

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 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.

Amended by R.1998 d.577, effective December 7, 1998.  
See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).

Inserted references to NJ KidCare fee-for-service and substituted references to beneficiaries for references to recipients throughout; and in (a), changed N.J.A.C. reference.

Amended by R.2003 d.182, effective May 5, 2003.  
See: 34 N.J.R. 4303(a), 35 N.J.R. 1901(a).

In (c), substituted references to NJ FamilyCare for references to NJ KidCare fee-for-service in the introductory paragraph, rewrote 2, and substituted "FD-07A "Request for Prior Authorization: Supplemental Information" " for "prior authorization" in 3.

Amended by R.2004 d.75, effective February 17, 2004.  
See: 35 N.J.R. 2154(a), 36 N.J.R. 952(b).

In (b) and (e), substituted "FamilyCare" for "KidCare"; rewrote (c) and (d).

Amended by R.2004 d.208, effective June 7, 2004.  
See: 36 N.J.R. 324(a), 36 N.J.R. 2834(a).

Rewrote the section.

### 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.

(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:

<u>Group</u>	<u>Maximum Fee Allowance</u>
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.

(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:

(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.

(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 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.

(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 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.

(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 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:

(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:

(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.

(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 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 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.

Amended by R.1996 d.331, effective July 15, 1996.

See: 28 N.J.R. 1952(b), 28 N.J.R. 3573(b).

Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

See: 30 N.J.R. 1060(a).

Rewrote (d).

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.

See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 without change.

Amended by R.1998 d.577, effective December 7, 1998.

See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).

Inserted references to NJ KidCare fee-for-service and substituted references to beneficiaries for references to recipients throughout; in (a), and inserted a reference to NJ KidCare-Plan A or B fee-for-service patients in 1; in (d)2, changed N.J.A.C. reference in the introductory paragraph, rewrote the first sentence of i, and inserted a reference to NJ KidCare-Plan A fee-for-service payments in ii; in (d)3vi, inserted a reference to NJ KidCare Plan A; in (d)6, substituted a reference to NJ KidCare Plan A for a reference to NJ KidCare in the introductory paragraph, and substituted a reference to the Division of Medical Assistance and Health Services for a reference to Medicaid in ii; and in (d)7, substituted a reference to NJ KidCare Plan A for a reference to NJ KidCare in the introductory paragraph, substituted a reference to DMAHS for a reference to the New Jersey Medicaid program in ii, and inserted a reference to NJ KidCare in v.

Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).

See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).

Amended by R.2002 d.271, effective August 19, 2002.

See: 33 N.J.R. 4087(a), 34 N.J.R. 2966(a).

In (d), substituted "for" for "of" preceding "services" and substituted "for periods prior to January 1, 2001 shall be" for "is" following "(FQHC)" in the introductory paragraph; added new (e); recodified former (e) as (f).

Amended by R.2004 d.208, effective June 7, 2004.

See: 36 N.J.R. 324(a), 36 N.J.R. 2834(a).

Rewrote the section.

Amended by R.2004 d.334, effective September 7, 2004.

See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).

### 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 is agents upon request.

Amended by R.1998 d.577, effective December 7, 1998.

See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).

Inserted references to NJ KidCare fee-for-service and substituted references to beneficiaries for references to recipients throughout.

Amended by R.2004 d.208, effective June 7, 2004.

See: 36 N.J.R. 324(a), 36 N.J.R. 2834(a).

Rewrote (b); substituted "FamilyCare" for "KidCare" throughout.

### Case Notes

Adapted tricycle was medically required for treating chronic encephalopathy. K.H. v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 3.

### 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.