**HUMAN SERVICES**

#### DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

**Independent Clinic Services**

**Proposed Readoption with Amendments:**  **N.J.A.C. 10:66**

**Proposed Repeal: N.J.A.C. 10:66-2.19**

Authorized By:Elizabeth Connolly, Acting Commissioner, Department of Human Services.

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

Calendar Reference:See Summary below for explanation of exception to calendar requirement.

Agency Control Number:16-P-07.

Proposal Number:PRN 2016-205.

Submit comments by February 17, 2017, to:

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The agency proposal follows:

**Summary**

Pursuant to N.J.S.A. 52:14B-5.1, N.J.A.C. 10:66, the Independent Clinic Services chapter, was scheduled to expire on November 4, 2016. As the Department of Human Services (Department) filed this notice of readoption with the Office of Administrative Law on that date, the expiration date is extended 180 days to May 3, 2017, pursuant to N.J.S.A. 52:14B-5.1.c(2). The chapter provides information about the provision of independent clinic services under the New Jersey Medicaid and the NJ FamilyCare fee-for-service (FFS) benefit programs.

The Department has determined that N.J.A.C. 10:66 should be readopted because the rules are necessary, reasonable, adequate, efficient, and responsive for the purposes for which they were promulgated. This rulemaking is designed to readopt the chapter with amendments.

The chapter contains six subchapters and a chapter appendix, described immediately below.

N.J.A.C. 10:66-1, General Provisions, provides: requirements regarding the scope of service for clinic services; definitions; provisions for provider participation; prior authorization requirements; basis for reimbursement for clinic services; recordkeeping requirements; personal contribution to care requirements for NJ FamilyCare-Plan C and copayments for NJ FamilyCare-Plan D; and the medical exception process.

N.J.A.C. 10:66-2, Provision of Services, 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 are separately identified and discussed only where unique characteristics or requirements exist. This subchapter provides an introduction and the clinic service requirements for: dental services; drug treatment center services; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services; family planning services; laboratory services; mental health services; evaluation and management services; pharmaceutical services; podiatric services; radiological services; rehabilitative services; renal dialysis services for end-stage renal disease; sterilization services; termination of pregnancy; transportation services; vision care services; hospital and personal care assistant services; and vaccines.

N.J.A.C. 10:66-3, HealthStart, provides information about HealthStart 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 and NJ FamilyCare fee-for-service beneficiaries.

N.J.A.C. 10:66-4, Federally Qualified Health Center (FQHC), contains information about FQHCs, including rules governing the provision of services; the forms used by FQHCs to determine Medicaid and NJ FamilyCare-Plan A fee-for-service reimbursement amounts; and instructions for the proper completion of the forms. The subchapter also contains four appendices.

N.J.A.C. 10:66-5, Ambulatory Surgical Center, contains requirements for ambulatory surgical centers, including covered services, anesthesia services, facility services, and medical records.

N.J.A.C. 10:66-6, Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System (HCPCS), contains procedure codes and maximum fee allowances corresponding to the Medicaid-reimbursable services governed by N.J.A.C. 10:66.

The chapter Appendix contains information related to the Fiscal Agent Billing Supplement. The Fiscal Agent Billing Supplement is not reproduced in the Administrative Code but is filed with the Office of Administrative Law.

**General Amendments**

Throughout the chapter, references to the “Department of Health and Senior Services” are replaced with references to the “Department of Health” to reflect the current name of that Department pursuant to P.L. 2012, c. 17.

Throughout the chapter, references to the “Division of Mental Health Services” and “DMHS” are replaced with references to the “Division of Mental Health and Addiction Services” and “DMAHS,” as appropriate, to reflect the current name of that Division within the Department of Human Services.

Throughout the chapter, references to “Unisys” are replaced with references to “Molina Medicaid Solutions” to reflect the current name of the DMAHS fiscal agent.

Throughout the chapter, all references to “drug treatment centers” are changed to “substance use disorder treatment facilities” and the term “substance abuse” is changed to “substance use disorder.”

Throughout the chapter: minor non-substantive revisions of grammar, style, spelling, and punctuation are being proposed; unnecessary cross-references and any duplicative or otherwise unnecessary text are proposed for deletion; and names and/or contact information and addresses of agencies are updated when indicated. Parentheses are eliminated and associated text is revised, as appropriate.

**Specific Amendments**

At N.J.A.C. 10:66-1.1(a), substance use disorder treatment facilities and mental health clinics are added to the list of clinic types that provide services under the rules of this chapter.

At N.J.A.C. 10:66-1.2, proposed amendments add definitions for “American Society of Addiction Medicine (ASAM),” “ASAM level of care,” “behavioral health services,” “DHS,” “Division of Mental Health and Addiction Services,” “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.”

At N.J.A.C. 10:66-1.2, a proposed amendment deletes the definition for “Drug treatment center” since those facilities are now referred to as “substance use disorder treatment facilities.”

At N.J.A.C. 10:66-1.3(c)5, a proposed amendment adds that a substance use disorder treatment facility must also be approved by the Division of Mental Health and Addiction Services (DMHAS) as a condition of participation as a Medicaid and NJ FamilyCare provider.

At N.J.A.C. 10:66-1.4(a), a proposed amendment adds substance use disorder as a condition for which treatment requires prior authorization.

At N.J.A.C. 10:66-1.4(c), a proposed amendment lists the general types of services that require prior authorization when the cost for said services exceeds $6,000 in a 12-month period. The services being added to the list include substance use disorder outpatient rehabilitative services, including individual, group, and family therapy, as well as family consultation.

At N.J.A.C. 10:66-1.4(e), a proposed amendment memorializes the practice that transportation to and from a substance use disorder treatment facility is authorized and arranged by LogistiCare, the DMAHS transportation broker and provides contact information for the broker.

Proposed new N.J.A.C. 10:66-1.4(f) details the required prior authorization procedures for the provision of substance use disorder services. Prior authorization shall be provided either by the DMHAS or any DHS agency or contracted agent approved to authorize services.

At N.J.A.C. 10:66-1.7(d)1, a proposed amendment indicates that a newborn must be enrolled in a specific managed care organization, not only the managed care program.

