CHAPTER 66

INDEPENDENT CLINIC SERVICES

Authority

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

Source and Effective Date

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

Chapter Expiration Date

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

Chapter Historical Note

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

Chapter 66, Manual for Independent Clinic Services, was repealed and a new Chapter 66, Independent Clinic Services Manual, was adopted as R.1980 d.249, effective June 30, 1980.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

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

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

Chapter 66, Independent Clinic Services Manual, was repealed and a new Chapter 66, Independent Clinic Services, was adopted as R.1993 d.641, effective December 6, 1993.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

Pursuant to Executive Order No. 66(1978), Chapter 66, Independent Clinic Services, was readopted as R.1998 d.577, effective November 12, 1998. See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).

Chapter 66, Independent Clinic Services, was readopted as R.2004 d.208, effective May 10, 2004. See: Source and Effective Date. See, also, section annotations.

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SUBCHAPTER 1. GENERAL PROVISIONS

10:66–1.1 Scope of service

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

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

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

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

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

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

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

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

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

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

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

Amended by R.1998 d.577, effective December 7, 1998.
See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).
Inserted references to NJ KidCare fee-for-service and NJ KidCare-covered services throughout; in (c), substituted a reference to beneficiaries for a reference to recipients; and in (d)4, inserted a reference to NJ KidCare-Plan A fee-for-service.
Amended by R.2004 d.208, effective June 7, 2004.
See: 36 N.J.R. 324(a), 36 N.J.R. 2834(a).
Rewrote the section.

10:66–1.2 Definitions

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

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

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

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) Vision care services require prior authorization as indicated in the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' Vision Care Services chapter, N.J.A.C. 10:62–1.16 and 2.5.

(e) Transportation services to and from a drug treatment center shall be prior authorized after 60 days of treatment at the drug treatment center. The provider shall request prior authorization by completing and forwarding Form MC–12(A), Transportation Prior Authorization Form, to: Unisys Corporation, Transportation Unit, PO Box 4813, Trenton, NJ 08650, or fax to 1–609–588–0816. See the Fiscal Agent Billing Supplement, N.J.A.C. 10:66 Appendix, for instructions on the completion of the prior authorization form.

Amended by R.1998 d.577, effective December 7, 1998.
See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).
Inserted references to NJ KidCare fee-for-service and substituted references to beneficiaries for references to recipients throughout; and in (a), changed N.J.A.C. reference.
Amended by R.2003 d.182, effective May 5, 2003.
See: 34 N.J.R. 4303(a), 35 N.J.R. 1901(a).
In (c), substituted references to NJ FamilyCare for references to NJ KidCare fee-for-service in the introductory paragraph, rewrote 2, and substituted "FD–07A "Request for Prior Authorization: Supplemental Information" " for "prior authorization" in 3.
Amended by R.2004 d.75, effective February 17, 2004.
See: 35 N.J.R. 2154(a), 36 N.J.R. 952(b).
In (b) and (e), substituted "FamilyCare" for "KidCare"; rewrote (c) and (d).
Amended by R.2004 d.208, effective June 7, 2004.
See: 36 N.J.R. 324(a), 36 N.J.R. 2834(a).
Rewrote the section.

10:66–1.5 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 and NJ FamilyCare fee-for-service-participating practitioners in "private" (independent) practice. Reimbursement is made directly to the clinic.

1. An independent clinic shall charge for services to all patients, except as provided by legislation. No charge will be made directly to the Medicaid or NJ FamilyCare fee-for-service beneficiary, and the charge to the New Jersey Medicaid and NJ FamilyCare fee-for-service programs 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 and NJ FamilyCare fee-for-service-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 a 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 and NJ FamilyCare fee-for-service 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 a classification system as specified by CMS and published in the Federal Register in accordance with 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 or NJ FamilyCare fee-for-service 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
9	$794.00

Note: Should the Centers for Medicare & Medicaid Services (CMS) 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 and NJ FamilyCare fee-for-service programs' Physician Maximum Fee Allowance for specialist and non-specialist, N.J.A.C. 10:54, and the following:

i. When submitting a claim, the physician performing the surgical procedure shall use the applicable claim form, billing the New Jersey Medicaid or NJ FamilyCare fee-for-service program either as an individual provider or as a member of a physician's group.

ii. A physician on salary for administrative duties (such as a medical director) shall be permitted to submit claims for surgical/medical services performed. Administrative duties shall be considered a direct cost of the facility and shall be included in the clinic payment.

(d) The basis for reimbursement for services provided in a Federally qualified health center (FQHC) for periods prior to January 1, 2001 shall be 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. 10:54–9 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 Medicaid fee-for-service FQHC encounter. FQHCs shall bill HCPCS fees excluding the encounter procedure codes. 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 and NJ KidCare–Plan A fee-for-service 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 beneficiaries.

(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 and NJ KidCare–Plan A programs 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 beneficiaries prior to July 15, 1996, the actual encounter rate shall be calculated based upon reasonable costs of Medicaid services provided to Medicaid beneficiaries.

ii. For services rendered to Medicaid beneficiaries 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. Reimbursement costs shall be determined by multiplying the actual encounter rate times the number of paid Medicaid and NJ KidCare–Plan A encounters for the cost reporting period. Should there be a discrepancy between the FQHC's reported encounters and the fiscal agent's reported encounters, the fiscal agent's encounters shall be used for determination of reimbursable costs. Final Settlement shall be determined as the difference between reimbursable costs and all payments made on behalf of Medicaid or NJ KidCare–Plan A beneficiaries, which includes managed care organization payments.

i. If the final settlement results in an underpayment, a lump sum payment shall be made to the FQHC.

ii. If the final settlement results in an overpayment made to the FQHC, the Division of Medical Assistance and Health Services (DMAHS) shall arrange repayment from the FQHC through a lump-sum refund or through an offset against subsequent payments, or a combination of both.

7. A Medicaid cost report including the FQHC's audited financial statements in accordance with N.J.A.C. 10:66–4 and N.J.A.C. 10:66–4 Appendix A shall be submitted to the Director, Administrative and Financial Services, Division of Medical Assistance and Health Services, Mail Code #23, PO Box 712, Trenton, New Jersey 08625–0712, or the Director's designee. The cost report shall be legible and complete in order to be considered acceptable. See N.J.A.C. 10:66–4 Appendix A, incorporated herein by reference.

i. The Medicaid cost report and audited financial statements shall be filed following the close of a provider's reporting period. Cost reports and audited financial statements are due on or before the last day of the fifth month following the close of the period covered by the report.

ii. A 30–day extension of the due date of a cost report may, for good cause, be granted by the DMAHS. Good cause means a valid reason or justifiable purpose in seeking an extension; it is one that supplies a substantial reason, affords a legal excuse for delay, or is the result of an intervening action beyond one's control. Acts of omission and/or negligence by the FQHC, its employees, or its agent, shall not constitute "good cause."

iii. To be granted this extension the provider must submit a written request to, and obtain written approval from, the Director, Administrative and Financial Services, Division of Medical Assistance and Health Services, Mail Code #23, PO Box 712, Trenton, New Jersey 08625–0712, or the Director's designee.

iv. A request for an extension must be received by the Director, Administrative and Financial Services, Division of Medical Assistance and Health Services, or the Director's designee, at least 30 days before the due date of the Medicaid cost report and audited financial statements.

v. If a provider's agreement to participate in the Medicaid or NJ KidCare program terminates or the provider experiences a change of ownership, the cost report is due no later than 45 days following the effective date of the termination of the provider agreement or change of ownership. An extension of the cost report due date cannot be granted when the provider agreement is terminated or a change in ownership occurs.

vi. Failure to submit an acceptable cost report on a timely basis may result in suspension of interim payments. Payments for claims received on or after the date of suspension may be withheld until an acceptable cost report is received.

