (e)1vi(1)) and inflation using the percentage increase in the Medicare Economic Index (MEI) (defined in section 1842(i)(3) of the Social Security Act) applicable to primary care services (as defined in section 1842(i)(4)) furnished through December 31, 2000.

(2) The final PPS encounter rate for services provided from January 1, 2001 to June 30, 2001 shall be calculated by adding the final settled Medicaid costs of the FY 1999 and FY 2000 cost reports together and dividing the total by the number of final settled encounters provided to Medicaid beneficiaries during the FY 1999 and FY 2000 fiscal years, adjusted for a change in scope of services (in accordance with (e)1vi(1)) and inflation using the percentage increase in the MEI (defined in section 1842(i)(3) of the Social Security Act) applicable to primary care services (as defined in section 1842(i)(4)) furnished through December 31, 2000. The final settled Medicaid costs for the FY 1999 and FY 2000 cost reports shall be calculated with the administrative and productivity screens and overall Medicaid limit per encounter in accordance with the rule adopted July 15, 1996 (N.J.A.C. 10:66-1.5, subchapter 4 and Appendix).

(3) A financial transaction will be processed through the Medicaid fiscal agent for the difference between the interim and final PPS encounter rate for services provided to Medicaid beneficiaries that were reimbursed at the interim encounter rate. For FQHC obligations that are not paid within 30 days from the date the recovery is initiated, interest shall be assessed in accordance with N.J.S.A. 30:4D-17(e), (f) and N.J.S.A. 31:1-1(a).

(4) The alternative methodology to calculate the final PPS encounter rate for services provided from January 1, 2001 to June 30, 2001 is as follows: the greater of the FY 1999 or FY 2000 encounter rates adjusted for a change in scope of services (in accordance with (e)1vi(1) below) and inflation using the percentage increase in the MEI (defined in section 1842(i)(3) of the Social Security Act) applicable to primary care services (as defined in section 1842(i)(4)) furnished through December 31, 2000. The

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final settled Medicaid costs of the FY 1999 and FY 2000 cost reports shall be calculated with the administrative and productivity screens and overall Medicaid limit per encounter in accordance with the rules adopted July 15, 1996 (N.J.A.C. 10:66-1.5, 10:66-4 and 10:66-4 Appendix A). Paragraphs (e)1i(1) and (3) above shall be followed under the alternative methodology. In order to qualify to receive the alternative methodology calculation of the PPS encounter rate, an FQHC shall sign a written agreement with the State. The alternative methodology shall result in a payment to the FQHC of an amount that is at least equal to the PPS methodology and satisfies the BIPA requirements.

ii. The baseline PPS encounter rates for services provided from July 1, 2001 to December 31, 2001 shall be based on the FY 1999 and FY 2000 cost reports and shall be calculated based on the following:

(1) Interim PPS encounter rates shall be calculated using data from the most recent final cost report settlement as follows:

(A) FQHC administrative reimbursement shall be subject to an administrative cost limit of 30 percent of total allowable cost;

(B) FQHC reimbursement for productivity standards shall be based on those standards applied by Medicare for cost reporting purposes in the base year;

(C) The overall per encounter limit on FQHC Medicaid costs shall be the base year Medicare limit plus \$ 14.42;

(D) Allowable costs shall be determined by following Medicare principles of reasonable cost reimbursement;

(E) The encounter rate may be adjusted for a change in scope of services (in accordance with (e)1vi(1)); and

(F) The encounter rate shall be adjusted for inflation using the percentage increase in the MEI (defined in section 1842(i)(3) of the Social Security Act) applicable to primary care services (as defined in section 1842(i)(4)) furnished through December 31, 2000.

(2) The final PPS encounter rate for services provided from July 1, 2001 to December 31, 2001, shall be calculated by adding the final settled Medicaid costs of the FY 1999 and FY 2000 cost reports together and dividing the total by the sum of the number of final settled encounters for FY 1999 and FY 2000 provided to Medicaid beneficiaries during the FY 1999 and FY 2000 fiscal years, adjusted for a change in scope of services in accordance with (e)1vi(1) and inflation using the percentage increase in the MEI (defined in section 1842(i)(3) of the Social Security Act) applicable to primary care services (as defined in section 1842(i)(4)) furnished through December 31, 2000.

(A) The final settled Medicaid costs from the FY 1999 and FY 2000 cost reports shall be adjusted as follows:

(i) FQHC administrative reimbursement shall be subject to an administrative cost limit of 30 percent of total allowable cost;

(ii) FQHC reimbursement for productivity standards shall be based on those standards applied by Medicare for cost reporting purposes in the base year;

(iii) The overall per encounter limit on FQHC Medicaid costs shall be the base year Medicare limit plus \$ 14.42; and

(iv) Allowable costs shall be determined by following Medicare principles of reasonable cost reimbursement.

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(3) A financial transaction will be processed through the Medicaid fiscal agent for the difference between the interim and final PPS encounter rate for services provided to Medicaid beneficiaries that were reimbursed at the interim encounter rate. For FQHC obligations that are not paid within 30 days from the date the recovery is initiated, interest shall be assessed in accordance with N.J.S.A. 30:4D-17(e), (f) and N.J.S.A. 31:1-1(a).

(4) The alternative methodology to calculate final PPS encounter rate for services provided from July 1, 2001 to December 31, 2001 shall be calculated on the greater of the FY 1999 or FY 2000 final settled Medicaid cost report, adjusted for a change in scope of services in accordance with (e)1vi(1) and inflation using the percentage increase in the MEI (as defined in section 1842(i)(3) of the Social Security Act) applicable to primary care services (as defined in section 1842(i)(4)) furnished through December 31, 2000. The alternative methodology shall result in a payment to the FQHC of an amount that is at least equal to the PPS methodology and satisfies the BIPA requirements. FQHCs that have elected the alternative methodology shall have a single opportunity to request a change to the PPS methodology, which shall be applied prospectively. Once an FQHC has opted out of the alternative methodology, it is no longer eligible to receive the alternative methodology.

(A) The final settled Medicaid costs for the FY 1999 and FY 2000 cost reports shall be adjusted as follows:

(i) FQHC administrative reimbursement shall be subject to an administrative cost limit of 30 percent of total allowable cost;

(ii) FQHC reimbursement for productivity standards shall be based on those standards applied by Medicare for cost reporting purposes in the base year;

(iii) The overall per encounter limit on FQHC Medicaid costs shall be the base year Medicare limit plus \$ 14.42; and

(iv) Allowable costs shall be determined by following Medicare principles of reasonable cost reimbursement.

(B) Paragraphs (1) and (3) above shall be followed under the alternative methodology. In order to qualify to receive the alternative methodology calculation of the PPS encounter rate, an FQHC shall sign a written agreement with the State.

iii. The final PPS encounter rate shall be effective for services from July 1, 2001 through December 31, 2001. Each year thereafter, the rate year will begin on January 1 and end on December 31.

(1) For both the PPS and the alternative methodology, the interim PPS encounter rates effective January 1, 2002, will be calculated using the encounter rate from the most recent final cost report settlement, and will be adjusted for inflation using the MEI effective on January 1, 2002 and for a change in scope of services (in accordance with (e)1vi(1)). The interim PPS encounter rates will be adjusted to final PPS encounter rates upon reconciliation of the FY 1999 and FY 2000 cost reports.

(2) For rates effective January 1, 2003 and every January 1, thereafter, the final PPS encounter rate effective January 1, of the preceding year will be increased by the MEI applicable to primary care services of the current year and adjusted for a change in

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scope of services in accordance with (e)1vi below to calculate the PPS final encounter rate.

(3) A financial transaction will be processed through the Medicaid fiscal agent for the difference between the interim and final encounter rate for services provided to Medicaid beneficiaries that were reimbursed at the interim encounter rate. For FQHC obligations that are not paid within 30 days from the date recovery is initiated, interest shall be assessed in accordance with N.J.S.A. 30:4D-17(e), (f) and N.J.S.A. 31:1-1(a).

iv. The reimbursement of donation costs related to outstationed eligibility workers will be made on a lump-sum basis once each calendar quarter.

v. FQHCs shall have a one-time option to revise their FY 1999 and FY 2000 cost reports to include/exclude the direct and indirect delivery costs, encounters and revenues associated with deliveries for purposes of establishing the January 1, 2001 and July 1, 2001 PPS encounter rates. The option chosen by the FQHC would apply to both FY 1999 and FY 2000 cost reports. The revisions to include/exclude direct and indirect delivery costs, encounters and revenues from the cost report will be solely for the calculation of the PPS encounter rate, and will not result in a revised settlement for the period covered by the cost report.

vi. The PPS encounter payment rates may be adjusted for increases or decreases in the scope of services furnished by the FQHC during that fiscal year.

(1) A change in scope of service is defined as follows:

(A) The addition of a new FQHC covered service that is not incorporated in the baseline PPS rate or a deletion of a FQHC covered service that is incorporated in the baseline PPS rate;

(B) A change in scope of service due to amended regulatory requirements or rules;

(C) A change in scope of service resulting from relocation, remodeling, opening a new clinic or closing an existing clinic site; and/or

(D) A change in scope of service due to applicable technology and medical practice.

(2) The process to request a change of scope adjustment is as follows:

(A) Providers shall follow the guidelines in the "Change in Scope of Service Application Requirements" contained in N.J.A.C. 10:66-4 Appendix D, incorporated herein by reference. Providers shall notify the Division of Medical Assistance and Health Services (DMAHS) in writing at least 60 days prior to the effective date of any changes and explain the reasons for the change.

(B) Providers shall submit documentation or schedules which substantiate the changes and the increase/decrease in services and costs (reasonable costs following the tests of reasonableness used in developing the baseline rates) related to these changes. The changes shall be significant with substantial increases or decreases in costs, as defined in (3) below, and documentation must include data to support the calculation of an adjustment to the PPS rate. It is recognized that the change of scope will be time-limited in most cases, due to start-up or phase-in costs associated with the change of scope. As the utilization level phases in, the need for the enhanced rate will diminish. The provider must address this in the change of scope request.

(3) Providers may submit requests for scope of service changes either:

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(A) Once during a calendar year, by October 1, with an effective date of January 1 of the following year; or

(B) When the scope of service change(s) exceed(s) 2.5 percent of the allowable per encounter rate as determined for the fiscal period. The effective date shall be the implementation date of the change of scope that exceeds the 2.5 percent minimum threshold for a mid-year adjustment.

(4) The provider shall be notified by DMAHS of any adjustment to the rate by written notification following a review of the submitted documentation.

(5) The provider shall be paid its PPS rate as initially determined by DMAHS, pending the determination as to whether an adjustment is necessary and if so, the amount of the adjustment. A payment or recovery shall be made for the period from the effective date of the adjustment to the date the revised rate is incorporated into the claims payment system.

(6) Providers may appeal DMAHS' determination for an adjustment or the amount of the adjustment by writing to the Director, DMAHS within 60 days of the date of the determination letter. The provider shall identify the specific items of disagreement and the amount in question, and provide reasons and documentation to support the provider's position.

vii. For new providers (entities first qualifying as FQHCs after December 31, 2000), interim PPS encounter rates shall be calculated. These rates shall be subject to final settlements through December 31 of the initial and second year of the FQHC's existence. New FQHCs' rate years shall be calendar years, thus the initial year may represent less than a full year of operation.

(1) The interim PPS encounter rates shall be the Statewide average PPS encounter rate.

(2) In establishing the interim PPS encounter rate, DMAHS may take into account existing costs, which may have occurred when in operation as another healthcare facility.

(3) The final PPS encounter rates for the initial and second years of operation shall be calculated from the FQHC's cost report data contained in N.J.A.C. 10:66-4 Appendix C, "New FQHC Medicaid Cost Reports for First and Second Years of Operation," incorporated herein by reference:

(A) FQHC administrative reimbursement shall be subject to an administrative cost limit of 30 percent of total allowable cost;

(B) FQHC reimbursement for productivity standards shall be based on those standards applied by Medicare for cost reporting purposes in the base year;

(C) The overall per encounter limit on FQHC Medicaid costs shall be the 2000 calendar year Medicare limit plus \$ 14.42, inflated by the MEI applicable to primary care services for all years up to the year of operation; and

(D) Allowable costs shall be determined by following Medicare principles of reasonable cost reimbursement.

(4) Final settlements for the first two years shall be processed in accordance with sections (3)(A) through (D) above.

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(5) For each year thereafter, the PPS encounter rate shall be the final rate of the second year of operations (possibly the first full year of operations) adjusted by the MEI applicable to primary care services and changes in scope of services as described above.

viii. Managed care wrap-around payments shall be made on a quarterly basis.

(1) To qualify for wrap-around reimbursement, the FQHC administration shall have a signed contract with the managed care organization as of the time period covered, and for the time period covered, and the FQHC shall comply with the reporting requirements below and contained in N.J.A.C. 10:66-4 Appendix E, incorporated herein by reference.

(2) The FQHC shall provide to the Division, upon request, copies of any and all managed care contracts the FQHC has entered into during the cost report period. FQHCs shall provide copies of any requested managed care contracts to the Division within 30 days of the date of the Division's request. Failure to provide copies of the contract(s) as requested shall result in suspension of interim payments or wrap-around payments until the contract copy is received by the Division.

(3) For new providers (entities first qualifying as FQHCs after December 31, 2000), the wrap-around shall be calculated at the FQHC's interim PPS encounter rate until the final PPS encounter rate is established. New FQHCs shall be reimbursed for 85 percent of the difference between reasonable costs and the managed care receipts received for services provided to Medicaid beneficiaries. After the final PPS encounter rate is calculated, a financial transaction shall be processed for the difference between the interim and final PPS encounter rate for encounters provided to Medicaid managed care beneficiaries. In the event of an underpayment, the Division shall reimburse the provider 100 percent of the amount due. In the event of an overpayment, the provider shall reimburse the Division 100 percent of the overpayment within 30 days of the due date of the Managed Care Wraparound Report. For FQHC obligations that are not paid within 30 days of the date recovery is initiated, interest shall be assessed in accordance with N.J.S.A. 30:4D-17(e), (f) and N.J.S.A. 31:1-1(a).

(4) For FQHCs that have a final PPS encounter rate established, all quarterly wrap-around reports shall be reconciled at 100 percent of the difference between the final rate and the managed care receipts received for services provided to Medicaid and FamilyCare managed care beneficiaries. In the event of an underpayment, the Division shall reimburse the provider 100 percent of the amount due. In the event of an overpayment, the provider shall reimburse the Division 100 percent of the overpayment within 30 days of the due date of the Managed Care Wrap-around Report. For FQHC obligations that are not paid within 30 days of the date recovery is initiated, interest shall be assessed in accordance with N.J.S.A. 30:4D-17(e), (f) and N.J.S.A. 31:1-1(a).

(5) Reporting time periods shall be calendar year quarters (March, June, September, and December), regardless of an FQHC's fiscal year end.

(6) Reporting Encounters: Medicaid and NJ FamilyCare managed care encounters provided during the calendar year quarter shall be reported on the Medicaid Managed Care Encounter Detail Report in N.J.A.C. 10:66-4 Appendix E, incorporated herein by reference. For example, all managed care encounters provided to Medicaid and NJ FamilyCare beneficiaries from October 1, 2003 through December 31, 2003 shall be

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included on the Medicaid Managed Care Encounter Detail Reports for the quarter ended December 31, 2003. Each Medicaid Managed Care Encounter Detail Report shall contain encounters provided during one specific month. In total, there are three Medicaid Managed Care Encounter Detail Reports for each quarter.

(7) Reporting Receipts: All Medicaid and NJ FamilyCare managed care payments received by the FQHC for the quarter, including capitation, fee-for-service, supplemental or administration fund, and any other managed care payments received from the first day of the quarter to the 25th day following the end of the calendar year quarter, shall be reported on the Medicaid Managed Care Receipts Report in N.J.A.C. 10:66-4 Appendix E.

(8) Managed care organizations may use their own funds to include financial incentives in their contracts with FQHCs. Financial incentives are used as an incentive to reduce unnecessary utilization of services or otherwise reduce patient costs. Such incentives may be negative, such as withholding a portion of the capitation payments. In this example, if utilization goals are not satisfied, the provider foregoes the withheld amount in whole or part. Incentives may also be positive, such as a bonus that is paid if desired utilization outcomes are achieved. These incentive amounts (whether positive or negative) are separate from the managed care organization's payment for services provided under the contract with the provider, and shall not be included by the FQHC in the Medicaid Managed Care Receipts Report.

(9) Date of Quarterly Report requirements are as follows: FQHCs shall submit the Medicaid Managed Care Encounter Detail Reports and the Medicaid Managed Care Receipts Report with managed care receipts data through the 25th day following the end of the calendar year quarter. For example, the receipts report for the quarter ending December 31, 2003, shall be submitted with the receipts received through January 25, 2004. This will allow for most, if not all, managed care receipts for the quarter to be received by the submission date of the quarterly wrap-around report. These reports are due to Medicaid by the 55th day following the end of each calendar quarter. Failure to submit acceptable Medicaid Managed Care Encounter Detail Reports and Medicaid Managed Care Receipts Reports by the due date may result in suspension of interim payments. Payments for claims received on or after the date of suspension may be withheld until acceptable Medicaid Managed Care Encounter Detail Reports and Medicaid Managed Care Receipts Reports are received.

(10) Adjustments for prior periods requirements are as follows: A separate Medicaid Managed Care Encounter Detail Report and/or Medicaid Managed Care Receipts Report shall be prepared for receipts and/or encounters not previously reported. Use separate Medicaid Managed Care Encounter Detail Reports and/or separate Medicaid Managed Care Receipts Reports to report prior period adjustments. An adjustment for a prior period is a correction to an earlier report. Managed care additions and subtractions relating to prior periods will be adjusted in the State's payment to the FQHC for the most recent quarter.

(11) The prior period adjustments shall be separated by a provider's fiscal year. For example, a provider with a December fiscal year end receives managed care receipts in June 2003 for services rendered in December 2001 and January 2002. The provider

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shall prepare a separate Medicaid Managed Care Receipts Report for each prior period: the provider's fiscal years ending 2001 and 2002; these attachments shall be clearly identified as adjustments for fiscal years 2001 and 2002. Similarly, if a provider becomes aware of differences in encounters for prior fiscal year periods, the provider shall prepare a separate Medicaid Managed Care Encounter Detail Report for each prior fiscal year period.

ix. FQHCs shall maintain an accounting system, which identifies costs in a manner that conforms to generally accepted accounting principles and maintain documentation to support all data.

(1) On an annual basis and no later than five months after the close of each facility's fiscal year, an FQHC shall submit the annual cost report contained in N.J.A.C. 10:66-4 Appendix B, incorporated herein by reference.

(2) If all annual cost report items listed in N.J.A.C. 10:66-4 Appendix B, incorporated herein by reference, are not received by the due date, then all payments (including managed care wraparound payments) for services shall be suspended until all items are received. One 30-day maximum extension shall be granted upon written request only when a provider's operations are significantly adversely affected due to extraordinary circumstances beyond the control of the provider, as provided in Medicare guidelines.

(3) Each provider shall keep financial, statistical and medical records of the cost reporting year for at least six years after submitting the cost report to the DMAHS, or as long as an outstanding appeal exists, whichever is longer, and shall also make such records available upon request to authorized State or Federal representatives.

(4) DMAHS or its fiscal agent may periodically conduct either on-site or desk audits of cost reports, including financial, statistical, and medical records.

(5) The providers shall submit other information (statistics, cost and financial data) when deemed necessary by the Department.

(f) The basis for reimbursement of services provided in an ambulatory care/family planning facility is as follows:

1. Reimbursement for the services of an ambulatory care/family planning/surgical facility shall be made for services rendered by both the facility and the attending physician, if the physician is not reimbursed for surgical/medical services by the facility.

2. The facility reimbursement rate shall equal 70 percent of the applicable ambulatory surgical center rate for the procedures, in accordance with reimbursement rates, N.J.A.C. 10:66-1.5(c).

3. Physician reimbursement shall be in accordance with the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' Physician Maximum Fee Allowance for specialist and non-specialist, N.J.A.C. 10:54, and the following:

i. When submitting a claim, the physician performing the surgical procedure shall use the applicable claim form, billing the New Jersey Medicaid or NJ FamilyCare fee-for-service program either as an individual provider or as a member of a physician's group.

ii. A physician on salary for administrative duties (such as a medical director shall be permitted to submit claims for surgical/medical services performed if outside his or her

administrative duties and not billed by the facility. Administrative duties shall be considered a direct cost of the facility and shall be included in the clinic payment.

10:66-1.6 Recordkeeping

(a) An individual record shall be prepared and retained by an independent clinic that fully discloses the kind and extent of the service provided to a Medicaid or NJ FamilyCare fee-for-service beneficiary, as well as the medical necessity for the service.

(b) At a minimum, a beneficiary's record shall include a progress note for each visit which supports the procedure code(s) billed, except where specified otherwise.

(c) Additional requirements governing medical records in an ambulatory surgical center are located in N.J.A.C. 10:66-5.

(d) The information described in this subsection shall be made available to the New Jersey Medicaid and NJ FamilyCare fee-for-service programs or its agents upon request.

10:66-1.7 Personal contribution to care requirements for NJ FamilyCare-Plan C and copayments for NJ FamilyCare-Plan D

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

(b) Personal contribution to care for NJ FamilyCare-Plan C services is \$ 5.00 a visit for clinic visits, except when the service is provided as indicated in (e) below.

1. A clinic visit is defined as a face-to-face contact with a medical professional under the direction of a physician or dentist, which meets the documentation requirements of this chapter.

2. Clinic visits include medical professional services provided in the office, patient's home, or any other site, excluding a hospital, where the beneficiary may have been examined by the clinic staff. Generally, these procedure codes are in the 90000 HCPCS series of reimbursable codes at N.J.A.C. 10:66-9.

3. Clinic services which do not meet the requirements of a clinic visit as defined in this chapter, such as surgical services, immunizations, laboratory or x-ray services, do not require a personal contribution to care.

4. Encounter procedure codes billed by Federally Qualified Health Centers do not require a personal contribution to care.

(c) Clinics are required to collect the personal contribution to care for the above-mentioned NJ FamilyCare-Plan C services if the NJ FamilyCare-Plan C services Identification Card indicates that a personal contribution to care is required and the

beneficiary does not have a NJ FamilyCare form which indicates that the beneficiary has reached their cost share limit and no further personal contributions to care is required until further notice.

(d) Personal contributions to care are effective upon date of enrollment.

1. Exception: A personal contribution to care shall not apply to services rendered to a newborn until the newborn is enrolled in a managed care program.

(e) No personal contribution to care shall be charged for well child visits in accordance with the schedule recommended by the American Academy of Pediatrics; lead screening and treatment; age appropriate immunizations; preventive dental services; prenatal care; for family planning services; or for substance abuse treatment services.

(f) The copayment for clinic services under NJ FamilyCare-Plan D shall be \$ 5.00 per visit;

1. A \$ 10.00 copayment shall apply for services rendered during non-clinic hours.

2. The \$ 5.00 copayment shall apply only to the first prenatal visit.

(g) Clinics are required to collect the copayment specified in (f) above except for those situations described in (h) below. Copayments shall not be waived.

(h) Clinics will not charge a copayment under Plan D for services provided to newborns, who are covered under fee-for-service for Plan D; or for preventive services, including well child visits in accordance with the schedule recommended by the American Academy of Pediatrics; or for lead screening and treatment; or for age appropriate immunizations; or for preventive dental services covered for children under 12.

10:66-1.8 Medical exception process (MEP)

(a) For pharmacy claims with service dates on or after September 1, 1999, which exceed Prospective Drug Utilization Review (PDUR) standards recommended by the New Jersey DUR Board and approved by the Commissioners of DHS and DHSS, the Division of Medical Assistance and Health Services has established a Medical Exception Process (MEP).

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

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

(d) The medical exception process is as follows:

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

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

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

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

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

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

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

END OF SUBCHAPTER 1

SUBCHAPTER 2. PROVISION OF SERVICES

10:66-2.1 Introduction

This subchapter describes the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' policies and procedures for the provision of Medicaid-covered and NJ FamilyCare fee-for-service covered services in an independent clinic setting. Services, as described in N.J.A.C. 10:49-5, are separately identified and discussed only where unique characteristics or requirements exist. Unless indicated otherwise, reimbursement requirements are located in N.J.A.C. 10:66-1.5, Basis for reimbursement.

10:66-2.2 Dental services

(a) All diagnostic, preventive or corrective dental procedures shall be administered by, or under, the direct supervision of a dentist enrolled in the New Jersey Medicaid and NJ FamilyCare fee-for-service program.

(b) Dental services provided in an independent clinic shall follow the policies and procedures outlined in the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' Dental Services chapter, N.J.A.C. 10:56.

(c) The New Jersey Medicaid and NJ FamilyCare fee-for-service programs' Dental Services chapter, N.J.A.C. 10:56-3 (HCPCS), contains dental procedure codes and maximum fee allowances.

10:66-2.3 Drug treatment center services

(a) Medicaid and NJ FamilyCare fee-for-service beneficiaries shall be eligible for drug treatment center services only if those services:

1. Are prescribed by a physician;
2. Meet the Federal financial participation requirements under Title XIX of the Social Security Act (42 U.S.C. § 1396); and
3. Are included in the facility's Medicaid or NJ FamilyCare fee-for-service approval letter.

(b) Medicaid and NJ FamilyCare fee-for-service beneficiaries shall receive a minimum of one counseling session per week during the first four months after initiation of treatment, and at least one counseling session every two weeks thereafter until discharged. (See N.J.A.C. 8:43A-26.5.)

(c) For the purposes of the AIDS Community Care Alternatives Program (ACCAP) only, services indicated by an asterisk at N.J.A.C. 10:66-6.3(m) may be provided to ACCAP-eligible individuals in the home.

(d) Transportation services to and from a drug treatment center shall be prior authorized after 60 days of treatment at the drug treatment center, in accordance with N.J.A.C. 10:66-1.4(e).

10:66-2.4 Early and periodic screening, diagnosis and treatment (EPSDT)

(a) Early and periodic screening, diagnosis and treatment (EPSDT) is a Federally mandated comprehensive child health program for Medicaid and NJ FamilyCare fee-for-service beneficiaries from birth through 20 years of age. (See 42 CFR 441 Subpart B.)

(b) EPSDT includes screening services; vision services; dental services; hearing services; and other necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

1. An expanded program for Medicaid and NJ FamilyCare fee-for-service beneficiaries up to the age of two is known as HealthStart. For additional information, including provider enrollment requirements, see N.J.A.C. 10:66-3.

(c) Components of an EPSDT screening are as follows:

1. A comprehensive health and developmental history including assessment of both physical and mental health development;
2. A comprehensive unclothed physical exam including vision and hearing screening, dental inspection, and nutritional assessment;
3. Appropriate immunizations according to age and health history;
4. Appropriate tests, including:
 - i. Hemoglobin/hematocrit;
 - ii. Urinalysis;
 - iii. Tuberculin test;
 - iv. Blood lead level assessment shall be performed for all children between nine through 18 months of age (preferably at 12 months) and again at two years of age. In addition, between the ages of two and six years, a child shall be screened if there is no evidence of prior screening;
 - v. Other medically-necessary procedures;
5. Health education, including anticipatory guidance; and
6. Referral for further diagnosis and treatment or follow up to correct or ameliorate abnormalities, uncovered or suspected. Referral may be to the provider conducting the screening examination, or to another provider, as appropriate.

(d) EPSDT screening services (unless modified as follows in (e), (f) and (g) below) shall be provided periodically according to the following schedule which reflects the age of the child:

1. Under six weeks;
2. Two months;
3. Four months;

4. Six months;
5. Nine months;
6. 12 months;
7. 15 months;
8. 18 months;
9. 24 months; and
10. Annually through age 20.

(e) Vision screening shall include the following:

1. A newborn examination including general inspection of the eyes, visualization of the red reflex, and evaluation of ocular motility;
2. An appropriate medical and family history;
3. An evaluation, by age six months, of eye fixation preference, muscle imbalance, and pupillary light reflex;
4. A repeated examination with visual acuity testing by age three or four years;
5. Periodicity testing for school-aged children as follows:
 - i. Kindergarten or first grade (five or six years);
 - ii. Second grade (seven years);
 - iii. Fifth grade (10-11 years);
 - iv. Eighth grade (13-14 years); and
 - v. Tenth or eleventh grades (15-17 years).
6. Children should be referred for further evaluation if they:
 - i. Cannot read the majority of the 20/40 line before their fifth birthday;
 - ii. Have a two-line difference of visual acuity between the eyes;
 - iii. Have suspected strabismus; or
 - iv. Have an abnormal light or red reflex.

(f) The following apply to dental screening:

1. Intraoral examination is an integral part of a general physical examination.
2. A formal referral to a dentist is recommended at one year of age. It is mandatory for children three years of age and older.
3. Dental inspection and prophylaxis should be carried out every six months until 17 years of age, then annually.

(g) The following apply to hearing screening:

1. Hearing screening shall be included in all preventive periodic examinations.
2. Audiometric testing shall be administered annually to all children between three and eight years of age. After age eight, children shall be tested every other year.

10:66-2.5 Family planning services

(a) Family planning services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continued medical supervision, continuity of

care, and genetic counseling. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related clinic visits, drugs, laboratory services, radiological and diagnostic services, and surgical procedures are not covered by the New Jersey Medicaid or NJ FamilyCare fee-for-service program.

1. Exception: When a service is provided that is ordinarily considered an infertility service, but is provided for another purpose, then the independent clinic must submit the claim with supporting documentation for medical review and approval of payment to the Division of Medical Assistance and Health Services, Office of Utilization Management, PO Box 712, (Mail Code #14), Trenton, New Jersey 08625-0712.