At N.J.A.C. 10:66-1.8(d)1i and 3, references to an “HSP number” are replaced with references to the current term, which is “Medicaid/NJ FamilyCare eligibility identification number.”

The heading of N.J.A.C. 10:66-2.3 is proposed to be changed to “Substance use disorder treatment services.”

Proposed new N.J.A.C. 10:66-2.3(a) lists the services that are considered substance use disorder treatment services provided in independent clinic settings. As a result of this proposed language, existing N.J.A.C. 10:66-2.3(a) is proposed for recodification as a subpart of new subsection (a).

Recodified N.J.A.C. 10:66-2.3(a)1i is proposed to be revised to indicate that an advanced practice nurse (APN) is also allowed to prescribe treatment for substance use disorder.

Proposed new N.J.A.C. 10:66-2.3(a)1iv requires substance use disorder treatment services to be provided in facilities that are licensed by the Department of Human Services. The chapters containing the licensure requirements are listed.

N.J.A.C. 10:66-2.3(b) is proposed for amendment to require that a minimum one counseling session per week be provided during the first three months, rather than four months, after the initiation of treatment. This is consistent with the requirements of N.J.A.C. 8:43A-26.5.

Existing N.J.A.C. 10:66-2.3(c) is proposed for deletion because the AIDS Community Care Alternatives Program (ACCAP) no longer exists; the services previously covered under that program are now provided as part of the Medicaid Comprehensive Waiver.

N.J.A.C. 10:66-2.3(d) is proposed for deletion because authorization requirements for transportation services are discussed at N.J.A.C. 10:66-1.4(e).

Proposed new N.J.A.C. 10:66-2.3(c) lists substance use disorder outpatient rehabilitative services, described as those services that meet the program standards at N.J.A.C. 10:161B and that approximate ASAM Level of Care 1 and 2 by including intake and assessment, physician or advanced practice nurse (APN) medical visit, individual, group, and/or family counseling, as indicated.

Proposed new N.J.A.C. 10:66-2.3(c)1 allows for the provision of more than one service per day provided that they are different types of service.

Proposed new N.J.A.C. 10:66-2.3(c)2 prohibits the billing of outpatient rehabilitative services and participation in an intensive outpatient program on the same day.

Proposed new N.J.A.C. 10:66-2.3(c)3 allows for a physician visit to be provided on the same day as any outpatient rehabilitative service.

Proposed new N.J.A.C. 10:66-2.3(c)4 allows for opioid treatment being provided with outpatient rehabilitative services.

Proposed new N.J.A.C. 10:66-2.3(d) provides information about substance use disorder – intensive outpatient (IOP) services, as those services that meet the program standards at N.J.A.C. 10:161B-11 and that approximate ASAM Level of Care 2.1. Programming hours and restrictions are provided.

Proposed new N.J.A.C. 10:66-2.3(e) provides information about substance use disorder – partial care services as those services that meet the program standards at N.J.A.C. 10:161B and that approximate ASAM Level of Care 2.5. Programming hours and restrictions are provided.

Proposed new N.J.A.C. 10:66-2.3(f) provides information about non-hospital based withdrawal management as services that are provided in a residential setting and are designed to provide short-term care to individuals whose withdrawal symptoms are severe enough to require 23 hours of medical monitoring and that meet the program standards at N.J.A.C. 10:161A and that approximate ASAM Level of Care 3.7D.

Proposed new N.J.A.C. 10:66-2.3(g) requires that ambulatory outpatient withdrawal management services be provided in DMHAS-approved facilities, to clients who meet ASAM criteria of Level 1-D or 2-D, in accordance with N.J.A.C. 10:161B-12.

Proposed new N.J.A.C. 10:66-2.3(h) provides information about short-term residential treatment in a facility that provides a prescribed 23 hours per day activity regimen that meet the program standards at N.J.A.C. 10:161A and that approximate ASAM Level of Care 3.7.

Proposed new N.J.A.C. 10:66-2.3(i) provides information about opioid treatment/maintenance programs. This term encompasses opioid withdrawal management, short-term withdrawal management, long-term withdrawal management, maintenance treatment, comprehensive maintenance treatment, and interim 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 be required to comply with the standards set forth in N.J.A.C. 10:161B-11.

Proposed new N.J.A.C. 10:66-2.3(i)1 memorializes that for services provided on or after July 1, 2016, the medication assisted treatment provided by the opioid treatment program is billed as part of a weekly bundled rate and specifies what is and what is not included in the bundled rate.

Proposed new N.J.A.C. 10:66-2.3(i)2 requires that the bundled rate begin on the day of admission and comply with the billing requirements of N.J.A.C. 10:161-11 and DMHAS Annex A contracts. Information regarding obtaining a copy of the contracts is provided.

At N.J.A.C. 10:66-2.5(b)1 through 6, proposed amendments replace the brand name “Norplant System (NPS)” with the generic term of the product “subdermal contraceptive implant” because, although the policies regarding the provision and use of this type of product have not changed, there are more brands of this product on the market and the Medicaid/NJ FamilyCare programs do not restrict coverage to just one brand name.

Proposed new N.J.A.C. 10:66-2.6(e) requires that the outpatient substance use disorder treatment program either provide for, or ensure the availability of, laboratory services.

At N.J.A.C. 10:66-2.7(b)1, a proposed amendment adds “assessment” to the list of mental health services provided in the clinic setting.

Proposed new N.J.A.C. 10:66-2.7(b)2 adds individual, group, or family psychotherapy services to the list of services allowed to be billed more than once a day. The types of therapy and the provision limits are discussed.

Proposed new N.J.A.C. 10:66-2.7(b)3 states that an assessment can be done on the same date of services as individual, group, or family therapy, but must be counted toward the weekly number of units allowed.

Proposed new N.J.A.C. 10:66-2.7(b)4 states that evaluation and management visits by a physician or APN may be provided as part of the evaluation and it will not count toward the total number of units that were authorized.

Existing N.J.A.C. 10:66-2.7(e) is proposed to be relocated to N.J.A.C. 10:66-2.7(f) to make the rule more cohesive. N.J.A.C. 10:66-2.7(e) will be held in reserve to preserve the organization of the remainder of the section.

