

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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APPENDIX

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.

“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.

“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.

“Hour” means a standard 60-minute period.

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

“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. §1395x(v), and 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). The MEI is determined in accordance with section 1842(b)(3) of the Act, 42 U.S.C. §1395b(3) and regulation at 42 C.F.R. 405.504.

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

Amended by R.1996 d.331, effective July 15, 1996.
See: 28 N.J.R. 1952(b), 28 N.J.R. 3573(b).

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, PO Box-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 encounter that departs from the plan of care in terms of increased need, scheduling, frequency, or duration of services furnished (for example, unscheduled emergency services furnished during an acute psychotic episode).

6. If the request for prior authorization is approved, the Division's fiscal agent shall notify the provider in writing regarding the Division's decision; authorized date or time frame; and activation of the prior authorization number. If the request is modified, denied, or if the Division requires additional information, the provider is so notified in writing by the fiscal agent.

(d) 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 (CWA) staff to determine Medicaid eligibility. An FQHC's financial responsibility for outstationing activities is equivalent to the non-Federal share (currently 50 percent) of estimated CWA costs for the calendar year.

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

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

2. For cost reporting periods beginning on and after January 1, 1994, FQHC reimbursement shall be based on the same HCPCS procedure code fees, conditions and definitions for corresponding services governing the reimbursement of Medicaid-participating and NJ KidCare-participating practitioners in "private" (independent) practice, in accordance with N.J.A.C. 10:54-4 and 10:56-3 and reimbursement of independent clinics in accordance with this chapter.

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

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

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

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

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

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

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

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

(1) The interim encounter rate shall be the prior year's actual encounter rate as calculated from the Medicaid cost report which shall be incremented by the medical care component of the Consumer Price Index. The interim encounter rate may be adjusted to approximate the reimbursable cost the FQHC is currently incurring to provide covered services to Medicaid 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 periods beginning on and after January 1, 1994 and prior to January 1, 1995:

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

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

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

(1) For those FQHCs that have filed a Medicaid cost report, the interim encounter rate shall be the prior year's actual encounter rate as calculated from the Medicaid cost report which shall be incremented by the medical care component of the Consumer

Price Index. The interim encounter rate may be adjusted to approximate the reimbursable cost the FQHC is currently incurring in providing covered services to Medicaid recipients.

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

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

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

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

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

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

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

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

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

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

vi. The interim encounter rate may be adjusted during an accounting period. Such adjustment may be made either upon request of the facility, or if there is evidence available to the Medicaid 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. For services rendered to Medicaid recipients prior to July 15, 1996, the actual encounter rate shall be calculated based upon reasonable costs of Medicaid services provided to Medicaid recipients.

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

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

(2) The Medicaid limit per encounter.

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

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

(A) 50 percent of compensated hours; or

(B) Actual hours providing direct care.

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

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

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

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

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

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

6. Reimbursable 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 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, Medicaid 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 services provided during the cost reporting year shall be submitted to the Director, Administrator 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 and audited financial statements may, for good cause, be granted by the New Jersey Medicaid program. Good cause means a valid reason or justifiable purpose; 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 agents, 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 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.

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.

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.

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 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, PO Box 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.

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

ii. An institutionalized individual is an individual who is:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

i. In labor or childbirth;

ii. Seeking to obtain or obtaining an abortion; or

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

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

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

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

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

10:66-2.4 Laboratory

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

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

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

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

10:66-2.5 Mental health

(a) Mental health services include: comprehensive intake evaluation, individual psychotherapy, off-site crisis intervention, family therapy, family conference, group psychotherapy, psychological testing, partial care, and medication management.

(b) Only one type of mental health service per recipient is reimbursable to an independent clinic on a given day. Exception: Medication management may be reimbursed when provided to a Medicaid recipient in addition to one of the following mental health services: individual psychotherapy, group psychotherapy, family therapy, and family conference.

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

(d) For purposes of partial care, full day means five or more hours of participation in active programming exclusive of meals; half day means at least three hours but less than five hours of participation in active programming exclusive of meals. Additional details are located at N.J.A.C. 10:66-6.

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

1. Evaluates the recipient's mental condition;

2. Determines whether treatment in the program is appropriate, based on the recipient's diagnosis;

3. Includes certification (signed statement) by the evaluation team that the program is appropriate to meet the recipient's treatment needs; and

4. Is made part of the recipient's records.

5. The evaluation for the intake process shall include a physician and an individual experienced in diagnosis and treatment of mental illness. Both criteria may be satisfied by the same individual, if appropriately qualified.

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

1. A written description of the treatment objectives including both the treatment regimen and the specific medical/remedial services, therapies, and activities that shall be used to meet the objectives;

2. A projected schedule for service delivery which includes the frequency and duration of each type of planned therapeutic session or encounter;

3. The type of personnel that will be furnishing the services; and

4. A projected schedule for completing reevaluations of the recipient's condition and updating the plan of care.

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

1. This documentation, at a minimum, shall consist of:

i. The specific services rendered, such as individual psychotherapy, group psychotherapy, family therapy, etc., and a description of the encounter itself (that is, statement of patient progress noted, significant observations noted, etc.);

ii. The date and time that services were rendered;

iii. The duration of services provided (one hour, ½ hour, etc.);

iv. The signature of the practitioner or provider who rendered the services;

v. The setting in which services were rendered; and

vi. A notation of unusual occurrences or significant deviations from the treatment described in the plan of care.

2. Clinical progress, complications and treatment which affect prognosis and/or progress shall be documented in the recipient's medical record at least once a week, as well as any other information important to the clinical picture, therapy, and prognosis.

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

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

1. The periodic review shall determine:
 - i. The recipient's progress toward the treatment objectives;
 - ii. The appropriateness of the services being furnished; and
 - iii. The need for the recipient's continued participation in the program.
2. Periodic reviews shall be documented in detail in the recipient's records and made available upon request to the New Jersey Medicaid program or its agents.

10:66-2.6 Rehabilitation

(a) Rehabilitative services include physical therapy, occupational therapy, and speech-language pathology and audiology, including the use of such supplies and equipment as are necessary in the provision of such services. Rehabilitative services and other restorative services are provided for the purpose of attaining maximum reduction of physical or mental disability and restoration of a Medicaid recipient to his or her best functional level. Rehabilitative services shall be made available to Medicaid recipients as an integral part of a comprehensive medical program.

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

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

(c) Physical therapy is a service prescribed by a physician and provided to a Medicaid recipient by or under the direction of a qualified physical therapist. Physical therapy does not include therapy which is purely palliative, such as the application of heat in any form; massage; routine calisthenics; group exercises; assistance in any activity; use

of a simple mechanical device; or other services not requiring the special skill of a licensed physical therapist.

1. A physical therapist is an individual who is:
 - i. Licensed by the State of New Jersey as a physical therapist in accordance with N.J.A.C. 13:39A; and
 - ii. A graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent.
2. If treatment or services are provided in a state other than New Jersey, the physical therapist shall meet the requirements of that state, including licensure if applicable, and all applicable Federal requirements.

(d) Occupational therapy is a service prescribed by a physician and provided to a Medicaid recipient by or under the direction of a qualified occupational therapist.

1. An occupational therapist is an individual who is:
 - i. Registered by the American Occupational Therapy Association; or
 - ii. A graduate of a program in occupational therapy approved by the Committee on Allied Health Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.
2. If treatment or services are provided in a state other than New Jersey, the occupational therapist shall meet the requirements of that state, including licensure if applicable, and all applicable Federal requirements.

(e) Speech-language pathology services and audiology services are diagnostic, screening, preventive, or corrective services prescribed by a physician and provided to a Medicaid recipient by or under the direction of a speech-language pathologist or audiologist.

1. A speech-language pathologist or audiologist is an individual who is licensed by the State of New Jersey as a speech-language pathologist or audiologist, in accordance with N.J.A.C. 13:44C, and meets all applicable Federal requirements including:
 - i. A Certificate of Clinical Competence in Speech-Language Pathology or Audiology from the American Speech-Language-Hearing Association;
 - ii. Completion of the equivalent educational requirements and work experience necessary for the certificate(s); or
 - iii. Completion of the academic program and in the process of acquiring supervised work experience in order to qualify for the certificate(s).

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

(f) No portion of the time spent on therapy treatments may be considered as part of the time parameters of a clinic visit. Clinic visits billed during the same day shall clearly and separately meet the time and other parameters described in the applicable HCPCS procedure codes, N.J.A.C. 10:66-6.

(g) When prior authorized, reimbursement to a clinic may be made for more than one type of rehabilitative service performed on a Medicaid recipient on the same day, for example, physical therapy and speech-language pathology.

(h) When the same type of rehabilitative service is performed on a Medicaid recipient more than once on the same day, for example, two physical therapy services, reimbursement shall be made for one service only. Likewise, when the treatment performed on a Medicaid recipient is merely a different modality within the same type of rehabilitative service, reimbursement shall be made for only one service per recipient per day.

10:66-2.7 Transportation

(a) Transportation service is Medicaid covered when the following conditions are met:

1. The clinic is approved to provide transportation service by the New Jersey Medicaid program.
 - i. Approval by the New Jersey Medicaid program shall not be granted for the provision of ambulance or invalid coach service.
2. Transportation service is provided either:
 - i. By the clinic, in a clinic owned or leased vehicle; or
 - ii. By a transportation company under contract to the clinic.
3. The purpose of providing transportation, one way or round trip, is to enable a Medicaid recipient to obtain a Medicaid-covered service at the clinic.
4. A Medicaid recipient is transported:
 - i. To the clinic, from the recipient's residence or a designated central point; or
 - ii. From the clinic, to the recipient's residence or a designated central point.

10:66-2.8 Miscellaneous

(a) The following applies to the provision of dental services:

1. All diagnostic, preventive or corrective dental procedures shall be administered by, or under, the direct supervision of a dentist enrolled in the New Jersey Medicaid program.

2. Dental services provided in an independent clinic shall follow the policies and procedures outlined in the New Jersey Medicaid program's Dental Services chapter, N.J.A.C. 10:56.

3. The New Jersey Medicaid program's Dental Services chapter, N.J.A.C. 10:56-3 (HCPCS), contains dental procedure codes and maximum fee allowances.

(b) The following applies to the provision of drug treatment services:

1. Medicaid-covered services delivered to Medicaid recipients in a drug treatment center are only those services that are:

- i. Prescribed by a physician;
- ii. Eligible for Federal financial participation under Title XIX of the Social Security Act; and
- iii. Included in the facility's Medicaid approval letter.

2. Only one type of mental health service per recipient is reimbursable to a drug treatment center on a given day. See N.J.A.C. 10:66-2.5(b) for the exception concerning medication management.

3. For the purposes of the AIDS Community Care Alternatives Program (ACCAP) only, certain services as indicated at N.J.A.C. 10:66-6.2(m) may be provided to ACCAP-eligible individuals in the home.

(c) The following applies to hospital visits:

1. An inpatient hospital visit performed by a clinic physician for a registered patient of a Federally qualified health center shall be reimbursed only if the clinic is specifically approved to provide this service by the Program.

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

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

(d) Obstetrical services, which may include obstetrical delivery, may be reimbursed when performed by a licensed physician and/or certified nurse-midwife in a licensed ambulatory care facility which is specifically approved to perform such services by the New Jersey Medicaid program.

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

(f) For covered pharmaceutical services, see the New Jersey Medicaid program's Pharmaceutical Services chapter, N.J.A.C. 10:51. See N.J.A.C. 10:51-1.22 for bundled drug services.

(g) Specified radiological services may be reimbursed when provided in a clinic that is specifically approved to provide such services by the New Jersey Medicaid program, and performed by a physician who is recognized as a specialist in radiology by the New Jersey Medicaid program. See the New Jersey Medicaid program's Physician's Services chapter, N.J.A.C. 10:54, for additional information.

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

(i) Termination of pregnancy is a Medicaid-covered service when the following conditions are present:

1. If performed in an appropriately licensed ambulatory care facility, an ambulatory surgical center, or an ambulatory care/family planning/surgical facility licensed and authorized by the New Jersey State of Health to perform abortions with specific approval of the New Jersey Medicaid program;

2. If performed in accordance with the requirements of the New Jersey Board of Medical Examiners, N.J.A.C. 13:35;

3. If performed by a physician licensed to practice medicine and surgery in the State of New Jersey; and

4. If medically necessary. A physician may take the following factors into consideration in determining whether a termination of pregnancy is medically necessary:

- i. Physical, emotional, and psychological factors;
- ii. Family reasons; and
- iii. Age.

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

6. A Physician Certification (Form FD-179) must be attached to any Medicaid claim form relating to termination of pregnancy services.

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

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

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

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

- i. Each personal care provider employing personal care assistants shall be individually approved by the New Jersey Medicaid program before it will be reimbursed for services rendered to Medicaid recipients. The Division of Medical Assistance and Health Services will recognize upon approval, agencies under contract to the Division of Mental Health and Hospitals.

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

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

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

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

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

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

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

notes shall be signed and dated by the personal care assistant.

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

v. Home visitation; and

vi. Outreach, referral and follow-up services.

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

SUBCHAPTER 3. HEALTHSTART

10:66-3.1 Purpose

(a) The purpose of HealthStart is to provide for comprehensive maternity care services to pregnant Medicaid recipients, including those determined to be presumptively eligible, and preventative child health care services for Medicaid recipients up to the age of two.

1. Pediatric HealthStart services are an expansion of the EPSDT program as described at N.J.A.C. 10:66-2.2.

10:66-3.2 Scope of services

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

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

1. Medical maternity care services include:
 - i. Ambulatory prenatal services;
 - ii. Admission arrangements for delivery;
 - iii. Obstetrical delivery services; and
 - iv. Postpartum medical services.
2. Health support services include:
 - i. Case coordination services;
 - ii. Health education assessment and counseling services;
 - iii. Nutrition assessment and counseling services;
 - iv. Social-psychological assessment and counseling services;

10:66-3.3 HealthStart provider participation criteria

(a) The following Medicaid-enrolled provider types are eligible to participate as HealthStart providers: independent clinics, hospital outpatient departments, local health departments meeting the New Jersey State Department of Health's Improved Pregnancy Outcome criteria and/or approved as Child Health Conferences, physicians and physician groups, and certified nurse midwives.

(b) In addition to New Jersey Medicaid program rules applicable to provider participation, HealthStart providers shall:

1. Sign an Addendum to the New Jersey Medicaid program's Provider Agreement;
2. Have a valid HealthStart Provider Certificate for HealthStart Maternity Care Service, HealthStart Medical Maternity Service, HealthStart Health Support Service, or HealthStart Pediatric Care Service; and
3. Provide maternity care and/or pediatric care services in accordance with the requirements for issuance of a HealthStart Provider Certificate and in accordance with the New Jersey State Department of Health's Guidelines for HealthStart Maternity Care Providers and HealthStart Pediatric Care Providers.

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

1. Shall participate in program evaluation and training activities, including, but not limited to, site monitoring, agency and patient record review, and submission of required summary information on each patient according to the New Jersey State Department of Health's Guidelines for HealthStart Providers; and
2. May determine presumptive eligibility for the New Jersey Medicaid program if approved by the Division of Medical Assistance and Health Services.

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

(e) A site review may be required to ascertain an applicant's ability to meet the standards for a HealthStart Provider Certificate and to provide services in accordance with the New Jersey State Department of Health's Guidelines for HealthStart Providers in the appropriate area.