(b) The Norplant System (NPS) is a Medicaid-covered and NJ FamilyCare fee-for-service-covered service when provided as follows:

1. The NPS is used only in reproductive age women with established regular menstrual cycles;

2. The Food and Drug Administration-approved physician prescribing information is followed; and

3. Patient education and counseling are provided relating to the NPS, including pre and post insertion instructions, indications, contraindications, benefits, risks, side effects, and other contraceptive modalities.

4. A clinic visit relating only to the insertion or removal of the Norplant System (NPS) is not reimbursable on the day of the insertion or removal.

5. Only two insertions and two removals of the NPS per beneficiary are permitted during a five-year continuous period.

6. The clinic shall not be reimbursed for the NPS in conjunction with other forms of contraception, for example, intra-uterine device.

10:66-2.6 Laboratory services

(a) As required by the Clinical Laboratory Improvement Amendments of 1988 (CLIA), referenced at 42 CFR 493, all facilities or entities that perform clinical laboratory testing shall have their CLIA identification number on file with the New Jersey Medicaid and NJ FamilyCare fee-for-service programs.

(b) A clinic shall only claim reimbursement for those laboratory services that have been performed by them on their premises, for their patients, and for which they have received approval by the New Jersey Medicaid and NJ FamilyCare fee-for-service programs, as indicated in N.J.A.C. 10:66-1.3(a).

(c) Laboratory procedures are reimbursable only when performed in accordance with the applicable CLIA-mandated certificate of registration, certificate of waiver, or certificate of physician-performed microscopy procedures.

(d) Specific laboratory procedures are reimbursable when performed in conjunction with an EPSDT screening, if the requirements of (a), (b) and (c) above are met.

10:66-2.7 Mental health services

(a) Mental health services shall include comprehensive intake evaluation, individual psychotherapy, off-site crisis intervention, family therapy, family conference, group psychotherapy, psychological testing, partial care, and medication management. Mental health services shall not include:

1. Student education, including preparation of school-assigned classwork or homework; or
2. Incentive programs, including, but not limited to, non-therapeutic token economies and subcontract work responsibilities.

(b) Only one type of mental health service per beneficiary shall be reimbursable to an independent clinic per day, with the following exception:

1. Medication management may be reimbursed when provided to a Medicaid or NJ FamilyCare fee-for-service beneficiary in addition to one of the following mental health services: individual psychotherapy, group psychotherapy, family therapy, and family conference.

(c) Mental health clinics shall provide mental health services by, or under the direction of, a psychiatrist.

(d) For purposes of partial care, full day means five or more hours of participation in active programming exclusive of meals, breaks and transportation; half day means at least three hours but less than five hours of participation in active programming exclusive of meals, breaks and transportation. The smallest unit of partial care that may be prior authorized by NJ Medicaid/FamilyCare is one hour, with a minimum of two hours per day and a maximum of five hours per day. For example, prior authorization for a full day of partial care (five hours) shall be reflected as five units, four hours shall be reflected as four units, a half day (three hours) shall be reflected as three units, and two hours shall be reflected as two units. Additional details are located at N.J.A.C. 10:66-6.

(e) The Division shall reimburse a provider for prevocational services provided within the context of a partial care program.

(f) Prevocational services shall be interventions, strategies and activities within the context of a partial care program that assist individuals to acquire general work behaviors, attitudes and skills needed to take on the role of worker and in other life domains, such as responding appropriately to criticism, decision making, negotiating for needs, dealing with interpersonal issues managing psychiatric symptoms and medication adherence. Services or interventions which are not considered prevocational will not be reimbursed by Medicaid and NJ FamilyCare. Examples of services or interventions not considered to be prevocational include:

1. Technical or occupational skills training;

2. College preparation;
3. Student education, including preparation of school-assigned classwork or homework; and
4. Individualized job development.

(g) The Division will not reimburse any provider for vocational services provided within the context of a partial care program.

1. Vocational services shall be those interventions, strategies and activities that assist individuals to acquire skills to enter a specific occupation and take on the role of colleague (that is, a member of a profession) and/or assist the individual to directly enter the workforce and take on the role of an employee, working as a member of an occupational group for pay with a specific employer.

(h) When, in the judgment of the treatment team, an individual is determined appropriate for discharge or referral to another employment-related service provider or situation, and has demonstrated mastery of individualized goals and objectives, such as: an ability to respond appropriately to criticism, make decisions, negotiate for needs, deal with interpersonal issues, manage psychiatric symptoms and adhere to medical prescriptions, the service provider shall:

1. Update the individual treatment goal;
2. Revise the discharge plan; and
3. Refer the individual to a community work setting, if such referral is appropriate for the individual.

(i) The Division will reimburse a provider for prevocational services provided to eligible beneficiaries within the context of a partial care program when the services consist of therapeutic subcontract work activity, and when all of the following requirements are met:

1. The therapeutic subcontract work activity shall consist of production, assembly and/or packing/collating tasks for which individuals with disabilities performing these tasks are paid less than minimum wage, and, pursuant to 29 C.F.R. § 525, a special minimum wage certificate has been issued to the organization/program by the U.S. Department of Labor;
2. The individual's plan of care shall contain a stipulation that the therapeutic subcontract work activity is a form of intervention intended to address the individual deficits of the patient as identified in the client's assessment;
3. The therapeutic subcontract work activity shall be facilitated by a qualified mental health services worker;
4. The therapeutic subcontract work activity shall be performed within the line of sight of the qualified mental health services worker; and
5. The staff to client ratio shall not exceed a ratio of 1:10 qualified mental health services worker to client.

(j) An intake evaluation shall be performed within 14 days of the first encounter or by the third clinic visit, whichever is later, for each beneficiary being considered for continued treatment. This evaluation shall consist of a written assessment that:

1. Evaluates the beneficiary's mental condition;
 2. Determines whether treatment in the program is appropriate, based on the beneficiary's diagnosis;
 3. Includes certification (signed statement) by the evaluation team that the program is appropriate to meet the beneficiary's treatment needs; and
 4. Is made part of the beneficiary's records.
5. The evaluation for the intake process shall include a physician and an individual experienced in diagnosis and treatment of mental illness. Both criteria may be satisfied by the same individual, if appropriately qualified.

(k) A written, individualized plan of care shall be developed for each beneficiary who receives continued treatment. The plan of care shall be designed to improve the beneficiary's condition to the point where continued participation in the program (beyond occasional maintenance visits) is no longer necessary. The plan of care shall be included in the beneficiary's records and shall consist of:

1. A written description of the treatment objectives including both the treatment regimen and the specific medical/remedial services, therapies, and activities that shall be used to meet the objectives;
2. A projected schedule for service delivery which includes the frequency and duration of each type of planned therapeutic session or encounter;
3. The type of personnel that will be furnishing the services; and
4. A projected schedule for completing reevaluations of the beneficiary's condition and updating the plan of care.

(l) The mental health clinic shall develop and maintain legibly written documentation to support each medical/remedial therapy service, activity, or session for which billing is made.

1. This documentation, at a minimum, shall consist of:
 - i. The specific services rendered, such as individual psychotherapy, group psychotherapy, family therapy, etc., and a description of the encounter itself (that is, statement of patient progress noted, significant observations noted, etc.);
 - ii. The date and time that services were rendered;
 - iii. The duration of services provided (one hour, 1/2 hour, etc.);
 - iv. The signature of the practitioner or provider who rendered the services;
 - v. The setting in which services were rendered; and
 - vi. A notation of unusual occurrences or significant deviations from the treatment described in the plan of care.
2. Clinical progress, complications and treatment which affect prognosis and/or progress shall be documented in the beneficiary's medical record at least once a week, as well as any other information important to the clinical picture, therapy, and prognosis.

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3. The individual services under partial care shall be documented on a daily basis. More substantive documentation, including progress notes and any other information important to the clinical picture, are required at least once a week.

(m) Periodic review of the beneficiary's plan of care shall take place on a regular basis (at least every 90 days during the first year and every six months thereafter).

1. The periodic review shall determine:

- i. The beneficiary's progress toward the treatment objectives;
- ii. The appropriateness of the services being furnished; and
- iii. The need for the beneficiary's continued participation in the program.

2. Periodic reviews shall be documented in detail in the beneficiary's records and made available upon request to the New Jersey Medicaid or NJ FamilyCare program or its agents.

(n) When requesting reimbursement for the following HCPCS procedure codes for rehabilitative services, a separate service line shall be completed for each day that the service is provided. Providers shall not "span bill" for services.

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10:66-2.8 (Reserved)

10:66-2.9 Other services

Other services, such as evaluation and management (E/M), and minor surgery are reimbursable when billed by an independent clinic individually approved to provide the service(s) as indicated at N.J.A.C. 10:66-1.3, Provisions for provider participation. See N.J.A.C. 10:66-6 (HCPCS) for the procedure codes and maximum fee allowances corresponding to the Medicaid-reimbursable and NJ FamilyCare fee-for-service-reimbursable service(s).

10:66-2.10 Pharmaceutical services

For covered pharmaceutical services, see the New Jersey Medicaid and NJ FamilyCare fee-for-service program's Pharmaceutical Services chapter, N.J.A.C. 10:51.

10:66-2.11 Podiatric services

(a) Podiatric services that are medically necessary are Medicaid and NJ FamilyCare fee-for-service reimbursable when performed by a licensed podiatrist in an independent clinic which is specifically approved to perform such services by the New Jersey Medicaid and NJ FamilyCare fee-for-service program. See the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' Podiatry Services chapter, N.J.A.C. 10:57, for additional information.

(b) A podiatrist should be Board Qualified, or preferably, Board-Certified by a Board recognized by the American Podiatric Medical Association.

10:66-2.12 Radiological services

Specified radiological services may be reimbursed when provided in a clinic that is specifically approved to provide such services by the New Jersey Department of Environmental Protection, Bureau of Radiological Health (see N.J.A.C. 7:28-22), and performed by or under the direction of a physician who is recognized as a specialist in radiology by the New Jersey Medicaid and NJ FamilyCare fee-for-service programs. See the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' Physician's Services chapter, N.J.A.C. 10:54, for additional information.

10:66-2.13 Rehabilitative services

(a) Rehabilitative services, as provided in an independent clinic setting, include physical therapy, occupational therapy, speech-language pathology and audiology, including the use of such supplies and equipment as are necessary in the provision of such services. Rehabilitative services are provided for the purpose of attaining maximum reduction of physical or mental disability. Rehabilitative services shall be made available to Medicaid and NJ FamilyCare fee-for-service beneficiaries as an integral part of a comprehensive medical program.

(b) Rehabilitative services shall be provided by or under the direction of a physical therapist, occupational therapist, speech-language pathologist or audiologist employed by or under contract to the clinic. These therapy services are discussed at (c), (d) and (e) below, respectively.

1. All treatments shall be individual and shall consist of a minimum of 30 minutes.
2. A plan of treatment shall be completed during the Medicaid or NJ FamilyCare fee-for-service beneficiary's initial evaluation visit and retained on file.
 - i. The plan of treatment shall be definitive as to the type, amount, frequency, and duration of the rehabilitative services that are to be furnished and shall include the beneficiary's diagnosis and the anticipated goal(s) of the treatment.

(c) Physical therapy is a service prescribed by a physician or an advanced practice nurse and provided to a Medicaid or NJ FamilyCare fee-for-service beneficiary by or under the direction of a qualified physical therapist. Physical therapy does not include therapy which is purely palliative, such as the application of heat in any form; massage; routine calisthenics; group exercises; assistance in any activity; use of a simple mechanical device; or other services not requiring the special skill of a licensed physical therapist.

1. A physical therapist is an individual who is:
 - i. Licensed by the New Jersey Department of Law and Public Safety, State Board of Physical Therapy as a physical therapist in accordance with N.J.A.C. 13:39A; and

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ii. A graduate of a program of physical therapy accredited by an accrediting agency recognized by the Council on Post-Secondary Accreditation and the United States Department of Education.

2. If treatment or services are provided in a state other than New Jersey, the physical therapist shall meet the requirements of that state, including licensure if applicable, and all applicable Federal requirements.

(d) Occupational therapy is a service prescribed by a physician or an advanced practice nurse and provided to a Medicaid or NJ FamilyCare fee-for-service beneficiary by or under the direction of a qualified occupational therapist.

1. An occupational therapist is an individual who is:

i. Licensed by the New Jersey Occupational Therapy Advisory Council as an occupational therapist in accordance with N.J.A.C. 13:44K-2.1(a); and

ii. A graduate of a program in occupational therapy accredited by the American Occupational Therapy Association, the World Federation of Occupational Therapy or other nationally-recognized occupational therapist accrediting agency.

2. If treatment or services are provided in a state other than New Jersey, the occupational therapist shall meet the requirements of that state, including licensure if applicable, and all applicable Federal requirements.

(e) Speech-language pathology services and audiology services are diagnostic, screening, preventive, or corrective services prescribed by a physician or an advanced practice nurse and provided to a Medicaid or NJ FamilyCare fee-for-service beneficiary by or under the direction of a speech-language pathologist or audiologist.

1. A speech-language pathologist or audiologist is an individual who is licensed by the State of New Jersey as a speech-language pathologist or audiologist, in accordance with N.J.A.C. 13:44C, and meets all applicable Federal requirements including:

i. A Certificate of Clinical Competence in Speech-Language Pathology or Audiology from the American Speech-Language-Hearing Association;

ii. Completion of the equivalent educational requirements and work experience necessary for the certificate(s); or

iii. Completion of the academic program and in the process of acquiring supervised work experience in order to qualify for the certificate(s).

2. If treatment or services are provided in a state other than New Jersey, the speech-language pathologist or audiologist shall meet the requirements of that state, including licensure if applicable, and all applicable Federal requirements.

(f) Clinic visits billed during the same day shall clearly and separately meet the time and other parameters described in the applicable HCPCS procedure codes, N.J.A.C. 10:66-6.

(g) When the same type of rehabilitative service, regardless of modality, is provided to a Medicaid or NJ FamilyCare fee-for-service beneficiary more than once on the same day, for example, two physical therapy sessions, reimbursement shall be made for one service only. Reimbursement shall be made for a maximum of three units (one unit equals a 30-minute therapy session) per beneficiary per day.

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(h) When requesting reimbursement for the following HCPCS procedure codes for rehabilitative services, a separate service line shall be completed for each day that the service is provided. Providers shall not "span bill" for services.

92507
97799
H5300

10:66-2.14 Renal dialysis service for end-stage renal disease (ESRD)

An independent clinic providing renal dialysis service for end-stage renal disease (ESRD) shall comply with all applicable Federal regulations and State rules in accordance with N.J.A.C. 8:43A.

10:66-2.15 Sterilization services

(a) Sterilization is any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing.

1. The individual to be sterilized shall be at least 21 years of age at the time the sterilization consent form is signed by the individual to be sterilized.

2. The individual to be sterilized shall not be mentally incompetent or institutionalized.

i. A mentally incompetent individual is an individual who has been declared mentally incompetent by a Federal, State, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

ii. An institutionalized individual is an individual who is:

(1) Involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or

(2) Confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.

3. The individual to be sterilized shall have voluntarily given informed consent in accordance with all the requirements prescribed in 42 CFR 441.257 through 441.258.

4. At least 30 days, but not more than 180 days, shall have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization.

i. In the case of premature delivery, the informed consent shall have been given at least 30 days before the expected date of delivery.

ii. If an individual desires to be sterilized at the time of delivery, the consent form should be signed by the individual no earlier than the fifth month of pregnancy to minimize the possibility of exceeding the 180 day limit.

5. Informed consent is considered to be given only if:

i. The person who obtained consent for the sterilization procedure offered to answer any questions the individual may have concerning the procedure, provided a copy of the consent form and provided orally all of the following information or advice to the individual to be sterilized:

(1) Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any Federally funded program benefits to which the individual might otherwise be entitled;

(2) A description of available alternative methods of family planning and birth control;

(3) Advice that the sterilization procedure is considered to be irreversible;

(4) A thorough explanation of the specific sterilization procedure to be performed;

(5) A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of type and possible effects of any anesthetic to be used;

(6) A full description of the benefits or advantages that may be expected as a result of the sterilization; and

(7) Advice that the sterilization shall not be performed for at least 30 days, except under the circumstances specified in (c)4 above.

ii. Suitable arrangements were made to insure that the information specified in (a)5i above was effectively communicated to any individual who is blind, deaf, or otherwise handicapped;

iii. An interpreter was provided if the individual to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent;

iv. The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained;

v. The consent form requirements of 42 CFR 441.258 were met; and

vi. Any additional requirement of State or local law for obtaining consent, except a requirement for spousal consent, was followed.

6. Informed consent may not be obtained while the individual to be sterilized is:

i. In labor or childbirth;

ii. Seeking to obtain or obtaining an abortion; or

iii. Under the influence of alcohol or other substances that affect the individual's state of awareness.

7. The consent form shall be an exact replica of the Federal form.

i. The consent form shall be signed and dated by the individual to be sterilized; the interpreter, if one was provided; the person who obtained the consent; and the physician who performed the sterilization procedure. A copy of the consent form shall be given to the individual.

ii. The Fiscal Agent Billing Supplement, N.J.A.C. 10:66-Appendix, contains additional information and instructions for the consent form's proper completion.

8. Claims for sterilization services are hard-copy restricted; electronic billing is not permitted.

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10:66-2.16 Termination of pregnancy

(a) Termination of pregnancy is a Medicaid-covered and NJ FamilyCare fee-for-service-covered service when the following conditions are present:

1. The procedure is performed in an appropriately licensed ambulatory care facility, an ambulatory surgical center, or an ambulatory care/family planning/surgical facility licensed and authorized by the New Jersey State Department of Health and Senior Services to perform abortions with specific approval of the New Jersey Medicaid or NJ FamilyCare program;
2. The procedure is performed in accordance with the requirements of the New Jersey Board of Medical Examiners, N.J.A.C. 13:35;
3. The procedure is performed by a physician licensed to practice medicine and surgery in the State of New Jersey; and
4. The procedure is medically necessary. A physician may take the following factors into consideration in determining whether a termination of pregnancy is medically necessary:
 - i. To save the life of the mother;
 - ii. The pregnancy was the result of an act of rape;
 - iii. The pregnancy was the result of an act of incest;
 - iv. Physical, emotional, and psychological factors;
 - v. Family reasons; and
 - vi. Age.

(b) Claims for termination of pregnancy services are hard-copy restricted; electronic billing is not permitted.

(c) A Physician Certification (Form FD-179) shall be completed, signed and attached to any Medicaid or NJ FamilyCare fee-for-service claim form relating to termination of pregnancy services.

1. The Fiscal Agent Billing Supplement contains a sample Physician Certification (Form FD-179) and item-by-item instructions for the form's proper completion.

10:66-2.17 Transportation services

(a) Transportation services shall be covered under the Medicaid and NJ FamilyCare-Plan A programs only. Transportation services shall be covered under the Medicaid and NJ FamilyCare-Plan A programs when the following conditions are met:

1. The clinic is approved to provide transportation service by the Division.
 - i. Approval by the Division shall not be granted for the provision of ambulance or mobility assistance vehicle (MAV) service.
2. Transportation service is provided either:
 - i. By the clinic, in a clinic owned or leased vehicle; or
 - ii. By a transportation company under contract to the clinic, which meets the requirements of N.J.A.C. 10:49-9.8 and (b) below.

3. The purpose of providing transportation, one way or round trip, is to enable a Medicaid or NJ FamilyCare-Plan A fee-for-service beneficiary to obtain a Medicaid-covered or NJ FamilyCare-covered service at the clinic.

4. A Medicaid or NJ FamilyCare-Plan A fee-for-service beneficiary is transported:

- i. To the clinic, from the beneficiary's residence or a designated central point; or
- ii. From the clinic, to the beneficiary's residence or a designated central point.

5. The least expensive mode of transportation suitable to the beneficiary's needs shall be used, as indicated at N.J.A.C. 10:50-1.6(a).

i. A clinic shall not seek reimbursement from the Medicaid or NJ FamilyCare programs for the transport of an individual who is capable of utilizing an accessible, alternative mode of transportation at a lesser cost to the Medicaid or NJ FamilyCare programs, such as a taxicab, train, bus, other public conveyance, or livery-type, lower-mode vehicle.

ii. Prior to seeking reimbursement from the Medicaid or NJ FamilyCare programs for a clinic-provided or subcontracted transportation service, the patient's medical record shall contain documentation concerning the individual's specific transportation-related needs, including the reason(s) why an accessible, alternative less-expensive mode of service is not appropriate.

iii. Following are examples of factors that may be considered when determining the individual's ability to use an alternative mode of service: walking distance to/from the points of pick up and discharge, weather conditions at the time of transport, time of day or night, safety issues, the patient's need for an escort/attendant, and the patient's inability to access public transportation.

(b) Each vehicle used by a clinic or its subcontractor(s) in providing services to a Medicaid or NJ FamilyCare beneficiary shall be appropriately registered by the New Jersey Division of Motor Vehicles, in accordance with all applicable laws and rules of the New Jersey Division of Motor Vehicles (see Title 39 of the Revised Statutes) or the New Jersey Department of Transportation (see Title 48 of the Revised Statutes).

1. All applicable Federal and State motor vehicle laws shall be followed, including laws governing seat belts and infant car seats.

(c) Each person (driver) who operates a motor vehicle under the terms of this section shall possess and have readily available for inspection a current and valid New Jersey driver's license, as required by Title 39 of the Revised Statutes of New Jersey.

1. A driver of a commercial motor vehicle that is designed to transport eight to 15 passengers including the driver (Group C), and is used for hire, shall possess a commercial driver's license (CDL) with a passenger endorsement issued by the New Jersey Motor Vehicle Commission, in accordance with N.J.S.A. 39:3-10.11 and N.J.A.C. 13:21-23.5;

2. Each driver shall be at least 18 years old;

3. (Reserved)

4. Each driver shall wear an identification badge that includes his or her name and the name of the transportation company or the clinic;

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5. Each driver shall maintain an acceptable standard of personal grooming and behavior in order to present a neat, clean and professional appearance while providing services to Medicaid/NJ FamilyCare fee-for-service beneficiaries;

6. Each driver shall assist beneficiaries in entering and leaving the vehicle by using a step stool if necessary, and shall provide door-through-door escort and assistance, if necessary, at the beneficiary's place of departure and destination;

7. Each driver shall supervise the well being of individuals while in the vehicle to ensure their privacy, comfort, and appropriate care;

8. Each driver shall ensure that all vehicle occupants wear automobile safety belts;

9. Each driver shall operate the vehicle in a safe manner, starting and stopping slowly and smoothly, and complying with all applicable motor vehicle laws;

10. Each driver shall ensure that smoking is prohibited within the vehicle at all times;

11. No person shall be allowed to operate a vehicle under the terms of this section:

- i. While under the influence of intoxicating liquor or narcotic or habit forming drugs;
- ii. In a reckless manner;
- iii. At excessive speed; or
- iv. While engaging in any illegal conduct.

(d) (Reserved)

10:66-2.18 Vision care services

Vision care services are reimbursable when administered by a licensed ophthalmologist or optometrist as indicated in the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' Vision Care Services chapter, N.J.A.C. 10:62. See the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' Vision Care Services chapter, N.J.A.C. 10:62-3 (HCPCS), for procedure codes and maximum fee allowance for reimbursement of both professional services and optical appliances and services.

10:66-2.19 Personal care assistant (PCA) services (mental health)

(a) The following applies to the provision of personal care assistant services:

1. Personal care assistant services (mental health) are health-related tasks performed by a qualified individual in a beneficiary's home under the supervision of a registered professional nurse, as certified by a physician in accordance with a written plan of care.

i. Each personal care provider employing personal care assistants shall be individually approved by the New Jersey Medicaid and NJ FamilyCare programs before it will be reimbursed for services rendered to Medicaid or NJ FamilyCare-Plan A fee-for-service beneficiaries. The Division of Medical Assistance and Health Services will recognize upon approval, agencies under contract to the Division of Mental Health Services.

(1) For information and rules pertaining to personal care assistant services for the mentally ill provided by a home health or homemaker agency, refer to N.J.A.C. 10:60-1.7 in the Home Care Services chapter.

2. Personal care assistant services provided by a family member are not covered services.

3. Personal care assistant services shall be provided only in instances where a family support system or other informal care giver is unavailable, inaccessible or inappropriate.

4. The registered professional nurse, in accordance with the physician's plan of care, prepares written instructions for the personal care assistant to include the amount and kind of supervision needed, the specific needs of the patient and the resources of the patient, the family and other interested persons.

5. Supervision of the personal care assistant shall be provided by a registered nurse at a minimum of one visit every 60 days to assess the patient's health condition, as well as the quality of personal care assistant services received.

6. An initial nursing assessment visit must be made to evaluate the need for personal care assistant service. Following the initial visit, a nursing reassessment visit may be provided at least once every six months, or more frequently if the recipient's condition warrants, to reevaluate the recipient's need for continued care.

7. The personal care assistant shall enter progress notes on a weekly basis in the recipient's record, including the recipient's progress toward goals. These progress notes shall be signed and dated by the personal care assistant.

END OF SUBCHAPTER 2

SUBCHAPTER 3. HEALTHSTART

10:66-3.1 Purpose

(a) The purpose of HealthStart is to provide for comprehensive maternity care services to pregnant Medicaid and NJ FamilyCare fee-for-service beneficiaries, including those determined to be presumptively eligible, and preventive child health care services for Medicaid beneficiaries up to the age of two and NJ FamilyCare fee-for-service beneficiaries.

1. Pediatric HealthStart services are an expansion of the EPSDT program as described at N.J.A.C. 10:66-2.4.

10:66-3.2 Scope of services

(a) HealthStart maternity care services provided by a HealthStart-certified provider are obstetrical care services provided in accordance with the recommendations of the American College of Obstetricians and Gynecologists and a program of support services provided in accordance with N.J.A.C. 10:54-6. HealthStart pediatric care services include up to nine preventive visits, as recommended by the American Academy of Pediatrics, provided by a HealthStart-certified provider who assumes the primary responsibility for coordination and continuity of care.

(b) HealthStart comprehensive maternity care includes both medical maternity care services and health support services, which are described below in (b)1 and 2, respectively.

1. Medical maternity care services include:
 - i. Ambulatory prenatal services;
 - ii. Admission arrangements for delivery;
 - iii. Obstetrical delivery services; and
 - iv. Postpartum medical services.
2. Health support services include:
 - i. Case coordination services;
 - ii. Health education assessment and counseling services;
 - iii. Nutrition assessment and counseling services;
 - iv. Social-psychological assessment and counseling services;
 - v. Home visitation; and
 - vi. Outreach, referral and follow-up services.

(c) HealthStart comprehensive pediatric care includes nine preventive child health visits; all the recommended immunizations; case coordination and continuity of care including, but not limited to, the provision or arrangement for sick care, 24 hour telephone access, and referral and follow-up for complex or extensive medical, social, psychological, and nutritional needs.

10:66-3.3 HealthStart provider participation criteria

(a) The following Medicaid-enrolled and NJ FamilyCare fee-for-service-enrolled provider types are eligible to participate as HealthStart providers: independent clinics, hospital outpatient departments, local health departments, physician groups, and certified nurse midwives meeting the New Jersey State Department of Health and Senior Services' Improved Pregnancy Outcome criteria.

(b) In addition to New Jersey Medicaid and NJ FamilyCare fee-for-service programs' rules applicable to provider participation, HealthStart providers shall:

1. Sign an Addendum to the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' Provider Agreement;
2. Have a valid HealthStart Provider Certificate for HealthStart Maternity Care Service, HealthStart Medical Maternity Service, HealthStart Health Support Service, or HealthStart Pediatric Care Service; and
3. Provide maternity care and/or pediatric care services in accordance with the requirements for issuance of a HealthStart Provider Certificate and in accordance with N.J.A.C. 10:54-6.

(c) In addition to (a) and (b) above, a HealthStart maternity care provider with more than one care site or more than one maternity clinic at the same site that uses different staff, shall apply for a separate HealthStart provider Certificate for each separate clinic. Only those sites which hold a HealthStart Provider Certificate shall be reimbursed for HealthStart services. Such sites:

1. Shall participate in program evaluation and training activities, including, but not limited to, site monitoring, agency and patient record review, and submission of required summary information on each patient according to N.J.A.C. 10:54-6; and
2. May determine presumptive eligibility for the New Jersey Medicaid and NJ FamilyCare fee-for-service programs if approved by the Division of Medical Assistance and Health Services.

(d) In addition to (a) and (b) above, a HealthStart pediatric care provider shall participate in program evaluation and training activities including, but not limited to, documentation of outreach and follow-up activities in the patient's record.

(e) A site review may be required to ascertain an applicant's ability to meet the standards for a HealthStart Provider Certificate and to provide services in accordance with N.J.A.C. 10:54-6.

(f) A HealthStart Provider Certificate shall be reviewed by the New Jersey State Department of Health and Senior Services at least every 18 months from the date of issuance.

(g) An application for a HealthStart Provider Certificate is available from:

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HealthStart Program
New Jersey State Department of Health and Senior Services
PO Box 364
Trenton, NJ 08625-0364

- (h) A HealthStart Program Provider Agreement is available from:
Chief, Provider Enrollment Unit
Division of Medical Assistance and Health Services
Mail Code #9
PO Box 712
Trenton, NJ 08625-0712

10:66-3.4 Termination of HealthStart Provider Certificate

(a) The New Jersey State Department of Health and Senior Services shall be responsible for enforcement of its requirements for HealthStart Provider Certificates and for evaluation and enforcement of its requirements within the Standards and Guidelines for HealthStart Providers.

(b) Failure to comply with HealthStart standards shall be cause for termination of the HealthStart Provider Certificate by the New Jersey State Department of Health and Senior Services.