(e) The basis for reimbursement for services provided in an FQHC for periods beginning January 1, 2001 shall be as follows:

1. Effective with services performed on or after January 1, 2001 and for each year thereafter, Medicaid payments to the FQHCs shall be based on prospective payment rates, as determined in accordance with this rule, and shall be used solely to reimburse for encounters.

i. PPS encounter rates effective January 1, 2001 through June 30, 2001 shall be calculated based on the FY 1999 and FY 2000 cost reports. The FY 1999 cost reports shall include individual FQHC fiscal year cost reports with individual year-end dates ranging from June 1, 1999 to May 31, 2000. The FY 2000 cost reports shall include individual FQHC fiscal year cost reports with individual year-end dates ranging from June 1, 2000 to May 31, 2001. The calculation of the PPS encounter payment rates to be used to reimburse FQHC services performed on or after January 1, 2001 shall be based on the following:

(1) Interim PPS encounter rates for services provided from January 1, 2001 to June 30, 2001 shall be calculated using the encounter rate from the most recent final cost report settlement, derived by dividing the final Medicaid settled costs by the number of final settled encounters, adjusted for a change in scope of services (in accordance with (e)1vi(1)) and inflation using the percentage increase in the Medicare Economic Index (MEI) (defined in section 1842(i)(3) of the Social Security Act) applicable to primary care services (as defined in section 1842(i)(4)) furnished through December 31, 2000.

(2) The final PPS encounter rate for services provided from January 1, 2001 to June 30, 2001 shall be calculated by adding the final settled Medicaid costs of the FY 1999 and FY 2000 cost reports together and dividing the total by the number of final settled encounters provided to Medicaid beneficiaries during the FY 1999 and FY 2000 fiscal years, adjusted for a change in scope of services (in accordance with (e)1vi(1)) and inflation using the percentage increase in the MEI (defined in section 1842(i)(3) of the Social Security Act) applicable to primary care services (as defined in section 1842(i)(4)) furnished through December 31, 2000. The final settled Medicaid costs for the FY 1999 and FY 2000 cost reports shall be calculated with the administrative and productivity screens and overall Medicaid limit per encounter in accordance with the rule adopted July 15, 1996 (N.J.A.C. 10:66–1.5, subchapter 4 and Appendix).

(3) A financial transaction will be processed through the Medicaid fiscal agent for the difference between the interim and final PPS encounter rate for services provided to Medicaid beneficiaries that were reimbursed at the interim encounter rate. For FQHC obligations that are not paid within 30 days from the date the recovery is initiated, interest shall be assessed in accordance with N.J.S.A. 30:4D–17(e), (f) and N.J.S.A. 31:1–1(a).

(4) The alternative methodology to calculate the final PPS encounter rate for services provided from January 1, 2001 to June 30, 2001 is as follows: the greater of the FY 1999 or FY 2000 encounter rates adjusted for a change in scope of services (in accordance with (e)1vi(1) below) and inflation using the percentage increase in the MEI (defined in section 1842(i)(3) of the Social Security Act) applicable to primary care services (as defined in section 1842(i)(4)) furnished through December 31, 2000. The final settled Medicaid costs of the FY 1999 and FY 2000 cost reports shall be calculated with the administrative and productivity screens and overall Medicaid limit per encounter in accordance with the rules adopted July 15, 1996 (N.J.A.C. 10:66–1.5, 10:66–4 and 10:66–4 Appendix A). Paragraphs (e)1i(1) and (3) above shall be followed under the alternative methodology. In order to qualify to receive the alternative methodology calculation of the PPS encounter rate, an FQHC shall sign a written agreement with the State. The alternative methodology shall result in a payment to the FQHC of an amount that is at least equal to the PPS methodology and satisfies the BIPA requirements.

ii. The baseline PPS encounter rates for services provided from July 1, 2001 to December 31, 2001 shall be based on the FY 1999 and FY 2000 cost reports and shall be calculated based on the following:

(1) Interim PPS encounter rates shall be calculated using data from the most recent final cost report settlement as follows:

(A) FQHC administrative reimbursement shall be subject to an administrative cost limit of 30 percent of total allowable cost;

(B) FQHC reimbursement for productivity standards shall be based on those standards applied by Medicare for cost reporting purposes in the base year;

(C) The overall per encounter limit on FQHC Medicaid costs shall be the base year Medicare limit plus $14.42;

(D) Allowable costs shall be determined by following Medicare principles of reasonable cost reimbursement;

(E) The encounter rate may be adjusted for a change in scope of services (in accordance with (e)1vi(1)); and

(F) The encounter rate shall be adjusted for inflation using the percentage increase in the MEI (defined in section 1842(i)(3) of the Social Security Act) applicable to primary care services (as defined in section 1842(i)(4)) furnished through December 31, 2000.

(2) The final PPS encounter rate for services provided from July 1, 2001 to December 31, 2001, shall be calculated by adding the final settled Medicaid costs of the FY 1999 and FY 2000 cost reports together and dividing the total by the sum of the number of final settled encounters for FY 1999 and FY 2000 provided to Medicaid beneficiaries during the FY 1999 and FY 2000 fiscal years, adjusted for a change in scope of services in accordance with (e)1vi(1) and inflation using the percentage increase in the MEI (defined in section 1842(i)(3) of the Social Security Act) applicable to primary care services (as defined in section 1842(i)(4)) furnished through December 31, 2000.

(A) The final settled Medicaid costs from the FY 1999 and FY 2000 cost reports shall be adjusted as follows:

(i) FQHC administrative reimbursement shall be subject to an administrative cost limit of 30 percent of total allowable cost;

(ii) FQHC reimbursement for productivity standards shall be based on those standards applied by Medicare for cost reporting purposes in the base year;

(iii) The overall per encounter limit on FQHC Medicaid costs shall be the base year Medicare limit plus $14.42; and

(iv) Allowable costs shall be determined by following Medicare principles of reasonable cost reimbursement.

(3) A financial transaction will be processed through the Medicaid fiscal agent for the difference between the interim and final PPS encounter rate for services provided to Medicaid beneficiaries that were reimbursed at the interim encounter rate. For FQHC obligations that are not paid within 30 days from the date the recovery is initiated, interest shall be assessed in accordance with N.J.S.A. 30:4D–17(e), (f) and N.J.S.A. 31:1–1(a).