Proposed new N.J.A.C. 10:66-2.7(k)1i allows for temporary deviation, with proper documentation, from the written treatment plan to address unforeseen circumstances; however, if the change becomes permanent, the treatment plan must be revised to include the activity.

Proposed new N.J.A.C. 10:66-2.10(b) requires independent clinics providing substance use disorder treatment services to adhere to the requirements of N.J.A.C. 10:161B-14, in addition to N.J.A.C. 10:51.

N.J.A.C. 10:66-2.11(b) is proposed for deletion. These requirements are included in the definition of specialist in podiatry at N.J.A.C. 10:66-1.2.

At N.J.A.C. 10:66-2.15(a)6, a proposed amendment changes the term “abortion” to “termination of pregnancy” to be consistent with the terminology used at N.J.A.C. 10:66-2.16.

At N.J.A.C. 10:66-2.17(a), a proposed amendment allows the clinic to provide transportation services to beneficiaries of all NJ FamilyCare plans and the Alternative Benefit Program (ABP) who attend partial care programs.

At N.J.A.C. 10:66-2.17(a)1 through 3, proposed amendments specify that the independent clinic is authorized to provide transportation for beneficiaries to access partial care services only.

At N.J.A.C. 10:66-2.17(a)4, a reference to the ABP program is proposed to be added.

At N.J.A.C. 10:66-2.17(a)5i, references to types of transportation no longer utilized are proposed for deletion and a reference to a bus pass provided by the transportation broker is proposed to be added.

N.J.A.C. 10:66-2.19, Personal care assistant services (mental health), is proposed for repeal. These types of services are now provided under N.J.A.C. 10:79B, Community Support Services for Adults with Mental Illnesses. See 47 N.J.R. 1899(a), 48 N.J.R. 1678(a), effective August 15, 2016.

At N.J.A.C. 10:66-2.20(c), a proposed amendment updates the name of the Centers for Disease Control and Prevention. The acronym “CDC” is not changed; this is consistent with the official website for the agency.

At N.J.A.C. 10:66-4 Appendix C, under the general completion instructions for FQHC-2001-07 Worksheet 2, Encounters—(vii), the brand name “Norplant System (NPS)” is replaced with the generic term of the product “subdermal contraceptive implants” consistent with the proposed amendments at N.J.A.C. 10:66-2.5(b).

Additionally, In Appendix C, under the completion instructions for Part II of FQHC-2001-07 Worksheet 4, Encounter Rate Calculation, the brand name “Norplant System (NPS)” is replaced with the generic term of the product “subdermal contraceptive implants” consistent with the proposed amendments at N.J.A.C. 10:66-2.5(b).

At N.J.A.C. 10:66-5.1(a), proposed amendments revise the references to the list of Medicare-approved surgical procedures for ambulatory surgical centers to eliminate references to an “eight-group classification system” in favor of the term “classification system” to allow for an increase or decrease in the number of groups used by CMS.

At N.J.A.C. 10:66-6.1(a), a proposed amendment states that the Healthcare Common Procedure Coding System (HCPCS) procedure codes assigned by the Centers for Medicare and Medicaid Services (CMS) is a two-level coding system, rather than a three-level coding system.

N.J.A.C. 10:66-6.1(a)3 is proposed for deletion because Level III codes are no longer nationally recognized or used when billing for Medicaid or NJ FamilyCare services.

At N.J.A.C. 10:66-6.1(b), a proposed amendment to the description of the modifier “UC” adds a reference to transportation-related to mental health services. This means that when submitting the HCPCS code to request transportation for the specified services the modifier must be attached to the base code. Additionally, a reference to N.J.A.C. 10:66-6.2(l) is added to the list of citations at which the specific base codes can be found. The reference to N.J.A.C. 10:66-6.2(o) is proposed for deletion because that subsection is proposed for deletion as described below.

At N.J.A.C. 10:66-6.2(l), a proposed amendment adds the HCPCS code A0425 to the list of codes used for the reimbursement of transportation services.

N.J.A.C. 10:66-6.2(m) is proposed to be renamed “Substance use disorder treatment facility services.”

At N.J.A.C. 10:66-6.2(m), a proposed amendment deletes the HCPCS codes Z1830, Z1834, and Z1835 because these codes, used to bill for substance use services for beneficiaries in the AIDS Community Care Alternatives Program (ACCAP) program, are obsolete because the ACCAP program no longer exists. The beneficiaries previously served by that program now receive substance use disorder services through other programs of the Department. The explanation of the asterisk that was attached to these codes is also proposed for deletion.

N.J.A.C. 10:66-6.2(o) is proposed for deletion, consistent with the deletion of N.J.A.C. 10:66-2.19, as described above.

At N.J.A.C. 10:66-6.3, a proposed amendment deletes a reference to Level III codes from the heading of the section.

At N.J.A.C. 10:66-6.3(e), a proposed amendment adds the HCPCS code A0425 to the list of codes used for the reimbursement of transportation services and provides a description of the service.

N.J.A.C. 10:66-6.3(f) is proposed to be renamed “Substance use disorder treatment facility services.” Also, a proposed amendment deletes the HCPCS codes Z1834 and Z1835 consistent with the proposed deletion of these codes at N.J.A.C. 10:66-6.2(m). The explanation of the asterisk that was attached to these codes is also proposed for deletion.

N.J.A.C. 10:66-6.3(h), Personal care assistant services, is proposed for deletion consistent with the deletion of N.J.A.C. 10:66-2.19, as discussed above.

N.J.A.C. 10:66-6.4(a)2ii is proposed to be revised by removing duplicative language and recodifying the last two sentences as N.J.A.C. 10:66-6.4(a)iii and iv to make the rule easier for the reader to understand.

At N.J.A.C. 10:66-6.4(c), proposed amendments replace the brand name “Norplant” with the generic term “subdermal contraceptive implants.”

At N.J.A.C. 10:66-6.4(f) proposed amendments change the codes that are used for the listed mental health services. Beneficiary eligibility and provider reimbursement are not changing, only the CMS-assigned codes used to request reimbursement for the provision of the services.