1. Termination of the HealthStart Provider Certificate shall result in the termination of the HealthStart Provider Agreement with the New Jersey Medicaid and NJ FamilyCare fee-for-service programs. Providers who are terminated by the New Jersey Medicaid or NJ FamilyCare fee-for-service program have the right to request a hearing as indicated in the Administration chapter in N.J.A.C. 10:49-10.3, Opportunity for fair hearing.

2. A HealthStart Provider Certificate is time limited. Failure to complete the recertification process shall result in termination of the provider's HealthStart provider status by the New Jersey State Department of Health and Senior Services.

10:66-3.5 Standards for a HealthStart Comprehensive Maternity Care Provider Certificate

(a) Comprehensive maternity care services must be integrated and coordinated.

(b) HealthStart maternity care providers, excluding physicians and nurse midwives who are in private practice, shall provide comprehensive maternity care services within the following organizational requirements:

1. The provider shall provide directly or through an approved agreement, at one contiguous site, the following services: ambulatory prenatal and postpartum care, case coordination services; nutrition assessment, guidance and counseling services; health education assessment and instruction; social-psychological assessment, guidance and counseling;

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2. The provider shall provide or arrange for the admission of the patient to the appropriate level of care facility for obstetrical delivery services;
3. The provider shall provide or arrange for all necessary laboratory services;
4. The provider shall provide one or more prenatal home visits for each high risk patient;
5. The provider shall provide at least one postpartum home visit for each high risk patient;
6. The provider shall adopt procedures and policies which assure the delivery of coordinated, integrated and comprehensive care; and
7. The provider shall provide referral and follow-up services, which must include, but not be limited to: referral for specialized evaluation, counseling and treatment for extensive social, psychological, nutritional and medical needs.

(c) The provider shall be responsible for linking the mother and newborn infant to a pediatric care provider; if feasible, the linkage should be with a HealthStart pediatric care provider.

(d) An independent clinic may provide the HealthStart health support services component alone upon entering into a written agreement with a private practitioner(s) who shall provide the HealthStart medical care services component. This agreement shall delineate which party is to take primary responsibility for provision of all HealthStart services.

10:66-3.6 Access to service

- (a) All HealthStart services shall be accessible to patients.
- (b) HealthStart maternity care providers shall facilitate patient access to services by scheduling an initial medical visit appointment within two weeks of the patient's first request for services.
- (c) HealthStart maternity care providers shall provide or arrange for 24 hour access to case coordination and medical services for emergency situations.
- (d) HealthStart maternity care providers shall arrange for language translation and/or interpretation services.
- (e) HealthStart maternity care providers may implement a presumptive eligibility processing if so approved by the Division of Medical Assistance and Health Services.
- (f) HealthStart maternity care providers shall undertake community outreach activities to encourage women to seek early prenatal care and increase awareness of the availability of maternity care services.

10:66-3.7 Care plan

(a) A care plan shall be developed and maintained by the case coordinator for each patient.

(b) A care plan shall be based on the medical, nutritional, social-psychological and health education assessments.

(c) A care plan shall include, but not be limited to: identification of risk conditions and/or problems, prioritization of needs, outcome objectives, planned interventions, time frames, referrals and follow-up activities, and identification of staff persons responsible for the services.

(d) The care plan shall be developed and revised in consultation with the patient and staff providing services to the patient.

(e) The initial care plan shall be completed after a case conference and no later than one month after the initial registration visit.

10:66-3.8 Maternity medical care services

(a) Maternity medical care services include antepartum, intrapartum and postpartum care provided by the obstetrical care practitioner(s) in accordance with N.J.A.C. 10:54-6.

(b) Prenatal services are as follows:

1. Frequency of prenatal visits for an uncomplicated pregnancy shall be every four weeks during the first 28 weeks, then every two weeks until 36 weeks, and weekly thereafter. Prenatal visits for complications should be scheduled as needed.

2. Initial prenatal visit content shall include, but not be limited to:

- i. History;
- ii. Review of systems;
- iii. Comprehensive physical examination;
- iv. Risk assessment;
- v. Patient counseling;
- vi. Routine laboratory tests;
- vii. Development of the care plan; and
- viii. Special tests and/or procedures as medically indicated.

3. Subsequent prenatal visit content shall include, but not be limited to:

- i. Review and revision of the patient care plan;
- ii. Interim history;
- iii. Physical examination;
- iv. Patient counseling and treatment;
- v. Laboratory tests;

- vi. Special tests and/or procedures which are medically indicated;
 - vii. Identification of new or developing problems; and
 - viii. Management, including transfer, of any new or persistent problems.
4. Transfer of the prenatal records to the hospital of delivery shall occur no later than 34 weeks gestation.

- (c) Obstetrical delivery services shall include, but not be limited to:
- 1. Determination of and arrangements for delivery site;
 - 2. Attendance at or provision for obstetrical delivery by a qualified physician or certified nurse midwife; and
 - 3. Medical care during the entire period of confinement.

- (d) A postpartum visit shall be provided by the 60th day after delivery, and shall include, but not be limited to:
- 1. History;
 - 2. Review of the prenatal, labor and delivery record;
 - 3. Physical examination;
 - 4. Patient counseling and treatment;
 - 5. Patient/infant assessment;
 - 6. Referral/consultation, as indicated; and
 - 7. Procedures/tests, as indicated.

(e) All HealthStart maternity care providers shall have policies and protocols which are consistent with national standards regarding consultation, and/or transfer of medically high risk patients to tertiary-level maternity care facilities or specialists, and to genetic counseling and testing facilities.

10:66-3.9 Health support services

(a) Case coordination services shall facilitate the delivery of continuous, coordinated and comprehensive services for each patient in accordance with N.J.A.C. 10:54-6 as follows:

- 1. A permanent case coordinator shall be assigned to each patient no later than two weeks after the HealthStart enrollment visit.
- 2. Prenatal case coordination activities shall include, but not be limited to:
 - i. Orienting the patient to all services;
 - ii. Developing, maintaining and coordinating the care plan in consultation with the patient;
 - iii. Coordinating and monitoring the delivery of all services and referrals;
 - iv. Monitoring and facilitating the patient's entry into and continuation with maternity services;
 - v. Facilitating and providing advocacy for obtaining referral services;
 - vi. Reinforcing health teachings and providing support;
 - vii. Providing vigorous follow up for missed appointments and referrals;

- viii. Arranging home visits;
 - ix. Meeting with the patient and coordinating patient care conferences; and
 - x. Reviewing, monitoring and updating the patient's complete record.
3. Postpartum care coordination activities shall include, but not be limited to:
- i. Arranging and coordinating the postpartum visit and any home visit;
 - ii. Arranging with the obstetrical care provider to obtain the labor, delivery and postpartum hospital summary record information no later than two weeks after delivery;
 - iii. Linking the patient to appropriate service agencies including: the Special Supplemental Food Program for Women, Infants and Children (WIC), pediatric care (preferably with a HealthStart pediatric care provider), future family planning, Special Child Health Services County Case Management Unit, early intervention services for infants with disabilities, and other health and social agencies, if needed;
 - iv. Arranging for the transfer of pertinent information or records to the pediatric care and/or future family planning service providers;
 - v. Coordinating referrals and following up on missed appointments and referrals; and
 - vi. Reinforcing health instructions for mother and baby.

(b) Nutrition assessment and basic guidance services shall be provided to orient and educate all patients to nutritional needs during pregnancy and educate the patient to good dietary practices in accordance with N.J.A.C. 10:54-6. Specialized nutrition assessment and counseling must be provided to those women with additional needs. Services shall be provided as follows:

1. Initial assessment services, which shall include, but not be limited to:
 - i. Review of the patient's chart;
 - ii. Identification of dental problems which may interfere with nutrition;
 - iii. Nutritional history;
 - iv. Current nutritional status;
 - v. Determination of participation in WIC or other food supplement programs; and
 - vi. Identification of need for specialized nutritional counseling;
2. Subsequent nutritional assessment, which shall include, but not be limited to:
 - i. Monitoring of weight gain/loss;
 - ii. Identification of special dietary needs; and
 - iii. Identification of need for specialized nutritional counseling services;
3. Prenatal nutritional guidance, which shall include, but not be limited to:
 - i. Basic instruction on nutritional needs during pregnancy including balanced diet, vitamins and recommended daily allowances;
 - ii. Review and reinforcement of other nutritional and dietary counseling services the patient may be receiving;
 - iii. Instruction on food purchase, storage and preparation;
 - iv. Instruction on food substitutions, as indicated;
 - v. Discussion of infant feeding and nutritional needs; and
 - vi. Referral to food supplementation programs through the case coordinator;
4. Specialized nutrition assessment and counseling, which shall be provided to those women with additional needs;

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5. Referral for extensive specialized nutritional services which shall be initiated by the medical care provider or the nutritionist under the supervision of the medical care provider in coordination with the case coordinator; and

6. Postpartum nutritional assessment and basic guidance services which shall include, but not be limited to:

- i. Review and reinforcement of good dietary practices;
- ii. Review of instruction on dietary requirement changes; and
- iii. Instruction on breast feeding and/or formula preparation and feeding.

(c) Social-psychological assessment and basic guidance services shall be provided to all patients to assist the patient in resolving social-psychological needs, in accordance with N.J.A.C. 10:54-6. Specialized social-psychological assessment and short-term counseling shall be provided to those women with additional needs. Services shall be provided as follows:

1. Initial social-psychological assessment services which shall include, but not be limited to:

- i. Determining financial resources and living conditions;
- ii. Determining the patient's personal support system;
- iii. Determining the patient's attitudes and concerns regarding the pregnancy;
- iv. Ascertaining present and prior involvement by the patient with other social programs or agencies and current social service needs;
- v. Ascertaining educational and/or employment status and needs; and
- vi. Identification of the need for specialized social-psychological and/or mental health evaluation and counseling services;

2. Subsequent social-psychological assessment services which shall include, but not be limited to:

- i. Determination of patient's reaction to pregnancy;
- ii. Ascertaining the reaction of family, friends and actual support person to the pregnancy;
- iii. Identification of the need for social service interventions and advocacy; and
- iv. Identification of the need for specialized social-psychological and/or mental health evaluation and counseling;

3. Basic social-psychological guidance, which shall include, but not be limited to:

- i. Orientation and information on available community resources;
- ii. Orientation regarding stress and stress reduction during pregnancy; and
- iii. Assistance with arrangements for transportation, child care and financial needs;

4. Specialized, short-term social-psychological counseling, which shall be provided to women who are identified through assessment or basic counseling as having need for more intense service;

5. Referral for extensive specialized social-psychological services, which shall be initiated by the medical care provider or by the social worker under the supervision of the medical care provider and in coordination with the case coordinator; and

6. Postpartum social-psychological assessment and guidance which shall include, but not be limited to:

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- i. Review of prenatal, labor, delivery and postpartum course;
- ii. Assessment of the patient's current social-psychological status, including mother and infant bonding and the acceptance of the infant by the father and/or family, as applicable;
- iii. Identification of the need for additional social-psychological services;
- iv. Review of available community resources for mother and infant, as applicable;
- v. Counseling regarding fetal loss or infant death, if applicable; and
- vi. Counseling regarding school/employment planning.

(d) Health education assessment and instruction shall be provided to all patients at intervals throughout the pregnancy, based on the patient's needs and in accordance with N.J.A.C. 10:54-6. Services shall be provided as follows:

1. Initial assessment of health educational needs, which shall include, but not be limited to:

- i. Identification of general educational background;
- ii. Patient's health education needs; and
- iii. Previous education and experience concerning pregnancy, birth and infant care;

2. Health education instruction, which shall be provided for all patients based on their identified health education needs, shall include at least the following:

- i. Normal course of pregnancy;
- ii. Fetal growth and development;
- iii. Warning signs, such as signs of pre-term labor, and identification of emergency situations;
- iv. Personal hygiene;
- v. Exercise and activity;
- vi. Childbirth preparation, including management of labor and delivery;
- vii. Preparation for hospital admission;
- viii. Substance, occupational and environmental hazards;
- ix. Need for continuing medical and dental care;
- x. Future family planning;
- xi. Parenting, basic infant care and development;
- xii. Availability of pediatric and family medical care in the community; and
- xiii. Normal postpartum physical and emotional changes;

3. Health education services, which shall include guidance in decision making and in the implementation of decisions concerning pregnancy, birth and infant care; and

4. Postpartum assessment of health education needs shall be conducted.

(e) One face-to-face preventive health care contact must be provided or arranged for during the time after hospital discharge and prior to the required medical postpartum visit. This requirement is in accordance with N.J.A.C. 10:54-6, as follows:

1. This contact shall include, but not be limited to:

- i. Review of the mother's health status;
- ii. Review of the infant's health status;
- iii. Review of mother/infant interaction;

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- iv. Revision of the care plan; and
 - v. Provision of additional services, as indicated; and
2. The provider shall provide or arrange for one or more home visits for each high risk patient in accordance with N.J.A.C. 10:54-6.

(f) HealthStart maternity care providers shall utilize existing community services to enhance the maternity care services.

(g) HealthStart maternity care providers shall have written procedures which identify specific agencies or practitioners and criteria for referral of patients requiring services which are extensive, complex or expected to extend beyond the pregnancy. These procedures shall include but are not limited to: nutritional and food supplementation services, substance abuse treatment facilities, mental health services, county/local social and welfare agencies, parenting and child care educational programs, future family planning services, fetal alcohol syndrome and AIDS counseling services.

10:66-3.10 Professional staff requirements for HealthStart comprehensive maternity care services

(a) All HealthStart comprehensive maternity care services shall be delivered through a team approach by qualified professionals.

(b) Physicians and/or certified nurse midwives shall be Medicaid and NJ FamilyCare fee-for-service providers and have obstetrical admitting privileges at a licensed maternity care facility.

(c) Case coordinators shall have as a minimum a license as a registered nurse; or a bachelor's degree in social work, health or behavioral science.

(d) Health professionals shall have a valid license to practice their professions as required by the State of New Jersey.

(e) All other professionals, for whom no license to practice is required, shall meet generally accepted professional standards for qualification.

(f) Paraprofessionals shall be familiar with the local community, have knowledge and/or skills in maternal and child health services and be supervised by a health professional.

(g) Prenatal, delivery, and postpartum medical services shall be delivered by a physician and/or a certified nurse midwife.

(h) Nutritional, social-psychological and health education assessment and development of the care plan shall be provided by the appropriate professional in each of the specialty areas or the case coordinator or medical care professional. If the nutritional or

social-psychological assessment portion of the care plan are provided by the case coordinator or medical care professional, then they shall be reviewed by the nutritionist or social worker, respectively.

(i) Nutritional and social-psychological basic counseling shall be provided by a case coordinator with at least one year of experience in providing services to maternity patients or by the appropriate specialist in each of the areas or by a registered nurse or obstetrical care provider.

(j) Short term specialized social-psychological and nutritional counseling services shall be provided by a social worker and nutritionist respectively. The social worker and nutritionist shall be available on site during patient visits.

(k) There shall be adequate professional, paraprofessional and clerical staff to provide, in a timely manner, maternity care services as described herein which meet the needs of the patients.

10:66-3.11 Records: documentation, confidentiality and informed consent for HealthStart comprehensive maternity care providers

(a) HealthStart maternity care providers shall have policies which protect patient confidentiality, provide for informed consent, and document prenatal, labor, delivery and postpartum services in accordance with N.J.A.C. 10:54-6.

(b) An individual record shall be maintained for each patient throughout the pregnancy.

(c) Each record shall be confidential and shall include at least the following: history and physical examination findings, assessment, a care plan, treatment services, laboratory reports, counseling and health instructions provided, and documentation of referral and follow-up services.

(d) There shall be policies and procedures for appropriate informed consent for all HealthStart services.

10:66-3.12 Standards for HealthStart pediatric care certificate

(a) Pediatric care services shall be comprehensive, integrated and coordinated.

(b) HealthStart pediatric care providers shall:

1. Directly provide preventive child health care, maintenance of complete patient history, outreach for preventive care, initiation of referrals for appropriate medical, educational, social, psychological and nutritional services, and follow-up of referrals and sick care;

2. Directly provide or arrange for non emergency room-based, 24-hour physician telephone access to eligible patients; and
3. Directly provide or arrange for sick care and emergency care.

10:66-3.13 Professional requirements for HealthStart pediatric care providers

(a) All HealthStart pediatric care providers shall be pediatricians or have a physician on staff who possesses a knowledge of pediatrics. This may be demonstrated by eligibility for board certification by the American Academy of Pediatrics, the American Osteopathic Board of Pediatrics, and/or by hospital admitting privileges in pediatrics.

10:66-3.14 Preventive care services by HealthStart pediatric care providers

(a) HealthStart pediatric care providers shall provide preventive health visits in accordance with the recommended guidelines of the American Academy of Pediatrics and the New Jersey State Department of Health and Senior Services' Guidelines for HealthStart Pediatric Care. The schedule shall include a two-to-four week visit, a two-month visit, a four-month visit, a six-month visit, a nine-month visit, a 12-month visit, a 15-month visit, an 18-month visit and a 23 to 24-month visit. Each visit shall include, at a minimum, medical, family and social history, unclothed physical examination, developmental and nutritional assessment, vision and hearing screening, dental assessment, assessment of behavior and social environment, anticipatory guidance, age appropriate laboratory examinations and immunizations. Referrals shall be made as appropriate.

(b) Each provider shall provide or arrange for sick care and 24 hour telephone physician access during non-office hours. If not directly provided by the HealthStart provider, sick care and 24 hour telephone access shall be provided for each child by a single designated provider via a documented agreement. Information on care given shall be communicated to the primary HealthStart pediatric care provider. Telephone access provided exclusively via emergency room staff is not permitted. Referral to the emergency room should occur only for emergency medical care or urgent care.

(c) Case coordination, outreach and follow-up services shall include letter and/or telephone call reminders to the child's parent or guardian for preventive well-child visits and letters and/or telephone follow-up of missed appointments. Referrals for home visit services for follow-up shall be made when appropriate. For all referrals and follow-up visits, the provider shall document the completion of such referrals and/or visits. If the referral is not completed, a letter or phone call to the child's parent or guardian and/or to the referred agency shall be sent or made. All of the activity shall be recorded on the patient's chart.

10:66-3.15 Referral services by HealthStart pediatric care providers

(a) All HealthStart pediatric care providers shall make provision for consultation for specialized health and other pediatric services. Services shall include medical services, as well as social, psychological, educational and nutritional services.

1. This may include, but is not limited to: the Special Supplemental Food Program for Women, Infants and Children (WIC); Division of Youth and Family Services; Special Child Health Services Case Management Units and Child Evaluation Centers; early intervention programs; county welfare agencies/boards of social services; certified home health agencies; community mental health centers; and local and county health departments.

10:66-3.16 Records: documentation, confidentiality and informed consent for HealthStart pediatric care providers

(a) HealthStart pediatric care providers shall have policies which protect patient confidentiality, provide for informed consent and document comprehensive care services in accordance with the New Jersey State Department of Health and Senior Services' Guidelines for HealthStart Pediatric Care Providers.

(b) An individual record shall be maintained for each patient.

(c) Each record shall be confidential and shall include at least the following: history and physical examination, results of required assessments, care plan, treatment services, laboratory reports, counseling and health instruction provided and documentation of referral and follow-up services.

(d) There shall be policies and procedures for appropriate informed consent for all HealthStart pediatric services.

END OF SUBCHAPTER 3

SUBCHAPTER 4. FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

10:66-4.1 Federally qualified health center (FQHC) services

(a) Federally qualified health center (FQHC) services are services provided by physicians, physician assistants, advanced practice nurses, nurse midwives, psychologists, dentists, clinical social workers, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as incident to a physician's services.

1. FQHCs shall accommodate an outstationed County Board of Social Services (CBOSS) employee(s) for the purpose of determining Medicaid and NJ FamilyCare eligibility, pursuant to 1902(a)(55) of the Social Security Act, 42 U.S.C. § 1396a.

2. A medical encounter is a face-to-face contact between a beneficiary and a physician or other licensed practitioner acting within his or her respective scope of practice, including a podiatrist, optometrist, chiropractor, advanced practice nurse, or nurse midwife.

i. Normally, only one medical encounter is covered per beneficiary, per day. More than one medical encounter is covered, however, when the beneficiary is seen by more than one licensed practitioner for the prevention, treatment or diagnosis of different injuries or illnesses, and practitioners of appropriate different specialties are involved.

ii. More than one medical encounter is also allowed if a beneficiary leaves the center after having been seen by a practitioner, then returns to the center and is seen by another practitioner on the same day.

iii. More than two medical encounters during a week for a beneficiary require clear documentation in the beneficiary's medical record demonstrating the medical necessity of the encounter(s).

iv. Interpretation of results of tests or procedures not requiring face-to-face contact between a beneficiary and a practitioner, and referrals to specialists, do not constitute a medical encounter.

3. A psychiatric encounter is a face-to-face contact between a beneficiary and a licensed mental health professional in which a covered mental health clinic service is provided.

4. A dental encounter is a face-to-face contact between a beneficiary and a dentist or a licensed dental professional in which a covered dental procedure is provided. All procedures shall be administered by or under the direct supervision of a dentist.

5. An Early and Periodic Screening, Diagnosis and Treatment (EPSDT) medical encounter is a face-to-face contact between a beneficiary and a physician or other licensed practitioner acting within his or her respective scope of practice, including a podiatrist, optometrist, chiropractor, nurse, practitioner, or nurse midwife in which a covered EPSDT service is provided.

10:66-4.2 Hospital visits

(a) An inpatient hospital visit performed by a clinic physician for a registered Medicaid or NJ FamilyCare fee-for-service patient of a Federally qualified health center shall be reimbursed only if the clinic is specifically approved to provide this service by the programs.

1. For a salaried physician in a Federally qualified health center, an inpatient hospital visit shall be billed by the FQHC as a medical encounter.

2. For a physician under contract with a Federally qualified health center, the physician may receive reimbursement as an individual provider as long as the clinic is not also billing for the same service. The only contracted physician's costs that may be reported in the FQHC's Medicaid cost report are for visits that are billed by the FQHC.

10:66-4.3 Audited financial statement

(a) The audited financial statement of a Federally qualified health center shall be:

1. Conducted by one of the following:

i. A licensed certified public accountant or persons working for a licensed certified public accounting firm; or

ii. A public accountant licensed on or before December 31, 1970; or

iii. Persons working for a public accounting firm licensed on or before December 31, 1970, sufficiently independent as defined by GAO standards, to produce unbiased opinions, conclusions, or judgements;

2. Conducted annually based on the FQHC's fiscal year;

3. Conducted on an organization-wide basis to ascertain that the financial statements fairly present the financial position and results of the FQHC's total operations and cash flows;

4. Submitted within 150 days of the FQHC's fiscal year end;

5. Conducted in accordance with the following standards, incorporated herein by reference, and as amended and supplemented:

i. Generally accepted auditing standards established by the American Institute of Certified Public Accountants (AICPA);

ii. Government Auditing Standards established by the Comptroller General of the United States and issued by the U.S. General Accounting Office;

iii. The AICPA audit and accounting guide Audits of State and Local Governmental Units and, as applicable, AICPA industry audit guides or Statements of Position;

iv. Federal Single Audit Act of 1984 (P.L. 98-502);

v. Federal OMB Circular A-133, "Audits of Institutions of Higher Education and Other Nonprofit Organizations";

vi. Federal OMB "Compliance Supplement for Single Audits of State and Local Governments" (September 1990);

vii. Federal OMB "Compliance Supplement for Single Audits of Educational Institutions and Other Nonprofit Organizations," when issued, may supersede the Federal "Compliance Supplement for Single Audits of State and Local Governments," and

viii. Federal OMB Circulars A-87 "Cost Principles for State and Local Governments" or A-122 "Costs Principles for Nonprofit Organizations," as applicable.

(b) The audit report shall include the following:

1. An opinion on the financial statements taken as a whole;
2. Presentation of financial statements in accordance with the following applicable AICPA audit and accounting guides--Audits of State and Local Governmental Units, industry audit guides, or Statements of Position;
3. A supplementary schedule and opinion thereon of the FQHC's state and federal financial assistance programs, showing expenditures by program (see the AICPA's audit guide, Audits of State and Local Governmental Units, Fifth Edition, pages 196 and 230);
4. A report(s) on the auditor's considerations of the internal control structure covering:
 - i. The internal control structure relevant to the financial statement audit; and
 - ii. The internal control structure used in administering state/federal financial assistance programs;
5. Compliance Report Based on an Audit of General Purpose or Basic Financial Statements Performed in Accordance with Government Auditing Standards;
6. Single audit compliance report(s) covering:
 - i. General requirements applicable to major programs;
 - ii. Opinion on compliance with specific requirements applicable to major programs;and
 - iii. Requirements applicable to nonmajor programs;
7. A specific statement that all required tax returns have been filed and taxes (including, but not limited to, payroll taxes) have been paid;
8. A copy of the management advisory letter when provided as a routine part of the audit engagement;
9. A statement of the FQHC's response to findings of deficiencies in internal control and compliance, including a description of corrective action taken or planned on prior findings; and
10. A report on fraud, abuse or illegal acts, or indications of such acts when discovered (a separate written report is required).

(c) Report guidance can be obtained from AICPA Statements of Position 89-6 and 90-9. If other guidance from the AICPA or the Federal government is issued, it may supersede some of these requirements.

(d) If the audit uncovers or suggests any potentially fraudulent acts, these acts shall be communicated immediately by the independent public accountant to:

Department of Human Services
Director, Office of Auditing
Capital Place One
PO Box 700
Trenton, New Jersey 08625-0700

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APPENDIX A

Pre-2001 Cost Report

Cost Report Instructions for Federally Qualified Health Centers (FQHCs) for all fiscal years ending prior to April 1, 2001

(a) Each Federally qualified health center (FQHC) participating as an independent clinic provider in the Medicaid and NJ KidCare programs shall complete a cost report, as indicated at N.J.A.C. 10:66-1.5(e). This requirement is necessary to determine the amount of reimbursement to be paid to the FQHC for services provided to Medicaid or NJ KidCare-Plan A beneficiaries.

(b) All Worksheets, Statistical Information, and a Certification Page must be completed as appropriate. Additional documentation in the form of sub-worksheets, etc. may be provided by a FQHC to support a particular cost or reclassification, adjustment to expenses, or other item(s). Calculations requiring a percentage shall be carried to five places.

(c) The completion of a cost report serves as the basis for an FQHC's interim reimbursement rate and the total Medicaid or NJ KidCare-Plan A reimbursement due to an FQHC for services provided to Medicaid and NJ KidCare-Plan A beneficiaries.

(d) A copy of the FQHC's audited financial statements shall be submitted with the Medicaid cost report.

(e) The following pages contain the cost report forms and instructions for their proper completion.

FQHC-93-01 (Certification)--(i) (ii)

COMPLETION INSTRUCTIONS

- | Field | Explanation |
|-------|---|
| 1. | Enter the Federally qualified health center's name and mailing address. |
| 2. | Enter the Medicaid Provider Number assigned to the FQHC. |
| 3. | Enter the fiscal period of the FQHC being reported. |
| 4. | Circle the category of control most representative of the FQHC. |
| 5. | List each owner possessing an amount of ownership in the FQHC, regardless of the level. |
| 6. | All other Federally qualified health centers, providers of service, or suppliers and other entities related to the center through common ownership or control must be listed here. The use of a sub-schedule is permitted as necessary. |
| 7. | All grants received by the FQHC shall be listed here. The name, number and source of the grant (for example, State of New Jersey |

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Grant #XXXXX, Public Health Service Grant #XXXXX) duration of the grant and the total grant dollars under each grant are to be listed. If additional space is required attach a supporting sub-schedule listing.

Certification statement:

Enter the full name of the FQHC and the reporting period covered by the report. Note: Enter the signature of the officer/owner of the FQHC and his/her title and date after the completion of the cost report.

FQHC-93-01 (Reclassification and Adjustment of Trial Balance of Expenses) - (Worksheet 1)--(iii)(iv)(v)

COMPLETION INSTRUCTIONS:

Worksheet 1 is used to record the trial balance of expense accounts from the books and records of the center for the year being reported. This worksheet provides for any adjustments or reclassifications to the FQHC's cost centers that may be required.

The order of the cost centers is designed to flow to subsequent worksheets, where applicable, to aid in the cost report preparation. It is recognized that not all of the cost centers will apply to every center. For example, not every facility will offer dental services. Where a cost center is listed that does not apply, leave that center blank.

Blank lines for use by the center are provided wherein a unique cost center or situation may exist. If these are used, the center must identify what specific cost (center/service) are included.

Columns 1 and 2--Compensation and Fringe Benefits:

The compensation and fringe benefit expenses recorded on the books of the center, for the period of the cost report, are to be entered on the appropriate cost center lines. These expenses come directly from the trial balance of the center without adjustment. Any needed reclassification or adjustment must be recorded in columns 5 and 7, as appropriate.

Columns 1 and 2, Line 23--Pneumococcal and Influenza Vaccine Services

The amounts for this line will be taken from the Medicare Cost Report, Supplemental Worksheet B-1. If a FQHC is not required to complete a Medicare Cost Report, Supplemental Worksheet B-1 must be completed as an attachment to the Medicaid cost report. Supplemental Worksheet B-1 is the mechanism for Medicaid and NJ KidCare-Plan A reimbursement of pneumococcal and influenza vaccine services.

Column 1, Line 23, Compensation--Enter the amount of "Pneumococcal and Influenza Vaccine Health Care Staff Costs" From Line 3 of the Medicare Cost Report, Supplemental Worksheet B-1. These amounts are excluded from the totals calculations, as they are not subject to cost limitations.