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

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

HealthStart Program
New Jersey State Department of Health
CN 364
Trenton, NJ 08625-0364

(h) A HealthStart Program Provider Agreement is available from:

Chief, Provider Enrollment Unit
Division of Medical Assistance and Health Services
Mail Code # 9
CN 712
Trenton, N.J. 08625-0712

10:66-3.4 Termination of HealthStart Provider Certificate

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

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

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

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

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

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

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

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

2. The provider shall provide or arrange for the admission of the patient to the appropriate level of care facility for obstetrical delivery services;

3. The provider shall provide or arrange for all necessary laboratory services;

4. The provider shall provide one or more prenatal home visits for each high risk patient;

5. The provider shall provide at least one postpartum home visit for each high risk patient;

6. The provider shall adopt procedures and policies which assure the delivery of coordinated, integrated and comprehensive care; and

7. The provider shall provide referral and follow-up services, which must include, but not be limited to: referral for specialized evaluation, counseling and treatment for extensive social, psychological, nutritional and medical needs.

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

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

10:66-3.6 Access to service

(a) All HealthStart services shall be accessible to patients.

(b) HealthStart maternity care providers shall facilitate patient access to services by scheduling an initial medical visit appointment within two weeks of the patient's first request for services.

(c) HealthStart maternity care providers shall provide or arrange for 24 hour access to case coordination and medical services for emergency situations.

(d) HealthStart maternity care providers shall arrange for language translation and/or interpretation services.

(e) HealthStart maternity care providers may implement a presumptive eligibility processing if so approved by the Division of Medical Assistance and Health Services.

(f) HealthStart maternity care providers shall undertake community outreach activities to encourage women to seek early prenatal care and increase awareness of the availability of maternity care services.

10:66-3.7 Care plan

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

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

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

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

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

10:66-3.8 Maternity medical care services

(a) Maternity medical care services include antepartum, intrapartum and postpartum care provided by the obstetrical care practitioner(s) in accordance with the New Jersey State Department of Health's Guidelines for HealthStart Maternity Care Providers.

(b) Prenatal services are as follows:

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

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

- i. History;
- ii. Review of systems;
- iii. Comprehensive physical examination;

iv. Risk assessment;

v. Patient counseling;

vi. Routine laboratory tests;

vii. Development of the care plan; and

viii. Special tests and/or procedures as medically indicated.

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

i. Review and revision of the patient care plan;

ii. Interim history;

iii. Physical examination;

iv. Patient counseling and treatment;

v. Laboratory tests;

vi. Special tests and/or procedures which are medically indicated;

vii. Identification of new or developing problems; and

viii. Management, including transfer, of any new or persistent problems.

4. Transfer of the prenatal records to the hospital of delivery shall occur no later than 34 weeks gestation.

(c) Obstetrical delivery services shall include, but not be limited to:

1. Determination of and arrangements for delivery site;

2. Attendance at or provision for obstetrical delivery by a qualified physician or certified nurse midwife; and

3. Medical care during the entire period of confinement.

(d) A postpartum visit shall be provided by the 60th day after delivery, and shall include, but not be limited to:

1. History;

2. Review of the prenatal, labor and delivery record;

3. Physical examination;

4. Patient counseling and treatment;

5. Patient/infant assessment;

6. Referral/consultation, as indicated; and

7. Procedures/tests, as indicated.

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

10:66-3.9 Health support services

(a) Case coordination services shall facilitate the delivery of continuous, coordinated and comprehensive services for each patient in accordance with the New Jersey State Department of Health's Guidelines for HealthStart Maternity Care Providers as follows:

1. A permanent case coordinator shall be assigned to each patient no later than two weeks after the HealthStart enrollment visit.
2. Prenatal case coordination activities shall include, but not be limited to:
 - i. Orienting the patient to all services;
 - ii. Developing, maintaining and coordinating the care plan in consultation with the patient;
 - iii. Coordinating and monitoring the delivery of all services and referrals;
 - iv. Monitoring and facilitating the patient's entry into and continuation with maternity services;
 - v. Facilitating and providing advocacy for obtaining referral services;
 - vi. Reinforcing health teachings and providing support;
 - vii. Providing vigorous follow up for missed appointments and referrals;
 - viii. Arranging home visits;
 - ix. Meeting with the patient and coordinating patient care conferences; and
 - x. Reviewing, monitoring and updating the patient's complete record.
3. Postpartum care coordination activities shall include, but not be limited to:
 - i. Arranging and coordinating the postpartum visit and any home visit;
 - ii. Arranging with the obstetrical care provider to obtain the labor, delivery and postpartum hospital summary record information no later than two weeks after delivery;
 - iii. Linking the patient to appropriate service agencies including: the Special Supplemental Food Program for Women, Infants and Children (WIC), pediatric care (preferably with a HealthStart pediatric care provider), future family planning, Special Child Health Services County Case Management Unit, and other health and social agencies, if needed;
 - iv. Arranging for the transfer of pertinent information or records to the pediatric care and/or future family planning service providers;

- v. Coordinating referrals and following up on missed appointments and referrals; and
- vi. Reinforcing health instructions for mother and baby.

(b) Nutrition assessment and basic guidance services must be provided to orient and educate all patients to nutritional needs during pregnancy and educate the patient to good dietary practices in accordance with the New Jersey State Department of Health's Guidelines for HealthStart Maternity Care Providers. Specialized nutrition assessment and counseling must be provided to those women with additional needs. Services shall be provided as follows:

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

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

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

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

(c) Social-psychological assessment and basic guidance services shall be provided to all patients to assist the patient in resolving social-psychological needs, in accordance with the New Jersey State Department of Health's Guidelines for HealthStart Maternity Care Providers. Specialized social-psychological assessment and short-term counseling shall be provided to those women with additional needs. Services shall be provided as follows:

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

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

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

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

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

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

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

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

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

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

(d) Health education assessment and instruction shall be provided to all patients at intervals throughout the pregnancy, based on the patient's needs and in accordance with the New Jersey State Department of Health's Guidelines for HealthStart Maternity Care Providers. Services shall be provided as follows:

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

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

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

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

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

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

(e) One face-to-face preventive health care contact must be provided or arranged for during the time after hospital discharge and prior to the required medical postpartum visit. This requirement is in accordance with the New Jersey State Department of Health's Guidelines for HealthStart Maternity Care Providers, as follows:

1. This contact shall include, but not be limited to:
 - i. Review of the mother's health status;
 - ii. Review of the infant's health status;
 - iii. Review of mother/infant interaction;
 - iv. Revision of the care plan; and
 - v. Provision of additional services, as indicated; and

2. The provider shall provide or arrange for one or more home visits for each high risk patient in accordance with the New Jersey State Department of Health's Guidelines for HealthStart Maternity Care Providers.

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

(g) HealthStart maternity care providers shall have written procedures which identify specific agencies or practition-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) HealthStart maternity care providers shall have policies which protect patient confidentiality, provide for informed consent, and document prenatal, labor, delivery and postpartum services in accordance with the New Jersey State Department of Health's Guidelines for HealthStart Maternity Care Providers.

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

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

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

10:66-3.12 Standards for HealthStart pediatric care certificate

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

(b) HealthStart pediatric care providers shall:

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

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

3. Directly provide or arrange for sick care and emergency care.

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

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

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

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

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

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

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

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

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

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

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

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, clinical nurse practitioners, certified 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.

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. 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.

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.

3. 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.

4. 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.

Amended by R.1996 d.331, effective July 15, 1996.
See: 28 N.J.R. 1952(b), 28 N.J.R. 3573(b).

10:66-4.2 Audited financial statement

(a) The audited financial statement of a Federally Qualified Health Center shall be:

1. Conducted by one of the following:

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

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

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

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

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

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

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

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

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

- iii. The AICPA audit and accounting guide Audits of State and Local Governmental Units and, as applicable, AICPA industry audit guides or Statements of Position;
 - iv. Federal Single Audit Act of 1984 (P.L. 98-502);
 - v. Federal OMB Circular A-133, "Audits of Institutions of Higher Education and Other Nonprofit Organizations";
 - vi. Federal OMB "Compliance Supplement for Single Audits of State and Local Governments" (September 1990);
 - vii. Federal OMB "Compliance Supplement for Single Audits of Educational Institutions and Other Nonprofit Organizations," when issued, may supersede the Federal "Compliance Supplement for Single Audits of State and Local Governments;" and
 - viii. Federal OMB Circulars A-87 "Cost Principles for State and Local Governments" or A-122 "Costs Principles for Nonprofit Organizations," as applicable.
- (b) The audit report shall include the following:
- 1. An opinion on the financial statements taken as a whole;
 - 2. Presentation of financial statements in accordance with the following applicable AICPA audit and accounting guides—Audits of State and Local Governmental Units, industry audit guides, or Statements of Position;
 - 3. A supplementary schedule and opinion thereon of the FQHC's state and federal financial assistance programs, showing expenditures by program (see the AICPA's audit guide, Audits of State and Local Governmental Units, Fifth Edition, pages 196 and 230;
 - 4. A report(s) on the auditor's considerations of the internal control structure covering:
 - i. The internal control structure relevant to the financial statement audit; and
 - ii. The internal control structure used in administering state/federal financial assistance programs;
 - 5. Compliance Report Based on an Audit of General Purpose or Basic Financial Statements Performed in Accordance with Government Auditing Standards;
 - 6. Single audit compliance report(s) covering:
 - i. General requirements applicable to major programs;
 - ii. Opinion on compliance with specific requirements applicable to major programs; and
 - iii. Requirements applicable to nonmajor programs;

- 7. A specific statement that all required tax returns have been filed and taxes (including, but not limited to, payroll taxes) have been paid;
- 8. A copy of the management advisory letter when provided as a routine part of the audit engagement;
- 9. A statement of the FQHC's response to findings of deficiencies in internal control and compliance, including a description of corrective action taken or planned on prior findings; and
- 10. A report on fraud, abuse or illegal acts, or indications of such acts when discovered (a separate written report is required).

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

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

Department of Human Services
 Director, Office of Auditing
 Capital Place One
 CN 700
 Trenton, New Jersey 08625

New Rule, R.1996 d.331, effective July 15, 1996.
 See: 28 N.J.R. 1952(b), 28 N.J.R. 3573(b).

APPENDIX

Cost Report

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

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

FQHC-93-01 (Certification)—(i) (ii)

COMPLETION INSTRUCTIONS

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

Certification statement:

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

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

COMPLETION INSTRUCTIONS:

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

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

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

Columns 1 and 2—Compensation and Fringe Benefits:

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

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

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

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

Column 2, Line 23, Fringe Benefits

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

Column 3—Other:

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

Column 3, Line 23, Other

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

Column 4—Sub-Totals:

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

Column 5—Expense Reclassifications:

Enter any reclassification among cost centers in column 4 which are necessary to effect proper cost recognition and allocation. Reclassifications are to be used when the expenses of a particular cost center are applicable to more than one of the cost centers listed on the worksheet, and are maintained in a single cost center on the books and records of the center. For example, where a physician performs certain administrative duties, the appropriate portion of

his/her compensation and fringe would need to be reclassified from the "Physician" cost center to "Administrative Costs Staff—Administration" cost center. Thus, his/her administrative time (cost) would be properly recognized.

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

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

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

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

Introduction to Column 6:

All reclassifications shall be specifically identified via supporting schedules to the cost report as prepared by the center. The supporting schedules must provide an appropriate explanation to each of the affected cost centers. Any reduction of expense is to be shown in < > brackets. The net total of the supporting schedule and column must equal zero.

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

Column 6—Reclassified Trial Balance:

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

Column 7—Adjustments (Decreases) Increases:

Enter the amount of any adjustment to the center's reclassified trial balance expenses. Adjustments are required to adjust (increase or <decrease>) actual expenses in accordance with Medicaid 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.

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

COMPLETION INSTRUCTIONS:

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

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

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

COMPLETION INSTRUCTIONS:

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

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

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

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

FQHC-93-01 Worksheet 2—ENCOUNTERS—(viii)

COMPLETION INSTRUCTIONS:

General:

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

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

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

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

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

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

Column 4, Managed Care Encounters—Enter in the appropriate service category the number of encounters provided to managed care patients which are not eligible for cost-based reimbursement. Include in these numbers any Managed care encounters provided to Medicaid beneficiaries which are not allowable for cost-based reimbursement in

Column 2. On line 16, enter the number of pneumococcal and influenza vaccine injections.

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

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

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

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

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

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

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

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

COMPLETION INSTRUCTIONS:

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

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

COMPLETION INSTRUCTIONS:

This Worksheet is used to determine if the productivity screens of the various core and other services are being met. It develops the various encounters that will be used in the

determination of an encounter rate for each core and specialized service. Additionally, it reflects the numbers of staff assigned to each of the areas. Completion of Worksheet 3 requires completion of Worksheets 6, 7 and 8.

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

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

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

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

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

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

COMPLETION INSTRUCTIONS:

General:—This worksheet is used to determine the per encounter rate by specific service category that is to be used in the Medicaid reconciliation process on Worksheet 5.

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

Part I: Item (B) Allowable Administrative costs. Item (B) is reported as the LOWER of:

Worksheet 1, Line 71, Column 8 plus
Worksheet 1, Line 89, Column 8

or

30% of Item (A) Total Facility Direct Health Services

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

Part II—Specialized Services

Column 1—Direct Cost:

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

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

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

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

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

Column 4—Total Cost of Special Service Cost:

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

Column 5—Productivity Screening Encounters

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

Column 6—Computed Encounter Rate:

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

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

COMPLETION INSTRUCTIONS:

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

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

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

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

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

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

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

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

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

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

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

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

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

COMPLETION INSTRUCTIONS:

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

All Services—Lines 1 through 12:

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

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

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

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

Column 4:—To determine the Medicaid Reimbursable cost for each type of service, multiply the amounts found in column 2 by column 3. Enter the result here.

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

Line 14: requires no entry

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

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

(1) The day prior to the first Medicaid rate limitation change occurring during the FQHC's fiscal year.

or

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

Period 2—Period 2 will be the period from the date of the first Medicaid rate limitation change occurring during the FQHC's fiscal year through the earlier of:

(1) The day prior to the second Medicaid rate limitation change occurring during the FQHC's fiscal year.

or

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

Period 3—Period 3 will be the period from the date of the second Medicaid rate limitation change occurring during the FQHC's fiscal year through the end of the FQHC's fiscal year.

Line 16, Medicaid Limit—Enter the amount of the Medicaid limit in place during each period entered on line 15. The Medicaid limit is scheduled to be phased in over a 3 year period as follows:

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

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

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

A twenty percent per annum factor will be used by Medicaid to determine the Medicaid limit. The Medicaid limit should not impact an FQHC's encounter rate more than twenty percent of the prior year's finalized encounter rate. (Finalized is defined as the issuance of a Notification of Final Settlement by the Division of Medical Assistance and Health Services, and acceptance by the FQHC.)

Line 17, Medicaid Encounters Per Period—Enter the Medicaid encounters rendered during each period reported on line 15. The sum of all Medicaid encounters entered on line 17 should equal the total Medicaid encounters on Line 13, Column 2.

