

**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Chapter 66, Manual for Independent Clinic Services, was repealed and a new Chapter 66, Independent Clinic Services Manual, was adopted as R.1980 d.249, effective June 30, 1980.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Chapter 66, Independent Clinic Services Manual, was repealed and a new Chapter 66, Independent Clinic Services, was adopted as R.1993 d.641, effective December 6, 1993.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.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. GENERAL PROVISIONS

- 10:66-1.1 Scope of service
- 10:66-1.2 Definitions
- 10:66-1.3 Provisions for provider participation
- 10:66-1.4 Prior authorization (PA)
- 10:66-1.5 Basis for reimbursement
- 10:66-1.6 Recordkeeping
- 10:66-1.7 Personal contribution to care requirements for NJ FamilyCare-Plan C and copayments for NJ FamilyCare-Plan D
- 10:66-1.8 Medical exception process (MEP)

SUBCHAPTER 2. PROVISION OF SERVICES

- 10:66-2.1 Introduction
- 10:66-2.2 Dental services
- 10:66-2.3 Drug treatment center services
- 10:66-2.4 Early and periodic screening, diagnosis and treatment (EPSDT)
- 10:66-2.5 Family planning services
- 10:66-2.6 Laboratory services
- 10:66-2.7 Mental health services

- 10:66-2.8 (Reserved)
- 10:66-2.9 Other services
- 10:66-2.10 Pharmaceutical services
- 10:66-2.11 Podiatric services
- 10:66-2.12 Radiological services
- 10:66-2.13 Rehabilitative services
- 10:66-2.14 Renal dialysis service for end-stage renal disease (ESRD)
- 10:66-2.15 Sterilization services
- 10:66-2.16 Termination of pregnancy
- 10:66-2.17 Transportation services
- 10:66-2.18 Vision care services
- 10:66-2.19 Personal care assistant (PCA) services (mental health)

SUBCHAPTER 3. HEALTHSTART

- 10:66-3.1 Purpose
- 10:66-3.2 Scope of services
- 10:66-3.3 HealthStart provider participation criteria
- 10:66-3.4 Termination of HealthStart Provider Certificate
- 10:66-3.5 Standards for a HealthStart Comprehensive Maternity Care Provider Certificate
- 10:66-3.6 Access to service
- 10:66-3.7 Care plan
- 10:66-3.8 Maternity medical care services
- 10:66-3.9 Health support services
- 10:66-3.10 Professional staff requirements for HealthStart comprehensive maternity care services
- 10:66-3.11 Records: documentation, confidentiality and informed consent for HealthStart comprehensive maternity care providers
- 10:66-3.12 Standards for HealthStart pediatric care certificate
- 10:66-3.13 Professional requirements for HealthStart pediatric care providers
- 10:66-3.14 Preventive care services by HealthStart pediatric care providers
- 10:66-3.15 Referral services by HealthStart pediatric care providers
- 10:66-3.16 Records: documentation, confidentiality and informed consent for HealthStart pediatric care providers

SUBCHAPTER 4. FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

- 10:66-4.1 Federally qualified health center (FQHC) services
- 10:66-4.2 Hospital visits
- 10:66-4.3 Audited financial statement

APPENDIX A

APPENDIX B

APPENDIX C

APPENDIX D

APPENDIX E

SUBCHAPTER 5. AMBULATORY SURGICAL CENTER (ASC)

- 10:66-5.1 Covered services
- 10:66-5.2 Anesthesia services
- 10:66-5.3 Facility services
- 10:66-5.4 Medical records

SUBCHAPTER 6. CENTERS FOR MEDICARE & MEDICAID SERVICES HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

- 10:66-6.1 Introduction
- 10:66-6.2 HCPCS procedure code numbers and maximum fee allowance schedule
- 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)

10:66-6.4 HCPCS procedure codes—qualifiers
 10:66-6.5 HealthStart

APPENDIX. FISCAL AGENT BILLING SUPPLEMENT

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 be in compliance with 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. Services provided in an out-of-State independent clinic setting shall be in compliance with all applicable laws, rules and regulations of the state in which the facility is located.

(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.

Amended by R.2006 d.25, effective January 17, 2006.

See: 37 N.J.R. 3176(a), 38 N.J.R. 802(a).

In (b), substituted "be in compliance with" for "meet" and added the last sentence.

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, or similarly licensed by a comparable agency of the state in which the facility is located, 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