N.J.A.C. 10:66

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 66. INDEPENDENT CLINIC SERVICES

Title 10, Chapter 66 -- Chapter Notes

Statutory Authority

CHAPTER AUTHORITY:

N.J.S.A. 30:4D-1 et seq., and 30:4J-8 et seq.

History

CHAPTER SOURCE AND EFFECTIVE DATE:

Effective: February 5, 2024.

See: 56 N.J.R. 380(a).

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Chapter 66, Manual for Independent Clinic Services, was repealed and a new Chapter 66, Independent Clinic Services Manual, was adopted as R.1980 d.249, effective June 30, 1980.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Chapter 66, Independent Clinic Services Manual, was repealed and a new Chapter 66, Independent Clinic Services, was adopted as R.1993 d.641, effective December 6, 1993.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. As a part of R.2004 d.208, Subchapter 6, HCFA Common Procedure Coding System (HCPCS), was renamed Healthcare Common Procedure Coding System (HCPCS), effective June 7, 2004. See: 36 N.J.R. 324(a), 36 N.J.R. 2834(a).

Subchapter 6, HCFA Common Procedure Coding System (HCPCS), was renamed Centers for Medicare & Medicaid Services Healthcare Common Procedure Coding System (HCPCS), by R.2004 d.334, effective September 7, 2004. See: *36 N.J.R. 312(a)*, *36 N.J.R. 4136(a)*.

Chapter 66, Independent Clinic Services, was readopted as R.2009 d.376, effective November 4, 2009. See: *41 N.J.R. 2561(a)*, *41 N.J.R. 4791(a)*.

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 66, Independent Clinic Services, was scheduled to expire on November 4, 2016. See: *43 N.J.R. 1203(a)*.

Chapter 66, Independent Clinic Services, was readopted as R.2017 d.113, effective May 3, 2017. See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

Chapter 66, Independent Clinic Services, was readopted, effective February 5, 2024. See: Source and Effective Date.

Chapter 66, Independent Clinic Services, was updated by administrative change, effective November 4, 2024, to change all references to county welfare agencies (CWA) and county welfare boards to county social service agencies (CSSA) and county social services boards, respectively. See: *56 N.J.R. 2299(a)*.

Annotations

Notes

Chapter Notes

Research References & Practice Aids

CHAPTER EXPIRATION DATE:

Chapter 66, Independent Clinic Services, expires on February 5, 2031.

End of Document

N.J.A.C. 10:66-1.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:66-1.1 Scope of service

(a) This chapter 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 services in an independent clinic setting. The term independent clinic includes, but is not limited to, clinic types, such as: ambulatory care facilities, ambulatory surgical centers, ambulatory care/family planning clinics, substance use disorder treatment facilities, mental health independent clinics, and Federally qualified health centers (FQHCs).

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

History

HISTORY:

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.

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

Rewrote (a) and (e).

Annotations

Notes

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N.J.A.C. 10:66-1.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 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, 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, or similarly licensed by a comparable agency of the state in which the facility is located, to provide specified surgical procedures.

"Ambulatory surgical center (ASC)" means any distinct entity that: operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization; has an agreement with the Centers for Medicare & Medicaid Services (CMS) as a Medicare participating provider for ambulatory surgical services; is licensed, if required, by the New Jersey State Department of Health, or is similarly licensed by a comparable agency of the state in which the facility is located; and meets the enrollment requirements of the New Jersey Medicaid/NJ FamilyCare programs as indicated in the Administration chapter at *N.J.A.C. 10:49-3.2* and *N.J.A.C. 10:66-1.3*.

"American Society of Addiction Medicine (ASAM)" means the professional society representing physicians, clinicians, and associated professionals in the field of addiction medicine. Their main office is located at 4601 North Park Ave., Upper Arcade, Suite 101, Chevy Chase, MD 20815, or they can be contacted on their website at: *www.asam.org*.

"ASAM level of care" refers to the ASAM Patient Placement Criteria developed by the American Society of Addiction Medicine, contained in "Patient Placement Criteria for the Treatment of Substance Related Disorder," 2nd Edition revised (2001) (ASAM PPC-2R), incorporated herein by reference, as amended and supplemented, which can be obtained from the ASAM Publications Center, by calling 1-800-844-8948.

"Audited financial statements" are defined in requirements set forth in *N.J.A.C. 10:66-4.3*. This section provides a set of guidelines so that FQHC providers will know the criteria for a satisfactory audit.

"Behavioral health services" refers to the treatment and amelioration of behavioral/mental health conditions, as well as efforts to prevent and intervene in substance use disorder.

"Clinical practitioner" means a physician (including doctor of medicine, osteopathy, dentistry, podiatry, optometry, and chiropractic medicine), advanced practice nurse, certified nurse midwife, and clinical psychologist.

"Clinic services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not a part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients:

1. Services furnished at the clinic by or under the direction of a physician or dentist; and

2. Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

"Compensated hours" means, in the case of a Federally qualified health center only, all hours for which an employee receives compensation, payment or any form of remuneration, including regular time, overtime, vacation time, sick time, personal time, educational time, and all other compensated time.

"Dental clinic" means an independent clinic, whether freestanding, or a distinct component of a multi-service ambulatory care facility, licensed by the New Jersey State Board of Dentistry, or similarly licensed by a comparable agency of the state in which the facility is located.

"Dentist" means an individual who is licensed to practice dentistry in the state in which treatment is provided, whose practice is limited solely to dentistry and its specialties, as recognized by the American Dental Association, and who meets the requirements of *N.J.A.C. 10:56*.

"DHS" means the New Jersey Department of Human Services.

"Division of Mental Health and Addiction Services" or "DMHAS" means the division of the New Jersey Department of Human Services that is responsible for the administration of the State's mental health and addiction programs.

"End Stage Renal Disease (ESRD) facility" means a freestanding facility approved by the Centers for Medicare & Medicaid Services (CMS) for participation in the Medicare program as an end stage renal disease facility.

"Federally qualified health center (FQHC)" means an entity that is receiving a grant under Section 330 of the Public Health Service Act; or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under Section 330 of the Public Health Service Act; or based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant; or was treated by the Secretary, for purposes of Medicare Part B, as a Federally Funded Health Center as of January 1, 1990; and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act for the provision of primary health services.

"Freestanding facility" means a facility which may not be part of a hospital. However, a clinic may be located in the same building as a hospital, as long as there is no administrative, organizational, financial or other connection between the clinic and the hospital.

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

"Level of Care Index-Adult-3 (LOCI 3)" is a comprehensive program for guiding assessments and documenting treatment, placement, and planning information for the six dimensions of the ASAM criteria placement findings for adults. This program can be accessed on the ASAM website: *http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria*.

"Local health department clinic" means an independent clinic that is licensed or approved by the New Jersey State Department of Health (DOH) to provide medical care to outpatients in accordance with *N.J.A.C. 8:52*.

"Managed care wraparound payments" means DMAHS payments made to FQHCs for the difference between the Medicaid FQHC encounter rate and amounts paid to FQHCs by managed care organizations for encounters provided to Medicaid and FamilyCare beneficiaries.

"Medical director" means a physician, doctor of medicine (M.D.) or osteopathy (D.O.), who is responsible for the direction, provision and quality of medical services provided to patients and who is qualified in accordance with *N.J.A.C. 8:43A-1.14*.

"Medicare Economic Index (MEI)" means that factor that adjusts reimbursement rates for annual inflation, which is determined in accordance with section 1842(b)(3) of the Social Security Act, *42 U.S.C. § 1395u(b)(3)* and regulation at *42 C.F.R. 405.504*.

"Medicare limit" means the Medicare FQHC urban payment limit as provided for in section 1833(a)(3) of the Social Security Act, *42 U.S.C. § 1395l(a)* and *section 1861(v)(1)(A)* of the Social Security Act, *42 U.S.C. § 1395x(v)*, and *section 1886(d)(2)(D)* of the Social Security Act, *42 U.S.C. § 1395ww(d)*. The Medicare limit is adjusted for inflation annually by the Medicare Economic Index (MEI) applicable to primary care services.

"Mental health clinic" means an independent clinic, whether freestanding, or a distinct component of a multi-service ambulatory care facility, that meets the minimum standards established by the Community Mental Health Services Act implementing rules, including, but not limited to, *N.J.A.C. 10:37*, and is approved by the Division of Mental Health and Addiction Services (DMHAS), in accordance with that Division's rules, or is similarly licensed by a comparable agency of the state in which the facility is located.

"Mental health services worker" means an individual who possesses a bachelor's degree or associate's degree in psychosocial rehabilitation or mental health services, or related life or work experience, such as assuming leadership roles during participation in mental health services or mental health consumer initiatives.

"New Jersey Substance Abuse Monitoring System (NJSAMS)" is the automated client data collection system required by DHS to be used by all DHS New Jersey substance use disorder treatment facilities and providers to record and report consumer data including, but not limited to, admission, status, treatment services, utilization management, and discharge information.

"Opioid" means both opiates and synthetic narcotics.

"Opioid treatment provider" is a program licensed by DHS where opioid agonist treatment medication, such as methadone or buprenorphine, is dispensed, along with a comprehensive range of medical and rehabilitative services to alleviate the adverse medical, psychological, or physical effects attributed to the use of opioids. The program must be certified as an Opioid Treatment Program by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) and comply with all regulations enforced by the Drug Enforcement Administration (DEA) as referenced in *N.J.A.C. 10:161B-11.1*.

"Outpatient" means a patient of an organized medical facility, or a distinct part of that facility who is expected by the facility to receive and who does receive professional services for less than a 24-hour period, regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.

"PA" means prior authorization. See *N.J.A.C. 10:66-1.4*.

"Patient" means a beneficiary who is receiving needed professional services that are directed by a licensed practitioner of the healing arts towards the maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

"Personal care assistant" means a person who has successfully completed a training program in personal care services and is certified by the New Jersey State Department of Law and Public Safety, Board of Nursing, as a homemaker-home health aide; who successfully completes a minimum of 12 hours in-service education per year offered by the agency; and who is supervised by a registered professional nurse employed by a Division homemaker/personal care assistant provider agency.

"Physician" means a doctor of medicine (M.D.) or osteopathy (D.O.) licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners, or similarly licensed by comparable agencies of the state in which he or she practices.

"Podiatrist" means an individual licensed to practice podiatry in the state in which treatment is provided, and whose practice is limited to podiatry, within the scope of practice for that state.

"Prevocational services" means interventions, strategies and activities within the context of a partial care program that assist individuals to acquire general work behaviors, attitudes and skills needed to

take on the role of worker and in other life domains, such as: responding to criticism, decision making, negotiating for needs, dealing with interpersonal issues, managing psychiatric symptoms and adherence to prescribed medication directions/schedules. Examples of interventions not considered prevocational or covered by Medicaid and NJ FamilyCare include: technical occupational skills training, college preparation, student education, including preparation of school assigned classwork or homework and individualized job development.

"Prospective Payment System (PPS)" means a payment rate per encounter which is determined in accordance with *42 U.S.C. § 1396a(a)* and adjusted annually by the MEI applicable to primary care services.

"Psychologist" means an individual who is licensed to practice psychology in the state in which treatment is provided, and who is a Diplomate of the American Board of Professional Psychology (Diplomate Qualified) or has been notified of admissibility to the examination by the American Board of Professional Psychology (Diplomate Eligible).

"Satellite" means an affiliate of a separately enrolled independent clinic. A satellite is located at a site distinct from that of the separately enrolled independent clinic but shares the same governing authority.

"Special minimum wage certificate" means a certificate issued by the U.S. Department of Labor pursuant to 29 C.F.R. § 525, which permits a worker with a disability to be paid at a rate below the rate which would otherwise be required by statute.

"Specialist" means a fully licensed physician who:

1. Is a diplomate of a specialty board approved by the American Board of Medical Specialties or the Advisory Board of the American Osteopathic Association;

2. Is a fellow of the appropriate American specialty college or a member of an osteopathic specialty college;

3. Is currently admissible to take the examination administered by a specialty board approved by the American Board of Medical Specialties or the Advisory Board of the American Osteopathic Association, or has evidence of completion of an appropriate qualifying residency approved by the American Medical Association or American Osteopathic Association;

4. Holds an active staff appointment with specialty privileges in a voluntary or governmental hospital which is approved for training in the specialty in which the physician has privileges; or

5. Is recognized in the community as a specialist by his or her peers.

"Specialist in dentistry" means an individual who is licensed to practice dentistry in the state in which treatment is provided, and whose practice is limited solely to his or her specialty, which is recognized by the American Dental Association. Additional conditions regarding the qualifications for a dental specialist for the New Jersey Medicaid and NJ FamilyCare fee-for-service programs are located in the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' Dental Services chapter, *N.J.A.C. 10:56*.

"Specialist in podiatry" means an individual who is licensed to practice podiatry in the state in which treatment is provided, and who is a Diplomate of the appropriate American Podiatry Association-recognized board or has been notified of admissibility to examination by the appropriate American Podiatry Association recognized board.

"Substance use disorder treatment facility" means an independent clinic, whether freestanding, or a distinct part of a facility, that is licensed or approved by the New Jersey State Department of Health (DOH), or is similarly licensed by DHS, Division of Mental Health and Addiction Services (DMHAS), to provide health care for the prevention and treatment of drug addiction and drug abuse, in accordance with N.J.A.C. 8:43A-26 and/or 10:161B, as applicable.

"Therapeutic subcontract work activity" means production, assembly and/or packing/collating tasks for which individuals with disabilities performing these tasks are paid less than minimum wage and,

pursuant to 29 C.F.R. § 525, a special minimum wage certificate has been issued to the organization/program by the U.S. Department of Labor.

"Vocational services" means those interventions, strategies and activities that assist individuals to acquire skills to enter a specific occupation and take on the role of colleague (that is, a member of a profession) and/or assist the individual to directly enter the workforce and take on the role of an employee, working as a member of an occupational group for pay with a specific employer.

"Withdrawal management" or "detoxification" means the short-term provision of care, usually not in excess of 30 days, prescribed by a physician and conducted under medical supervision, for the purpose of withdrawing a person from a specific psychoactive substance in a safe and effective manner, according to established written medical protocols.

History

HISTORY:

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)*.

In "Personal care assistant", inserted references to NJ KidCare throughout 1; and in "Specialist in dentistry", inserted references to NJ KidCare fee-for-service throughout.

Amended by R.2002 d.271, effective August 19, 2002.

See: *33 N.J.R. 4087(a)*, *34 N.J.R. 2966(a)*.

Added "Managed care wraparound payments", "Medicare Economic Index (MEI)" and "Prospective Payment System (PPS); rewrote "Medicare limit".

Amended by R.2004 d.75, effective February 17, 2004.

See: *35 N.J.R. 2154(a)*, *36 N.J.R. 952(b)*.

Added definitions for "Mental health services worker", Prevocational services", "Special minimum wage certificate", "Therapeutic subcontract work activity" and "Vocational services".

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)*.

Added "or similarly licensed by a comparable agency of the state in which the facility is located" to definitions "Ambulatory care facility," "Ambulatory care/family planning facility," Ambulatory surgical center (ASC)," "Dental clinic," "Drug treatment center" and "Mental health clinic."

Amended by R.2009 d.376, effective December 21, 2009.

See: *41 N.J.R. 2561(a)*, *41 N.J.R. 4791(a)*.

In definition "Compensated hours", substituted "Federally qualified" for "Federally-qualified"; and in definition "Specialist in dentistry", substituted "FamilyCare" for "KidCare" twice.

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

In definitions "Ambulatory care facility", "Ambulatory care/family planning facility", and "Ambulatory surgical center (ASC)", deleted "and Senior Services" following "Health"; in definition "Ambulatory surgical center (ASC)", deleted a comma following the first N.J.A.C. reference; in definition "Local health department clinic", substituted "that" for "which" and "(DOH)" for "and Senior Services (DHSS)"; in definition "Medicare limit", updated the first and second U.S.C. references; in definition "Mental health clinic", substituted the first occurrence of "that" for "which", and inserted "and Addiction" and "(DMHAS)"; added definitions "American Society of Addiction Medicine (ASAM)", "ASAM level of care", "Behavioral health services", "DHS", " 'Division of Mental Health and Addiction Services' or 'DMHAS' ", "Level of Care Index-Adult-3 (LOCI 3)", "New Jersey Substance Abuse Monitoring System (NJSAMS)", "Opioid", "Opioid treatment provider", "Substance use disorder treatment facility", and " 'Withdrawal management' or 'detoxification' "; and deleted definition "Drug treatment center".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:66-1.3

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§ 10:66-1.3 Provisions for provider participation

(a) Each independent clinic, including each satellite, shall be individually approved by the New Jersey Medicaid and NJ FamilyCare fee-for-service programs and enrolled with the Division's fiscal agent, for approved service(s). If a clinic wishes to add a service(s), approval from the New Jersey Medicaid and NJ FamilyCare fee-for-service programs shall be obtained before reimbursement for the service(s) may be claimed. For additional details, see the Administration chapter, *N.J.A.C. 10:49-3.2*, Enrollment process, and *N.J.A.C. 10:49-3.3*, Providers with multi-locations.

1. All clinical practitioners directly affiliated with the clinic shall enroll in the New Jersey Medicaid and NJ FamilyCare fee-for-service programs, as indicated in the Administration chapter at *N.J.A.C. 10:49-3.4*, in order to obtain an individual Medicaid and NJ FamilyCare fee-for-service Provider Number(s).

2. (Reserved)

(b) Each independent clinic seeking enrollment in the New Jersey Medicaid and NJ FamilyCare fee-for-service programs shall possess a certificate of need and/or license, if required, from the New Jersey State Department of Health, or the Division of Mental Health and Addiction Services, or from both agencies, or possess similar documentation by a comparable agency of the state in which the facility is located.

1. The facility shall provide only those services for which it is licensed or authorized to provide by the New Jersey State Department of Health or the Division of Mental Health and Addiction Services, or both, if applicable, or for which the facility is similarly licensed or authorized by a comparable agency of the state in which the facility is located.

2. A photocopy of the license shall be forwarded to the New Jersey Medicaid and NJ FamilyCare fee-for-service programs as an attachment to the clinic's initial application for enrollment and when the license is renewed on an annual basis.

(c) In addition to (a) and (b) above, each independent clinic shall obtain approval from the relevant Federal and State agencies, as required by law, rule, and/or regulation, including, but not limited to, the following:

1. For an ambulatory surgical center, an agreement with the Centers for Medicare & Medicaid Services (CMS) under Medicare to participate as an ambulatory surgical center and licensure as an ambulatory surgical center, by the New Jersey State Department of Health or by a comparable agency of the state in which the facility is located;

2. For a Federally qualified health center, approval by the Centers for Medicare & Medicaid Services as a Federally qualified health center and licensure, by the New Jersey State Department of Health or by a comparable agency of the state in which the facility is located, as an ambulatory care facility;

3. For an ambulatory care/family planning/surgical facility, licensure as an ambulatory care/family planning/surgical facility by the New Jersey State Department of Health or by a comparable agency of the state in which the facility is located;

4. For a dental clinic, a permit to operate shall be obtained from the State Board of Registration and Examination in Dentistry (see *N.J.A.C. 13:30-4.2*) or from a comparable agency of the state in which the facility is located, prior to enrollment as a dental clinic provider, and shall remain in effect;

5. For a mental health clinic or substance use disorder treatment facility, approval by the Division of Mental Health and Addiction Services or by a comparable agency of the state in which the facility is located; and

6. For child health conferences, approval by the New Jersey State Department of Health in accordance with *N.J.A.C. 8:52* and as indicated at N.J.A.C. 10:66-3, or by a comparable agency of the state in which the facility is located.

(d) Each out-of-State clinic seeking reimbursement for services provided to New Jersey Medicaid and NJ FamilyCare fee-for-service beneficiaries shall enroll, if the clinic is approved by Title XIX (Medicaid) in its own state, in the New Jersey Medicaid and NJ FamilyCare fee-for-service programs as indicated in the Administration chapter at *N.J.A.C. 10:49-3.2(c)*.

(e) Each Medicaid or NJ FamilyCare fee-for-service beneficiary's care in an independent clinic shall be under the supervision of a physician directly affiliated with the clinic. The Medical Director or his or her designee shall assume professional responsibility for the services provided and thus assure that the services are medically appropriate.

(f) A physician affiliated with a clinic shall spend as much time in the facility as is necessary to assure that Medicaid and NJ FamilyCare fee-for-service beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of medical and dental practice.

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

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

(h) The clinic's medical staff, including physicians, dentists, and other practitioners, shall be appropriately licensed in order to provide the medical care delivered to Medicaid and NJ FamilyCare fee-for-service beneficiaries.

History

HISTORY:

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 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)*.

Rewrote (b).

Amended by R.2009 d.376, effective December 21, 2009.

See: *41 N.J.R. 2561(a)*, *41 N.J.R. 4791(a)*.

In (b)2, substituted "NJ" for "New Jersey".

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

In (b) and (c), deleted "and Senior Services" following "Health" throughout; in the introductory paragraph of (b), and in (b)1 and (c)5, substituted "and Addiction Services" for "Services of the New Jersey Department of Human Services"; in the introductory paragraph of (c), substituted "(a)" for "*N.J.A.C. 10:66-1.3(a)*" and "agencies" for "agency(ies)", and inserted a comma following "rule"; and in (c)5, inserted "or substance use disorder treatment facility".

Annotations

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DMAHS's action in terminating Medicaid provider numbers on the basis that the provider was no longer licensed as an independent clinic providing drug and alcohol treatment services was sustained. One requirement for retention of Medicaid provider numbers was that the provider continued to be licensed to provide the services which were eligible for Medicaid reimbursement. Once the provider surrendered its license to provide such services to the DHS Office of Licensing, the clinic was no longer authorized to retain its Medicaid provider numbers. Given those facts, DMAHS had good cause to terminate the clinic's Medicaid provider numbers. Step by Step Health & Family Servs. v. DMAHS, OAL DKT. NO. HMA 5389-13 (Slip Opinion), Initial Decision (February 18, 2015).

N.J.A.C. 10:66-1.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:66-1.4 Prior authorization (PA)

(a) In addition to N.J.A.C. 10:49-6.1, this section outlines prior authorization (PA) requirements for dental, mental health, substance use disorder, and vision care services, as specified in (b), (c), and (d) below. Prior authorization as specified in N.J.A.C. 10:49-6.2 shall be required for out-of-State clinics for specified dental, mental health, substance use disorder, and vision care services in accordance with N.J.A.C. 10:49-6 and in accordance with specific provider chapters. Prior authorization requirements by the Primary Care Provider (PCP) for persons participating in managed health care programs are located at N.J.A.C. 10:49-21.4(c).

(b) Dental services shall be prior authorized as indicated in the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' Dental Services chapter, N.J.A.C. 10:56-1.4.

(c) In addition to the other requirements of this section, mental health and substance use disorder outpatient rehabilitative services, including individual psychotherapy, group therapy, family consultation, and family therapy, provided to each Medicaid or NJ FamilyCare fee-for-service beneficiary require prior authorization when payment to an independent clinic exceeds $ 6,000 for that Medicaid or NJ FamilyCare fee-for-service beneficiary in any 12-month period, commencing with the beneficiary's initial visit.

1. The maximum period of authorization shall not exceed 12 months for all mental health services. Additional authorizations may be requested.

i. The maximum period of authorization for partial care shall not exceed six months.

2. When requesting prior authorization, Forms FD-07 and FD-07A, "Request for Authorization of Mental Health Services and/or Mental Health Rehabilitation Services" and "Request for Prior Authorization: Supplemental Information," shall be completed and forwarded to: the Medical Assistance Customer Center (MACC) that serves the county in which the services are rendered. See the Fiscal Agent Billing Supplement, N.J.A.C. 10:66--Appendix, for instructions on the completion of the prior authorization forms.

3. The "Brief Clinical History" and "Present Clinical Status" sections of the FD-07A "Request for Prior Authorization: Supplemental Information" form are particularly important and must provide sufficient medical information to justify and support the proposed treatment request. Failure to comply may result in a reduction or denial of requested services.

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

5. Similarly, a new request for authorization is required for a medical/remedial therapy session or encounter that departs from the plan of care in terms of increased need, scheduling, frequency, or duration of services furnished (for example, unscheduled emergency services furnished during an acute psychotic episode).

6. If the request for prior authorization is approved, the Division's fiscal agent shall notify the provider in writing regarding the Division's decision; authorized date or time frame; and activation of the prior

authorization number. If the request is modified, denied, or if the Division requires additional information, the provider is so notified in writing by the fiscal agent.

(d) 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 substance use disorder treatment facility will be authorized and provided by the DMAHS transportation broker. Providers are responsible for arranging the transportation by contacting the DMAHS transportation broker. A link to the transportation broker can be found on the DMAHS website: *http://www.state.nj.us/humanservices/dmahs/home/index.html*. If you do not have internet access call the Provider Services hotline at 1-800-776-6334.

(f) With the exception of an intake assessment, all other substance use disorder services provided by a substance use disorder treatment facility shall require prior authorization including, but not limited to, substance use disorder-partial care programs, substance use disorder-intensive outpatient services, non-hospital based detoxification, short-term residential services, and opioid treatment/maintenance services. Prior authorization shall be provided by the Division of Mental Health and Addiction Services (DMHAS) or any DHS State agency or contracted entity approved to authorize these services.

1. The maximum period of authorization shall not exceed 12 months for outpatient mental health or substance use disorder services. Additional authorizations may be requested.

2. The maximum period of authorization for partial care services for mental health or substance use disorders shall not exceed six months.