(4) The alternative methodology to calculate final PPS encounter rate for services provided from July 1, 2001 to December 31, 2001 shall be calculated on the greater of the FY 1999 or FY 2000 final settled Medicaid cost report, adjusted for a change in scope of services in accordance with (e)1vi(1) and inflation using the percentage increase in the MEI (as defined in section 1842(i)(3) of the Social Security Act) applicable to primary care services (as defined in section 1842(i)(4)) furnished through December 31, 2000. The alternative methodology shall result in a payment to the FQHC of an amount that is at least equal to the PPS methodology and satisfies the BIPA requirements. FQHCs that have elected the alternative methodology shall have a single opportunity to request a change to the PPS methodology, which shall be applied prospectively. Once an FQHC has opted out of the alternative methodology, it is no longer eligible to receive the alternative methodology.

(A) The final settled Medicaid costs for the FY 1999 and FY 2000 cost reports shall be adjusted as follows:

(i) FQHC administrative reimbursement shall be subject to an administrative cost limit of 30 percent of total allowable cost;

(ii) FQHC reimbursement for productivity standards shall be based on those standards applied by Medicare for cost reporting purposes in the base year;

(iii) The overall per encounter limit on FQHC Medicaid costs shall be the base year Medicare limit plus $14.42; and

(iv) Allowable costs shall be determined by following Medicare principles of reasonable cost reimbursement.

(B) Paragraphs (1) and (3) above shall be followed under the alternative methodology. In order to qualify to receive the alternative methodology calculation of the PPS encounter rate, an FQHC shall sign a written agreement with the State.

iii. The final PPS encounter rate shall be effective for services from July 1, 2001 through December 31, 2001. Each year thereafter, the rate year will begin on January 1 and end on December 31.

(1) For both the PPS and the alternative methodology, the interim PPS encounter rates effective January 1, 2002, will be calculated using the encounter rate from the most recent final cost report settlement, and will be adjusted for inflation using the MEI effective on January 1, 2002 and for a change in scope of services (in accordance with (e)1vi(1)). The interim PPS encounter rates will be adjusted to final PPS encounter rates upon reconciliation of the FY 1999 and FY 2000 cost reports.

(2) For rates effective January 1, 2003 and every January 1, thereafter, the final PPS encounter rate effective January 1, of the preceding year will be increased by the MEI applicable to primary care services of the current year and adjusted for a change in scope of services in accordance with (e)1vi below to calculate the PPS final encounter rate.

(3) A financial transaction will be processed through the Medicaid fiscal agent for the difference between the interim and final encounter rate for services provided to Medicaid beneficiaries that were reimbursed at the interim encounter rate. For FQHC obligations that are not paid within 30 days from the date recovery is initiated, interest shall be assessed in accordance with N.J.S.A. 30:4D–17(e), (f) and N.J.S.A. 31:1–1(a).

iv. The reimbursement of donation costs related to outstationed eligibility workers will be made on a lump-sum basis once each calendar quarter.

v. FQHCs shall have a one-time option to revise their FY 1999 and FY 2000 cost reports to include/exclude the direct and indirect delivery costs, encounters and revenues associated with deliveries for purposes of establishing the January 1, 2001 and July 1, 2001 PPS encounter rates. The option chosen by the FQHC would apply to both FY 1999 and FY 2000 cost reports. The revisions to include/exclude direct and indirect delivery costs, encounters and revenues from the cost report will be solely for the calculation of the PPS encounter rate, and will not result in a revised settlement for the period covered by the cost report.

vi. The PPS encounter payment rates may be adjusted for increases or decreases in the scope of services furnished by the FQHC during that fiscal year.

(1) A change in scope of service is defined as follows:

(2) The process to request a change of scope adjustment is as follows:

(A) Providers shall follow the guidelines in the "Change in Scope of Service Application Requirements" contained in N.J.A.C. 10:66–4 Appendix D, incorporated herein by reference. Providers shall notify the Division of Medical Assistance and Health Services (DMAHS) in writing at least 60 days prior to the effective date of any changes and explain the reasons for the change.

(B) Providers shall submit documentation or schedules which substantiate the changes and the increase/decrease in services and costs (reasonable costs following the tests of reasonableness used in developing the baseline rates) related to these changes. The changes shall be significant with substantial increases or decreases in costs, as defined in (3) below, and documentation must include data to support the calculation of an adjustment to the PPS rate. It is recognized that the change of scope will be time-limited in most cases, due to start-up or phase-in costs associated with the change of scope. As the utilization level phases in, the need for the enhanced rate will diminish. The provider must address this in the change of scope request.

(3) Providers may submit requests for scope of service changes either:

(A) Once during a calendar year, by October 1, with an effective date of January 1 of the following year; or

(B) When the scope of service change(s) exceed(s) 2.5 percent of the allowable per encounter rate as determined for the fiscal period. The effective date shall be the implementation date of the change of scope that exceeds the 2.5 percent minimum threshold for a mid-year adjustment.

(4) The provider shall be notified by DMAHS of any adjustment to the rate by written notification following a review of the submitted documentation.

(5) The provider shall be paid its PPS rate as initially determined by DMAHS, pending the determination as to whether an adjustment is necessary and if so, the amount of the adjustment. A payment or recovery shall be made for the period from the effective date of the adjustment to the date the revised rate is incorporated into the claims payment system.

(6) Providers may appeal DMAHS' determination for an adjustment or the amount of the adjustment by writing to the Director, DMAHS within 60 days of the date of the determination letter. The provider shall identify the specific items of disagreement and the amount in question, and provide reasons and documentation to support the provider's position.

vii. For new providers (entities first qualifying as FQHCs after December 31, 2000), interim PPS encounter rates shall be calculated. These rates shall be subject to final settlements through December 31 of the initial and second year of the FQHC's existence. New FQHCs' rate years shall be calendar years, thus the initial year may represent less than a full year of operation.

(1) The interim PPS encounter rates shall be the Statewide average PPS encounter rate.

(2) In establishing the interim PPS encounter rate, DMAHS may take into account existing costs, which may have occurred when in operation as another healthcare facility.

(3) The final PPS encounter rates for the initial and second years of operation shall be calculated from the FQHC's cost report data contained in N.J.A.C. 10:66–4 Appendix C, "New FQHC Medicaid Cost Reports for First and Second Years of Operation," incorporated herein by reference:

(A) FQHC administrative reimbursement shall be subject to an administrative cost limit of 30 percent of total allowable cost;

(B) FQHC reimbursement for productivity standards shall be based on those standards applied by Medicare for cost reporting purposes in the base year;

(C) The overall per encounter limit on FQHC Medicaid costs shall be the 2000 calendar year

Medicare limit plus $14.42, inflated by the MEI applicable to primary care services for all years up to the year of operation; and

(D) Allowable costs shall be determined by following Medicare principles of reasonable cost reimbursement.

(4) Final settlements for the first two years shall be processed in accordance with sections (3)(A) through (D) above.

(5) For each year thereafter, the PPS encounter rate shall be the final rate of the second year of operations (possibly the first full year of operations) adjusted by the MEI applicable to primary care services and changes in scope of services as described above.

viii. Managed care wrap-around payments shall be made on a quarterly basis.

(1) To qualify for wrap-around reimbursement, the FQHC administration shall have a signed contract with the managed care organization as of the time period covered, and for the time period covered, and the FQHC shall comply with the reporting requirements below and contained in N.J.A.C. 10:66–4 Appendix E, incorporated herein by reference.