Column 2, Line 23, Fringe Benefits

Leave Blank, the amounts from fringe benefits are included in Column 1.

Column 3--Other:

Enter the expenses of the various cost centers that are not compensation or fringe benefits. These expenses come directly from the trial balance of the center without adjustment. Any needed reclassification or adjustment must be recorded in columns 5 and 7, as appropriate.

Column 3, Line 23, Other

Enter the amount of "Medical Supplies Cost--Pneumococcal and Influenza Vaccine" from line 4 of the Medicare Cost Report, Supplemental Worksheet B-1.

Column 4--Sub-Totals:

The sum of columns 1, 2 and 3, for each line is entered here.

Column 5--Expense Reclassifications:

Enter any reclassification among cost centers in column 4 which are necessary to effect proper cost recognition and allocation. Reclassifications are to be used when the expenses of a particular cost center are applicable to more than one of the cost centers listed on the worksheet, and are maintained in a single cost center on the books and records of the center. For example, where a physician performs certain administrative duties, the appropriate portion of his/her compensation and fringe would need to be reclassified from the "Physician" cost center to "Administrative Costs Staff--Administration" cost center. Thus, his/her administrative time (cost) would be properly recognized.

Worksheet 1, Page 2-3, Line 59--Medical Records

Enter costs associated with Medical Records in Columns 1, 2 and 3. In Column 5, reclassify any or all amounts to appropriate Core or Specialized Services categories. Appropriate schedules detailing the method of allocation must be maintained for audit purposes.

Worksheet 1, Page 3-3, Line 79--Insurance--Malpractice

Enter costs associated with Insurance--Malpractice in Columns 1, 2, & 3. In Column 5, reclassify any or all amounts to appropriate Core or Specialized Services categories. Appropriate schedules detailing the method of allocation must be maintained for audit purposes.

Introduction to Column 6:

All reclassifications shall be specifically identified via supporting schedules to the cost report as prepared by the center. The supporting schedules must provide an appropriate explanation to each of the affected cost centers. Any reduction of expense

is to be shown in < brackets. The net total of the supporting schedule and column must equal zero.

Worksheet 1, Support Schedule A is to be used for all reclassifications. See instructions for specifics of this schedule.

Column 6--Reclassified Trial Balance:

This column is the total of column 4, plus or minus column 5. The total of column 6, all pages, as found on Worksheet 1, line 108, Total Center Costs, must equal that of column 4, line 108, Total Center Costs.

Column 7--Adjustments (Decreases/Increases):

Enter the amount of any adjustment to the center's reclassified trial balance expenses. Adjustments are required to adjust (increase or <decrease) actual expenses in accordance with Medicaid and NJ KidCare-Plan A rules on allowable cost. An example of a situation in which adjustment to expense would be required is where the clinic receives an allocation from a central (home) office, has a practitioner assigned by the National Health Service Corps, or the identification of pneumococcal vaccine administration costs.

All adjustments reflected in column 7 shall be detailed on a supporting schedule prepared by the clinic. The schedule shall provide an explanation or rationale for the adjustment, whether the adjustment basis is cost or amount received and the identification of any and all cost centers affected.

Worksheet 1, Support Schedule B is to be used to document and detail the adjustments contained in column 7. See instructions for specifics of this schedule.

Column 8--Adjusted Net Expenses:

This column is used to combine the reclassified trial balance amounts in column 6 with the adjustment amounts found in column 7 by individual cost center. The amounts resulting in column 8 will be used in later schedules in the determination of reimbursement of cost for services rendered to Medicaid and NJ KidCare-Plan A beneficiaries.

FQHC-93-01 Worksheet 1--Support Schedule A--Reclassifications--(vi)

COMPLETION INSTRUCTIONS:

This supporting schedule is designed to document any reclassification of cost performed on the Trial Balance of Expenses, column 4. A full explanation of the reclassification must accompany each reclassification. A letter code (A), (B), (C), etc., should be used to identify each reclassification shown. This will enable identification of reclassifications should this be necessary. An example of a reclassification would be the identification of the administration and the pharmaceutical expenses for pneumococcal vaccine. Cost could be reclassified from pharmacy and the physician assistant cost centers to the pneumococcal vaccine services cost center.

For every cost amount reclassified, a specific cost center (columns 3 or 6) and line (columns 4 & 7) must be recorded. Increases are to be identified in columns 3, 4, & 5, with decreases shown in columns 6, 7, & 8. The totals of column 5 and column 8 must equal.

FQHC-93-01 Worksheet 1--Support Schedule B--Adjustments to Expense Detail-- (vii)
COMPLETION INSTRUCTIONS:

This supporting schedule is used to provide the necessary detail for all adjustments, either (decreases) or increases, affecting cost centers on Worksheet 1, Pages 1, 2, & 3.

A full explanation of the adjustment is to be entered in column 1. In column 2 an alpha identifier of either C (cost) or R (revenue) should be entered. This designates the amount of the adjustment as either a revenue (received) offset or an actual cost offset.

An example of a revenue offset would be the revenues received from the operation of a vending machine in the center. The revenue received should be offset against the cost of providing the service. An actual expense offset would be made where the cost could actually be determined, such as when an adjustment to depreciation is necessary due to an independent audit firm finding.

The total of column 3 must agree to the total found on Worksheet 1, line 108, column 7.

FQHC-93-01 Worksheet 2--ENCOUNTERS--(viii)
COMPLETION INSTRUCTIONS:

General:

Worksheet 2 is used by the center to summarize the total encounters actually occurring during the cost reporting period. The form is divided into two primary sections, that of core services, and that of other ambulatory services. Space has been provided in the other specialized service area for a service that may be unique to a center and not specifically identified.

It should be noted, that some services are specifically identified under the specialized services category, yet they would be provided by a physician, such as Norplant, and would be considered physician services. However, for purposes of reporting and to uniquely track these expenses for rate establishment, they are to be identified separately and the encounter associated with these services shown under their specific category. For Norplant services, line 15, the number of Norplant insertions/removals are to be recorded. The actual visit should not be included in the Physician Cost Center, line 1, column 2.

While care has been taken to account for the variety of services provided in a center and establish a corresponding service line, blank lines have been provided for reporting

of additional special service centers and associated cost. Refer to N.J.A.C. 10:66-4.1(b) for the appropriate definition of a medical encounter.

Column 1, Medicaid Fee-for-Service--Enter in the appropriate service category the number of actual, valid Medicaid and NJ KidCare-Plan A fee-for-service encounters. On line 16, enter the number of Medicaid and NJ KidCare-Plan A fee-for-service pneumococcal and influenza vaccine injections.

Column 2, Medicaid Managed Care--Enter in the appropriate service category the number of actual, valid Medicaid and NJ KidCare-Plan A Managed Care encounters for which cost-based reimbursement is allowable. On line 16, enter the number of allowable Medicaid and NJ KidCare-Plan A Managed Care pneumococcal and influenza vaccine injections. If data is entered into this Column the FQHC is required to complete Worksheet 2, Support Schedule A.

Column 3, Medicaid Total Encounters--Total of Columns 1 + 2.

Column 4, Managed Care Encounters--Enter in the appropriate service category the number of encounters provided to managed care patients which are not eligible for cost-based reimbursement. Include in these numbers any managed care encounters provided to Medicaid and NJ KidCare beneficiaries which are not allowable for cost-based reimbursement in Column 2. On line 16, enter the number of pneumococcal and influenza vaccine injections.

Column 5, New Jersey Department of Health and Senior Services--Enter in the appropriate service category the number of encounters provided under letter of agreement with the New Jersey Department of Health and Senior Services. This amount must include the base level visits assigned by the New Jersey Department of Health and Senior Services. On line 16, enter the number of pneumococcal and influenza vaccine injections provided under agreement with the New Jersey Department of Health and Senior Services.

Column 6, Medicare--Enter in the appropriate service category the number of Medicare encounters. On line 16, enter the number of Medicare pneumococcal and influenza vaccine injections.

Column 7, Self-Pay--Enter in the appropriate service category the number of encounters provided to individuals who are either personally liable or have private insurance. On line 16, enter the number of Self-Pay pneumococcal and influenza vaccine injections.

Column 8, Other--Enter in the appropriate service category the number of encounters which have not been previously reported. On line 16, enter the number of Other pneumococcal and influenza vaccine injections.

Line 7--All Columns--Enter the sum of lines 1 through 6, Core Services--all columns.

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Line 26--All Columns--Enter the sum of lines 10 through 25 for each column as appropriate.

Line 28--All Columns--Enter the sum of lines 7 and 26. Cross foot all columns to column 7.

FQHC-93-01 Worksheet 2--Support Schedule A--Medicaid Managed Care Encounter Detail--(ix)

COMPLETION INSTRUCTIONS:

Column Headings (1-9)--Enter the name of each Managed Care Company with which the FQHC contracts. If the FQHC is under contract with more than nine Medicaid and NJ KidCare HMOs, additional pages/columns must be included. Enter in the appropriate service category the number of actual, valid Medicaid and NJ KidCare-Plan A Managed Care encounters provided for each Managed Care Company. On Line 16, enter the number of Medicaid and NJ KidCare-Plan A Managed Care pneumococcal and influenza vaccine injections.

FQHC-93-01 Worksheet 3--PRODUCTIVITY SCREENING--(x)

COMPLETION INSTRUCTIONS:

This Worksheet is used to determine if the productivity screens of the various core and other services are being met. It develops the various encounters that will be used in the determination of an encounter rate for each core and specialized service. Additionally, it reflects the numbers of staff assigned to each of the areas. Completion of Worksheet 3 requires completion of Worksheets 6, 7 and 8.

Columns 1 and 1a--Number of FTEs and Total Hours--Staffing is to be reported by hours compensated and on the basis of full time equivalents. The total hours reported in column 1a, for Physicians (line 1), Nurse Practitioners (line 2), Nurse Mid-Wives (line 3), Dentists (line 10) and Dental Hygienists (line 11) should be taken from the appropriate total line. Column 8, in either Worksheet 6, 7 or 8. All other hours reported in column 1a should be taken from the FQHC's records. The total hours are then divided by the number of hours the clinic considers to be full-time for that position. (Example 40 hours per week times 52 weeks = 2080 hours = 1 FTE). The resultant rounded to the nearest two decimal places is the full time equivalent for the position. If the cost report is for less than a full reporting period (i.e., less than 52 weeks) then the numbers of weeks in the reporting period multiplied by the weekly hours 40 should be used as the standard required (FTE) hours. Partial weeks should be rounded up to a full week. Note: The line for Pneumococcal/Influenza Vaccine injections, line 16, column 1, is to be left blank. The physician(s) (FTEs) involved in the center is/are to be reported in line 1.

Column 2--Total Encounters--The total number of encounters reported in Column 2 should be taken from the corresponding line in Worksheet 2, Column 9.

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For Pneumococcal/Influenza Vaccine Services, line 16, the number of injections given are to be shown in this column.

Column 4--Minimum Encounters--The result of multiplying column 1a by column 3 for all service lines is to be entered here. The resultant is the minimum encounter requirement for the appropriate center (Productivity Screen).

Column 5--Enter here the greater of column 2 or column 4 for all services. This will reflect the productivity standard application where applicable and the resultant will be used for development of the actual per encounter rate on subsequent worksheets.

FQHC-93-01 Worksheet 4--Encounter Rate Calculation--(xi)

COMPLETION INSTRUCTIONS:

General--This worksheet is used to determine the per visit encounter rate by specific service category that is to be used in the Medicaid and NJ KidCare-Plan A reconciliation process on Worksheet 5.

Part I--Item (A) total actual facility direct health service cost is calculated from taking Worksheet 1, line 36 column 8 plus the sum of Worksheet 1, lines 52 & 56, column 8.

Part I: Item (B) Allowable Administrative costs. Item (B) is reported as the LOWER of: Worksheet 1, Line 71, Column 8 plus Worksheet 1, Line 89, Column 8 or 30% of Item (A) Total Facility Direct Health Services

Part I: Item (C) Allowable Facility Overhead Cost is calculated from adding Item (B) Allowable Administrative Costs, PLUS, Worksheet 1, Line 103, Column 8.

Part II--Specialized Services

Column 1--Direct Cost:

Transfer to the appropriate line the total cost of each specialized service area as found on Worksheet 1, Page 1, column 8. Note: The total expense of the dentist/dental hygienist is the sum of worksheet 1, lines 17 & 18 column 8.

Column 2-- Ratio of Special Service Center to Total Direct Health Services:

Enter here the resultant of column 1 of this section divided by the total facility direct health service cost (Worksheet 4, Part I, Item (A)). The percentage derived will be the percentage of each of the special service centers direct cost to total cost. Remember to carry all decimal figures to 5 places.

Column 3--Facility Overhead Applicable to the Special Service Center:

Enter here the percentage shown in column 2 of this section multiplied by Worksheet 4, Page 1-2, Part I, Item (C). The amount derived is the percentage of allowable facility overhead attributed to the individual special service cost center.

Column 4--Total Cost of Special Service Cost:

Enter the sum of column 1 and 3 of this section for each special service cost center. This amount reflects the total calculated cost for each of the special service cost centers.

Column 5--Productivity Screening Encounters

Enter the productivity screening encounters from Worksheet 3, Page 1, column 5 for each special service cost center. Amount shown as Total should agree to Worksheet 3, Page 1-1, column 5, line 26. (Note: The visits for Norplant are the actual Norplant Implant Procedures done and the Pneumococcal/Influenza Vaccine line will reflect the actual number of injections given as shown on Worksheet 3, Page 1-1, lines 15 and 16 respectively, column 2. Dental/Dental Hygienist encounters are the sum of Worksheet 3, line 10 and line 11, column 5.)

Column 6--Computed Encounter Rate:

Divide column 4 by column 5 and enter the answer here. This is your computed encounter rate for each specialized service to include direct and allowable facility overhead costs.

FQHC-93-01 Worksheet 4--Encounter Rate Calculation--(xii)

COMPLETION INSTRUCTIONS:

Part III--Core Services:--The function of this Part of Worksheet 4 is to isolate the cost of direct core and other health service costs and to allocate overhead based on the ratio of these costs to total direct health care service costs. This amount is then divided by the total number of Core Service encounters to arrive at an average Per Encounter Rate for the facility.

Line 15:--The amount from Worksheet 4, Page 1-2, Part I, Item (A) is transferred to this line.

Line 16:--The total direct cost of specialized services is transferred to this line from Worksheet 4, page 1-2, Part II, line 14, column 1.

Line 17:--The non-reimbursable cost center's expenses, as found on Worksheet 1--Trial Balance of Expense, line 56, column 8, are transferred to this line.

Line 18:--Add amounts appearing on line 16 and line 17 and place resulting figure here.

Line 19:--Subtract line 18 from line 15 and enter remainder here.

Line 20:--Divide line 19 by line 15 to determine percentage of direct core and other health service cost to total health service cost.

Line 21:--Enter the allowable facility overhead from Worksheet 4, Page 1-2, Part I, Item (C).

Line 22:--To determine the amount of allowable facility overhead applicable to direct Core and other health services multiply line 20 by line 21. Enter the resultant here.

Line 23:--Enter the sum of line 19 plus line 22. This is the total direct and allocated core and other health services reimbursable cost.

Line 24:--Enter the total core service encounters from Worksheet 3, Page 1, line 7, column 5 on this line.

Line 25:--Divide line 23 by line 24 to obtain the average cost per encounter for core services.

FQHC-93-01 Worksheet 5--Final Settlement Determination--(xiii)

COMPLETION INSTRUCTIONS:

General:--This worksheet will determine the actual total reimbursable cost for all Medicaid and NJ KidCare-Plan A encounters for services rendered during the cost reporting period and the final settlement amount either due to or <from a facility.

All Services--Lines 1 through 13:

Column 2:--For each of the line items, enter the Medicaid-covered and NJ KidCare-Plan A encounters from Worksheet 2, Page 1-1, column 3, as appropriate. These amounts should agree with the facility's State-produced summary report for the same period as that of the cost report. The encounters produced in the State's summary report will represent the maximum encounters to be reimbursed.

Line 1:--Enter the figure from Worksheet 2, Page 1-1, line 7, column 3.

Lines 2-12:--Enter the figures from the appropriate line item on Worksheet 2, Page 1-1, column 3.

Column 3:--Enter the computed encounter rate for each applicable line item from Worksheet 4, Page 1-2, column 6, (Specialized Services) or Worksheet 4, Page 2-2, line 25, (Core Services).

Column 4:--To determine the Medicaid and NJ KidCare-Plan A reimbursable cost for each type of service, multiply the amounts found in column 2 by column 3. Enter the result here.

Line 13:--For columns 2 and 4, enter the sum of lines 1 through 12. Column 4, line 13, is the total paid Medicaid or NJ KidCare-Plan A encounters and costs for services provided by the facility for the period covered by the cost report.

Line 14: requires no entry

Line 15, Rate Periods--Identify the periods for which different limits apply during an FQHC's fiscal year.

Period 1:--Period 1 will be from the first day of the FQHC's fiscal year through the earlier of:

(1) The day prior to the first Medicaid/NJ KidCare-Plan A rate limitation change occurring during the FQHC's fiscal year.

or

(2) The end of the FQHC's fiscal year.

Period 2:--Period 2 will be the period from the date of the first Medicaid/NJ KidCare-Plan A rate limitation change occurring during the FQHC's fiscal year through the earlier of:

(1) The day prior to the second Medicaid/NJ KidCare-Plan A rate limitation change occurring during the FQHC's fiscal year.

or

(2) The end of the FQHC's fiscal year.

Period 3:--Period 3 will be the period from the date of the second Medicaid/NJ KidCare-Plan A rate limitation change occurring during the FQHC's fiscal year through the end of the FQHC's fiscal year.

Line 16, Medicaid Limit:--Enter the amount of the Medicaid/NJ KidCare-Plan A fee-for-service limit in place during each period entered on line 15. The Medicaid/NJ KidCare-Plan A limit is scheduled to be phased in over a 3 year period as follows:

July 1, 1996	120% of Medicare limit
July 1, 1997	115% of Medicare limit
July 1, 1998 and thereafter	110% of Medicare limit

The Medicare limit changes annually on January 1st. Therefore, the Medicare limit established on January 1, 1996 will be inflated by 20% to establish the initial Medicaid/NJ KidCare-Plan A limit effective July 1, 1996.

FQHC's with a fiscal year beginning prior to July 1, 1996 will report that portion of the fiscal year on the previous cost reporting document. All FQHC's will be required to complete the revised cost report for all or the remaining portion of the fiscal year beginning July 1, 1996.

A twenty percent per annum factor will be used by Medicaid/NJ KidCare-Plan A to determine the Medicaid/NJ KidCare-Plan A limit. The Medicaid/NJ KidCare-Plan A limit

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should not impact an FQHC's encounter rate more than twenty percent of the prior year's finalized encounter rate. (Finalized is defined as the issuance of a Notification of Final Settlement by the Division of Medical Assistance and Health Services, and acceptance by the FQHC.)

Line 17, Medicaid/NJ KidCare-Plan A Encounters Per Period:--Enter the Medicaid/NJ KidCare-Plan A encounters rendered during each period reported on line 15. The sum of all Medicaid/NJ KidCare-Plan A encounters entered on line 17 should equal the total Medicaid or NJ KidCare-Plan A encounters on line 13, column 2.

Line 18, Maximum Allowable Medicaid Costs--Line 18 is the product of line 16 multiplied by line 17.

Line 19, Reimbursable Costs--Line 19 determines reimbursable costs from the lower of line 13 or 18.

Line 20, Outstationed Eligibility Worker--Enter on line 20 the amounts charged during the cost reporting period for outstationed eligibility workers.

Line 21, Pneumococcal/Influenza Vaccine Services:--Transfer the number of Medicaid or NJ KidCare-Plan A injections from Worksheet 2, Page 1-1, Line 16, Column 3. Enter the rate from Worksheet 4, Page 1-2, Line 6, Column 6. In Column 4 multiply the rate by the Medicaid or NJ KidCare-Plan A injections to determine reimbursable pneumococcal/influenza costs.

Line 22: Total Reimbursable Costs--Medicaid--Enter the total of lines 19, 20 and 21.

Line 23, Less: Payments Received for Medicaid Services:--Enter the total amount of interim payments received by the facility for Medicaid and NJ KidCare-Plan A services it rendered during the period of the cost report. Please note that this figure is arrived at using the accrual method of accounting and not a cash or modified cash, etc., basis. This amount must agree to the summary report issued by the State for the respective period of the cost report. The figure should include all payments regardless of payment methodology including fee-for-service, capitation, and all payments received from managed care funds as well as per encounter interim payments.

Line 24, Net Due to or (From) Center:--Subtract line 23 from line 22 and enter the amount here. If line 24 is positive, the resulting figure is the amount owed to the facility based on the costs contained in the cost report. If the amount on line 24 is negative the resultant figure is the amount the facility has been overpaid during the period of the cost report for Medicaid or NJ KidCare-Plan A services rendered. This amount <negative should be placed in parenthesis. If the figure on line 24 reflects an overpayment, amounts will be recouped in accordance with N.J.A.C. 10:66-1.5(d)6ii.

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Line 25, Adjustment of Interim Payment Rate:--Enter the amount from line 24 divided by total Medicaid or NJ KidCare-Plan A encounters Line 13, Column 2. This amount must be further adjusted to reflect the phase-in of the Medicaid/NJ KidCare-Plan A limit.

FQHC-93-01 Worksheet 6--Physician Detail--(xiv)

Enter the required data for all physicians employed by the FQHC.

Column 1--Enter the date which the physician entered employment with the FQHC.

Column 2--If the physician's employment terminated during the cost report period, enter the date.

Column 3--Enter the physician's social security number.

Column 4--Enter the physician's Medicaid Provider Number.

Column 5--Enter the number of encounters performed by the physician. The total amounts reported must reconcile to the figure reported on Worksheet 2, Page 1-1, Line 1, Column 9.

Column 6--Enter the amount of gross salary paid to the physician. The total amounts reported must reconcile to the amount reported on Worksheet 1, Page 1-3, Line 2, Column 1.

Column 7--Enter the number of hours for which the physician was compensated. Employment contracts and time records must be maintained for audit purposes.

Column 8--Enter the number of physician hours for screening purposes. Each hour a physician is compensated represents 1 hour to be reported for productivity screening in column 8. The only adjustment allowed is for the medical director, for which reported hours are the greater of either:

1. 50% of compensated hours, or
2. Actual hours providing direct care.

The total hours reported in column 8 must reconcile to the hours reported on Worksheet 3, Page 1-1, Line 1, Column 1a.

FQHC-93-01 Worksheet 7--Clinical Nurse Practitioner/Certified Nurse Mid-Wife Detail--(xv)

Enter the required data for all Clinical Nurse Practitioners (CNP) and Certified Nurse Mid-Wives (CNM) employed by the FQHC.

Column 1--Enter the date which the CNP/CNM entered employment with the FQHC.

Column 2--If the CNP/CNM's employment terminated during the cost report period, enter the date.

Column 3--Enter the CNP/CNM's social security number.

Column 4--Enter the CNP/CNM's License and/or Qualification.

Column 5--Enter the number of encounters performed by the CNP/CNM. The total amounts reported must reconcile to the figure reported on Worksheet 2, Page 1-1, Lines 2 and 3, respectively, Column 9.

Column 6--Enter the amount of gross salary paid to the CNP/CNM. The total amounts reported must reconcile to the amounts reported on Worksheet 1, Page 1-3, Line 3 or 4, respectively, Column 1.

Column 7--Enter the number of hours for which the CNP/CNM was compensated. Employment contracts and time records must be maintained for audit purposes.

Column 8--Enter the number of CNP/CNM hours for screening purposes. Each hour a NP/NMW is compensated represents 1 hour to be reported for productivity screening in column 8. The total hours reported in column 8 must reconcile to the hours reported on Worksheet 3, Page 1-1, Line 2 or 3, respectively, Column 1a.

FQHC-93-01 Worksheet 8--Dentist/Dental Hygienist Detail--(xvi)

Enter the required data for all Dentists and Dental Hygienists employed by the FQHC.

Column 1--Enter the date which the Dentist/Dental Hygienist entered employment with FQHC.

Column 2--If the Dentist/Dental Hygienist employment terminated during the cost report period, enter the date.

Column 3--Enter the Dentist/Dental Hygienist social security number.

Column 4--Enter the Dentist/Dental Hygienist License and/or Qualification.

Column 5--Enter the number of encounters performed by the Dentist/Dental Hygienist. The total amounts reported must reconcile to the figure reported on Worksheet 2, Page 1-1, Lines 10 and 11, respectively, Column 9.

Column 6--Enter the amount of gross salary paid to the Dentist/Dental Hygienist. The total amounts reported must reconcile to the amounts reported on Worksheet 1, Page 1-3, Line 17 or 18, respectively, Column 1.

Column 7--Enter the number of hours for which the Dentist/Dental Hygienist was compensated. Employment contracts and time records must be maintained for audit purposes.

Column 8--Enter the number of Dentist/Dental Hygienist hours for screening purposes. Each hour a Dentist/Dental Hygienist is compensated represents 1 hour to be reported for productivity screening in column 8. The total hours reported in column 8 must reconcile to the hours reported on Worksheet 3, Page 1-1, Line 10 or 11, respectively, Column 1a.

APPENDIX B

FQHC Annual Cost Reporting Requirements

The following cost report instructions apply to FQHCs that were Medicaid providers on October 31, 2000, for their fiscal years ending on and after June 30, 2001.

In addition, these cost report instructions are for the third year and thereafter, for FQHCs that become Medicaid providers on and after November 1, 2000. The FQHC's first year as a Medicaid provider may represent less than a full year of operation, but is counted as a full year for cost reporting, and a cost report is due to the Division for this period, ending on December 31 of the initial year.

Federally qualified health centers (FQHCs) shall file the Medicare Cost Report (CMS 222-92 (3/93) and all updates), with the Division of Medical Assistance and Health Services (DMAHS). There are services covered by Medicaid that are not covered by Medicare. The cost information below should be included on the Medicare Cost Report that is submitted to Medicare and to the Division. This information will provide Medicaid with cost detail for the additional Medicaid covered services.

Add the following lines to the FQHC Medicare Cost Report, Worksheet A under the category of Facility Health Care Staff Costs:

Cost Center	Line Number
Obstetrics/Gynecology	11
Podiatrist	11.01
Cardiologist	11.02
Specialty Physician (Specify type)	11.03
Specialty Nurse Practitioner (Specify type)	11.04
Nurse Mid-Wife	11.05

Add the following lines added under the category of Costs Other than RHC/FQHC Services:

Cost Center	Line Number
Radiology	56
Outreach	56.01
Community Service	56.02
Patient Transportation	56.03

The above subscribed lines will provide additional detailed data on specific costs. The Medicare Cost Report with subscribed lines should be submitted both in hard copy format and on disk to the Division. In addition, FQHCs are required to submit encounter data on Worksheet 2 of the Medicaid Cost Report appearing in N.J.A.C. 10:66-4 Appendix C and the audited financial statements for the cost reporting period. These

items are due to the Division on an annual basis and no later than five months after the close of each FQHC's fiscal year.

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APPENDIX C

New FQHC Medicaid Cost Reports for First and Second Years of Operation

Cost Report--Instructions for FQHCs that become Medicaid providers on and after November 1, 2001. These cost report instructions are for the first and second calendar years that the FQHC is a Medicaid provider. The FQHC's first year as a Medicaid provider may represent less than a full year of operation, but is counted as a full year for cost reporting, and a cost report is due to the Division for this period, ending on December 31 of the initial year.

Following are the cost report forms and instructions for their proper completion:

FQHC-2001-07 (Certification)--(i) (ii)

COMPLETION INSTRUCTIONS

- | Field | Explanation |
|-------|--|
| 1. | Enter the Federally Qualified Health Center's name and mailing address. |
| 2. | Enter the Medicaid Provider Number assigned to the FQHC. |
| 3. | Enter the fiscal period of the FQHC being reported. |
| 4. | Circle the category of control most representative of the FQHC. |
| 5. | List each owner possessing an amount of ownership in the FQHC, regardless of the level. |
| 6. | All other Federally Qualified Health Centers, providers of service, or suppliers and other entities related to the center through common ownership or control must be listed here. The use of a subschedule is permitted as necessary. |
| 7. | All grants received by the FQHC shall be listed here. The name, number and source of the grant (for example, State of New Jersey Grant #XXXXX, Public Health Service Grant #XXXXX) duration of the grant and the total grant dollars under each grant are to be listed. If additional space is required attach a supporting subschedule listing. |

Certification statement:

Enter the full name of the FQHC and the reporting period covered by the report. Note: Enter the signature of the officer/owner of the FQHC and his or her title and date after the completion of the cost report.

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**FQHC-2001-07 (Reclassification and Adjustment of Trial Balance of Expenses)--
(Worksheet 1)--(iii)(iv)(v)**

COMPLETION INSTRUCTIONS:

Worksheet 1 is used to record the trial balance of expense accounts from the books and records of the center for the year being reported. This worksheet provides for any adjustments or reclassifications to the FQHC's cost centers that may be required.

The order of the cost centers is designed to flow to subsequent worksheets, where applicable, to aid in the cost report preparation. It is recognized that not all of the cost centers will apply to every FQHC. For example, not every facility will offer dental services. Where a cost center is listed that does not apply, leave that center blank.

Blank lines for use by the center are provided wherein a unique cost center or situation may exist. If these are used, the center must identify what specific cost (center/service) are included.

Columns 1 and 2--Compensation and Fringe Benefits:

The compensation and fringe benefit expenses recorded on the books of the center, for the period of the cost report, are to be entered on the appropriate cost center lines. These expenses come directly from the trial balance of the center without adjustment. Any needed reclassification or adjustment must be recorded in columns 5 and 7, as appropriate.