3. A departure from the American Society of Addiction Medicine (ASAM) level of care requires a new request for prior authorization when a change in the beneficiary's clinical condition necessitates an increase or decrease in the frequency and intensity of services, or change in the type of services that exceeds the cost of the services authorized.

History

HISTORY:

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.

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

Rewrote (a), (c), and (e); and added (f).

Annotations

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Initial Decision (2005 N.J. AGEN LEXIS 1319) adopted, which concluded that a mental health service provider improperly billed full-day rates for children who did not receive the required full five hours of care and that the facility's executive officer was personally liable, within the meaning of *N.J.S.A. 30:4D-7(h)*, for any incorrect or illegal Medicaid payments, including non-preauthorized payments. *Hentz v. DMAHS, OAL Dkt. No. HMA 5140-04, 2005 N.J. AGEN LEXIS 1320*, Final Decision (November 18, 2005).

End of Document

N.J.A.C. 10:66-1.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 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/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/NJ FamilyCare fee-for-service beneficiary, and the charge to the New Jersey Medicaid/NJ FamilyCare fee-for-service program may not exceed the charge by the clinic for identical services to other groups or individuals in the community.

(b) The HCPCS procedure code system, N.J.A.C. 10:66-6, refers to procedure codes and maximum fee allowances corresponding to Medicaid/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/NJ FamilyCare fee-for-service Provider Services Number and the National Provider Identifier 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 416.167 through 416.179, the Federal regulations governing payment for 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.

3. Physician reimbursement shall be in accordance with the New Jersey Medicaid/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/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 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:

(A) The addition of a new FQHC covered service that is not incorporated in the baseline PPS rate or a deletion of a FQHC covered service that is incorporated in the baseline PPS rate;

(B) A change in scope of service due to amended regulatory requirements or rules;

(C) A change in scope of service resulting from relocation, remodeling, opening a new clinic or closing an existing clinic site; and/or

(D) A change in scope of service due to applicable technology and medical practice.

(2) "Change in Scope of Service Applications" shall be governed by the following procedures:

(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 (d)1vi(3) below, and documentation must include data to support the calculation of an adjustment to the PPS rate. It is recognized that the change in scope of service will be time-limited in most cases, due to start-up/phase-in costs or shut down/phase out costs associated with the change in scope of service. The provider must address this in the Change in Scope of Service Application.

(3) Providers may submit Change in Scope of Service Applications 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 change(s) in scope of service 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 in scope of service 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.

(A) Effective for service dates on and after July 11, 2008 for Medicaid/NJ FamilyCare fee-for-service beneficiaries, FQHCs that provide deliveries and/or OB/GYN surgeries will be required to comply with the encounter reporting requirements in (d)1viii(6)(B) through (D) below and contained in N.J.A.C. 10:66-4 Appendix E, incorporated herein by reference.

(B) The FQHC must report all managed care encounters performed during the reporting period, with the exception of the delivery and OB/GYN surgical encounters on Worksheet 2, Support Schedule A located in N.J.A.C. 10:66-4 Appendix E.

(C) The FQHC must report all managed care delivery encounters performed during the reporting period on Worksheet 2, Support Schedule C located in N.J.A.C. 10:66-4 Appendix E.

(D) The FQHC must report all managed care OB/GYN surgical encounters performed during the reporting period on Worksheet 2, Support Schedule E located in N.J.A.C. 10:66-4 Appendix E.

(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.

(A) Effective for service dates on and after July 11, 2008 for Medicaid/NJ FamilyCare fee-for-service beneficiaries, FQHCs that provide deliveries and/or OB/GYN surgeries will be required to comply with the receipt reporting requirements in (d)1viii(7)(B) to (D) below and contained in N.J.A.C. 10:66-4 Appendix E, incorporated herein by reference.

(B) The FQHC must report all managed care receipts received during the reporting period with the exception of receipts for delivery and OB/GYN surgical encounters on Worksheet 2, Support Schedule B located in Appendix E.

(C) The FQHC must report all managed care delivery receipts received during the reporting period on Worksheet 2, Support Schedule D located in Appendix E.

(D) The FQHC must report all managed care OB/GYN surgical receipts received during the reporting period on Worksheet 2, Support Schedule F located in 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. Effective for service dates on and after July 11, 2008 for Medicaid/NJ FamilyCare fee-for-service beneficiaries, FQHCs shall receive reimbursement for deliveries and OB/GYN surgeries, specified at (d)1ix(1) below, at the higher of the Medicaid fee-for-service rate for the particular code or the FQHC's PPS encounter rate. Reimbursement for surgical assistants will be at the Medicaid fee-for-service rate for the particular code.

(1) Delivery codes are listed on Table A. OB/GYN surgical codes are listed on Table B. Tables A and B and annual updates will be posted on the Unisys website: *www.njmmis.com*.

(2) Antepartum and Postpartum encounters provided to Medicaid/NJ FamilyCare fee-for-service beneficiaries that are not included in the delivery code reimbursement, may be reimbursed to the FQHC at the PPS encounter rate.

(3) Post surgical encounters provided to Medicaid/NJ FamilyCare fee-for-service beneficiaries that are not included in the OB/GYN surgical code reimbursement, may be reimbursed to the FQHC at the PPS encounter rate.

(4) Effective for service dates on and after July 11, 2008 for Medicaid/NJ FamilyCare managed care beneficiaries, FQHCs shall receive reimbursement for deliveries and OB/GYN surgeries, specified at (d)1ix(1) above from the managed care organization(s). FQHCs shall receive reimbursement for surgical assistants related to these deliveries and OB/GYN surgeries from the managed care organization(s). Deliveries, OB/GYN surgeries and services provided by surgical assistants for deliveries and OB/GYN surgeries are not eligible for wraparound reimbursement.

(5) Antepartum and Postpartum encounters provided to Medicaid/NJ FamilyCare managed care beneficiaries that are not included in the delivery code reimbursement are eligible for wraparound reimbursement. Antepartum and postpartum encounters that are covered by the managed care delivery reimbursement are not eligible for wraparound reimbursement.

(6) Post surgical encounters provided to Medicaid/NJ FamilyCare managed care beneficiaries that are not included in the OB/GYN surgical code reimbursement are eligible for wraparound reimbursement. Post surgical encounters that are covered by the managed care OB/GYN surgical reimbursement are not eligible for wraparound reimbursement.

x. 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.

(e) 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 of 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.

History

HISTORY:

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.

Amended by R.2004 d.334, effective September 7, 2004.

See: *36 N.J.R. 312(a)*, *36 N.J.R. 4136(a)*.

Administrative correction.

See: *36 N.J.R. 4315(a)*.

Amended by R.2009 d.376, effective December 21, 2009.

See: *41 N.J.R. 2561(a)*, *41 N.J.R. 4791(a)*.

In the introductory paragraph of (b), substituted "refers to" for "contains"; in (b)1, inserted "and the National Provider Identifier"; in the introductory paragraph of (c)3, substituted "Medicaid/NJ" for "Medicaid and NJ"; in (c)3i, substituted "Medicaid/NJ" for "Medicaid or NJ"; deleted former (d); recodified former (e) and (f) as new (d) and (e); rewrote (d)1vi, added (d)1viii(6)(A) through (d)1viii(6)(D) and (d)1viii(7)(A) through (d)1viii(7)(D); added new (d)ix; and recodified former (d)ix as (d)x.

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

In (e)3ii, inserted a closing parenthesis following "director", and inserted the first occurrence of "of".

Amended by R.2019 d.065, effective June 17, 2019.

See: *51 N.J.R. 17(a)*, *51 N.J.R. 1056(a)*.

In the introductory paragraph of (a), substituted "Medicaid/NJ" for "Medicaid-participating and NJ"; in (a)1, substituted "Medicaid/NJ" for "Medicaid or NJ" and for "Medicaid and NJ", and substituted "program" for "programs"; in the introductory paragraph of (b), substituted "Medicaid/NJ" for "Medicaid-reimbursable and NJ"; in (b)1, substituted "Medicaid/NJ" for "Medicaid and NJ"; in the introductory paragraph of (c)2, updated the CFR references, and inserted "payment for"; and deleted (c)2iii.

Annotations

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N.J.A.C. 10:66-1.6

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 66. INDEPENDENT CLINIC SERVICES > SUBCHAPTER 1. GENERAL PROVISIONS

§ 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.

History

HISTORY:

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.

Annotations

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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.

End of Document

N.J.A.C. 10:66-1.7

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 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. 10:66-6.

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 organization.

(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.

(f) The copayment for clinic services under NJ FamilyCare-Plan D shall be $ 5.00 per visit;

1. A $ 10.00 copayment shall apply for services rendered during non-clinic hours.

2. The $ 5.00 copayment shall apply only to the first prenatal visit.

(g) Clinics are required to collect the copayment specified in (f) above except for those situations described in (h) below. Copayments shall not be waived.

(h) Clinics will not charge a copayment under Plan D for services provided to newborns, who are covered under fee-for-service for Plan D; or for preventive services, including well child visits in accordance with the schedule recommended by the American Academy of Pediatrics; or for lead screening and treatment; or for age appropriate immunizations; or for preventive dental services covered for children under 12.

History

HISTORY:

New Rule, R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

See: *30 N.J.R. 1060(a)*.

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.

See: *30 N.J.R. 1060(a)*, *30 N.J.R. 3519(a)*.

Readopted the provisions of R.1998 d.154 with changes, effective September 21, 1998.

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)*.

In (a), added reference to copayments for NJ KidCare-Plan D; added (f) through (h).

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 "direction of a physician or dentist" for "supervision of the physician" in 1, and "beneficiary" for "child" in 2; substituted "FamilyCare" for "KidCare" throughout.

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

In (b)2, updated the N.J.A.C. reference; and in (d)1, substituted "organization" for "program".

Annotations

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N.J.A.C. 10:66-1.8

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:66-1.8 Medical exception process (MEP)

(a) For pharmacy claims that exceed Prospective Drug Utilization Review (PDUR) standards recommended by the New Jersey DUR Board and approved by the Commissioners of DHS and DOH, the Division of Medical Assistance and Health Services has established a Medical Exception Process (MEP).

(b) The medical exception process (MEP) shall be administered by a contractor, referred to as the MEP contractor, under contract with the Department of Human Services.

(c) The medical exception process shall apply to all pharmacy claims, regardless of claim media, unless there is a recommended exemption by the New Jersey DUR Board that has been approved by the Commissioners of DHS and DOH, in accordance with the rules of those Departments.

(d) The medical exception process is as follows:

1. The MEP contractor shall contact prescribers of conflicting drug therapies or drug therapies that exceed established PDUR standards to request written justification to determine medical necessity for continued drug utilization.

i. The MEP contractor shall send a Prescriber Notification Letter, which includes, but may not be limited to, the beneficiary name, Medicaid/NJ FamilyCare eligibility identification number, dispense date, drug quantity, and drug description. The prescriber shall be requested to provide the reason for medical exception, diagnosis, expected duration of therapy, and expiration date for medical exception.

ii. The prescriber shall provide information requested on the Prescriber Notification to the MEP contractor.

2. Following review and approval of a prescriber's written justification, if appropriate, the MEP contractor shall override existing PDUR edits through the issuance of a prior authorization number.

3. The MEP contractor shall notify the pharmacy and prescriber of the results of their review and include at a minimum, the beneficiary's name, mailing address, Medicaid/NJ FamilyCare eligibility identification number, the reviewer, service description, service date, and prior authorization number, if approved, the length of the approval, and the appeals process if the pharmacist does not agree with the results of the review.

4. Prescribers may request a fair hearing to appeal decisions rendered by the MEP contractor concerning denied claims. See N.J.A.C. 10:49-10, Notices, Appeals and Fair Hearings.

5. Claims subject to the medical exception process which have not been justified by the prescriber within 30 calendar days shall not be authorized by the MEP contractor and shall not be covered.

History

HISTORY:

New Rule, R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).

See: *31 N.J.R. 245(a)*, *31 N.J.R. 1956(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), inserted "Prospective Drug Utilization Review" preceding "(PDUR)".

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

In (a), substituted "that" for "with service dates on or after September 1, 1999, which"; in (a) and (c), substituted "DOH" for "DHSS"; in (c) and (d)1, substituted "that" for "which"; in (d)1, deleted a comma following the first occurrence of "therapies"; in (d)1i, inserted a comma following "Letter", inserted the first occurrence of "and", and substituted "Medicaid/NJ FamilyCare eligibility" for "HSP"; in (d)3, substituted "Medicaid/NJ FamilyCare eligibility identification" for "HSP", and inserted a comma following "approval"; and in (d)4, substituted ". See" for "(see", and deleted a closing parenthesis following "Hearings".

Annotations

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Chapter Notes

N.J.A.C. 10:66-2.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 66. INDEPENDENT CLINIC SERVICES > SUBCHAPTER 2. PROVISION OF SERVICES

§ 10:66-2.1 Introduction

This subchapter describes the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' policies and procedures for the provision of Medicaid-covered and NJ FamilyCare fee-for-service covered services in an independent clinic setting. Services, as described in N.J.A.C. 10:49-5, are separately identified and discussed only where unique characteristics or requirements exist. Unless indicated otherwise, reimbursement requirements are located in *N.J.A.C. 10:66-1.5*, Basis for reimbursement.

History

HISTORY:

Amended by R.1998 d.577, effective December 7, 1998.

See: *30 New Jersey Register 3434(a)*, *30 New Jersey Register 4225(b)*.

Inserted references to NJ KidCare fee-for-service throughout.

Amended by R.2004 d.208, effective June 7, 2004.

See: *36 New Jersey Register 324(a)*, *36 New Jersey Register 2834(a)*.

Inserted N.J.A.C. reference, substituted "requirements" for "issues" in the last sentence, and substituted "FamilyCare" for "KidCare" throughout.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:66-2.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 66. INDEPENDENT CLINIC SERVICES > SUBCHAPTER 2. PROVISION OF SERVICES

§ 10:66-2.2 Dental services

(a) All diagnostic, preventive or corrective dental procedures shall be administered by, or under, the direct supervision of a dentist enrolled in the New Jersey Medicaid and NJ FamilyCare fee-for-service program.

(b) Dental services provided in an independent clinic shall follow the policies and procedures outlined in the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' Dental Services chapter, *N.J.A.C. 10:56*.

(c) The New Jersey Medicaid and NJ FamilyCare fee-for-service programs' Dental Services chapter, N.J.A.C. 10:56-3 (HCPCS), contains dental procedure codes and maximum fee allowances.

History

HISTORY:

New Rule, R.1998 d.577, effective December 7, 1998.

See: *30 New Jersey Register 3434(a)*, *30 New Jersey Register 4225(b)*.

Former *N.J.A.C. 10:66-2.2*, Early and periodic screening, diagnosis and treatment (EPSDT), recodified to *N.J.A.C. 10:66-2.4*.

Amended by R.2004 d.208, effective June 7, 2004.

See: *36 New Jersey Register 324(a)*, *36 New Jersey Register 2834(a)*.

In (a), substituted "and" for "or" following "Medicaid"; substituted "FamilyCare" for "KidCare" throughout.

Annotations

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N.J.A.C. 10:66-2.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:66-2.3 Substance use disorder treatment services

(a) Substance use disorder treatment services provided in independent clinics include: substance use disorder outpatient rehabilitative services; substance use disorder intensive outpatient (IOP) services; substance use disorder partial care services; non-hospital based withdrawal management services; ambulatory outpatient withdrawal management services; short-term residential services; and opioid treatment and maintenance services, in accordance with *N.J.A.C. 10:161A* and 10:161B.

1. Medicaid and NJ FamilyCare fee-for-service beneficiaries shall be eligible for substance use disorder treatment facility services only if those services:

i. Are prescribed by a physician or an advanced practice nurse (APN) as described in (c) through (i) below;

ii. Meet the Federal financial participation requirements under Title XIX of the Social Security Act (*42 U.S.C. § 1396*);

iii. Are included in the facility's Medicaid or NJ FamilyCare fee-for-service approval letter; and

iv. Are licensed by the State of New Jersey Department of Human Services as per *N.J.A.C. 10:161A* for residential services, *N.J.A.C. 10:161B* for outpatient, and/or N.J.A.C. 10:161B-11 for opioid treatment services, as applicable.

(b) Medicaid and NJ FamilyCare fee-for-service beneficiaries shall receive a minimum of one counseling session per week during the first three months after initiation of treatment, and at least one counseling session every two weeks thereafter until discharged. See *N.J.A.C. 8:43A-26.5*.

(c) Substance use disorder outpatient rehabilitative services is a set of treatment activities designed to help the client achieve changes in his or her alcohol or other drug using behaviors. Outpatient rehabilitative services approximate ASAM Level of Care 1 and 2 and the services shall include: intake and assessment by appropriately licensed staff; and individual counseling, group counseling, and/or family counseling. See *N.J.A.C. 10:161B* for program standards including documentation, staffing, and licensing requirements. Services are provided in regularly scheduled sessions of fewer than nine contact hours per week in a licensed substance use disorder treatment facility.

1. Multiple services may be provided on the same date of service, but no more than one of the same service type.

2. Outpatient rehabilitative services shall not be billed on the same date of service as IOP services.

3. A physician visit may be provided and billed on the same date of service as any outpatient rehabilitative service.

4. Opioid treatment can be provided with outpatient services as per N.J.A.C. 10:161B-11.

5. In accordance with *N.J.A.C. 10:161B-8.1*, the intake assessment shall include obtaining health related information from the client and recording the information in the client's record. If there is an

indication for medical treatment or screening, the staff person shall coordinate referral for services. Resolution of health related problems shall be included as part of the comprehensive treatment plan and all referrals or treatment, and shall be documented in the client chart.

(d) Substance use disorder IOP services are bundled rehabilitative services designed to help clients change alcohol or drug use and related behaviors while receiving treatment in a licensed substance use disorder facility. This service consists of nine to 12 hours of service per week that are delivered at a minimum of three hours per day, for a minimum of three days per week. This level of care approximates ASAM level 2.1. Services shall include: individual counseling; group substance use disorder counseling; other group counseling; and family counseling. Services are provided as listed in N.J.A.C. 10:161B-11. IOP services cannot be combined with individual outpatient rehabilitative services or partial care services.

1. In accordance with *N.J.A.C. 10:161B-8.1*, the intake assessment shall include obtaining health related information from the client and recording the information in the client's record. If there is an indication for medical treatment or screening, the staff person shall coordinate referral for services. Resolution of health related problems shall be included as part of the comprehensive treatment plan and all referrals or treatment, and shall be documented in the client chart.

(e) Substance Use Disorder-Partial Care Services is a bundled service program that provides a broad range of clinically intensive treatment services in a structured environment for a minimum of 20 hours per week, up to five days per week at a licensed substance use disorder treatment facility. Services shall be delivered for no less than four hours per day. This level of care approximates ASAM level 2.5. Services shall include: individual counseling; group substance use disorder counseling; group counseling; family counseling; and lab services. Services are provided as described in *N.J.A.C. 10:161B*. Services are billed in units of one hour per day, with a maximum of five hours per day, not to exceed 25 units per week. Substance use disorder partial care services may be provided along with opioid treatment but cannot be provided concurrently with intensive outpatient services.

1. In accordance with *N.J.A.C. 10:161B-7.1*, a partial care program shall have written protocols to ensure ready access to psychiatric and medical services if needed.

2. In accordance with *N.J.A.C. 10:161B-8.1*, the intake assessment shall include obtaining health related information from the client and recording the information in the client's record. If there is an indication for medical treatment or screening, the staff person shall coordinate referral for services. Resolution of health related problems shall be included as part of the comprehensive treatment plan and all referrals or treatment, and shall be documented in the client chart.

(f) Non-hospital based withdrawal management rehabilitative services are provided in residential rehabilitative substance use disorder treatment facilities designed primarily to provide short-term care, which has been prescribed by a physician and conducted under medical supervision, to treat a client's physical symptoms caused by addiction according to medical protocols appropriate to each specific type of addiction. This level provides care to clients whose withdrawal signs and symptoms are sufficiently severe to require 23-hour medical monitoring care but can be monitored outside of an inpatient hospital setting. All other licensing requirements for medical services must be followed. This service generally approximates ASAM level 3.7D. Services are provided as listed in *N.J.A.C. 10:161A*.

(g) Ambulatory outpatient withdrawal management services shall be provided by substance use disorder treatment programs that have been approved by DMHAS to provide outpatient withdrawal management, including opioid treatment programs providing short-term, meaning less than 30 days, opiate withdrawal management using methadone and/or other approved medications. Programs shall accept and provide withdrawal management services only to clients who meet the ASAM Criteria, Level 1-D or 2-D. All programs must comply with N.J.A.C. 10:161B-12.

(h) Short-term residential services is rehabilitative treatment at a facility in which treatment is designed primarily to address specific addiction and living skills problems through a prescribed 23-hour per day activity regimen on a short-term basis. Short-term residential services shall provide a minimum of seven hours of structured programs provided on a billable day. Structured activities shall include a minimum of 12

hours per week of services including, but not limited to, individual counseling, group counseling, and family therapy. Service admission is recommended by a physician or a licensed practitioner within his or her scope of practice. This service approximates ASAM level 3.7 treatment services. Services are provided as listed in *N.J.A.C. 10:161A*.

(i) Opioid treatment and maintenance service programs dispense opioid agonist treatment medication, including methadone or other approved medications, along with a comprehensive range of medical and rehabilitative services, to the individual to alleviate the adverse medical, psychological, or physical effects related to opiate addiction. These services must be determined to be medically necessary by a licensed clinician and provided in compliance with State rules. This term encompasses: opioid withdrawal management, short-term withdrawal management, long-term withdrawal management, initial maintenance treatment, interim maintenance treatment, and comprehensive maintenance treatment. Opioid treatment programs providing withdrawal management that is less than 30 days shall comply with the provisions in N.J.A.C. 10:161B-12. Licensed opioid treatment programs shall comply with the standards set forth in N.J.A.C. 10:161B-11, including maintaining certification as an opioid treatment program with the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) and complying with all regulations enforced by the Drug Enforcement Administration (DEA), as referenced in N.J.A.C. 10:161B-11.

1. Effective for claims with dates of service on or after July 1, 2016, Medication Assisted Treatment (MAT) delivered by an Opioid Treatment Program (OTP) shall be billed with a bundled weekly rate. A bundled weekly rate applies to Methadone and non-Methadone opioid treatment services including, but not limited to, buprenorphine/buprenorphine-naloxone. The bundled weekly rate includes coverage for medication dispensing, drug costs, individual or group counseling sessions, a case management session, and medication monitoring related to MAT. The bundled rate does not include transportation, intensive outpatient services, or an intake or psychiatric evaluation. The same bundled weekly rate applies to Phase I-VI consumers.

2. The weekly bundled services billing rate shall begin the date of admission for seven days. Minimum billing requirements must be in accordance with provided services outlined in *N.J.A.C. 10:161B-11.8* and comply with DMHAS Annex A contracts provided to Opioid Treatment Providers upon approval as providers. If a replacement copy of the annex is needed, one can be obtained by sending a request to:

Division of Mental Health and Addiction Services

222 South Warren St.

PO Box 700

Trenton, NJ 08625-0700

History

HISTORY:

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. 10:66-2.3*, Family planning, recodified to *N.J.A.C. 10:66-2.5*.

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); in (c), amended the N.J.A.C. reference; added (d); and substituted "FamilyCare" for "KidCare" throughout.

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

Section was "Drug treatment center services". Rewrote the section.

Annotations

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End of Document

N.J.A.C. 10:66-2.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:66-2.4 Early and periodic screening, diagnostic and treatment (EPSDT) services program

(a) The early and periodic screening, diagnostic and treatment (EPSDT) services program is a Federally mandated comprehensive child health program for Medicaid and NJ FamilyCare fee-for-service beneficiaries from birth through 20 years of age. (See 42 CFR 441 Subpart B.)

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

1. An expanded program for Medicaid and NJ FamilyCare fee-for-service beneficiaries up to the age of two is known as HealthStart. For additional information, including provider enrollment requirements, see N.J.A.C. 10:66-3.

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

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

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

3. Appropriate immunizations according to age and health history;

4. Appropriate tests, including:

i. Hemoglobin/hematocrit;

ii. Urinalysis;

iii. Tuberculin test;

iv. Blood lead level assessment shall be performed for all children between nine through 18 months of age (preferably at 12 months) and again at two years of age. In addition, between the ages of two and six years, a child shall be screened if there is no evidence of prior screening;

v. Other medically-necessary procedures;

5. Health education, including anticipatory guidance; and

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

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

1. Under six weeks;

2. Two months;

3. Four months;

4. Six months;

5. Nine months;

6. 12 months;

7. 15 months;

8. 18 months;

9. 24 months; and

10. Annually through age 20.

(e) Vision screening shall include the following:

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

2. An appropriate medical and family history;

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

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

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

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

ii. Second grade (seven years);

iii. Fifth grade (10-11 years);

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

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

6. Children should be referred for further evaluation if they:

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

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

iii. Have suspected strabismus; or

iv. Have an abnormal light or red reflex.

(f) The following apply to dental screening:

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

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

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

(g) The following apply to hearing screening:

1. Hearing screening shall be included in all preventive periodic examinations.

2. Audiometric testing shall be administered annually to all children between three and eight years of age. After age eight, children shall be tested every other year.

History

HISTORY:

Recodified from *N.J.A.C. 10:66-2.2* and 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. Former *N.J.A.C. 10:66-2.4*, Laboratory, recodified to *N.J.A.C. 10:66-2.6*.

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.2009 d.376, effective December 21, 2009.