(2) The FQHC shall provide to the Division, upon request, copies of any and all managed care contracts the FQHC has entered into during the cost report period. FQHCs shall provide copies of any requested managed care contracts to the Division within 30 days of the date of the Division's request. Failure to provide copies of the contract(s) as requested shall result in suspension of interim payments or wrap-around payments until the contract copy is received by the Division.

(3) For new providers (entities first qualifying as FQHCs after December 31, 2000), the wrap-around shall be calculated at the FQHC's interim PPS encounter rate until the final PPS encounter rate is established. New FQHCs shall be reimbursed for 85 percent of the difference between reasonable costs and the managed care receipts received for services provided to Medicaid beneficiaries. After the final PPS encounter rate is calculated, a financial transaction shall be processed for the difference between the interim and final PPS encounter rate for encounters provided to Medicaid managed care beneficiaries. In the event of an underpayment, the Division shall reimburse the provider 100 percent of the amount due. In the event of an overpayment, the provider shall reimburse the Division 100 percent of the overpayment within 30 days of the due date of the Managed Care Wraparound Report. For FQHC obligations that are not paid within 30 days of the date recovery is initiated, interest shall be assessed in accordance with N.J.S.A. 30:4D–17(e), (f) and N.J.S.A. 31:1–1(a).

(4) For FQHCs that have a final PPS encounter rate established, all quarterly wrap-around reports shall be reconciled at 100 percent of the difference between the final rate and the managed care receipts received for services provided to Medicaid and FamilyCare managed care beneficiaries. In the event of an underpayment, the Division shall reimburse the provider 100 percent of the amount due. In the event of an overpayment, the provider shall reimburse the Division 100 percent of the overpayment within 30 days of the due date of the Managed Care Wrap-around Report. For FQHC obligations that are not paid within 30 days of the date recovery is initiated, interest shall be assessed in accordance with N.J.S.A. 30:4D–17(e), (f) and N.J.S.A. 31:1–1(a).

(5) Reporting time periods shall be calendar year quarters (March, June, September, and December), regardless of an FQHC's fiscal year end.

(6) Reporting Encounters: Medicaid and NJ FamilyCare managed care encounters provided during the calendar year quarter shall be reported on the Medicaid Managed Care Encounter Detail Report in N.J.A.C. 10:66–4 Appendix E, incorporated herein by reference. For example, all managed care encounters provided to Medicaid and NJ FamilyCare beneficiaries from October 1, 2003 through December 31, 2003 shall be included on the Medicaid Managed Care Encounter Detail Reports for the quarter ended December 31, 2003. Each Medicaid Managed Care Encounter Detail Report shall contain encounters provided during one specific month. In total, there are three Medicaid Managed Care Encounter Detail Reports for each quarter.

(7) Reporting Receipts: All Medicaid and NJ FamilyCare managed care payments received by the FQHC for the quarter, including capitation, fee-for-service, supplemental or administration fund, and any other managed care payments received from the first day of the quarter to the 25th day following the end of the calendar year quarter, shall be reported on the Medicaid Managed Care Receipts Report in N.J.A.C. 10:66–4 Appendix E.

(8) Managed care organizations may use their own funds to include financial incentives in their contracts with FQHCs. Financial incentives are used as an incentive to reduce unnecessary utilization of services or otherwise reduce patient costs. Such incentives may be negative, such as withholding a portion of the capitation payments. In this example, if utilization goals are not satisfied, the provider foregoes the withheld amount in whole or part. Incentives may also be positive, such as a bonus that is paid if desired utilization outcomes are achieved. These incentive amounts (whether positive or negative) are separate from the managed care organization's payment for services provided under the contract with the provider, and shall not be included by the FQHC in the Medicaid Managed Care Receipts Report.

(9) Date of Quarterly Report requirements are as follows: FQHCs shall submit the Medicaid Managed Care Encounter Detail Reports and the Medicaid Managed Care Receipts Report with managed care receipts data through the 25th day following the end of the calendar year quarter. For example, the receipts report for the quarter ending December 31, 2003, shall be submitted with the receipts received through January 25, 2004. This will allow for most, if not all, managed care receipts for the quarter to be received by the submission date of the quarterly wrap-around report. These reports are due to Medicaid by the 55th day following the end of each calendar quarter. Failure to submit acceptable Medicaid Managed Care Encounter Detail Reports and Medicaid Managed Care Receipts Reports by the due date may result in suspension of interim payments. Payments for claims received on or after the date of suspension may be withheld until acceptable Medicaid Managed Care Encounter Detail Reports and Medicaid Managed Care Receipts Reports are received.

(10) Adjustments for prior periods requirements are as follows: A separate Medicaid Managed Care Encounter Detail Report and/or Medicaid Managed Care Receipts Report shall be prepared for receipts and/or encounters not previously reported. Use separate Medicaid Managed Care Encounter Detail Reports and/or separate Medicaid Managed Care Receipts Reports to report prior period adjustments. An adjustment for a prior period is a correction to an earlier report. Managed care additions and subtractions relating to prior periods will be adjusted in the State's payment to the FQHC for the most recent quarter.

(11) The prior period adjustments shall be separated by a provider's fiscal year. For example, a provider with a December fiscal year end receives managed care receipts in June 2003 for services rendered in December 2001 and January 2002. The provider shall prepare a separate Medicaid Managed Care Receipts Report for each prior period: the provider's fiscal years ending 2001 and 2002; these attachments shall be clearly identified as adjustments for fiscal years 2001 and 2002. Similarly, if a provider becomes aware of differences in encounters for prior fiscal year periods, the provider shall prepare a separate Medicaid Managed Care Encounter Detail Report for each prior fiscal year period.

ix. FQHCs shall maintain an accounting system, which identifies costs in a manner that conforms to generally accepted accounting principles and maintain documentation to support all data.

(1) On an annual basis and no later than five months after the close of each facility's fiscal year, an FQHC shall submit the annual cost report contained in N.J.A.C. 10:66–4 Appendix B, incorporated herein by reference.

(2) If all annual cost report items listed in N.J.A.C. 10:66–4 Appendix B, incorporated herein by reference, are not received by the due date, then all payments (including managed care wraparound payments) for services shall be suspended until all items are received. One 30–day maximum extension shall be granted upon written request only when a provider's operations are significantly adversely affected due to extraordinary circumstances beyond the control of the provider, as provided in Medicare guidelines.

(3) Each provider shall keep financial, statistical and medical records of the cost reporting year for at least six years after submitting the cost report to the DMAHS, or as long as an outstanding appeal exists, whichever is longer, and shall also make such records available upon request to authorized State or Federal representatives.

(4) DMAHS or its fiscal agent may periodically conduct either on-site or desk audits of cost reports, including financial, statistical, and medical records.

(5) The providers shall submit other information (statistics, cost and financial data) when deemed necessary by the Department.

(f) The basis for reimbursement of services provided in an ambulatory care/family planning facility is as follows:

1. Reimbursement for the services of an ambulatory care/family planning/surgical facility shall be made for services rendered by both the facility and the attending physician, if the physician is not reimbursed for surgical/medical services by the facility.

