CHAPTER 66

INDEPENDENT CLINIC SERVICES

Authority

N.J.S.A. 30:4D–6, 7 and 12; 42 CFR 405.2401(b), 440.40(b), 440.90, 441 Subpart B, 441.20, 491 and 493.

Source and Effective Date

R.1998 d.577, effective November 12, 1998.
See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).

Executive Order No. 66(1978) Expiration Date

Chapter 66, Independent Clinic Services, expires on November 12, 2003.

Chapter Historical Note

Chapter 66, Manual for Independent Clinic Services, was adopted as R.1973 d.228, effective October 1, 1973. See: 5 N.J.R. 226(c), 5 N.J.R. 339(b).

Chapter 66, Manual for Independent Clinic Services, was repealed and a new Chapter 66, Independent Clinic Services Manual, was adopted as R.1980 d.249, effective June 30, 1980. See: 12 N.J.R. 275(b), 12 N.J.R. 418(f).

Pursuant to Executive Order No. 66(1978), Chapter 66, Independent Clinic Services Manual, was readopted as R.1983 d.615, effective December 15, 1983. See: 15 N.J.R. 1732(a), 16 N.J.R. 145(a).

Pursuant to Executive Order No. 66(1978), Chapter 66, Independent Clinic Services Manual, was readopted as R.1989 d.33, effective December 15, 1988. See: 20 N.J.R. 2562(a), 21 N.J.R. 162(a).

Chapter 66, Independent Clinic Services Manual, was repealed and a new Chapter 66, Independent Clinic Services, was adopted as R.1993 d.641, effective December 6, 1993. See: 25 N.J.R. 4379(a), 25 N.J.R. 5528(c).

Pursuant to Executive Order No. 66(1978), Chapter 66, Independent Clinic Services, was readopted as R.1998 d.577, effective November 12, 1998. See: Source and Effective Date. See, also, section annotations.

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SUBCHAPTER 1. GENERAL PROVISIONS

10:66–1.1 Scope of service

(a) This chapter (N.J.A.C. 10:66) describes the policies and procedures of the New Jersey Medicaid and NJ Kid-

Care fee-for-service programs pertaining to the provision of, and reimbursement for, medically necessary Medicaid-covered and NJ KidCare-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 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 and NJ KidCare fee-for-service laws, and all applicable policies, rules and regulations as specified in the appropriate provider services manual of the New Jersey Medicaid and NJ KidCare fee-for-service programs.

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

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

1. N.J.A.C. 10:66–1 contains scope of service, definitions, provisions for provider participation, prior authorization, basis for reimbursement, and recordkeeping requirements.

2. N.J.A.C. 10:66–2 contains policies and procedures pertaining to specific Medicaid-covered and NJ KidCare-covered services provided in an independent clinic setting. Where unique characteristics or requirements exist concerning a particular Medicaid-covered or NJ KidCare-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 rules governing the provision of services; the Medicaid cost report containing the forms used by Federally qualified health centers to determine Medicaid and NJ KidCare-Plan A fee-for-service reimbursement amounts; and 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.

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 NJ KidCare-covered services throughout; in (c), substituted a reference to beneficiaries for a reference to recipients; and in (d)4, inserted a reference to NJ KidCare-Plan A fee-for-service.

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 and Senior Services, which provides preventive, diagnostic, and treatment services to persons who come to the facility to receive services and depart from the facility on the same day.

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

"Ambulatory surgical center" 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 Senior Services; 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.

"Audited financial statements" are defined in requirements set forth in N.J.A.C. 10:66–4.2. This section provides a set of guidelines so that FQHC providers will know the criteria for a satisfactory audit.

"Compensated hours" means all hours for which an employee receives compensation, payment or any form of remuneration, including regular time, overtime, vacation time, sick time, personal time, educational time, and all other compensated time.

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 include managed care organization payments and personal contribution to care payments received from NJ KidCare–Plan A beneficiaries. Accounting records or documentation of total personal contribution to care payments received must be maintained by each FQHC. Should there be a discrepancy between the FQHC's reported payments and the fiscal agent's reported payments, the fiscal agent's payments shall be used for determination of final settlement.

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. 10:66–4.2, Appendix of this chapter, and a letter signed by an officer of the FQHC indicating the total amount of personal contribution to care payments received for NJ KidCare–Plan A services provided during the cost reporting year 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 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 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 KidCare 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 KidCare 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.

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 KidCare fee-for-service beneficiary, as well as the medical necessity for the service.

(b) At a minimum, a clinic shall include a progress note in the Medicaid or NJ KidCare fee-for-service beneficiary'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 beneficiary'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 and NJ KidCare 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.

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 KidCare-Plan C

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

(b) Personal contribution to care for NJ KidCare-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 supervision of the physician, 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 child 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 KidCare-Plan C services if the NJ KidCare-Plan C services Identification Card indicates that a personal contribution to care is required and the beneficiary does not have a NJ KidCare 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.

New Rule, R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
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 with changes, effective September 21, 1998.

SUBCHAPTER 2. PROVISION OF SERVICES

10:66–2.1 Introduction

This subchapter describes the New Jersey Medicaid and NJ KidCare fee-for-service programs' policies and procedures for the provision of Medicaid-covered and NJ KidCare fee-for-service-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.