See: *41 N.J.R. 2561(a)*, *41 N.J.R. 4791(a)*.

Section was "Early and periodic screening, diagnosis and treatment (EPSDT)". In (a), substituted "The early" for "Early" and "diagnostic" for "diagnosis", and inserted "services program".

Annotations

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N.J.A.C. 10:66-2.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:66-2.5 Family planning services

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

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

(b) Subdermal contraceptive implants are a Medicaid-covered and NJ FamilyCare fee-for-service-covered service when provided as follows:

1. Subdermal contraceptive implants are used only in reproductive age women with established regular menstrual cycles;

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

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

4. A clinic visit relating only to the insertion or removal of the subdermal contraceptive implants is not reimbursable on the day of the insertion or removal.

5. Only two insertions and two removals of subdermal contraceptive implants per beneficiary are permitted during the FDA-approved clinically appropriate timeframe for the specific device.

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

History

HISTORY:

Recodified from *N.J.A.C. 10:66-2.3* and 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; in (b), substituted a reference to beneficiaries for a reference to recipients in 5; and deleted a former (c). Former *N.J.A.C. 10:66-2.5*, Mental health, recodified to *N.J.A.C. 10:66-2.7*.

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)1, substituted "Utilization Management" for "Medical Affairs and Provider Relations"; substituted "FamilyCare" for "KidCare" throughout.

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

Rewrote (b).

Annotations

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N.J.A.C. 10:66-2.6

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 66. INDEPENDENT CLINIC SERVICES > SUBCHAPTER 2. PROVISION OF SERVICES

§ 10:66-2.6 Laboratory services

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

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

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

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

(e) The outpatient substance use disorder treatment program shall provide laboratory services directly in the program or shall ensure the availability of services through written affiliation agreements, as indicated in N.J.A.C. 10:161B-13.

History

HISTORY:

Recodified from N.J.A.C. 10:66-2.4 and amended by R.1998 d.577, effective December 7, 1998.

See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).

In (a) and (b), inserted references to NJ KidCare fee-for-service. Former N.J.A.C. 10:66-2.6, Rehabilitation, recodified to N.J.A.C. 10:66-2.13.

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.

Amended by R.2017 d.113, effective June 5, 2017.

See: 48 N.J.R. 2737(a), 49 N.J.R. 1405(a).

Added (e).

Annotations

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N.J.A.C. 10:66-2.7

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:66-2.7 Mental health services

(a) Mental health services shall include comprehensive intake evaluation, individual psychotherapy, off-site crisis intervention, family therapy, family conference, group psychotherapy, psychological testing, partial care, and medication management. Mental health services shall not include:

1. Student education, including preparation of school-assigned classwork or homework; or

2. Incentive programs, including, but not limited to, non-therapeutic token economies and subcontract work responsibilities.

(b) Only one type of mental health service per beneficiary shall be reimbursable to an independent clinic per day, with the following exceptions:

1. Medication management may be reimbursed when provided to a Medicaid or NJ FamilyCare fee-for-service beneficiary in addition to one of the following mental health services: assessment, individual psychotherapy, group psychotherapy, family therapy, and family conference.

2. Individual, group, or family psychotherapy services may be provided on the same date of service, but are limited to one unit each of individual psychotherapy, group psychotherapy, family therapy, or family conference. A maximum of three individual or group psychotherapy sessions may be provided per day, but are limited to five units per week. The provision of multiple services in one day is meant to supplant the need for partial care services and may not be billed on the same date of service as partial care.

3. An assessment may be completed on the same date of service as individual, group, or family therapy, but shall count toward the total of three units per day and five units per week.

4. Evaluation and management by a physician or APN may be provided concurrently with assessment or psychotherapy services and shall not count toward the total of three units per day or five units per week.

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

(d) For purposes of partial care, full day means five or more hours of participation in active programming exclusive of meals, breaks and transportation; half day means at least three hours but less than five hours of participation in active programming exclusive of meals, breaks and transportation. The smallest unit of partial care that may be prior authorized by NJ Medicaid/FamilyCare is one hour, with a minimum of two hours per day and a maximum of five hours per day. For example, prior authorization for a full day of partial care (five hours) shall be reflected as five units, four hours shall be reflected as four units, a half day (three hours) shall be reflected as three units, and two hours shall be reflected as two units. Additional details are located at N.J.A.C. 10:66-6.

(e) (Reserved.)

(f) The Division shall reimburse a provider for prevocational services provided within the context of a partial care program. Prevocational services shall be interventions, strategies, and activities, within the context of

a partial care program, that assist individuals to acquire general work behaviors, attitudes, and skills needed to take on the role of worker and in other life domains, such as responding appropriately to criticism, decision making, negotiating for needs, dealing with interpersonal issues, managing psychiatric symptoms, and medication adherence. Services or interventions which are not considered prevocational will not be reimbursed by the Medicaid and NJ FamilyCare programs. Examples of services or interventions not considered to be prevocational include:

1. Technical or occupational skills training;

2. College preparation;

3. Student education, including preparation of school-assigned classwork or homework; and

4. Individualized job development.

(g) The Division will not reimburse any provider for vocational services provided within the context of a partial care program.

1. Vocational services shall be those interventions, strategies, and activities that assist individuals to acquire skills to enter a specific occupation and take on the role of colleague, that is, a member of a profession, and/or assist the individual to directly enter the workforce and take on the role of an employee, working as a member of an occupational group for pay with a specific employer.

(h) When, in the judgment of the treatment team, an individual is determined appropriate for discharge or referral to another employment-related service provider or situation, and has demonstrated mastery of individualized goals and objectives, such as: an ability to respond appropriately to criticism, make decisions, negotiate for needs, deal with interpersonal issues, manage psychiatric symptoms and adhere to medical prescriptions, the service provider shall:

1. Update the individual treatment goal;

2. Revise the discharge plan; and

3. Refer the individual to a community work setting, if such referral is appropriate for the individual.

(i) The Division will reimburse a provider for prevocational services provided to eligible beneficiaries within the context of a partial care program when the services consist of therapeutic subcontract work activity, and when all of the following requirements are met:

1. The therapeutic subcontract work activity shall consist of production, assembly and/or packing/collating tasks for which individuals with disabilities performing these tasks are paid less than minimum wage, and, pursuant to 29 C.F.R. § 525, a special minimum wage certificate has been issued to the organization/program by the U.S. Department of Labor;

2. The individual's plan of care shall contain a stipulation that the therapeutic subcontract work activity is a form of intervention intended to address the individual deficits of the patient as identified in the client's assessment;

3. The therapeutic subcontract work activity shall be facilitated by a qualified mental health services worker;

4. The therapeutic subcontract work activity shall be performed within the line of sight of the qualified mental health services worker; and

5. The staff to client ratio shall not exceed a ratio of 1:10 qualified mental health services worker to client.

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

1. Evaluates the beneficiary's mental condition;

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

3. Includes certification, in the form of a signed statement, by the evaluation team, that the program is appropriate to meet the beneficiary's treatment needs; and

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

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

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

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

i. Due to the nature of mental illness and the provision of program services, there may be instances in which a temporary deviation from the services written in the treatment plan occurs. In this event, the client may participate in alternate programming. The reason for the deviation should be clearly explained in the daily or weekly documentation. Deviations that do not resolve shall require a written change in the treatment plan;

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

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

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

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

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

i. The specific services rendered, such as individual psychotherapy, group psychotherapy, family therapy, etc., and a description of the encounter itself. The description shall include, but is not limited to, a statement of patient progress noted, significant observations noted, etc.;

ii. The date and time that services were rendered;

iii. The duration of services provided;

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

v. The setting in which services were rendered; and

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

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

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

(m) Periodic review of the beneficiary's plan of care shall take place at least every 90 days during the first year and every six months thereafter.

1. The periodic review shall determine:

i. The beneficiary's progress toward the treatment objectives;

ii. The appropriateness of the services being furnished; and

iii. The need for the beneficiary's continued participation in the program.

2. Periodic reviews shall be documented in detail in the beneficiary's records and made available upon request to the New Jersey Medicaid or NJ FamilyCare program or its agents.

(n) When requesting reimbursement for the following HCPCS procedure codes for rehabilitative services, a separate service line shall be completed for each day that the service is provided. Providers shall not "span bill" for services.

90870

History

HISTORY:

Recodified from *N.J.A.C. 10:66-2.5* and 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; in (b), inserted a reference to NJ KidCare fee-for-service; and in (h)2, inserted a reference to NJ KidCare. Former *N.J.A.C. 10:66-2.7*, Transportation services, recodified to *N.J.A.C. 10:66-2.17*.

Amended by R.2003 d.69, effective February 3, 2003.

See: *34 N.J.R. 3183(a)*, *35 N.J.R. 888(a)*.

In (b) and (h)2, substituted "NJ FamilyCare" for "NJ KidCare"; added (i).

Amended by R.2004 d.75, effective February 17, 2004.

See: *35 N.J.R. 2154(a)*, *36 N.J.R. 952(b)*.

Rewrote (a), (b) and (d); added new (e) through (i); recodified former (e) through (i) as (j) through (n).

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.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

Rewrote the section.

Annotations

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Case Notes

Initial Decision (2005 N.J. AGEN LEXIS 1319) adopted, which concluded that a mental health service provider improperly billed full-day rates for children who did not receive the required full five hours of care and that the facility's executive officer was personally liable, within the meaning of *N.J.S.A. 30:4D-7(h)*, for any incorrect or illegal Medicaid payments. *Hentz v. DMAHS, OAL Dkt. No. HMA 5140-04, 2005 N.J. AGEN LEXIS 1320*, Final Decision (November 18, 2005).

Executive officer of a mental health service provider was required to produce sufficient back-up for claims for partial care under Medicaid; since the officer was put on notice in June 2000 that the 1997-1999 dates of service were being questioned, the documents should have been safeguarded. *Hentz v. DMAHS, OAL Dkt. No. HMA 5140-04, 2005 N.J. AGEN LEXIS 1320*, Final Decision (November 18, 2005).

End of Document

N.J.A.C. 10:66-2.8

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§ 10:66-2.8 (Reserved)

History

HISTORY:

New Rule, R.1998 d.577, effective December 7, 1998.

See: *30 New Jersey Register 3434(a)*, *30 New Jersey Register 4225(b)*.

Former *N.J.A.C. 10:66-2.8*, Miscellaneous, recodified to *N.J.A.C. 10:66-2.19*.

Repealed by R.2004 d.208, effective June 7, 2004.

See: *36 New Jersey Register 324(a)*, *36 New Jersey Register 2834(a)*.

Section was "Obstetrical services".

Annotations

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N.J.A.C. 10:66-2.9

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§ 10:66-2.9 Other services

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

History

HISTORY:

New Rule, R.1998 d.577, effective December 7, 1998.

See: *30 New Jersey Register 3434(a)*, *30 New Jersey Register 4225(b)*.

Amended by R.2004 d.208, effective June 7, 2004.

See: *36 New Jersey Register 324(a)*, *36 New Jersey Register 2834(a)*.

Inserted "E/M" following "evaluation and management" in the first sentence and substituted "FamilyCare" for "KidCare" in the final sentence.

Annotations

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N.J.A.C. 10:66-2.10

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§ 10:66-2.10 Pharmaceutical services

(a) For covered pharmaceutical services, see the New Jersey Medicaid and NJ FamilyCare fee-for-service program's Pharmaceutical Services chapter, *N.J.A.C. 10:51*.

(b) For specific requirements for the provision of pharmaceutical services in independent clinics, in addition to those in (a) above, providing substance use disorder treatment services, see N.J.A.C. 10:161B-14.

History

HISTORY:

New Rule, R.1998 d.577, effective December 7, 1998.

See: *30 N.J.R. 3434(a)*, *30 N.J.R. 4225(b)*.

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".

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

Rewrote the section.

Annotations

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N.J.A.C. 10:66-2.11

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§ 10:66-2.11 Podiatric services

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

History

HISTORY:

New Rule, R.1998 d.577, effective December 7, 1998.

See: *30 N.J.R. 3434(a)*, *30 N.J.R. 4225(b)*.

Amended by R.2004 d.208, effective June 7, 2004.

See: *36 N.J.R. 324(a)*, *36 N.J.R. 2834(a)*.

Designated existing text as (a) and substituted "FamilyCare" for "KidCare" throughout; added (b).

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

Deleted (b).

Annotations

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N.J.A.C. 10:66-2.12

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

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§ 10:66-2.12 Radiological services

Specified radiological services may be reimbursed when provided in a clinic that is specifically approved to provide such services by the New Jersey Department of Environmental Protection, Radiation Protection Element, and performed by or under the direction of a physician who is recognized as a specialist in radiology by the New Jersey Medicaid and NJ FamilyCare fee-for-service programs. See the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' Physician's Services chapter, *N.J.A.C. 10:54*, for additional information.

History

HISTORY:

New Rule, R.1998 d.577, effective December 7, 1998.

See: *30 N.J.R. 3434(a)*, *30 N.J.R. 4225(b)*.

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.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

Substituted "Radiation Protection Element" for "Bureau of Radiological Health (see N.J.A.C. 7:28-22)".

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N.J.A.C. 10:66-2.13

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:66-2.13 Rehabilitative services

(a) Rehabilitative services, as provided in an independent clinic setting, include physical therapy, occupational therapy, speech-language pathology and audiology, including the use of such supplies and equipment as are necessary in the provision of such services. Rehabilitative services are provided for the purpose of attaining maximum reduction of physical or mental disability. Rehabilitative services shall be made available to Medicaid and NJ FamilyCare fee-for-service beneficiaries as an integral part of a comprehensive medical program.

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

1. All treatments shall be individual and shall consist of a minimum of 30 minutes.

2. A plan of treatment shall be completed during the Medicaid or NJ FamilyCare fee-for-service beneficiary's initial evaluation visit and retained on file.

i. The plan of treatment shall be definitive as to the type, amount, frequency, and duration of the rehabilitative services that are to be furnished and shall include the beneficiary's diagnosis and the anticipated goal(s) of the treatment.

(c) Physical therapy is a service prescribed by a physician or an advanced practice nurse and provided to a Medicaid or NJ FamilyCare fee-for-service beneficiary by or under the direction of a qualified physical therapist. Physical therapy does not include therapy which is purely palliative, such as the application of heat in any form; massage; routine calisthenics; group exercises; assistance in any activity; use of a simple mechanical device; or other services not requiring the special skill of a licensed physical therapist.

1. A physical therapist is an individual who is:

i. Licensed by the New Jersey Department of Law and Public Safety, State Board of Physical Therapy as a physical therapist in accordance with *N.J.A.C. 13:39A*; and

ii. A graduate of a program of physical therapy accredited by an accrediting agency recognized by the Council on Post-Secondary Accreditation and the United States Department of Education.

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

(d) Occupational therapy is a service prescribed by a physician or an advanced practice nurse and provided to a Medicaid or NJ FamilyCare fee-for-service beneficiary by or under the direction of a qualified occupational therapist.

1. An occupational therapist is an individual who is:

i. Licensed by the New Jersey Occupational Therapy Advisory Council as an occupational therapist in accordance with *N.J.A.C. 13:44K-2.1(a)*; and

ii. A graduate of a program in occupational therapy accredited by the American Occupational Therapy Association, the World Federation of Occupational Therapy or other nationally-recognized occupational therapist accrediting agency.

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

(e) Speech-language pathology services and audiology services are diagnostic, screening, preventive, or corrective services prescribed by a physician or an advanced practice nurse and provided to a Medicaid or NJ FamilyCare fee-for-service beneficiary by or under the direction of a speech-language pathologist or audiologist.

1. A speech-language pathologist or audiologist is an individual who is licensed by the State of New Jersey as a speech-language pathologist or audiologist, in accordance with *N.J.A.C. 13:44C*, and meets all applicable Federal requirements including:

i. A Certificate of Clinical Competence in Speech-Language Pathology or Audiology from the American Speech-Language-Hearing Association;

ii. Completion of the equivalent educational requirements and work experience necessary for the certificate(s); or

iii. Completion of the academic program and in the process of acquiring supervised work experience in order to qualify for the certificate(s).

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

(f) Clinic visits billed during the same day shall clearly and separately meet the time and other parameters described in the applicable HCPCS procedure codes, N.J.A.C. 10:66-6.

(g) When the same type of rehabilitative service, regardless of modality, is provided to a Medicaid or NJ FamilyCare fee-for-service beneficiary more than once on the same day, for example, two physical therapy sessions, reimbursement shall be made for one service only. Reimbursement shall be made for a maximum of three units (one unit equals a 30-minute therapy session) per beneficiary per day.

(h) When requesting reimbursement for the following HCPCS procedure codes for rehabilitative services, a separate service line shall be completed for each day that the service is provided. Providers shall not "span bill" for services.

92507

97535

97799

History

HISTORY:

Recodified from *N.J.A.C. 10:66-2.6* and 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.2003 d.69, effective February 3, 2003.

See: *34 N.J.R. 3183(a)*, *35 N.J.R. 888(a)*.

Substituted "NJ FamilyCare" for "NJ KidCare" throughout; added (i).

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.2009 d.376, effective December 21, 2009.

See: *41 N.J.R. 2561(a)*, *41 N.J.R. 4791(a)*.

In (h), inserted HCPCS procedure code "97535" and deleted HCPCS procedure code "H5300" following code "97799".

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N.J.A.C. 10:66-2.14

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

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§ 10:66-2.14 Renal dialysis service for end-stage renal disease (ESRD)

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

History

HISTORY:

New Rule, R.1998 d.577, effective December 7, 1998.

See: *30 New Jersey Register 3434(a)*, *30 New Jersey Register 4225(b)*.

Amended by R.2004 d.208, effective June 7, 2004.

See: *36 New Jersey Register 324(a)*, *36 New Jersey Register 2834(a)*.

Substituted "in accordance with" for "as indicated in" preceding N.J.A.C. reference.

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N.J.A.C. 10:66-2.15

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:66-2.15 Sterilization services

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

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

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

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

ii. An institutionalized individual is an individual who is:

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

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

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

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

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

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

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

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

(1) Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without

loss or withdrawal of any Federally funded program benefits to which the individual might otherwise be entitled;

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

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

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

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

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

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

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

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

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

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

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

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

i. In labor or childbirth;

ii. Seeking to obtain or obtaining termination of pregnancy services; or

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

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

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

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

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

History

HISTORY:

New Rule, R.1998 d.577, effective December 7, 1998.

See: *30 N.J.R. 3434(a)*, *30 N.J.R. 4225(b)*.

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

In (a)5i, inserted a comma preceding and following "orally"; in (a)5i(7), substituted "(a)4" for "(c)4" and a semicolon for a period; and in (a)6ii, substituted "termination of pregnancy services" for "an abortion".

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N.J.A.C. 10:66-2.16

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:66-2.16 Termination of pregnancy

(a) Termination of pregnancy is a Medicaid and NJ FamilyCare fee-for-service-covered service when the following conditions are present:

1. The procedure is performed in an appropriately licensed ambulatory care facility, an ambulatory surgical center, or an ambulatory care/family planning/surgical facility licensed and authorized by the New Jersey State Department of Health to perform terminations of pregnancy with specific approval of the New Jersey Medicaid or NJ FamilyCare program;

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

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

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

i. To save the life of the mother;

ii. The pregnancy was the result of an act of rape;

iii. The pregnancy was the result of an act of incest;

iv. Physical, emotional, and psychological factors;

v. Family reasons; and

vi. Age.

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

(c) A Physician Certification (Form FD-179) shall be completed, signed and attached to any Medicaid or NJ FamilyCare fee-for-service claim form relating to termination of pregnancy services.

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

History

HISTORY:

New Rule, R.1998 d.577, effective December 7, 1998.

See: *30 N.J.R. 3434(a)*, *30 N.J.R. 4225(b)*.

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 "abortion" for "family planning/surgical" preceding "facility" in 1, added new i to iii and recodified former i to iii as iv to vi in 4; in (c), inserted "completed, signed and" following "(Form FD-179) shall be"; and substituted "FamilyCare" for "KidCare" throughout.

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

In the introductory paragraph of (a), substituted "Medicaid" for "Medicaid-covered"; and in (a)1, deleted "and Senior Services" following "Health", and substituted "terminations of pregnancy" for "abortions".

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N.J.A.C. 10:66-2.17

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:66-2.17 Transportation services

(a) Transportation services shall be covered under the Medicaid and NJ FamilyCare-Plan A, B, C, and D programs and the Alternate Benefit Program (ABP) when the following conditions are met:

1. The clinic is approved to provide transportation service by the Division to partial care programs only.

i. Approval by the Division shall not be granted for the provision of ambulance or mobility assistance vehicle (MAV) service.

2. Transportation service to the partial care programs is provided either:

i. By the clinic, in a clinic owned or leased vehicle; or

ii. By a transportation company under contract to the clinic, which meets the requirements of *N.J.A.C. 10:49-9.8* and (b) below.

3. The purpose of providing transportation, one way or round trip, is to enable a Medicaid/NJ FamilyCare or ABP beneficiary to obtain partial care services.

4. A Medicaid/NJ FamilyCare or ABP beneficiary is transported:

i. To the clinic, from the beneficiary's residence or a designated central point; or

ii. From the clinic, to the beneficiary's residence or a designated central point.

5. The least expensive mode of transportation suitable to the beneficiary's needs shall be used, as indicated at *N.J.A.C. 10:50-1.6(a)*.

i. A clinic shall not seek reimbursement from the Medicaid or NJ FamilyCare programs for the transport of an individual who is capable of utilizing an accessible, alternative mode of transportation at a lesser cost to the Medicaid or NJ FamilyCare programs, such as a bus pass provided by the transportation broker for the beneficiary's use.

ii. Prior to seeking reimbursement from the Medicaid or NJ FamilyCare programs for a clinic-provided or subcontracted transportation service, the patient's medical record shall contain documentation concerning the individual's specific transportation-related needs, including the reason(s) why an accessible, alternative less-expensive mode of service is not appropriate.

iii. Following are examples of factors that may be considered when determining the individual's ability to use an alternative mode of service: walking distance to/from the points of pick up and discharge, weather conditions at the time of transport, time of day or night, safety issues, the patient's need for an escort/attendant, and the patient's inability to access public transportation.

(b) Each vehicle used by a clinic or its subcontractor(s) in providing services to a Medicaid or NJ FamilyCare beneficiary shall be appropriately registered by the New Jersey Motor Vehicle Commission, in accordance with all applicable laws and rules of the New Jersey Motor Vehicle Commission, Title 39 of the Revised Statutes, or the New Jersey Department of Transportation, Title 27 of the Revised Statutes).

1. All applicable Federal and State motor vehicle laws shall be followed, including laws governing seat belts and infant car seats.

(c) Each person (driver) who operates a motor vehicle under the terms of this section shall possess and have readily available for inspection a current and valid New Jersey driver's license, as required by Title 39 of the Revised Statutes of New Jersey.

1. A driver of a commercial motor vehicle that is designed to transport eight to 15 passengers including the driver (Group C), and is used for hire, shall possess a commercial driver's license (CDL) with a passenger endorsement issued by the New Jersey Motor Vehicle Commission, in accordance with *N.J.S.A. 39:3-10.11* and *N.J.A.C. 13:21-23.5*;

2. Each driver shall be at least 18 years old;

3. (Reserved)

4. Each driver shall wear an identification badge that includes his or her name and the name of the transportation company or the clinic;

5. Each driver shall maintain an acceptable standard of personal grooming and behavior in order to present a neat, clean and professional appearance while providing services to Medicaid/NJ FamilyCare fee-for-service beneficiaries;

6. Each driver shall assist beneficiaries in entering and leaving the vehicle by using a step stool if necessary, and shall provide door-through-door escort and assistance, if necessary, at the beneficiary's place of departure and destination;

7. Each driver shall supervise the well being of individuals while in the vehicle to ensure their privacy, comfort, and appropriate care;

8. Each driver shall ensure that all vehicle occupants wear automobile safety belts;

9. Each driver shall operate the vehicle in a safe manner, starting and stopping slowly and smoothly, and complying with all applicable motor vehicle laws;

10. Each driver shall ensure that smoking is prohibited within the vehicle at all times;

11. No person shall be allowed to operate a vehicle under the terms of this section:

i. While under the influence of intoxicating liquor or narcotic or habit forming drugs;

ii. In a reckless manner;

iii. At excessive speed; or

iv. While engaging in any illegal conduct.

(d) (Reserved)

History

HISTORY:

Recodified from *N.J.A.C. 10:66-2.7* and 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.1998 d.581, effective December 21, 1998.

See: *30 N.J.R. 2809(a)*, *30 N.J.R. 4383(a)*.

Rewrote the section.

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)1i, substituted "mobility assistance vehicle (MAV) service" for "invalid coach service"; added (c); and substituted "FamilyCare" for "KidCare" throughout.

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

Rewrote (a) and (b).

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N.J.A.C. 10:66-2.18

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§ 10:66-2.18 Vision care services

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

History

HISTORY:

New Rule, R.1998 d.577, effective December 7, 1998.

See: *30 New Jersey Register 3434(a)*, *30 New Jersey Register 4225(b)*.

Amended by R.2004 d.208, effective June 7, 2004.

See: *36 New Jersey Register 324(a)*, *36 New Jersey Register 2834(a)*.

Substituted "FamilyCare" for "KidCare" throughout.

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N.J.A.C. 10:66-2.19

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§ 10:66-2.19 (Reserved)

History

HISTORY:

Recodified from N.J.A.C. 10:66-2.8 and amended by R.1998 d.577, effective December 7, 1998.

