

**CHAPTER 66**  
**INDEPENDENT CLINIC SERVICES**

**Authority**

N.J.S.A. 30:4D-6b(3); 30:4D-7, 7a, b, and c; 30:4D-12; 42 CFR 405.2401(b); 42 CFR 440.40(b); 42 CFR 440.90; 42 CFR 441 Subpart B; 42 CFR 441.20; 42 CFR 491 and 493; 1902(a)(9) of the Social Security Act, 42 U.S.C. 1396a; 1902(a)(13)(E) of the Social Security Act, 42 U.S.C. 1396a; 1902(a)(55) of the Social Security Act, 42 U.S.C. 1396a; 1905(a)(2)(C) of the Social Security Act, 42 U.S.C. 1396d; 1905(a)(4)(C) of the Social Security Act, 42 U.S.C. 1396d; N.J.A.C. 13:35; N.J.A.C. 13:39A.

**Source and Effective Date**

R.1993 d.641, effective December 6, 1993.  
See: 25 N.J.R. 4379(a), 25 N.J.R. 5528(c).

**Executive Order No. 66(1978) Expiration Date**

Chapter 66, Independent Clinic Services, expires on December 6, 1998.

**Chapter Historical Note**

All provisions of this chapter, "Manual for Independent Clinic Services" became effective October 1, 1973 as R.1973 d.228. See: 5 N.J.R. 226(c), 5 N.J.R. 339(b).

1971 Revisions: Additional rules on this subject were previously codified as N.J.A.C. 10:58 and became effective on April 21, 1971 as R.1971 d.54. See: 3 N.J.R. 42(b), 3 N.J.R. 82(c).

1974 Revisions: Amendments became effective November 15, 1974 as R.1974 d.295. See: 6 N.J.R. 347(b), 6 N.J.R. 477(b).

1976 Revisions: Amendments became effective October 26, 1976, as R.1976 d.335 and codified to N.J.A.C. 10:58-1.1 were miscodified and should have amended N.J.A.C. 10:66-1.4.

1977 Revisions: Amendments became effective February 17, 1977 as R.1977 d.38. See: 8 N.J.R. 551(c), 9 N.J.R. 125(d).

1980 Revisions: Chapter 66 was amended by deletion of the existing text and insertion of new material effective June 30, 1980 as R.1980 d.249. See: 12 N.J.R. 275(b), 12 N.J.R. 418(f). Amendments became effective November 3, 1980 as R.1980 d.478. See: 12 N.J.R. 538(a), 12 N.J.R. 704(f).

1981 Revisions: Amendments became effective September 10, 1981 as R.1981 d.331. See: 13 N.J.R. 413(a), 13 N.J.R. 575(a).

1982 Revisions: Amendments became effective February 1, 1982 as R.1982 d.19. See: 13 N.J.R. 662(a), 14 N.J.R. 158(c).

1983 Revisions: This chapter was readopted pursuant to Executive Order 66(1978) effective December 15, 1983 as R.1983 d.615. See: 15 N.J.R. 1732(a), 16 N.J.R. 145(a).

1984 Revisions: Amendments became effective January 17, 1984 as R.1984 d.637. See: 15 N.J.R. 1337(a), 16 N.J.R. 144(c). Further amendments became effective February 6, 1984 as R.1984 d.21. See: 15 N.J.R. 1726(a), 16 N.J.R. 239(c). Further amendments became effective July 2, 1984 as R.1984 d.271. See: 16 N.J.R. 811(a), 16 N.J.R. 1788(a).

1985 Revisions: Amendments became effective February 19, 1985 (operative March 1, 1985) as R.1985 d.52. See: 16 N.J.R. 3153(a), 17 N.J.R. 2894(b). Further amendments became effective August 19, 1985 as R.1985 d.428. See: 17 N.J.R. 1377(a), 17 N.J.R. 2046(a). Further amendments became effective December 2, 1985 as R.1985 d.532. See: 16 N.J.R. 3153(a), 17 N.J.R. 2894(b).