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

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

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

Line 21, Pneumococcal/Influenza Vaccine Services—Transfer the number of Medicaid injections from Worksheet 2, Page 1-1, Line 16, Column 3. Enter the rate from Worksheet 4, Page 1-2, Line 6, Column 6. In Column 4 multiply the rate by the Medicaid injections to determine reimbursable Pneumococcal/Influenza costs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Reclassification and Adjustment of Trial Balance of Expenses			FQHC Number:		Reporting Period				Worksheet 1 Page 1-3
Cost Center	Compensation	Fringe Benefits	Other	Sub-Totals (Columns 1 + 2 + 3)	Expense Reclass- ifications	Reclass. Trial Balance (Col. 4(+ -)5)	Adjustments (Decreases) Increases	Adjusted Net Expenses (Col. 6(+ -)7)	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	
Core Services Staff Cost									
2	Physician								
3	Nurse Practitioner								
4	Nurse Mid-Wife								
5	Clinical Psychologist								
6	Clinical Social Worker								
7	Physician Services—Under Arr. (List)								
8									
9									
10									
11									
12									
13									
14									
15	Total Core Services Costs (Lines 2-7)								
Other Specialized Services									
17	Dentist								
18	Dental Hygienist								
19	Obstetrics/Gynecology								
20	Obstetrics/Gynecology—Delivery Only								
21	Home Care Services								
22	Norplant								
23	Pneumococcal/Influenza Vaccine Services								
24	Podiatry								
25	Eye Care Program								
26	Chiropractic Services								
27	Family Planning								
28	EPSDT Services								
29	Other (Specify)								
30	Total Other Spec. Ser. (Lines 17-22 + 24-29)								
31	Physician Assistant								
32	Nursing								
33	Laboratory (CLIA # _____)								
34	Radiology								
35	Total PA, Nur Lab & Rad. (Lines 31-34)								
36	Page Totals (Sum Lines 15, 30, & 35)								

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Reclassification and Adjustment of Trial Balance of Expenses		FQHC Number:		Reporting Period				Worksheet 1 Page 2-3
Cost Center	Compensation	Fringe Benefits	Other	Sub-Totals (Columns 1 + 2 + 3)	Expense Reclass- ifications	Reclass. Trial Balance (Col. 4(+)-5)	Adjustments (Decreases) Increases	Adjusted Net Expenses (Col. 6(+)-7)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Other Service Cost—Cost Centers								
38	Pharmacy—Legend Drugs							
39	Pharmacy—Non-Legend Drugs							
40	Medical Supplies							
41	Nutrition							
42	Durable Medical Equipment (DME)							
43	Patient Transportation							
44	Community Service							
45	Clinical Social Worker—Case Mgmt.							
46	Outreach—Program (Specify)							
47								
48								
49	Health Education (Specify)							
50								
51								
52	Total Other Services (Lines 38-51)							
Non Reimbursable Cost Centers								
54								
55								
56	Total Non Reimb. Cost (Lines 54 & 55)							
Administrative Costs—								
58	Administration							
59	Medical Records							
60	Marketing							
61	Legal							
62	Accounting							
63	Data Processing							
64	Housekeeping—Maintenance							
65	Security							
66	Other Admin.—Cost (specify)							
67								
68								
69								
70								
71	Total Admin. Cost (Lines 58-70)							
72	Tot. Page (Sum Lines 52, 56, & 71)							

Reclassification and Adjustment of Trial Balance of Expenses		FQHC Number:		Reporting Period				Worksheet 1 Page 3-3
Cost Center	Compensation	Fringe Benefits	Other	Sub-Totals (Columns 1 + 2 + 3)	Expense Reclass- ifications	Reclass. Trial Balance (Col. 4(+ -)5)	Adjustments (Decreases) Increases	Adjusted Net Expenses (Col. 6(+ -)7)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)

Administrative Cost—Other

74	Telephone							
75	Utilities							
76	Postage							
77	Transportation Costs—Staff							
78	Insurance—Professional Serv.							
79	Insurance—Malpractice							
80	Insurance—Other							
81	Office Supplies							
82	Interest Expense—Other							
83	Dues & Subscriptions							
84	Travel							
85	Other—(Specify)							
86								
87								
88								
89	Total Admin.—Other (Lines 74-88)							

Building—Equipment—

91	Rent/Lease—Building							
92	Depreciation—Building							
93	Mortgage Interest							
94	Insurance—Building							
95	Other—Building							
96	Depreciation—Moveable Equipment							
97	Rent/Lease—Moveable Equipment							
98	Vehicle							
99	Depreciation—Auto/Truck							
100	Maintenance—Auto/Truck							
101	Insurance—Auto/Truck							
102	Lease Cost—Auto/Truck							
103	Tot. Bldg-Equip-Vehic (Lines 91-102)							
104								
105	Totals, Page 3-3, Lines 89 & 103							
106	Totals, Page 1-3, Line 36							
107	Totals, Page 2-3, Line 72							
108	Total Cntr. Costs (Lines 105 + 106 + 107)							

Federally Qualified Health Center Supporting Documentation					FQHC Number:		Worksheet 1 Support Schedule A	
Reporting Period:							Detail of Expense Reclass- ification	
Reclassifications								
Explanation of Reclassification	Code (a)	INCREASE			DECREASE			
		Cost Center	Line No.	Amount (b)	Cost Center	Line No.	Amount (b)	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
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- (a) A letter code [A - B - C - etc] must be entered on each line to identify each reclassification entry
- (b) Transfer to Worksheet 1, Page 1, 2, or 3, Column 5 as appropriate.

Federally Qualified Health Center Supporting Documentation				FQHC Number:		Worksheet 1 Support Schedule B Adjustments To Expense Detail
Adjustments to Expenses				Reporting Period:		
	Basis For Adjust- ment(s)*	Amount	Cost Center		Worksheet 1 Line Number	
(1)	(2)	(3)	(4)		(5)	
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27	Total (Sum of Lines 1 through 25)					
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* Basis for adjustment: [C = Actual Cost] [R = Amount Received] (see instructions)

Federally Qualified Health Center ENCOUNTERS							FQHC Number:		Worksheet 2 Page 1-1	
Reporting Period:										
FQHC Encounter Detail		Medicaid Cost Based Reimbursable			Mgd. Care	NJDOH**	Medicare	Self-Pay	Other	Total FQHC Encounters (cols 3-8) (9)
		Fee For Svcs. Encounters	Mgd. Care* Encounters	Total Encounters	Encounters	Encounters	Encounters	Encounters	Encounters	
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	
Core Services										
1	Physician									
2	Nurse Practitioner									
3	Nurse—Mid-Wife									
4	Clinical Psychologist									
5	Clinical Social Worker									
6	Physician Services Under Arr.									
7	Total Core Encounter (Lines 1-6)									
8										
Other Specialized Services										
10	Dentist									
11	Dental Hygienist									
12	Ob/Gynecology									
13	Ob/Gynecology—Delivery ONLY									
14	Home Care Services									
15	Norplant									
16	* Pneumococcal/Influenza Vaccine Injections									
17	Podiatry									
18	Eye Care Program									
19	Chiropractic Services									
20	Family Planning									
21	EPSDT Services									
22	Other (Specify)									
23										
24										
25										
26	Total Other Spec. Ser. (Lines 10-15 + 17-25)									
27	Total Federally Qualified Health Cntr.									
28	Encounters (Sum Line 7 + Line 26)									
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* Requires Completion of Worksheet 2 Support Schedule A
 **Include base level PHS allocation

Federally Qualified Health Center MEDICAID MANAGED CARE ENCOUNTER DETAIL							FQHC Number:			Worksheet 2 Support Schedule A
Reporting Period:										
Detail all Medicaid Reimbursable Managed Care Encounters										Total Medicaid HMO Encounters
HMO #1	HMO #2	HMO #3	HMO #4	HMO #5	HMO #6	HMO #7	HMO #8	HMO #9		
Name: _____	Name: _____	Name: _____	Name: _____	Name: _____	Name: _____	Name: _____	Name: _____	Name: _____		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	
Core Services										
1	Physician									
2	Nurse Practitioner									
3	Nurse—Mid-Wife									
4	Clinical Psychologist									
5	Clinical Social Worker									
6	Physician Services Under Arr.									
7	Total Core Encounter (Lines 1-6)									
8										
Other Specialized Services										
10	Dentist									
11	Dental Hygienist									
12	Ob/Gynecology									
13	Ob/Gynecology—Delivery ONLY									
14	Home Care Services									
15	Norplant									
16	* Pneumococcal/Influenza Vaccine Injections									
17	Podiatry									
18	Eye Care Program									
19	Chiropractic Services									
20	Family Planning									
21	EPSDT Services									
22	Other (Specify)									
23										
24										
25										
26	Total Other Spec. Svs. (Lines 10-15 + 17-25)									
27	Total Medicaid Managed Care									
28	Encounters (Sum Line 7 + Line 26)									
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Federally Qualified Health Center PRODUCTIVITY SCREENING					FQHC Number:		Worksheet 3 Page 1-1
Productivity Screening		Reporting Period:					
	Number of FTE's (1)	Total Hours (see instr.) (1a)	Total Encounters (see instr.) (2)	Productivity Standard (as applic.) (3)	Minimum Encounters (Col 1a x 3) (4)		Greater of Column 2 OR Column 4 (5)

Core Services

1	Physician			2.10			
2	Nurse Practitioner			1.10			
3	Nurse—Mid-Wife			1.10			
4	Clinical Psychologist						
5	Clinical Social Worker						
6	Physician Services Under Arr.						
7	Total Core Encounter (Lines 1-6)						
8							

Other Specialized Services

10	Dentist			1.25			
11	Dental Hygienist			1.25			
12	Ob/Gynecology—With Delivery						
13	Ob/Gynecology—Delivery Only						
14	Home Care Services						
15	Norplant						
16	* Pneumococcal/Influenza Vaccine Injections						
17	Podiatry						
18	Eye Care Program						
19	Chiropractic Services						
20	Family Planning						
21	EPSDT Services						
22	Other (Specify)						
23	Physician Assistant						
24	Laboratory						
25	Radiology						
26	Total Other Spec. Svs. (Lines 10-15 + 17-25)						
27							
28	Productivity (Sum Lines 7 + Line 26)						

Other Center Staffing

30	Administrative						
31	Other (specify)						
32							
33	Staffing (Sum Line 28 + 30 + 31)						

Federally Qualified Health Center Encounter Rate Determination	FQHC Number:	Worksheet 4 Page 1-2
---	--------------	-------------------------

Per Encounter Rate Calculation

Reporting Period:

Part I

(A) —Total Facility Direct Health Service Cost (TFDHS)	Sum of WS 1, Page 1-3, Line 36, Col. 8 + W/S 1, Page 2-3, Lines 52 & 56, Col. 8	(A)
(B) —Allowable Administrative Costs	Lower of W/S1, Page *[1-2]* *2-3*, Line 71, Col. 8 + W/S 1, Page *[1-3]* *3-3*, Line 89, Col. 8 Or 30% of (A) Total Facility Direct Health Services	(B)
(C) —Allowable Facility Overhead Cost	Admin. Costs (B) + W/S 1, Page 1-3, Line 103, Column 8, Building, Equip. & Veh.	(C)

Part II

	Direct Cost Specialized Service From W/S 1, Page 1-3 Column 8	Result of Column 1 Divided By Part I Item (A) above	Result of Column 2 Multiplied By Part I Item (C) above	Sum of Column 1 Plus Column 3	Total Productivity Screening Encounters From W/S 3 Page 1 Column (5)	Encounter Rate Column 4 Divided By Column 5
	(1)	(2)	(3)	(4)	(5)	(6)

Specialized Services

1	Dentist/Dental Hygienist					
2	Obstetrics/Gyn.—With Delivery					
3	Obstetrics/Gyn.—Delivery Only					
4	Home Care Services					
5	Norplant					
6	Pneumococcal/Influenza Vaccine Service					
7	Podiatry					
8	Eye Care Program					
9	Chiropractic Services					
10	Family Planning					
11	EPSDT Services					
12	Other (Specify)					
13						
14	Total—(Sum Lines 1-13)					

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Federally Qualified Health Center Encounter Rate Determination		FQHC Number:	Worksheet 4 Page 2-2
Per Encounter Rate Calculation—Core Services		Reporting Period:	
Part III			
Core Services			Amount
15	Total Direct Health care Service Cost—(Worksheet 4, Page 1-2, Part I, Item (A))		
16	Specialized Services Total Direct Cost (Worksheet 4, Page 1-2, Part II, Line 14, Column 1)	(a)	
17	Non Reimbursable Cost (From Worksheet 1, Page 2-3, Line 56, Column 8)	(b)	
18	Sum of Lines 16 & 17 [(a) + (b)]		
19	Direct Core and Other Health Service Cost (Line 15 minus Line 18)		
20	Percentage of Direct Core and Other Health Services to Total Health Services (Line 19 divided by Line 15)		
21	Total Facility Overhead (Worksheet 4, Page 1-2, Part I, Item (C))		
22	Overhead Allocation—Direct Core/Other Health Services (Line 20 multiplied by Line 21)		
23	Total Core/Other Services Reimbursable Cost (Line 19 plus Line 22)		
24	Total Core Service Encounters (W/S-3, Page 1, Line 7, Column 5)		
25	Encounter Core Rate Services—(Line 23 divided by Line 24)		
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Federally Qualified Health Center Final Settlement Determination		FQHC Number:		Worksheet 5 Page 1-1	
FINAL SETTLEMENT		Reporting Period:			
Reconciliation Of Interim and Final Payments Federally Qualified Health Clinic Services					
		<i>For Medicaid Use Only</i>	Medicaid Encounters From W/S-2 Page 1-1 Column 3	Computed Encounter Rate From W/S-4 Page 1-2 Column 6	Total Costs Column 2×3
		(1)	(2)	(3)	(4)
Medicaid FQHC Services—Reimbursement					
1	Core Services (*)				
2	Dentist/Dental Hygienist				
3	Obstetric/Gynecology				
4	Obstetric/Gynecology—Delivery Only				
5	Home Care Service				
6	Norplant				
7	Podiatry				
8	Eye Care Program				
9	Chiropractic Services				
10	Family Planning				
11	EPSDT Services				
12	Other (Specify)				
13	Total (Sum Lines 1-13)				
14	Medicaid Limit	Period 1	Period 2	Period 3	
15	Rate Periods	mm/dd/yy-mm/dd/yy	mm/dd/yy-mm/dd/yy	mm/dd/yy-mm/dd/yy	
16	Medicaid Limit				
17	Encounters Per Period				
18	Maximum Allowable Medicaid Costs				
19	Reimbursable Costs—Lower of Total Costs (Line 13) or Maximum Allowable Medicaid Costs (Line 18)				
20	Outstationed Eligibility Worker				
21	Pneumococcal/Influenza Vaccine Services	Medicaid Injections	Rate		
22	Total Reimbursable Costs—Medicaid				
23	Less: Payments Received For Medicaid Services				
24	Net Due to or (From) Center (Line 22 minus Line 23)				
25	Adjustment to Interim Payment Rate (Line 24 Divided by Total Medicaid Encounters)				
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Federally Qualified Health Center Physician Detail		FQHC Number:				Reporting Period		Worksheet 6 PHYSICIANS	
Must Complete for all Physicians									
Last Name, First Name, Middle Init.		Start Date (1)	Termination Date (2)	Social Security Number (3)	Medicaid Number (4)	# of Encounters Performed (5)	Gross Salary/Pmt. (6)	Number of Hours Compensated (7)	Number of Hours For Screening** (8)
1	—Med. Dir.								
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									
37									
38									
39	Totals								

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**See instructions for reporting requirements.