See: 30 N.J.R. 3434(a), 30 N.J.R. 4225(b).

Rewrote the section.

Amended by R.2004 d.208, effective June 7, 2004.

See: 36 N.J.R. 324(a), 36 N.J.R. 2834(a).

Deleted (a); recodified former (b) as (a) and substituted "beneficiary's" for "recipient's" in the introductory paragraph of 1, and inserted "for the mentally ill" following "personal care assistant services" in 4(1); and substituted "FamilyCare" for "KidCare" throughout.

Repealed by R.2017 d.113, effective June 5, 2017.

See: 48 N.J.R. 2737(a), 49 N.J.R. 1405(a).

Section was "Personal care assistant (PCA) services (mental health)".

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N.J.A.C. 10:66-2.20

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:66-2.20 Vaccines for Children program

(a) The Vaccines for Children (VFC) program provides free vaccines for administration to beneficiaries under 19 years of age who are eligible for New Jersey Medicaid and NJ FamilyCare--Plan A services. The vaccines covered under the VFC program may also be provided to any child without health insurance and to any child who is an American Indian or an Alaskan Native.

(b) Providers shall receive an enhanced administration fee for the administration of vaccines ordered directly from the VFC Program. The Medicaid/NJ FamilyCare--Plan A program shall not provide reimbursement to providers for administering vaccines that are not obtained from the VFC program.

(c) The Centers for Disease Control and Prevention (CDC) is expected to periodically update the approved list of vaccines covered under the VFC program. The Medicaid/NJ FamilyCare--Plan A program will not reimburse for any vaccine so added to the VFC list of approved vaccines that are not obtained from the VFC program. Upon receipt of updates from the CDC, the Medicaid/NJ FamilyCare Program will update the list of VFC-covered vaccines at *N.J.A.C. 10:66-6.2(q)* by notice of administrative change.

(d) Providers shall bill the HCPCS procedure codes 90465, 90466, 90467, 90468, 90471, 90472, 90473 or 90474 when administering vaccines under this program, as appropriate.

(e) Vaccines which are covered by the VFC program but are administered to beneficiaries over 19 years of age shall be billed with only the appropriate HCPCS procedure code and be reimbursed the fee-for-service rate. The administration fee is included in the reimbursement for the vaccine.

History

HISTORY:

New Rule, R.2009 d.376, effective December 21, 2009.

See: *41 N.J.R. 2561(a)*, *41 N.J.R. 4791(a)*.

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

In (c), inserted "and Prevention".

Annotations

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§ 10:66-2.20 Vaccines for Children program

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N.J.A.C. 10:66-3.1

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§ 10:66-3.1 Purpose

(a) The purpose of HealthStart is to provide for comprehensive maternity care services to pregnant Medicaid and NJ FamilyCare fee-for-service beneficiaries, including those determined to be presumptively eligible, and preventive child health care services for Medicaid beneficiaries up to the age of two and NJ FamilyCare fee-for-service beneficiaries.

1. Pediatric HealthStart services are an expansion of the EPSDT program as described at *N.J.A.C. 10:66-2.4*.

History

HISTORY:

Amended by R.1998 d.577, effective December 7, 1998.

See: *30 New Jersey Register 3434(a)*, *30 New Jersey Register 4225(b)*.

In (a), inserted references to NJ KidCare fee-for-service and substituted references to beneficiaries for references to recipients in the introductory paragraph, and changed N.J.A.C. reference in 1.

Amended by R.2004 d.208, effective June 7, 2004.

See: *36 New Jersey Register 324(a)*, *36 New Jersey Register 2834(a)*.

In (a), substituted "FamilyCare" for "KidCare" throughout the introductory paragraph.

Annotations

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N.J.A.C. 10:66-3.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:66-3.2 Scope of services

(a) HealthStart maternity care services provided by a HealthStart-certified provider are obstetrical care services provided in accordance with the recommendations of the American College of Obstetricians and Gynecologists and a program of support services provided in accordance with N.J.A.C. 10:54-6. HealthStart pediatric care services include up to nine preventive visits, as recommended by the American Academy of Pediatrics, provided by a HealthStart-certified provider who assumes the primary responsibility for coordination and continuity of care.

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

1. Medical maternity care services include:

i. Ambulatory prenatal services;

ii. Admission arrangements for delivery;

iii. Obstetrical delivery services; and

iv. Postpartum medical services.

2. Health support services include:

i. Case coordination services;

ii. Health education assessment and counseling services;

iii. Nutrition assessment and counseling services;

iv. Social-psychological assessment and counseling services;

v. Home visitation; and

vi. Outreach, referral and follow-up services.

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

History

HISTORY:

Amended by R.2004 d.208, effective June 7, 2004.

See: *36 New Jersey Register 324(a)*, *36 New Jersey Register 2834(a)*.

In (a), rewrote the first sentence.

Annotations

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N.J.A.C. 10:66-3.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:66-3.3 HealthStart provider participation criteria

(a) The following Medicaid-enrolled and NJ FamilyCare fee-for-service-enrolled provider types are eligible to participate as HealthStart providers: independent clinics, hospital outpatient departments, local health departments, physician groups, and certified nurse midwives meeting the New Jersey State Department of Health Improved Pregnancy Outcome criteria.

(b) In addition to New Jersey Medicaid and NJ FamilyCare fee-for-service programs' rules applicable to provider participation, HealthStart providers shall:

1. Sign an Addendum to the New Jersey Medicaid and NJ FamilyCare fee-for-service programs' Provider Agreement;

2. Have a valid HealthStart Provider Certificate for HealthStart Maternity Care Service, HealthStart Medical Maternity Service, HealthStart Health Support Service, or HealthStart Pediatric Care Service; and

3. Provide maternity care and/or pediatric care services in accordance with the requirements for issuance of a HealthStart Provider Certificate and in accordance with N.J.A.C. 10:54-6.

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

1. Shall participate in program evaluation and training activities, including, but not limited to, site monitoring, agency and patient record review, and submission of required summary information on each patient according to N.J.A.C. 10:54-6; and

2. May determine presumptive eligibility for the New Jersey Medicaid and NJ FamilyCare fee-for-service programs if approved by the Division of Medical Assistance and Health Services.

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

(e) A site review may be required to ascertain an applicant's ability to meet the standards for a HealthStart Provider Certificate and to provide services in accordance with N.J.A.C. 10:54-6.

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

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

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

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

Chief, Provider Enrollment Unit
Division of Medical Assistance and Health Services
Mail Code #9
PO Box 712
Trenton, NJ 08625-0712

History

HISTORY:

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)*.

Rewrote (a); substituted N.J.A.C. reference for references to the New Jersey State Department of Health and Senior Services' Guidelines for HealthStart throughout, and substituted "FamilyCare" for "KidCare" throughout.

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

In (a), deleted "and Senior Services' " following "Health"; and in (f) and the address in (g), deleted "and Senior Services" following "Health".

Annotations

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Chapter Notes

N.J.A.C. 10:66-3.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 66. INDEPENDENT CLINIC SERVICES > SUBCHAPTER 3. HEALTHSTART

§ 10:66-3.4 Termination of HealthStart Provider Certificate

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

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

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

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

History

HISTORY:

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)1, 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).

In (b)1, substituted "FamilyCare" for "KidCare".

Amended by R.2017 d.113, effective June 5, 2017.

See: 48 N.J.R. 2737(a), 49 N.J.R. 1405(a).

In (a), the introductory paragraph of (b), and (b)2, deleted "and Senior Services" following "Health".

Annotations

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§ 10:66-3.4 Termination of HealthStart Provider Certificate

Chapter Notes

N.J.A.C. 10:66-3.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 66. INDEPENDENT CLINIC SERVICES > SUBCHAPTER 3. HEALTHSTART

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

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

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

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

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

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

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

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

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

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

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

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

Annotations

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End of Document

N.J.A.C. 10:66-3.6

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 66. INDEPENDENT CLINIC SERVICES > SUBCHAPTER 3. HEALTHSTART

§ 10:66-3.6 Access to service

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

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

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

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

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

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

Annotations

Notes

Chapter Notes

End of Document

§ 10:66-3.7 Care plan

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

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

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

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

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

Annotations

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N.J.A.C. 10:66-3.8

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:66-3.8 Maternity medical care services

(a) Maternity medical care services include antepartum, intrapartum and postpartum care provided by the obstetrical care practitioner(s) in accordance with N.J.A.C. 10:54-6.

(b) Prenatal services are as follows:

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

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

i. History;

ii. Review of systems;

iii. Comprehensive physical examination;

iv. Risk assessment;

v. Patient counseling;

vi. Routine laboratory tests;

vii. Development of the care plan; and

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

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

i. Review and revision of the patient care plan;

ii. Interim history;

iii. Physical examination;

iv. Patient counseling and treatment;

v. Laboratory tests;

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

vii. Identification of new or developing problems; and

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

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

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

1. Determination of and arrangements for delivery site;

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

3. Medical care during the entire period of confinement.

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

1. History;

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

3. Physical examination;

4. Patient counseling and treatment;

5. Patient/infant assessment;

6. Referral/consultation, as indicated; and

7. Procedures/tests, as indicated.

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

History

HISTORY:

Amended by R.1998 d.577, effective December 7, 1998.

See: *30 New Jersey Register 3434(a)*, *30 New Jersey Register 4225(b)*.

Amended by R.2004 d.208, effective June 7, 2004.

See: *36 New Jersey Register 324(a)*, *36 New Jersey Register 2834(a)*.

In (a), amended N.J.A.C. reference.

Annotations

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N.J.A.C. 10:66-3.9

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:66-3.9 Health support services

(a) Case coordination services shall facilitate the delivery of continuous, coordinated and comprehensive services for each patient in accordance with N.J.A.C. 10:54-6 as follows:

1. A permanent case coordinator shall be assigned to each patient no later than two weeks after the HealthStart enrollment visit.

2. Prenatal case coordination activities shall include, but not be limited to:

i. Orienting the patient to all services;

ii. Developing, maintaining and coordinating the care plan in consultation with the patient;

iii. Coordinating and monitoring the delivery of all services and referrals;

iv. Monitoring and facilitating the patient's entry into and continuation with maternity services;

v. Facilitating and providing advocacy for obtaining referral services;

vi. Reinforcing health teachings and providing support;

vii. Providing vigorous follow up for missed appointments and referrals;

viii. Arranging home visits;

ix. Meeting with the patient and coordinating patient care conferences; and

x. Reviewing, monitoring and updating the patient's complete record.

3. Postpartum care coordination activities shall include, but not be limited to:

i. Arranging and coordinating the postpartum visit and any home visit;

ii. Arranging with the obstetrical care provider to obtain the labor, delivery and postpartum hospital summary record information no later than two weeks after delivery;

iii. Linking the patient to appropriate service agencies including: the Special Supplemental Food Program for Women, Infants and Children (WIC), pediatric care (preferably with a HealthStart pediatric care provider), future family planning, Special Child Health Services County Case Management Unit, early intervention services for infants with disabilities, and other health and social agencies, if needed;

iv. Arranging for the transfer of pertinent information or records to the pediatric care and/or future family planning service providers;

v. Coordinating referrals and following up on missed appointments and referrals; and

vi. Reinforcing health instructions for mother and baby.

(b) Nutrition assessment and basic guidance services shall be provided to orient and educate all patients to nutritional needs during pregnancy and educate the patient to good dietary practices in accordance with

N.J.A.C. 10:54-6. Specialized nutrition assessment and counseling must be provided to those women with additional needs. Services shall be provided as follows:

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

i. Review of the patient's chart;

ii. Identification of dental problems which may interfere with nutrition;

iii. Nutritional history;

iv. Current nutritional status;

v. Determination of participation in WIC or other food supplement programs; and

vi. Identification of need for specialized nutritional counseling;

2. Subsequent nutritional assessment, which shall include, but not be limited to:

i. Monitoring of weight gain/loss;

ii. Identification of special dietary needs; and

iii. Identification of need for specialized nutritional counseling services;

3. Prenatal nutritional guidance, which shall include, but not be limited to:

i. Basic instruction on nutritional needs during pregnancy including balanced diet, vitamins and recommended daily allowances;

ii. Review and reinforcement of other nutritional and dietary counseling services the patient may be receiving;

iii. Instruction on food purchase, storage and preparation;

iv. Instruction on food substitutions, as indicated;

v. Discussion of infant feeding and nutritional needs; and

vi. Referral to food supplementation programs through the case coordinator;

4. Specialized nutrition assessment and counseling, which shall be provided to those women with additional needs;

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

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

i. Review and reinforcement of good dietary practices;

ii. Review of instruction on dietary requirement changes; and

iii. Instruction on breast feeding and/or formula preparation and feeding.

(c) Social-psychological assessment and basic guidance services shall be provided to all patients to assist the patient in resolving social-psychological needs, in accordance with N.J.A.C. 10:54-6. Specialized social-psychological assessment and short-term counseling shall be provided to those women with additional needs. Services shall be provided as follows:

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

i. Determining financial resources and living conditions;

ii. Determining the patient's personal support system;

iii. Determining the patient's attitudes and concerns regarding the pregnancy;

iv. Ascertaining present and prior involvement by the patient with other social programs or agencies and current social service needs;

v. Ascertaining educational and/or employment status and needs; and

vi. Identification of the need for specialized social-psychological and/or mental health evaluation and counseling services;

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

i. Determination of patient's reaction to pregnancy;

ii. Ascertaining the reaction of family, friends and actual support person to the pregnancy;

iii. Identification of the need for social service interventions and advocacy; and

iv. Identification of the need for specialized social-psychological and/or mental health evaluation and counseling;

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

i. Orientation and information on available community resources;

ii. Orientation regarding stress and stress reduction during pregnancy; and

iii. Assistance with arrangements for transportation, child care and financial needs;

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

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

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

i. Review of prenatal, labor, delivery and postpartum course;

ii. Assessment of the patient's current social-psychological status, including mother and infant bonding and the acceptance of the infant by the father and/or family, as applicable;

iii. Identification of the need for additional social-psychological services;

iv. Review of available community resources for mother and infant, as applicable;

v. Counseling regarding fetal loss or infant death, if applicable; and

vi. Counseling regarding school/employment planning.

(d) Health education assessment and instruction shall be provided to all patients at intervals throughout the pregnancy, based on the patient's needs and in accordance with N.J.A.C. 10:54-6. Services shall be provided as follows:

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

i. Identification of general educational background;

ii. Patient's health education needs; and

iii. Previous education and experience concerning pregnancy, birth and infant care;

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

i. Normal course of pregnancy;

ii. Fetal growth and development;

iii. Warning signs, such as signs of pre-term labor, and identification of emergency situations;

iv. Personal hygiene;

v. Exercise and activity;

vi. Childbirth preparation, including management of labor and delivery;

vii. Preparation for hospital admission;

viii. Substance, occupational and environmental hazards;

ix. Need for continuing medical and dental care;

x. Future family planning;

xi. Parenting, basic infant care and development;

xii. Availability of pediatric and family medical care in the community; and

xiii. Normal postpartum physical and emotional changes;

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

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

(e) One face-to-face preventive health care contact must be provided or arranged for during the time after hospital discharge and prior to the required medical postpartum visit. This requirement is in accordance with N.J.A.C. 10:54-6, as follows:

1. This contact shall include, but not be limited to:

i. Review of the mother's health status;

ii. Review of the infant's health status;

iii. Review of mother/infant interaction;

iv. Revision of the care plan; and

v. Provision of additional services, as indicated; and

2. The provider shall provide or arrange for one or more home visits for each high risk patient in accordance with N.J.A.C. 10:54-6.

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

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

History

HISTORY:

Amended by R.1998 d.577, effective December 7, 1998.

See: *30 New Jersey Register 3434(a)*, *30 New Jersey Register 4225(b)*.

Amended by R.2004 d.208, effective June 7, 2004.

See: *36 New Jersey Register 324(a)*, *36 New Jersey Register 2834(a)*.

In (a)3iii, inserted "early intervention services for infants with disabilities," following "Case Management Unit"; amended N.J.A.C. reference throughout.

Annotations

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Chapter Notes

End of Document

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

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

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

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

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

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

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

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

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

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

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

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

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

History

HISTORY:

Amended by R.1998 d.577, effective December 7, 1998.

See: *30 New Jersey Register 3434(a)*, *30 New Jersey Register 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 New Jersey Register 324(a)*, *36 New Jersey Register 2834(a)*.

In (b), substituted "FamilyCare" for "KidCare".

Annotations

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Chapter Notes

End of Document

N.J.A.C. 10:66-3.11

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

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

(a) HealthStart maternity care providers shall have policies which protect patient confidentiality, provide for informed consent, and document prenatal, labor, delivery and postpartum services in accordance with N.J.A.C. 10:54-6.

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

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

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

History

HISTORY:

Amended by R.1998 d.577, effective December 7, 1998.

See: *30 New Jersey Register 3434(a)*, *30 New Jersey Register 4225(b)*.

Amended by R.2004 d.208, effective June 7, 2004.

See: *36 New Jersey Register 324(a)*, *36 New Jersey Register 2834(a)*.

In (a), amended N.J.A.C. reference.

Annotations

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N.J.A.C. 10:66-3.12

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

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§ 10:66-3.12 Standards for HealthStart pediatric care certificate

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

(b) HealthStart pediatric care providers shall:

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

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

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

Annotations

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Chapter Notes

End of Document

N.J.A.C. 10:66-3.13

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

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

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

Annotations

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N.J.A.C. 10:66-3.14

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

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

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

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

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

History

HISTORY:

Amended by R.1998 d.577, effective December 7, 1998.

See: *30 N.J.R. 3434(a)*, *30 N.J.R. 4225(b)*.

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

In (a), deleted "and Senior Services' " following "Health"; and inserted a comma following the eighth occurrence of "visit" and following "examinations".

Annotations

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Chapter Notes

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N.J.A.C. 10:66-3.15

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

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§ 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 Child Protection and Permanency; Special Child Health Services Case Management Units and Child Evaluation Centers; early intervention programs; county social service agencies/boards of social services; certified home health agencies; community mental health centers; and local and county health departments.

History

HISTORY:

Amended by R.1998 d.577, effective December 7, 1998.

See: *30 N.J.R. 3434(a)*, *30 N.J.R. 4225(b)*.

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

In the introductory paragraph of (a), inserted a comma following "educational"; and in (a)1, substituted "Child Protection and Permanency" for "Youth and Family Services".

Annotations

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End of Document

N.J.A.C. 10:66-3.16

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

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

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

History

HISTORY:

Amended by R.1998 d.577, effective December 7, 1998.

See: *30 N.J.R. 3434(a)*, *30 N.J.R. 4225(b)*.

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

In (a), substituted "that" for "which", inserted a comma following "consent", and deleted "and Senior Services' " following "Health".

Annotations

Notes

Chapter Notes

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N.J.A.C. 10:66-4.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

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

(a) Federally qualified health center (FQHC) services are services provided by physicians, physician assistants, advanced practice nurses, 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 *42 U.S.C. § 1396a(a)(55)*.

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, advanced practice nurse, 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.

i. Normally, only one dental encounter is covered per beneficiary, per day. Only one dental encounter is covered when the beneficiary is seen by a licensed general practitioner and a dental hygienist or when the beneficiary is seen by two general practitioners on the same date of service.

ii. More than one dental encounter is covered, however, when the beneficiary is seen by a licensed general practitioner and a licensed specialist, such as an oral surgeon or an endodontist.

iii. More than two dental encounters during a week for a beneficiary require clear documentation in the beneficiary's dental record demonstrating the medical necessity for the multiple encounters.

iv. Interpretation of results of tests or procedure results not requiring face-to-face contact between the beneficiary and practitioner and referrals to specialists do not constitute a dental encounter.

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.

6. An OB/GYN 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, but not limited to, a certified nurse midwife, in which a delivery or approved OB/GYN surgical procedure listed on Table A or Table B on the Molina website is performed. Delivery codes are listed on Table A. OB/GYN surgical codes are listed on Table B. Tables A and B and annual updates are posted on the Molina website: *www.njmmis.com*.

History

HISTORY:

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.

Amended by R.2004 d.334, effective September 7, 2004.

See: *36 N.J.R. 312(a)*, *36 N.J.R. 4136(a)*.

Amended by R.2009 d.376, effective December 21, 2009.

See: *41 N.J.R. 2561(a)*, *41 N.J.R. 4791(a)*.

Added (a)4i through (a)4iv and (a)6.

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

Rewrote (a)1; and in (a)6, substituted "Molina" for "Unisys" twice, and substituted the third occurrence of "are" for "will be".

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N.J.A.C. 10:66-4.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 66. INDEPENDENT CLINIC SERVICES > SUBCHAPTER 4. FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

§ 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.

History

HISTORY:

New Rule, R.1998 d.577, effective December 7, 1998.

See: *30 New Jersey Register 3434(a)*, *30 New Jersey Register 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 New Jersey Register 324(a)*, *36 New Jersey Register 2834(a)*.

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

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N.J.A.C. 10:66-4.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 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 judgments;

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; and

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. Government Accountability Office;

iii. The AICPA audit and accounting guide Audits of State and Local Governmental Units and, as applicable, AICPA industry audit guides or Statements of Position;

iv. Federal Single Audit Act of 1984 (P.L. 98-502);

v. Federal OMB Circular A-133, "Audits of Institutions of Higher Education and Other Nonprofit Organizations";

vi. Federal OMB "Compliance Supplement for Single Audits of State and Local Governments" (September 1990);

vii. Federal OMB "Compliance Supplement for Single Audits of Educational Institutions and Other Nonprofit Organizations," when issued, may supersede the Federal "Compliance Supplement for Single Audits of State and Local Governments;" and

viii. Federal OMB Circulars A-87 "Cost Principles for State and Local Governments" or A-122 "Costs Principles for Nonprofit Organizations," as applicable.

(b) The audit report shall include the following:

1. An opinion on the financial statements taken as a whole;

2. Presentation of financial statements in accordance with the following applicable AICPA audit and accounting guides--Audits of State and Local Governmental Units, industry audit guides, or Statements of Position;

3. A supplementary schedule and opinion thereon of the FQHC's state and Federal financial assistance programs, showing expenditures by program. See the AICPA's audit guide, Audits of State and Local Governmental Units, Fifth Edition, pages 196 and 230;

4. A report(s) on the auditor's considerations of the internal control structure covering:

i. The internal control structure relevant to the financial statement audit; and

ii. The internal control structure used in administering state/federal financial assistance programs;

5. Compliance Report Based on an Audit of General Purpose or Basic Financial Statements Performed in Accordance with Government Auditing Standards;

6. Single audit compliance report(s) covering:

i. General requirements applicable to major programs;

ii. Opinion on compliance with specific requirements applicable to major programs; and

iii. Requirements applicable to nonmajor programs;

7. A specific statement that all required tax returns have been filed and taxes including, but not limited to, payroll taxes, have been paid;

8. A copy of the management advisory letter when provided as a routine part of the audit engagement;

9. A statement of the FQHC's response to findings of deficiencies in internal control and compliance, including a description of corrective action taken or planned on prior findings; and

10. A report on fraud, abuse or illegal acts, or indications of such acts when discovered. A separate written report is required.

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

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

Department of Human Services
Director, Office of Auditing
Capital Place One
PO Box 700
Trenton, New Jersey 08625-0700

History

HISTORY:

New Rule, R.1996 d.331, effective July 15, 1996.

See: *28 N.J.R. 1952(b)*, *28 N.J.R. 3573(b)*.

Recodified from *N.J.A.C. 10:66-4.2* and amended by R.1998 d.577, effective December 7, 1998.

See: *30 N.J.R. 3434(a)*, *30 N.J.R. 4225(b)*.

§ 10:66-4.3 Audited financial statement

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

In (a)1iii, substituted "judgments" for "judgements"; in (a)4, inserted "and"; in (a)5ii, substituted "Government Accountability" for "General Accounting"; in (b)3, substituted "Federal" for "federal" and "See" for "(see"; in(b)7, deleted an opening parenthesis preceding "including", and substituted a comma for a closing parenthesis following "taxes"; and in (b)10, substituted the second occurrence of "A" for "(a", and deleted a closing parenthesis following "required".

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N.J.A.C. 10:66-4, Appx. A

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

APPENDIX A

(RESERVED)

History

HISTORY:

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)*.

Inserted references to NJ KidCare Plan A throughout; in (a) and (c), substituted references to beneficiaries for references to recipients; and in (a), inserted "approved site of a" following "Each" and inserted a reference to NJ KidCare in the first sentence.

Amended by R.2004 d.208, effective June 7, 2004.

See: *36 N.J.R. 324(a)*, *36 N.J.R. 2834(a)*.

Designated former text as Appendix A, rewrote "Cost Report".

Repealed by R.2009 d.376, effective December 21, 2009.

See: *41 N.J.R. 2561(A)*, *41 N.J.R. 4791(a)*.

Section was "Appendix A".

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This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

APPENDIX B

FQHC Annual Cost Reporting Requirements

The following cost report instructions apply to FQHCs that were Medicaid providers on October 31, 2000, for their fiscal years ending on and after June 30, 2001.

In addition, these cost report instructions are for the third year and thereafter, for FQHCs that become Medicaid providers on and after November 1, 2000. The FQHC's first year as a Medicaid provider may represent less than a full year of operation, but is counted as a full year for cost reporting, and a cost report is due to the Division for this period, ending on December 31 of the initial year.

Federally qualified health centers (FQHCs) shall file the Medicare Cost Report (CMS 222-92 (3/93) and all updates), with the Division of Medical Assistance and Health Services (DMAHS). There are services covered by Medicaid that are not covered by Medicare. The cost information below should be included on the Medicare Cost Report that is submitted to Medicare and to the Division. This information will provide Medicaid with cost detail for the additional Medicaid covered services.

