

CHAPTER 66

INDEPENDENT CLINIC SERVICES

Authority

N.J.S.A. 30:4D-1 et seq., specifically 7 and 12.

Source and Effective Date

36 N.J.R. 324(a), 36 N.J.R. 2834(a).
R.2004 d.208, effective May 10, 2004.

Chapter Expiration Date

Chapter 66, Independent Clinic Services, expires on May 10, 2009.

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Chapter 66, Manual for Independent Clinic Services, was repealed and a new Chapter 66, Independent Clinic Services Manual, was adopted as R.1980 d.249, effective June 30, 1980.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Chapter 66, Independent Clinic Services Manual, was repealed and a new Chapter 66, Independent Clinic Services, was adopted as R.1993 d.641, effective December 6, 1993.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: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).

Chapter 66, Independent Clinic Services, was readopted as R.2004 d.208, effective May 10, 2004. 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 FamilyCare fee-for-service programs pertaining to the provision of, and reimbursement for, medically necessary Medicaid-covered and NJ FamilyCare-covered services in an independent clinic setting. The term independent clinic includes, but is not limited to, clinic types such as: ambulatory care facility, ambulatory surgical center, ambulatory care/family planning clinic, and Federally qualified health center.

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

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

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

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

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

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

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

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

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

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

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.

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

Rewrote the section.

10:66-1.2 Definitions

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

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

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

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

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

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

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

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

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

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

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

“Drug treatment center” means an independent clinic, whether freestanding, or a distinct part of a facility which is licensed or approved by the New Jersey State Department of Health and Senior Services (DHSS) to provide health care for the prevention and treatment of drug addiction and

drug abuse, in accordance with N.J.A.C. 8:43A-26, Drug Abuse Treatment Services.

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

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

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

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

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

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

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

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

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

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

Mental health services worker“ means an individual who possesses a bachelor’s degree or associate’s degree in psychosocial rehabilitation or mental health services, or related life or work experience, such as assuming leadership roles during participation in mental health services or mental health consumer initiatives.

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

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

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

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

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

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

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

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

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

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

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

“Specialist” means a fully licensed physician who:

1. Is a diplomate of a specialty board approved by the American Board of Medical Specialties or the Advisory Board of the American Osteopathic Association;
2. Is a fellow of the appropriate American specialty college or a member of an osteopathic specialty college;
3. Is currently admissible to take the examination administered by a specialty board approved by the American Board of Medical Specialties or the Advisory Board of the American Osteopathic Association, or has evidence of completion of an appropriate qualifying residency approved by the American Medical Association or American Osteopathic Association;

4. Holds an active staff appointment with specialty privileges in a voluntary or governmental hospital which is approved for training in the specialty in which the physician has privileges; or

5. Is recognized in the community as a specialist by his or her peers.

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

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

“Therapeutic subcontract work activity” means production, assembly and/or packing/collating tasks for which individuals with disabilities performing these tasks are paid less than minimum wage and, pursuant to 29 C.F.R. § 525, a special minimum wage certificate has been issued to the organization/program by the U.S. Department of Labor.

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

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.577, effective December 7, 1998.

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

In “Personal care assistant”, inserted references to NJ KidCare throughout 1; and in “Specialist in dentistry”, inserted references to NJ KidCare fee-for-service throughout.

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

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

Added “Managed care wraparound payments”, “Medicare Economic Index (MEI)” and “Prospective Payment System (PPS); Rewrote “Medicare limit”.

Amended by R.2004 d.75, effective February 17, 2004.

See: 35 N.J.R. 2154(a), 36 N.J.R. 952(b).

Added definitions for “Mental health services worker”, Prevocational services”, “Special minimum wage certificate”, “Therapeutic subcontract work activity” and “Vocational services”.

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

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

Rewrote the section.

10:66-1.3 Provisions for provider participation

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

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

2. (Reserved)

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

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

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

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

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

2. For a Federally qualified health center, approval by the Centers for Medicare & Medicaid Services as a Federally qualified health center and licensure by the New Jersey State Department of Health and Senior Services as an ambulatory care facility;

3. For an ambulatory care/family planning/surgical facility, licensure as an ambulatory care/family planning/surgical facility by the New Jersey State Department of Health and Senior Services;

4. For a dental clinic, a permit to operate shall be obtained from the State Board of Registration and Examination in Dentistry (see N.J.A.C. 13:30-4.2) prior to enrollment as a dental clinic provider, and shall remain in effect;

5. For a mental health clinic, approval by the Division of Mental Health Services of the New Jersey Department of Human Services; and

6. For child health conferences, approval by the New Jersey State Department of Health and Senior Services in accordance with N.J.A.C. 8:52 and as indicated at N.J.A.C. 10:66-3.3.

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

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

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

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

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

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

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

Rewrote the section.

10:66-1.4 Prior authorization (PA)

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

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

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

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

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

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

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

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

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

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

Inserted references to NJ KidCare fee-for-service and substituted references to beneficiaries for references to recipients throughout. Amended by R.2004 d.208, effective June 7, 2004.