Federally Qualified Health Center Nursing Detail		FQHC Number:				Reporting Period		Worksheet 7 NURSING		
Must Complete for Nurse Practitioners and Nurse Mid-Wives										
	Start Date	Termination Date	Social Security Number	License/Qualific.	# of Encounters Performed	Gross Salary/Pmt.	Number of Hours Compensated	Number of Hours For Screening		
Last Name, First Name, Middle Init.	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)		
Nurse Practitioners										
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19	Total Nurse Practitioners						\$			
Nurse Mid-Wives										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										
37										
38										
39	Total Nurse Mid-Wives						\$			
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Federally Qualified Health Center Dental Detail		FQHC Number:				Reporting Period		Worksheet 8 DENTAL	
Must Complete for all Dentists and Dental Hygienists									
Last Name, First Name, Middle Init.		Start Date	Termination Date	Social Security Number	License/Qualific.	# of Encounters Performed	Gross Salary/Pmt.	Number of Hours Compensated	Number of Hours For Screening
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Dentists									
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19	Total Dentists						\$		
Dental Hygienists									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									
37									
38									
39	Total Dental Hygienists						\$		

Amended by R.1996 d.331, effective July 15, 1996.
See: 28 N.J.R. 1952(b), 28 N.J.R. 3573(b).

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;



3. Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances and equipment commonly furnished in connection with a surgical procedure. Drugs and biologicals are limited to those which cannot be self administered;

4. Diagnostic or therapeutic items and services furnished by ASC staff in connection with a covered surgical procedure, for example, simple tests such as urinalysis, blood hemoglobin, or hematocrit, administered in conjunction with the surgical procedure;

5. Administrative, recordkeeping and housekeeping items and services;

6. Blood, blood plasma, platelets, etc.; and

7. Material for anesthesia.

(b) ASC facility services do not include medical or other health services for which payment could be made under other provisions of the Medicaid program such as laboratory, x-ray, or diagnostic procedures (other than those directly related to performance of the surgical procedure). Examples of items or services that are not ASC facility services include:

1. Physicians' services;
2. The sale, lease, or rental of durable medical equipment to ASC patients for use in their homes;
3. Prosthetic devices (including artificial legs and arms);
4. Transportation services;
5. Leg, arm, back, and neck braces;
6. Artificial eyes; and
7. Services furnished by an independent clinical laboratory.

10:66-5.4 Medical records

(a) In addition to the requirements set forth at 42 CFR 416.47, medical records in an ASC shall include, but are not limited to:

1. Patient identification;
2. Significant medical history and results of physical examination;
3. Pre-operative diagnostic studies (entered before surgery), if performed;
4. Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body;
5. Any allergies and abnormal drug reactions;
6. Entries related to anesthesia administration;
7. Documentation of properly executed informed consent; and

8. Discharge diagnosis.

SUBCHAPTER 6. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:66-6.1 Introduction

(a) The New Jersey Medicaid program utilizes the Health Care Financing Administration's (HCFA) Common Procedure Code System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedure Terminology—4th Edition (CPT-4) architecture, employing a five-position code and as many as two 2-position modifiers. Unlike the CPT-4 numeric design, the HCFA-assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three-level coding system.

1. Level I codes (narratives found in CPT-4): These codes are adapted from CPT-4 for utilization primarily by physicians, podiatrists, optometrists, certified nurse-midwives, independent clinics and independent laboratories. CPT-4 is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians. Copyright restrictions make it impossible to print excerpts from CPT-4 procedure narratives for Level I codes. Thus, in order to determine those narratives it is necessary to refer to CPT-4, which is incorporated herein by reference, as amended and supplemented.

2. Level II codes (narratives found at N.J.A.C. 10:66-6.3): These codes are assigned by HCFA for physician and non-physician services which are not in CPT-4.

3. Level III codes (narratives found at N.J.A.C. 10:66-6.3): These codes are assigned by the Division to be used for those services not identified by CPT-4 codes or HCFA-assigned codes. Level III codes identify services unique to New Jersey.

(b) Regarding specific elements of HCPCS codes which require the attention of providers, the lists of HCPCS code numbers for independent clinic services are arranged in tabular form with specific information for a code given under columns with titles such as: "IND", "HCPCS CODE", "MOD", "DESCRIPTION", "FOLLOW-UP DAYS" and "MAXIMUM FEE ALLOWANCE". The information given under each column is summarized below:

Column Title	Description
IND	(Indicator-Qualifier) lists alphabetic symbols used to refer the provider to information concerning the New Jersey Medicaid program's qualifications and requirements when a procedure or service code is used. An explanation of the indicators and qualifiers used in this column are located below and in paragraph 1, "Alphabetic and numeric symbols", as follows:

Column Title	Description	Modifier Code	Description
HCPCS CODE MOD	"L" preceding any procedure code indicates that the complete narrative for the code is located at N.J.A.C. 10:66-6.3.	WY	Only applies to billing by an ambulatory surgical center: To identify the trimester (1st trimester) of an abortion procedure, add the modifier "WY" to the procedure code.
	"N" preceding any procedure code means that qualifiers are applicable to that code. These qualifiers are listed by procedure code number at N.J.A.C. 10:66-6.4.	WZ	Only applies to billing by an ambulatory surgical center: To identify the trimester (2nd trimester) of an abortion procedure, add the modifier "WZ" to the procedure code.
	HCPCS procedure code numbers.	YR	Routine foot care podiatry: To identify routine foot care provided by a podiatrist, add the modifier "YR" to only those procedure codes so indicated at N.J.A.C. 10:66-6.2(h).
	Alphabetic and numeric symbols: Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances are identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid program's recognized modifier codes for independent clinic services are as follows:	ZI	Independent clinic: To identify certain mental health services provided by independent clinic providers, add the modifier "ZI" to only those procedure codes so indicated at N.J.A.C. 10:66-6.2(f) and 10:66-6.2(o).
		DESCRIPTION	Code narrative: Narratives for Level I codes are found in CPT-4. Narratives for Level II and III codes are found at N.J.A.C. 10:66-6.3.
Modifier Code	Description		
22	Unusual services: When the service provided is greater than that usually required for the listed procedure, it may be identified by adding modifier "22" to the usual procedure number.	FOLLOW-UP DAYS	Number of days for follow-up care.
50	Bilateral procedures: Unless otherwise identified in the listings, bilateral procedures requiring a separate incision that are performed at the same operative session should be identified by the appropriate five-digit code describing the first procedure. The second (bilateral) procedure is identified by adding modifier "50" to the procedure number.	MAXIMUM FEE ALLOWANCE	New Jersey Medicaid program's maximum reimbursement allowance for specialist and non-specialist: If the symbols "B.R." (By Report) are listed instead of a dollar amount, it means that additional information will be required in order to properly evaluate the service. Attach a copy of the report to the claim form.
52	Reduced services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier "52", signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. NOTE: Providers billing for the injection only should use the modifier "52" (reduced service) with the appropriate HCPCS procedure code on the claim form when billing for any immunizations. The provider will be reimbursed \$2.50 for an injection. Do not use HCPCS procedure code 90799 when billing for immunizations with free vaccine.		1. Alphabetic and numeric symbols under "IND" & "MOD": These symbols, when listed under the "IND" and "MOD" columns, are elements of the HCPCS coding system used as qualifiers or indicators ("IND" column) and as modifiers ("MOD" column). They assist the provider in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes. i. These symbols and/or letters must not be ignored because they reflect requirements, in addition to the narrative which accompanies the CPT/HCPCS procedure code as written in the CPT-4, for which the provider is liable. These additional requirements must be fulfilled before reimbursement is requested. ii. If there is no identifying symbol listed, the CPT/HCPCS procedure code narrative prevails.
WF	Family planning: To identify procedures performed for the sole purpose of family planning, add the modifier "WF" to only those procedure codes so indicated at N.J.A.C. 10:66-6.2.		(c) Listed below are both general and specific policies of the New Jersey Medicaid program that pertain to HCPCS. Specific information concerning the responsibilities of an independent clinic provider when rendering Medicaid-covered services and requesting reimbursement are located at N.J.A.C. 10:66-Subchapters 1 through 5, and 10:66-Appendix.
WM	Certified nurse-midwife: To identify procedures performed by a certified nurse-midwife, add the modifier "WM" to only those procedure codes so indicated at N.J.A.C. 10:66-6.2.		

1. General requirements are as follows:

i. When filing a claim, the appropriate HCPCS procedure codes must be used in conjunction with modifiers when applicable.

ii. The use of a procedure code will be interpreted by the New Jersey Medicaid program as evidence that the provider personally furnished, as a minimum, the services for which it stands.

iii. When billing, the provider must enter onto the claim form a CPT/HCPCS procedure code as listed in CPT-4 or in this subchapter (N.J.A.C. 10:66-6). If an appropriate code is not listed, place a "N/A" (not applicable) in the procedure code column and submit a narrative description of the service. If possible, insert a CPT code closest to the narrative description you have written.

iv. Date(s) of service(s) must be indicated on the claim form and in the provider's own record for each service billed.

v. The "MAXIMUM ALLOWANCE" as noted with these procedure codes, "S" for specialist and "NS" for non-specialist, represents the maximum payment for the given procedure. When submitting a claim, the clinic must always use its usual and customary fee.

(1) Listed values for all surgical procedures include the surgery and the follow-up care for the period indicated in days in the column titled "Follow-Up Days."

(2) All references to time parameters shall mean the practitioner's personal time in reference to the service rendered unless it is otherwise indicated.

vi. Written records in substantiation of the use of a given procedure code must be available for review and/or inspection if requested by the New Jersey Medicaid program.

vii. All references to performance of any or all parts of a history or physical examination shall mean that for reimbursement purposes these services were personally performed by a physician, dentist, podiatrist, optometrist, certified nurse midwife, psychologist, and other program recognized mental health professionals in a mental health clinic, whichever is applicable. (Exception: Procedure Code W9820, EPSDT, permits the services of a pediatric nurse practitioner under the direct supervision of a physician.)

2. Specific requirements concerning medicine are as follows:

i. To qualify as documentation that the service was rendered by the practitioner during an inpatient stay, the medical record must contain the practitioner's notes indicating that he or she personally:

(1) Reviewed the patient's medical history with the patient and/or his or her family, depending upon the medical situation;

(2) Performed an examination as appropriate;

(3) Confirmed or revised the diagnosis; and

(4) Visited and examined the patient on the days for which a claim for reimbursement is made.

ii. The practitioner's involvement must be clearly demonstrated in notes reflecting his or her personal involvement with the service rendered. This refers to those occasions when these notes are written into the medical record by interns, residents, other house staff members, or nurses. A counter-signature alone is not sufficient.

3. Specific requirements concerning surgery are as follows:

i. Certain of the listed procedures are commonly carried out as an integral part of a total service and, as such, do not warrant a separate charge. When such a procedure is carried out as a separate entity not immediately related to other services, the indicated value for "separate procedure" is applicable.

4. Specific requirements concerning radiology are as follows:

i. Values include usual contrast media, equipment and materials.

ii. Values include consultation and written report to the referring physician.

iii. S&I (Supervision and Interpretation) only for the procedure given. This code is used only when a procedure is performed by more than one physician. Values include consultation and written report.

iv. All films taken of an area which is to be subject to a contrast study will, for reimbursement purposes, be considered part of the contrast study unless stated otherwise.

v. The fee listed represents the combined technical and professional component of the reimbursement for the procedure code notwithstanding any statement to the contrary in the narrative. It will be paid only to one provider and will not be broken down into its component parts.

Administrative Correction.
See: 26 N.J.R. 797(a).

10:66-6.2 HCPCS procedure code numbers and maximum fee allowance schedule

(a) Evaluation and management and other procedures:

* An asterisk preceding any procedure code may also be performed in a drug treatment center.

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units	Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
				S	\$	NS						S	\$	NS	
	36415			1.80		1.80		99383				22.00		17.00	
	90701			16.34		16.34		*99384				22.00		17.00	
	90701	52		2.50		2.50		*99385				22.00		17.00	
	90702			3.29		3.29		*99386				22.00		17.00	
	90702	52		2.50		2.50		*99387				22.00		17.00	
	90703			3.40		3.40		99391				16.00		14.00	
	90703	52		2.50		2.50		99392				22.00		17.00	
	90704			23.60		23.60		99393				22.00		17.00	
	90704	52		2.50		2.50		*99394				22.00		17.00	
	90705			18.39		18.39		*99395				22.00		17.00	
	90705	52		2.50		2.50		99396				22.00		17.00	
	90706			22.04		22.04		99397				22.00		17.00	
	90706	52		2.50		2.50		J2790				20.40		20.40	
	90707			39.87		39.87		J2790	22			72.07		72.07	
	90707	52		2.50		2.50	L	W9050				27.00		NA	
	90712			14.44		14.44	L	W9055				27.00		23.00	
	90712	52		2.50		2.50	L	W9060	WT			23.00		18.00	
	90713			22.80		22.80	L	W9061	WT			23.00		18.00	
	90713	52		2.50		2.50	L	W9062	WT			23.00		18.00	
	90714			3.03		3.03	L	W9063	WT			23.00		18.00	
	90714	52		2.50		2.50	L	W9064	WT			23.00		18.00	
	90717			3.03		3.03	L	W9065	WT			23.00		18.00	
	90717	52		2.50		2.50	L	W9066	WT			23.00		18.00	
	90718			3.35		3.35	L	W9067	WT			23.00		18.00	
	90718	52		2.50		2.50	L	W9068	WT			23.00		18.00	
	90724			6.97		6.97	L	W9096				17.46		17.46	
	90724	52		2.50		2.50	L	W9096	52			2.50		2.50	
	90732			14.35		14.35	L	W9096	22			32.79		32.79	
	90732	52		2.50		2.50	L	W9096	2252			2.50		2.50	
	90733			17.48		17.48	L	W9097				17.46		17.46	
	90733	52		2.50		2.50	L	W9097	52			2.50		2.50	
	90737			25.79		25.79	L	W9098				32.79		32.79	
	90737	52		2.50		2.50	L	W9098	52			2.50		2.50	
	90741			Prior authorization required			L	W9099				63.57		63.57	
	90742			Prior authorization required			L	W9099	52			2.50		2.50	
N	90799			2.50		2.50	L	W9333				27.88		27.88	
N	90801			37.00		26.00	L	W9333	52			2.50		2.50	
	93000			16.00		16.00	L	W9334				27.88		27.88	
N	99150			45.00		40.00	L	W9334	52			2.50		2.50	
N	99151			Per Hour		Per Hour	L	W9335				62.09		62.09	
				45.00		40.00	L	W9335	52			2.50		2.50	
				Per Hour		Per Hour	L	W9338				30.27		30.27	
	*99201			16.00		14.00	L	W9338	52			2.50		2.50	
	*99202			16.00		14.00		W9820				23.00		18.00	
	*99203			22.00		17.00									
	*99204			22.00		17.00									
	*99205			22.00		17.00									
	*99211			16.00		14.00									
	99211	WM		NA		11.20									
	*99212			16.00		14.00									
	99212	WM		NA		11.20									
	*99213			16.00		14.00									
	99213	WM		NA		11.20									
	*99214			16.00		14.00									
	99214	WM		NA		11.20									
	*99215			16.00		14.00									
	99215	WM		NA		11.20	N	11976			90	100.00		85.00	
	99241			44.00		NA	N	11977	22		90	100.00		85.00	
	99242			44.00		NA						Direct	package plus	price	
	99243			44.00		NA									
	99244			62.00		NA	N	55250			30	200.00		170.00	
	99245			62.00		NA	N	55450			30	90.00		79.00	
	99251			44.00		NA	N	57451			45	42.00		37.00	
	99252			44.00		NA	N	58301			45	182.00		158.00	
	99253			44.00		NA		58301	WM			16.40		16.40	
	99254			62.00		NA	N	58600			45	NA		16.40	
	99255			62.00		NA	N	58605			45	211.00		184.00	
	99261			16.00		14.00	N	58982			45	151.00		131.00	
	99262			16.00		14.00	N	58983			45	182.00		158.00	
	99263			16.00		14.00		58983			45	182.00		158.00	
	99271			44.00		NA		88150				6.00		6.00	
	99272			44.00		NA		88151				6.00		6.00	
	99273			44.00		NA		88155				6.00		6.00	
	99274			62.00		NA	N	99201	WF			45.00		45.00	
	99274	YY		50.00		NA	N	99201	WFWM			NA		31.50	
	99274	ZZ		50.00		NA	N	99202	WF			45.00		45.00	
	99275			62.00		NA	N	99202	WFWM			NA		31.50	
	99291			45.00		40.00	N	99203	WF			45.00		45.00	
	99292			22.50		20.00	N	99203	WFWM			NA		31.50	
	99382			22.00		17.00	N	99204	WF			45.00		45.00	
							N	99204	WFWM			NA		31.50	

(b) Dental services (See N.J.A.C. 10:56-3).