1986 Revisions: Amendments became effective January 6, 1986 as R.1985 d.656. See: 17 N.J.R. 2327(a), 18 N.J.R. 87(b). Also, R.1986 d.52, effective March 3, 1986. See: 17 N.J.R. 1519(b), 18 N.J.R. 478(a). Further amendments became effective March 17, 1986 as R.1986 d.59. See: 17 N.J.R. 1235(a), 18 N.J.R. 559(b). Further amendments became effective June 16, 1986 as R.1986 d.220. See: 18 N.J.R. 541(a), 18 N.J.R. 1294(a). Further amendments became effective June 16, 1986 (operative July 1, 1986), as R.1986 d.236. See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a).

1987 Revisions: Amendments became effective October 5, 1987 as R.1987 d.408. See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).

1988 Revisions: Amendments became effective February 1, 1988 as R.1988 d.62. See: 19 N.J.R. 1978(a), 20 N.J.R. 278(b). Further amendments became effective October 17, 1988 as R.1988 d.481. See: 20 N.J.R. 1054(a), 20 N.J.R. 2576(a).

1989 Revisions: This chapter was readopted pursuant to Executive Order 66(1978) effective December 15, 1988 as R.1989 d.33. See: 20 N.J.R. 2562(a), 21 N.J.R. 162(a).

Chapter 66 was further amended by R.1989 d.135 and d.162, effective March 20, 1989. See: 20 N.J.R. 2558(a), 21 N.J.R. 760(a); 20 N.J.R. 1052(a), 21 N.J.R. 761(a). R.1989 d.503, effective September 18, 1989. See: 21 N.J.R. 1794(b), 21 N.J.R. 3005(b). R.1991 d.481, effective September 16, 1991, and R.1991 d.508, effective October 7, 1991. See: 23 N.J.R. 2091(a), 23 N.J.R. 2862(b); 23 N.J.R. 2213(a), 23 N.J.R. 3027(a). R.1992 d.69, effective February 3, 1992, and R.1992 d.98, effective March 2, 1992. See: 23 N.J.R. 3265(a), 24 N.J.R. 465(b); 23 N.J.R. 281(a), 23 N.J.R. 1310(a), 24 N.J.R. 845(a). R.1993 d.444, effective September 7, 1993, and R.1993 d.475, effective September 20, 1993. See: 25 N.J.R. 2683(a), 25 N.J.R. 4104(a); 25 N.J.R. 3058(a), 25 N.J.R. 4498(a).

Chapter 66 was repealed and new rules on Independent Clinic Services were adopted as R.1993 d.641. See: Source and Effective Date.

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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 program pertaining to the provision of, and reimbursement for, medically necessary Medicaid-covered services in an independent clinic setting. An independent clinic setting includes, but is not limited to, clinic types such as an ambulatory care facility, ambulatory surgical center, ambulatory care/family planning/surgical facility, and a Federally qualified health center.

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

(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 recipient 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, and recordkeeping requirements.

2. N.J.A.C. 10:66-2 contains policies and procedures pertaining to specific Medicaid-covered services provided in an independent clinic setting. Where unique characteristics or requirements exist concerning a particular Medicaid-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 Appendix contain information about Federally qualified health centers, including (a) rules governing the provision of services; (b) the Medicaid cost report containing the forms used by Federally qualified health centers to determine Medicaid reimbursement amounts; and (c) instructions for the proper completion of the forms contained in the cost report.

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

6. N.J.A.C. 10:66-6 pertains to the Health Care Financing Administration's Common Procedure Coding System (HCPCS). The HCPCS procedure code system 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, 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, 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/surgical facility” means a health care facility or a distinct part of a health care facility, licensed by the New Jersey State Department of Health to provide specified surgical procedures.

“Ambulatory surgical center” means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization; has an agreement with the Health Care Financing Administration (HCFA) under Medicare to participate as an ambulatory surgical center; is licensed as an ambulatory surgical center, if required, by the New Jersey State Department of Health; and meets the enrollment requirements as indicated in the Administration chapter at N.J.A.C. 10:49-3.2, Enrollment process, and at N.J.A.C. 10:66-1.3, Provisions for provider participation.

“Dental clinic” means a freestanding independent facility, or a distinct component of a multi-service ambulatory care facility, which meets the standards for dental clinics established by the New Jersey State Board of Dentistry.