Add the following lines to the FQHC Medicare Cost Report, Worksheet A under the category of Facility Health Care Staff Costs:

Cost Center	Line Number
Obstetrics/Gynecology	11
Podiatrist	11.01
Cardiologist	11.02
Specialty Physician (Specify type)	11.03
Specialty Nurse Practitioner (Specify type)	11.04
Nurse Mid-Wife	11.05

Add the following lines added under the category of Costs Other than RHC/FQHC Services:

Cost Center	Line Number
Radiology	56
Outreach	56.01
Community Service	56.02
Patient Transportation	56.03

The above subscripted lines will provide additional detailed data on specific costs. The Medicare Cost Report with subscripted lines should be submitted both in hard copy format and on disk to the Division. In addition, FQHCs are

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required to submit encounter data on Worksheet 2 of the Medicaid Cost Report appearing in N.J.A.C. 10:66-4 Appendix C and the audited financial statements for the cost reporting period. These items are due to the Division on an annual basis and no later than five months after the close of each FQHC's fiscal year.

History

HISTORY:

New Rule, R.2004 d.208, effective June 7, 2004.

See: *36 New Jersey Register 324(a)*, *36 New Jersey Register 2834(a)*.

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N.J.A.C. 10:66-4, Appx. C

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

APPENDIX C

New FQHC Medicaid Cost Reports for First and Second Years of Operation

Cost Report--Instructions for FQHCs that become Medicaid providers on and after November 1, 2001. These cost report instructions are for the first and second calendar years that the FQHC is a Medicaid provider. The FQHC's first year as a Medicaid provider may represent less than a full year of operation, but is counted as a full year for cost reporting, and a cost report is due to the Division for this period, ending on December 31 of the initial year.

Each Federally qualified health center (FQHC) participating as an independent clinic provider in the Medicaid/NJ FamilyCare program shall complete a cost report, as indicated at N.J.A.C. 10:66-1.5(d). This requirement is necessary to determine the amount of reimbursement to be paid to the FQHC for services provided to Medicaid/NJ FamilyCare beneficiaries.

All Worksheets, Statistical Information, and a Certification Page must be completed as appropriate. Additional documentation in the form of sub-worksheets etc. may be provided by a FQHC to support a particular cost or reclassification, adjustment to expenses, or other item(s). Calculations requiring a percentage shall be carried to five decimal places.

The completion of a cost report serves as the basis for an FQHC's interim reimbursement rate and the total Medicaid or NJ FamilyCare-Plan A reimbursement due to an FQHC for services provided to Medicaid and NJ FamilyCare-Plan A beneficiaries.

A copy of the Medicare cost report and the FQHC's audited financial statements shall be submitted with the Medicaid cost report.

Following are the cost report forms and instructions for their proper completion:

FQHC-2001-07 (Certification)--(i) (ii)

COMPLETION INSTRUCTIONS

Field	Explanation
1.	Enter the Federally Qualified Health Center's name and mailing address.
2.	Enter the Medicaid Provider Number assigned to the FQHC.
3.	Enter the fiscal period of the FQHC being reported.
4.	Circle the category of control most representative of the FQHC.
5.	List each owner possessing an amount of ownership in the FQHC, regardless of the level.
6.	All other Federally Qualified Health Centers, providers of service, or suppliers and other entities related to the center through common ownership or control must be listed here. The use of a subschedule is permitted as necessary.
7.	All grants received by the FQHC shall be listed here. The name, number and source of the grant (for example, State of New

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Jersey Grant #XXXXX, Public Health Service Grant #XXXXX) duration of the grant and the total grant dollars under each grant are to be listed. If additional space is required attach a supporting subschedule listing.

Certification statement:

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

FQHC-2001-07 (Reclassification and Adjustment of Trial Balance of Expenses)--(Worksheet 1)--(iii)(iv)(v)

COMPLETION INSTRUCTIONS:

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

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

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

Columns 1 and 2--Compensation and Fringe Benefits:

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

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

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

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

Column 2, Line 23, Fringe Benefits

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

Column 3--Other:

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

Column 3, Line 23, Other

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

Column 4--Sub-Totals:

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

Column 5--Expense Reclassifications:

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

administrative duties, the appropriate portion of his or her compensation and fringe would need to be reclassified from the "Physician" cost center to "Administrative Costs Staff--Administration" cost center. Thus, his or her administrative time (cost) would be properly recognized.

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

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

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

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

Introduction to Column 6:

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

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

Column 6--Reclassified Trial Balance:

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

Column 7--Adjustments (Decreases/Increases):

Enter the amount of any adjustment to the center's reclassified trial balance expenses. Adjustments are required to adjust (increase or <decrease>) actual expenses in accordance with Medicaid and NJ FamilyCare rules on allowable cost. An example of a situation in which adjustment to expense would be required is where the clinic receives an allocation from a central (home) office, has a practitioner assigned by the National Health Service Corps, or the identification of pneumococcal vaccine administration costs.

All adjustments reflected in column 7 shall be detailed on a supporting schedule prepared by the clinic. The schedule shall provide an explanation or rationale for the adjustment, whether the adjustment basis is cost or amount received and the identification of any and all cost centers affected.

Worksheet 1, Support Schedule B is to be used to document and detail the adjustments contained in column 7. See instructions for specifics of this schedule.

Column 8--Adjusted Net Expenses:

This column is used to combine the reclassified trial balance amounts in column 6 with the adjustment amounts found in column 7 by individual cost center. The amounts resulting in column 8 will be used in later schedules in the determination of reimbursement of cost for services rendered to Medicaid and NJ FamilyCare beneficiaries.

FQHC-2001-07 Worksheet 1 Support Schedule A--Reclassifications--(vi)

COMPLETION INSTRUCTIONS:

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

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

FQHC-2001-07 Worksheet 1 Support Schedule B--Adjustments to Expense Detail--(vii)

COMPLETION INSTRUCTIONS:

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

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

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

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

FQHC-2001-07 Worksheet 2 ENCOUNTERS--(viii)

COMPLETION INSTRUCTIONS:

General:

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

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

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

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

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

Column 3, Medicaid Total Encounters--Total of Columns 1 and 2.

Column 4, Managed Care Encounters--Enter in the appropriate service category the number of encounters provided to managed care beneficiaries who are not eligible for cost-based reimbursement. Include in these numbers any managed care encounters provided to Medicaid and NJ FamilyCare beneficiaries which are not allowable for cost-based reimbursement in Column 2. On line 16, enter the number of pneumococcal and influenza vaccine injections.

Column 5, New Jersey Department of Health--Enter in the appropriate service category the number of encounters provided under letter of agreement with the New Jersey Department of Health. This amount

must include the base level visits assigned by the New Jersey Department of Health. On line 16, enter the number of pneumococcal and influenza vaccine injections provided under agreement with the New Jersey Department of Health.

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

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

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

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

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

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

FQHC-2001-07 Worksheet 2 Support Schedule A--Medicaid Managed Care Encounter Detail--(ix)

COMPLETION INSTRUCTIONS:

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

FQHC 2001-07--Worksheet 2--Support Schedule B-Medicaid Managed Care Receipts Detail-(x)

COMPLETION INSTRUCTIONS:

Line 1--Enter the name of each Managed Care Company with which the FQHC contracts in Columns A through K. If the FQHC is under contract with more than ten Medicaid and NJ FamilyCare HMOs, additional pages/columns must be included.

Line 2 Enter the effective date of the contract with each managed care company entered on line 1.

Lines 3 through 9--Enter the receipts received to date for the services provided to Medicaid and NJ FamilyCare beneficiaries for the period covered by the cost report.

Line 10--Enter the total of the amounts entered in lines 3 through 9.

Line 11--Enter the total of the amounts entered in line 10, columns F and L.

FQHC-2001-07 Worksheet 3--PRODUCTIVITY SCREENING--(xi)

COMPLETION INSTRUCTIONS:

This Worksheet is used to determine if the productivity screens of the various core and other services are being met. It develops the various encounters that will be used in the determination of an encounter rate for each core and specialized service. Additionally, it reflects the numbers of staff assigned to each of the areas. Completion of Worksheet 3 requires completion of Worksheets 6, 7 and 8.

Columns 1 and 1a--Number of FTEs and Total Hours--Staffing is to be reported by FTEs and hours worked. FTEs should be reported using the method prescribed by Medicare for the Medicare FQHC Cost Report (CMS-222-92) Worksheet B, Part 1. For FQHCs that file a Medicare Cost Report with Medicare, FTEs should match the FTEs reported on the Medicare FQHC Cost Report (CMS-222-92), Worksheet B, Part 1 for Physicians, Nurse Practitioners, Clinical Psychologists and Clinical Social Workers.

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

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

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

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

FQHC-2001-07--Worksheet 4 Encounter Rate Calculation--(xii)

COMPLETION INSTRUCTIONS:

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

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

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

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

Line 89, Column 8

or

30 percent of Total Center Costs from Worksheet 1,

Line 108, Column 8

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

Part II-- Specialized Services

Column 1--Direct Cost:

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

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

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

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

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

Column 4--Total Cost of Special Service Cost:

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

Column 5--Productivity Screening Encounters

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

Column 6--Computed Encounter Rate:

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

FQHC-2001-07--Worksheet 4 Encounter Rate Calculation--(xiii)

COMPLETION INSTRUCTIONS:

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

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

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

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

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

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

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

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

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

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

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

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

FQHC-2001-07--Worksheet 5 Final Settlement Determination--(xiv)

COMPLETION INSTRUCTIONS:

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

All Services--Lines 1 through 13:

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

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

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

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

Column 4:--To determine the Medicaid and NJ FamilyCare reimbursable cost for each type of service, multiply the amounts found in column 2 by column 3. Enter the result here.

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

Line 14: requires no entry

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

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

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

or

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

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

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

or

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

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

Line 16, Medicaid Limit:--Enter the amount of the Medicaid/NJ FamilyCare fee-for-service limit in place during each period entered on line 15. The Medicaid/NJ FamilyCare limit is scheduled to be phased in over a three-year period as follows:

July 1, 1996

120 percent of Medicare limit

July 1, 1997

115 percent of Medicare limit

July 1, 1998 and thereafter

110 percent of Medicare limit

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

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

A 20 percent per annum factor will be used by Medicaid/NJ FamilyCare to determine the Medicaid/NJ FamilyCare limit. The Medicaid/NJ FamilyCare limit should not impact an FQHC's encounter rate more than 20 percent of the prior year's finalized encounter rate. (Finalized is defined as the issuance of a Notification of Final Settlement by the Division of Medical Assistance and Health Services, and acceptance by the FQHC.)

Line 17, Medicaid/NJ FamilyCare Encounters Per Period:--Enter the Medicaid/NJ FamilyCare encounters rendered during each period reported on line 15. The sum of all Medicaid/NJ FamilyCare encounters entered on line 17 should equal the total Medicaid or NJ FamilyCare encounters on line 13, column 2.

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

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

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

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

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

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

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

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

FQHC-2001-07--Worksheet 6 Physician Detail--(xv)

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

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

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

Column 3--Enter the physician's Social Security Number.

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

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

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

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

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

1.-- Fifty percent of compensated hours, or

2.-- Actual hours providing direct care.

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

FQHC-2001-07--Worksheet 7 Clinical Nurse Practitioner/Certified Nurse Mid-Wife Detail--(xvi)

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

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

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

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

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

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

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

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

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

FQHC-2001-07--Worksheet 8 Dentist/Dental Hygienist Detail--(xvii)

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

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

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

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

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

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

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

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

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

History

HISTORY:

New Rule, R.2004 d.208, effective June 7, 2004.

See: *36 N.J.R. 324(a)*, *36 N.J.R. 2834(a)*.

Amended by R.2009 d.376, effective December 21, 2009.

See: *41 N.J.R. 2561(a)*, *41 N.J.R. 4791(a)*.

Inserted the second, third and fourth paragraphs; and substituted a colon for a semicolon following the "COMPLETION INSTRUCTIONS" phrase under "FQHC 2001-07 Worksheet 2--Support Schedule B-Medicaid Managed Care Receipts Detail-(x)".

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

In "FQHC-2001-07 Worksheet 2 ENCOUNTERS--(viii)", deleted a comma following "noted" and substituted "subdermal contraceptive implants" for "Norplant" three times in the second paragraph, updated the N.J.A.C. reference in the third paragraph; and deleted "and Senior Services" following "Health" throughout the eighth paragraph; and in "FQHC-2001-07--Worksheet 4 Encounter Rate Calculation--(xii)", in the paragraph following "Column 5--Productivity Screening Encounters", deleted "(Note" preceding "The visits", substituted "subdermal

contraceptive implants" for "Norplant" and "subdermal contraceptive implant procedures done," for "Norplant Implant Procedures done", inserted a comma following the second occurrence of "line", and deleted a closing parenthesis from the end.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:66-4, Appx. D

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

APPENDIX D

Change In Scope Of Service Application Requirements

The following items must be completed for each change in scope of service incurred by a Federally qualified health center (FQHC). Items below, labeled as A, B, and C, must be submitted in narrative format to the Division of Medical Assistance and Health Services (DMAHS).

The item labeled D is the instructions for the Change in Scope of Service Certification Statement and Reporting Forms 1 through 5. THE INITIAL SUBMISSION MUST INCLUDE SEPARATE FORMS FOR EACH YEAR OF THE PHASE-IN PERIOD IN WHICH THE CHANGE IN SCOPE OF SERVICE OCCURS. Within five months of the completion of each phase-in year, complete the same forms with actual data and send hard copy with disk to DMAHS.

DMAHS reserves the right to request additional information as needed.

A. DESCRIPTION OF THE SERVICE AREA AND TARGET POPULATION

1. List address(es) where the change in scope of service will occur.

2. Describe the service area(s)/community(ies) to be served by the new program.

3. Describe the target population(s) within the service area. Attach a copy of the target population submitted to HRSA (Form 3) and explain in detail any differences.

4. Describe how many people will be served and the number of projected encounters for each location for each year during phase-in, up to and including the year in which the new program will be fully implemented.

5. Attach a copy of the Notice of Grant Award or the approval letter from the Health Resources and Services Administration (HRSA) or state that it is not reviewable by HRSA.

B. SERVICE DELIVERY MODEL

1. Provide an overview of the service delivery model of the new program or services.

2. Describe whether and/or how the project expands upon or replaces pre-existing services.

C. BUDGET NARRATIVE

1. Discuss the appropriateness and reasonableness of the annualized budgets for each year during the phase-in period in terms of:

(a) Staffing: Describe how health care services will be provided--via staff providers, contract and/or through referral. Describe clinical staffing pattern (for example, number and mix of primary care physicians and other providers and clinical support staff, language and cultural appropriateness, etc.) of the new program or service. Have the clinical and other staff members for the new program or service been hired and if not, when will they start working? What is the plan for phasing in the staff?

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(b) The total financial resources required to achieve the goals and objectives (that is, to achieve the applicant's proposed service delivery plan) of the new program or service. Supply all budget documents submitted to HRSA and any budget estimates that were prepared subsequent to the HRSA submission. Explain in detail the differences between HRSA and Medicaid submissions. If the change in scope of service is not reviewable by HRSA, include a statement to that effect.

(c) The number of proposed unduplicated patients and encounters at full operational capacity (Change of Scope Form 2, Annualized Encounters).

(d) One-time minor capital needs.

D. MEDICAID CHANGE IN SCOPE OF SERVICE REPORTING FORMS

The Medicaid Change in Scope of Service Reporting Forms must be completed whenever a change in scope of service (as defined in the Medicaid regulations) occurs. The initial submission must include separate forms for each year of the phase-in period in which the change in scope of service occurs. Please remember that all information reported on forms 1 through 5 are projected numbers, except when reporting actual information.

Instructions for Form Completion

Change in Scope of Service Certification Statement

Enter the FQHC name and FQHC provider number(s) of the site(s) affected by the change in scope of service.

Enter the reporting period of the data included in the application.

Circle the appropriate change in scope phase-in year.

Enter the name of the person who prepared the change in scope of service application.

Enter the signature of the officer of the FQHC and his or her title and date after the completion of the change in scope of service application.

Circle interim if based on projected data and circle actual if the phase-in year is complete.

Change in Scope of Service--Form 1, Annualized Budget

This form is used to record the annual costs related to the change in scope of service. The form should be used for each year from the beginning of the change in scope of service until the change in scope of service is fully phased in. Expense information must include further detail, as described below. In addition, if there are budget items for which costs are shared with other programs, the basis for allocation of costs between programs must be explained.

Enter the FQHC Name and FQHC provider number(s) of the site(s) affected by the change in scope of service. If the budget is based on projected data, circle interim budget and if the budget is based on actual data following the completion of a phase-in year, circle actual budget.

Enter the reporting period of the data included in the application.

Circle the appropriate change in scope phase-in year.

Line A--Personnel: Enter the total personnel costs for all new staff to be employed as a result of the change in scope of service. Include any increase in costs for existing staff that will be employed in the change in scope of service.

Line B--Fringe Benefits: Itemize the components that comprise the fringe benefit rate (for example, Health insurance, FICA, SUTA, life insurance, retirement plan). For any increase over the prior year rate, provide an explanation.

Line C--Equipment: Only major (with cost over $ 5,000 per unit) equipment items need to be itemized. Items costing less than $ 5,000 should be aggregated with a brief explanation.

Line D--Supplies: Categorize supplies according to type--medical, lab, pharmacy and office. Explain how the amounts were developed (for example, medical supplies were based on 20,000 encounters at $ 2.00 per encounter to arrive at the $ 40,000 appearing in the budget).

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Line E--Travel: Itemize travel costs according to traveler type (Executive Director, Project Director, Board, provider for continuing medical education (CME), etc.) and explain how the amounts were developed. It is not necessary to itemize each trip or the costs associated with each trip. (Example: Physician CME 12 trips at $ 1,200 each)

Line F--Contractual: Categorize substantive programmatic or administrative contract costs according to type (for example, medical referral, lab referral, management consultant) under two headings--Patient care and non-patient care by costs.

Line G--Alteration and Renovation (A & R): Describe all A & R in progress.

Line H--Other: Itemize all costs in this category and explain in sufficient detail. Add additional lines, if necessary. In most cases, consultant costs for technical assistance, legal fees, rent, utilities, insurance, dues, subscriptions, and audit related costs would fall under this category.

Line I--Total: Sum the costs from lines A through H.

Change in Scope of Service--Form 2, Annualized Encounters

This form is used to record the annual encounters related to the change in scope of service. The form should be used for each year from the beginning of the change in scope of service until the change in scope of service is fully phased in.

Enter the FQHC name and FQHC provider number(s) of the site(s) affected by the change in scope of service.

Enter the reporting period of the data included in the application.

Circle the appropriate change in scope phase-in year.

Circle interim if based on projected data and circle actual if the phase-in year is complete.

Lines 1-21--Number of Medicaid Encounters: For the reporting period, enter the number of Medicaid encounters in column 2 relating to the category listed in column 1 on each line.

Lines 1-21--Total Encounters: For the reporting period, enter the total encounters in column 3 relating to the category listed in column 1 on each line (include Medicaid encounters in the total reported in column 3).

Line 22--Total Encounters: Sum the encounters from lines 1 through 21 in column 2 and column 3.

Line 23--Number of Unduplicated Patients by Year: Enter the number of unduplicated Medicaid patients served during the reporting period in column 2. Enter the total number of unduplicated Medicaid patients served during the reporting period in column 3.

Change in Scope of Service--Form 3, Annualized Visits

This form is used to record the number of visits related to the change in scope of service. The form should be used for each year from the beginning of the change in scope of service until the change in scope of service is fully phased in. (The data in this form is a copy of the data in form 3 of the BPHC Policy Information *Notice 2001-18*.)

Enter the FQHC name and FQHC provider number(s) of the site(s) affected by the change in scope of service.

Enter the reporting period of the data included in the application.

Circle the appropriate change in scope phase-in year.

Circle interim if based on projected data and circle actual if the phase-in year is complete.

Lines 1-13--Visits: Enter the number of visits relating to the payor category listed on each line.

Line 14--Grand Total: Sum the visits entered on lines 4, 7, 8, 9, 10, 11, 12 and 13.

Change in Scope of Service--Forms 4-A and 4-B, Personnel Costs

These forms are used to record all new or existing staff costs associated with the change in scope of service. These forms should be used for each year from the beginning of the change in scope of service until the change of scope is fully phased in.

Enter the FQHC name and FQHC provider number(s) of the site(s) affected by the change in scope of service.

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Enter the reporting period of the data included in the application.

Circle the appropriate change in scope phase-in year.

Circle interim if based on projected data and circle actual if the phase-in year is complete.

Lines 1-68, Compensation, Fringe Benefits and Other

Column 1--Enter compensation expenses for the change in scope of service corresponding to the appropriate cost center lines.

Column 2--Enter Fringe Benefit expenses for the change in scope of service corresponding to the appropriate cost center lines.

Column 3--Enter any personnel expenses of various cost centers that are not compensation or fringe benefits, that are related to the change in scope of service.

Column 4--The sum of columns 1, 2 and 3 for each line is entered here.

Line 15, Total--Sum lines 2 through 14.

Line 30, Total--Sum lines 17 through 22 plus lines 24 through 29.

Line 35, Total--Sum lines 31 through 34.

Line 36, Page Totals--Sum lines 15, 30 and 35.

Line 52, Total--Sum lines 38 through 51.

Line 67, Total Administrative Costs--Sum lines 54 through 66.

Line 68, Page Totals--Sum lines 52 and 67.

Change in Scope of Service--Form 4-C, Physician Detail

This form is to record Physician data associated with the change in scope of service.

Enter the FQHC name and FQHC provider number(s) of the site(s) affected by the change in scope of service.

Enter the reporting period of the data included in the application.

Circle the appropriate change in scope phase-in year.

Circle interim if based on projected data and circle actual if the phase-in year is complete.

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

Column 2--If the physician's employment terminated during the change in scope period, enter the date.

Column 3--Enter the physician's Medicaid Provider Number.

Column 4--Enter the number of encounters performed by the physician corresponding to the change in scope of service.

Column 5--Enter the amount of gross compensation, including fringe benefits paid to the physician.

Column 6--Enter the number of hours for which the physician was compensated. Employment contracts and time records must be maintained for audit purposes.

Line 25, Total--Sum lines 1 through 24.

Change in Scope of Service--Form 4-D, Nursing Detail

This form is used to record Nurse Practitioner and Nurse Midwife data associated with the change in scope of service.

Enter the FQHC name and FQHC provider number(s) of the site(s) affected by the change in scope of service.

Enter the reporting period of the data included in the application.

Circle the appropriate change in scope phase-in year.

Circle interim if based on projected data and circle actual if the phase-in year is complete.

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

Column 2--If the CNP/CNM'S employment terminated during the change in scope period, enter the date.

Column 3--Enter the CNP/CNM's License and/or Qualification.

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Column 4--Enter the number of encounters performed by the CNP/CNM associated with the change in scope of service.

Column 5--Enter the amount of gross compensation, including fringe benefits, paid to the CNP/CNM.

Column 6--Enter the number of hours for which the CNP/CNM was compensated. Employment contracts and time records must be maintained for audit purposes.

Line 10, Total Nurse Practitioners--Sum lines 1 through 9.

Line 25, Total Nurse Mid-Wives--Sum lines 12 through 24.

Change in Scope of Service--Form 4 E, Dental Detail

This form is used to record Dental and Dental Hygienist data associated with the change in scope of service.

Enter the FQHC name and FQHC provider number(s) of the site(s) affected by the change in scope of service.

Enter the reporting period of the data included in the application.

Circle the appropriate change in scope phase-in year.

Circle interim if based on projected data and circle actual if the phase-in year is complete.

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

Column 2--If the Dentist/Dental Hygienist employment terminated during the change in scope period, enter the date.

Column 3--Enter the Dentist/Dental Hygienist License and/or Qualification.

Column 4--Enter the number of encounters performed by the Dentist/Dental Hygienist associated with the change in scope of service.

Column 5--Enter the amount of gross compensation, including fringe benefits, paid to the Dentist/Dental Hygienist.

Column 6--Enter the number of hours for which the Dentist/Dental Hygienist was compensated. Employment contracts and time records must be maintained for audit purposes.

Line 10, Total Dentists--Sum lines 1 through 9.

Line 25, Total Dental Hygienists--Sum lines 12 through 24.

Change in Scope of Service--Form 5 Current Services Provided

Form 5 is used to record the current services provided on-site or by referral, for the site where the change in scope of service will occur. A separate form must be completed for each site where the change in scope of service will occur.

Click here to view image.

History

HISTORY:

New Rule, R.2004 d.208, effective June 7, 2004.

See: *36 New Jersey Register 324(a)*, *36 New Jersey Register 2834(a)*.

Annotations

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End of Document

N.J.A.C. 10:66-4, Appx. E

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

APPENDIX E

Medicaid Managed Care Wraparound Reports

FQHC-2001-07 Worksheet 2--Support Schedule A--Medicaid Managed Care Encounter Detail

Medicaid managed care encounters provided by Federally Qualified Health Center practitioners must be segregated by calendar month of service. The encounters reported on this worksheet shall not include delivery and OB/GYN surgical encounters reported on Worksheet 2--Support Schedules C and E.

COMPLETION INSTRUCTIONS:

Enter the FQHC Name and FQHC provider number.

Enter the service month and service year.