2. The facility reimbursement rate shall equal 70 percent of the applicable ambulatory surgical center rate for the procedures, in accordance with reimbursement rates, N.J.A.C. 10:66–1.5(c).

3. Physician reimbursement shall be in accordance with the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' Physician Maximum Fee Allowance for specialist and non-specialist, N.J.A.C. 10:54, and the following:

i. When submitting a claim, the physician performing the surgical procedure shall use the applicable claim form, billing the New Jersey Medicaid or NJ FamilyCare fee-for-service program either as an individual provider or as a member of a physician's group.

ii. A physician on salary for administrative duties (such as a medical director shall be permitted to submit claims for surgical/medical services performed if outside his or her administrative duties and not billed by the facility. Administrative duties shall be considered a

direct cost of the facility and shall be included in the clinic payment.

Amended by R.1996 d.331, effective July 15, 1996.
See: 28 N.J.R. 1952(b), 28 N.J.R. 3573(b).
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
Rewrote (d).
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.
Amended by R.1998 d.577, effective December 7, 1998.
See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).
Inserted references to NJ KidCare fee-for-service and substituted references to beneficiaries for references to recipients throughout; in (a), and inserted a reference to NJ KidCare–Plan A or B fee-for-service patients in 1; in (d)2, changed N.J.A.C. reference in the introductory paragraph, rewrote the first sentence of i, and inserted a reference to NJ KidCare–Plan A fee-for-service payments in ii; in (d)3vi, inserted a reference to NJ KidCare Plan A; in (d)6, substituted a reference to NJ KidCare Plan A for a reference to NJ KidCare in the introductory paragraph, and substituted a reference to the Division of Medical Assistance and Health Services for a reference to Medicaid in ii; and in (d)7, substituted a reference to NJ KidCare Plan A for a reference to NJ KidCare in the introductory paragraph, substituted a reference to DMAHS for a reference to the New Jersey Medicaid program in ii, and inserted a reference to NJ KidCare in v.
Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).
See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).
Amended by R.2002 d.271, effective August 19, 2002.
See: 33 N.J.R. 4087(a), 34 N.J.R. 2966(a).
In (d), substituted "for" for "of" preceding "services" and substituted "for periods prior to January 1, 2001 shall be" for "is" following "(FQHC)" in the introductory paragraph; added new (e); recodified former (e) as (f).
Amended by R.2004 d.208, effective June 7, 2004.
See: 36 N.J.R. 324(a), 36 N.J.R. 2834(a).
Rewrote the section.

10:66–1.6 Recordkeeping

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

(b) At a minimum, a beneficiary's record shall include a progress note for each visit which supports the procedure code(s) billed, except where specified otherwise.

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

(d) The information described in this subsection shall be made available to the New Jersey Medicaid and NJ FamilyCare fee-for-service programs or is agents upon request.

Amended by R.1998 d.577, effective December 7, 1998.
See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).
Inserted references to NJ KidCare fee-for-service and substituted references to beneficiaries for references to recipients throughout.
Amended by R.2004 d.208, effective June 7, 2004.
See: 36 N.J.R. 324(a), 36 N.J.R. 2834(a).
Rewrote (b); substituted "FamilyCare" for "KidCare" throughout.

Case Notes

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

10:66–1.7 Personal contribution to care requirements for NJ FamilyCare–Plan C and copayments for NJ FamilyCare–Plan D

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

(b) Personal contribution to care for NJ FamilyCare–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 direction of a physician or dentist, 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 beneficiary 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 FamilyCare–Plan C services if the NJ FamilyCare–Plan C services Identification Card indicates that a personal contribution to care is required and the beneficiary does not have a NJ FamilyCare 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.

Amended by R.1998 d.577, effective December 7, 1998.
See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).

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.

Amended by R.1998 d.577, effective December 7, 1998.
See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).

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 and Senior Services' 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.

Amended by R.1998 d.577, effective December 7, 1998.
See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).

SUBCHAPTER 4. FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

10:66–4.1 Federally qualified health center (FQHC) services

(a) Federally qualified health center (FQHC) services are services provided by physicians, physician assistants, nurse practitioners, 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 incident to a physician's services.

1. FQHCs shall accommodate an outstationed County Board of Social Services (CBOSS) employee(s) for the purpose of determining Medicaid and NJ FamilyCare 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 beneficiary 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 beneficiary, per day. More than one medical encounter is covered, however, when the beneficiary 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 beneficiary 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 beneficiary require clear documentation in the beneficiary'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 beneficiary 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 beneficiary 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 beneficiary 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.

5. An Early and Periodic Screening, Diagnosis and Treatment (EPSDT) medical encounter is a face-to-face contact between a beneficiary 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 in which a covered EPSDT service is provided.

Amended by R.1996 d.331, effective July 15, 1996.
See: 28 N.J.R. 1952(b), 28 N.J.R. 3573(b).
Amended by R.1998 d.577, effective December 7, 1998.
See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).
Substituted references to beneficiaries for references to recipients throughout; and in (a)1, inserted a reference to NJ KidCare Plan A.

Amended by R.2004 d.208, effective June 7, 2004.
See: 36 N.J.R. 324(a), 36 N.J.R. 2834(a).
In (a), substituted "County Board of Social Services (CBOSS)" for "county welfare agency (CWA)", "FamilyCare" for "KidCare", deleted "Plan A" in 1, added 5.

10:66–4.2 Hospital visits

(a) An inpatient hospital visit performed by a clinic physician for a registered Medicaid or NJ FamilyCare fee-for-service patient of a Federally qualified health center shall be reimbursed only if the clinic is specifically approved to provide this service by the programs.

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

2. For a physician under contract with a Federally qualified health center, 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 costs that may be reported in the FQHC's Medicaid cost report are for visits that are billed by the FQHC.

New Rule, R.1998 d.577, effective December 7, 1998.
See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).
Former N.J.A.C. 10:66–4.2, Audited financial statement, recodified to N.J.A.C. 10:66–4.3.
Amended by R.2004 d.208, effective June 7, 2004.
See: 36 N.J.R. 324(a), 36 N.J.R. 2834(a).
In (a), substituted "FamilyCare" for "KidCare" in the introductory paragraph.

10:66–4.3 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;

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

SUBCHAPTER 5. AMBULATORY SURGICAL CENTER (ASC)

10:66–5.1 Covered services

(a) Medicaid-covered and NJ FamilyCare fee-for-service 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 and NJ FamilyCare fee-for-service programs).

i. If additional surgical procedures are approved, each procedure will be assigned to one of the existing eight Medicare payment groups.

(b) Medicaid-covered and NJ FamilyCare fee-for-service 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.

Amended by R.1998 d.577, effective December 7, 1998.
See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).
Inserted references to NJ KidCare fee-for-service throughout.
Amended by R.2004 d.208, effective June 7, 2004.
See: 36 N.J.R. 324(a), 36 N.J.R. 2834(a).
Substituted "FamilyCare" for "KidCare" throughout.

10:66–5.2 Anesthesia services

(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.

Amended by R.1998 d.577, effective December 7, 1998.
See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).

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 and NJ FamilyCare fee-for-service programs 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.