“Drug treatment center” means a facility or a distinct part of a facility which is licensed or approved by the New Jersey State Department of Health to provide health care for the prevention and treatment of drug addiction and drug abuse, as indicated in the Manual of Standards for Licensure of Drug Treatment Facilities, N.J.A.C. 8:42B.

“Federally qualified health center” means an entity that is receiving a grant under Section 329, 330, or 340 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 329, 330, or 340 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.

“Freestanding facility” means a facility which is not located in a hospital but may, or may not, be under its auspices.

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

“Mental health clinic” means a freestanding independent community facility or distinct component of a multi-service ambulatory care facility, which meets the minimum stan-

dards established by the Community Mental Health Services Act implementing rules at N.J.A.C. 10:37.

“Personal care assistant” means a person who has:

1. Successfully completed a minimum 40 hours training program in personal care services approved by the New Jersey Medicaid program. The individual is assigned and supervised by a registered professional nurse of a Medicaid-approved personal care provider agency.
- i. The individual is primarily involved in the treatment and care of mentally handicapped and developmentally disabled patients in community settings, and is employed by a State agency or by an agency under contract with a State agency.

“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.

“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 program are located in the New Jersey Medicaid program’s 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.

“Specialist in psychology” 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).

### 10:66-1.3 Provisions for provider participation

(a) Each independent clinic, including each satellite, shall be individually approved by the New Jersey Medicaid program in conjunction with the Program’s fiscal agent, for each service provided. If a clinic wishes to add a service(s), approval from the New Jersey Medicaid program 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. A clinic’s medical staff, including physicians, dentists, and other practitioners, shall enroll in the New Jersey Medicaid program, as indicated in the Administration chapter at N.J.A.C. 10:49-3.4, in order to obtain an individual Medicaid Provider Services Number to be used when the clinic submits a claim to the Division’s fiscal agent.

(b) Each independent clinic seeking enrollment in the New Jersey Medicaid program shall possess a certificate of need and/or license, if required, from the New Jersey State Department of Health.

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.

2. A photocopy of the license shall be forwarded to the New Jersey Medicaid program as an attachment to a 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), if required. For example:

1. For an ambulatory surgical center, an agreement with the Health Care Financing Administration (HCFA) under Medicare to participate as an ambulatory surgical center and licensure as an ambulatory surgical center, if required, by the New Jersey State Department of Health;

2. For a Federally qualified health center, approval by the Health Care Financing Administration as a Federally qualified health center and licensure by the New Jersey State Department of Health 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;

4. For a dental clinic, approval by the New Jersey State Board of Dentistry and the Bureau of Dental Services, Division of Medical Assistance and Health Services (DMAHS) of the New Jersey Department of Human Services;

5. For a mental health clinic, approval by the Division of Mental Health and Hospitals (DMH & H) of the New Jersey Department of Human Services; and

6. For child health conferences, approval by the New Jersey State Department of Health as indicated at N.J.A.C. 10:66-3.3.

(d) Requests for approval to perform radiological services, with Medicaid reimbursement, shall be submitted to the New Jersey Medicaid program and shall include:

1. The radiologist’s name(s) and copy(ies) of the license(s); and

2. Documentation from the New Jersey State Department of Health relating to the installation and safety of X-ray equipment.

(e) Each out-of-State clinic seeking reimbursement for services provided to New Jersey Medicaid recipients shall enroll, if the clinic is approved by Title XIX (Medicaid) in its own state, in the New Jersey Medicaid program as indicated in the Administration chapter at N.J.A.C. 10:49-3.2(c). Services are reimbursable under the following circumstances:

1. If the services are provided to Division of Youth and Family Services children residing out-of-State; or

2. If the services are provided in an emergency.

(f) Each Medicaid recipient’s care in an independent clinic shall be under the supervision of a physician directly affiliated with the clinic. The physician shall assume professional responsibility for the services provided and thus assure that the services are medically appropriate.

(g) A physician affiliated with a clinic shall spend as much time in the facility as is necessary to assure that Medicaid recipients are receiving services in a safe and efficient manner in accordance with accepted standards of medical and dental practice.