In Columns 1 though 6, enter the name of each HMO with which the FQHC contracts. If the FQHC is under contract with more than six Medicaid/NJ FamilyCare HMOs, additional pages/columns must be included.

Lines 1 through 6 - In a separate column for each HMO, enter in the appropriate service category the number of encounters provided to Medicaid/NJ FamilyCare managed care patients.

Line 7 - Enter the sum of lines 1 through 6.

Lines 10 through 15 - In a separate column for each HMO, enter in the appropriate service category the number of encounters provided to managed care patients.

Line 16 - In a separate column for each HMO, enter the pneumococcal/influenza vaccine injections provided to Medicaid/NJ FamilyCare managed care patients.

Lines 17 through 25 - In a separate column for each HMO enter in the appropriate service category the number of encounters provided to Medicaid/NJ FamilyCare managed care patients.

Line 26 - Enter the sum of lines 10 through 15, and 17 through 25.

Column 7 - Enter the sum of Columns 1 through 6 for each line.

FQHC-2001-07 Worksheet 2--Support Schedule B-Medicaid Managed Care Receipts

Medicaid managed care receipts received by the Federally Qualified Health Center must be segregated by calendar month of service. The receipts reported on this worksheet shall not include delivery and OB/GYN surgical receipts reported on Worksheet 2 - Support Schedules D and F.

COMPLETION INSTRUCTIONS:

Enter the FQHC Name and FQHC provider number.

Enter the service month and service year.

Line 1 - In Columns A through K, enter the name of each HMO with which the FQHC contracts. If the FQHC is under contract with more than ten Medicaid/NJ FamilyCare HMOs, additional pages/columns must be included.

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Line 2 - Enter the effective date of the contract with each managed care company entered on line 1.

Lines 3 through 9 - In a separate column for each HMO, enter the receipts received to date for the services provided to Medicaid/NJ FamilyCare beneficiaries for the service month and year.

Line 10 - Enter the total of the amounts entered in lines 3 through 9.

Column F - Enter the sum of Columns A through E for lines 3 through 9.

Column L - Enter the sum of Columns G through K for lines 3 through 9.

Line 11 - Enter the total of the amounts entered in line 10, columns F and L.

Worksheet 2--Support Schedule C--Medicaid Managed Care Delivery Encounters

Medicaid managed care encounters for delivery encounters provided by Federally Qualified Health Center practitioners must be segregated by calendar month of service.

COMPLETION INSTRUCTIONS:

Enter the FQHC Name and FQHC provider number.

Enter the service month and service year.

Line 3: In Columns B through F, enter the name of each HMO with which the FQHC contracts. If the FQHC is under contract with more than five Medicaid/NJ FamilyCare HMOs, additional pages/columns must be included.

Lines 2 - 27, Column A: Enter the delivery procedure code for encounters provided to Medicaid/NJFamilyCare beneficiaries during the service month and year.

Lines 2 - 17, Columns B through F: In a separate column for each HMO, enter all delivery encounters by procedure code provided for the service month and year.

Lines 2 - 27, Column G: Enter the sum of Columns B through F for each line.

Line 28: Enter the sum of Lines 2 through 27 in Columns B through G.

Worksheet 2--Support Schedule D--Medicaid Managed Care Delivery Receipts

Medicaid managed care receipts for delivery encounters provided by Federally Qualified Health Center practitioners must be segregated by calendar month of service.

COMPLETION INSTRUCTIONS:

Enter the FQHC Name and FQHC provider number.

Enter the service month and service year.

Line 3: In Columns B through F, enter the name of each HMO with which the FQHC contracts. If the FQHC is under contract with more than five Medicaid/NJ FamilyCare HMOs, additional pages/columns must be included.

Lines 2 - 27, Column A: Enter the delivery procedure code for which receipts were received for services provided to Medicaid/NJ FamilyCare beneficiaries for the service month and year.

Lines 2 - 17, Columns B through F: In a separate column for each HMO, enter all delivery receipts received for each procedure code for the service month and year.

Lines 2 - 27, Column G: Enter the sum of Columns B through F for each line.

Line 28: Enter the sum of Lines 2 through 27 in Columns B through G.

Worksheet 2--Support Schedule E--Medicaid Managed Care Ob/Gyn Surgical Encounters

Medicaid managed care encounters for Ob/Gyn surgical encounters provided by Federally Qualified Health Center practitioners must be segregated by calendar month of service.

COMPLETION INSTRUCTIONS:

Enter the FQHC Name and FQHC provider number.

Enter the service month and service year.

Line 3: In Columns B through F, enter the name of each HMO with which the FQHC contracts. If the FQHC is under contract with more than five Medicaid/NJ FamilyCare HMOs, additional pages/columns must be included.

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Lines 2 - 27, Column A: Enter the Ob/Gyn surgical procedure code for encounters provided during the service month and year.

Lines 2 - 17, Columns B through F: In a separate column for each HMO, enter all Ob/Gyn surgical encounters by procedure code provided to Medicaid/NJFamilyCare beneficiaries during the service month and year.

Lines 2 - 27, Column G: Enter the sum of Columns B through F for each line.

Line 28: Enter the sum of Lines 2 through 27 in Columns B through G.

Worksheet 2--Support Schedule F--Medicaid Managed Care Ob/Gyn Surgical Receipts

Medicaid managed care receipts for Ob/Gyn surgical encounters provided by Federally Qualified Health Center practitioners must be segregated by calendar month of service.

COMPLETION INSTRUCTIONS:

Enter the FQHC Name and FQHC provider number.

Enter the service month and service year.

Line 3: In Columns B through F, enter the name of each HMO with which the FQHC contracts. If the FQHC is under contract with more than five Medicaid/NJ FamilyCare HMOs, additional pages/columns must be included.

Lines 2 - 27, Column A: Enter the Ob/Gyn surgical procedure code for receipts received for services provided to Medicaid/NJ FamilyCare beneficiaries during the service month and year.

Lines 2 - 17, Columns B through F: In a separate column for each HMO, enter all Ob/Gyn surgical receipts received for each procedure code for the service month and year.

Lines 2 - 27, Column G: Enter the sum of Columns B through F for each line.

Line 28: Enter the sum of Lines 2 through 27 in Columns B through G.

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Federally Qualified Health Center MEDICAID MANAGED CARE ENCOUNTER DETAIL		FQHC Number:		Worksheet 2 Support Schedule A
	Reporting Month:			
	Detail all Medicaid Reimbursable Managed Care Encounters			Total Medicaid HMO Encounters
HMO Name	HMO #1	HMO #2	HMO #3	HMO #4	HMO #5	HMO #6	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Core Services							
1 Physician							0
2 Nurse Practitioner							0
3 Nurse - Mid-Wife							0
4 Clinical Psychologist							0
5 Clinical Social Worker							0
6 Physician Services Under Arr.							0
7 Total Core Encounter (Lines 1-6)	0	0	0	0	0	0	0
8							
Other Specialized Services							
10 Dentist							0
11 Dental Hygienist							0
12 Ob/Gynecology							0
13 Ob/Gynecology-Delivery ONLY							0
14 Home Care Services							0
15 Norplant							0
16 * Pneumococcal/Influenza Vaccine Injections							0
17 Podiatry							0
18 Eye Care Program							0
19 Chiropractic Services							0
20 Family Planning							0
21 EPSDT Services							0
22 Other (Specify)							0
23							
24							
25							
26 Total Other Spec. Svs. (Lines 10-15	0	0	0	0	0	0	0
27 Total Medicaid Managed Care							
28 Encounters (Sum Line 7 + Line 26)	0	0	0	0	0	0	0

State of New Jersey Medicaid Form FQHC-2001-07 [07/01/01]

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Federally Qualified Health Center MEDICAID MANAGED CARE RECEIPTS				FQHC Number:		Worksheet 2 Support Schedule B
	Reporting Month:					
	Detail all Medicaid Managed Care Receipts					
	A	B	C	D	E	F
	HMO #1	HMO #2	HMO #3	HMO #4	HMO #5	Total Medicaid HMO Receipts
1 HMO Name						
2 Date of Contract						
3 Capitation Receipts						$0
4 Referral Fund Receipts						$0
5 Case Management Fees						$0
6 Fee for Service						$0
7 Other (Specify)						$0
8 Other (Specify)						$0
9 Other (Specify)						$0
10 Total Receipts (Lines 3-9)	$0	$0	$0	$0	$0	$0
	G	H	I	J	K	L
	HMO #6					Total Medicaid HMO Receipts
1 HMO Name						
2 Date of Contract						
3 Capitation Receipts						$0
4 Referral Fund Receipts						$0
5 Case Management Fees						$0
6 Fee for Service						$0
7 Other (Specify)						$0
8 Other (Specify)						$0
9 Other (Specify)						$0
10 Total Receipts (Lines 3-9)	$0	$0	$0	$0	$0	$0
11 Grand Total (Col. F, Line10 + Col. L, Line 10)						$0
	State of New Jersey Medicaid Form FQHC-2001-07			[07/01/01]		

APPENDIX E

1.	Federally Qualified Health Center Name			FQHC Number			Worksheet 2
2.							
3.	Medicaid Managed Care Delivery Encounters Detail Service Month/Year						Support Schedule C
	A	B	C	D	E	F	G
		HMO #1	HMO #2	HMO #3	HMO #4	HMO #5	Total Medicaid Deliv-ery
4.	HMO Name	Americhoice	Amerigroup	Horizon	PHS	UHP	
	Delivery Procedure Code						Encounters
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							
21.							
22.							
23.							
24.							
25.							
26.							
27.							
28.							
29.							
30.							
31.	Total (Lines 5 through 30)						

APPENDIX E

1.	Federally Qualified Health Center Name			FQHC Number			Worksheet 2
2.	Medicaid Managed Care Delivery Receipts						Support Schedule D
3.	Service Month/Year						
	A	B	C	D	E	F	G
		HMO #1	HMO #2	HMO #3	HMO #4	HMO #5	Total Medicaid Deliv-
4.	HMO Name	Americhoice	Amerigroup	Horizon	PHS	UHP	ery
	Delivery Procedure Code						Receipts
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							
21.							
22.							
23.							
24.							
25.							
26.							
27.							
28.							
29.							
30.							
31.	Total (Lines 5 through 30)						

APPENDIX E

1.	Federally Qualified Health Center Name			FQHC Number			Worksheet 2
2.	Medicaid Managed Care Ob/GYN Surgical Encounters Detail						Support Schedule E
3.	Service Month/Year						
	A	B	C	D	E	F	G
		HMO #1	HMO #2	HMO #3	HMO #4	HMO #5	Total Medicaid
4.	HMO Name	Americhoice	Amerigroup	Horizon	PHS	UHP	OB/GYN
	Ob/GYN Surgical Procedure Code						Surgical Encounters
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							
21.							
22.							
23.							
24.							
25.							
26.							
27.							
28.							
29.							
30.							
31.	Total (Lines 5 through 30)						

APPENDIX E

1.	Federally Qualified Health Center Name			FQHC Number			Worksheet 2
2.	Medicaid Managed Care Ob/GYN Surgical Receipts						Support Schedule F
3.	Service Month/Year						
	A	B	C	D	E	F	G
		HMO #1	HMO #2	HMO #3	HMO #4	HMO #5	Total Medicaid
4.	HMO Name	Americhoice	Amerigroup	Horizon	PHS	UHP	OB/GYN Surgical
	Ob/GYN Surgical Procedure Code						Receipts
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							
21.							
22.							
23.							
24.							
25.							
26.							
27.							
28.							
29.							
30.							
31.	Total (Lines 5 through 30)						

History

HISTORY:

New Rule, R.2004 d.208, effective June 7, 2004.

See: *36 N.J.R. 324(a)*, *36 N.J.R. 2834(a)*.

Amended by R.2009 d.376, effective December 21, 2009.

See: *41 N.J.R. 2561(a)*, *41 N.J.R. 4791(a)*.

Rewrote the Appendix.

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End of Document

N.J.A.C. 10:66-5.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:66-5.1 Covered services

(a) Medicaid and NJ FamilyCare fee-for-service covered procedures in an ambulatory surgical center (ASC) are those surgical and medical procedures that appear at *42 CFR 416.166*, the Federal regulations governing ASC services.

(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, meaning 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.

(c) For reimbursement information for ASC services, see *N.J.A.C. 10:66-1.5*.

History

HISTORY:

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.

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

Rewrote the introductory paragraph of (a); in the introductory paragraph of (a)1, and in (a)1i, deleted "eight" preceding "Medicare"; and in (b)2, substituted "meaning" for an opening parenthesis, and substituted a comma for a closing parenthesis following "overnight".

Amended by R.2019 d.065, effective June 17, 2019.

See: *51 N.J.R. 17(a)*, *51 N.J.R. 1056(a)*.

Rewrote (a); and added (c).

Annotations

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N.J.A.C. 10:66-5.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 66. INDEPENDENT CLINIC SERVICES > SUBCHAPTER 5. AMBULATORY SURGICAL CENTER (ASC)

§ 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.

History

HISTORY:

Amended by R.1998 d.577, effective December 7, 1998.

See: *30 New Jersey Register 3434(a)*, *30 New Jersey Register 4225(b)*.

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N.J.A.C. 10:66-5.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 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.

History

HISTORY:

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.

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

In the introductory paragraph of (b), inserted a comma following "programs" and following "procedures", and deleted an opening parenthesis preceding "other" and a closing parenthesis following "procedure".

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N.J.A.C. 10:66-5.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 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.

History

HISTORY:

Amended by R.1998 d.577, effective December 7, 1998.

See: *30 New Jersey Register 3434(a)*, *30 New Jersey Register 4225(b)*.

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N.J.A.C. 10:66-6.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 66. INDEPENDENT CLINIC SERVICES > SUBCHAPTER 6. CENTERS FOR MEDICARE & MEDICAID SERVICES 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) for 2009, established and maintained by CMS in accordance with the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, and incorporated herein by reference, as amended and supplemented, and as published by PMIC, 4727 Wilshire Blvd., Suite 302, Los Angeles, CA 90010. Revisions to the Healthcare Common Procedure Coding System made by CMS, including, but not limited to, code additions, code deletions and replacement codes, will be reflected in this subchapter through publication of a notice of administrative change in the New Jersey Register. Revisions to existing reimbursement amounts specified by the Department and specification of new reimbursement amounts for new codes will be made by rulemaking in accordance with the Administrative Procedure Act, *N.J.S.A. 52:14B-1* et seq. HCPCS follows the American Medical Association's Physicians' Current Procedure Terminology (CPT) architecture, employing a five-position code and as many as two two-position modifiers. Unlike the CPT numeric design, the CMS-assigned codes and modifiers contain alphabetic characters. HCPCS is a two-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. An updated copy of the CPT (Level I) codes may be obtained from the American Medical Association, P.O. Box 10950, Chicago, IL 60610, or by accessing *www.ama-assn.org*. An updated copy of the HCPCS (Level II) codes may be obtained by accessing the HCPCS website at *www.cms.hhs.gov/medicare/hcpcs* or by contacting PMIC, 4727 Wilshire Blvd., Suite 300, Los Angeles, CA 90010.

2. Level II codes: These codes are assigned by CMS for physician and non-physician services that are not in CPT. Narratives for Level II codes can be found at *N.J.A.C. 10:66-6.3*.

(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

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:
Indicator	Description
"L"	"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"	"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.
AA	Anesthesia services performed personally by an anesthesiologist.
EP	Services provided as part of Medicaid Early Periodic Screening, Diagnostic and Treatment (EPSDT) Services Program; add the modifier "EP" to only those procedure codes so indicated at N.J.A.C. 10:66-6.2.
N	Preceding any code means that qualifiers are applicable to that code.
UC	Independent clinic: To identify certain mental health and related transportation services provided by independent clinic providers, add the modifier "UC" to only those procedure codes so indicated at N.J.A.C. 10:66-6.2(f) and (
FP	Family planning: To identify procedures performed for the sole purpose of family planning, add the modifier "FP" to only those procedure codes so indicated at N.J.A.C. 10:66-6.2.
HD	OB/GYN encounter in FQHC
HE	Mental health program services
SA	Advanced Practice Nurse: to identify procedures performed by an Advanced Practice Nurse; add the modifier "SA" to only those procedure codes so

	indicated at N.J.A.C. 10:66-6.2.
SB	Certified nurse-midwife: To identify procedures performed by a certified nurse-midwife, add the modifier "SB" to only those procedure codes so indicated at N.J.A.C. 10:66-6.2.
SM	Second surgical opinion.
SN	Third surgical opinion.
UA	Only applies to billing by an ambulatory surgical center: To identify the trimester (1st trimester) of an abortion procedure, add the modifier "UA" to the procedure code.
UB	Only applies to billing by an ambulatory surgical center: To identify the trimester (2nd trimester) of an abortion procedure, add the modifier "UB" to the procedure code.
UD	Procedure performed in relation to abortion services.
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. 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: EPSDT permits the services of a pediatric advanced practice nurse 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, meaning 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.

History

HISTORY:

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.

Amended by R.2004 d.334, effective September 7, 2004.

See: *36 N.J.R. 312(a)*, *36 N.J.R. 4136(a)*.

Amended by R.2006 d.26, effective February 6, 2006.

See: *37 N.J.R. 3538(a)*, *38 N.J.R. 966(a)*.

In (b), added a description of the "N" indicator.

Amended by R.2007 d.188, effective June 18, 2007.

See: *39 N.J.R. 337(a)*, *39 N.J.R. 2360(a)*.

In the table in (b), added entry for "UC" and deleted entry for "ZI".

Amended by R.2009 d.376, effective December 21, 2009.

See: *41 N.J.R. 2561(a)*, *41 N.J.R. 4791(a)*.

Rewrote the introductory paragraph of (a); in (a)1, inserted the last two sentences; rewrote the HCPCS code table in (b); in (c)1vii, deleted "Procedure Code W9820," preceding and a comma following "EPSDT"; and deleted (c)4v.

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

Rewrote (a); in the table in (b), in the entry for Modifier Code "UC", inserted "and related transportation", and substituted "(*l*)" for "(*o*)"; in (c)1iii, deleted "(N.J.A.C. 10:66-6)" following "subchapter"; in (c)1vii, deleted an opening parenthesis preceding "Exception:" and a closing parenthesis from the end; and in (c)4iii, substituted ", meaning" for an opening parenthesis, and substituted a comma for a closing parenthesis following "Interpretation".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:66-6.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 66. INDEPENDENT CLINIC SERVICES > SUBCHAPTER 6. CENTERS FOR MEDICARE & MEDICAID SERVICES HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

§ 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 substance use disorder treatment facility.

	HCPCS	Follow Up Ind	Code	Mod
N	36415		1.80	1.80
N	67221	90	283.00	241.00
N	67225		23.00	20.00
	90746		65.25	65.25
	93000		16.00	16.00
	93005		11.00	11.00

93010		5.00	5.00
93012		11.00	9.00
93014		5.00	4.25
93015		80.00	68.00
93016		10.00	10.00
93017		35.00	35.00
93018		13.51	11.49
93268		32.00	27.00
93268	TC	19.00	19.00
93268	9326	13.00	11.00
93270		17.00	14.00
93271		35.00	30.00
93272		20.00	17.00
96372		2.50	2.50
96373		9.47	8.05
96374		32.22	27.39
96401		36.09	30.68
96402		22.34	18.99
96405		16.00	14.00
96406		20.00	17.00
96409		66.57	56.58
96411		37.94	32.24
96413		90.24	76.70

	96415		19.96	16.96
	96416		98.05	83.34
	96417		44.34	37.69
	96420		16.00	14.00
	96422		32.00	28.00
	96423		16.00	14.00
	96425		16.00	14.00
	96440		38.00	32.00
	96445		38.00	32.00
	96450		61.00	52.00
	96521		78.82	67.00
	96522		62.77	53.35
	96542		61.00	52.00
	99173		5.00	5.00
N	99201		23.50	20.60
N	99201	SA	NA	19.60
N	99201	SB	NA	16.50
N	99202		23.50	20.60
N	99202	SA	NA	19.60
N	99202	SB	NA	16.50
N	99203		32.30	25.00
N	99203	SA	NA	23.80
N	99203	SB	NA	22.60

N	99203	UD	32.30	25.00
N	*99204		32.30	25.00
N	99204	SA	NA	23.80
N	99204	SB	NA	22.60
N	*99205		32.30	25.00
N	99211		16.00	14.00
N	99211	SA	NA	13.30
N	99211	SB	NA	11.20
N	99212		23.50	20.60
N	99212	SA	NA	19.60
N	99212	SB	NA	16.50
N	*99213		23.50	20.60
N	99213	SA	NA	19.60
N	99213	SB	NA	16.50
N	99213	UD	23.50	20.60
N	*99214		23.50	20.60
N	99214	SA	NA	19.60
N	99214	SB	NA	16.50
N	99215		23.50	20.60
	99215	SA	NA	19.60
N	99215	SB	NA	16.50
	99217		23.50	20.60
	99221		32.30	25.00

	99221	SA	NA	23.80
	99221	SB	NA	22.60
	99222		32.30	25.00
	99223		32.30	25.00
	99231		23.50	20.60
	99231	SA	NA	19.60
	99231	SB	NA	16.50
	99232		23.50	20.60
	99232	SA	NA	19.60
	99232	SB	NA	16.50
	99233		23.50	20.60
	99234		55.90	47.00
	99235		55.90	47.00
	99236		55.90	47.00
	99238		23.50	20.60
	99239		23.50	20.60
N	99241		44.00	37.00
N	99242		64.70	54.40
N	99243		64.70	54.40
N	99244		91.10	77.90
	99244	SM	73.50	62.50
	99244	SN	73.50	62.50
N	99245		91.10	77.90

N	99251		34.50	29.30
N	99252		64.70	54.40
N	99253		64.70	54.40
N	99254		91.10	77.90
N	99255		91.10	77.90
	99261		16.00	14.00
	99262		23.50	20.60
	99263		23.50	20.60
	99281		16.00	14.00
	99281	SA	NA	13.30
	99282		23.50	20.60
	99282	SA	NA	19.60
	99283		23.50	20.60
	99283	SA	NA	19.60
	99284		32.30	25.00
	99284	SA	NA	23.80
	99285		32.30	25.00
N	99291		66.20	58.80
N	99292		33.10	29.40
N	99354		66.20	58.80
N	99354	SA	NA	55.90
N	99355		33.10	29.40
N	99355	SA	NA	27.90

99356		66.20	58.80
99357		33.10	29.40
99381		80.06	68.05
99381	22	80.06	68.05
99381	SA	NA	64.65
99381	EP	NA	64.65
	SA		
99381	22	80.06	68.05
	EP		
99381	22	NA	64.65
	SA		
99382		86.53	73.55
99382	EP	86.53	73.55
99382	EP	NA	69.87
	SA		
99382	22	86.53	73.55
	EP		
99382	SA	NA	69.87
99382	SA	NA	69.87
	52		
99382	22	86.53	73.55
99382	22	NA	69.87
	SA		

*99383		85.17	72.39
99383	EP	85.17	72.39
99383	SA	NA	68.77
99383	SA	NA	68.77
	52		
*99384		92.67	78.77
99384	EP	92.67	78.77
99384	SA	NA	74.83
99384	SA	NA	74.83
	52		
99384	SB	NA	64.87
*99385		32.30	25.00
99385	EP	92.67	78.77
99385	SA	NA	23.80
99385	SA	NA	23.80
	52		
99385	SB	NA	22.60
*99386		32.30	25.00
99386	SA	NA	23.80
99386	SB	NA	22.60
*99387		32.30	25.00
99387	SA	NA	23.80
99387	SB	NA	22.60
99391		64.05	54.44

99391	SA	NA	51.72
99391	EP	64.05	54.44
99391	22	64.05	54.44
99391	EP	NA	51.72
	SA		
99391	22	64.05	54.44
	EP		
99392		71.54	60.81
99392	EP	71.54	60.81
99392	22	71.54	60.81
99392	SA	NA	51.72
99392	22	NA	51.72
	SA		
99392	EP	NA	51.72
	SA		
99392	22	71.54	60.81
	EP		
99392	SA	NA	51.72
	52		
*99393		70.86	60.23
99393	SA	NA	57.22
99393	EP	70.86	60.23
99393	SA	NA	57.22

	52		
*99394		77.68	66.03
99394	EP	77.68	66.03
99394	SA	NA	62.73
99394	SA	NA	62.73
	52		
99394	SB	NA	54.38
*99395		32.30	25.00
99395	EP	78.36	66.61
99395	SA	NA	23.80
99395	SA	NA	23.80
	52		
99395	SB	NA	22.60
99396		32.30	25.00
99396	SA	NA	23.80
99396	SB	NA	22.60
*99397		32.30	25.00
99397	SA	NA	23.80
99397	SB	NA	22.60
99460		51.37	43.66
99460	SA	NA	41.48
99461		73.46	62.44
99463		69.22	58.83
99463	SA	NA	55.89

99464	65.14	55.37	
99465	127.74	108.58	

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

(c) Family planning services:

	HCPCS	Ind	Follow Up	Code		Mod
	11975	FP	30	B.R.	B.R.	
N	11975	22	30	B.R.	B.R.	
	11976	FP	90	190.00	190.00	
N	11977	22	90	B.R.	B.R.	
	11981	FP		100.00	100.00	
	11982	FP		100.00	100.00	
	11983	FP		180.00	180.00	
	36415	FP		3.40	3.40	
	36416	FP		1.80	1.80	
	54056	FP		32.00	32.00	3
N	5525		30	90.00	79.00	3