Amended by R.1998 d.577, effective December 7, 1998.
See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).
In (b), inserted a reference to NJ KidCare fee-for-service.
Amended by R.2004 d.208, effective June 7, 2004.
See: 36 N.J.R. 324(a), 36 N.J.R. 2834(a).

In (b), substituted "FamilyCare" for "KidCare" in the introductory paragraph.

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 not be 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.

Amended by R.1998 d.577, effective December 7, 1998.
See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).

SUBCHAPTER 6. HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:66–6.1 Introduction

(a) The New Jersey Medicaid and NJ FamilyCare fee-for-service programs utilize the Centers for Medicare & Medicaid Services (CMS)'s Healthcare Common Procedure Code System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedure Terminology (CPT) architecture, employing a five-position code and as many as two 2–position modifiers. Unlike the CPT numeric design, the CMS-assigned codes and modifiers contain alphabetic characters. HCPCS was developed as a three-level coding system.

1. Level 1 codes (narratives found in CPT): These codes are adapted from CPT for utilization primarily by physicians, podiatrists, optometrists, certified nurse-midwives, independent clinics and independent laboratories. CPT 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 procedure narratives for Level I codes. Thus, in order to determine those narratives it is necessary to refer to CPT, 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.

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 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 and NJ FamilyCare fee-for-service 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: "L" preceding any procedure code indicates that the complete narrative for the code is located at N.J.A.C. 10:66–6.3. "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.
HCPCS CODE	HCPCS procedure code numbers.
MOD	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 and NJ FamilyCare fee-for-service program's recognized modifier codes for independent clinic services are as follows:
Modifer 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.
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.
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.

Column Title	Description
	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.
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.
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.
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.
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.
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).
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. Narratives for Level II and III codes are found at N.J.A.C. 10:66-6.3.
FOLLOW-UP DAYS	Number of days for follow-up care.
MAXIMUM FEE ALLOWANCE	New Jersey Medicaid and NJ FamilyCare fee-for-service programs 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.

1. Alphabetic and numeric symbols under "IND" and "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, 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.

(c) Listed below are both general and specific policies of the New Jersey Medicaid and NJ FamilyCare fee-for-service programs that pertain to HCPCS. Specific information concerning the responsibilities of an independent clinic provider when rendering Medicaid-covered and NJ FamilyCare fee-for-service-covered services and requesting reimbursement are located at N.J.A.C. 10:66–1 through 5, and 10:66 Appendix.

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 and NJ FamilyCare fee-for-service programs 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 or in this subchapter (N.J.A.C. 10:66–6). If an appropriate code is not listed, place an "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 or NJ FamilyCare fee-for-service 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).
Amended by R.1998 d.577, effective December 7, 1998.
See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).
Inserted references to NJ KidCare fee-for-service and substituted references to CPT for references to CPT–4 throughout.
Amended by R.2004 d.208, effective June 7, 2004.
See: 36 N.J.R. 324(a), 36 N.J.R. 2834(a).
In (a), Substituted "Centers for Medicare & Medical Services (CMS)'s Healthcare" for "HealthCare Financing Administration's (HCFA)", "CMS" for "HCFA"; in b and (c), substituted "FamilyCare" for "KidCare" throughout.

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 S	$	NS	Anes. Basic Units
*N	36415			1.80		1.80	
	90701			16.34		16.34	
	90701	52		2.50		2.50	
	90702			3.29		3.29	
	90702	52		2.50		2.50	
	90703			3.40		3.40	
	90703	52		2.50		2.50	
	90704			23.60		23.60	
	90704	52		2.50		2.50	
	90705			18.39		18.39	
	90705	52		2.50		2.50	
	90706			22.04		22.04	
	90706	52		2.50		2.50	
	90707			39.87		39.87	
	90707	52		2.50		2.50	
	90712			14.44		14.44	
	90712	52		2.50		2.50	
	90713			22.80		22.80	
	90713	52		2.50		2.50	
	90714			3.03		3.03	
	90714	52		2.50		2.50	
	90717			3.03		3.03	
	90717	52		2.50		2.50	
	90718			3.35		3.35	
	90718	52		2.50		2.50	
	90724			6.97		6.97	
	90724	52		2.50		2.50	
	90732			14.35		14.35	
	90732	52		2.50		2.50	
	90733			17.48		17.48	
	90733	52		2.50		2.50	
	90737			25.79		25.79	
	90737	52		2.50		2.50	
	90741			Prior authorization required			
	90742			Prior authorization required			
	90746			63.57		63.57	
L	90746	52		2.50		2.50	
N	90799			2.50		2.50	
N	90801			37.00		26.00	

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes. Basic Units
	93000			16.00		16.00	
N	99150			45.00		40.00	
				Per Hour		Per Hour	
N	99151			45.00		40.00	
				Per Hour		Per Hour	
	99173			5.00		5.00	
N	*99201			16.00		14.00	
N	*99202			16.00		14.00	
N	*99203			22.00		17.00	
N	*99204			22.00		17.00	
N	*99205			22.00		17.00	
N	*99211			16.00		14.00	
N	99211	WM		NA		11.20	
N	*99212			16.00		14.00	
N	99212	WM		NA		11.20	
N	*99213			16.00		14.00	
N	99213	WM		NA		11.20	
N	*99214			16.00		14.00	
N	99214	WM		NA		11.20	
N	*99215			16.00		14.00	
N	99215	WM		NA		11.20	
N	99241			44.00		NA	
N	99242			44.00		NA	
N	99243			44.00		NA	
N	99244			62.00		NA	
N	99245			62.00		NA	
N	99251			44.00		NA	
N	99252			44.00		NA	
N	99253			44.00		NA	
N	99254			62.00		NA	
N	99255			62.00		NA	
	99261			16.00		14.00	
	99262			16.00		14.00	
	99263			16.00		14.00	
N	99271			44.00		NA	
N	99272			44.00		NA	
N	99273			44.00		NA	
N	99274			62.00		NA	
N	99274	YY		50.00		NA	
N	99274	ZZ		50.00		NA	
N	99275			62.00		NA	
N	99291			45.00		40.00	
N	99292			22.50		20.00	
	99382			22.00		17.00	
	99383			22.00		17.00	
	*99384			22.00		17.00	
	*99385			22.00		17.00	
	*99386			22.00		17.00	
	*99387			22.00		17.00	
	99391			16.00		14.00	
	99392			22.00		17.00	
	99393			22.00		17.00	
	*99394			22.00		17.00	
	*99395			22.00		17.00	
	99396			22.00		17.00	
	99397			22.00		17.00	
	J2790			20.40		20.40	
	J2790	22		72.07		72.07	
L	W9050			27.00		NA	
L	W9055			27.00		23.00	
L	W9060	WT		23.00		18.00	
L	W9061	WT		23.00		18.00	
L	W9062	WT		23.00		18.00	
L	W9063	WT		23.00		18.00	
L	W9064	WT		23.00		18.00	
L	W9065	WT		23.00		18.00	
L	W9066	WT		23.00		18.00	
L	W9067	WT		23.00		18.00	
L	W9068	WT		23.00		18.00	
L	W9096			17.46		17.46	
L	W9096	52		2.50		2.50	
L	W9096	22		32.79		32.79	
L	W9096	2252		2.50		2.50	
L	W9097			17.46		17.46	
L	W9097	52		2.50		2.50	
L	W9098			32.79		32.79	
L	W9098	52		2.50		2.50	
L	W9333			27.88		27.88	
L	W9333	52		2.50		2.50	
L	W9334			27.88		27.88	
L	W9334	52		2.50		2.50	
L	W9335			62.09		62.09	
L	W9335	52		2.50		2.50	
L	W9338			30.27		30.27	
L	W9338	52		2.50		2.50	
	W9820			23.00		18.00	