(h) 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 recipients.

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

(i) The size of the clinic and the type of services it provides determines the number of physicians that must be affiliated with the clinic.

(j) 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 recipients.

#### 10:66-1.4 Prior authorization

(a) In addition to N.J.A.C. 10:49-6.1, this section outlines prior authorization requirements for dental, mental health, rehabilitative, and vision care services, in (b), (c), (d) and (e) below, respectively. Prior authorization requirements by the Physician Case Manager for persons participating in the Garden State Health Plan or other managed health care programs are located at N.J.A.C. 10:49-20.5(a)3.

(b) Dental services require prior authorization as indicated in the New Jersey Medicaid program's Dental Services chapter, N.J.A.C. 10:56.

(c) Mental health services provided to each Medicaid recipient require prior authorization when payment to an independent clinic exceeds \$6,000 for that Medicaid recipient in any 12-month period, commencing with the recipient's initial visit.

1. The maximum period of authorization is up to 12 months for all mental health services. Additional authorizations may be requested.

2. When requesting prior authorization, Form FD-07, Request for Authorization of Mental Health Services, shall be completed and forwarded to: Mental Health Consultant, Division of Medical Assistance and Health Services, Mail Code # 18, CN-712, Trenton, New Jersey 08625-0712. See the Fiscal Agent Billing Supplement, N.J.A.C. 10:66-Appendix, for instructions on the completion of the prior authorization form.

3. The "Brief Clinical History" and "Present Clinical Status" sections of the prior authorization 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 recipient'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 en-

counter 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) Rehabilitative services require prior authorization from the appropriate Medicaid District Office (MDO) after the initial evaluation visit.

1. When requesting prior authorization or reauthorization, Form FD-06, Request for Prior Authorization for Rehabilitative Services, shall be completed and forwarded to the recipient's respective MDO. See the Fiscal Agent Billing Supplement for instructions on the completion of the prior authorization form.

2. Authorization shall be considered only when the request includes a written prescription from a licensed physician.

3. The prescription shall substantiate the need, type of treatment, objective of treatment, and an estimate of the number of treatment days.

4. The prescription shall be definitive as to type and scope. A prescription for "Physical therapy three times a week" is not acceptable.

5. The maximum period of authorization is 60 days.

i. Reauthorizations for periods not exceeding 60 days may be approved by the MDO when the request is supported by:

(1) The physician's written prescription;

(2) A statement of the anticipated number of treatments required; and

(3) A progress report of the recipient's condition.

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.

(e) Vision care services require prior authorization as indicated in the New Jersey Medicaid program's Vision Care Services chapter, N.J.A.C. 10:62.

**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 practitioners in "private" (independent) practice. Reimbursement is made directly to the clinic.

1. An independent clinic shall make a charge for services to all patients, except as provided by legislation, with the proviso that no charge will be made directly to the Medicaid patient, and the charge to the New Jersey Medicaid program 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 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 the 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 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 an eight-group classification system as designated at 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 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

Note: Should the Health Care Financing Administration (HCFA) 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 Program's 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 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.

(d) The basis for reimbursement of services provided in a Federally qualified health center (FQHC) is 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 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 practitioners in "private" (independent) practice, in accordance with N.J.A.C. 10:54-4 and 10:56-3.

i. FQHC reimbursement shall include an interim encounter rate as described in (d)3 below to be billed once for each FQHC visit. 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 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 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:

(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 recipients.

(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 period beginning on and after January 1, 1994:

(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:

(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. The interim encounter rate shall approximate the reimbursable cost the FQHC is currently incurring in furnishing covered services to Medicaid recipients.