Proposed new N.J.A.C. 10:66-6.4(l)2 adds the code A4025 to the list of transportation codes, consistent with the addition of this code at N.J.A.C. 10:66-6.3(e). Proposed new N.J.A.C. 10:66-6.4(l)2i and ii instruct providers that this code is to be billed in conjunction with Z0330, when the clinic provides transportation to or from a partial care program, and that reimbursement shall be limited to two trips per day, per beneficiary, to the same partial care program.

The heading of N.J.A.C. 10:66-6.4(m) is proposed to be changed to “Substance use disorder treatment services.”

Existing N.J.A.C. 10:66-6.4(m)1 through 3 are proposed for deletion because the ACCAP program no longer exists. The beneficiaries previously served by that program now receive substance use disorder services through other programs of the Department. As a result of this deletion, N.J.A.C. 10:66-6.4(m)4 through 22 are proposed to be recodified as N.J.A.C. 10:66-6.4(m)1 through 18.

At N.J.A.C. 10:66-6.4(n), the term “abortion” is replaced with the term “termination of pregnancy” to be consistent with the term used at N.J.A.C. 10:66-2.16.

The Department has determined that the comment period for this notice of proposal will be 60 days; therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, this notice is excepted from the rulemaking calendar requirement.

**Social Impact**

During State Fiscal Year 2015, approximately 11,157 Medicaid or NJ FamilyCare clients received independent clinic services each month from approximately 638 participating providers.

The readoption of the existing rules will have a positive impact on the beneficiaries because independent clinic and FQHC services will continue to be provided without interruption to individuals who otherwise may be unable to afford medical care. The proposed amendments to the chapter will have no negative social impact on the providers or beneficiaries.

The proposed amendments regarding the provision of substance use disorder services will have a positive social impact on the Medicaid and NJ FamilyCare beneficiaries because the services have been expanded, the rules are more comprehensive and are provided in accordance with nationally recognized standards of treatment and in cooperation between the Division of Medical Assistance and Health Services and the Division of Mental Health and Addiction Services. These amendments will result in a more comprehensive approach to the treatment provided to Medicaid and NJ FamilyCare beneficiaries with substance use disorder.

The proposed amendments removing ACCAP from the list of programs whose beneficiaries would be eligible to receive substance use disorder services will not result in a loss of these services for this population because the ACCAP program was subsumed by the Comprehensive Medicaid Waiver, which provides, in addition to other services, substance use disorder services.

**Economic Impact**

During State Fiscal Year 2015, the Division spent approximately $151,854,771 (Federal and State combined) for fee-for-service independent clinic services rendered to Medicaid and NJ FamilyCare clients.

The readoption of the existing rules will have a positive economic impact on clients as the services will continue to be provided, without interruption, to individuals who otherwise may be unable to afford medical care. Except for established co-payments for certain NJ FamilyCare beneficiaries, Medicaid or NJ FamilyCare clients are not required to pay for services rendered in independent clinics and this requirement is not changing as a result of these proposed amendments.

There are no costs to providers specifically associated with these rules, beyond the costs of maintaining records adequate for billing purposes. The rules proposed for readoption with amendments and a repeal will have a positive economic impact on providers of the services covered by these rules because they will continue to be reimbursed for those services.

**Federal Standards Statement**

Sections 1902(a)(10) and 1905(a) of the Social Security Act, 42 U.S.C. §§ 1396a(a)(10) and 1396d(a), respectively, allow a state Title XIX program to provide clinic services. Section 1905(a)(9) of the Social Security Act, 42 U.S.C. § 1396d(a)9, provides a definition of clinic services. The Federal statute and regulations allow a state broad latitude in defining clinic services, including the types of clinics the state enrolls into its program.

Section 1903(r)(1)(B)(iv) of the Social Security Act requires that states incorporate compatible methodologies of the National Correct Coding Initiative (NCCI) administered by the Secretary of the United States Department of Health and Human Services (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) and such other methodologies of that Initiative (or such other national correct coding methodologies), as the Secretary identifies.

Section 1905(a)(2)(c) of the Social Security Act, 42 U.S.C. § 1396d(a)(2)(c), requires states to cover Federally Qualified Health Center (FQHC) services. FQHC services are defined at Section 1905(l)(2)(A) of the Social Security Act, 42 U.S.C. § 1396d(l)(2)(A).

Title XXI of the Social Security Act allowes states to establish a children’s health insurance program for targeted low-income children. Section 2103 of the Social Security Act, 42 U.S.C. § 1397cc, provides broad coverage guidelines for the program. Section 2110 of the Act, 42 U.S.C. § 1397jj, allows clinic services for the children’s health insurance program.

The Department has reviewed the Federal statutory and regulatory requirements and has determined that the rules proposed for readoption with amendments and a repeal do not exceed Federal standards. Therefore, a Federal standards analysis is not required.

**Jobs Impact**

The rules proposed for readoption with amendments and a repeal will not cause the generation or loss of jobs in the State of New Jersey, for either the Division or the providers.

**Agriculture Industry Impact**

Since the rules proposed for readoption with amendments and a repeal concern the provision of independent clinic services to Medicaid and NJ FamilyCare beneficiaries, the Department anticipates that the rulemaking will have no impact on the agriculture industry in the State of New Jersey.

**Regulatory Flexibility Analysis**

The rules proposed for readoption with amendments and a repeal affect only those independent clinic service providers who provide services to beneficiaries residing in the community. Some of these providers may be considered small businesses under the terms of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

The proposed amendments do not impose any additional recordkeeping, compliance, or reporting requirements on small businesses. All providers, regardless of size, are required to maintain sufficient records to indicate the name of the patient, dates of service, nature, and any additional information as may be required by N.J.A.C. 10:49 and N.J.S.A. 30:4D-1 et seq., specifically N.J.S.A. 30:4D-12.

All recordkeeping, reporting, and compliance requirements must be equally applicable to all providers regardless of business size, and the Department does not differentiate between large and small businesses in these rules, due to the need for consistent standards for provider reimbursement and quality of beneficiary care.

There should be no capital costs or ongoing compliance costs associated with the rules proposed for readoption or the proposed amendments.