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

(c) Family planning services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes. Basic Units
N	11975	22	30	Direct	package plus	price	
				100.00		85.00	
N	11976		90	100.00		85.00	
N	11977	22	90	Direct	package plus	price	
				200.00		170.00	
	36416	WF		1.80		1.80	
N	55250		30	90.00		79.00	3
N	55450		30	42.00		37.00	3
	56820	WF		88.00		NA	
	56821	WF		113.00		NA	
	57420	WF		71.00		NA	
	57421	WF		93.00		NA	
N	57451		45	182.00		158.00	6
	58301			16.40		16.40	
	58301	WM		NA		16.40	
N	58600		45	211.00		184.00	6
N	58605		45	151.00		131.00	6
N	58982		45	182.00		158.00	6
N	58983		45	182.00		158.00	6
	88150			6.00		6.00	
	88151			6.00		6.00	
	88155			6.00		6.00	
N	99201	WF		45.00		45.00	
N	99201	WFWM		NA		31.50	
N	99202	WF		45.00		45.00	
N	99202	WFWM		NA		31.50	
N	99203	WF		45.00		45.00	
N	99203	WFWM		NA		31.50	
N	99204	WF		45.00		45.00	
N	99204	WFWM		NA		31.50	
N	99205	WF		45.00		45.00	
N	99205	WFWM		NA		31.50	
N	99211	WF		7.60		7.60	
N	99211	WFWM		NA		5.35	
N	99212	WF		7.60		7.60	
N	99212	WFWM		NA		5.35	
N	99213	WF		7.60		7.60	
N	99213	WFWM		NA		5.35	
N	99214	WF		23.00		23.00	
N	99214	WFWM		NA		16.40	
N	99215	WF		23.00		23.00	
N	99215	WFWM		NA		16.40	
N	99395	WF		45.00		45.00	
N	99395	WFWM		NA		31.50	
L	W0001	WF		188.00		188.00	
L	W0001	WFWM		NA		177.00	
L	W0002	WF		123.00		123.00	
L	W0002	WFWM		NA		112.00	
L	W0004	WF		204.00		204.00	
L	W0004	WFWM		NA		188.00	
L	W0008	WF		139.00		139.00	
L	W0008	WFWM		NA		123.00	

(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 Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes. Basic Units
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	
*	11711			6.00		6.00	
*	11730			10.00		10.00	
*	11750		30	42.00		37.00	
*	12001			18.00		16.00	
*	12002			24.00		21.00	
*	12004			30.00		26.00	
	12005		7	46.00		39.00	
	12006		7	57.00		48.00	
	12007		7	82.50		70.00	
	12011			18.00		16.00	
	12013			24.00		21.00	
	12014		7	30.00		26.00	
	12031		30	30.00		26.00	
	12032		30	48.00		42.00	
*	12041		30	30.00		26.00	
*	12042		30	67.00		59.00	
	12051		30	38.00		33.00	
	12052		30	67.00		59.00	
	13100		30	34.00		29.00	
	13101		30	68.00		63.00	
	13120		30	48.00		42.00	
	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	

(f) Mental health services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes. Basis Units
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	
	90870	ZI		32.00		26.00	
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					15.40	15.40

(g) Obstetrical services (maternity):

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes. Basic Units
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	

(h) Podiatry services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes. Basic Units
	29580			18.00		16.00	3
N	99211	YR		16.00		14.00	
N	99212	YR		16.00		14.00	
N	99213	YR		16.00		14.00	
N	99214	YR		16.00		14.00	
N	99215	YR		16.00		14.00	
L	W2650			21.00		21.00	
L	W2655			5.00		5.00	

NOTE: See N.J.A.C. 10:66–6.2(f), Surgery, for additional procedures.

(i) Radiology services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes. Basic Units
	70030				15.00		
	70100				15.00		
	70110				20.00		
	70120				15.00		
	70130				20.00		
	70140				15.00		
	70150				20.00		
	70160				15.00		
	70170				20.00		
	70190				15.00		
	70200				25.00		

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes. Basic Units
	70210				20.00		
	70220				25.00		
	70240				15.00		
	70250				15.00		
	70260				25.00		
	70300				5.00		
	70310				10.00		
	70320				15.00		
	70328				13.00		
	70330				20.00		
	70350				8.00		
	70360				10.00		
	70370				20.00		
	70380				15.00		
	70390				15.00		
	70551				300.00		
MN	71010				10.00		
MN	71020				15.00		
MN	71030				20.00		
MN	71034				20.00		
	71100				15.00		
	71110				20.00		
	71120				15.00		
	71130				20.00		
	72010				40.00		
	72040				15.00		
	72050				20.00		
	72052				25.00		
	72070				15.00		
	72080				15.00		
	72100				20.00		
	72110				25.00		
	72114				20.00		
N	72170				15.00		
	72190				20.00		
	72200				20.00		
	72220				15.00		
	73000				10.00		
	73010				15.00		
	73020				15.00		
	73030				15.00		
	73040				15.00		
	73050				18.00		
	73060				15.00		
	73070				15.00		
	73080				15.00		
	73085				15.00		
	73090				10.00		
	73092				20.00		
	73100				10.00		
	73110				15.00		
	73115				15.00		
	73120				10.00		
	73130				15.00		
	73140				5.00		
N	73500				18.00		
N	73510				20.00		
	73520				25.00		
	73525				15.00		
	73530				30.00		
	73540				15.00		
	73550				15.00		
	73560				15.00		
	73562				15.00		
	73580				15.00		
	73590				15.00		
	73592				20.00		
	73600				10.00		
	73610				13.00		
	73615				15.00		
	73620				10.00		
	73630				13.00		
	73650				10.00		
	73660				5.00		
	74000				10.00		
	74010				15.00		
	74020				15.00		
N	74220				20.00		
N	74240				40.00		
N	74241				45.00		
N	74245				50.00		
N	74250				30.00		
	74270				30.00		
	74280				40.00		
	74290				35.00		
	74305				25.00		
	74400				35.00		
	74405				50.00		
	74420				35.00		
	74430				15.00		
	74450				20.00		
	74455				20.00		
	74470				20.00		
N	74710				25.00		
	74740				20.00		
	76000				45.00		
	76020				15.00		
	76040				20.00		
	76061				35.00		
	76062				90.00		
	76080				15.00		
	76090				26.00		
	76091				36.00		
	76100				35.00		
	76100	50			50.00		
	76805				55.00		
	76815				25.00		
	76816				25.00		

