CHAPTER 66

INDEPENDENT CLINIC SERVICES

Authority

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

Source and Effective Date

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

Executive Order No. 66(1978) Expiration Date

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

Chapter Historical Note

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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SUBCHAPTER 1. GENERAL PROVISIONS

10:66–1.1 Scope of service

(a) This chapter (N.J.A.C. 10:66) describes the policies and procedures of the New Jersey Medicaid program pertaining to the provision of, and reimbursement for, medically necessary Medicaid-covered services in an independent clinic setting. An independent clinic setting includes, but is not limited to, clinic types such as an ambulatory care facility, ambulatory surgical center, ambulatory care/family planning/surgical facility, and a Federally qualified health center.

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

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

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

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

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

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

4. N.J.A.C. 10:66–4 and its Appendix contain information about Federally qualified health centers, including (a) rules governing the provision of services; (b) the Medicaid cost report containing the forms used by Federally qualified health centers to determine Medicaid reimbursement amounts; and (c) instructions for the proper completion of the forms contained in the cost report.

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

6. N.J.A.C. 10:66–6 pertains to the Health Care Financing Administration's Common Procedure Coding System (HCPCS). The HCPCS procedure code system contains procedure codes and maximum fee allowances corresponding to Medicaid-reimbursable services.

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

10:66–1.2 Definitions

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

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

2. If the services are provided in an emergency.

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

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

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

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

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

(j) The clinic's medical staff, including physicians, dentists, and other practitioners, shall be appropriately licensed in order to provide the medical care delivered to Medicaid recipients.

10:66–1.4 Prior authorization

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

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

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

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

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

3. The "Brief Clinical History" and "Present Clinical Status" sections of the prior authorization form are particularly important and must provide sufficient medical information to justify and support the proposed treatment request. Failure to comply may result in a reduction or denial of requested services.

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

5. Similarly, a new request for authorization is required for a medical/remedial therapy session or 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 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 visit. The interim encounter rate shall be based upon all reasonable costs not reimbursed by the HCPCS procedure code fees, and shall include an add-on for the cost expended by a FQHC for the outstationing of county welfare agency staff to determine Medicaid eligibility. An FQHC's financial responsibility for outstationing activities is equivalent to the non-Federal share (currently 50 percent) of estimated CWA costs for the calendar year.

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

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

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

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

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

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

ii. For cost reporting periods beginning on and after January 1, 1992 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, CN 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 encounters for the cost reporting period. Should there be a discrepancy between the FQHC's reported encounters and the Medicaid fiscal agent's reported encounters, the Medicaid 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 recipients. Should there be a discrepancy between the FQHC's reported payments and the Medicaid fiscal agent's reported payments, the Medicaid 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 shall be submitted to the Director, Administrative and Financial Services, Division of Medical Assistance and Health Services, Mail Code #23, CN 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, CN 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).

10:66–1.6 Recordkeeping

(a) An individual record shall be prepared and retained by an independent clinic that fully discloses the kind and extent of the service provided to a Medicaid recipient, as well as the medical necessity for the service.

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

(c) Additional requirements governing medical records in an ambulatory surgical center are located in N.J.A.C. 10:66–5.

(d) The information described in this subsection shall be made available to the New Jersey Medicaid program or its agents upon request.

Case Notes

Adapted tricycle was medically required for treating chronic encephalopathy. K.H. v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 3.

SUBCHAPTER 2. PROVISION OF SERVICES

10:66–2.1 Introduction

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

10:66–2.2 Early and periodic screening, diagnosis, and treatment (EPSDT)

(a) Early and periodic screening, diagnosis and treatment (EPSDT) is a Federally mandated comprehensive child health program for Medicaid recipients from birth through 20 years of age. (See 42 CFR 441 Subpart B.)

(b) EPSDT includes screening services; vision services; dental services; hearing services; and other necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

1. An expanded program for Medicaid recipients up to the age of two is known as HealthStart. For additional information, including provider enrollment requirements, see N.J.A.C. 10:66–3.