Columns 1 and 2, Line 23--Pneumococcal and Influenza Vaccine Services

The amounts for this line will be taken from the Medicare Cost Report, Supplemental Worksheet B-1. If a FQHC is not required to complete a Medicare Cost Report, Supplemental Worksheet B-1 must be completed as an attachment to the Medicaid cost report. Supplemental Worksheet B-1 is the mechanism for Medicaid and NJ FamilyCare reimbursement of pneumococcal and influenza vaccine services.

Column 1, Line 23, Compensation--Enter the amount of "Pneumococcal and Influenza Vaccine Health Care Staff Costs" From Line 3 of the Medicare Cost Report, Supplemental Worksheet B-1. These amounts are excluded from the totals calculations, as they are not subject to cost limitations.

Column 2, Line 23, Fringe Benefits

Leave Blank, the amounts from fringe benefits are included in Column 1.

Column 3 Other:

Enter the expenses of the various cost centers that are not compensation or fringe benefits. These expenses come directly from the trial balance of the center without

adjustment. Any needed reclassification or adjustment must be recorded in columns 5 and 7, as appropriate.

Column 3, Line 23, Other

Enter the amount of "Medical Supplies Cost--Pneumococcal and Influenza Vaccine" from line 4 of the Medicare Cost Report, Supplemental Worksheet B-1.

Column 4 Sub-Totals:

The sum of columns 1, 2 and 3, for each line is entered here.

Column 5 Expense Reclassifications:

Enter any reclassification among cost centers in column 4 which are necessary to effect proper cost recognition and allocation. Reclassifications are to be used when the expenses of a particular cost center are applicable to more than one of the cost centers listed on the worksheet, and are maintained in a single cost center on the books and records of the center. For example, where a physician performs certain administrative duties, the appropriate portion of his or her compensation and fringe would need to be reclassified from the "Physician" cost center to "Administrative Costs Staff--Administration" cost center. Thus, his or her administrative time (cost) would be properly recognized.

Worksheet 1, Page 2-3, Line 59 Medical Records

Enter costs associated with Medical Records in Columns 1, 2 and 3. In Column 5, reclassify any or all amounts to appropriate Core or Specialized Services categories. Appropriate schedules detailing the method of allocation must be maintained for audit purposes.

Worksheet 1, Page 3-3, Line 79 Insurance--Malpractice

Enter costs associated with Insurance--Malpractice in Columns 1, 2 and 3. In Column 5, reclassify any or all amounts to appropriate Core or Specialized Services categories. Appropriate schedules detailing the method of allocation must be maintained for audit purposes.

Introduction to Column 6:

All reclassifications shall be specifically identified via supporting schedules to the cost report as prepared by the center. The supporting schedules must provide an appropriate explanation to each of the affected cost centers. Any reduction of expense is to be shown in < angle brackets. The net total of the supporting schedule and column must equal zero. Worksheet 1, Support Schedule A is to be used for all reclassifications. See instructions for specifics of this schedule.

Column 6 Reclassified Trial Balance:

This column is the total of column 4, plus or minus column 5. The total of column 6, all pages, as found on Worksheet 1, line 108, Total Center Costs, must equal that of column 4, line 108, Total Center Costs.

Column 7 Adjustments (Decreases/Increases):

Enter the amount of any adjustment to the center's reclassified trial balance expenses. Adjustments are required to adjust (increase or <decrease) actual expenses in accordance with Medicaid and NJ FamilyCare rules on allowable cost. An example of a situation in which adjustment to expense would be required is where the clinic receives an allocation from a central (home) office, has a practitioner assigned by the National Health Service Corps, or the identification of pneumococcal vaccine administration costs.

All adjustments reflected in column 7 shall be detailed on a supporting schedule prepared by the clinic. The schedule shall provide an explanation or rationale for the adjustment, whether the adjustment basis is cost or amount received and the identification of any and all cost centers affected.

Worksheet 1, Support Schedule B is to be used to document and detail the adjustments contained in column 7. See instructions for specifics of this schedule.

Column 8 Adjusted Net Expenses:

This column is used to combine the reclassified trial balance amounts in column 6 with the adjustment amounts found in column 7 by individual cost center. The amounts resulting in column 8 will be used in later schedules in the determination of reimbursement of cost for services rendered to Medicaid and NJ FamilyCare beneficiaries.

FQHC-2001-07 Worksheet 1 Support Schedule A--Reclassifications--(vi)

COMPLETION INSTRUCTIONS:

This supporting schedule is designed to document any reclassification of cost performed on the Trial Balance of Expenses, column 4. A full explanation of the reclassification must accompany each reclassification. A letter code (A), (B), (C), etc., should be used to identify each reclassification shown. This will enable identification of reclassifications, should this be necessary. An example of a reclassification would be the identification of the administration and the pharmaceutical expenses for pneumococcal vaccine. Cost could be reclassified from pharmacy and the physician assistant cost centers to the pneumococcal vaccine services cost center.

For every cost amount reclassified, a specific cost center (columns 3 or 6) and line (columns 4 and 7) must be recorded. Increases are to be identified in columns 3, 4 and 5, with decreases shown in columns 6, 7 and 8. The totals of column 5 and column 8 must equal.

FQHC-2001-07 Worksheet 1 Support Schedule B--Adjustments to Expense Detail--(vii)
COMPLETION INSTRUCTIONS:

This supporting schedule is used to provide the necessary detail for all adjustments, either (decreases) or increases, affecting cost centers on Worksheet 1, Pages 1, 2 and 3.

A full explanation of the adjustment is to be entered in column 1. In column 2 an alpha identifier of either C (cost) or R (revenue) should be entered. This designates the amount of the adjustment as either a revenue (received) offset or an actual cost offset. An example of a revenue offset would be the revenues received from the operation of a vending machine in the center. The revenue received should be offset against the cost of providing the service. An actual expense offset would be made where the cost could actually be determined, such as when an adjustment to depreciation is necessary due to an independent audit firm finding.

The total of column 3 must agree to the total found on Worksheet 1, line 108, column 7.

FQHC-2001-07 Worksheet 2 ENCOUNTERS--(viii)
COMPLETION INSTRUCTIONS:

General:

Worksheet 2 is used by the center to summarize the total encounters actually occurring during the cost reporting period. The form is divided into two primary sections, that of core services, and that of other ambulatory services. Space has been provided in the other specialized service area for a service that may be unique to a center and not specifically identified.

It should be noted, that some services are specifically identified under the specialized services category, yet they would be provided by a physician, such as Norplant, and would be considered physician services. However, for purposes of reporting and to uniquely track these expenses for rate establishment, they are to be identified separately and the encounter associated with these services shown under their specific category. For Norplant services, line 15, the number of Norplant insertions/removals are to be recorded. The actual visit should not be included in the Physician Cost Center, line 1, column 2.

While care has been taken to account for the variety of services provided in a center and establish a corresponding service line, blank lines have been provided for reporting of additional special service centers and associated cost. Refer to N.J.A.C. 10:66-4.1(b) for the appropriate definition of a medical encounter.

Column 1, Medicaid Fee-for-Service--Enter in the appropriate service category the number of actual, valid Medicaid and NJ FamilyCare fee-for-service encounters. On line 16, enter the number of Medicaid and NJ FamilyCare fee-for-service pneumococcal and influenza vaccine injections.

Column 2, Medicaid Managed Care--Enter in the appropriate service category the number of actual, valid Medicaid and NJ FamilyCare Managed Care encounters for which cost-based reimbursement is allowable. On line 16, enter the number of allowable Medicaid and NJ FamilyCare Managed Care pneumococcal and influenza vaccine injections. If data is entered into this Column the FQHC is required to complete Worksheet 2, Support Schedule A.

Column 3, Medicaid Total Encounters--Total of Columns 1 and 2.

Column 4, Managed Care Encounters--Enter in the appropriate service category the number of encounters provided to managed care beneficiaries who are not eligible for cost-based reimbursement. Include in these numbers any managed care encounters provided to Medicaid and NJ FamilyCare beneficiaries which are not allowable for cost-based reimbursement in Column 2. On line 16, enter the number of pneumococcal and influenza vaccine injections.

Column 5, New Jersey Department of Health and Senior Services--Enter in the appropriate service category the number of encounters provided under letter of agreement with the New Jersey Department of Health and Senior Services. This amount must include the base level visits assigned by the New Jersey Department of Health and Senior Services. On line 16, enter the number of pneumococcal and influenza vaccine injections provided under agreement with the New Jersey Department of Health and Senior Services.

Column 6, Medicare--Enter in the appropriate service category the number of Medicare encounters. On line 16, enter the number of Medicare pneumococcal and influenza vaccine injections.

Column 7, Self-Pay--Enter in the appropriate service category the number of encounters provided to individuals who are either personally liable or have private insurance. On line 16, enter the number of Self-Pay pneumococcal and influenza vaccine injections.

Column 8, Other--Enter in the appropriate service category the number of encounters which have not been previously reported. On line 16, enter the number of Other pneumococcal and influenza vaccine injections.

Line 7 All Columns:--Enter the sum of lines 1 through 6, Core Services--all columns.

Line 26 All Columns:--Enter the sum of lines 10 through 25 for each column as appropriate.

Line 28 All Columns:--Enter the sum of lines 7 and 26. Cross foot all columns to column 7.

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FQHC-2001-07 Worksheet 2 Support Schedule A--Medicaid Managed Care Encounter Detail--(ix)

COMPLETION INSTRUCTIONS:

Column Headings (1-9)--Enter the name of each Managed Care Company with which the FQHC contracts. If the FQHC is under contract with more than nine Medicaid and NJ FamilyCare HMOs, additional pages/columns must be included. Enter in the appropriate service category the number of actual, valid Medicaid and NJ FamilyCare Managed Care encounters provided for each Managed Care Company. On Line 16, enter the number of Medicaid and NJ FamilyCare Managed Care pneumococcal and influenza vaccine injections.

FQHC 2001-07--Worksheet 2--Support Schedule B-Medicaid Managed Care Receipts Detail-(x)

COMPLETION INSTRUCTIONS;

Line 1--Enter the name of each Managed Care Company with which the FQHC contracts in Columns A through K. If the FQHC is under contract with more than ten Medicaid and NJ FamilyCare HMOs, additional pages/columns must be included.

Line 2 Enter the effective date of the contract with each managed care company entered on line 1.

Lines 3 through 9--Enter the receipts received to date for the services provided to Medicaid and NJ FamilyCare beneficiaries for the period covered by the cost report.

Line 10--Enter the total of the amounts entered in lines 3 through 9.

Line 11--Enter the total of the amounts entered in line 10, columns F and L.

FQHC-2001-07 Worksheet 3--PRODUCTIVITY SCREENING--(xi)

COMPLETION INSTRUCTIONS:

This Worksheet is used to determine if the productivity screens of the various core and other services are being met. It develops the various encounters that will be used in the determination of an encounter rate for each core and specialized service. Additionally, it reflects the numbers of staff assigned to each of the areas. Completion of Worksheet 3 requires completion of Worksheets 6, 7 and 8.

Columns 1 and 1a--Number of FTEs and Total Hours--Staffing is to be reported by FTEs and hours worked. FTEs should be reported using the method prescribed by Medicare for the Medicare FQHC Cost Report (CMS-222-92) Worksheet B, Part 1. For FQHCs that file a Medicare Cost Report with Medicare, FTEs should match the FTEs reported on the Medicare FQHC Cost Report (CMS-222-92), Worksheet B, Part 1 for Physicians, Nurse Practitioners, Clinical Psychologists and Clinical Social Workers.

Column 2--Total Encounters--The total number of encounters reported in Column 2 should be taken from the corresponding line in Worksheet 2, Column 9.

For Pneumococcal/Influenza Vaccine Services, line 16, the number of injections given are to be shown in this column.

Column 4--Minimum Encounters:--The result of multiplying column 1 by column 3 for all service lines is to be entered here. The resultant is the minimum encounter requirement for the appropriate center (Productivity Screen).

Column 5:--Enter here the greater of column 2 or column 4 for all services. This will reflect the productivity standard application where applicable and the resultant will be used for development of the actual per encounter rate on subsequent worksheets.

FQHC-2001-07--Worksheet 4 Encounter Rate Calculation--(xii)

COMPLETION INSTRUCTIONS:

General:--This worksheet is used to determine the per visit encounter rate by specific service category that is to be used in the Medicaid and NJ FamilyCare reconciliation process on Worksheet 5.

Part I:--Item (A) total actual facility direct health service cost is calculated from taking Worksheet 1, line 36 column 8 plus the sum of Worksheet 1, lines 52 and 56, column 8.

Part I: Item (B) Allowable Administrative costs. Item (B) is reported as the LOWER of:
Worksheet 1, Line 71, Column 8 plus Worksheet 1,
Line 89, Column 8

or

30 percent of Total Center Costs from Worksheet 1,
Line 108, Column 8

Part I: Item (C) Allowable Facility Overhead Cost is calculated from adding Item (B) Allowable Administrative Costs, PLUS, Worksheet 1, Line 103, Column 8.

Part II--Specialized Services

Column 1 Direct Cost:

Transfer to the appropriate line the total cost of each specialized service area as found on Worksheet 1, Page 1, column 8. Note: The total expense of the dentist/dental hygienist is the sum of worksheet 1, lines 17 and 18 column 8.

Column 2 Ratio of Special Service Center to Total Direct Health Services:

Enter here the resultant of column 1 of this section divided by the total facility direct health service cost (Worksheet 4, Part I, Item (A)). The percentage derived will be the

percentage of each of the special service centers direct cost to total cost. Remember to carry all decimal figures to five places.

Column 3--Facility Overhead Applicable to the Special Service Center:

Enter here the percentage shown in column 2 of this section multiplied by Worksheet 4, Page 1-2, Part I, Item (C). The amount derived is the percentage of allowable facility overhead attributed to the individual special service cost center.

Column 4--Total Cost of Special Service Cost:

Enter the sum of column 1 and 3 of this section for each special service cost center. This amount reflects the total calculated cost for each of the special service cost centers.

Column 5--Productivity Screening Encounters

Enter the productivity screening encounters from Worksheet 3, Page 1, column 5 for each special service cost center. Amount shown as Total should agree to Worksheet 3, Page 1-1, column 5, line 26. (Note: The visits for Norplant are the actual Norplant Implant Procedures done and the Pneumococcal/Influenza Vaccine line will reflect the actual number of injections given as shown on Worksheet 3, Page 1-1, lines 15 and 16, respectively, column 2. Dental/Dental Hygienist encounters are the sum of Worksheet 3, line 10 and line 11, column 5.)

Column 6--Computed Encounter Rate:

Divide column 4 by column 5 and enter the answer here. This is your computed encounter rate for each specialized service to include direct and allowable facility overhead costs.

FQHC-2001-07--Worksheet 4 Encounter Rate Calculation--(xiii)

COMPLETION INSTRUCTIONS:

Part III--Core Services:--The function of this Part of Worksheet 4 is to isolate the cost of direct core and other health service costs and to allocate overhead based on the ratio of these costs to total direct health care service costs. This amount is then divided by the total number of Core Service encounters to arrive at an average Per Encounter Rate for the facility.

Line 15:--The amount from Worksheet 4, Page 1-2, Part I, Item (A) is transferred to this line.

Line 16:--The total direct cost of specialized services is transferred to this line from Worksheet 4, page 1-2, Part II, line 14, column 1.

Line 17:--The non-reimbursable cost center's expenses, as found on Worksheet 1 Trial Balance of Expense, line 56, column 8, are transferred to this line.

Line 18.--Add amounts appearing on line 16 and line 17 and place resulting figure here.

Line 19:--Subtract line 18 from line 15 and enter remainder here.

Line 20:--Divide line 19 by line 15 to determine percentage of direct core and other health service cost to total health service cost.

Line 21:--Enter the allowable facility overhead from Worksheet 4, Page 1-2, Part I, Item (C).

Line 22:--To determine the amount of allowable facility overhead applicable to direct Core and other health services multiply line 20 by line 21. Enter the resultant here.

Line 23:--Enter the sum of line 19 plus line 22. This is the total direct and allocated core and other health services reimbursable cost.

Line 24:--Enter the total core service encounters from Worksheet 3, Page 1, line 7, column 5 on this line.

Line 25:--Divide line 23 by line 24 to obtain the average cost per encounter for core services.

FQHC-2001-07--Worksheet 5 Final Settlement Determination--(xiv)

COMPLETION INSTRUCTIONS:

General:--This worksheet will determine the actual total reimbursable cost for all Medicaid and NJ FamilyCare encounters for services rendered during the cost reporting period and the final settlement amount either due to or from a facility.

All Services--Lines 1 through 13:

Column 2:--For each of the line items, enter the Medicaid-covered and NJ FamilyCare encounters from Worksheet 2, Page 1-1, column 3, as appropriate. These amounts should agree with the facility's State-produced summary report for the same period as that of the cost report. The encounters produced in the State's summary report will represent the maximum encounters to be reimbursed.

Line 1:--Enter the figure from Worksheet 2, Page 1-1, line 7, column 3.

Lines 2-12:--Enter the figures from the appropriate line item on Worksheet 2, Page 1-1, column 3.

Column 3:--Enter the computed encounter rate for each applicable line item from

Worksheet 4, Page 1-2, column 6, (Specialized Services) or Worksheet 4, Page 2-2, line 25, (Core Services).

Column 4:--To determine the Medicaid and NJ FamilyCare reimbursable cost for each type of service, multiply the amounts found in column 2 by column 3. Enter the result here.

Line 13:--For columns 2 and 4, enter the sum of lines 1 through 12. Column 4, line 13, is the total paid Medicaid or NJ FamilyCare encounters and costs for services provided by the facility for the period covered by the cost report.

Line 14: requires no entry

Line 15, Rate Periods--Identify the periods for which different limits apply during an FQHC's fiscal year.

Period 1:--Period 1 will be from the first day of the FQHC's fiscal year through the earlier of:

(1) The day prior to the first Medicaid/NJ FamilyCare rate limitation change occurring during the FQHC's fiscal year.

or

(2) The end of the FQHC's fiscal year.

Period 2:--Period 2 will be the period from the date of the first Medicaid/NJ FamilyCare rate limitation change occurring during the FQHC's fiscal year through the earlier of:

(1) The day prior to the second Medicaid/NJ FamilyCare rate limitation change occurring during the FQHC's fiscal year.

or

(2) The end of the FQHC's fiscal year.

Period 3:--Period 3 will be the period from the date of the second Medicaid/NJ FamilyCare rate limitation change occurring during the FQHC's fiscal year through the end of the FQHC's fiscal year.

Line 16, Medicaid Limit:--Enter the amount of the Medicaid/NJ FamilyCare fee-for-service limit in place during each period entered on line 15. The Medicaid/NJ FamilyCare limit is scheduled to be phased in over a three-year period as follows:

July 1, 1996	120 percent of Medicare limit
July 1, 1997	115 percent of Medicare limit
July 1, 1998 and thereafter	110 percent of Medicare limit

The Medicare limit changes annually on January 1st. Therefore, the Medicare limit established on January 1, 1996 will be inflated by 20 percent to establish the initial Medicaid/NJ FamilyCare limit effective July 1, 1996.

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FQHCs with a fiscal year beginning prior to July 1, 1996 will report that portion of the fiscal year on the previous cost reporting document. All FQHCs will be required to complete the revised cost report for all or the remaining portion of the fiscal year beginning July 1, 1996.

A 20 percent per annum factor will be used by Medicaid/NJ FamilyCare to determine the Medicaid/NJ FamilyCare limit. The Medicaid/NJ FamilyCare limit should not impact an FQHC's encounter rate more than 20 percent of the prior year's finalized encounter rate. (Finalized is defined as the issuance of a Notification of Final Settlement by the Division of Medical Assistance and Health Services, and acceptance by the FQHC.)

Line 17, Medicaid/NJ FamilyCare Encounters Per Period--Enter the Medicaid/NJ FamilyCare encounters rendered during each period reported on line 15. The sum of all Medicaid/NJ FamilyCare encounters entered on line 17 should equal the total Medicaid or NJ FamilyCare encounters on line 13, column 2.

Line 18, Maximum Allowable Medicaid Costs--Line 18 is the product of line 16 multiplied by line 17.

Line 19, Reimbursable Costs--Line 19 determines reimbursable costs from the lower of line 13 or 18.

Line 20, Outstationed Eligibility Worker--Enter on line 20 the amounts charged during the cost reporting period for outstationed eligibility workers.

Line 21, Pneumococcal/Influenza Vaccine Services--Transfer the number of Medicaid or NJ FamilyCare injections from Worksheet 2, Page 1-1, Line 16, Column 3. Enter the rate from Worksheet 4, Page 1-2, Line 6, Column 6. In Column 4 multiply the rate by the Medicaid or NJ FamilyCare injections to determine reimbursable pneumococcal/influenza costs.

Line 22: Total Reimbursable Costs--Medicaid--Enter the total of lines 19, 20 and 21.

Line 23, Less: Payments Received for Medicaid Services--Enter the total amount of interim payments received by the facility for Medicaid and NJ FamilyCare services it rendered during the period of the cost report. Please note that this figure is arrived at using the accrual method of accounting and not a cash or modified cash, etc., basis. This amount must agree to the summary report issued by the State for the respective period of the cost report. The figure should include all payments regardless of payment methodology including fee-for-service, capitation, and all payments received from managed care funds as well as per encounter interim payments.

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Line 24, Net Due to or (From) Center:--Subtract line 23 from line 22 and enter the amount here. If line 24 is positive, the resulting figure is the amount owed to the facility based on the costs contained in the cost report. If the amount on line 24 is negative the resultant figure is the amount the facility has been overpaid during the period of the cost report for Medicaid or NJ FamilyCare services rendered. This amount <negative should be placed in angle brackets. If the figure on line 24 reflects an overpayment, amounts will be recouped in accordance with N.J.A.C. 10:66-1.5(d)6ii.

Line 25, Adjustment of Interim Payment Rate:--Enter the amount from line 24 divided by total Medicaid or NJ FamilyCare encounters Line 13, Column 2. This amount must be further adjusted to reflect the phase-in of the Medicaid/NJ FamilyCare limit.

FQHC-2001-07--Worksheet 6 Physician Detail--(xv)

Enter the required data for all physicians employed by the FQHC.

Column 1--Enter the date which the physician entered employment with the FQHC.

Column 2--If the physician's employment terminated during the cost report period, enter the date.

Column 3--Enter the physician's Social Security Number.

Column 4--Enter the physician's Medicaid Provider Number.

Column 5--Enter the number of encounters performed by the physician. The total amounts reported must reconcile to the figure reported on Worksheet 2, Page 1-1, Line 1, Column 9.

Column 6--Enter the amount of gross salary paid to the physician. The total amounts reported must reconcile to the amount reported on Worksheet 1, Page 1-3, Line 2, Column 1.

Column 7--Enter the number of hours for which the physician was compensated. Employment contracts and time records must be maintained for audit purposes.

Column 8--Enter the number of physician hours for screening purposes. Each hour a physician is compensated represents one hour to be reported for productivity screening in column 8. The only adjustment allowed is for the medical director, for which reported hours are the greater of either:

- 1.--Fifty percent of compensated hours, or
- 2.--Actual hours providing direct care.

The total hours reported in column 8 must reconcile to the hours reported on Worksheet 3, Page 1-1, Line 1, Column 1a.

FQHC-2001-07--Worksheet 7 Clinical Nurse Practitioner/Certified Nurse Mid-Wife Detail--(xvi)

Enter the required data for all Clinical Nurse Practitioners (CNP) and Certified Nurse Mid-Wives (CNM) employed by the FQHC.

Column 1--Enter the date which the CNP/CNM entered employment with the FQHC.

Column 2--If the CNP/CNM's employment terminated during the cost report period, enter the date.

Column 3--Enter the CNP/CNM's social security number.

Column 4--Enter the CNP/CNM's License and/or Qualification.

Column 5--Enter the number of encounters performed by the CNP/CNM. The total amounts reported must reconcile to the figure reported on Worksheet 2, Page 1-1, Lines 2 and 3, respectively, Column 9.

Column 6--Enter the amount of gross salary paid to the CNP/CNM. The total amounts reported must reconcile to the amounts reported on Worksheet 1, Page 1-3, Line 3 or 4, respectively, Column 1.

Column 7--Enter the number of hours for which the CNP/CNM was compensated. Employment contracts and time records must be maintained for audit purposes.

Column 8--Enter the number of CNP/CNM hours for screening purposes. Each hour a NP/NMW is compensated represents one hour to be reported for productivity screening in column 8. The total hours reported in column 8 must reconcile to the hours reported on Worksheet 3, Page 1-1, Line 2 or 3, respectively, Column 1a.

FQHC-2001-07--Worksheet 8 Dentist/Dental Hygienist Detail--(xvii)

Enter the required data for all Dentists and Dental Hygienists employed by the FQHC.

Column 1--Enter the date which the Dentist/Dental Hygienist entered employment with FQHC.

Column 2--If the Dentist/Dental Hygienist employment terminated during the cost report period, enter the date.

Column 3--Enter the Dentist/Dental Hygienist social security number.

Column 4 Enter the Dentist/Dental Hygienist License and/or Qualification.

Column 5 Enter the number of encounters performed by the Dentist/Dental Hygienist. The total amounts reported must reconcile to the figure reported on Worksheet 2, Page 1-1, Lines 10 and 11, respectively, Column 9.

Column 6--Enter the amount of gross salary paid to the Dentist/Dental Hygienist. The total amounts reported must reconcile to the amounts reported on Worksheet 1, Page 1-3, Line 17 or 18, respectively, Column 1.

Column 7--Enter the number of hours for which the Dentist/Dental Hygienist was compensated. Employment contracts and time records must be maintained for audit purposes.

Column 8--Enter the number of Dentist/Dental Hygienist hours for screening purposes. Each hour a Dentist/Dental Hygienist is compensated represents one hour to be reported for productivity screening in column 8. The total hours reported in column 8 must reconcile to the hours reported on Worksheet 3, Page 1-1, Line 10 or 11, respectively, Column 1a.

APPENDIX D

Change In Scope Of Service Application Requirements

The following items must be completed for each change in scope of service incurred by a Federally qualified health center (FQHC). Items below, labeled as A, B, and C, must be submitted in narrative format to the Division of Medical Assistance and Health Services (DMAHS).

The item labeled D is the instructions for the Change in Scope of Service Certification Statement and Reporting Forms 1 through 5. THE INITIAL SUBMISSION MUST INCLUDE SEPARATE FORMS FOR EACH YEAR OF THE PHASE-IN PERIOD IN WHICH THE CHANGE IN SCOPE OF SERVICE OCCURS. Within five months of the completion of each phase-in year, complete the same forms with actual data and send hard copy with disk to DMAHS.

DMAHS reserves the right to request additional information as needed.

A. DESCRIPTION OF THE SERVICE AREA AND TARGET POPULATION

1. List address(es) where the change in scope of service will occur.
2. Describe the service area(s)/community(ies) to be served by the new program.
3. Describe the target population(s) within the service area. Attach a copy of the target population submitted to HRSA (Form 3) and explain in detail any differences.
4. Describe how many people will be served and the number of projected encounters for each location for each year during phase-in, up to and including the year in which the new program will be fully implemented.
5. Attach a copy of the Notice of Grant Award or the approval letter from the Health Resources and Services Administration (HRSA) or state that it is not reviewable by HRSA.

B. SERVICE DELIVERY MODEL

1. Provide an overview of the service delivery model of the new program or services.
2. Describe whether and/or how the project expands upon or replaces pre-existing services.

C. BUDGET NARRATIVE

1. Discuss the appropriateness and reasonableness of the annualized budgets for each year during the phase-in period in terms of:
 - (a) Staffing: Describe how health care services will be provided--via staff providers, contract and/or through referral. Describe clinical staffing pattern (for example, number and mix of primary care physicians and other providers and clinical support staff, language and cultural appropriateness, etc.) of the new program or service. Have the clinical and other staff members for the new program or service been hired and if not, when will they start working? What is the plan for phasing in the staff?

(b) The total financial resources required to achieve the goals and objectives (that is, to achieve the applicant's proposed service delivery plan) of the new program or service. Supply all budget documents submitted to HRSA and any budget estimates that were prepared subsequent to the HRSA submission. Explain in detail the differences between HRSA and Medicaid submissions. If the change in scope of service is not reviewable by HRSA, include a statement to that effect.

(c) The number of proposed unduplicated patients and encounters at full operational capacity (Change of Scope Form 2, Annualized Encounters).

(d) One-time minor capital needs.

D. MEDICAID CHANGE IN SCOPE OF SERVICE REPORTING FORMS

The Medicaid Change in Scope of Service Reporting Forms must be completed whenever a change in scope of service (as defined in the Medicaid regulations) occurs. The initial submission must include separate forms for each year of the phase-in period in which the change in scope of service occurs. Please remember that all information reported on forms 1 through 5 are projected numbers, except when reporting actual information.

Instructions for Form Completion

Change in Scope of Service Certification Statement

Enter the FQHC name and FQHC provider number(s) of the site(s) affected by the change in scope of service.

Enter the reporting period of the data included in the application.

Circle the appropriate change in scope phase-in year.

Enter the name of the person who prepared the change in scope of service application.

Enter the signature of the officer of the FQHC and his or her title and date after the completion of the change in scope of service application.

Circle interim if based on projected data and circle actual if the phase-in year is complete.

Change in Scope of Service--Form 1, Annualized Budget

This form is used to record the annual costs related to the change in scope of service. The form should be used for each year from the beginning of the change in scope of service until the change in scope of service is fully phased in. Expense information must include further detail, as described below. In addition, if there are budget items for which

costs are shared with other programs, the basis for allocation of costs between programs must be explained.