(j) Rehabilitation services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes. Basic Units
N	92507			7.00		7.00	
N	92552			11.00		11.00	
N	92553			14.00		14.00	
N	92557			19.00		19.00	
	92562			3.00		NA	
	92563			3.00		NA	
	92564			4.00		NA	
N	92567			5.00		NA	
N	92568			5.00		NA	
N	92572			20.00		NA	
N	92576			30.00		NA	
N	92582			14.00		14.00	
	92585			45.00		NA	
N	92589			10.00		NA	
	92590			40.00		NA	
	92591			40.00		NA	
N	97799			7.00		7.00	
L	H5300			7.00		7.00	
L	Z0270			7.00		7.00	
L	Z0280			7.00		7.00	
L	Z0300			7.00		7.00	
L	Z0310			45.00		45.00	

(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 S	$	NS	Anes. Basic Units
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 S	$	NS	Anes. Basic Units
*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	

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

(n) Federally qualified health care services:

IND	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes Basic Units
	90844	22		contract		contract	
L	W9840			contract		contract	
	W9843			contract		contract	
L	Y3333			contract		contract	

(o) Personal care assistant services:

Ind	HCPCS Code	Mod	Follow Up Days	Maximum Fee Allowance S	$	NS	Anes. Basic Units
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 S	$	NS	Anes. Basic Units
	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.
Amended by R.2000 d.435, effective November 6, 2000.
See: 32 N.J.R. 2690(a), 32 N.J.R. 3992(a).
In (a), inserted references to HCPCS Code 90746, and deleted references to HCPCS Code W9099.
Amended by R.2003 d.69, effective February 3, 2003.
See: 34 N.J.R. 3183(a), 35 N.J.R. 888(a).
In (f), inserted reference to HCPCS Code 90870.
Amended by R.2004 d.24, effective January 20, 2004.
See: 35 N.J.R. 4037(a), 36 N.J.R. 572(a).
In (c), added HCPCS Codes 36416, 56820, 56821, 57420, and 57421.
Amended by R.2004 d.75, effective February 17, 2004.
See: 35 N.J.R. 2154(a), 36 N.J.R. 952(b).
In (f), amended HCPCS code Z0170 and deleted HCPCS code Z0180.
Amended by R.2004 d.208, effective June 7, 2004.
See: 36 N.J.R. 324(a), 36 N.J.R. 2834(a).
In (n), amended the table.

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

(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;				

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 counsellor 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 beneficiary 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 counsellor 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).
Amended by R.1998 d.577, effective December 7, 1998.
See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).
Substituted references to beneficiaries for references to recipients throughout; and in (a)6i, inserted a reference to NJ KidCare fee-for-service.
Amended by R.2003 d.15, effective January 6, 2003.
See: 34 N.J.R. 2676(a), 35 N.J.R. 230(c).
Added (c)11.

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	Description	Maximum Fee Allowance S	$	NS	$	WM
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					19.00

HCPCS Code	Mod	Description	Maximum Fee Allowance S	$	NS	$	WM
		6. Laboratory services on site or by referral, as appropriate 7. Referrals for other medical consultations, as appropriate 8. Coordination with HealthStart case coordinator. **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.					
W9027		HealthStart Regular Delivery	465.00		418.00		
W9027	WM	HealthStart Regular Delivery 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: (a) Mother's hospital discharge summary and the (b) Infant's discharge summary, as appropriate 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 CMS 1500. claim form in Item 24A.					371.00
W9028		HealthStart Postpartum Care Visit	22.00		21.00		
W9028	WM	HealthStart Postpartum Care Visit by Certified Nurse Midwife 1. Outpatient postpartum care by the 60th day after the vaginal or caesarean section delivery (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					19.00

HCPCS Code	Mod	Description	Maximum Fee Allowance S $	NS $	WM
		(e) Referral for ongoing medical care when appropriate (f) Patient counseling and treatment NOTE: The postpartum visit shall be made by the 60th postpartum day. Include the delivery date on the CMS 1500 claim form in Item 24A.			
W9029		HealthStart Regular Delivery and Postpartum	487.00	439.00	
W9029	WM	HealthStart Regular Delivery and Postpartum by Certified Nurse Midwife includes: 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: (a) Mother's hospital discharge summary (b) Infant's discharge summary, as appropriate 6. Outpatient postpartum care by the 60th day after the delivery (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 CMS 1500 claim form in Item 24A.			390.00
W9030		HealthStart Total Obstetrical Care	867.00	802.00	
W9030	WM	HealthStart Total Obstetrical Care by Certified Nurse Midwife 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			723.00

HCPCS Code	Mod	Description	Maximum Fee Allowance S	$	NS	$	WM
		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 **NOTE:** Include the delivery date on the HCFA 1500 claim form in Item 24A. 3. Postpartum care visit by certified nurse midwife: Outpatient postpartum care by the 60th day after the vaginal delivery (full term or premature): 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					
W9031		HealthStart Cesarean Section Delivery 1. Admission history 2. Complete physical examination 3. Cesarean section delivery 4. Inpatient postpartum care 5. Referral to postpartum follow-up care provider, including: a. Mother's hospital discharge summary b. Infant's discharge summary, as appropriate **NOTE:** Include the delivery date on the claim form.	595.00		531.00		
W9040		HealthStart enrollment process	30.00				

HCPCS Code	Mod	Description	Maximum Fee Allowance $	NS $	WM
		1. Assistance with the presumptive eligibility determination for Maternity Care beneficiaries, when and if applicable 2. Patient registration and scheduling of the initial appointments 3. Counseling and referral for WIC, food stamps, and other community-based services 4. Assignment of HealthStart case coordinator 5. Outreach and follow-up on missed appointments **NOTE:** This code may be billed only once during pregnancy by the same provider.			
W9041		HealthStart Development of Maternity Plan of Care 1. Case coordination services 2. Initial assessments a. nutrition b. health education c. social/psychological 3. Case conference with Maternity Medical Care provider 4. Initial plan of care developed by the HealthStart case coordinator 5. Basic guidance and health education services 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.	120.00		
W9042		HealthStart Subsequent Maternity Health Support Services Visit 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.	50.00		
W9043		HealthStart Postpartum Maternity Health Support Services 1. Case coordination services 2. Review of the plan of care 3. Review of the summary of hospital stay records and current medical status	100.00		

HCPCS Code	Mod	Description	Maximum Fee Allowance S	$	NS	$	WM
		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.

HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance S	$	NS	$	WM
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);

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:

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, CMS 1500, and a HealthStart Preventive Child Health Form.

HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance S	$	NS	$	WM
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 or NJ KidCare fee-for-service program 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 —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.	13.00	13.00			

Administrative Correction.
See: 26 N.J.R. 235(a).
Amended by R.1998 d.577, effective December 7, 1998.
See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).
Substituted references to HCFA 1500 claim forms for references to 1500 NJ claim forms throughout; and in (b), inserted a reference to NJ KidCare fee-for-service throughout.
Amended by R.2004 d.208, effective June 7, 2004.
See: 36 N.J.R. 324(a), 36 N.J.R. 2834(a).
Amended the tables throughout.

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.

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

Unisys
PO Box 4801
Trenton, New Jersey 08650–4801
or contact:

Office of Administrative Law
Quakerbridge Plaza, Bldg. 9
PO Box 049
Trenton, New Jersey 08625–0049

Amended by R.1998 d.577, effective December 7, 1998.
See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).
Updates addresses.