

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.

(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.

Amended by R.1994 d.600, effective December 5, 1994.
See: 26 N.J.R. 3345(a), 26 N.J.R. 4762(a).

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.