**Housing Affordability Impact Analysis**

 Since the rules proposed for readoption with amendments and a repeal concern the provision of independent clinic services to Medicaid and NJ FamilyCare beneficiaries, the Department anticipates that the proposed rules will have no impact on the affordability of housing or on the average costs of housing in the State.

**Smart Growth Development Impact Analysis**

 Since the rules proposed for readoption with amendments and a repeal concern the provision of independent clinic services to Medicaid and NJ FamilyCare beneficiaries, the rules will have an insignificant impact on smart growth and would not evoke a change in housing production in Planning Areas 1 or 2, or within designated centers, under the State Development and Redevelopment Plan in New Jersey.

**Full text** of the rules proposed for readoption may be found in the New Jersey Administrative Code at N.J.A.C. 10:66.

**Full text** of the rules proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 10:66-2.19.

**Full text** of the proposed amendments follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

(**Agency Note:** The text of N.J.A.C. 10:66-6.1(b), 6.2(l) and (m), 6.3(e) and (h) below all contain tables with headings. The codified headings of all the tables are intended to be permanent boldface and are not proposed to be changed by the Department.)

SUBCHAPTER 1. GENERAL PROVISIONS

10:66-1.1 Scope of service

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

(b) – (d) (No change.)

(e) [The Appendix following] 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 [forms (]claim forms, prior authorization forms, and consent forms[)] used in the billing process.

10:66-1.2 Definitions

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

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

"Ambulatory care/family planning facility" means a health care facility or a distinct part of a health care facility, licensed by the New Jersey State Department of Health [and Senior Services], 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 [and Senior Services], 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.**

...

**“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.**

...

["Drug treatment center" means an independent clinic, whether freestanding, or a distinct part of a facility which is licensed or approved by the New Jersey State Department of Health and Senior Services (DHSS), or is similarly licensed by a comparable agency of the state in which the facility is located, 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, Drug Abuse Treatment Services.]

**“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.**

...

**“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 [which] **that** is licensed or approved by the New Jersey State Department of Health [and Senior Services (DHSS)] **(DOH)** to provide medical care to outpatients in accordance with N.J.A.C. 8:52.

...

"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. § [13951(a)] **1395l(a)** and section 1861(v)(1)(A) of the Social Security Act, 42 U.S.C. § [1395(x)(v)] **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, [which] **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.

...

**“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.**

...

**"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.**

...

**“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.**

10:66-1.3 Provisions for provider participation

(a) (No change.)

(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 [and Senior Services], or the Division of Mental Health **and Addiction** Services [of the New Jersey Department of Human 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 [and Senior Services] or the Division of Mental Health **and Addiction** Services [of the New Jersey Department of Human 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. (No change.)

(c) In addition to [N.J.A.C. 10:66-1.3(a)] **(a)** and (b) above, each independent clinic shall obtain approval from the relevant Federal and State [agency(ies)] **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 [and Senior Services] 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 [and Senior Services] 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 [and Senior Services] or by a comparable agency of the state in which the facility is located;

4. (No change.)

5. For a mental health clinic **or substance use disorder treatment facility**, approval by the Division of Mental Health **and Addiction** Services [of the New Jersey Department of Human 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 [and Senior Services] 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) – (h) (No change.)

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[, respectively]. Prior authorization as specified in N.J.A.C. 10:49-[2.6]**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) (No change.)

(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. – 6. (No change.)

(d) (No change.)

(e) Transportation services to and from a [drug treatment centershall be prior authorized after 60 days of treatment at the drug treatment center. The provider shall request prior authorization by completing and forwarding Form MC-12(A), Transportation Prior Authorization Form, to: Unisys Corporation, Transportation Unit, PO Box 4813, Trenton, NJ 08650, or fax to 1-609-588-0816. See the Fiscal Agent Billing Supplement, N.J.A.C. 10:66 Appendix, for instructions on the completion of the prior authorization form.] **substance use disorder treatment facility** **will be authorized and provided by LogistiCare, the DMAHS transportation broker. Providers are responsible for arranging the transportation by contacting the LogistiCare reservation center by phone at 866-527-9945, or fax at 866-457-3316. Additional information and resources can be found on LogistiCare’s website: https://facilityinfo.logisticare.com/njfacility/Home.aspx.**

**(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.**

10:66-1.5 Basis for reimbursement

(a) – (d) (No change.)

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

1. – 2. (No change.)

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. (No change.)

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.

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

(a) (No change.)

(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. (No change.)

2. Clinic visits include medical professional services provided in the office, patient's home, or any other site, excluding a hospital, where the beneficiary may have been examined by the clinic staff. Generally, these procedure codes are in the 90000 HCPCS series of reimbursable codes at N.J.A.C. 10:66-[9]**6**.

3. – 4. (No change.)

(c) (No change.)

(d) Personal contributions to care are effective upon date of enrollment.

1. Exception: A personal contribution to care shall not apply to services rendered to a newborn until the newborn is enrolled in a managed care [program] **organization**.

(e) – (h) (No change.)

10:66-1.8 Medical exception process (MEP)

(a) For pharmacy claims [with service dates on or after September 1, 1999, which] **that** exceed Prospective Drug Utilization Review (PDUR) standards recommended by the New Jersey DUR Board and approved by the Commissioners of DHS and [DHSS] **DOH**, the Division of Medical Assistance and Health Services has established a Medical Exception Process (MEP).

(b) (No change.)

(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 [which] **that** has been approved by the Commissioners of DHS and [DHSS] **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 [which] **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, [HSP] **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. (No change.)

2. (No change.)

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, [HSP] **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] **See** N.J.A.C. 10:49-10, Notices, Appeals and Fair Hearings[)].

5. (No change.)

SUBCHAPTER 2. PROVISION OF SERVICES

10:66-2.3 [Drug treatment center] **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.**

[(a)] **1.** Medicaid and NJ FamilyCare fee-for-service beneficiaries shall be eligible for [drug] **substance use disorder** treatment center services only if those services:

[1.] **i.** Are prescribed by a physician **or an advanced practice nurse (APN)**;

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

[3.] **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 [four] **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) For the purposes of the AIDS Community Care Alternatives Program (ACCAP) only, services indicated by an asterisk at N.J.A.C. 10:66-6.3(m) may be provided to ACCAP-eligible individuals in the home.