Enter the FQHC Name and FQHC provider number(s) of the site(s) affected by the change in scope of service. If the budget is based on projected data, circle interim budget and if the budget is based on actual data following the completion of a phase-in year, circle actual budget.

Enter the reporting period of the data included in the application.

Circle the appropriate change in scope phase-in year.

Line A--Personnel: Enter the total personnel costs for all new staff to be employed as a result of the change in scope of service. Include any increase in costs for existing staff that will be employed in the change in scope of service.

Line B--Fringe Benefits: Itemize the components that comprise the fringe benefit rate (for example, Health insurance, FICA, SUTA, life insurance, retirement plan). For any increase over the prior year rate, provide an explanation.

Line C--Equipment: Only major (with cost over \$ 5,000 per unit) equipment items need to be itemized. Items costing less than \$ 5,000 should be aggregated with a brief explanation.

Line D--Supplies: Categorize supplies according to type--medical, lab, pharmacy and office. Explain how the amounts were developed (for example, medical supplies were based on 20,000 encounters at \$ 2.00 per encounter to arrive at the \$ 40,000 appearing in the budget).

Line E--Travel: Itemize travel costs according to traveler type (Executive Director, Project Director, Board, provider for continuing medical education (CME), etc.) and explain how the amounts were developed. It is not necessary to itemize each trip or the costs associated with each trip. (Example: Physician CME 12 trips at \$ 1,200 each)

Line F--Contractual: Categorize substantive programmatic or administrative contract costs according to type (for example, medical referral, lab referral, management consultant) under two headings--Patient care and non-patient care by costs.

Line G--Alteration and Renovation (A & R): Describe all A & R in progress.

Line H--Other: Itemize all costs in this category and explain in sufficient detail. Add additional lines, if necessary. In most cases, consultant costs for technical assistance, legal fees, rent, utilities, insurance, dues, subscriptions, and audit related costs would fall under this category.

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Line I--Total: Sum the costs from lines A through H.

Change in Scope of Service--Form 2, Annualized Encounters

This form is used to record the annual encounters related to the change in scope of service. The form should be used for each year from the beginning of the change in scope of service until the change in scope of service is fully phased in.

Enter the FQHC name and FQHC provider number(s) of the site(s) affected by the change in scope of service.

Enter the reporting period of the data included in the application.

Circle the appropriate change in scope phase-in year.

Circle interim if based on projected data and circle actual if the phase-in year is complete.

Lines 1-21 Number of Medicaid Encounters: For the reporting period, enter the number of Medicaid encounters in column 2 relating to the category listed in column 1 on each line.

Lines 1-21 Total Encounters: For the reporting period, enter the total encounters in column 3 relating to the category listed in column 1 on each line (include Medicaid encounters in the total reported in column 3).

Line 22 Total Encounters: Sum the encounters from lines 1 through 21 in column 2 and column 3.

Line 23 Number of Unduplicated Patients by Year: Enter the number of unduplicated Medicaid patients served during the reporting period in column 2. Enter the total number of unduplicated Medicaid patients served during the reporting period in column 3.

Change in Scope of Service--Form 3, Annualized Visits

This form is used to record the number of visits related to the change in scope of service. The form should be used for each year from the beginning of the change in scope of service until the change in scope of service is fully phased in. (The data in this form is a copy of the data in form 3 of the BPHC Policy Information Notice 2001-18.)

Enter the FQHC name and FQHC provider number(s) of the site(s) affected by the change in scope of service.

Enter the reporting period of the data included in the application.

Circle the appropriate change in scope phase-in year.

Circle interim if based on projected data and circle actual if the phase-in year is complete.

Lines 1-13 Visits: Enter the number of visits relating to the payor category listed on each line.

Line 14 Grand Total: Sum the visits entered on lines 4, 7, 8, 9, 10, 11, 12 and 13.

Change in Scope of Service--Forms 4 A and 4 B, Personnel Costs

These forms are used to record all new or existing staff costs associated with the change in scope of service. These forms should be used for each year from the beginning of the change in scope of service until the change of scope is fully phased in.

Enter the FQHC name and FQHC provider number(s) of the site(s) affected by the change in scope of service.

Enter the reporting period of the data included in the application.

Circle the appropriate change in scope phase-in year.

Circle interim if based on projected data and circle actual if the phase-in year is complete.

Lines 1-68, Compensation, Fringe Benefits and Other

Column 1--Enter compensation expenses for the change in scope of service corresponding to the appropriate cost center lines.

Column 2--Enter Fringe Benefit expenses for the change in scope of service corresponding to the appropriate cost center lines.

Column 3--Enter any personnel expenses of various cost centers that are not compensation or fringe benefits, that are related to the change in scope of service.

Column 4--The sum of columns 1, 2 and 3 for each line is entered here.

Line 15, Total--Sum lines 2 through 14.

Line 30, Total--Sum lines 17 through 22 plus lines 24 through 29.

Line 35, Total--Sum lines 31 through 34.

Line 36, Page Totals--Sum lines 15, 30 and 35.

Line 52, Total--Sum lines 38 through 51.

Line 67, Total Administrative Costs--Sum lines 54 through 66.

Line 68, Page Totals--Sum lines 52 and 67.

Change in Scope of Service--Form 4 C, Physician Detail

This form is to record Physician data associated with the change in scope of service.

Enter the FQHC name and FQHC provider number(s) of the site(s) affected by the change in scope of service.

Enter the reporting period of the data included in the application.

Circle the appropriate change in scope phase-in year.

Circle interim if based on projected data and circle actual if the phase-in year is complete.

Column 1--Enter the date which the physician entered employment with the FQHC.

Column 2--If the physician's employment terminated during the change in scope period, enter the date.

Column 3--Enter the physician's Medicaid Provider Number.

Column 4--Enter the number of encounters performed by the physician corresponding to the change in scope of service.

Column 5--Enter the amount of gross compensation, including fringe benefits paid to the physician.

Column 6--Enter the number of hours for which the physician was compensated. Employment contracts and time records must be maintained for audit purposes.

Line 25, Total--Sum lines 1 through 24.

Change in Scope of Service--Form 4 D, Nursing Detail

This form is used to record Nurse Practitioner and Nurse Midwife data associated with the change in scope of service.

Enter the FQHC name and FQHC provider number(s) of the site(s) affected by the change in scope of service.

Enter the reporting period of the data included in the application.

Circle the appropriate change in scope phase-in year.

Circle interim if based on projected data and circle actual if the phase-in year is complete.

Column 1--Enter the date which the CNP/CNM entered employment with the FQHC.

Column 2--If the CNP/CNM'S employment terminated during the change in scope period, enter the date.

Column 3--Enter the CNP/CNM's License and/or Qualification.

Column 4--Enter the number of encounters performed by the CNP/CNM associated with the change in scope of service.

Column 5--Enter the amount of gross compensation, including fringe benefits, paid to the CNP/CNM.

Column 6--Enter the number of hours for which the CNP/CNM was compensated. Employment contracts and time records must be maintained for audit purposes.

Line 10, Total Nurse Practitioners--Sum lines 1 through 9.

Line 25, Total Nurse Mid-Wives--Sum lines 12 through 24.

Change in Scope of Service--Form 4 E, Dental Detail

This form is used to record Dental and Dental Hygienist data associated with the change in scope of service.

Enter the FQHC name and FQHC provider number(s) of the site(s) affected by the change in scope of service.

Enter the reporting period of the data included in the application.

Circle the appropriate change in scope phase-in year.

Circle interim if based on projected data and circle actual if the phase-in year is complete.

Column 1--Enter the date which the Dentist/Dental Hygienist entered employment with FQHC.

Column 2--If the Dentist/Dental Hygienist employment terminated during the change in scope period, enter the date.

Column 3--Enter the Dentist/Dental Hygienist License and/or Qualification.

Column 4--Enter the number of encounters performed by the Dentist/Dental Hygienist associated with the change in scope of service.

Column 5--Enter the amount of gross compensation, including fringe benefits, paid to the Dentist/Dental Hygienist.

Column 6--Enter the number of hours for which the Dentist/Dental Hygienist was compensated. Employment contracts and time records must be maintained for audit purposes.

Line 10, Total Dentists--Sum lines 1 through 9.

Line 25, Total Dental Hygienists--Sum lines 12 through 24.

Change in Scope of Service--Form 5 Current Services Provided

Form 5 is used to record the current services provided on-site or by referral, for the site where the change in scope of service will occur. A separate form must be completed for each site where the change in scope of service will occur.

APPENDIX E

Medicaid Managed Care Wraparound Reports

END OF SUBCHAPTER 4

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SUBCHAPTER 5. AMBULATORY SURGICAL CENTER (ASC)

10:66-5.1 Covered services

(a) Medicaid-covered and NJ FamilyCare fee-for-service covered procedures in an ambulatory surgical center (ASC) are those surgical and medical procedures which appear at 42 CFR 416.65(c), the Federal regulations governing ASC services. Surgical procedures performed in an ASC are separated into an eight-group classification system.

1. A request by an ASC to add additional surgical procedures not specifically included in one of the eight Medicare payment groups must be reviewed and evaluated by the Division of Medical Assistance and Health Services (New Jersey Medicaid and NJ FamilyCare fee-for-service programs).

i. If additional surgical procedures are approved, each procedure will be assigned to one of the existing eight Medicare payment groups.

(b) Medicaid-covered and NJ FamilyCare fee-for-service covered surgical procedures include, but are not limited to, those procedures that:

1. Are commonly performed in a hospital, but may be safely performed in an ASC;
 - i. Are not commonly or safely performed in a physician's office;
2. Require a dedicated operating room or suite, and require a postoperative recovery room or short-term (not overnight) convalescent room;
3. Do not generally exceed a total of 90 minutes operating time and four hours recovery or convalescent time; and
4. Are not emergent or life threatening in nature, for example:
 - i. Do not generally result in extensive blood loss;
 - ii. Do not require major or prolonged invasion of body cavities; or
 - iii. Do not directly involve major blood vessels.

10:66-5.2 Anesthesia services

(a) If a covered surgical procedure requires anesthesia, the anesthesia shall be:

1. Local or regional anesthesia; or
2. General anesthesia of 90 minutes or less duration.

10:66-5.3 Facility services

(a) Facility services include, but are not limited to:

1. Nursing services, services of technical personnel, and other related services;
2. The use by the patient of the ASC's facilities;
3. Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances and equipment commonly furnished in connection with a surgical procedure. Drugs and biologicals are limited to those which cannot be self administered;

4. Diagnostic or therapeutic items and services furnished by ASC staff in connection with a covered surgical procedure, for example, simple tests such as urinalysis, blood hemoglobin, or hematocrit, administered in conjunction with the surgical procedure;
5. Administrative, recordkeeping and housekeeping items and services;
6. Blood, blood plasma, platelets, etc.; and
7. Material for anesthesia.

(b) ASC facility services do not include medical or other health services for which payment could be made under other provisions of the Medicaid and NJ FamilyCare fee-for-service programs such as laboratory, x-ray, or diagnostic procedures (other than those directly related to performance of the surgical procedure). Examples of items or services that are not ASC facility services include:

1. Physicians' services;
2. The sale, lease, or rental of durable medical equipment to ASC patients for use in their homes;
3. Prosthetic devices (including artificial legs and arms);
4. Transportation services;
5. Leg, arm, back, and neck braces;
6. Artificial eyes; and
7. Services furnished by an independent clinical laboratory.

10:66-5.4 Medical records

(a) In addition to the requirements set forth at 42 CFR 416.47, medical records in an ASC shall include, but not be limited to:

1. Patient identification;
2. Significant medical history and results of physical examination;
3. Pre-operative diagnostic studies (entered before surgery), if performed;
4. Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body;
5. Any allergies and abnormal drug reactions;
6. Entries related to anesthesia administration;
7. Documentation of properly executed informed consent; and
8. Discharge diagnosis.

END OF SUBCHAPTER 5

SUBCHAPTER 6. CENTERS FOR MEDICARE & MEDICAID SERVICES HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:66-6.1 Introduction

(a) The New Jersey Medicaid and NJ FamilyCare fee-for-service programs utilize the Centers for Medicare & Medicaid Services (CMS)'s Healthcare Common Procedure Code System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedure Terminology (CPT) architecture, employing a five-position code and as many as two 2-position modifiers. Unlike the CPT numeric design, the CMS-assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three-level coding system.

1. Level I codes (narratives found in CPT): These codes are adapted from CPT for utilization primarily by physicians, podiatrists, optometrists, certified nurse-midwives, independent clinics and independent laboratories. CPT is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians. Copyright restrictions make it impossible to print excerpts from CPT procedure narratives for Level I codes. Thus, in order to determine those narratives it is necessary to refer to CPT, which is incorporated herein by reference, as amended and supplemented.

2. Level II codes (narratives found at N.J.A.C. 10:66-6.3): These codes are assigned by HCFA for physician and non-physician services which are not in CPT.

3. Level III codes (narratives found at N.J.A.C. 10:66-6.3): These codes are assigned by the Division to be used for those services not identified by CPT codes or HCFA-assigned codes. Level III codes identify services unique to New Jersey.

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

Column Title	Description
IND	(Indicator-Qualifier) lists alphabetic symbols used to refer the provider to information concerning the New Jersey Medicaid and NJ FamilyCare fee-for-service program's qualifications and requirements when a procedure or service code is used. An explanation of the indicators and qualifiers used in this column are located below and in paragraph 1, "Alphabetic and numeric symbols," as follows:

"L" preceding any procedure code indicates that the

complete narrative for the code is located at N.J.A.C. 10:66-6.3.

"N" preceding any procedure code means that qualifiers are applicable to that code. These qualifiers are listed by procedure code number at N.J.A.C. 10:66-6.4.

HCPCS CODE

HCPCS procedure code numbers.

MOD

Alphabetic and numeric symbols: Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances are identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid and NJ FamilyCare fee-for-service program's recognized modifier codes for independent clinic services are as follows:

Modifier Code

Description

22

Unusual services: When the service provided is greater than that usually required for the listed procedure, it may be identified by adding modifier "22" to the usual procedure number.

50

Bilateral procedures: Unless otherwise identified in the listings, bilateral procedures requiring a separate incision that are performed at the same operative session should be identified by the appropriate five-digit code describing the first procedure. The second (bilateral) procedure is identified by adding modifier "50" to the procedure number.

52

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

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NOTE: Providers billing for the injection only should use the modifier "52" (reduced service) with the appropriate HCPCS procedure code on the claim form when billing for any immunizations. The provider will be reimbursed \$ 2.50 for an injection. Do not use HCPCS procedure code 90799 when billing for immunizations with free vaccine.

N	Preceding any procedure code means that qualifiers are applicable to that code.
WF	Family planning: To identify procedures performed for the sole purpose of family planning, add the modifier "WF" to only those procedure codes so indicated at N.J.A.C. 10:66-6.2.
WM	Certified nurse-midwife: To identify procedures performed by a certified nurse-midwife, add the modifier "WM" to only those procedure codes so indicated at N.J.A.C. 10:66-6.2.
WY	Only applies to billing by an ambulatory surgical center: To identify the trimester (1st trimester) of an abortion procedure, add the modifier "WY" to the procedure code.
WZ	Only applies to billing by an ambulatory surgical center: To identify the trimester (2nd trimester) of an abortion procedure, add the modifier "WZ" to the procedure code.
YR	Routine foot care podiatry: To identify routine foot care provided by a podiatrist, add the modifier "YR" to only those procedure codes so indicated at N.J.A.C. 10:66-6.2(h).
ZI	Independent clinic: To identify certain mental health services provided by independent clinic providers, add the modifier "ZI" to only those procedure codes so indicated at N.J.A.C. 10:66-6.2(f) and 10:66-6.2(o).
DESCRIPTION	Code narrative: Narratives for Level I codes are found in CPT. Narratives for Level II and III codes are found at N.J.A.C. 10:66-6.3.

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FOLLOW-UP DAYS	Number of days for follow-up care.
MAXIMUM FEEALLOWANCE	New Jersey Medicaid and NJ FamilyCare fee-for-service programs maximum reimbursement allowance for specialist and non-specialist: If the symbols "B.R." (By Report) are listed instead of a dollar amount, it means that additional information will be required in order to properly evaluate the service. Attach a copy of the report to the claim form.

1. Alphabetic and numeric symbols under "IND" and "MOD": These symbols, when listed under the "IND" and "MOD" columns, are elements of the HCPCS coding system used as qualifiers or indicators ("IND" column) and as modifiers ("MOD" column). They assist the provider in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

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

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

(c) Listed below are both general and specific policies of the New Jersey Medicaid and NJ FamilyCare fee-for-service programs that pertain to HCPCS. Specific information concerning the responsibilities of an independent clinic provider when rendering Medicaid-covered and NJ FamilyCare fee-for-service-covered services and requesting reimbursement are located at N.J.A.C. 10:66-1 through 5, and 10:66 Appendix.

1. General requirements are as follows:

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

ii. The use of a procedure code will be interpreted by the New Jersey Medicaid and NJ FamilyCare fee-for-service programs as evidence that the provider personally furnished, as a minimum, the services for which it stands.

iii. When billing, the provider must enter onto the claim form a CPT/HCPCS procedure code as listed in CPT or in this subchapter (N.J.A.C. 10:66-6). If an appropriate code is not listed, place an "N/A" (not applicable) in the procedure code column and submit a narrative description of the service. If possible, insert a CPT code closest to the narrative description you have written.

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

v. The "MAXIMUM ALLOWANCE" as noted with these procedure codes, "S" for specialist and "NS" for non-specialist, represents the maximum payment for the given

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procedure. When submitting a claim, the clinic must always use its usual and customary fee.

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

(2) All references to time parameters shall mean the practitioner's personal time in reference to the service rendered unless it is otherwise indicated.

vi. Written records in substantiation of the use of a given procedure code must be available for review and/or inspection if requested by the New Jersey Medicaid or NJ FamilyCare fee-for-service program.

vii. All references to performance of any or all parts of a history or physical examination shall mean that for reimbursement purposes these services were personally performed by a physician, dentist, podiatrist, optometrist, certified nurse midwife, psychologist, and other program recognized mental health professionals in a mental health clinic, whichever is applicable. (Exception: Procedure Code W9820, EPSDT, permits the services of a pediatric advanced practice nurse under the direct supervision of a physician.)

2. Specific requirements concerning medicine are as follows:

i. To qualify as documentation that the service was rendered by the practitioner during an inpatient stay, the medical record must contain the practitioner's notes indicating that he or she personally:

(1) Reviewed the patient's medical history with the patient and/or his or her family, depending upon the medical situation;

(2) Performed an examination as appropriate;

(3) Confirmed or revised the diagnosis; and

(4) Visited and examined the patient on the days for which a claim for reimbursement is made.

ii. The practitioner's involvement must be clearly demonstrated in notes reflecting his or her personal involvement with the service rendered. This refers to those occasions when these notes are written into the medical record by interns, residents, other house staff members, or nurses. A counter-signature alone is not sufficient.

3. Specific requirements concerning surgery are as follows:

i. Certain of the listed procedures are commonly carried out as an integral part of a total service and, as such, do not warrant a separate charge. When such a procedure is carried out as a separate entity not immediately related to other services, the indicated value for "separate procedure" is applicable.

4. Specific requirements concerning radiology are as follows:

i. Values include usual contrast media, equipment and materials.

ii. Values include consultation and written report to the referring physician.

iii. S&I (Supervision and Interpretation) only for the procedure given. This code is used only when a procedure is performed by more than one physician. Values include consultation and written report.

iv. All films taken of an area which is to be subject to a contrast study will, for reimbursement purposes, be considered part of the contrast study unless stated otherwise.

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

10:66-6.2 HCPCS procedure code numbers and maximum fee allowance schedule

(a) Evaluation and management and other procedures

* An asterisk preceding any procedure code may also be performed in a drug treatment center.

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
				S	\$	NS	
*N	36415			1.80		1.80	
N	67221		90	283.00		241.00	
N	67225			23.00		20.00	
	90701			16.34		16.34	
	90701	52		2.50		2.50	
	90702			3.29		3.29	
	90702	52		2.50		2.50	
	90703			3.40		3.40	
	90703	52		2.50		2.50	
	90704			23.60		23.60	
	90704	52		2.50		2.50	
	90705			18.39		18.39	
	90705	52		2.50		2.50	
	90706			22.04		22.04	
	90706	52		2.50		2.50	
	90707			39.87		39.87	
	90707	52		2.50		2.50	
	90712			14.44		14.44	
	90712	52		2.50		2.50	
	90713			22.80		22.80	
	90713	52		2.50		2.50	
	90714			3.03		3.03	
	90714	52		2.50		2.50	
	90717			3.03		3.03	
	90717	52		2.50		2.50	
	90718			3.35		3.35	
	90718	52		2.50		2.50	
	90724			6.97		6.97	

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	90724	52	2.50	2.50
	90732		14.35	14.35
	90732	52	2.50	2.50
	90733		17.48	17.48
	90733	52	2.50	2.50
	90737		25.79	25.79
	90737	52	2.50	2.50
	90741		Prior authorization required	
	90742		Prior authorization required	
	90746		63.57	63.57
L	90746	52	2.50	2.50
N	90799		2.50	2.50
N	90801		37.00	26.00
	93000		16.00	16.00
N	99150		45.00	40.00
			Per Hour	Per Hour
N	99151		45.00	40.00
			Per Hour	Per Hour
	99173		5.00	5.00
N	*99201		16.00	14.00
N	*99202		16.00	14.00
N	*99203		22.00	17.00
N	*99204		22.00	17.00
N	*99205		22.00	17.00
N	*99211		16.00	14.00
N	99211	WM	NA	11.20
N	*99212		16.00	14.00
N	99212	WM	NA	11.20
N	*99213		16.00	14.00
N	99213	WM	NA	11.20
N	*99214		16.00	14.00
N	99214	WM	NA	11.20
N	*99215		16.00	14.00
N	99215	WM	NA	11.20
N	99241		44.00	NA
N	99242		44.00	NA
N	99243		44.00	NA
N	99244		62.00	NA
N	99245		62.00	NA
N	99251		44.00	NA
N	99252		44.00	NA
N	99253		44.00	NA
N	99254		62.00	NA
N	99255		62.00	NA

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	99261		16.00	14.00
	99262		16.00	14.00
	99263		16.00	14.00
N	99271		44.00	NA
N	99272		44.00	NA
N	99273		44.00	NA
N	99274		62.00	NA
N	99274	YY	50.00	NA
N	99274	ZZ	50.00	NA
N	99275		62.00	NA
N	99291		45.00	40.00
N	99292		22.50	20.00
	99382		22.00	17.00
	99383		22.00	17.00
	*99384		22.00	17.00
	*99385		22.00	17.00
	*99386		22.00	17.00
	*99387		22.00	17.00
	99391		16.00	14.00
	99392		22.00	17.00
	99393		22.00	17.00
	*99394		22.00	17.00
	*99395		22.00	17.00
	99396		22.00	17.00
	99397		22.00	17.00
	J2790		20.40	20.40
	J2790	22	72.07	72.07
	J3395		Average wholesale Price (AWP)	
L	W9050		27.00	NA
L	W9055		27.00	23.00
L	W9060	WT	23.00	18.00
L	W9061	WT	23.00	18.00
L	W9062	WT	23.00	18.00
L	W9063	WT	23.00	18.00
L	W9064	WT	23.00	18.00
L	W9065	WT	23.00	18.00
L	W9066	WT	23.00	18.00
L	W9067	WT	23.00	18.00
L	W9068	WT	23.00	18.00
L	W9096		17.46	17.46
L	W9096	52	2.50	2.50
L	W9096	22	32.79	32.79
L	W9096	2252	2.50	2.50
L	W9097		17.46	17.46

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L	W9097	52	2.50	2.50
L	W9098		32.79	32.79
L	W9098	52	2.50	2.50
L	W9333		27.88	27.88
L	W9333	52	2.50	2.50
L	W9334		27.88	27.88
L	W9334	52	2.50	2.50
L	W9335		62.09	62.09
L	W9335	52	2.50	2.50
L	W9338		30.27	30.27
L	W9338	52	2.50	2.50
	W9820		23.00	18.00

(b) Dental services (See N.J.A.C. 10:56-3).

(c) Family planning services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
				S	\$	NS	
N	11975	22	30		Direct package price plus		
				100.00		85.00	
N	11976		90	100.00		85.00	
N	11977	22	90		Direct package price plus		
				200.00		170.00	
	36416	WF		1.80		1.80	
N	55250		30	90.00		79.00	3
N	55450		30	42.00		37.00	3
	56820	WF		88.00		NA	
	56821	WF		113.00		NA	
	57420	WF		71.00		NA	
	57421	WF		93.00		NA	
N	57451		45	182.00		158.00	6
	58301			16.40		16.40	
	58301	WM		NA		16.40	
N	58600		45	211.00		184.00	6
N	58605		45	151.00		131.00	6
N	58982		45	182.00		158.00	6
N	58983		45	182.00		158.00	6
	88150			6.00		6.00	
	88151			6.00		6.00	
	88155			6.00		6.00	
N	99201	WF		45.00		45.00	
N	99201	WFWM		NA		31.50	
N	99202	WF		45.00		45.00	

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N	99202	WFWM	NA	31.50
N	99203	WF	45.00	45.00
N	99203	WFWM	NA	31.50
N	99204	WF	45.00	45.00
N	99204	WFWM	NA	31.50
N	99205	WF	45.00	45.00
N	99205	WFWM	NA	31.50
N	99211	WF	7.60	7.60
N	99211	WFWM	NA	5.35
N	99212	WF	7.60	7.60
N	99212	WFWM	NA	5.35
N	99213	WF	7.60	7.60
N	99213	WFWM	NA	5.35
N	99214	WF	23.00	23.00
N	99214	WFWM	NA	16.40
N	99215	WF	23.00	23.00
N	99215	WFWM	NA	16.40
N	99395	WF	45.00	45.00
N	99395	WFWM	NA	31.50
L	W0001	WF	188.00	188.00
L	W0001	WFWM	NA	177.00
L	W0002	WF	123.00	123.00
L	W0002	WFWM	NA	112.00
L	W0004	WF	204.00	204.00
L	W0004	WFWM	NA	188.00
L	W0008	WF	139.00	139.00
L	W0008	WFWM	NA	123.00

(d) Laboratory services (See N.J.A.C. 10:61-3).

(e) Minor surgery:

* An asterisk preceding any procedure code may also be performed by a podiatrist.

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
				S	\$	NS	
N	10040			18.00		16.00	
*	10060			13.00		11.00	
*	10061		30	48.00		42.00	
	10080			30.00		26.00	
*	10120			18.00		16.00	
*	10121		30	34.00		29.00	
*	10140			18.00		16.00	

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*	10160		13.00	11.00
*	11000		13.00	11.00
*	11001		6.00	5.00
*	11040		13.00	11.00
*	11041		13.00	11.00
*	11042		16.00	14.00
*	11043		16.00	14.00
*	11100	7	13.00	11.00
*	11400	15	18.00	16.00
*	11401	15	22.00	20.00
*	11402	15	27.00	24.00
*	11403	15	32.00	27.00
*	11404	15	32.00	27.00
*	11406	15	32.00	27.00
*	11420	15	18.00	16.00
*	11421	15	22.00	20.00
*	11422	15	27.00	24.00
*	11423	15	32.00	27.00
*	11424	15	32.00	27.00
*	11426	15	32.00	27.00
	11440	15	18.00	16.00
	11441	15	22.00	20.00
	11442	15	27.00	24.00
	11443	15	32.00	27.00
	11444	15	32.00	27.00
	11446	15	32.00	27.00
*	11600	90	37.00	32.00
*	11601	90	47.00	42.00
*	11602	90	61.00	53.00
*	11620	90	61.00	53.00
*	11621	90	90.00	79.00
*	11622	90	121.00	105.00
	11640	90	90.00	79.00
	11641	90	121.00	105.00
	11642	90	150.00	131.00
*	11700		13.00	11.00
*	11701		6.00	6.00
*	11710		13.00	11.00
*	11711		6.00	6.00
*	11730		10.00	10.00
*	11750	30	42.00	37.00
*	12001		18.00	16.00
*	12002		24.00	21.00
*	12004		30.00	26.00

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	12005		7	46.00	39.00
	12006		7	57.00	48.00
	12007		7	82.50	70.00
	12011			18.00	16.00
	12013			24.00	21.00
	12014		7	30.00	26.00
	12031		30	30.00	26.00
	12032		30	48.00	42.00
*	12041		30	30.00	26.00
*	12042		30	67.00	59.00
	12051		30	38.00	33.00
	12052		30	67.00	59.00
	13100		30	34.00	29.00
	13101		30	68.00	63.00
	13120		30	48.00	42.00
	13121		30	106.00	92.00
*	13131		30	67.00	59.00
*	13132		30	145.00	126.00
	13150		30	38.00	33.00
	13151		30	82.00	71.00
	13152		30	193.00	168.00
*	17000			16.00	14.00
*	17010			42.00	36.00
*	17100			18.00	15.00
*	17105			100.00	85.00
*	17110			16.00	14.00
*	17200			16.00	14.00
*	17304			100.00	85.00
L*	W1650			24.00	21.00
L*	W1650	22		37.00	32.00

(f) Mental health services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basis Units
				S	\$	NS	
N	90801	ZI		45.00		45.00	
N	90843	ZI		13.00		13.00	
N	90844	ZI		26.00		26.00	
N	90847	ZI		26.00		26.00	
N	90847	ZI22		32.00		32.00	
	90862	ZI		4.50		4.50	
	90870	ZI		32.00		26.00	
N	90887	ZI		13.00		13.00	

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LN	H5025	ZI		8.00	8.00	
L	Z0100			22.50	22.50	
L	Z0130			25.00	25.00	
L	Z0150			8.00	8.00	
L	Z0160			15.50	15.50	
L	Z0170				15.40	15.40

(g) Obstetrical services (maternity):

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
				S	\$	NS	
N	59400		60	468.00		403.00	4
N	59400	WM	60	NA		328.00	4
N	59410		60	320.00		272.00	4
N	59410	WM	60	NA		224.00	4
N	59420			16.00		14.00	
N	59420	WM		NA		11.20	
N	59420	22		22.00		17.00	
N	59420	WM22		NA		15.40	
N	59430		0	20.00		18.00	0
N	59430	WM	0	NA		14.00	0
	59510		45	598.00		516.00	7
	59515		45	450.00		385.00	7
	59525		45	362.00		308.00	8
	59812		45	105.00		91.00	3
L	Z0250	WM		NA		40.00	

(h) Podiatry services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
				S	\$	NS	
	29580			18.00		16.00	3
N	99211	YR		16.00		14.00	
N	99212	YR		16.00		14.00	
N	99213	YR		16.00		14.00	
N	99214	YR		16.00		14.00	
N	99215	YR		16.00		14.00	
L	W2650			21.00		21.00	
L	W2655			5.00		5.00	

NOTE: See N.J.A.C. 10:66-6.2(f), Surgery, for additional procedures.