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 program 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. The actual encounter rate shall be calculated based upon reasonable costs of Medicaid services provided to Medicaid recipients.
- ii. FQHCs are subject to guidelines to test the reasonableness of the productivity of the staff employed by an FQHC, as follows:
- (1) At least 2.1 encounters per hour, per physician;
  - (2) At least 1.1 encounters per hour, per nurse practitioner or nurse midwife; and
  - (3) At least 1.25 encounters per hour, per dentist or dental hygienist.
- iii. 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 Assistant Director, Office of Budget, Fiscal and Informational Systems, Division of Medical Assistance and Health Services, Mail Code # 23, CN 712, Trenton, New Jersey 08625-0712, or the Assistant 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. The total reimbursement amount due is compared with total payments made to the FQHC for the reporting period, and the difference constitutes the amount of the reconciliation.
- i. If the reconciliation results in an underpayment, a lump sum payment shall be made to the FQHC.
- ii. If the reconciliation results in an overpayment made to the FQHC, Medicaid shall arrange repayment from the FQHC through a lump-sum refund or through an offset against subsequent payments, or a combination of both. The FQHC shall be charged the maximum legal rate of interest on the overpayment as of the date of the notice of Medicaid reimbursement.
7. A Medicaid cost report shall be submitted to the Assistant Director, Office of Budget, Fiscal and Informational Systems, Division of Medical Assistance and Health Services, Mail Code, # 23, CN 712, Trenton, New Jersey 08625-0712, or the Assistant 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, incorporated herein by reference.
- i. The Medicaid cost report shall be filed following the close of a provider's reporting period. Cost reports are due on or before the last day of the third 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 New Jersey Medicaid program. 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.
- iii. To be granted this extension the provider must submit a written request to, and obtain written approval from, Assistant Director, Office of Budget, Fiscal and Informational Systems, Division of Medical Assistance and Health Services, Mail Code, # 23, CN 712, Trenton, New Jersey 08625-0712, or the Assistant Director's designee.
- iv. A request for an extension must be received by the Assistant Director, Office of Budget, Fiscal and Informational Systems, Division of Medical Assistance and Health Services or the Assistant Director's designee, at least 30 days before the due date of the Medicaid cost report.
- v. If a provider's agreement to participate in the Medicaid 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 of services provided in an ambulatory care/family planning/surgical 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 program's 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 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 recipient, as well as the medical necessity for the service.

(b) At a minimum, a clinic shall include a progress note in the Medicaid recipient’s medical/health record for each visit which supports the procedure code(s) billed, except where specified otherwise. The progress note shall include a description of signs and symptoms, treatment and/or medication(s) given, the recipient’s response, and any changes in physical or emotional condition.

(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 program or its agents upon request.

**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.

**SUBCHAPTER 2. PROVISION OF SERVICES**

**10:66-2.1 Introduction**

This subchapter describes the New Jersey Medicaid program’s policies and procedures for the provision of Medicaid-covered services in an independent clinic setting. Services are separately identified and discussed only where unique characteristics or requirements exist. Unless indicated otherwise, reimbursement issues are located in N.J.A.C. 10:66-1.5, Basis for reimbursement.

**10:66-2.2 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 recipients 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 recipients 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 laboratory tests, including:

i. Hemoglobin/hematocrit;

ii. Urinalysis;

iii. Tuberculin test;

iv. Lead blood level assessment, appropriate to age and risk, which shall be performed annually for children between six months and six years of age; and

v. Other appropriate medically-necessary procedures;

5. Health education, including anticipatory guidance; and

6. Referral for further diagnosis and treatment or follow up of all correctable 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 includes:

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; and

4. A second examination with visual acuity testing by age three or four years.

5. Periodicity testing for school aged children is 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 vision screening 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. An individual hearing screening should be administered annually to all children through age eight and to all children at risk of hearing impairment.

2. After age eight, children should be screened every other year.

### 10:66-2.3 Family planning

(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 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 Medical Affairs and Provider Relations, CN 712, (Mail Code # 14), Trenton, New Jersey 08625-0712.

(b) The Norplant System (NPS) is a Medicaid-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 recipient 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.

(c) 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.

**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's 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.

ii. More than one medical encounter is also allowed if a recipient 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 recipient requires clear documentation in the recipient'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 recipient and a practitioner, and referrals to specialists, do not constitute a medical encounter.

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

5. A dental encounter is a face-to-face contact between a recipient 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.

**SUBCHAPTER 4. FEDERALLY QUALIFIED HEALTH CENTER (FQHC)**

**10:66-4.1 Federally qualified health center services**

(a) Federally qualified health center (FQHC) services are services provided by physicians, physician assistants, nurse practitioners, 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 an incident to a physician's services.