(d) Transportation services to and from a drug treatment center shall be prior authorized after 60 days of treatment at the drug treatment center, in accordance with N.J.A.C. 10:66-1.4(e).]

**(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; a medical visit by a physician or an APN; 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.**

**(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: physician or APN visits; 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.**

**(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: a physician or an APN visit; 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.**

**(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**

10:66-2.5 Family planning services

(a) (No change.)

(b) [The Norplant System (NPS) is] **Subdermal contraceptive implants** **are** a Medicaid-covered and NJ FamilyCare fee-for-service-covered service when provided as follows:

1. [The NPS is] **Subdermal contraceptive implants** **are** used only in reproductive age women with established regular menstrual cycles;

2. (No change.)

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

4. A clinic visit relating only to the insertion or removal of the [Norplant System (NPS)] **subdermal contraceptive implants** is not reimbursable on the day of the insertion or removal.

5. Only two insertions and two removals of [the NPS] **subdermal contraceptive implants** per beneficiary are permitted during a five-year continuous period.

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

10:66-2.6 Laboratory services

(a) – (d) (No change.)

**(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.**

10:66-2.7 Mental health services

(a) (No change.)

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

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) – (d) (No change.)

(e) [The Division shall reimburse a provider for prevocational services provided within the context of a partial care program.] **(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 andNJ FamilyCare **programs**. Examples of services or interventions not considered to be prevocational include:

1. – 4. (No change.)

(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) – (i) (No change.)

(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. – 2. (No change.)

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. – 5. (No change.)

(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 [both] 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. – 4. (No change.)

(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[(that is,]**.** **The description shall include, but is not limited to, a** statement of patient progress noted, significant observations noted, etc.[)];

ii. (No change.)

iii. The duration of services provided [(one hour, 1/2 hour, etc.)];

iv - vi. (No change.)

2. – 3. (no change.)

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

1. – 2. (No change.)

(n) (No change.)

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.**

10:66-2.11 Podiatric services

(a) (No change.)

[(b) A podiatrist should be Board Qualified, or preferably, Board-Certified by a Board recognized by the American Podiatric Medical Association.]

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, [Bureau of Radiological Health (see N.J.A.C. 7:28-22)] **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.

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. – 4. (No change.)

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) – (6) (No change.)

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

ii. – vi. (No change.)

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

i. (No change.)

ii. Seeking to obtain or obtaining [an abortion] **termination of pregnancy services**; or

iii. (No change.)

7. – 8. (No change.)

10:66-2.16 Termination of pregnancy

(a) Termination of pregnancy is a [Medicaid-covered] **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 [and Senior Services] to perform [abortions] **terminations of pregnancy** with specific approval of the New Jersey Medicaid or NJ FamilyCare program;

2. - 4. (No change.)

(b) - (c) (No change.)

10:66-2.17 Transportation services

(a) [Transportation services shall be covered under the Medicaid and NJ FamilyCare-Plan A programs only.] 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. (No change.)

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

i. - ii. (No change.)

3. The purpose of providing transportation, one way or round trip, is to enable a [Medicaid or NJ FamilyCare-Plan A fee-for-service] **Medicaid/NJ FamilyCare or ABP** beneficiary to obtain [a Medicaid-covered or NJ FamilyCare-covered service at the clinic] **partial care services**.

4. A [Medicaid or NJ FamilyCare-Plan A fee-for-service] **Medicaid/NJ FamilyCare or ABP** beneficiary is transported:

i. - ii. (No change.)

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 [taxicab, train, bus, other public conveyance, or livery-type, lower-mode vehicle] **bus pass provided by the transportation broker for the beneficiary’s use**.

ii.-iii. (No change.)

 (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 [Division of] Motor Vehicle[s] **Commission**, in accordance with all applicable laws and rules of the New Jersey [Division of] Motor Vehicle[s] **Commission** [(see]**,** Title 39 of the Revised Statutes[)]**,** or the New Jersey Department of Transportation [(see]**,** Title [48]**27** of the Revised Statutes).

1. (No change.)

(c) – (d) (No change.)

**10:66-2.19** **(Reserved)**

10:66-2.20 Vaccines for Children program

(a) – (b) (No change.)

(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) – (e) (No change.)

SUBCHAPTER 3. HEALTHSTART

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 [and Senior Services'] Improved Pregnancy Outcome criteria.

(b) – (e) (No change.)

(f) A HealthStart Provider Certificate shall be reviewed by the New Jersey State Department of Health [and Senior Services] 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 [and Senior Services]

PO Box 364

Trenton, NJ 08625-0364

(h) (No change.)

10:66-3.4 Termination of HealthStart Provider Certificate

(a) The New Jersey State Department of Health [and Senior Services] 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 [and Senior Services].

1. (No change.)

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 [and Senior Services].

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 [and Senior Services'] 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) – (c) (No change.)

10:66-3.15 Referral services by HealthStart pediatric care providers

(a) All HealthStart pediatric care providers shall make provision for consultation for specialized health and other pediatric services. Services shall include medical services, as well as social, psychological, educational**,** and nutritional services.

1. This may include, but is not limited to: the Special Supplemental Food Program for Women, Infants and Children (WIC); Division of [Youth and Family Services] **Child Protection and Permanency**; Special Child Health Services Case Management Units and Child Evaluation Centers; early intervention programs; county welfare agencies/boards of social services; certified home health agencies; community mental health centers; and local and county health departments.

10:66-3.16 Records: documentation, confidentiality and informed consent for HealthStart pediatric care providers

(a) HealthStart pediatric care providers shall have policies [which] **that** protect patient confidentiality, provide for informed consent**,** and document comprehensive care services in accordance with the New Jersey State Department of Health [and Senior Services'] Guidelines for HealthStart Pediatric Care Providers.

(b) – (d) (No change.)

SUBCHAPTER 4. FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

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

(a) Federally qualified health center (FQHC) services are services provided by physicians, physician assistants, 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] **county board of social services** (CBOSS) employee(s) for the purpose of determining Medicaid and NJ FamilyCare eligibility, pursuant to [1902(a)(55) of the Social Security Act,] 42 U.S.C. § 1396a**(a)(55)**.