	0					
N	55450		30	42.00	37.00	3
	56501	FP		29.00	29.00	3
	56820	FP	30	88.00	NA	
	56821	FP	30	113.00	NA	
	57420	FP		71.00	NA	3
	57421	FP	15	93.00	NA	3
	57452	FP		39.90	39.90	3
	57454	FP		64.60	64.60	3
	57511	FP	45	45.60	45.60	3
	58300	FP	5830	74.10	74.10	3
	58300	SA	5830	NA	29.85	3
		FP				
	58300	SB	5830	NA	29.85	3
		FP				
	58301			16.40	16.40	
	58301	FP		31.20	31.20	
	58301	SA		NA	16.40	3
		FP				
	58301	SB		NA	16.40	
		FP				
	81000	FP		1.20	1.20	
	81002	FP		1.00	1.00	
	8102	F		3.00	3.00	

5	P		
82465	FP	3.00	3.00
82947	FP	4.34	4.34
82948	FP	1.50	1.50
85013	FP	1.50	1.50
85018	FP	2.00	2.00
86592	FP	1.50	1.50
86701	FP	12.00	12.00
86762	FP	12.00	12.00
87086	FP	6.00	6.00
87184	FP	9.00	9.00
87270	FP	10.00	10.00
87274	FP	12.80	12.80
87320	FP	12.50	12.50
87490	FP	20.00	20.00
87491	FP	38.00	38.00
87590	FP	25.00	25.00
87591	FP	38.00	38.00
87620	FP	25.00	25.00
87621	FP	38.00	38.00
88141	FP	6.00	6.00
88142	FP	18.00	18.00
88143	FP	18.00	18.00
88147	F	13.48	13.48

	8	P		
	88150	FP	6.00	6.00
	88151		6.00	6.00
	88152	FP	6.00	6.00
	88153	FP	6.00	6.00
	88154	FP	6.00	6.00
	88164	FP	6.00	6.00
	88165	FP	6.00	6.00
	88166	FP	6.00	6.00
	88167	FP	6.00	6.00
	88305	FP	40.00	40.00
	90471	FP	16.18	16.18
	90649	FP	153.25	153.25
	90671	FP	16.18	16.18
	96372	FP	4.80	4.80
N	99201	FP	83.70	83.70
N	99201	FP	NA	31.50
		SB		
N	99201	FP	79.70	79.70
		52		
N	99202	FP	83.70	83.70
N	99202	FP	NA	31.50
		SB		
N	99202	FP	79.70	79.70

		52		
N	99203	FP	83.70	83.70
N	99203	FP	NA	31.50
		SB		
N	99203	FP	79.70	79.70
		52		
N	99204	FP	83.70	83.70
N	99204	FP	NA	31.50
		SB		
N	99204	FP	79.70	79.70
		52		
N	99205	FP	83.70	83.70
N	99205	FP	NA	31.50
		SB		
N	99205	FP	79.70	79.70
		52		
N	99211	FP	41.90	41.90
N	99211	FP	NA	16.40
		SB		
N	99211	FP	37.90	37.90
		52		
N	99212	FP	41.90	41.90
N	99212	FP	NA	16.40
		SB		
N	9921	F	37.90	37.90

	2	P		
		52		
N	99213	FP	41.90	41.90
N	99213	FP	NA	16.40
		SB		
N	99213	FP	37.90	37.90
		52		
N	99214	FP	41.90	41.90
N	99214	FP	NA	16.40
		SB		
N	99214	FP	37.90	37.90
		52		
N	99215	FP	41.90	41.90
N	99215	FP	NA	16.40
		SB		
N	99215	FP	37.90	37.90
		52		
N	99395	FP	79.70	79.70
N	99395	FP	NA	31.50
		SB		
N	99395	FP	83.70	83.70
		22		
	J0696	FP	12.97	12.97
	J1055	FP	53.97	53.97
	J1056	FP	22.60	22.60

J7300	FP	396.64	396.64
J7302	FP	450.88	450.88
J7303	FP	40.02	40.02
J7304	FP	15.72	15.72
J7307	FP	620.08	620.08
Q0111	FP	2.40	2.40
Y7633	FP	95.00	95.00
Y7634	FP	47.50	47.50
Z4333	FP	19.94	19.94
Z4334	FP	15.09	15.09

(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.

	HCPCS Ind	Follow	Code	Up	Mod
N	10040	10	18.00	16.00	3
*	10060	10	13.00	11.00	3
*	1006	10	48.00	42.00	3

	1				
	10080	10	30.00	26.00	3
*	10120	10	18.00	16.00	3
*	10121	10	34.00	29.00	3
*	10140		18.00	16.00	3
*	10160		13.00	11.00	3
*	11000		13.00	11.00	3
*	11001		6.00	5.00	3
*	11040		13.00	11.00	3
*	11041		13.00	11.00	3
*	11042		16.00	14.00	3
*	11043		16.00	14.00	3
*	11100		13.00	11.00	3
*	11400	10	18.00	16.00	3
*	11401	10	22.00	20.00	3
*	11402	10	27.00	24.00	3
*	11403	10	32.00	27.00	3
*	11404	10	32.00	27.00	3
*	11406	10	32.00	27.00	3
*	11420	10	18.00	16.00	3
*	11421	10	22.00	20.00	3
*	11422	10	27.00	24.00	3
*	11423	10	32.00	27.00	3
*	1142	10	32.00	27.00	3

	4				
*	11426	10	32.00	27.00	3
	11440	10	18.00	16.00	5
	11441	10	22.00	20.00	5
	11442	10	27.00	24.00	5
	11443	10	32.00	27.00	5
	11444	10	32.00	27.00	5
	11446	10	32.00	27.00	5
*	11600	10	37.00	32.00	3
*	11601	10	47.00	42.00	3
*	11602	10	61.00	53.00	3
*	11620	10	61.00	53.00	3
*	11621	10	90.00	79.00	3
*	11622	10	121.00	105.00	3
	11640	10	90.00	79.00	5
	11641	10	121.00	105.00	5
	11642	10	150.00	131.00	5
*	11730		10.00	10.00	3
*	11750	10	42.00	37.00	3
*	12001	10	18.00	16.00	3
*	12002	10	24.00	21.00	3
*	12004	10	30.00	26.00	3
	12005	10	46.00	39.00	3
	1200	10	57.00	48.00	3

	6				
	12007	10	82.50	70.00	3
	12011	10	18.00	16.00	5
	12013	10	24.00	21.00	5
	12014	10	30.00	26.00	5
	12031	10	30.00	26.00	3
	12032	10	48.00	42.00	3
*	12041	10	30.00	26.00	3
*	12042	10	67.00	59.00	4
	12051	10	38.00	33.00	4
	12052	10	67.00	59.00	4
	13100	1310	34.00	29.00	4
	13101	1310	68.00	63.00	4
	13120	10	48.00	42.00	4
	13121	10	106.00	92.00	4
*	13131	10	67.00	59.00	4
*	13132	10	145.00	126.00	4
	13150	10	38.00	33.00	4
	13151	10	82.00	71.00	4
	13152	10	193.00	168.00	4
*	17000	10	16.00	14.00	3
*	17110	7110	16.00	14.00	3
	20526		13.00	11.00	3
*	2055		13.00	11.00	5

	0				
*	20551		13.00	11.00	3
*	20552		13.00	11.00	3
*	20553		13.00	11.00	553

(f) Mental health services:

Ind	**HCPCS**		**Follow Up Code**		**Mod**
N	90801	UC	45.00	45.00	
	90804	UC	13.00	13.00	
	90805	UC	13.00	13.00	
	90806	UC	26.00	26.00	
	90807	UC	26.00	26.00	
N	90847	UC	32.00	32.00	
		22			
N	90853	UC	8.00	8.00	
	90862	UC	9.00	9.00	
N	90887	UC	13.00	13.00	
	96101	UC	30.00	30.00	

	96102	UC	18.88	18.88
	96103	UC	17.26	17.26
	96105	UC	25.00	25.00
N	96150	UC	14.00	14.00
N	96151	UC	14.00	14.00
N	96152	UC	13.00	13.00
N	96153	UC	5.00	5.00
N	96154	UC	13.00	13.00
N	96155	UC	12.00	12.00
L	20100		22.50	22.50
L	Z0170		14.55	14.55

(g) Obstetrical services (maternity):

Ind	**HCPCS Code**	**Follow Up**		**Mod**
	51798	16.00	13.00	
	59000	37.00	32.00	4
	5900	47.00	40.00	4

	1					
N	59400		60	468.00	403.00	4
N	59400	SB	60	NA	328.00	4
	59409		60	300.00	254.00	5
	59409	SB	60	NA	210.00	5
N	59410		60	320.00	272.00	4
N	59410	SB	60	NA	224.00	4
	59425			16.00	14.00	
	59425	SA		NA	13.30	
	59425	SB		NA	11.20	
	59426			16.00	14.00	
	59426	SA		NA	13.30	
	59426	SB		NA	11.20	
N	59430		430	20.00	18.00	0
N	59430	SB	430	NA	14.00	0
	59610		45	468.00	403.00	5
	59610	SB	45	NA	328.00	5
	59612		45	300.00	254.00	5
	59612	SB	45	NA	210.00	5
	59614		45	320.00	272.00	5
	59614	SB	45	NA	224.00	5
	59812		45	105.00	91.00	3

(h) Podiatry services:

Follo

		w		
	HCPCS		Up	
	Ind	Code		Mod
	29580	18.00	16.00	3
N	99211	16.00	14.00	
N	99212	23.50	20.60	
N	99213	23.50	20.60	
N	99214	23.50	20.60	
N	99215	23.50	20.60	

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

(i) Radiology services:

		Follow		
	HCPCS		Up	
	Ind	Code		Mod

70030		15.00	3
70030	TC	7.80	
70030	26	7.20	
70100		15.00	3
70100	TC	9.60	
70100	26	5.40	
70110		20.00	3
70110	TC	11.00	
70110	26	9.00	
70120		15.00	3
70120	TC	7.80	
70120	26	7.20	
70130		20.00	3
70130	TC	9.20	
70130	26	10.80	
70140		15.00	3
70140	TC	9.60	
70140	26	5.40	
70150		20.00	3
70150	TC	11.00	
70150	26	9.00	
70160		15.00	3

70160	TC	9.60	
70160	26	5.40	
70170		20.00	3
70170	TC	12.80	
70170	26	7.20	
70190		15.00	3
70190	TC	9.60	
70190	26	5.40	
70200		25.00	3
70200	TC	16.00	
70200	26	9.00	
70210		20.00	3
70210	TC	14.60	
70210	26	5.40	
70220		25.00	3
70220	TC	16.00	
70220	26	9.00	
70240		15.00	3
70240	TC	7.80	
70240	26	7.20	
70250		15.00	3
70250	TC	9.60	
70250	26	5.40	

70260		25.00	3
70260	TC	16.00	
70260	7026	9.00	
70300		5.00	3
70300	TC	3.20	
70300	26	1.80	
70310		10.00	3
70310	TC	6.40	
70310	26	3.60	
70320		15.00	3
70320	TC	7.80	
70320	26	7.20	
70328		13.00	3
70328	TC	7.60	
70328	26	5.40	
70330		20.00	3
70330	TC	11.00	
70330	26	9.00	
70350		8.00	3
70350	TC	4.40	
70350	26	3.60	
70360		10.00	3
70360	TC	6.40	

	70360	26	3.60	
	70370		20.00	3
	70370	TC	11.00	
	70370	26	9.00	
	70380		15.00	3
	70380	TC	9.60	
	70380	26	5.40	
	70390		15.00	3
	70390	TC	7.80	
	70390	26	7.20	
MN	71010		10.00	3
MN	71010	TC	6.40	
MN	71010	26	3.60	
MN	71020		15.00	3
MN	71020	TC	9.60	
MN	71020	26	5.40	
MN	71030		20.00	3
MN	71030	TC	11.00	
MN	71030	26	9.00	
MN	71034		20.00	3
MN	71034	TC	11.00	
MN	71034	26	9.00	
	71100		15.00	3

71100	TC	9.60	
71100	26	5.40	
71110		20.00	3
71110	TC	11.00	
71110	26	9.00	
71120		15.00	3
71120	TC	9.60	
71120	26	5.40	
71130		20.00	3
71130	TC	12.80	
71130	26	7.20	
72010		40.00	3
72010	TC	23.80	
72010	26	16.20	
72040		15.00	3
72040	TC	9.60	
72040	26	5.40	
72050		20.00	3
72050	TC	12.80	
72050	26	7.20	
72052		25.00	3
72052	TC	16.00	
72052	26	9.00	

	72070		15.00	3
	72070	TC	9.60	
	72070	26	5.40	
	72080		15.00	3
	72080	TC	9.60	
	72080	26	5.40	
	72100		20.00	3
	72100	TC	12.80	
	72100	26	7.20	
	72110		25.00	3
	72110	TC	16.00	
	72110	26	9.00	
	72114		20.00	3
	72114	TC	12.80	
	72114	26	7.20	
N	72170		15.00	3
N	72170	TC	9.60	
N	72170	26	5.40	
	72190		20.00	3
	72190	TC	12.80	
	72190	26	7.20	
	72200		20.00	3
	72200	TC	14.60	

72200	26	5.40	
72220		15.00	3
72220	TC	9.60	
72220	26	5.40	
73000		10.00	3
73000	TC	6.40	
73000	26	3.60	
73010		15.00	3
73010	TC	9.60	
73010	26	5.40	
73020		15.00	3
73020	TC	11.40	
73020	26	3.60	
73030		15.00	3
73030	TC	9.60	
73030	26	5.40	
73040		15.00	3
73040	TC	4.20	
73040	26	10.80	
73050		18.00	3
73050	TC	10.80	
73050	26	7.20	
73060		15.00	3

73060	TC	9.60	
73060	26	5.40	
73070		15.00	3
73070	TC	11.40	
73070	26	3.60	
73080		15.00	3
73080	TC	9.60	
73080	26	5.40	
73085		15.00	3
73085	TC	4.20	
73085	26	10.80	
73090		10.00	3
73090	TC	6.40	
73090	26	3.60	
73092		20.00	3
73092	TC	13.79	
73092	26	6.21	
73100		10.00	3
73100	TC	6.40	
73100	26	3.60	
73110		15.00	3
73110	TC	9.60	
73110	26	5.40	

	73115		15.00	3
	73115	TC	4.20	
	73115	26	10.80	
	73120		10.00	3
	73120	TC	6.40	
	73120	26	3.60	
	73130		15.00	3
	73130	TC	9.60	
	73130	26	5.40	
	73140		5.00	3
	73140	TC	1.40	
	73140	26	3.60	
N	73500		18.00	3
N	73500	TC	12.60	
N	73500	TC	5.40	
N	73510		20.00	
N	73510	TC	12.80	
N	73510	26	7.20	
	73520		25.00	3
	73520	TC	17.80	
	73520	26	7.20	
	73525		15.00	3
	73525	TC	4.20	

73525	26	10.80	
73530		30.00	3
73530	TC	21.00	
73530	26	9.00	
73540		15.00	3
73540	TC	7.80	
73540	26	7.20	
73550		15.00	3
73550	TC	9.60	
73550	26	5.40	
73560		15.00	3
73560	TC	11.40	
73560	26	3.60	
73562		15.00	3
73562	TC	9.60	
73562	26	5.40	
73580		15.00	3
73580	TC	4.20	
73580	26	10.80	
73590		15.00	3
73590	TC	11.40	
73590	26	3.60	
73592		20.00	3

73592	TC	13.79	
73592	26	6.21	
73600		10.00	3
73600	TC	6.40	
73600	26	3.60	
73610		13.00	3
73610	TC	7.60	
73610	26	5.40	
73615		28.80	3
73615	TC	18.00	
73615	26	10.80	
73620		10.00	3
73620	TC	6.40	
73620	26	3.60	
73630		13.00	3
73630	TC	7.60	
73630	26	5.40	
73650		10.00	3
73650	TC	6.40	
73650	26	3.60	
73660		5.00	3
73660	TC	1.40	
73660	26	3.60	

	74000		10.00	3
	74000	TC	4.60	
	74000	26	5.40	
	74010		15.00	3
	74010	TC	7.80	
	74010	26	7.20	
	74020		15.00	3
	74020	TC	7.80	
	74020	26	7.20	
N	74220		20.00	3
N	74220	TC	11.00	
N	74220	26	9.00	
N	74240		40.00	3
N	74240	TC	25.60	
N	74240	26	14.40	
N	74241		45.00	3
N	74241	TC	28.80	
N	74241	26	16.20	
N	74245		50.00	3
N	74245	TC	30.20	
N	74245	26	19.80	
N	74250		30.00	5
N	74250	TC	19.20	

N	74250	26	10.80	
	74270		30.00	5
	74270	TC	16.50	
	74270	26	13.50	
	74280		40.00	5
	74280	TC	23.80	
	74280	26	16.20	
	74290		35.00	5
	74290	TC	26.00	
	74290	26	9.00	
	74305		25.00	5
	74305	TC	14.20	
	74305	26	10.80	
	74400		35.00	3
	74400	TC	22.40	
	74400	26	12.60	
	74420		35.00	5
	74420	TC	26.00	
	74420	26	9.00	
	74430		15.00	3
	74430	TC	6.00	
	74430	26	9.00	
	74450		20.00	3

	74450	TC	11.00	
	74450	26	9.00	
	74455		20.00	3
	74455	TC	3.80	
	74455	26	16.20	
	74470		20.00	3
	74470	TC	11.00	
	74470	26	9.00	
N	74710		25.00	5
N	74710	TC	16.00	
N	74710	26	9.00	
	74740		20.00	5
	74740	TC	11.00	
	74740	26	9.00	
	76000		45.00	7
	76000	TC	38.70	
	76000	26	6.30	
	76020		15.00	3
	76020	TC	9.60	
	76020	26	5.40	
	76040		20.00	5
	76040	TC	11.00	
	76040	26	9.00	

76061		35.00	3
76061	TC	17.00	
76061	26	18.00	
76062		90.00	3
76062	TC	66.22	
76062	26	23.78	
76080		15.00	3
76080	TC	6.00	
76080	26	9.00	
76100		35.00	3
76100	TC	21.00	
76100	26	14.00	
76801		55.00	
76801	TC	33.00	
76801	26	22.00	
76802		43.00	
76802	TC	25.00	
76802	26	18.00	
76805		55.00	3
76805	TC	29.80	
76805	26	25.20	
76810		50.00	3
76810	TC	29.00	

76810	26	21.00	
76811		204.00	
76811	TC	145.00	
76811	26	59.00	
76812		122.00	
76812	TC	74.28	
76812	26	47.72	
76815		25.00	3
76815	TC	14.20	
76815	26	10.80	
76816		25.00	3
76816	TC	14.20	
76816	26	10.80	
76817		81.00	
76817	TC	48.00	
76817	26	33.00	
77055		45.34	7
77055	TC	27.30	
77055	26	18.04	
77056		57.24	7
77056	TC	34.99	
77056	26	22.88	
77057		45.53	7

77057	TC		27.49
77057	26		18.04

(j) Rehabilitation services:

	HCPCS		Follow Up	
	Ind	**Code**		**Mod**
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	3.00	
	92563	3.00	3.00	
	92564	4.00	4.00	
N	92567	5.00	5.00	
N	92568	5.00	5.00	
N	92572	3.50	3.50	
N	92576	19.50	16.50	
N	9258	14.00	14.00	

	2		
	92585	45.00	42.00
	92590	40.00	34.00
	92591	40.00	34.00
	92620	34.15	29.03
	92621	8.47	7.20
	92625	33.94	28.84
	97001	7.00	7.00
	97002	7.00	7.00
	97003	7.00	7.00
	97004	7.00	7.00
N	97535	7.00	7.00
N	97799	7.00	7.00
	Z0310	45.00	45.00

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

(l) Transportation services:

HCPCS	**Ind**	**Code**	**Follow Up Mod**

LN	A0425	UC	2.50	2.50
LN	Z0330		4.50	4.50

(m) Substance use disorder treatment facility services:

	HCPCS	**Ind**	**Follow Up Code**		**Mod**
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	
LN	Z3348		45.00	45.00	
LN	Z3349		35.00	35.00	

LN	Z3353	4.50	4.50
LN	Z3354	45.00	45.00
LN	Z3355	20.00	20.00
LN	Z3356	15.00	15.00
LN	Z3357	4.00	4.00
LN	Z3358	23.00	23.00
LN	Z3359	5.20	5.20

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:

	HCPCS		**Follow Up**		**Mod**
Ind			**Code**		
L	W9840		contract	contract	
	W9843		contract	contract	
L	D0120	22	contract	contract	
	T1015		contract	contract	
	T1015	EP	contract	contract	

	T1015	HD	contract	contract
L	T1015	HE	contract	contract

(o) (Reserved)

(p) Vaccine for Children Program Administration Codes:

	Code		
N	90465		16.18
N	90466		11.50
N	90467		11.44
N	90468		8.77
N	90471		16.18
N	90472		11.50
N	90473		12.12
N	90474		8.43

(q) Immunizations:

		Code	
N	[illegible]	90632	80.95

	+	90633	38.24
	+		
N		90636	103.04
	+	90647	31.52
	+		
	+	90648	29.54
	+		
N		90649	153.25
	+	90655	19.33
	+		
	+	90656	20.64
	+		
	+	90657	9.41
	+		
	+	90658	17.56
	+		
	+	90660	25.69
	+		
		90665	B.R.
	+	90669	94.62
	+		
		90675	B.R.
	+	90680	88.64
	+		
		90681	130.44
		90691	79.90
	+	90696	61.75
	+		
	+	90698	92.70
	+		
	+	90700	28.68
	+		
		90702	31.56
		90703	17.72
		90704	29.08
		90705	24.21
		90706	25.37
	+	90707	56.96
	+		
	+	90713	33.03
	+		
	+	90714	26.05
	+		

	+	90715	47.25
	+	90716	98.27
		90717	81.35
	+	90718	17.50
	+	90721	55.35
	+	90723	90.90
N	+	90732	35.76
		90733	115.18
N	+	90734	114.10
		90736	188.66
		90740	209.86
	+	90743	74.28
	+	90744	29.62
N	+	90746	65.25
N	+	90748	56.20
		90749	B.R.

"++" Indicates that this vaccine is covered under the VFC Program. Providers must report both the appropriate VFC administration code and the associated HCPCS procedure code when requesting payment for the administration fee(s) for VFC vaccines to ensure appropriate reimbursement is provided. (See *N.J.A.C. 10:66-2.20*.)

(r) Miscellaneous services:

		Follow	
	HCPCS		**Up**

	Ind		Code		Mod
	58120	15	72.00	63.00	3
N	59840	45	79.00	68.00	3
N	59841	45	79.00	68.00	3

History

HISTORY:

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.

Amended by R.2006 d.26, effective February 6, 2006.

See: *37 N.J.R. 3538(a)*, *38 N.J.R. 966(a)*.

In (a), added HCPCS procedure codes J3395, 67221 and 67225.

Amended by R.2007 d.188, effective June 18, 2007.

See: *39 N.J.R. 337(a)*, *39 N.J.R. 2360(a)*.

In (f) and (*o*), substituted "UC" for "ZI" throughout.

Amended by R.2009 d.376, effective December 21, 2009.

See: *41 N.J.R. 2561(a)*, *41 N.J.R. 4791(a)*.

Rewrote the HCPCS code tables throughout; added new (p) and (q); and recodified former (p) as (r).

Amended by R.2012 d.050, effective March 5, 2012.

See: *43 N.J.R. 2112(a)*, *44 N.J.R. 594(a)*.

In the last entry in the table in (f), substituted "Z0170" for "20170" and substituted "14.55" for "15.40" twice.

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

In the paragraph preceding the table in (a), substituted "substance use disorder treatment facility" for "drug treatment center"; in the table in (*l*), inserted the entry for HCPCS Code "A0425"; rewrote (m); and reserved (*o*).

Administrative correction.

See: *50 N.J.R. 1814(a)*.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:66-6.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 66. INDEPENDENT CLINIC SERVICES > SUBCHAPTER 6. CENTERS FOR MEDICARE & MEDICAID SERVICES HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

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

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

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

(c) Mental health services:

HCPCS		Follow Up Ind	Code	Mod
Z0100	Off-Site Crisis Intervention--An emergency procedure by personnel			

	of a mental health clinic to an outpatient individual at locations other than the grounds or buildings of the clinic.	22.50	22.50
	Request for this service shall be initiated by the patient or other interested individual to meet the immediate needs of the patient, who is unable to present himself at the clinic.		

The procedure includes rapid intervention, written evaluation and a treatment plan. Use of procedure is limited to twice in six months for any one patient. This procedure is not applicable to institutionalized patients.

Partial Care: A mental health service whose primary

purpose is to maximize the client's independence and community living skills in order to reduce unnecessary hospitalization. It is directed toward the acute and chronically disabled individual. Partial Care programs shall provide, as listed below, a full system of services necessary

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

Assessment and evaluation;

Service procurement;

Therapy;

Information and referral;

Counseli

ng; Daily living educatio n; Commu nity organiza tion; Pre- vocation al therapy; Recreati onal therapy; and Health related services .		Partial Care programs shall be available daily for five days a week, with additional planned activities each week during evening and/or weekend

hours as needed. Individual clients need not attend every day but as needed. Partial Care programs specifically developed for children may be available four days a week, with one evening and/or weekend activity(ies). The staff of the Partial Care program should include a Director who shall be a

qualified professional from the specialties of psychiatry, psychology, social work, psychiatric nursing, vocational rehabilitation, or a related field with training and/or experience in direct service provision and administration. A qualified psychiatrist shall be available to the Partial

Care program on a regularly scheduled basis, for consultation. Other staff deemed necessary to implement a Partial Care program which meets the requirement of this section should include qualified mental health professionals, paraprofessionals and volunteers. In order to qualify as an

approved Partial Care program the Program must be certified by the Departme nt.