(b) FQHC rules are as follows:

1. FQHCs shall accommodate an outstationed county welfare agency (CWA) employee(s) for the purpose of determining Medicaid eligibility, pursuant to 1902 (a)(55) of the Social Security Act, 42 U.S.C. 1396a.

2. Each visit by an individual seeking services at a FQHC is called an encounter, which may be medical, psychiatric, or dental.

3. A medical encounter is a face-to-face contact between a recipient 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.

i. Normally, only one medical encounter is covered per recipient, per day. More than one medical encounter is covered, however, when the recipient 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.

**APPENDIX**

**Cost Report**

(a) Each Federally qualified health center (FQHC) participating as an independent clinic provider in the Medicaid program 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 a Medicaid recipient.

(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 reimbursement due to an FQHC for services provided to Medicaid recipients.

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

(See pages 4400 through 4402 for copy of Federally Qualified Health Center Medicaid Cost Reporting Forms)

**FQHC-93-01 (Certification) (i)(ii)  
COMPLETION INSTRUCTIONS:**

Field	Explanation
1.	Enter the Federally qualified health center mailing address.

Field	Explanation
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 are to be listed here. The name, number and source of the grant (i.e., State of New Jersey Grant # XXXXX, Public Health Service Grant # XXXXX, etc.) duration of the grant and the total grant dollars under each grant are to be listed. This information is purely for informational purposes. If additional space is required attach a supporting sub-schedule listing.
8.	The names and Medicaid Physician Billing numbers of physicians furnishing services at the center are to be entered here. As appropriate a sub-schedule may be used.
9.	Enter the name and number of hours worked by the supervisory physician(s) during the reporting period. Sub-schedules may be used as necessary.

#### 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.

(See pages 4403 through 4405 for copy of Federally Qualified Health Center Supporting Documentation forms)

**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. (For budgeted reports an estimated trial balance should be utilized.) This worksheet provides for any adjustments or reclassification to the center'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 doesn't 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.

#### 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 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.

#### 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 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 recipients.

(See page 4406 for copy of FQHC-93-01)

**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.

(See page 4407 for copy of FQHC-93-01)

**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, effecting 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.

(See page 4408 for copy of FQHC-93-01)

**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. (Note: A time allocation and/or other reclassification may be necessary on Worksheet A using Support Schedule A.)

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 & 4:**—Enter the total number of Medicaid encounters for the period according to their respective core service area and place of encounter (on site or off site).

**Column 2 & 5:**—Enter the total number of Medicaid encounters for the period according to their respective service area and place of encounter (on site or off site).

**Column 3 & 6:**—Enter other third party or non-payer encounters and place of encounter.

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

**Line 26—Columns 2, 3, 5, 6 & 7:**—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.

(See page 4409 for copy of FQHC-93-01)

**FQHC-93-01 Worksheet 3—PRODUCTIVITY SCREENING—(ix)**

#### 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 visits 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.

**Column 1—Number of FTE's:**—Staffing is to be reported on the basis of full time equivalents. The total number of hours per specialty or position listed on Worksheet 3 is determined from the center's time records. The total hours actually worked is 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 lines for the Pneumococcal Vaccine, 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 1a—Number of On Site Hours:**—The total on site hours worked by all FTE's in a cost center category, as recorded and taken from the center's records, are entered here.

**Column 2—Total Visits:**—The total number of visits taken from the center's patient log for the reporting period is entered by cost center category. A visit should be recorded in **one category only** on the worksheet. (Refer to N.J.A.C. 10:66 for the definition of an encounter). 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.

For Pneumococcal Vaccine Services, line 16, the number of injections given are to be shown in this column. The actual encounter would be recorded in one of the other service categories, as appropriate.

**Column 4—Minimum Visits:**—The result of multiplying column 1a by column 3 for all service lines is to be entered here. The resultant is the minimum visit 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.