2. – 5. (No change.)

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 [Unisys] **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 [will be] **are** posted on the [Unisys] **Molina** website: www.njmmis.com.

 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. – ii. (No change.)

iii. Persons working for a public accounting firm licensed on or before December 31, 1970, sufficiently independent as defined by GAO standards, to produce unbiased opinions, conclusions, or [judgements] **judgments**;

2. – 3. (No change.)

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. (No change.)

ii. Government Auditing Standards established by the Comptroller General of the United States and issued by the U.S. [General Accounting] **Government Accountability** Office;

iii. – viii. (No change.)

(b) The audit report shall include the following:

1. – 2. (No change.)

3. A supplementary schedule and opinion thereon of the FQHC's state and [federal] **Federal** financial assistance programs, showing expenditures by program**.** [(see] **See** the AICPA's audit guide, Audits of State and Local Governmental Units, Fifth Edition, pages 196 and 230;

4. – 6. (No change.)

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. – 9. (No change.)

10. A report on fraud, abuse or illegal acts, or indications of such acts when discovered**.** [(a]**A** separate written report is required[)].

(c) – (d) (No change.)

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 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 [Norplant] **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 [Norplant] **subdermal contraceptive implant** services, line 15, the number of [Norplant] **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(b)]**4.1(a)** for the appropriate definition of a medical encounter.

...

Column 5, New Jersey Department of Health [and Senior Services]--Enter in the appropriate service category the number of encounters provided under letter of agreement with the New Jersey Department of Health [and Senior Services]. This amount must include the base level visits assigned by the New Jersey Department of Health [and Senior Services]. On line 16, enter the number of pneumococcal and influenza vaccine injections provided under agreement with the New Jersey Department of Health [and Senior Services].

...

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 II--Specialized Services

...

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. [(Note:] The visits for [Norplant] **subdermal contraceptive implants** are the actual [Norplant Implant Procedures] **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.[)]

...

SUBCHAPTER 5. AMBULATORY SURGICAL CENTER (ASC)

10:66-5.1 Covered services

(a) [Medicaid-covered] **Medicaid** and NJ FamilyCare fee-for-service covered procedures in an ambulatory surgical center (ASC) are those surgical and medical procedures [which] **that** appear at 42 CFR [416.65(c)]**416.166**, the Federal regulations governing ASC services. Surgical procedures performed in an ASC are separated into [an eight-group] **a** classification system **by the Centers for Medicare and Medicaid Services (CMS)**.

1. A request by an ASC to add additional surgical procedures not specifically included in one of the [eight] Medicare payment groups must be reviewed and evaluated by the Division of Medical Assistance and Health Services (New Jersey Medicaid and NJ FamilyCare fee-for-service programs).

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

(b) Medicaid-covered and NJ FamilyCare fee-for-service covered surgical procedures include, but are not limited to, those procedures that:

1. (No change.)

2. Require a dedicated operating room or suite, and require a postoperative recovery room or short-term, [(] **meaning** not overnight[)]**,** convalescent room;

3. – 4. (No change.)

 10:66-5.3 Facility services

(a) (No change.)

(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. – 7. (No change.)

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 [300] **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 [was developed as a three-level] **is a two-level** coding system.

1. (No change.)

2. Level II codes [(narratives found at N.J.A.C. 10:66-6.3)]: These codes are assigned by [HCFA] **CMS** for physician and non-physician services [which] **that** are not in CPT. **Narratives for Level II codes can be found at N.J.A.C. 10:66-6.3.**

[3. Level III codes (narratives found at N.J.A.C. 10:66-6.3): These codes are assigned by the Division to be used for those services not identified by CPT codes or HCFA-assigned codes. Level III codes identify services unique to New Jersey.]

(b) Regarding specific elements of HCPCS codes which require the attention of providers, the lists of HCPCS code numbers for independent clinic services are arranged in tabular form with specific information for a code given under columns with titles such as: "IND," "HCPCS CODE," "MOD," "DESCRIPTION," "FOLLOW-UP DAYS" and "MAXIMUM FEE ALLOWANCE." The information given under each column is summarized below:

|  |  |
| --- | --- |
| **Column Title** | **Description** |
| ... |  |
| Modifer Code | Description |
| ... |   |
| 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 [(o)] **(l*)***. |
| ... |  |

(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. – ii. (No change.)

iii. When billing, the provider must enter onto the claim form a CPT/HCPCS procedure code as listed in CPT or in this subchapter [(N.J.A.C. 10:66-6)]. If an appropriate code is not listed, place an "N/A" (not applicable) in the procedure code column and submit a narrative description of the service. If possible, insert a CPT code closest to the narrative description you have written.

iv. – vi. (No change.)

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. – 3. (No change.)

4. Specific requirements concerning radiology are as follows:

i. – ii. (No change.)

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. (No change.)

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

(a) – (k) (No change.)

(l) Transportation services:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Ind** | **HCPCS****Code** | **Mod** | **Follow****Up****Days** | **Maximum Fee****Allowance** | **Anes.****Basic****Units** |
|  |  |  |  | **S** | **$** | **NS** |
| **LN** | **A0425** | **UC** |  | **2.50** | **2.50** |  |
| ... |  |  |  |  |  |

(m) [Drug treatment center] **Substance use disorder treatment facility** services:

[\* An asterisk preceding any procedure code indicates that the procedure may only be provided to ACCAP-eligible individuals in the home.]

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  | **Follow** | **Maximum** **Fee** | **Anes**. |
|  | **HCPCS** |  | **Up** | **Allowance** | **Basic** |
| **Ind** | **Code** | **Mod** | **Days** | **S** | $ | **NS** | **Units** |
|  |  |  |  |  |  |  |  |
| [ \*LN | Z1830 |  |  | 3.50 |  | 3.50 |  |
|  \*LN | Z1834 |  |  | 30.00 |  | 30.00 |  |
|  \*LN | Z1835 |  |  | 22.50 |  | 22.50] |  |
| ... |  |  |  |  |  |  |  |

(n) (No change.)