NOTE :

Except for transporta tion these rates reflect full payments with a prohibitio n against multiple billing for more than one service to a Medicaid patient in a given day.

(d) Vision care services. See N.J.A.C. 10:62-3.

(e) Transportation services:

HCPCS	**F o l l**

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

HCPCS	Ind	Code	Follow Up	Mod
A0425	UC	Per trip, one way, to/from a Partial Care program	2.50	2.50
Z0330		Transportation, one way.	4.50	4.50

(f) Substance use disorder treatment facility services:

HCPCS	Ind	Code	Follow Up	Mod
Z2000		Family	22.50	22.

			50
	therapy rendered in a drug treatment center.		
Z2001	Family conference rendered in a drug treatment center.	15.00	15.00
Z2002	Prescription visit rendered in a drug treatment center	4.50	4.50
Z2003	Psychotherapy rendered in a drug treatment center-full session.	16.00	16.00
Z2004	Group therapy rendered in a drug treatment center,	8.00	8.00

	per person.		
Z2005	Psychological testing rendered in a drug treatment center, per hour; maximum of five hours.	15.00	15.00
Z2006	Methadone treatment rendered in a drug treatment center.	2.50	2.50
Z2007	Psychotherapy rendered in a drug treatment center-half session.	8.00	8.00
Z2010	Urinalysis for drug addiction.	4.50	4.50
Z3348	Family therapy rendered	45.00	45.00

	in a narcotic/alcohol clinic, per hour		
Z3349	Family conference rendered in a narcotic/alcohol clinic, per visit	35.00	35.00
Z3353	Prescription visit rendered in a narcotic/alcohol clinic, per visit	4.50	4.50
Z3354	Psychotherapy rendered in a narcotic/alcohol clinic, per hour	45.00	45.00
Z3355	Group therapy rendered in	20.00	20.00

	a narcotic/alcohol clinic, per hour		
Z3356	Psychological testing rendered in a narcotic/alcohol clinic, per hour	15.00	15.00
Z3357	Methadone treatment rendered in a narcotic/alcohol clinic, per visit	4.00	4.00
Z3358	Psychotherapy half session rendered in a narcotic/alcohol clinic, per half hour	23.00	23.00
Z3359	Urinalysis rendered in	5.20	5.20

		a narcotic/alcohol clinic		

(g) Federally qualified health center services:

HCPCS			Follow Up	
Ind		**Code**		**Mod**
W9840		Medical encounter	contract	contract
W9843		EPSDT encounter	contract	contract
D0120	22	Dental encounter	contract	contract
T1015	HD	OB/GYN Encounter	contract	contract
T1015	HE	Mental health encounter	contract	contract

History

HISTORY:

Amended by R.1998 d.577, effective December 7, 1998.

See: *30 N.J.R. 3434(a)*, *30 N.J.R. 4225(b)*.

In (a), substituted references to beneficiaries for references to recipients throughout; and in (f), 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)*.

In (c), added HCPCS code G0001 WF (Routine Venipuncture).

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.

Amended by R.2006 d.26, effective February 6, 2006.

See: *37 N.J.R. 3538(a)*, *38 N.J.R. 966(a)*.

In (a), added HCPCS procedure codes 67221 and 67225.

Amended by R.2009 d.376, effective December 21, 2009.

See: *41 N.J.R. 2561(a)*, *41 N.J.R. 4791(a)*.

Rewrote the section.

Amended by R.2012 d.050, effective March 5, 2012.

See: *43 N.J.R. 2112(a)*, *44 N.J.R. 594(a)*.

In the table in (c), deleted the entries for HCPCS Codes "Z0170" and "Z0180".

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

Section was "HCPCS procedure codes and maximum fee allowance schedule for Level II and Level III codes and narratives (not located in CPT)". In (d), deleted an opening parenthesis preceding "See", and substituted "3" for "4)"; in the table in (e), inserted the entry for HCPCS Code "A0425"; rewrote (f); and deleted (h).

Annotations

Notes

Chapter Notes

Case Notes

Initial Decision (2005 N.J. AGEN LEXIS 1319) adopted, which concluded that a mental health service provider improperly billed full-day rates for children who did not receive the required full five hours of care and that the

facility's executive officer was personally liable, within the meaning of *N.J.S.A. 30:4D-7(h)*, for any incorrect or illegal Medicaid payments. *Hentz v. DMAHS, OAL Dkt. No. HMA 5140-04, 2005 N.J. AGEN LEXIS 1320*, Final Decision (November 18, 2005).

N.J.A.C. 10:66-6.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:66-6.4 HCPCS procedure codes--qualifiers

(a) Evaluation and management and other procedures:

1. Drawing of blood: 36415.

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

2. Photodynamic therapy: 67221 for one eye and 67225 for the second eye at single session.

i. Procedure code 67221 may be billed with 67225. This procedure must be rendered by ophthalmologists who are retinal specialists, and shall be limited to patients meeting the following criteria:

(1) Best corrected visual acuity equal to or better than 20/200, if the decreased visual acuity is caused by the macular degeneration;

(2) Classic subfoveal choroidal neovascularization (CNV), occupying 50 percent or greater of the entire ocular lesion; and

(3) For dates of service before October 1, 2015, a reported ICD-9-CM diagnosis of 115.02, 115.92, 362.21, or 362.52 (exudative senile macular degeneration), or for dates of service on or after October 1, 2015, a reported ICD-10-CM diagnosis of H35.32 or B39.9 w/H32.

ii. Procedure code 67225 must be billed with 67221. This procedure must be rendered by ophthalmologists who are retinal specialists, and shall be limited to patients meeting the criteria set forth in (a)2i(1) through (3) above.

iii. Report HCPCS procedure code 67225 on the CMS 1500 claim form for procedures performed on a second eye when both eyes are treated on the same date of service. Evaluation and management (E&M) services, fluorescent angiography (FA) and other ocular diagnostic services may also be billed separately when determined medically necessary and provided on the same date of service.

iv. Modifiers LT or RT should be used on all claims for codes 67221 and 67225 whether initial or subsequent treatment.

3. Injection (intradermal, subcutaneous, or intra-arterial): 96372 and 96373.

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

(1) A visit for the sole purpose of an injection is reimbursable only as an injection and not as a clinic visit and injection. However, if the criteria of a clinic visit is met, an injection may, if medically indicated, be considered as an add-on to the visit. The drug administered shall be

consistent with the diagnosis and shall conform to accepted medical and pharmacological principles with respect to dosage, frequency and route of administration.

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

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

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

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

(6) No reimbursement will be made for an injection given as a pre-operative medication or as a pre-operative local anesthetic which is part of an operative or surgical procedure since this injection would normally be included in the listed fee for such a procedure.

(7) Insert procedure code 96372 and 96373 as a separate item on the claim, followed by the name, dose of drug, and route of administration. The complete diagnosis, for which the injection was given, shall be indicated on the claim.

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

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

5. Prolonged detention: 99354 and 99355.

i. Prolonged detention with or without critical care will be covered under CPT 99354 and 99355, but the service shall be consistent with the following narrative in order to be reimbursed:

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

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

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

iii. The basis for this type of claim should be apparent on the claim form.

6. Evaluation and management--new patient; excludes preventive health care for patients through 20 years of age: 99201, 99201 FP, 99201 FP SB, 99201 SA, 99201 SB, 99201 FP 52, 99202, 99202 FP, 99202 FP SB, 99202 SA, 99202 SB, 99202 FP 52, 99203, 99203 FP, 99203 FP SB, 99203 SA, 99203 SB, 99203 UD, 99203 FP 52, 99204, 99204 FP, 99204 FP SB, 99204 SA, 99204 SB, 99204 FP 52, 99205, 99205 FP, 99205 FP SB, 99205 FP 52, and 99432.

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

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

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

(1) Chief complaint(s);

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

(3) Pertinent past medical history;

(4) Pertinent family history;

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

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

7. Evaluation and management services--established patient; excludes preventive health care for patients through 20 years of age: 99211, 99211 SA, 99211 SB, 99211 FP, 99211 FP SB, 99211 FP 52, 99212, 99212 FP, 99212 FP SB, 99212 FP 52, 99212 SB, 99212 SA, 99213, 99213 FP, 99213 FP SB, 99213 FP 52, 99213 SB, 99213 SA, 99213 UD, 99214, 99214 FP, 99214 FP 52, 99214 FP SB, 99214 SB, 99214 SA, 99215, 99215 FP, 99215 FP 52, 99215 FP SB, and 99215 SB.

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

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

(1) Purpose of visit;

(2) Pertinent history obtained;

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

(4) Procedures, if any, with results;

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

(6) Diagnosis.

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

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

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

(2) An alternative to (a)8i(1) above would be the utilization of one or more hours of the consulting physician's personal time in the performance of the consultation.

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

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

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

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

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

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

ii. Limited consultation: 99241, 99242, 99243, 99244, 99251, 99252 and 99253.

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

iii. Second opinion program consultation: 99244 SM.

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

iv. Third opinion consultation: 99244 SN.

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

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

9. Critical care services: 99291 and 99292.

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

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

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

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

10. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services through age 20: 99382 EP through 99385 EP and 99392 EP through 99395 EP.

i. If performed by an outside independent laboratory, the laboratory must submit the claim. Blood sample for lead screening test should be sent to the New Jersey State Department of Health.

ii. Procedure codes 99382 EP through 99385 EP, for initial visits, shall only be used once for the same patient during any 12-month period by the same physician, group, shared health care facility, or practitioner(s) sharing a common record. Reimbursement for these procedure codes is contingent upon submission of both a completed Report and Claim For EPSDT/HealthStart Screening and Related Procedures (MC-19) and the appropriate claim form within 30 days of the date of service. In the absence of a completed MC-19 form, reimbursement will be reduced to the level of an annual health maintenance examination.

11. Vaccines for Children program: 90465, 90466, 90467, 90468, 90471, 90472, 90473 and 90474. These codes apply only to the administration of vaccines to beneficiaries under 19 years of age who qualify for the Vaccines for Children (VFC) program. These codes must be billed in conjunction with the appropriate HCPCS procedure code for the specific vaccine(s) provided; however, separate reimbursement shall not be provided for the sera because the sera are provided free under the VFC program. See *N.J.A.C. 10:66-2.20*.

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

(c) Family planning services:

1. Subdermal contraceptive implants: 11976.

i. The maximum fee allowance includes the removal of the subdermal contraceptive implants and the post-removal visit.

2. Sterilization (male): 55250 and 55450.

i. Primary sterilization (family planning) procedure.

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

3. Sterilization (female): 58600, 58605 and 58611.

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

4. Initial medical visit: 99201 FP, 99201 FP SB, 99201 FP 52, 99202 FP, 99202 FP SB, 99202 FP 52, 99203 FP, 99203 FP SB, 99203 FP 52, 99204 FP, 99204 FP SB, 99204 FP 52, 99205 FP, 99205 FP SB and 99205 FP 52.

i. Family planning to include each of the following:

(1) Medical, social, obstetrical history

(2) Complete pelvic examination--including visual inspection of the cervix

(3) Breast examination

(4) Papanicolaou smear (excludes cytology study)

(5) Contraceptive counseling with referral as indicated.

ii. Includes the cost of birth control drugs dispensed. A prescription cannot be substituted. Procedure codes with the "52" modifier do not include the cost of birth control drugs.

iii. These procedure codes (initial medical visit) will be disallowed if procedure codes 99201, 99201 FP, 99201 FP SB, 99201 FP 52, 99202, 99202 FP, 99202 FP SB, 99202 FP 52, 99203, 99203 FP, 99203 FP SB, 99203 FP 52, 99204, 99204 FP, 99204 FP SB, 99204 FP 52, 99205, 99205 FP, 99205 FP SB and 99205 FP 52 have been performed during the prior 12 months by the same provider.

5. Routine or follow-up visit--brief: 99211 FP, 99211 FP SB, 99211 FP 52, 99212 FP, 99212 FP SB, 99212 FP 52, 99213 FP, 99213 FP SB and 99213 FP 52.

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

6. Medical revisit--family planning: 99214 FP, 99214 FP 52 and 99214 FP SB.

i. May include pelvic examination or changes in method or physician's or certified nurse-midwife's instructions. This code includes the cost of birth control drugs dispensed. A prescription cannot be substituted. Procedure codes with the "52" modifier do not include the cost of birth control drugs.

7. Routine or follow-up visit--prolonged: 99215 FP, 99215 FP 52 and 99215 FP SB.

i. May include pelvic examination or changes in method or physician's or certified nurse-midwife's instructions. Involves 20 or more minutes of personal time in patient contact, including documentation of time as well as adequate significant progress notes on the clinic record. This procedure code includes the cost of birth control drugs dispensed. A prescription cannot be substituted. Procedure codes with the "52" modifier do not include the cost of birth control drugs.

8. Annual medical revisit: 99395 FP and 99395 FP SB.

i. Family planning to include each of the following:

(1) Updating medical, social, obstetrical history;

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

(3) Breast examination; and

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

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

iii. Procedure code 99395 FP 22 will be disallowed if procedure codes 99201, 99201 FP, 99201 FP SB, 99201 FP 52, 99202, 99202 FP, 99202 FP SB, 99202 FP 52, 99203, 99203 FP, 99203 FP SB, 99203 FP 52, 99204, 99204 FP, 99204 FP SB, 99204 FP 52, 99205, 99205 FP, and 99205 FP SB have been performed during the prior 12 months by the same provider.

9. Code 36415 FP. This service is reimbursable to the Family Planning Clinic only when the specimen is referred out to an independent clinical laboratory for testing.

Note: Physicians/practitioners and Family Planning Clinics cannot bill when the tests are completed on the premises and are not referred out to independent clinical laboratories.

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

(e) Minor surgery:

1. Acne surgery, including, but not limited to, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules: 10040.

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

(f) Mental health services:

1. Comprehensive intake evaluation: 90791 UC; use 90792 UC for physician involved assessment.

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

ii. Although this procedure may be performed by a single individual, it is expected that it should be a team approach and of one and one-half hours duration.

2. Individual psychotherapy--20- to 30-minute session: 90832 UC and 90833 UC.

i. This code requires, for reimbursement purposes, a minimum of 20 to 30 minutes of direct personal clinical involvement with the patient and/or family member.

3. Individual psychotherapy--45- to 50-minute session: 90834 UC and 90836 UC.

i. This code requires, for reimbursement purposes, a minimum of 45 to 50 minutes of direct personal clinical involvement with the patient and/or family member.

4. Family therapy: 90847 UC.

i. This code requires, for reimbursement purposes, a minimum of 45 to 50 minutes of direct personal clinical involvement with the patient and/or family member. The CPT narrative otherwise remains applicable.

5. Family therapy: 90847 UC 22.

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

6. Family conference: 90887 UC.

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

7. Group psychotherapy: 90853 UC.

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

8. Health and behavior assessment; initial assessment: 96150 UC.

i. This code requires, for reimbursement purposes, a minimum of 15 minutes face-to-face with the beneficiary; the provider shall bill for each completed whole 15-minute unit of service.

9. Health and behavior assessment; re-assessment: 96151 UC.

i. This code requires, for reimbursement purposes, a minimum of 15 minutes face-to-face with the beneficiary; the provider shall bill for each completed whole 15-minute unit of service.

10. Health and behavior intervention; individual: 96152 UC.

i. This code requires, for reimbursement purposes, a minimum of 15 minutes face-to-face with the beneficiary; the provider shall bill for each completed whole 15-minute unit of service.

11. Health and behavior intervention; group of two or more patients: 96153 UC.

i. This code requires, for reimbursement purposes, a minimum of 15 minutes face-to-face with the beneficiary; the provider shall bill for each completed whole 15-minute unit of service.

12. Health and behavior intervention; family, with patient present: 96154 UC.

i. This code requires, for reimbursement purposes, a minimum of 15 minutes face-to-face with the beneficiary; the provider shall bill for each completed whole 15-minute unit of service.

13. Health and behavior intervention; family, without patient present: 96155 UC.

i. This code requires, for reimbursement purposes, a minimum of 15 minutes face-to-face with the beneficiary; the provider shall bill for each completed whole 15-minute unit of service.

(g) Obstetrical services (maternity):

1. Total obstetrical care: 59400.

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

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

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

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

2. Vaginal delivery: 59410.

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

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

3. Subsequent antepartum visit: 59425 and 59426.

i. Subsequent antepartum visit, provided as a separate procedure. Indicate specific dates of service.

4. Initial antepartum visit: 99203.

i. Initial antepartum visit, provided as a separate procedure.

5. Postpartum care: 59430.

i. Postpartum care rendered by a physician other than delivery physician.

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

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

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

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

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

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

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

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

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

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

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

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

8. Subsequent antepartum visit provided by a certified nurse-midwife: 59425 SB and 59426 SB.

i. Indicate specific date of service.

9. Initial antepartum visit provided by a certified nurse-midwife: 99203 SB.

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

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

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

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

11. Subsequent antepartum visit(s) provided by an advanced practice nurse: 59425 SA and 59426 SA.

i. Initial antepartum visit provided by an advanced practice nurse provided as a separate procedure.

(h) Podiatry services:

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

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

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

2. See *N.J.A.C. 10:66-6.2(e)*, Minor surgery, for additional procedures.

(i) Radiology services:

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

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

2. Pelvis: 72170.

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

3. Hip: 73500 and 73510.

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

4. Esophagus with fluoroscopy by the radiologist: 74220.

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

5. Pelvimetry: 74710.

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

(j) Rehabilitation services:

1. Speech therapy: 92507.

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

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

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

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

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

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

3. Physical therapy: 97799.

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

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

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

(2) Graduated range of motion exercises.

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

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

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

4. Occupational therapy: 97535.

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

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

(k) Vision care services (See N.J.A.C. 10:62-3).

(l) Transportation services:

1. Transportation, one way: Z0330.

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

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

2. Per trip, flat rate, one way trip: A0425.

i. Shall be billed in conjunction with Z0330 when the clinic transports a beneficiary either to or from a Partial Care program in any one day.

ii. Reimbursement is limited to two one-way trips per day for the same beneficiary, by the same clinic, to the same Partial Care program.

(m) Substance use disorder treatment facility services:

1. Family therapy rendered in a substance use disorder treatment facility: 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.

2. Family conference rendered in a substance use disorder treatment facility: 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.

3. Prescription visit rendered in a substance use disorder treatment facility: 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.

4. Psychotherapy rendered in a substance use disorder treatment facility-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.

5. Group therapy rendered in a substance use disorder treatment facility, 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.

6. Psychological testing rendered in a substance use disorder treatment facility, per hour; maximum of five hours: Z2005.

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

7. Methadone treatment rendered in a substance use disorder treatment facility: 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.

8. Psychotherapy rendered in a substance use disorder treatment facility--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.

9. Urinalysis for substance use disorder treatment facility: Z2010.

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

ii. To be used only by a substance use disorder treatment facility specifically approved by the Program to provide this service.

10. 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.

11. Family therapy rendered in a substance use disorder treatment facility for a WFNJ/SAI-eligible beneficiary: Z3348. Prior authorization is required.

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 counselor 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 shall bill only for the patient and not for other family members.

12. Family conference rendered in a substance use disorder treatment facility for a WFNJ/SAI-eligible beneficiary: Z3349. Prior authorization is required.

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 shall bill only for the patient and not for other family members.

13. Prescription visit rendered in a substance use disorder treatment facility for a WFNJ/SAI-eligible beneficiary: Z3353. Prior authorization is required.

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.

14. Psychotherapy rendered in a substance use disorder treatment facility-full session for a WFNJ/SAI-eligible beneficiary: Z3354. Prior authorization is required.

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

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

15. Group therapy rendered in a substance use disorder treatment facility, per person for a WFNJ/SAI-eligible beneficiary: Z3355. Prior authorization is required.

i. Verbal or other therapy methods provided by one or more physicians, or professional counselors 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.

16. Psychological testing rendered in a substance use disorder treatment facility, per hour; for a WFNJ/SAI-eligible beneficiary: Z3356. Prior authorization is required.

i. Psychometric and/or projective tests with a written report are included in the reimbursement.

17. Methadone treatment rendered in a substance use disorder treatment facility for a WFNJ/SAI-eligible beneficiary: Z3357. Prior authorization is required.

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.

18. Psychotherapy rendered in a substance use disorder treatment facility-half session for a WFNJ/SAI-eligible beneficiary: Z3358. Prior authorization is required.

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

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

19. Urinalysis for drug addiction rendered in a substance use disorder treatment facility for a WFNJ/SAI-eligible beneficiary: Z3359. Prior authorization is required.

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

ii. To be used only by a substance use disorder treatment facility specifically approved by the WFNJ/SAI Program to provide this service.

(n) Miscellaneous services:

1. Termination of pregnancy: 59840 and 59841.

i. See *N.J.A.C. 10:66-2.16*; 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 UA for first trimester or UB for second trimester.

History

HISTORY:

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)*.

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.

Amended by R.2007 d.188, effective June 18, 2007.

See: *39 N.J.R. 337(a)*, *39 N.J.R. 2360(a)*.

Deleted (a)3ii; in (f), substituted "UC" for "ZI" throughout; and in (f)1ii, deleted the last sentence.

Amended by R.2009 d.376, effective December 21, 2009.

See: *41 N.J.R. 2561(a)*, *41 N.J.R. 4791(a)*.

Rewrote (a), (c), (f), (g), (h), (j), (*l*), (m), and (n)1ii.

Amended by R.2016 d.051, effective June 6, 2016.

See: *47 N.J.R. 2041(a)*, *48 N.J.R. 962(b)*.

Rewrote (a)2i(3); and in (a)2ii, inserted "for dates of service before October 1, 2015,", inserted a comma following "362.21", inserted "or for dates of service on or after October 1, 2015, a reported ICD-10-CM diagnosis of H35.32 or B39.9 w/H32", and substituted "ICD-9-CM" for "ICD-9 CM".

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

Rewrote the section.

Annotations

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End of Document

N.J.A.C. 10:66-6.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 66. INDEPENDENT CLINIC SERVICES > SUBCHAPTER 6. CENTERS FOR MEDICARE & MEDICAID SERVICES HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

§ 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.

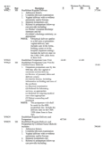
3. The enhanced reimbursement (that is, HealthStart procedure codes) for delivery and postpartum care shall be claimed only for a patient who received at least one antepartum HealthStart Maternity Medical or Health Support Service.

4. The modifier "SB" 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	S	Maximum Fee Allowance $	NS	$	SB
		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					

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

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

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

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

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

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

HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance S	S	N
W9070		Healthstart pediatric continuity of care	13.00		13.
W9828		EPSDT incentive payment	10.00		10.
99381	22	Infant, under 1 year of age	32.30		25.
99381	SA	Infant, under 1 year of age	NA		23.
99391	22	Infant, under 1 year of age	32.30		25.
99391	SA	Infant, under 1 year of age	NA		23.
99382	22	Early Childhood, age 1 through 4 years	32.30		25.
99382	SA	Early Childhood, age 1 through 4 years	NA		23.
99382	22	Early Childhood, age 1 through 4 years	32.30		25.
99382	SA	Early Childhood, age 1 through 4 years	NA		23.
99392	22	Early Childhood, age 1 through 4 years	32.30		25.
99392	SA	Early Childhood, age 1 through 4 years	NA		23.

i. History including behavior and environmental factors;

ii. Developmental assessment; and

iii. Complete, unclothed physical examination by a physician or an advanced practice nurse under the personal supervision of a physician, to include:

(1) Measurements: height, weight and head circumference;

(2) Vision and hearing screening; and

(3) Nutritional assessment.

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

v. Anticipatory guidance;

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

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

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

(2) Hemoglobin or hematocrit twice, at six to nine months and 20 to 24 months of age;

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

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

(5) Lead screening at six to 12 months and annually thereafter, or more often if clinically indicated.

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

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

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

HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance S	S	NS	S	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			

History

HISTORY:

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.

Amended by R.2004 d.334, effective September 7, 2004.

See: *36 N.J.R. 312(a)*, *36 N.J.R. 4136(a)*.

Amended by R.2009 d.376, effective December 21, 2009.

See: *41 N.J.R. 2561(a)*, *41 N.J.R. 4791(a)*.

Rewrote the section.

Annotations

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N.J.A.C. 10:66, Appx

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 66. INDEPENDENT CLINIC SERVICES

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. The Fiscal Agent Billing Supplement can be downloaded free of charge at *www.njmmis.com*. When revisions are made to the Fiscal Agent Billing Supplement, a revised version will be placed on the website and copies shall be filed with the Office of Administrative Law.

If you do not have access to the Internet and require a copy of the Fiscal Agent Billing Supplement, write to:

Molina Medicaid Solutions
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

History

HISTORY:

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.

Amended by R.2009 d.376, effective December 21, 2009.

See: *41 N.J.R. 2561(a)*, *41 N.J.R. 4791(a)*.

In the first paragraph, inserted the second sentence and substituted "a revised version will be placed on the website" for "replacement pages will be distributed to providers,"; and in the second paragraph, substituted "If you do not have access to the Internet and require" for "For".

Amended by R.2017 d.113, effective June 5, 2017.

See: *48 N.J.R. 2737(a)*, *49 N.J.R. 1405(a)*.

In the first address, substituted "Molina Medicaid Solutions" for "Unisys".

APPENDIX

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