(See page 4410 for copy of FQHC-93-01)

**FQHC-93-01 Worksheet 4—Encounter Rate Calculation—(x)**

#### 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 reconciliation process on Worksheet 5.

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

**Part I—Item (B)** reflects the total facility overhead costs associated with providing services during the period as derived from taking Worksheet 1, line 71, column 8 and Worksheet 1, line 105, 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 1, 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 (B). The amount derived is the percentage of total 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 Visits:**

Enter the productivity screening visit 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 Vaccine line will reflect the actual number of injections given as shown on Worksheet 3, Page 1-1, line 15 and 16, column 2. Dental/Dental Hygienist visits are the sum of Worksheet 3, line 10 and line 11, column 5.]

**Column 6—Computed Per Visit Encounter Rate:**

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

(See page 4411 for copy of FQHC-93-01)

**FQHC-93-01 Worksheet 4—Encounter Rate Calculation—(xi)****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 centers expenses, as found on Worksheet 1—Trial Balance of Expense, line 56, column 8, is 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 total facility overhead from Worksheet 4, Page 1-2, Part I, Item (B).

**Line 22:**—To determine the amount of total 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 8, column 5 on this line.

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

(See page 4412 for copy of FQHC-93-01)

**FQHC-93-01 Worksheet 5—Reconciliation Determination—(xii)****COMPLETION INSTRUCTIONS:**

**General:**—This worksheet will determine the actual total reimbursable cost for all Medicaid encounters covered during the cost reporting period and the final reconciliation amount either due to or < from > a facility.

**All Services—Lines 1 through 14:**

**Column 1:**—For each of the line items, enter the Medicaid covered Encounters from Worksheet 2, Page 1-1, column 2 plus column 5, as appropriate. These amounts should agree to the facility's State produced summary report for the same period as that of the cost report.

**Line 1:**—Enter the figure from Worksheet 2, Page 1-1, line 8, column 2 plus column 5.

**Lines 2-14:**—Enter the figures from appropriate line item on Worksheet 2, Page 1-1, column 2 plus column 5.

**Column 2:**—Enter the computed per visit 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 3:**—To determine the Medicaid Reimbursable cost for each type of service, multiply the amounts found in column 1 by column 2. Enter the result here.

**Line 15:**—For columns 1 and 3, enter the sum of lines 1 through 13. Column 3, line 15, is the total reimbursable Medicaid cost for all Medicaid services provided by the facility for the period covered by the cost report.

**Line 16:**—Enter the total amount of interim payments received by the facility for Medicaid 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. That is to say fee for service, as well as per encounter interim payments, should be reflected.

**Line 17:**—Subtract line 16 from line 15 and enter the amount here. If line 16 is less than the amount shown on line 15, the resulting figure is the amount owed to the facility based on the cost contained in the cost report. If the amount on line 16 is greater than the amount shown on line 15, the resultant figure is the amount the facility has been overpaid during the period of the cost report for Medicaid services rendered. This amount <negative> should be placed in parenthesis. If the figure on line 17 reflects an overpayment, the facility should expect the State Agency to adjust current interim payments until the recoupment/repayment of the entire amount has been accomplished. Any and all amounts recouped must be treated as payments to the facility for the subsequent cost reporting period.

(See page 4413 for copy of FQHC-93-01)

**FQHC-93-01 Worksheet 6—AVERAGE PER ENCOUNTER INTERIM RATE CALCULATION—(xiii)**

**COMPLETION INSTRUCTIONS:**

**General:**—This worksheet will enable the facility to determine an average per encounter interim reimbursement rate for the succeeding cost report period based on the file report. In certain instances, such as for new facilities or when major financial or patient population changes occur during the year, the facility may wish to prepare an interim cost report to determine the effect on their Medicaid interim rate. In this manner they may avoid large under or over payment situations, as well as provide a needed management tool for managing the facility. The completion of this worksheet will identify what the rate should be for the given cost contained on the report and the patient activity. Note that major changes in services provided or numbers of encounters, as well as the type of population served, (referred to as payer mix) will impact the development of the interim payment rate.

**SUBCHAPTER 5. AMBULATORY SURGICAL CENTER (ASC)**

**10:66-5.1 Covered services**

(a) Medicaid-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 program).

i. If additional surgical procedures are approved, each procedure will be assigned to one of the existing eight Medicare payment groups.

(b) Medicaid-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**

(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;