(i) Radiology services:

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Ind	HCPCS Code	Mod	Follow Up Days	S	Maximum Fee Allowance \$	NS	Anes. Basic Units
	70030				15.00		
	70100				15.00		
	70110				20.00		
	70120				15.00		
	70130				20.00		
	70140				15.00		
	70150				20.00		
	70160				15.00		
	70170				20.00		
	70190				15.00		
	70200				25.00		
	70210				20.00		
	70220				25.00		
	70240				15.00		
	70250				15.00		
	70260				25.00		
	70300				5.00		
	70310				10.00		
	70320				15.00		
	70328				13.00		
	70330				20.00		
	70350				8.00		
	70360				10.00		
	70370				20.00		
	70380				15.00		
	70390				15.00		
	70551				300.00		
MN	71010				10.00		
MN	71020				15.00		
MN	71030				20.00		
MN	71034				20.00		
	71100				15.00		
	71110				20.00		
	71120				15.00		
	71130				20.00		
	72010				40.00		
	72040				15.00		
	72050				20.00		
	72052				25.00		
	72070				15.00		

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	72080	15.00
	72100	20.00
	72110	25.00
	72114	20.00
N	72170	15.00
	72190	20.00
	72200	20.00
	72220	15.00
	73000	10.00
	73010	15.00
	73020	15.00
	73030	15.00
	73040	15.00
	73050	18.00
	73060	15.00
	73070	15.00
	73080	15.00
	73085	15.00
	73090	10.00
	73092	20.00
	73100	10.00
	73110	15.00
	73115	15.00
	73120	10.00
	73130	15.00
	73140	5.00
N	73500	18.00
N	73510	20.00
	73520	25.00
	73525	15.00
	73530	30.00
	73540	15.00
	73550	15.00
	73560	15.00
	73562	15.00
	73580	15.00
	73590	15.00
	73592	20.00
	73600	10.00
	73610	13.00
	73615	15.00
	73620	10.00
	73630	13.00
	73650	10.00

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	73660		5.00
	74000		10.00
	74010		15.00
	74020		15.00
	74220		20.00
N	74240		40.00
N	74241		45.00
N	74245		50.00
N	74250		30.00
	74270		30.00
	74280		40.00
	74290		35.00
	74305		25.00
	74400		35.00
	74405		50.00
	74420		35.00
	74430		15.00
	74450		20.00
	74455		20.00
	74470		20.00
N	74710		25.00
	74740		20.00
	76000		45.00
	76020		15.00
	76040		20.00
	76061		35.00
	76062		90.00
	76080		15.00
	76090		26.00
	76091		36.00
	76100		35.00
	76100	50	50.00
	76805		55.00
	76815		25.00
	76816		25.00

(j) Rehabilitation services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
				S	\$	NS	
N	92507				7.00		7.00
N	92552				11.00		11.00
N	92553				14.00		14.00

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N	92557	19.00	19.00
	92562	3.00	NA
	92563	3.00	NA
	92564	4.00	NA
N	92567	5.00	NA
N	92568	5.00	NA
N	92572	20.00	NA
N	92576	30.00	NA
N	92582	14.00	14.00
	92585	45.00	NA
N	92589	10.00	NA
	92590	40.00	NA
	92591	40.00	NA
N	97799	7.00	7.00
L	H5300	7.00	7.00
L	Z0270	7.00	7.00
L	Z0280	7.00	7.00
L	Z0300	7.00	7.00
L	Z0310	45.00	45.00

(k) Vision care services (See N.J.A.C. 10:62-4).

(l) Transportation services:

Ind	HCPCS Code	Mod	Follow Up Days	S	Maximum Fee Allowance \$	NS	Anes. Basic Units
LN	Z0330				4.50		4.50
LN	Z0335				9.00		9.00

(m) Drug treatment center services:

* An asterisk preceding any procedure code indicates that the procedure may only be provided to ACCAP-eligible individuals in the home.

Ind	HCPCS Code	Mod	Follow Up Days	S	Maximum Fee Allowance \$	NS	Anes. Basic Units
*LN	Z1830				3.50		3.50
*LN	Z1831				4.50		4.50
*LN	Z1832				24.00		24.00
*LN	Z1833				12.00		12.00
*LN	Z1834				30.00		30.00
*LN	Z1835				22.50		22.50

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LN	Z2000			22.50		22.50
LN	Z2001			15.00		15.00
LN	Z2002			4.50		4.50
LN	Z2003			16.00		16.00
LN	Z2004			8.00		8.00
LN	Z2005			15.00		15.00
LN	Z2006			2.50		2.50
LN	Z2007			8.00		8.00
LN	Z2010			4.50		4.50

NOTE: See N.J.A.C. 10:66-6.2(a), Evaluation and management and other procedures, for additional procedures preceded by an asterisk.

(n) Federally qualified health care services:

Ind	HCPCS Code	Mod	Follow Up Days	S	Maximum Fee Allowance \$	NS	Anes. Basic Units
	90844	22					
L	W9840				contract	contract	
	W9843				contract	contract	
L	Y3333				contract	contract	

(o) Personal care assistant services:

Ind	HCPCS Code	Mod	Follow Up Days	S	Maximum Fee Allowance \$	NS	Anes. Basic Units
L	Z1600	ZI			13.02	13.02	
L	Z1605	ZI			10.23	10.23	
L	Z1610	ZI			35.00	35.00	
L	Z1611	ZI			6.51	6.51	
L	Z1612	ZI			5.12	5.12	
L	Z1613	ZI			35.00	35.00	

(p) Miscellaneous services:

Ind	HCPCS Code	Mod	Follow Up Days	S	Maximum Fee Allowance \$	NS	Anes. Basic Units
	57820		15		72.00	63.00	
	58120		15		72.00	63.00	
N	59840		45		79.00	68.00	
N	59841		45		79.00	68.00	

10:66-6.3 HCPCS procedure codes and maximum fee allowance schedule for Level II and Level III codes and narratives (not located in CPT)

(a) Evaluation and Management and other procedures

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance		NS
					S	\$	
	67221		<p>Photodynamic therapy</p> <p>QUALIFIER: This procedure code may be billed with 67225. This procedure code must be rendered by ophthalmologists who are retinal specialists, and shall be limited to patients meeting the following criteria: Best corrected visual acuity equal to or better than 20/200, if the decreased visual acuity is caused by the macular degeneration; and Classic subfoveal choroidal neovascularization (CNV), occupying 50 percent or greater of the entire ocular lesion; and A reported ICD-9 CM diagnosis of 115.02, 115.92, 362.21 or 362.52 (exudative senile macular degeneration).</p> <p>NOTE: Report HCPCS procedure code 67225 on the CMS 1500 claim form for procedures performed on a second eye when both eyes are treated on the same date of service. Evaluation and management (E&M) services, fluorescent angiography (FA) and other ocular diagnostic services may also be billed separately when determined medically necessary and provided on the same date of service. Modifiers LT or RT should be used on all claims for codes 67221 and 67225, whether initial or subsequent treatment.</p>		283.00		241.00

67225	<p>Photodynamic therapy, second eye, at single session QUALIFIER: This procedure code must be billed with 67221. This procedure code must be rendered by ophthalmologists who are retinal specialists, and shall be limited to patients meeting the following criteria: Best corrected visual acuity equal to or better than 20/200, if the decreased visual acuity is caused by macular degeneration; and Classic subfoveal choroidal neovascularization (CNV), occupying 50 percent or greater of the entire ocular lesion; and A reported ICD-9 CM diagnosis of 115.02, 115.92, 362.21 or 362.52 (exudative senile macular degeneration). NOTE: Report HCPCS procedure code 67225 on the CMS 1500 claim form for procedures performed on a second eye when both eyes are treated on the same date of service. Evaluation and management (E&M) services, fluorescent angiography (FA) and other ocular diagnostic services may also be billed separately when determined medically necessary and provided on the same date of service. Modifiers LT or RT should be used on all claims for codes 67221 and 67225 whether initial or subsequent treatment.</p>	23.00	20.00
W9096	<p>22 Hepatitis B immunoprophylaxis with Recombivax HB, 0.5 ml does. This code applies only to newborns of HBsAg negative mothers.</p>	32.79	32.79
W9097	<p>Hepatitis B immunoprophylaxis with Recombivax HB, 0.25 ml dose. This code applies only to high risk beneficiaries under 11 years of age (exclusive of</p>	17.46	17.46

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		newborns).		
	W9098	Hepatitis B immunoprophylaxis with Recombivax HB, 0.5 ml dose. This code applies only to high risk beneficiaries 11 to 19 years of age.	32.79	32.79
	W9099	Hepatitis B immunoprophylaxis with Recombivax HB, 1.0 ml dose. This code applies only to high risk beneficiaries over 19 years of age.	63.57	63.57
	W9333	Hepatitis B immunoprophylaxis with Engerix-B, 0.5 ml does. This code applies only when immunizing newborns.	27.88	27.88
	W9334	Hepatitis B immunoprophylaxis with Engerix-B, 0.5 ml dose. This code applies only to high risk (exclusive of newborns).	27.88	27.88
	W9335	Hepatitis B immunoprophylaxis with Engerix-B, 1.0 ml dose. This code applies only to high risk beneficiaries over 11 years of age.	62.09	62.09
	W9338	Tetramune. this code is used when administering the primary immunization series to infants and toddlers. It eliminates the need for two separate injections of DTP and Haemonphilus b Conjugate Vaccine.	30.27	30.27
N	W9820	Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) through age 20. NOTE: If performed by outside independent laboratories, the laboratory must submit the claim. Blood sample for lead screening test should be sent to the New Jersey State Department of Health and Senior Services. NOTE: Procedure code W9820 shall be used only once for the same patient during any 12-month period by the same physician, group, shared health care facility,	23.00	18.00

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or practitioner(s) sharing a common record. Reimbursement for code W9820 is contingent upon the submission of both a completed Report and Claim For EPSDT/HealthStart Screening and Related Procedures (MC-19) and the appropriate claim form within 30 days of the date of service. In the absence of a completed MC-19 form, reimbursement will be reduced to the level of an annual health maintenance examination, that is, \$ 22.00-\$ 17.00.

(b) Dental services (See N.J.A.C. 10:56-3).

(c) Family planning services:

HCPCS			Follow Up Days	Maximum Fee Allowance		
IND	Code	Mod		Description	S	\$ NS
	G0001	WF		Routine Venipuncture	1.80	1.80
	W0001	WF		Supplying and inserting the intrauterine device 'Paragard' by a physician including the post-insertion visit.	188.00	188.00
	W0001	WMWF		Supplying and inserting the intrauterine device 'Paragard' by a certified nurse-midwife including the post-insertion visit.	NA	177.00
	W0002	WF		Supplying and inserting the intrauterine device 'Progestasert' by a physician including the post-insertion visit.	123.00	123.00
	W0002	WMWF		Supplying and inserting the intrauterine device 'Progestasert' by a certified nurse-midwife including the post-insertion visit.	NA	112.00
	W0004	WF		Removal of an IUD by a physician followed at the same visit by the insertion of the IUD 'Paragard' and including the post-insertion visit.	204.00	204.00

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W0004	WMWF	Removal of an IUD by a certified nurse-midwife followed at the same visit by the insertion of the IUD 'Paragard' and including the post-insertion visit.	NA	188.00
W0008	WF	Removal of an IUD by a physician followed at the same visit by the insertion of the IUD 'Progestasert' and including the post-insertion visit.	139.00	139.00
W0008	WMWF	Removal of an IUD by a certified nurse-midwife followed at the same visit by the insertion of the IUD 'Progestasert' and including the post-insertion visit.	NA	123.00

(d) Laboratory services (See N.J.A.C. 10:61-3).

(e) Minor surgery:

IND	HCPCS Code	MOD	Description	Follow Up Days	Maximum Fee Allowance		
					S	\$	NS
	W1650		Excision of plantar verruca, single site unilateral		24.00		21.00
	W1650	22	Excision of plantar verruca, multiple sites unilateral		37.000		32.00

(f) Mental health services:

IND	HCPCS Code	MOD	Description	Follow Up Days	Maximum Fee Allowance		
					S	\$	NS
	H5025	ZI	Group therapy: Verbal or other therapy methods provided by one or more psychiatrists, or professional counselors under the direction of a psychiatrist, in a personal involvement with two or more patients, with a		8.00		8.00

	<p>maximum of eight patients. A minimum session of 1 ½ hours is required. This includes preparation time in addition to the 1 ½ hours session time</p>		
Z0100	<p>Off-Site Crisis Intervention: An emergency procedure by personnel of a mental health clinic to an outpatient individual at locations other than the grounds or buildings of the clinic. Request for this service shall be initiated by the patient or other interested individual to meet the needs of the patient, who is unable to present himself at the clinic.</p>	22.50	22.50
	<p>The procedure includes rapid intervention, written evaluation and a treatment plan. Use of this procedure is limited to twice in six months for any one patient. This procedure not applicable to institutionalized patients.</p>		
Z0130	<p>Psychological testing: Maximum of five hours of psychometric and/or projective tests, with a written report.</p>	25.00/hour	25.00/hour
Z0170	<p>Partial Care: A mental health service whose primary purpose is to maximize the client's independence and community living skills in order to reduce unnecessary hospitalization. It is directed toward the acute and chronically disabled individual. Partial Care programs shall provide,</p>	15.40	15.40

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as listed below, a full system of services necessary to meet the comprehensive needs of the individual client. Services shall be provided or arranged for, to meet the individual needs of participating clients. These services shall include:

- Assessment and evaluation;
- Service procurement;
- Therapy;
- Information and referral;
- Counseling;
- Daily living education;
- Community organization;
- Pre-vocational therapy;
- Recreational therapy;
- Health related services.

Partial Care programs shall be available daily for five days a week, with additional planned activities each week during evening and/or weekend hours as needed. Individuals clients need not attend every day but as needed.

Partial Care programs specifically developed for children may be available four days a week, with one evening and/or weekend activity(ies). The staff of the Partial Care program should include a Director who shall be a qualified professional from the specialties of psychiatric nursing, vocational rehabilitation, or a related field with training and/or experience in direct service provision and administration. A qualified psychiatrist shall be available to the Partial Care program on a regularly scheduled basis, for consultation. Other staff deemed necessary to implement a Partial Care program which meets the requirements of this

section should include qualified mental health professionals, paraprofessionals and volunteers. In order to qualify as an approved Partial Care program the Program must be certified by the Department. Partial Care, per hour
 Note: Except for transportation these rates reflect full payments with a prohibition against multiple billing for more than one service to a Medicaid patient in a given day.

(g) Obstetrical services (maternity):

IND	HCPCS Code	MOD	Description	Follow Up Days	Maximum Fee Allowance		
					S	\$	NS
	Z0250	WM	Home Delivery Pack. All drugs and supplies, etc., necessary for delivery in this setting.			NA	40.00

(h) Podiatry services:

IND	HCPCS Code	MOD	Description	Follow Up Days	Maximum Fee Allowance		
					S	\$	NS
	W2650		Casting for molded shoes. Prior authorization is required.			21.00	21.00
	W2655		Casting for arch support. Prior authorization is required.			5.00	5.00

(i) Radiology services:

IND	HCPCS Code	MOD	Description	Follow Up Days	Maximum Fee Allowance		
					S	\$	NS
	W7200		Foot, complete (incl. special or calcis views)			20.00	20.00

W7250	Colon, barium enema, with or without K.U.B. air contrast only (with fluoroscopy by the radiologist).	30.00	30.00
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(j) Rehabilitation services:

IND	HCPCS Code	MOD	Description	Follow Up Days	Maximum Fee Allowance		
					S	\$	NS
	H5300		Occupational therapy		7.00		7.00
	Z0270		Physical therapy—initial visit, per individual, per provider		7.00		7.00
	Z0280		Occupational therapy—initial visit, per individual, per provider		7.00		7.00
	Z0300		Speech-language therapy—initial visit, per individual, per provider		7.00		7.00

(k) Vision care services (See N.J.A.C. 10:62-4).

(l) Transportation services:

IND	HCPCS Code	MOD	Description	Follow Up Days	Maximum Fee Allowance		
					S	\$	NS
	Z0330		Transportation, one way		4.50		4.50
	Z0335		Transportation, round trip		9.00		9.00

(m) Drug treatment center services:

* An asterisk preceding any procedure code indicates that the procedure may only be provided to ACCAP-eligible individuals in the home.

IND	HCPCS Code	MOD	Description	Follow Up Days	Maximum Fee Allowance		
					S	\$	NS
	*Z1830		Methadone treatment rendered by a drug treatment center at home, per visit		3.50		3.50

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*Z1831	Urinalysis for drug addiction at home, per visit.	4.50	4.50
*Z1832	Psychotherapy rendered by a drug treatment center at home—full session, per visit	24.00	24.00
*Z1833	Psychotherapy rendered by a drug treatment center at home—half session, per visit	12.00	12.00
*Z1834	Family therapy rendered by a drug treatment center at home, per visit.	30.00	30.00
*Z1835	Family conference rendered by a drug treatment center at home, per visit.	22.50	22.50
Z2000	Family therapy rendered in a drug treatment center.	22.50	22.50
Z2001	Family conference rendered in a drug treatment center.	15.00	15.00
Z2002	Prescription visit rendered in a drug treatment center.	4.50	4.50
Z2003	Psychotherapy rendered in a drug treatment center—full session.	16.00	16.00
Z2004	Group therapy rendered in a drug treatment center, per person.	8.00	8.00
Z2005	Psychological testing rendered in a drug treatment center, per hour, maximum of five hours.	15.00	15.00
Z2006	Methadone treatment rendered in a drug	2.50	2.50

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Z2007	treatment center. Psychotherapy rendered in a drug treatment center—half session	8.00	8.00
Z2010	Urinalysis for drug addiction	4.50	4.50

(n) Federally qualified health center services:

IND	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance		NS
					S	\$	
	W9840		Medical encounter		contract		contract
	W9843		EPSDT encounter		contract		contract
	Y3333		Dental encounter		contract		contract
	90844	22	Medical psychoth erapy		contract		contract

(Applicable to clinics under contract to the Division of Mental Health and Hospitals of the Department of Human Services.)

IND	HCPCS Code	MOD	Description	Follow Up Days	Maximum Fee Allowance		
					S	\$	NS
	Z1600	ZI	Personal Care Assistant Services, Individual, per hour		13.02		13.02
	Z1605	ZI	Personal Care Assistant Services, Group, per hour		10.23		10.23
	Z1610	ZI	Personal Care Assistant Services, Initial Nursing Assessment, per visit		35.00		35.00
	Z1611	ZI	Personal Care Assistant Services, Individual, per hour		6.51		6.51
	Z1612	ZI	Personal Care Assistant Services, Group, per hour		5.12		5.12
	Z1613	ZI	Nursing Reassessment Visit, per visit		35.00		35.00

10:66-6.4 HCPCS procedure codes--qualifiers

- (a) Evaluation and management and other procedures:
1. Drawing of blood: 36415.

i. Once per visit, per patient. (Not applicable if laboratory study, in any part, is performed by the clinic.)

2. Injection (intradermal, subcutaneous, or intra-arterial): 90799.

i. Reimbursement for the above injections are on a flat-fee basis and are all inclusive for the cost of the service as well as the materials. Be advised of the following:

(1) A visit for the sole purpose of an injection is reimbursable only as an injection and not as a clinic visit and injection. However, if the criteria of a clinic visit is met, an injection may, if medically indicated, be considered as an add-on to the visit. The drug administered shall be consistent with the diagnosis and shall conform to accepted medical and pharmacological principles with respect to dosage, frequency and route of administration.

(2) Intravenous and intraarterial injections are reimbursable only when performed by the physician.

(3) No reimbursement will be made for vitamins, liver or iron injections or combinations thereof except in laboratory proven deficiency states requiring parenteral therapy.

(4) No reimbursement will be made for placebos or any injections containing amphetamines or derivatives thereof.

(5) No reimbursement will be made for injections given for the treatment of obesity.

(6) No reimbursement will be made for an injection given as a pre-operative medication or as a pre-operative local anesthetic which is part of an operative or surgical procedure since this injection would normally be included in the listed fee for such a procedure.

(7) Insert procedure code 90799 as a separate item on the claim, followed by the name, dose of drug, and route of administration. The complete diagnosis, for which the injection was given, shall be indicated on the claim.

3. General clinical psychiatric diagnostic or evaluative interview procedures: 90801.

i. This code requires for reimbursement purposes a minimum of 50 minutes of direct personal clinical involvement with the patient or family member. The CPT narrative otherwise remains applicable.

ii. No more than one claim for the code 90801 is reimbursable per the same beneficiary, per the same physician, per year.

4. Prolonged detention: 99150 and 99151.

i. Prolonged detention with or without critical care will be covered under CPT 99150 and 99151, but the service shall be consistent with the following narrative in order to be reimbursed:

(1) The patient's situation requires constant physician attendance which is given by the physician to the exclusion of other patients and duties. This must be verified by the applicable records as defined by the setting.

(2) Records shall show in the physician's handwriting the time of onset and time of completion of the service.

ii. This code may not be used simultaneously with procedure codes that pay a reimbursement for the same time or type of service.

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iii. The basis for this type of claim should be apparent on the claim form. The listed fees of \$ 37.00 for specialist and \$ 32.00 for non-specialist are per hour.

5. Evaluation and management--new patient (excludes preventive health care for patients through 20 years of age): 99201, 99201WF, 99201WFWM, 99202, 99202WF, 99202WFWM, 99203, 99203WF, 99203WFWM, 99204, 99204WF, 99204WFWM, 99205, 99205WF, 99205WFWM and 99432.

i. When reference is made in the CPT manual to "Office--New Patient," the intent of the Medicaid program is to consider this service as the initial visit.

ii. Reimbursement for an initial clinic visit will be disallowed, if a preventive medicine service, EPSDT examination or clinic consultation were billed within a twelve month period by a clinic.

iii. It is also to be understood that in order to receive reimbursement for an initial visit, the following minimal documentation must be on the record regardless of the setting where the examination was performed. For example:

(1) Chief complaint(s);

(2) Complete history of the present illness and related systemic review, including recordings of pertinent negative findings;

(3) Pertinent past medical history;

(4) Pertinent family history;

(5) A full physical examination pertaining to but not limited to the history of the present illness and includes recording of pertinent negative findings; and

(6) Working diagnoses and treatment plan including ancillary services and drugs ordered.

6. Evaluation and management services--established patient (excludes preventive health care for patients through 20 years of age): 99211, 99211WM, 99211WF, 99211WFWM, 99212, 99212WF, 99212WFWM, 99212WM, 99213, 99213WF, 99213WFWM, 99213WM, 99214, 99214WF, 99214WFWM, 99214WM, 99215, 99215WF, 99215WFWM, and 99215WM.

i. Routine visit or follow-up care visit is defined for purposes of Medicaid and NJ KidCare fee-for-service reimbursement as the care and treatment by a physician or certified nurse-midwife, as appropriate, which includes those procedures ordinarily performed during a health care visit, which are dependent upon the setting and the physician's discipline.

ii. In order to document the record for reimbursement purposes, a progress note for the noted visits should include the following:

(1) Purpose of visit;

(2) Pertinent history obtained;

(3) Pertinent physical findings including pertinent negative findings based on the above;

(4) Procedures, if any, with results;

(5) Lab, X-ray, EKG, etc., ordered with results; and

(6) Diagnosis.

7. Consultations: A consultation is recognized for reimbursement only when performed by a specialist recognized as such by this Program and the request has been made by

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or through the patient's attending physician and the need for such a request would be consistent with good medical practice.

i. Comprehensive consultation: 99244, 99245, 99254, 99255, 99274 and 99275.

(1) In order to receive reimbursement for these HCPCS codes, the performance of a total systems evaluation by history and physical examination, including a total systems review and total system physical examination are required.

(2) An alternative to (a)7i(1) above would be the utilization of one or more hours of the consulting physician's personal time in the performance of the consultation.

(3) Reimbursement for HCPCS codes 99244, 99245, 99254, 99255, 99274 and 99275 (Comprehensive Consultation) requires the following applicable statements, or language essentially similar to those statements, to be inserted in the "remarks section" of the claim form. The form is to be signed by the provider who performed the consultation.

(A) I personally performed a total (all) systems evaluation by history and physical examination; or

(B) This consultation utilized 60 or more minutes of my personal time.

(4) The following rules regarding consultations shall also be recognized.

(A) If a consultation is performed and the patient is then transferred to the consultant's service during the course of that illness, the provider may not, in addition, bill for an Initial Visit if he or she has or intends to bill for the consultation.

(B) If there is no referring physician, then an Initial Visit code should be used instead of a consultation code.

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

(D) Consultation codes will be declined in a clinic setting if the consultation has been requested by or between members of the same group, shared health care facility or physicians sharing common records. A routine visit code is applicable under these circumstances.

(E) If a prior claim for comprehensive consultation visit has been made within the preceding 12 months, then a repeat claim for this code will be denied if made by the clinic except in those instances where the consultation required the utilization of one hour or more of the physician's personal time. Otherwise, applicable codes would be limited consultation code if their criteria are met.

ii. Limited consultation: 99241, 99242, 99243, 99251, 99252, 99253, 99271, 99272, and 99273.

(1) The area being covered for reimbursement purposes is "limited" in the sense that it requires less than the requirements designated as "comprehensive" as noted above.

iii. Second opinion program consultation: 99274YY.

(1) A consultation to satisfy the requirements of the mandated "Second Opinion" program will be reimbursed only if the requirements of that program are met and the consultation has been performed by the appropriate board certified specialist who has signed a separate provider agreement and whose selection has been through the Second Opinion Referral Service (1-800-676-6562).

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iv. Third opinion consultation: 99274ZZ.

(1) In the event that a patient receives two different points of view relative to a "Second Opinion" procedure, he or she may, if unable to reach a decision, request a third opinion.

(2) A third opinion consultation must be at the patient's request and under the circumstances described.

8. Critical care services: 99291 and 99292.

i. Critical care is reimbursable under codes 99291 and 99292 if the service is consistent with the following:

(1) The patient's situation requires constant physician attendance which is given by the physician to the exclusion of his or her other patients and duties and, therefore, represents what is beyond the usual service. This must be verified by the applicable records as defined by the setting and which records must show in the physician's handwriting the time of onset and time of completion of the service.

(2) All settings are applicable, such as clinic and hospital.

(3) These codes may not be used simultaneously with procedure codes that pay a reimbursement for the same time or type of service.

(b) Dental services (See N.J.A.C. 10:56-3).

(c) Family planning services:

1. Norplant--insertion, implantable contraceptive capsules: 1197522.

i. The maximum fee allowance includes the cost of the NPS kit, the insertion of the "Norplant System" (six levonorgestrel implants), and the post-insertion visit.

ii. Modifier "22" indicates that the billing includes the cost of the kit.

2. Norplant--removal, implantable contraceptive capsules: 11976.

i. The maximum fee allowance includes the removal of the "Norplant System" (six levonorgestrel implants) and the post-removal visit.

3. Norplant--removal with reinsertion, implantable contraceptive capsules: 1197722.

i. The maximum fee allowance includes the removal/insertion of the "Norplant System" (six levonorgestrel implants) and post-removal/reinsertion visit.

4. Sterilization (male): 55250 and 55450.

i. Primary sterilization (family planning) procedure.

ii. A completed consent form shall be attached to the claim form, in accordance with N.J.A.C. 10:66-2.3.

5. Sterilization (female): 58600, 58605, 58982, and 58983.

i. These procedures are always considered a sterilization procedure. Therefore, a completed consent form shall be attached to the claim form, in accordance with N.J.A.C. 10:66-2.3.

ii. 57451: If the procedure is performed for sterilization purposes, a completed consent form shall be attached to the claim form, in accordance with N.J.A.C. 10:66-2.3.

6. Initial medical visit: 99201WF, 99201WFWM, 99202WF, 99202WFWM, 99203WF, 99203WFWM, 99204WF, 99204WFWM, 99205WF, and 99205WFWM.

i. Family planning to include each of the following:

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- (1) Medical, social, obstetrical history
- (2) Complete pelvic examination--including visual inspection of the cervix
- (3) Breast examination
- (4) Papanicolaou smear (excludes cytology study)
- (5) Contraceptive counseling with referral as indicated.

ii. Includes the cost of birth control drugs dispensed. A prescription cannot be substituted.

iii. These procedure codes (initial medical visit) will be disallowed if procedure codes 99201, 99201WF, 99201WFWM, 99202, 99202WF, 99202WFWM, 99203, 99203WF, 99203WFWM, 99204, 99204WF, 99204WFWM, 99205, 99205WF, 99205WFWM and 99432 have been performed during the prior 12 months by the same provider.