(c) Family planning services:

Ind	HCPCS		Follow Up Days	Maximum Fee Allowance			Anes. Basic Units	Ind	HCPCS		Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
	Code	Mod		S	\$	NS			Code	Mod		S	\$	NS	
N	99205	WF		45.00		45.00	*	11711				6.00		6.00	
N	99205	WFWM		NA		31.50	*	11730				10.00		10.00	
N	99211	WF		7.60		7.60	*	11750		30		42.00		37.00	
N	99211	WFWM		NA		5.35	*	12001				18.00		16.00	
N	99212	WF		7.60		7.60	*	12002				24.00		21.00	
N	99212	WFWM		NA		5.35	*	12004				30.00		26.00	
N	99213	WF		7.60		7.60		12005		7		46.00		39.00	
N	99213	WFWM		NA		5.35		12006		7		57.00		48.00	
N	99214	WF		23.00		23.00		12007		7		82.50		70.00	
N	99214	WFWM		NA		16.40		12011				18.00		16.00	
N	99215	WF		23.00		23.00		12013				24.00		21.00	
N	99215	WFWM		NA		16.40		12014		7		30.00		26.00	
N	99395	WF		45.00		45.00		12031		30		30.00		26.00	
N	99395	WFWM		NA		31.50		12032		30		48.00		42.00	
L	W0001	WF		188.00		188.00	*	12041		30		30.00		26.00	
L	W0001	WFWM		NA		177.00	*	12042		30		67.00		59.00	
L	W0002	WF		123.00		123.00		12051		30		38.00		33.00	
L	W0002	WFWM		NA		112.00		12052		30		67.00		59.00	
L	W0004	WF		204.00		204.00		13100		30		34.00		29.00	
L	W0004	WFWM		NA		188.00		13101		30		68.00		63.00	
L	W0008	WF		139.00		139.00		13120		30		48.00		42.00	
L	W0008	WFWM		NA		123.00		13121		30		106.00		92.00	
							*	13131		30		67.00		59.00	
							*	13132		30		145.00		126.00	
							*	13150		30		38.00		33.00	
							*	13151		30		82.00		71.00	
							*	13152		30		193.00		168.00	
							*	17000				16.00		14.00	
							*	17010				42.00		36.00	
							*	17100				18.00		15.00	
							*	17105				100.00		85.00	
							*	17110				16.00		14.00	
							*	17200				16.00		14.00	
							*	17304				100.00		85.00	
							L*	W1650				24.00		21.00	
							L*	W1650	22			37.00		32.00	

(d) Laboratory services (See N.J.A.C. 10:61-3).

(e) Minor surgery:

* An asterisk preceding any procedure code may also be performed by a podiatrist.

Ind	HCPCS		Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
	Code	Mod		S	\$	NS	
N	10040			18.00		16.00	
*	10060			13.00		11.00	
*	10061		30	48.00		42.00	
*	10080			30.00		26.00	
*	10120			18.00		16.00	
*	10121		30	34.00		29.00	
*	10140			18.00		16.00	
*	10160			13.00		11.00	
*	11000			13.00		11.00	
*	11001			6.00		5.00	
*	11040			13.00		11.00	
*	11041			13.00		11.00	
*	11042			16.00		14.00	
*	11043			16.00		14.00	
*	11100		7	13.00		11.00	
*	11400		15	18.00		16.00	
*	11401		15	22.00		20.00	
*	11402		15	27.00		24.00	
*	11403		15	32.00		27.00	
*	11404		15	32.00		27.00	
*	11406		15	32.00		27.00	
*	11420		15	18.00		16.00	
*	11421		15	22.00		20.00	
*	11422		15	27.00		24.00	
*	11423		15	32.00		27.00	
*	11424		15	32.00		27.00	
*	11426		15	32.00		27.00	
*	11440		15	18.00		16.00	
*	11441		15	22.00		20.00	
*	11442		15	27.00		24.00	
*	11443		15	32.00		27.00	
*	11444		15	32.00		27.00	
*	11446		15	32.00		27.00	
*	11600		90	37.00		32.00	
*	11601		90	47.00		42.00	
*	11602		90	61.00		53.00	
*	11620		90	61.00		53.00	
*	11621		90	90.00		79.00	
*	11622		90	121.00		105.00	
*	11640		90	90.00		79.00	
*	11641		90	121.00		105.00	
*	11642		90	150.00		131.00	
*	11700			13.00		11.00	
*	11701			6.00		6.00	
*	11710			13.00		11.00	

(f) Mental health services:

Ind	HCPCS		Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
	Code	Mod		S	\$	NS	
N	90801	ZI		45.00		45.00	
N	90843	ZI		13.00		13.00	
N	90844	ZI		26.00		26.00	
N	90847	ZI		26.00		26.00	
N	90847	ZI22		32.00		32.00	
	90862	ZI		4.50		4.50	
N	90887	ZI		13.00		13.00	
LN	H5025	ZI		8.00		8.00	
L	Z0100			22.50		22.50	
L	Z0130			25.00		25.00	
L	Z0150			8.00		8.00	
L	Z0160			15.50		15.50	
L	Z0170			46.00		46.00	
L	Z0180			77.00		77.00	

(g) Obstetrical services (maternity):

Ind	HCPCS		Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
	Code	Mod		S	\$	NS	
N	59400		60	468.00		403.00	4
N	59400	WM	60	NA		328.00	4
N	59410		60	320.00		272.00	4
N	59410	WM	60	NA		224.00	4
N	59420			16.00		14.00	
N	59420	WM		NA		11.20	
N	59420	22		22.00		17.00	
N	59420	WM22		NA		15.40	
N	59430		0	20.00		18.00	0
N	59430	WM	0	NA		14.00	0
	59510		45	598.00		516.00	7
	59515		45	450.00		385.00	7
	59525		45	362.00		308.00	8
	59812		45	105.00		91.00	3
L	Z0250	WM		NA		40.00	

(k) Vision care services (See N.J.A.C. 10:62-4).

(l) Transportation services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
				S	\$	NS	
LN	Z0330			4.50		4.50	
LN	Z0335			9.00		9.00	

(m) Drug treatment center services:

* An asterisk preceding any procedure code indicates that the procedure may only be provided to ACCAP-eligible individuals in the home.

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
				S	\$	NS	
*LN	Z1830			3.50		3.50	
*LN	Z1831			4.50		4.50	
*LN	Z1832			24.00		24.00	
*LN	Z1833			12.00		12.00	
*LN	Z1834			30.00		30.00	
*LN	Z1835			22.50		22.50	
LN	Z2000			22.50		22.50	
LN	Z2001			15.00		15.00	
LN	Z2002			4.50		4.50	
LN	Z2003			16.00		16.00	
LN	Z2004			8.00		8.00	
LN	Z2005			15.00		15.00	
LN	Z2006			2.50		2.50	
LN	Z2007			8.00		8.00	
LN	Z2010			4.50		4.50	

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
				S	\$	NS	
	90844	22		150.00		150.00	
L	W9840			150.00		150.00	
L	Y3333			150.00		150.00	

(o) Personal care assistant services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
				S	\$	NS	
L	Z1600	ZI		13.02		13.02	
L	Z1605	ZI		10.23		10.23	
L	Z1610	ZI		35.00		35.00	
L	Z1611	ZI		6.51		6.51	
L	Z1612	ZI		5.12		5.12	
L	Z1613	ZI		35.00		35.00	

(p) Miscellaneous services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance			Anes. Basic Units
				S	\$	NS	
	57820		15	72.00		63.00	
	58120		15	72.00		63.00	
N	59840		45	79.00		68.00	
N	59841		45	79.00		68.00	

Amended by R.1998 d.127, effective March 2, 1998.

See: 29 N.J.R. 5046(a), 30 N.J.R. 827(b).

Inserted asterisks before codes 99384, 99385, 99386, 99387, 99394 and 99395.

NOTE: See N.J.A.C. 10:66-6.2(a), Evaluation and management and other procedures, for additional procedures preceded by an asterisk.

10:66-6.3 HCPCS procedure codes and maximum fee allowance schedule for Level II & Level III codes and narratives (not located in CPT-4)

(n) Federally qualified health care services:

(a) Evaluation and Management and other procedures:

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance		
					S	\$	NS
	J2790		RhoGAM, Rho (D) Immune Globulin (Human); single dose—Micro-Dose		20.40		20.40
	J2790	22	RhoGAM, Rho (D) Immune Globulin (Human); single dose—Full dose		72.07		72.07
	W9060	WT	Under six weeks				
	W9061	WT	Six weeks to three months				
	W9062	WT	Three months to five months				
	W9063	WT	Five months to eight months				
	W9064	WT	Eight months to 11 months				
	W9065	WT	11 months to 14 months				
	W9066	WT	14 months to 17 months				
	W9067	WT	17 months to 20 months				
	W9068	WT	20 months to 24 months				
			1. History including behavior and environmental factors;				
			2. Developmental assessment; and				
			3. Complete, unclothed physical examination by a physician or a nurse practitioner under the personal supervision of a physician, to include:				
			(a) Measurements: height, weight and head circumference;				

(b) Vision and hearing screening;
and

(c) Nutritional assessment.

4. Assessment and administration of immunizations (see appropriate HCPCS procedure codes for reimbursement amounts);

5. Anticipatory guidance;

6. Arrangement for diagnosis and treatment of medical problems uncovered during the visit. This includes self-referrals and/or referrals to other providers as medically indicated;

7. Appropriate laboratory procedures performed, or referred, in accordance with HealthStart Pediatric Care Guidelines.

(a) Sickle cell, PKU screening, as appropriate;

(b) Hemoglobin or hematocrit twice: at six to nine months and 20 to 24 months of age. (When done in conjunction with lead screening, this test is not reimbursable as a separate procedure.);

(c) Urinalysis, twice: at six to nine months and 20 to 24 months of age;

(d) Tuberculin test, twice: at 12 to 14 months and 20 to 24 months; and

(e) Lead screening (EP) at 12 to 14 months and 20 to 24 months.

8. Case coordination: referral for nutritional, psychological, social and other community services, as appropriate; and provision or arrangement for 24-hour telephone physician access and sick care; and outreach and follow-up activities in accordance with the HealthStart Pediatric Care Guidelines.

NOTE: Laboratory procedures performed by a physician in his or her office are not reimbursable to the physician; if such procedures are performed by an outside laboratory, the laboratory shall submit a separate claim.

W9096

Hepatitis B immunoprophylaxis with Recombivax HB, 0.25 ml dose. This code applies only to newborns of HBsAg negative mothers.

17.46

17.46

W9096

22

Hepatitis B immunoprophylaxis with Recombivax HB, 0.5 ml dose. This

W9097	code applies only to newborns of HBsAg negative mothers. Hepatitis B immunoprophylaxis with Recombivax HB, 0.25 ml dose. This code applies only to high risk recipients under 11 years of age (exclusive of newborns).	32.79	32.79
W9098	Hepatitis B immunoprophylaxis with Recombivax HB, 0.5 ml dose. This code applies only to high risk recipients 11 to 19 years of age.	17.46	17.46
W9099	Hepatitis B immunoprophylaxis with Recombivax HB, 1.0 ml dose. This code applies only to high risk recipients over 19 years of age.	32.79	32.79
W9333	Hepatitis B immunoprophylaxis with Engerix-B, 0.5 ml dose. This code applies only when immunizing newborns.	63.57	63.57
W9334	Hepatitis B immunoprophylaxis with Engerix-B, 0.5 ml dose. This code applies only to high risk recipients under 11 years of age (exclusive of newborns).	27.88	27.88
W9335	Hepatitis B immunoprophylaxis with Engerix-B, 1.0 ml dose. This code applies only to high risk recipients over 11 years of age	27.88	27.88
W9338	Tetramune. This code is used when administering the primary immunization series to infants and toddlers. It eliminates the need for two separate injections of DTP and Haemophilus b Conjugate Vaccine.	62.09	62.09
W9820	Early and Periodic Screening, Diagnosis and Treatment (EPSDT) through age 20.	30.27	30.27
	NOTE: If performed by outside independent laboratories, the laboratory must submit the claim. Blood sample for lead screening test should be sent to the New Jersey State Department of Health.	23.00	18.00
	NOTE: Procedure code W9820 shall be used only once for the same patient during any 12-month period by the same physician, group, shared health care facility, or practitioner(s) sharing a common record. Reimbursement for code W9820 is contingent upon the submission of both a Completed Report and Claim For		

EPSDT/HealthStart Screening and Related Procedures (MC-19) and the appropriate claim form within 30 days of the date of service.

In the absence of a completed MC-19 form, reimbursement will be reduced to the level of an annual health maintenance examination, that is, \$22.00-\$17.00

(b) Dental services (See N.J.A.C. 10:56-3).

(c) Family planning services:

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance	
					S	NS
	W0001	WF	Supplying and inserting the intrauterine device "Paragard" by a physician including the post-insertion visit.		188.00	188.00
	W0001	WMWF	Supplying and inserting the intrauterine device "Paragard" by a certified nurse-midwife including the post-insertion visit.		NA	177.00
	W0002	WF	Supplying and inserting the intrauterine device "Progestasert" by a physician including the post-insertion visit.		123.00	123.00
	W0002	WMWF	Supplying and inserting the intrauterine device "Progestasert" by a certified nurse-midwife including the post-insertion visit.		NA	112.00
	W0004	WF	Removal of an IUD by a physician followed at the same visit by the insertion of the IUD "Paragard" and including the post-insertion visit.		204.00	204.00
	W0004	WMWF	Removal of an IUD by a certified nurse-midwife followed at the same visit by the insertion of the IUD "Paragard" and including the post-insertion visit.		NA	188.00
	W0008	WF	Removal of an IUD by a physician followed at the same visit by the insertion of the IUD "Progestasert" and including the post-insertion visit.		139.00	139.00
	W0008	WMWF	Removal of an IUD by a certified nurse-midwife followed at the same visit by the insertion of the IUD "Progestasert" and including the post-insertion visit.		NA	123.00

(d) Laboratory services (See N.J.A.C. 10:61-3).