(c) Components of an EPSDT screening are as follows:

1. A comprehensive health and developmental history including assessment of both physical and mental health development;

2. A comprehensive unclothed physical exam including vision and hearing screening, dental inspection, and nutritional assessment;

3. Appropriate immunizations according to age and health history;

4. Appropriate laboratory tests, including:

i. Hemoglobin/hematocrit;

ii. Urinalysis;

iii. Tuberculin test;

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

v. Other appropriate medically-necessary procedures;

5. Health education, including anticipatory guidance; and

6. Referral for further diagnosis and treatment or follow up of all correctable abnormalities, uncovered or suspected. Referral may be to the provider conducting the screening examination, or to another provider, as appropriate.

(d) EPSDT screening services (unless modified as follows in (e), (f) and (g) below) shall be provided periodically according to the following schedule which reflects the age of the child:

1. Under six weeks;

2. Two months;

3. Four months;

4. Six months;

5. Nine months;

6. 12 months;

7. 15 months;

8. 18 months;

9. 24 months; and

10. Annually through age 20.

(e) Vision screening includes:

1. A newborn examination including general inspection of the eyes, visualization of the red reflex, and evaluation of ocular motility;

2. An appropriate medical and family history;

3. An evaluation, by age six months, of eye fixation preference, muscle imbalance, and pupillary light reflex; and

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

5. Periodicity testing for school aged children is as follows:

i. Kindergarten or first grade (five or six years);

ii. Second grade (seven years);

iii. Fifth grade (10/11 years);

iv. Eighth grade (13/14 years); and

v. Tenth or eleventh grades (15/17 years).

6. Children should be referred for vision screening if they:

i. Cannot read the majority of the 20/40 line before their fifth birthday;

ii. Have a two-line difference of visual acuity between the eyes;

iii. Have suspected strabismus; or

iv. Have an abnormal light or red reflex.

(f) The following apply to dental screening:

1. Intraoral examination is an integral part of a general physical examination.

2. A formal referral to a dentist is recommended at one year of age. It is mandatory for children three years of age and older.

3. Dental inspection and prophylaxis should be carried out every six months until 17 years of age, then annually.

(g) The following apply to hearing screening:

1. An individual hearing screening should be administered annually to all children through age eight and to all children at risk of hearing impairment.

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

10:66–2.3 Family planning

(a) Family planning services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continued medical supervision, continuity of care, and genetic counseling. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related clinic visits, drugs, laboratory services, radiological and diagnostic services, and surgical procedures are not covered by the New Jersey Medicaid program.

1. Exception: When a service is provided that is ordinarily considered an infertility service, but is provided for another purpose, then the independent clinic must submit the claim with supporting documentation for medical review and approval of payment to the Division of Medical Assistance and Health Services, Office of Medical Affairs and Provider Relations, CN 712, (Mail Code # 14), Trenton, New Jersey 08625–0712.

(b) The Norplant System (NPS) is a Medicaid-covered service when provided as follows:

1. The NPS is used only in reproductive age women with established regular menstrual cycles;

2. The Food and Drug Administration-approved physician prescribing information is followed; and

3. Patient education and counseling are provided relating to the NPS, including pre and post insertion instructions, indications, contraindications, benefits, risks, side effects, and other contraceptive modalities.

4. A clinic visit relating only to the insertion or removal of the Norplant System (NPS) is not reimbursable on the day of the insertion or removal.

5. Only two insertions and two removals of the NPS per recipient are permitted during a five year continuous period.

6. The clinic shall not be reimbursed for the NPS in conjunction with other forms of contraception, for example, intra-uterine device.

(c) Sterilization is any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing.

1. The individual to be sterilized shall be at least 21 years of age at the time the sterilization consent form is signed by the individual to be sterilized.

2. The individual to be sterilized shall not be mentally incompetent or institutionalized.