7. Routine or follow-up visit--brief: 99211WF, 99211WFWM, 99212WF, 99212WFWM, 99213WF, and 99213WFWM.

i. May include pelvic examination, changes in method or physician's or certified nurse-midwife's instructions at a minimum average time of five minutes, or a visit solely for a refill supply of birth control drugs for which a prescription cannot be substituted and professional contact is not necessary.

8. Medical revisit--family planning: 99214WF and 99214WFWM.

i. May include pelvic examination or changes in method or physician's or certified nurse-midwife's instructions. This code includes the cost of birth control drugs dispensed. A prescription cannot be substituted.

9. Routine or follow-up visit--prolonged: 99215WF and 99215WFWM.

i. May include pelvic examination or changes in method or physician's or certified nurse-midwife's instructions. Involves 20 or more minutes of personal time in patient contact, including documentation of time as well as adequate significant progress notes on the clinic record. This procedure code includes the cost of birth control drugs dispensed. A prescription cannot be substituted.

10. Annual medical revisit: 99395WF and 99395WFWM.

i. Family planning to include each of the following:

- (1) Updating medical, social, obstetrical history;
- (2) Complete pelvic examination including visual inspection of cervix;
- (3) Breast examination; and
- (4) Papanicolaou smear (excludes cytology study) with referral when indicated.

ii. This code includes the cost of birth control drugs dispensed. A prescription cannot be substituted.

iii. Procedure code 99395WF will be disallowed if procedure codes 99201, 99201WF, 99201WFWM, 99202, 99202WF, 99202WFWM, 99203, 99203WF, 99203WFWM, 99204, 99204WF, 99204WFWM, 99205, 99205WF, 99205WFWM and 99432 have been performed during the prior 12 months by the same provider.

11. Code G0001 WF This service is reimbursable to the Family Planning Clinic only when the specimen is referred out to an independent clinical laboratory for testing.

Note: Physicians/practitioners and Family Planning Clinics cannot bill when the tests are completed on the premises and are not referred out to independent clinical laboratories.

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(d) Laboratory services (See N.J.A.C. 10:61-3).

(e) Minor surgery:

1. Acne surgery (for example, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules): 10040.

i. Excision must involve the use of a scalpel and an expressor, but not an expressor alone. This code is limited to severe acne. For less than severe acne, utilize the procedure codes for routine office visits.

(f) Mental health services:

1. Comprehensive intake evaluation: 90801ZI.

i. An initial procedure performed at a mental health clinic to assess a new patient and recommend an appropriate treatment plan or additional diagnostic studies. The procedure includes initial interviews with the patient and other involved individuals, conferences with referral sources, examination of written material provided by the patient or others, staff conferences and written evaluation and treatment plan including recommendations for further consultations, studies or additional information.

ii. Although this procedure may be performed by a single individual, it is expected that it should be a team approach and of one and one-half hours duration. Use of procedure is limited to once per year for any one patient.

2. Individual psychotherapy--25 minute session: 90843ZI.

i. This code requires, for reimbursement purposes, a minimum of 25 minutes of direct personal clinical involvement with the patient and/or family member.

3. Individual psychotherapy--50 minute session: 90844ZI.

i. This code requires, for reimbursement purposes, a minimum of 50 minutes of direct personal clinical involvement with the patient and/or family member.

4. Family therapy: 90847ZI.

i. This code requires, for reimbursement purposes, a minimum of 50 minutes of direct personal clinical involvement with the patient and/or family member. The CPT narrative otherwise remains applicable.

5. Family therapy: 90847ZI22.

i. This code requires, for reimbursement purposes, a minimum of 80 minutes of direct personal clinical involvement with the patient and/or family member. The CPT narrative otherwise remains applicable.

6. Family conference: 90887ZI.

i. This code requires, for reimbursement purposes, a minimum of 25 minutes of direct personal clinical involvement with patient, family member or caretaker. The CPT narrative otherwise remains applicable.

7. Group psychotherapy: H5025ZI.

i. This code requires, for reimbursement purposes, a minimum of 90 minutes of direct clinical involvement with the patient as a member of a group of which 10 minutes can be used for documentation. The maximum number of the group is eight and the reimbursement is per person, per group session.

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(g) Obstetrical services (maternity):

1. Total obstetrical care: 59400.

i. Antepartum care consisting of initial antepartum visits and seven subsequent antepartum visits. Specific date of all visits are to be listed on the claim form.

(1) Reimbursement will be decreased by the fee for the initial antepartum visit (59420 22) if not seen for this visit. The total fee will also be decreased by the reimbursement sum for each subsequent antepartum visit (59420) which is less than seven.

(2) If medical necessity dictates, corroborated by the record, additional visits above seven antepartum may be reimbursed under the procedure codes for routine or follow-up clinic visit. The claim form shall clearly indicate the reason for the medical necessity and date for each listed.

ii. Obstetrical delivery with in-hospital postpartum care (with or without low forceps and/or episiotomy or a vaginal delivery full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours).

(1) This shall also include one visit between the 15th and 60th day postpartum day following delivery and out of hospital. Include name of hospital and delivery date on the claim.

2. Vaginal delivery: 59410.

i. Vaginal delivery full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours.

ii. This shall also include one visit between the 15th and 60th postpartum day following delivery and out of hospital. Include name of hospital and delivery date on the claim.

3. Subsequent antepartum visit: 59420.

i. Subsequent antepartum visit (separate procedure). Indicate specific dates of service.

4. Initial antepartum visit: 5942022.

i. Initial antepartum visit (separate procedure).

5. Postpartum care: 59430.

i. Postpartum care (other than delivery physician).

ii. This shall also include one visit between 15th and 60th postpartum day following delivery and out of hospital. Include name of hospital and delivery date on the claim.

6. Total obstetrical care by a certified nurse-midwife: 59400WM.

i. Total obstetrical care when given by a certified nurse-midwife, including:

(1) Antepartum care consisting of initial antepartum visit and seven subsequent antepartum visits. Specific dates of all visits are to be listed on the claim form.

(2) Reimbursement will be decreased by the fee for the initial antepartum visit (code 5942022WM) if patient not seen for this visit. The total fee will also be decreased by the reimbursement sum for each subsequent antepartum visit (code 59420WM) which is less than seven.

(3) If medical necessity dictates, corroborated by the record, additional visits above seven antepartum may be reimbursed under the procedure codes for routine or follow-up visit. The claim shall clearly indicate the reason for the medical necessity and date for each code listed.

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ii. Obstetrical delivery per vagina with or without episiotomy include postpartum care when provided by the certified nurse-midwife in the home, birthing center or in the hospital (inpatient setting).

(1) This applies to a vaginal delivery at full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours.

(2) This shall also include one visit between the 15th and 42nd postpartum day following delivery and out of the hospital. Include delivery date on the claim form.

7. Vaginal delivery by a certified nurse-midwife: 59410WM.

i. Obstetrical delivery per vagina with or without episiotomy including postpartum care when provided by the certified nurse-midwife in the home, birthing center or in the hospital (inpatient setting).

(1) This applies to a vaginal delivery at full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours.

(2) This shall also include one visit between the 15th and 42nd post-partum day following delivery and out of hospital. Include delivery date on the claim form.

8. Subsequent antepartum visit provided by a certified nurse-midwife: 59420WM.

i. Indicate specific date of service.

9. Initial antepartum visit provided by a certified nurse-midwife: 59420WM22.

i. Initial antepartum visit provided by a certified nurse-midwife (separate procedure).

10. Postpartum care provided by a certified nurse-midwife: 59430WM.

i. Postpartum care provided by a certified nurse-midwife who is other than the individual who performed the delivery and who is not related to this individual by any financial or contractual arrangement, e.g., group, clinic, employee, etc.

ii. One visit between the 15th and 60th postpartum day following delivery. Include delivery date on the claim (separate procedure).

(h) Podiatry services:

1. Routine or follow-up clinic visit: 99211YR, 99212YR, 99213YR, 99214YR, and 99215YR.

i. Routine or follow-up clinic visit. A podiatry service consisting of routine care and treatment by the podiatrist.

ii. Include significant written progress notes and office records which demonstrate positive findings and treatment changes.

2. See N.J.A.C. 10:66-6.4(f), Surgery, for additional procedures.

(i) Radiology services:

1. Chest: 71010, 71020, 71030, and 71034.

i. Routine chest X-rays without medical necessity in an office (clinic) are not reimbursable under Program guidelines.

2. Pelvis: 72170.

i. Pelvis X-ray is not eligible for separate payment when performed in conjunction with Complete Lumbosacral Spine X-rays (72110).

3. Hip: 73500 and 73510.

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i. Procedure 73520 should be used for bilateral hip X-rays when both hips are X-rayed instead of billing separately for each hip (73500 and 73510).

4. Esophagus (with fluoroscopy by the radiologist): 74220.

i. Not eligible for separate payment when performed in conjunction with a GI or Small Bowel Series (74240, 74241, 74245, and 74250).

5. Pelvimetry: 74710.

i. Use of the code for pelvimetry requires written evidence of medical necessity to accompany the claim.

(j) Rehabilitation services:

1. Speech therapy: 92507.

i. Minimum time, 30 minutes. Prior authorization required.

ii. Prescribed by a licensed physician, performed by a qualified speech-language pathologist.

2. Audiometric tests: 92552, 92553, 92557, 92567, 92568, 92572, 92576, 92582, and 92589.

i. May be reimbursed when prescribed by a physician and performed by an audiologist.

ii. Tympanometry (92567) and acoustic reflex testing (92568) are reimbursable only to a specialist.

iii. Acoustic reflex testing, 92568, shall include at least two frequencies per ear. Brief reflex screening at one frequency per ear is not reimbursable. Documentation of these tests shall appear in the patient's record.

3. Physical therapy: 97799.

i. Individual treatment session--minimum time, 30 minutes. No more than three patients can be treated simultaneously.

ii. Prior authorization required. Consists of any one or a combination of the following modalities, prescribed by a licensed physician, performed by a qualified physical therapist and related to the patient's active treatment regimen.

(1) Appropriate use of accepted mechanical device (such as parallel bar, weights, pulley system, friction wheels, steps, etc.).

(2) Graduated range of motion exercises.

(3) Therapeutic ultrasound, only when included as part of other forms of accepted therapy.

(4) Therapeutic use of physical agents (other than drugs) including heat, light, water, electricity and radiation.

(5) Instructions to responsible persons for follow-up procedures between therapy visits.

4. Occupational therapy: H5300.

i. Minimum time, 30 minutes. Prior authorization required.

ii. Prescribed by a licensed physician, performed by a qualified occupational therapist.

(k) Vision care services (See N.J.A.C. 10:62-4).

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(l) Transportation services:

1. Transportation, one way: Z0330.
 - i. Applicable when the clinic transports a beneficiary either to or from the clinic in any one day.
 - ii. Reimbursement is limited to two trips per day for the same beneficiary by the same clinic.
2. Transportation, round trip: Z0335.
 - i. Applicable when the clinic transports a beneficiary on a round trip basis to/from the clinic in any one day.
 - ii. Reimbursement is limited to one round trip per day for the same beneficiary by the same clinic.

(m) Drug treatment center services:

1. Methadone treatment rendered by a drug treatment center for an ACCAP-eligible individual at home, per visit: Z1830.
 - i. A per diem payment based on the number of days a beneficiary is supplied methadone during the billing period. This rate includes the cost of the drug, packaging, nursing time, and administrative costs.
2. Urinalysis for drug addiction for an ACCAP-eligible individual at home, per visit: Z1831.
 - i. To be used only when the drug treatment center is approved for this service; to determine what level if any, a drug is present in the urine.
3. Psychotherapy rendered by a drug treatment center for an ACCAP-eligible individual at home--full session, per visit: Z1832.
 - i. Verbal, drug augmented, or other therapy methods provided by a physician, or a professional counsellor under the direction of a physician, in a personal involvement with one patient to the exclusion of other patients and/or duties.
 - ii. A minimum of 50 minutes personal involvement with the patient is required. This includes a prescription visit when necessary.
4. Psychotherapy rendered by a drug treatment center for an ACCAP-eligible individual at home--half session, per visit: Z1833.
 - i. Verbal, drug augmented, or other therapy methods provided by a physician, or a professional counsellor under the direction of a physician in a personal involvement with one patient to the exclusion of other patients and/or duties.
 - ii. A minimum of 25 minutes personal involvement with the patient is required. This includes a prescription visit when necessary.
5. Family therapy rendered by a drug treatment center for an ACCAP-eligible individual at home, per visit: Z1834.
 - i. Therapy with the patient and with one or more family members present. Verbal or other therapy methods are provided by a physician, or a professional counsellor under the direction of a physician, in personal involvement with the patient and the family to the exclusion of other patients and/or duties.

- ii. A minimum session of one and one half hours is required with a minimum of 80 minutes personal involvement with the patient and the family and up to 10 minutes for the recording of data.
 - iii. The clinic may bill only for the patient and not for other family members.
6. Family conference rendered by a drug treatment center for an ACCAP-eligible individual at home, per visit: Z1835.
- i. Meeting with the family or other significant persons to interpret or explain medical, psychiatric or psychological examinations and procedures, other accumulated data and/or advice to the family or other significant persons on how to assist the patient.
 - ii. A minimum of 50 minutes of personal involvement with the family is required. The clinic may bill only for the patient and not for other family members.
7. Family therapy rendered in a drug treatment center: Z2000.
- i. Therapy with the patient and with one or more family members present. Verbal or other therapy methods are provided by a physician, or a professional counsellor under the direction of a physician, in personal involvement with the patient and the family to the exclusion of other patients and/or duties.
 - ii. A minimum session of one and one half hours is required with a minimum of 80 minutes personal involvement with the patient and the family and up to 10 minutes for the recording of data.
 - iii. The clinic may bill only for the patient and not for other family members.
8. Family conference rendered in a drug treatment center: Z2001.
- i. Meeting with the family or other significant persons to interpret or explain medical, psychiatric or psychological examinations and procedures, other accumulated data and/or advice to the family or other significant persons on how to assist the patient.
 - ii. A minimum of 50 minutes of personal involvement with the family is required. The clinic may bill only for the patient and not for other family members.
9. Prescription visit rendered in a drug treatment center: Z2002.
- i. A visit with a physician for review and evaluation of the medication history of the patient and the writing, or renewal of prescription, as necessary.
10. Psychotherapy rendered in a drug treatment center--full session: Z2003.
- ii. Verbal, drug augmented, or other therapy methods provided by a physician, or a professional counsellor under the direction of a physician, in a personal involvement with one patient to the exclusion of other patients and/or duties.
 - iii. A minimum of 50 minutes personal involvement with the patient is required. This includes a prescription visit when necessary.
11. Group therapy rendered in a drug treatment center, per person: Z2004.
- i. Verbal or other therapy methods provided by one or more physicians, or professional counsellors under the direction of physician, in a personal involvement with two or more patients, with a maximum of eight patients.
 - ii. A minimum session of one and one half hours is required. This includes preparation time in addition to the one and one half hours session time.
12. Psychological testing rendered in a drug treatment center, per hour; maximum of five hours: Z2005.
- i. Psychometric and/or projective tests with a written report.

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13. Methadone treatment rendered in a drug treatment center: Z2006.
- i. A per diem payment based on the number of days a beneficiary is supplied methadone during the billing period. This rate includes the cost of the drug, packaging, nursing time, and administrative costs.
14. Psychotherapy rendered in a drug treatment center--half session: Z2007.
- i. Verbal, drug augmented, or other therapy methods provided by a physician, or a professional counsellor under the direction of a physician in a personal involvement with one patient to the exclusion of other patients and/or duties.
 - ii. A minimum of 25 minutes personal involvement with the patient is required. This includes a prescription visit when necessary.
15. Urinalysis for drug addiction: Z2010.
- i. To determine what level, if any, a drug is present in the urine.
 - ii. To be used only by a drug treatment center specifically approved by the Program to provide this service.
16. Drawing of blood; see CPT-4 for narrative: 36415.
- i. Once per visit per patient. Not applicable if lab study, in any part, is to be performed by the clinic.

(n) Miscellaneous services:

1. Abortion: 59840 and 59841.
 - i. See N.J.A.C. 10:66-2.8; FD-179 form shall be attached to the claim form.
 - ii. For claims submitted by ambulatory surgical centers only, the trimester of pregnancy shall be identified on the claim form by using modifier "WY" for first trimester or "WZ" for second trimester.

10:66-6.5 HealthStart

(a) HealthStart Maternity Care code requirements are as follows:

1. Separate reimbursement shall be available for Maternity Medical Care Services and Maternity Health Support Services.
2. Maternity Medical Care Services shall be billed as a total obstetrical package when feasible, but may also be billed as separate services.
3. The enhanced reimbursement (that is, HealthStart procedure codes) for delivery and postpartum care shall be claimed only for a patient who received at least one antepartum HealthStart Maternity Medical or Health Support Service.
4. The modifier "WM" in the HCPCS lists of codes refers to those services provided by certified nurse midwives; include the modifier at the end of each code.
5. Laboratory, other diagnostic procedures, and all necessary medical consultations are eligible for separate reimbursement.
 - i. Laboratory procedures performed by an outside laboratory shall be reimbursed to the laboratory. The clinic may submit a claim for a venipuncture using procedure code 36415 when necessary to collect blood specimens.
6. HealthStart Maternity Medical Care Services codes are as follows:

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IND	HCPCS Code	MOD	Description	Maximum Fee Allowance		
				S	\$	NS
	W9025		HealthStart Initial Antepartum Maternity Medical Care Visit	72.00		60.00
	W9025	WM	HealthStart Initial Antepartum Maternity Medical Care Visit by Certified Nurse Midwife 1. History, including system review 2. Complete physical examination 3. Risk assessment 4. Initial care plan 5. Patient counseling and treatment 6. Routine and special laboratory tests on site, or by referral, as appropriate 7. Referral for other medical consultations, as appropriate (including dental) 8. Coordination with the HealthStart Health Support Services provider, as applicable.			67.00
	W9026		HealthStart Subsequent Antepartum Maternity Medical Care Visit	22.00		21.00
	W9026	WM	HealthStart Subsequent Antepartum Maternity Medical Care Visit by a Certified Nurse Midwife 1. Interim history 2. Physical examination 3. Risk assessment 4. Review of plan of care 5. Patient counseling and treatment 6. Laboratory services on site or by referral, as appropriate 7. Referrals for other medical consultations, as appropriate 8. Coordination with HealthStart case coordinator.			19.00

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NOTE: This code may be billed only for the 2nd through 15th antepartum visit.

NOTE: If medical necessity dictates, corroborated by the record, additional visits above the fifteenth visit may be reimbursed under procedure code, that is, 99211, 99211WM, 99212, 99212WM, 99213, 99213WM, 99214, 99214WM, 99215, and 99215WM. The date and place of service shall be included on each claim detail line on the 1500 N.J. claim form. The claim form should clearly indicate the reason for the medical necessity and date for each additional visit.

W9027		HealthStart Regular Delivery	465.00	418.00
W9027 WM		HealthStart Regular Delivery		371.00
		1. Admission history		
		2. Complete physical examination		
		3. Vaginal delivery with or without episiotomy and/or forceps		
		4. Inpatient postpartum care		
		5. Referral to postpartum follow-up care provider including:		
		(a) Mother's hospital discharge summary and the		
		(b) Infant's discharge summary, as appropriate		
		NOTE: Obstetrical delivery applies to a full term or premature vaginal delivery and includes care in the home, birthing center or in the hospital (inpatient setting). Include the delivery date on the CMS 1500. claim form in Item 24A.		
W9028		HealthStart Postpartum Care Visit	22.00	21.00
W9028	WM	HealthStart Postpartum Care Visit by a Certified Nurse Midwife		19.00

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1. Outpatient postpartum care by the 60th day after the vaginal or caesarean section delivery
 - (a) Review of prenatal, labor and delivery course
 - (b) Interim history, including information on feeding and care of the newborn
 - (c) Physical examination
 - (d) Referral for laboratory services, as appropriate
 - (e) Referral for ongoing medical care when appropriate
 - (f) Patient counseling and treatment

NOTE: The postpartum visit shall be made by the 60th postpartum day. Include the delivery date on the CMS 1500 claim form in Item 24A.

W9029	HealthStart Regular Delivery and Postpartum	487.00	439.00
W9029 WM	HealthStart Regular Delivery and Postpartum by Certified Nurse Midwife includes: 1. Admission history 2. Complete physical examination 3. Vaginal delivery with or without episiotomy and/or forceps 4. Inpatient postpartum care 5. Referral to postpartum follow-up care provider including: (a) Mother's hospital discharge summary (b) Infant's discharge summary, as appropriate 6. Outpatient postpartum care by the 60th day after the delivery (a) Review of prenatal, labor and delivery course (b) Interim history, including information on feeding and care of the newborn		390.00

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- (c) Physical examination
- (d) Referral for laboratory services, as appropriate
- (e) Referral for ongoing medical care when appropriate
- (f) Patient counseling and treatment

NOTE: This code applies to a full term or premature vaginal delivery and includes care in the home, birthing center or in the hospital (inpatient setting). Include delivery date on the CMS 1500 claim form in Item 24A.

W9030	HealthStart Total Obstetrical Care	867.00	802.00
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W9030 WM	HealthStart Total Obstetrical Care by a Certified Nurse Midwife total obstetrical care consists of:		723.00
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1. Initial antepartum visit and 14 subsequent antepartum visits. Specific dates are to be listed on the claim form.

NOTE: Reimbursement will be denied if the services delivered do not meet the criteria for the visits. The elements of the visits shall include the following:

- a. History (initial or review), including system review
- b. Complete physical examination
- c. Risk assessment
- d. Initial and ongoing care plan
- e. Patient counseling and treatment
- f. Routine and special laboratory tests on site, or by referral, as appropriate
- g. Referral for other medical consultations, as appropriate (including dental)
- h. Coordination with the

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HealthStart Health Support Services provider, as applicable.

2. Regular vaginal delivery by certified nurse midwife:

The elements of the care shall include the following:

- a. Admission History
- b. Complete physical examination
- c. Vaginal delivery with or without episiotomy and/or forceps
- d. Inpatient postpartum care

NOTE: Include the delivery date on the HCFA 1500 claim form in Item 24A.

3. Postpartum care visit by certified nurse midwife:

Outpatient postpartum care by the 60th day after the vaginal delivery (full term or premature):

- a. Review of prenatal, labor and delivery course
- b. Interim history, including information on feeding and care of the newborn
- c. Physical examination
- d. Referral for laboratory services, as appropriate
- e. Referral for ongoing medical care when appropriate
- f. Patient counseling and treatment.

W9031

HealthStart Cesarean Section Delivery

595.00

531.00

- 1. Admission history
- 2. Complete physical examination
- 3. Cesarean section delivery
- 4. Inpatient postpartum care
- 5. Referral to postpartum follow-up care provider, including:
 - a. Mother's hospital discharge summary

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W9040	<p>b. Infant's discharge summary, as appropriate NOTE: Include the delivery date on the claim form.</p> <p>HealthStart enrollment process</p> <ol style="list-style-type: none"> 1. Assistance with the presumptive eligibility determination for Maternity Care beneficiaries, when and if applicable 2. Patient registration and scheduling of the initial appointments 3. Counseling and referral for WIC, food stamps, and other community-based services 4. Assignment of HealthStart case coordinator 5. Outreach and follow-up on missed appointments <p>NOTE: This code may be billed only once during pregnancy by the same provider.</p>	30.00
W9041	<p>HealthStart Development of Maternity Plan of Care</p> <ol style="list-style-type: none"> 1. Case coordination services 2. Initial assessments <ol style="list-style-type: none"> a. nutrition b. health education c. social/psychological 3. Case conference with Maternity Medical Care provider 4. Initial plan of care developed by the HealthStart case coordinator 5. Basic guidance and health education services 6. Referral for other needed services including follow-up with County Boards of Social Services 7. Outreach, referral and follow-up activities including phone calls and letters. <p>NOTE: This code may be billed only once during the pregnancy</p>	120.00

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W9042	<p>by the same provider.</p> <p>HealthStart Subsequent Maternity Health Support Services Visit</p> <ol style="list-style-type: none"> 1. Case coordination 2. Review and update of care plan 3. Coordination with maternity medical care provider 4. Health education instruction 5. Social/psychological guidance 6. Nutrition guidance 7. Home visit for high risk clients 8. Outreach, referral and follow-up activities including phone calls and letters. <p>NOTE: This code may be billed only once per trimester and not more than twice per pregnancy.</p>	50.00
W9043	<p>HealthStart Postpartum Maternity Health Support Services</p> <ol style="list-style-type: none"> 1. Case coordination services 2. Review of the plan of care 3. Review of the summary of hospital stay records and current medical status 4. Nutrition assessment and counseling 5. Social/psychological assessment and counseling 6. Health education assessment and instruction 7. Home visit(s) as applicable 8. Referral, outreach and follow-up services 9. Referral for pediatric preventive care and follow-up 10. Transfer of pertinent information to pediatric, future family planning and medical care providers 11. Completion of the plan of care 	100.00

(b) HealthStart Pediatric Preventive Care code requirements are as follows:

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1. HealthStart Pediatric Care Guidelines provide for up to nine preventive child health visits for a child under two years of age.

i. All preventive child health visits shall be billed using the HealthStart Preventive Child Health Visit codes appropriate to the child's age at the time of visit. Each preventive child health visit HCPCS procedure code may be claimed only once per child.

ii. Claims shall be submitted using Form MC-19, EPSDT/HealthStart Screening and Related Procedures.

2. Laboratory, other diagnostic procedures, and all necessary medical consultations shall be eligible for separate reimbursement.

i. Laboratory procedures performed by an outside laboratory shall be reimbursed to the laboratory. The clinic may submit a claim for a venipuncture using procedure code 36415 when necessary to collect blood specimens.

3. HealthStart Pediatric Preventive Care codes represent visits based on an infant's age according to the following schedule:

HCPCS			Maximum Fee Allowance		
Code	Mod	Procedure Description	S	\$	NS
W9060		Under six weeks	31.00		26.00
W9061		Six weeks to three months	31.00		26.00
W9062		Three months to five months	31.00		26.00
W9063		Five months to eight months	31.00		26.00
W9064		Eight months to 11 months	31.00		26.00
W9065		11 months to 14 months	31.00		26.00
W9066		14 months to 17 months	31.00		26.00
W9067		17 months to 20 months	31.00		26.00
W9068		20 months to 24 months	31.00		26.00

4. A HealthStart Pediatric Preventive Care Visit includes the following elements:

i. History including behavior and environmental factors;

ii. Developmental assessment; and

iii. Complete, unclothed physical examination by a physician or an advanced practice nurse under the personal supervision of a physician, to include:

(1) Measurements: height, weight and head circumference;

(2) Vision and hearing screening; and

(3) Nutritional assessment.

iv. Assessment and administration of immunizations (see appropriate HCPCS procedure codes for reimbursement amounts);

v. Anticipatory guidance;

vi. Arrangement for diagnosis and treatment of medical problems uncovered during the visit. This includes self-referrals and/or referrals to other providers, as medically indicated;

vii. Appropriate laboratory procedures performed, or referred, in accordance with HealthStart Pediatric Care Guidelines.

(1) Sick cell, PKU screening, as appropriate;

(2) Hemoglobin or hematocrit twice, at six to nine months and 20 to 24 months of age;

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- (3) Urinalysis, twice: at six to nine months and 20 to 24 months of age;
- (4) Tuberculin test, twice: at 12 to 14 months and 20 to 24 months; and
- (5) Lead screening at six to 12 months and annually thereafter, or more often if clinically indicated.

viii. Case coordination: referral for nutritional, psychological, social and other community services, as appropriate; provision or arrangement for 24-hour telephone physician access and sick care; and outreach and follow-up activities in accordance with the HealthStart Pediatric Care Guidelines.

NOTE: As indicated in N.J.A.C. 10:66-2.4(b), laboratory procedures performed by a clinic are reimbursable to the clinic; if such procedures are performed by an outside laboratory, the laboratory shall submit a separate claim.

NOTE: As indicated in N.J.A.C. 10:66 Appendix, as referenced in N.J.A.C. 10:66-1.1(e), claims for HealthStart Preventive Care visits shall include a completed Health Insurance Claim Form, CMS 1500, and a HealthStart Preventive Child Health Form.

IND	HCPCS	MOD	Description	Maximum Fee Allowance		
Code				S	\$	NS
	W9070		HealthStart Pediatric Continuity of Care.	13.00		13.00

This is a service by a certified HealthStart Pediatric Care Services Provider which is a hospital outpatient department where physicians do not bill Medicaid or NJ KidCare fee-for-service program independently for professional services. This code shall include reimbursement for the following service components:

- Assignment of a case coordinator responsible for outreach, referral and follow-up activities;
- 24-hour telephone access for medical consultation outside clinic hours; and
- Provision or arrangement for sick care. (Referral to the emergency room shall only occur for emergency medical care or urgent care as recommended by the physician responsible for sick care.)

NOTE: This code may be billed only in conjunction with a pediatric preventive health care visit provided in accordance with HealthStart Regulations and Guidelines for HealthStart Providers. Claims shall be submitted using Form MC-19, EPSDT/HealthStart Screening and Related Procedures.

END OF SUBCHAPTER 6

APPENDIX

FISCAL AGENT BILLING SUPPLEMENT

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

For a copy of the Fiscal Agent Billing Supplement, write to:

Unisys
PO Box 4801
Trenton, New Jersey 08650-4801

or contact:

Office of Administrative Law
Quakerbridge Plaza, Bldg. 9
PO Box 049
Trenton, New Jersey 08625-0049