(e) Minor surgery:

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee \$	Fee Allowance \$	NS
	W1650		Excision of plantar verruca, single site unilateral		24.00		21.00
	W1650	22	Excision of plantar verruca, multiple sites, unilateral		37.00		32.00

(f) Mental health services:

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee \$	Fee Allowance \$	NS
	H5025	ZI	Group therapy: Verbal or other therapy methods provided by one or more psychiatrists, or professional counselors under the direction of a psychiatrist, in a personal involvement with two or more patients, with a maximum of eight patients. A minimum session of 1½ hours is required. This includes preparation time in addition to the 1½ hours session time.		8.00		8.00
	Z0100		Off-Site Crisis Intervention—An emergency procedure by personnel of a mental health clinic to an outpatient individual at locations other than the grounds or buildings of the clinic. Request for this service shall be initiated by the patient or other interested individual to meet the immediate needs of the patient, who is unable to present himself at the clinic. The procedure includes rapid intervention, written evaluation and a treatment plan. Use of procedure is limited to twice in six months for any one patient. This procedure is not applicable to institutionalized patients.		22.50		22.50
	Z0130		Psychological testing: Maximum of five hours of psychometric and/or projective tests with a written report. Partial Care: A mental health service whose primary purpose is to maximize the client's independence and community living skills in order to reduce unnecessary hospitalization. It is directed toward the acute and chronically disabled individual. Partial Care programs shall provide, as listed below, a full system of services necessary to meet the comprehensive		25.00 Per Hour		25.00 Per Hour

needs of the individual client. Services shall be provided or arranged for, to meet the individual needs of participating clients. These services shall include:

- Assessment and evaluation;
- Service procurement;
- Therapy;
- Information and referral;
- Counseling;
- Daily living education;
- Community organization;
- Pre-vocational therapy;
- Recreational therapy; and
- Health related services.

Partial Care programs shall be available daily for five days a week, with additional planned activities each week during evening and/or weekend hours as needed. Individual clients need not attend every day but as needed.

Partial Care programs specifically developed for children may be available four days a week, with one evening and/or weekend activity(ies).

The staff of the Partial Care program should include a Director who shall be a qualified professional from the specialties of psychiatry, psychology, social work, psychiatric nursing, vocational rehabilitation, or a related field with training and/or experience in direct service provision and administration.

A qualified psychiatrist shall be available to the Partial Care program on a regularly scheduled basis, for consultation. Other staff deemed necessary to implement a Partial Care program which meets the requirement of this section should include qualified mental health professionals, paraprofessionals and volunteers.

In order to qualify as an approved Partial Care program the Program must be certified by the Department.

Z0170	Partial Care, half day* *At least three hours but less than five hours of participation in active programming exclusive of meals.	46.00	46.00
Z0180	Partial Care, full day* *Five or more hours of participation in active programming exclusive of meals.	77.00	77.00

NOTE: Except for transportation these rates reflect full payments with a prohibition against multiple billing for more than one service to a Medicaid patient in a given day.

(g) Obstetrical services (maternity):

Ind	HCPCS	Mod	Description	Follow Up Days	Maximum Fee Allowance		
	Code				\$	\$	NS
	Z0250	WM	Home Delivery Pack. All drugs and supplies, etc., necessary for delivery in this setting.		NA		40.00

(h) Podiatry services:

Ind	HCPCS	Mod	Description	Follow Up Days	Maximum Fee Allowance		
	Code				\$	\$	NS
	W2650		Casting for molded shoes Prior authorization is required.		21.00		21.00
	W2655		Casting for arch support Prior authorization is required.		5.00		5.00

(i) Radiology services:

Ind	HCPCS	Mod	Description	Follow Up Days	Maximum Fee Allowance		
	Code				\$	\$	NS
	W7200		Foot, complete (incl. special or calcis views)		20.00		20.00
	W7250		Colon, barium enema, with or without K.U.B. air contrast only (with fluoroscopy by the radiologist).		30.00		30.00

(j) Rehabilitation services:

Ind	HCPCS	Mod	Description	Follow Up Days	Maximum Fee Allowance		
	Code				\$	\$	NS
	H5300		Occupational therapy		7.00		7.00
	Z0270		Physical therapy—initial visit, per individual, per provider		7.00		7.00
	Z0280		Occupational therapy—initial visit, per individual, per provider		7.00		7.00
	Z0300		Speech-language therapy—initial visit, per individual, per provider		7.00		7.00

(k) Vision care services (See N.J.A.C. 10:62-4).

(l) Transportation services:

Ind	HCPCS	Mod	Description	Follow Up Days	Maximum Fee Allowance		
	Code				\$	\$	NS
	Z0330		Transportation, one way.		4.50		4.50
	Z0335		Transportation, round trip.		9.00		9.00

(m) Drug treatment center services:

*An asterisk preceding any procedure code indicates that the procedure may only be provided to ACCAP-eligible individuals in the home.

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance		
					\$	\$	NS
	*Z1830		Methadone treatment rendered by a drug treatment center at home, per visit.		3.50		3.50
	*Z1831		Urinalysis for drug addiction at home, per visit.		4.50		4.50
	*Z1832		Psychotherapy rendered by a drug treatment center at home—full session, per visit.		24.00		24.00
	*Z1833		Psychotherapy rendered by a drug treatment center at home—half session, per visit.		12.00		12.00
	*Z1834		Family therapy rendered by a drug treatment center at home, per visit.		30.00		30.00
	*Z1835		Family conference rendered by a drug treatment center at home, per visit.		22.50		22.50
	Z2000		Family therapy rendered in a drug treatment center.		22.50		22.50
	Z2001		Family conference rendered in a drug treatment center.		15.00		15.00
	Z2002		Prescription visit rendered in a drug treatment center.		4.50		4.50
	Z2003		Psychotherapy rendered in a drug treatment center—full session.		16.00		16.00
	Z2004		Group therapy rendered in a drug treatment center, per person.		8.00		8.00
	Z2005		Psychological testing rendered in a drug treatment center, per hour; maximum of five hours.		15.00		15.00
	Z2006		Methadone treatment rendered in a drug treatment center.		2.50		2.50
	Z2007		Psychotherapy rendered in a drug treatment center—half session.		8.00		8.00
	Z2010		Urinalysis for drug addiction.		4.50		4.50

(n) Federally qualified health center services:

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance		
					\$	\$	NS
	W9840		Medical encounter		150.00		150.00
	Y3333		Dental encounter		150.00		150.00
	90844	22	Medical psychotherapy		150.00		150.00

(o) Personal care assistant services:

(Applicable to clinics under contract to the Division of Mental Health and Hospitals of the Department of Human Services.)

Ind	HCPCS Code	Mod	Description	Follow Up Days	Maximum Fee Allowance		
					S	\$	NS
	Z1600	ZI	Personal Care Assistant Services Individual, per hour		13.02		13.02
	Z1605	ZI	Personal Care Assistant Services Group, per hour		10.23		10.23
	Z1610	ZI	Personal Care Assistant Services Initial Nursing Assessment, per visit		35.00		35.00
	Z1611	ZI	Personal Care Assistant Services Individual, per hour		6.51		6.51
	Z1612	ZI	Personal Care Assistant Services Group, per hour		5.12		5.12
	Z1613	ZI	Nursing Reassessment Visit, per visit		35.00		35.00

10:66-6.4 HCPCS procedure codes—qualifiers

(a) Evaluation and management and other procedures:

1. Drawing of blood: 36415.

i. Once per visit, per patient. (Not applicable if laboratory study, in any part, is performed by the clinic.)

2. Injection (intradermal, subcutaneous, or intra-arterial): 90799.

i. Reimbursement for the above injections are on a flat-fee basis and are all inclusive for the cost of the service as well as the materials. Be advised of the following:

(1) A visit for the sole purpose of an injection is reimbursable only as an injection and not as a clinic visit and injection. However, if the criteria of a clinic visit is met, an injection may, if medically indicated, be considered as an add-on to the visit. The drug administered shall be consistent with the diagnosis and shall conform to accepted medical and pharmacological principles with respect to dosage, frequency and route of administration.

(2) Intravenous and intraarterial injections are reimbursable only when performed by the physician.

(3) No reimbursement will be made for vitamins, liver or iron injections or combinations thereof except in laboratory proven deficiency states requiring parenteral therapy.

(4) No reimbursement will be made for placebos or any injections containing amphetamines or derivatives thereof.

(5) No reimbursement will be made for injections given for the treatment of obesity.

(6) No reimbursement will be made for an injection given as a pre-operative medication or as a pre-operative local anesthetic which is part of an operative or surgical procedure since this injection would

normally be included in the listed fee for such a procedure.

(7) Insert procedure code 90799 as a separate item on the claim, followed by the name, dose of drug, and route of administration. The complete diagnosis, for which the injection was given, shall be indicated on the claim.

3. General clinical psychiatric diagnostic or evaluative interview procedures: 90801.

i. This code requires for reimbursement purposes a minimum of 50 minutes of direct personal clinical involvement with the patient or family member. The CPT narrative otherwise remains applicable.

ii. No more than one claim for the code 90801 is reimbursable per the same recipient, per the same physician, per year.

4. Prolonged detention: 99150 and 99151.

i. Prolonged detention with or without critical care will be covered under CPT 99150 and 99151, but the service shall be consistent with the following narrative in order to be reimbursed:

(1) The patient's situation requires constant physician attendance which is given by the physician to the exclusion of other patients and duties. This must be verified by the applicable records as defined by the setting.

(2) Records shall show in the physician's handwriting the time of onset and time of completion of the service.

ii. This code may not be used simultaneously with procedure codes that pay a reimbursement for the same time or type of service.

iii. The basis for this type of claim should be apparent on the claim form. The listed fees of \$37.00 for specialist and \$32.00 for non-specialist are per hour.

5. Evaluation and management—new patient (excludes preventive health care for patients through 20

years of age): 99201, 99201WF, 99201WFWM, 99202, 99202WF, 99202WFWM, 99203, 99203WF, 99203WFWM, 99204, 99204WF, 99204WFWM, 99205, 99205WF, 99205WFWM and 99432.

i. When reference is made in the CPT manual to "Office—New Patient," the intent of the Medicaid program is to consider this service as the initial visit.

ii. Reimbursement for an initial clinic visit will be disallowed, if a preventive medicine service, EPSDT examination or clinic consultation were billed within a twelve month period by a clinic.

iii. It is also to be understood that in order to receive reimbursement for an initial visit, the following minimal documentation must be on the record regardless of the setting where the examination was performed. For example:

(1) Chief complaint(s);

(2) Complete history of the present illness and related systemic review, including recordings of pertinent negative findings;

(3) Pertinent past medical history;

(4) Pertinent family history;

(5) A full physical examination pertaining to but not limited to the history of the present illness and includes recording of pertinent negative findings; and

(6) Working diagnoses and treatment plan including ancillary services and drugs ordered.

6. Evaluation and management services—established patient (excludes preventive health care for patients through 20 years of age): 99211, 99211WM, 99211WF, 99211WFWM, 99212, 99212WF, 99212WFWM, 99212WM, 99213, 99213WF, 99213WFWM, 99213WM, 99214, 99214WF, 99214WFWM, 99214WM, 99215, 99215WF, 99215WFWM, and 99215WM.

i. Routine visit or follow-up care visit is defined for purposes of Medicaid reimbursement as the care and treatment by a physician or certified nurse-midwife, as appropriate, which includes those procedures ordinarily performed during a health care visit, which are dependent upon the setting and the physician's discipline.

ii. In order to document the record for reimbursement purposes, a progress note for the noted visits should include the following:

(1) Purpose of visit;

(2) Pertinent history obtained;

(3) Pertinent physical findings including pertinent negative findings based on the above;

(4) Procedures, if any, with results;

(5) Lab, X-ray, EKG, etc., ordered with results; and

(6) Diagnosis.

7. Consultations: A consultation is recognized for reimbursement only when performed by a specialist recognized as such by this Program and the request has been made by or through the patient's attending physician and the need for such a request would be consistent with good medical practice.

i. Comprehensive consultation: 99244, 99245, 99254, 99255, 99274 and 99275.

(1) In order to receive reimbursement for these HCPCS codes, the performance of a total systems evaluation by history and physical examination, including a total systems review and total system physical examination are required.

(2) An alternative to (a)7i(1) above would be the utilization of one or more hours of the consulting physician's personal time in the performance of the consultation.

(3) Reimbursement for HCPCS codes 99244, 99245, 99254, 99255, 99274 and 99275 (Comprehensive Consultation) requires the following applicable statements, or language essentially similar to those statements, to be inserted in the "remarks section" of the claim form. The form is to be signed by the provider who performed the consultation.

(A) I personally performed a total (all) systems evaluation by history and physical examination; or

(B) This consultation utilized 60 or more minutes of my personal time.

(4) The following rules regarding consultations shall also be recognized.

(A) If a consultation is performed and the patient is then transferred to the consultant's service during the course of that illness, the provider may not, in addition, bill for an Initial Visit if he or she has or intends to bill for the consultation.

(B) If there is no referring physician, then an Initial Visit code should be used instead of a consultation code.

(C) If the patient is seen for the same illness on repeated visits, by the same consultant, then these visits are considered as routine visits or follow-up care visits and not as consultations.

(D) Consultation codes will be declined in a clinic setting if the consultation has been requested by or between members of the same group, shared health care facility or physicians sharing common records. A routine visit code is applicable under these circumstances.

(E) If a prior claim for comprehensive consultation visit has been made within the preceding 12 months, then a repeat claim for this code will be denied if made by the clinic except in those instances where the consultation required the utilization of one hour or more of the physician's personal time. Otherwise, applicable codes would be limited consultation code if their criteria are met.

ii. Limited consultation: 99241, 99242, 99243, 99251, 99252, 99253, 99271, 99272, and 99273.

(1) The area being covered for reimbursement purposes is "limited" in the sense that it requires less than the requirements designated as "comprehensive" as noted above.

iii. Second opinion program consultation: 99274YY.

(1) A consultation to satisfy the requirements of the mandated "Second Opinion" program will be reimbursed only if the requirements of that program are met and the consultation has been performed by the appropriate board certified specialist who has signed a separate provider agreement and whose selection has been through the Second Opinion Referral Service (1-800-676-6562).

iv. Third opinion consultation: 99274ZZ.

(1) In the event that a patient receives two different points of view relative to a "Second Opinion" procedure, he or she may, if unable to reach a decision, request a third opinion.

(2) A third opinion consultation must be at the patient's request and under the circumstances described.

8. Critical care services: 99291 and 99292.

i. Critical care is reimbursable under codes 99291 and 99292 if the service is consistent with the following:

(1) The patient's situation requires constant physician attendance which is given by the physician to the exclusion of his or her other patients and duties and, therefore, represents what is beyond the usual service. This must be verified by the applicable records as defined by the setting and which records must show in the physician's handwriting the time of onset and time of completion of the service.

(2) All settings are applicable, such as clinic and hospital.

(3) These codes may not be used simultaneously with procedure codes that pay a reimbursement for the same time or type of service.

(b) Dental services (See N.J.A.C. 10:56-3).

(c) Family planning services:

1. Norplant—insertion, implantable contraceptive capsules: 1197522.

i. The maximum fee allowance includes the cost of the NPS kit, the insertion of the "Norplant System" (six levonorgestrel implants), and the post-insertion visit.

ii. Modifier "22" indicates that the billing includes the cost of the kit.

2. Norplant—removal, implantable contraceptive capsules: 11976.

i. The maximum fee allowance includes the removal of the "Norplant System" (six levonorgestrel implants) and the post-removal visit.

3. Norplant—removal with reinsertion, implantable contraceptive capsules: 1197722.

i. The maximum fee allowance includes the removal/insertion of the "Norplant System" (six levonorgestrel implants) and post-removal/reinsertion visit.

4. Sterilization (male): 55250 and 55450.

i. Primary sterilization (family planning) procedure.

ii. A completed consent form shall be attached to the claim form, in accordance with N.J.A.C. 10:66-2.3.

5. Sterilization (female): 58600, 58605, 58982, and 58983.

i. These procedures are always considered a sterilization procedure. Therefore, a completed consent form shall be attached to the claim form, in accordance with N.J.A.C. 10:66-2.3.

ii. 57451: If the procedure is performed for sterilization purposes, a completed consent form shall be attached to the claim form, in accordance with N.J.A.C. 10:66-2.3.

6. Initial medical visit: 99201WF, 99201WFWM, 99202WF, 99202WFWM, 99203WF, 99203WFWM, 99204WF, 99204WFWM, 99205WF, and 99205WFWM.

i. Family planning to include each of the following:

- (1) Medical, social, obstetrical history
- (2) Complete pelvic examination—including visual inspection of the cervix
- (3) Breast examination
- (4) Papanicolaou smear (excludes cytology study)
- (5) Contraceptive counseling with referral as indicated.

ii. Includes the cost of birth control drugs dispensed. A prescription cannot be substituted.

iii. These procedure codes (initial medical visit) will be disallowed if procedure codes 99201, 99201WF, 99201WFWM, 99202, 99202WF, 99202WFWM, 99203, 99203WF, 99203WFWM, 99204, 99204WF, 99204WFWM, 99205, 99205WF, 99205WFWM and 99432 have been performed during the prior 12 months by the same provider.

7. Routine or follow-up visit—brief: 99211WF, 99211WFWM, 99212WF, 99212WFWM, 99213WF, and 99213WFWM.

i. May include pelvic examination, changes in method or physician's or certified nurse-midwife's instructions at a minimum average time of five minutes, or a visit solely for a refill supply of birth control drugs for which a prescription cannot be substituted and professional contact is not necessary.

8. Medical revisit—family planning: 99214WF and 99214WFWM.

i. May include pelvic examination or changes in method or physician's or certified nurse-midwife's instructions. This code includes the cost of birth control drugs dispensed. A prescription cannot be substituted.

9. Routine or follow-up visit—prolonged: 99215WF and 99215WFWM.

i. May include pelvic examination or changes in method or physician's or certified nurse-midwife's instructions. Involves 20 or more minutes of personal time in patient contact, including documentation of time as well as adequate significant progress notes on the clinic record. This procedure code includes the cost of birth control drugs dispensed. A prescription cannot be substituted.

10. Annual medical revisit: 99395WF and 99395WFWM.

i. Family planning to include each of the following:

- (1) Updating medical, social, obstetrical history;

(2) Complete pelvic examination including visual inspection of cervix;

(3) Breast examination; and

(4) Papanicolaou smear (excludes cytology study) with referral when indicated.

ii. This code includes the cost of birth control drugs dispensed. A prescription cannot be substituted.

iii. Procedure code 99395WF will be disallowed if procedure codes 99201, 99201WF, 99201WFWM, 99202, 99202WF, 99202WFWM, 99203, 99203WF, 99203WFWM, 99204, 99204WF, 99204WFWM, 99205, 99205WF, 99205WFWM and 99432 have been performed during the prior 12 months by the same provider.

(d) Laboratory services (See N.J.A.C. 10:61-3).

(e) Minor surgery:

1. Acne surgery (for example, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules): 10040.

i. Excision must involve the use of a scalpel and an expressor, but not an expressor alone. This code is limited to severe acne. For less than severe acne, utilize the procedure codes for routine office visits.

(f) Mental health services:

1. Comprehensive intake evaluation: 90801ZI.

i. An initial procedure performed at a mental health clinic to assess a new patient and recommend an appropriate treatment plan or additional diagnostic studies. The procedure includes initial interviews with the patient and other involved individuals, conferences with referral sources, examination of written material provided by the patient or others, staff conferences and written evaluation and treatment plan including recommendations for further consultations, studies or additional information.

ii. Although this procedure may be performed by a single individual, it is expected that it should be a team approach and of one and one-half hours duration. Use of procedure is limited to once per year for any one patient.

2. Individual psychotherapy—25 minute session: 90843ZI.

i. This code requires, for reimbursement purposes, a minimum of 25 minutes of direct personal clinical involvement with the patient and/or family member.

3. Individual psychotherapy—50 minute session: 90844ZI.

i. This code requires, for reimbursement purposes, a minimum of 50 minutes of direct personal clinical involvement with the patient and/or family member.

4. Family therapy: 90847ZI.

i. This code requires, for reimbursement purposes, a minimum of 50 minutes of direct personal clinical involvement with the patient and/or family member. The CPT narrative otherwise remains applicable.

5. Family therapy: 90847ZI22.

i. This code requires, for reimbursement purposes, a minimum of 80 minutes of direct personal clinical involvement with the patient and/or family member. The CPT narrative otherwise remains applicable.

6. Family conference: 90887ZI.

i. This code requires, for reimbursement purposes, a minimum of 25 minutes of direct personal clinical involvement with patient, family member or caretaker. The CPT narrative otherwise remains applicable.

7. Group psychotherapy: H5025ZI.

i. This code requires, for reimbursement purposes, a minimum of 90 minutes of direct clinical involvement with the patient as a member of a group of which 10 minutes can be used for documentation. The maximum number of the group is eight and the reimbursement is per person, per group session.

(g) Obstetrical services (maternity):

1. Total obstetrical care: 59400.

i. Antepartum care consisting of initial antepartum visits and seven subsequent antepartum visits. Specific date of all visits are to be listed on the claim form.

(1) Reimbursement will be decreased by the fee for the initial antepartum visit (5942022) if not seen for this visit. The total fee will also be decreased by the reimbursement sum for each subsequent antepartum visit (59420) which is less than seven.

(2) If medical necessity dictates, corroborated by the record, additional visits above seven antepartum may be reimbursed under the procedure codes for routine or follow-up clinic visit. The claim form shall clearly indicate the reason for the medical necessity and date for each listed.

ii. Obstetrical delivery with in-hospital postpartum care (with or without low forceps and/or episiotomy or a vaginal delivery full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours).

(1) This shall also include one visit between the 15th and 60th day postpartum day following delivery and out of hospital. Include name of hospital and delivery date on the claim.

2. Vaginal delivery: 59410.

i. Vaginal delivery full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours.

ii. This shall also include one visit between the 15th and 60th postpartum day following delivery and out of hospital. Include name of hospital and delivery date on the claim.

3. Subsequent antepartum visit: 59420.

i. Subsequent antepartum visit (separate procedure). Indicate specific dates of service.

4. Initial antepartum visit: 5942022.

i. Initial antepartum visit (separate procedure).

5. Postpartum care: 59430.

i. Postpartum care (other than delivery physician).

ii. This shall also include one visit between 15th and 60th postpartum day following delivery and out of hospital. Include name of hospital and delivery date on the claim.

6. Total obstetrical care by a certified nurse-midwife: 59400WM.

i. Total obstetrical care when given by a certified nurse-midwife, including:

(1) Antepartum care consisting of initial antepartum visit and seven subsequent antepartum visits. Specific dates of all visits are to be listed on the claim form.

(2) Reimbursement will be decreased by the fee for the initial antepartum visit (code 5942022WM) if patient not seen for this visit. The total fee will also be decreased by the reimbursement sum for each subsequent antepartum visit (code 59420WM) which is less than seven.

(3) If medical necessity dictates, corroborated by the record, additional visits above seven antepartum may be reimbursed under the procedure codes for routine or follow-up visit. The claim shall clearly indicate the reason for the medical necessity and date for each code listed.

ii. Obstetrical delivery per vagina with or without episiotomy include postpartum care when provided by the certified nurse-midwife in the home, birthing center or in the hospital (inpatient setting).

(1) This applies to a vaginal delivery at full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours.

(2) This shall also include one visit between the 15th and 42nd postpartum day following delivery and

out of the hospital. Include delivery date on the claim form.

7. Vaginal delivery by a certified nurse-midwife: 59410WM.

i. Obstetrical delivery per vagina with or without episiotomy including postpartum care when provided by the certified nurse-midwife in the home, birthing center or in the hospital (inpatient setting).

(1) This applies to a vaginal delivery at full term or premature following completion of at least 28 weeks of gestation or if baby lives over 24 hours.

(2) This shall also include one visit between the 15th and 42nd post-partum day following delivery and out of hospital. Include delivery date on the claim form.

8. Subsequent antepartum visit provided by a certified nurse-midwife: 59420WM.

i. Indicate specific date of service.

9. Initial antepartum visit provided by a certified nurse-midwife: 59420WM22.

i. Initial antepartum visit provided by a certified nurse-midwife (separate procedure).

10. Postpartum care provided by a certified nurse-midwife: 59430WM.

i. Postpartum care provided by a certified nurse-midwife who is other than the individual who performed the delivery and who is not related to this individual by any financial or contractual arrangement, e.g., group, clinic, employee, etc.

ii. One visit between the 15th and 60th postpartum day following delivery. Include delivery date on the claim (separate procedure).

(h) Podiatry services:

1. Routine or follow-up clinic visit: 99211YR, 99212YR, 99213YR, 99214YR, and 99215YR.

i. Routine or follow-up clinic visit. A podiatry service consisting of routine care and treatment by the podiatrist.

ii. Include significant written progress notes and office records which demonstrate positive findings and treatment changes.

2. See N.J.A.C. 10:66-6.4(f), Surgery, for additional procedures.

(i) Radiology services:

1. Chest: 71010, 71020, 71030, and 71034.

i. Routine chest X-rays without medical necessity in an office (clinic) are not reimbursable under Program guidelines.

2. Pelvis: 72170.

i. Pelvis X-ray is not eligible for separate payment when performed in conjunction with Complete Lumbosacral Spine X-rays (72110).

3. Hip: 73500 and 73510.

i. Procedure 73520 should be used for bilateral hip X-rays when both hips are X-rayed instead of billing separately for each hip (73500 and 73510).

4. Esophagus (with fluoroscopy by the radiologist): 74220.

i. Not eligible for separate payment when performed in conjunction with a GI or Small Bowel Series (74240, 74241, 74245, and 74250).

5. Pelvimetry: 74710.

i. Use of the code for pelvimetry requires written evidence of medical necessity to accompany the claim.

(j) Rehabilitation services:

1. Speech therapy: 92507.

i. Minimum time, 30 minutes. Prior authorization required.

ii. Prescribed by a licensed physician, performed by a qualified speech-language pathologist.

2. Audiometric tests: 92552, 92553, 92557, 92567, 92568, 92572, 92576, 92582, and 92589.

i. May be reimbursed when prescribed by a physician and performed by an audiologist.

ii. Tympanometry (92567) and acoustic reflex testing (92568) are reimbursable only to a specialist.

iii. Acoustic reflex testing, 92568, shall include at least two frequencies per ear. Brief reflex screening at one frequency per ear is not reimbursable. Documentation of these tests shall appear in the patient's record.

3. Physical therapy: 97799.

i. Individual treatment session—minimum time, 30 minutes. No more than three patients can be treated simultaneously.

ii. Prior authorization required. Consists of any one or a combination of the following modalities, prescribed by a licensed physician, performed by a qualified physical therapist and related to the patient's active treatment regimen.

(1) Appropriate use of accepted mechanical device (such as parallel bar, weights, pulley system, friction wheels, steps, etc.).

(2) Graduated range of motion exercises.

(3) Therapeutic ultrasound, only when included as part of other forms of accepted therapy.

(4) Therapeutic use of physical agents (other than drugs) including heat, light, water, electricity and radiation.

(5) Instructions to responsible persons for follow-up procedures between therapy visits.

4. Occupational therapy: H5300.

i. Minimum time, 30 minutes. Prior authorization required.

ii. Prescribed by a licensed physician, performed by a qualified occupational therapist.

(k) Vision care services (See N.J.A.C. 10:62-4).

(l) Transportation services:

1. Transportation, one way: Z0330.

i. Applicable when the clinic transports a recipient either to or from the clinic in any one day.

ii. Reimbursement is limited to two trips per day for the same recipient by the same clinic.

2. Transportation, round trip: Z0335.

i. Applicable when the clinic transports a recipient on a round trip basis to/from the clinic in any one day.

ii. Reimbursement is limited to one round trip per day for the same recipient by the same clinic.

(m) Drug treatment center services:

1. Methadone treatment rendered by a drug treatment center for an ACCAP-eligible individual at home, per visit: Z1830.

i. A per diem payment based on the number of days a recipient is supplied methadone during the billing period. This rate includes the cost of the drug, packaging, nursing time, and administrative costs.

2. Urinalysis for drug addiction for an ACCAP-eligible individual at home, per visit: Z1831.

i. To be used only when the drug treatment center is approved for this service; to determine what level if any, a drug is present in the urine.

3. Psychotherapy rendered by a drug treatment center for an ACCAP-eligible individual at home—full session, per visit: Z1832.

i. Verbal, drug augmented, or other therapy methods provided by a physician, or a professional counselor under the direction of a physician, in a personal involvement with one patient to the exclusion of other patients and/or duties.

ii. A minimum of 50 minutes personal involvement with the patient is required. This includes a prescription visit when necessary.

4. Psychotherapy rendered by a drug treatment center for an ACCAP-eligible individual at home—half session, per visit: Z1833.

i. Verbal, drug augmented, or other therapy methods provided by a physician, or a professional counselor under the direction of a physician in a personal involvement with one patient to the exclusion of other patients and/or duties.

ii. A minimum of 25 minutes personal involvement with the patient is required. This includes a prescription visit when necessary.

5. Family therapy rendered by a drug treatment center for an ACCAP-eligible individual at home, per visit: Z1834.

i. Therapy with the patient and with one or more family members present. Verbal or other therapy methods are provided by a physician, or a professional counsellor under the direction of a physician, in personal involvement with the patient and the family to the exclusion of other patients and/or duties.

ii. A minimum session of one and one half hours is required with a minimum of 80 minutes personal involvement with the patient and the family and up to 10 minutes for the recording of data.

iii. The clinic may bill only for the patient and not for other family members.

6. Family conference rendered by a drug treatment center for an ACCAP-eligible individual at home, per visit: Z1835.

i. Meeting with the family or other significant persons to interpret or explain medical, psychiatric or psychological examinations and procedures, other accumulated data and/or advice to the family or other significant persons on how to assist the patient.

ii. A minimum of 50 minutes of personal involvement with the family is required. The clinic may bill only for the patient and not for other family members.

7. Family therapy rendered in a drug treatment center: Z2000.

i. Therapy with the patient and with one or more family members present. Verbal or other therapy methods are provided by a physician, or a professional counsellor under the direction of a physician, in personal involvement with the patient and the family to the exclusion of other patients and/or duties.

ii. A minimum session of one and one half hours is required with a minimum of 80 minutes personal involvement with the patient and the family and up to 10 minutes for the recording of data.

iii. The clinic may bill only for the patient and not for other family members.

8. Family conference rendered in a drug treatment center: Z2001.

i. Meeting with the family or other significant persons to interpret or explain medical, psychiatric or psychological examinations and procedures, other accumulated data and/or advice to the family or other significant persons on how to assist the patient.

ii. A minimum of 50 minutes of personal involvement with the family is required. The clinic may bill only for the patient and not for other family members.

9. Prescription visit rendered in a drug treatment center: Z2002.

i. A visit with a physician for review and evaluation of the medication history of the patient and the writing, or renewal of prescription, as necessary.

10. Psychotherapy rendered in a drug treatment center—full session: Z2003.

i. Verbal, drug augmented, or other therapy methods provided by a physician, or a professional counselor under the direction of a physician, in a personal involvement with one patient to the exclusion of other patients and/or duties.

ii. A minimum of 50 minutes personal involvement with the patient is required. This includes a prescription visit when necessary.

11. Group therapy rendered in a drug treatment center, per person: Z2004.

i. Verbal or other therapy methods provided by one or more physicians, or professional counsellors under the direction of physician, in a personal involvement with two or more patients, with a maximum of eight patients.

ii. A minimum session of one and one half hours is required. This includes preparation time in addition to the one and one half hours session time.

12. Psychological testing rendered in a drug treatment center, per hour; maximum of five hours: Z2005.

i. Psychometric and/or projective tests with a written report.

13. Methadone treatment rendered in a drug treatment center: Z2006.

i. A per diem payment based on the number of days a recipient is supplied methadone during the billing period. This rate includes the cost of the drug, packaging, nursing time, and administrative costs.

14. Psychotherapy rendered in a drug treatment center—half session: Z2007.

i. Verbal, drug augmented, or other therapy methods provided by a physician, or a professional counselor under the direction of a physician in a personal involvement with one patient to the exclusion of other patients and/or duties.

ii. A minimum of 25 minutes personal involvement with the patient is required. This includes a prescription visit when necessary.

15. Urinalysis for drug addiction: Z2010.

i. To determine what level, if any, a drug is present in the urine.

ii. To be used only by a drug treatment center specifically approved by the Program to provide this service.

16. Drawing of blood; see CPT-4 for narrative: 36415.

i. Once per visit per patient. Not applicable if lab study, in any part, is to be performed by the clinic.

(n) Miscellaneous services:

1. Abortion: 59840 and 59841.

i. See N.J.A.C. 10:66-2.8; FD-179 form shall be attached to the claim form.

ii. For claims submitted by ambulatory surgical centers only, the trimester of pregnancy shall be identified on the claim form by using modifier "WY" for first trimester or "WZ" for second trimester.

Administrative Correction.
26 N.J.R. 797(a).

10:66-6.5 HealthStart

(a) HealthStart Maternity Care code requirements are as follows:

1. Separate reimbursement shall be available for Maternity Medical Care Services and Maternity Health Support Services.

2. Maternity Medical Care Services shall be billed as a total obstetrical package when feasible, but may also be billed as separate services.

3. The enhanced reimbursement (that is, HealthStart procedure codes) for delivery and postpartum care shall be claimed only for a patient who received at least one antepartum HealthStart Maternity Medical or Health Support Service.

4. The modifier "WM" in the HCPCS lists of codes refers to those services provided by certified nurse midwives; include the modifier at the end of each code.

5. Laboratory, other diagnostic procedures, and all necessary medical consultations are eligible for separate reimbursement.

i. Laboratory procedures performed by an outside laboratory shall be reimbursed to the laboratory. The clinic may submit a claim for a venipuncture using procedure code 36415 when necessary to collect blood specimens.

6. HealthStart Maternity Medical Care Services codes are as follows:

HCPCS Code	Mod	Procedure Description	S	Maximum Fee Allowance		WM
				\$	NS \$	
W9025		HealthStart Initial Antepartum Maternity Medical Care Visit	72.00		69.00	
W9025	WM	HealthStart Initial Antepartum Maternity Medical Care Visit by Certified Nurse Midwife 1. History, including system review 2. Complete physical examination 3. Risk assessment 4. Initial care plan 5. Patient counseling and treatment 6. Routine and special laboratory tests on site, or by referral, as appropriate 7. Referral for other medical consultations, as appropriate (including dental) 8. Coordination with the HealthStart Health Support Services provider, as applicable.				67.00
W9026		HealthStart Subsequent Antepartum Maternity Medical Care Visit	22.00		21.00	
W9026	WM	HealthStart Subsequent Antepartum Maternity Medical Care Visit by Certified Nurse Midwife 1. Interim history 2. Physical examination 3. Risk assessment 4. Review of plan of care 5. Patient counseling and treatment 6. Laboratory services on site or by referral, as appropriate 7. Referrals for other medical consultations, as appropriate 8. Coordination with HealthStart case coordinator.				19.00
		NOTE: This code may be billed only for the 2nd through 15th antepartum visit.				
		NOTE: If medical necessity dictates, corroborated by the record, additional visits above the fifteenth visit may be reimbursed under procedure code, that is, 99211, 99211WM, 99212, 99212WM, 99213, 99213WM, 99214, 99214WM, 99215, and 99215WM. The date and place of service shall be included on each claim detail line on the 1500 N.J. claim form. The claim form should clearly indicate the reason for the medical necessity and date for each additional visit.				

HCPCS Code	Mod	Procedure Description	S	Maximum Fee Allowance \$ NS \$	WM
W9027		HealthStart Regular Delivery	465.00	418.00	
W9027	WM	HealthStart Regular Delivery by Certified Nurse Midwife			371.00
		<ol style="list-style-type: none"> 1. Admission history 2. Complete physical examination 3. Vaginal delivery with or without episiotomy and/or forceps 4. Inpatient postpartum care 5. Referral to postpartum follow-up care provider including: <ol style="list-style-type: none"> (a) Mother's hospital discharge summary and the (b) Infant's discharge summary, as appropriate <p>NOTE: Obstetrical delivery applies to a full term or premature vaginal delivery and includes care in the home, birthing center or in the hospital (inpatient setting). Include the delivery date on the 1500 N.J. claim form in Item 24A.</p>			
W9028		HealthStart Postpartum Care Visit	22.00	21.00	
W9028	WM	HealthStart Postpartum Care Visit by Certified Nurse Midwife			19.00
		<ol style="list-style-type: none"> 1. Outpatient postpartum care by the 60th day after the vaginal or caesarean section delivery <ol style="list-style-type: none"> (a) Review of prenatal, labor and delivery course (b) Interim history, including information on feeding and care of the newborn (c) Physical examination (d) Referral for laboratory services, as appropriate (e) Referral for ongoing medical care when appropriate (f) Patient counseling and treatment <p>NOTE: The postpartum visit shall be made by the 60th postpartum day. Include the delivery date on the 1500 N.J. claim form in Item 24A.</p>			
W9029		HealthStart Regular Delivery and Postpartum	487.00	439.00	
W9029	WM	HealthStart Regular Delivery and Postpartum by Certified Nurse Midwife includes:			390.00
		<ol style="list-style-type: none"> 1. Admission history 2. Complete physical examination 3. Vaginal delivery with or without episiotomy and/or forceps 4. Inpatient postpartum care 5. Referral to postpartum follow-up care provider including: <ol style="list-style-type: none"> (a) Mother's hospital discharge summary (b) Infant's discharge summary, as appropriate 6. Outpatient postpartum care by the 60th day after the delivery 			

HCPCS Code	Mod	Procedure Description	S	Maximum Fee Allowance		WM
				\$	NS \$	
		(a) Review of prenatal, labor and delivery course				
		(b) Interim history, including information on feeding and care of the newborn				
		(c) Physical examination				
		(d) Referral for laboratory services, as appropriate				
		(e) Referral for ongoing medical care when appropriate				
		(f) Patient counseling and treatment				
		NOTE: This code applies to a full term or premature vaginal delivery and includes care in the home, birthing center or in the hospital (inpatient setting). Include delivery date on the 1500 N.J. claim form in Item 24A.				
W9030		HealthStart Total Obstetrical Care	867.00	802.00		
W9030	WM	HealthStart Total Obstetrical Care by Certified Nurse Midwife				723.00
		Total obstetrical care consists of:				
		1. Initial antepartum visit and 14 subsequent antepartum visits. Specific dates are to be listed on the claim form.				
		NOTE: Reimbursement will be denied if the services delivered do not meet the criteria for the visits.				
		The elements of the visits shall include the following:				
		a. History (initial or review), including system review				
		b. Complete physical examination				
		c. Risk assessment				
		d. Initial and ongoing care plan				
		e. Patient counseling and treatment				
		f. Routine and special laboratory tests on site, or by referral, as appropriate				
		g. Referral for other medical consultations, as appropriate (including dental)				
		h. Coordination with the HealthStart Health Support Services provider, as applicable.				
		2. Regular vaginal delivery by certified nurse midwife:				
		The elements of the care shall include the following:				
		a. Admission History				
		b. Complete physical examination				
		c. Vaginal delivery with or without episiotomy and/or forceps				
		d. Inpatient postpartum care				

HCPCS Code	Mod	Procedure Description	S	Maximum Fee Allowance		WM
				\$	NS \$	
		<p>NOTE: Include the delivery date on the 1500 N.J. claim form in Item 24A.</p> <p>3. Postpartum care visit by certified nurse midwife: Outpatient postpartum care by the 60th day after the vaginal delivery (full term or premature):</p> <ol style="list-style-type: none"> Review of prenatal, labor and delivery course Interim history, including information on feeding and care of the newborn Physical examination Referral for laboratory services, as appropriate Referral for ongoing medical care when appropriate Patient counseling and treatment 				
W9031		<p>HealthStart Cesarean Section Delivery</p> <ol style="list-style-type: none"> Admission history Complete physical examination Cesarean section delivery Inpatient postpartum care Referral to postpartum follow-up care provider, including: <ol style="list-style-type: none"> Mother's hospital discharge summary Infant's discharge summary, as appropriate <p>NOTE: Include the delivery date on the claim form.</p>	595.00	531.00		
W9040		<p>HealthStart enrollment process</p> <ol style="list-style-type: none"> Assistance with the presumptive eligibility determination for Maternity Care recipients, when and if applicable Patient registration and scheduling of the initial appointments Counseling and referral for WIC, food stamps, and other community-based services Assignment of HealthStart case coordinator Outreach and follow-up on missed appointments <p>NOTE: This code may be billed only once during pregnancy by the same provider.</p>	30.00			
W9041		<p>HealthStart Development of Maternity Plan of Care</p> <ol style="list-style-type: none"> Case coordination services Initial assessments <ol style="list-style-type: none"> nutrition health education social/psychological Case conference with Maternity Medical Care provider Initial plan of care developed by the HealthStart case coordinator Basic guidance and health education services 	120.00			

HCPCS Code	Mod	Procedure Description	S	Maximum Fee Allowance		WM
				\$	NS \$	
		6. Referral for other needed services including follow-up with County Boards of Social Services				
		7. Outreach, referral and follow-up activities including phone calls and letters.				
		NOTE: This code may be billed only once during the pregnancy by the same provider.				
W9042		HealthStart Subsequent Maternity Health Support Services Visit	50.00			
		1. Case coordination				
		2. Review and update of care plan				
		3. Coordination with maternity medical care provider				
		4. Health education instruction				
		5. Social/psychological guidance				
		6. Nutrition guidance				
		7. Home visit for high risk clients				
		8. Outreach, referral and follow-up activities including phone calls and letters.				
		NOTE: This code may be billed only once per trimester and not more than twice per pregnancy.				
W9043		HealthStart Postpartum Maternity Health Support Services	100.00			
		1. Case coordination services				
		2. Review of the plan of care				
		3. Review of the summary of hospital stay records and current medical status				
		4. Nutrition assessment and counseling				
		5. Social/psychological assessment and counseling				
		6. Health education assessment and instruction				
		7. Home visit(s) as applicable				
		8. Referral, outreach and follow-up services				
		9. Referral for pediatric preventive care and follow-up				
		10. Transfer of pertinent information to pediatric, future family planning and medical care providers				
		11. Completion of the plan of care				

(b) HealthStart Pediatric Preventive Care code requirements are as follows:

1. HealthStart Pediatric Care Guidelines provide for up to nine preventive child health visits for a child under two years of age.

i. All preventive child health visits shall be billed using the HealthStart Preventive Child Health Visit codes appropriate to the child's age at the time of visit. Each preventive child health visit HCPCS procedure code may be claimed only once per child.

ii. Claims shall be submitted using Form MC-19, EPSDT/HealthStart Screening and Related Procedures.

2. Laboratory, other diagnostic procedures, and all necessary medical consultations shall be eligible for separate reimbursement.

i. Laboratory procedures performed by an outside laboratory shall be reimbursed to the laboratory. The clinic may submit a claim for a venipuncture using procedure code 36415 when necessary to collect blood specimens.

3. HealthStart Pediatric Preventive Care codes represent visits based on an infant's age according to the following schedule:

HCPCS Code	Mod	Procedure Description	S	Maximum Fee Allowance		WM
				\$	NS	
W9060		Under six weeks	31.00		26.00	
W9061		Six weeks to three months	31.00		26.00	
W9062		Three months to five months	31.00		26.00	
W9063		Five months to eight months	31.00		26.00	
W9064		Eight months to 11 months	31.00		26.00	
W9065		11 months to 14 months	31.00		26.00	
W9066		14 months to 17 months	31.00		26.00	
W9067		17 months to 20 months	31.00		26.00	
W9068		20 months to 24 months	31.00		26.00	

4. A HealthStart Pediatric Preventive Care Visit includes the following elements:

- i. History including behavior and environmental factors;
- ii. Developmental assessment; and
- iii. Complete, unclothed physical examination by a physician or a nurse practitioner under the personal supervision of a physician, to include:
 - (1) Measurements: height, weight and head circumference;
 - (2) Vision and hearing screening; and
 - (3) Nutritional assessment.
- iv. Assessment and administration of immunizations (see appropriate HCPCS procedure codes for reimbursement amounts);
- v. Anticipatory guidance;
- vi. Arrangement for diagnosis and treatment of medical problems uncovered during the visit. This includes self-referrals and/or referrals to other providers, as medically indicated;
- vii. Appropriate laboratory procedures performed, or referred, in accordance with HealthStart Pediatric Care Guidelines.

- (1) Sickle cell, PKU screening, as appropriate;
- (2) Hemoglobin or hematocrit twice, at six to nine months and 20 to 24 months of age;
- (3) Urinalysis, twice: at six to nine months and 20 to 24 months of age;
- (4) Tuberculin test, twice: at 12 to 14 months and 20 to 24 months; and
- (5) Lead screening at six to 12 months and annually thereafter, or more often if clinically indicated.

viii. Case coordination: referral for nutritional, psychological, social and other community services, as appropriate; provision or arrangement for 24-hour telephone physician access and sick care; and outreach and follow-up activities in accordance with the HealthStart Pediatric Care Guidelines.

NOTE: As indicated in N.J.A.C. 10:66-2.4(b), laboratory procedures performed by a clinic are reimbursable to the clinic; if such procedures are performed by an outside laboratory, the laboratory shall submit a separate claim.

NOTE: As indicated in N.J.A.C. 10:66-Appendix, as referenced in N.J.A.C. 10:66-1.1(e), claims for HealthStart Preventive Care visits shall include a completed Health Insurance Claim Form, 1500 N.J., and a HealthStart Preventive Child Health Form.

HCPCS Code	Mod	Procedure Description	S	Maximum Fee Allowance		WM
				\$	NS	
W9070		HealthStart Pediatric Continuity of Care This is a service by a certified HealthStart Pediatric Care Services Provider which is a hospital outpatient department where physicians do not bill Medicaid independently for professional services. This code shall include reimbursement for the following service components: —Assignment of a case coordinator responsible for outreach, referral and follow-up activities; —24-hour telephone access for medical consultation outside clinic hours; and	13.00		13.00	

HCPCS Code	Mod	Procedure Description	S	Maximum Fee Allowance		WM
				\$	NS \$	
		—Provision or arrangement for sick care. (Referral to the emergency room shall only occur for emergency medical care or urgent care as recommended by the physician responsible for sick care.) NOTE: This code may be billed only in conjunction with a pediatric preventive health care visit provided in accordance with HealthStart Regulations and Guidelines for HealthStart Providers. Claims shall be submitted using Form MC-19, EPSDT/HealthStart Screening and Related Procedures.				

Administrative Correction.
See: 26 N.J.R. 235(a).

For a copy of the Fiscal Agent Billing Supplement, write to:

APPENDIX

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as a part of this chapter but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages shall be distributed to providers and copies shall be filed with the Office of Administrative Law.

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