(o) [Personal care assistant services:] **(Reserved)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| [**Ind** | **HCPCS** |  | **Follow** | **Maximum Fee** | **Anes.** |
|  | **Code** | **Mod** | **Up Days** | **Allowance** | **Basic Units** |
|  |  |  |  | **S** | **$** | **NS** |  |
| L | Z1600 | UC |  | 13.02 |  | 13.02 |  |
| L | Z1605 | UC |  | 10.23 |  | 10.23 |  |
| L | Z1610 | UC |  | 35.00 |  | 35.00 |  |
| L | Z1611 | UC |  | 6.51 |  | 6.51 |  |
| L | Z1612 | UC |  | 5.12 |  | 5.12 |  |
| L | Z1613 | UC |  | 35.00 |  | 35.00] |  |
|  |  |  |  |  |  |  |  |

(p) – (r) (No change.)

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

(a) – (c) (No change.)

(d) Vision care services**.** [(]See N.J.A.C. 10:62-[4)]**3**.

(e) Transportation services:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Ind** | **HCPCS****Code** | **Mod** | **Description** | **Follow****Up****Days** | **Maximum Fee****Allowance** |  |
|  |  |  |  |  | **S $** | **NS** |  |
|  | **A0425** | **UC** | **Per trip, one way, to/from a Partial Care program** |  | **2.50** | **2.50** |  |
| ... |  |  |  |  |  |

(f) [Drug treatment center]**Substance use disorder treatment facility** services:

[\* An asterisk preceding any procedure code indicates that the procedure may only be provided to ACCAP-eligible individuals in the home.]

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  | **Follow** | **Maximum** **Fee** |
|  | **HCPCS** |  |  | **Up**  | **Allowance** |
| **Ind** | **Code** | **Mod** | **Description** | **Days** | **S** | $ | **NS** |
|  | [\*Z1834 |  | Family therapy rendered by a drug treatment facility at home, per visit |  | 30.00 |  | 30.00 |
|  |  |  |  |  |  |  |  |
|  | \*Z1835 |  | Family conference rendered by a drug treatment center at home, per visit |  | 22.50 |  | 22.50] |
|  |  |  |  |  |  |  |  |
| ... |  |  |  |  |  |  |

(g) (No change.)

[(h) Personal care assistant services:

(Applicable to clinics under contract to the Division of Mental Health and Hospitals of the Department of Human Services.)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  | **Follow** | **Maximum Fee** |
|  | **HCPCS** |  |  | **Up** | **Allowance** |
| **Ind** | **Code** | **Mod** | **Description** | **Days** | **S** | **$** | **NS** |
|  | Z1600 | ZI | Personal Care Assistant Services, Individual, per hour |  | 13.02 |  | 13.02 |
|  | Z1605 | ZI | Personal Care Assistant Services, Group, per hour |  | 10.23 |  | 10.23 |
|  | Z1610 | ZI | Personal Care Assistant Services, Initial Nursing Assessment, per visit |  | 35.00 |  | 35.00 |
|  | Z1611 | ZI | Personal Care Assistant Services, Individual, per hour |  | 6.51 |  | 6.51 |
|  | Z1612 | ZI | Personal Care Assistant Services, Group, per hour |  | 5.12 |  | 5.12 |
|  | Z1613 | ZI | Personal Care Assistant Services, Nursing Reassessment, per visit |  | 35.00 |  | 35.00] |

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. (No change.)

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 [following] criteria[: best corrected visual acuity equal to or better than 20/200, if the decreased visual acuity is caused by macular degenera­tion; classic subfoveal choroidal neovascularization (CNV), occupying 50 percent or greater of the entire ocular lesion; and 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] **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. – 5. (No change.)

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. – iii. (No change.)

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. – ii. (No change.)

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) (No change.)

(2) An alternative to [(a)7i(1)] **(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) (No change.)

ii. – iv. (No change.)

9. (No change.)

 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 [and Senior Services].

ii. (No change.)

11. (No change.)

(b) (No change.)

(c) Family planning services:

1. [Norplant --removal, implantable contraceptive capsules] **Subdermal contraceptive implants**: 11976.

i. The maximum fee allowance includes the removal of the ["Norplant System" (six levonorgestrel implants)] **subdermal contraceptive implants** and the post-removal visit.

2. – 9. (No change.)

Note: (No change.)

(d) (No change.)

(e) Minor surgery:

1. Acne surgery**,** [(for example] **including, but not limited to**, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules[)]: 10040.

i. (No change.)

(f) Mental health services:

1. Comprehensive intake evaluation: [90801] **90791** UC**; use 90792 UC for physician involved assessment**.

i. – ii. (No change.)

2. Individual psychotherapy—[20] **20-** to 30-minute session: [90804] **90832** UC and [90805] **90833** UC.

i. (No change.)

3. Individual psychotherapy—[45] **45-** to 50-minute session: [90806] **90834** UC and [90807] **90836** UC.

i. (No change.)

4. – 13. (No change.)

(g) Obstetrical services (maternity):

1. Total obstetrical care: 59400.

i. (No change.)

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) (No change.)

2. (No change.)

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. (No change.)

6. Total obstetrical care by a certified nurse-midwife: 59400 SB.

i. (No change.)

ii. Obstetrical delivery per vagina with or without episiotomy include**s** postpartum care when provided by the certified nurse-midwife in the home, birthing center or in the hospital [(] **or other** inpatient setting[)].

(1) – (2) (No change.)

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) – (2) (No change.)

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. (No change.)

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. (No change.)

2. See N.J.A.C. 10:66-[6.4(f)]**6.2(e)**, [Surgery] **Minor surgery**, for additional procedures.

(i) Radiology services:

1. – 3. (No change.)

4. Esophagus [(]with fluoroscopy by the radiologist[)]: 74220.

i. (No change.)

5. (No change.)

(j) Rehabilitation services:

1. – 2. (No change.)

3. Physical therapy: 97799.

i. (No change.)

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) – (3) (No change.)

(4) Therapeutic use of physical agents [(]other than drugs**,**[)] including heat, light, water, electricity**,** and radiation.

(5) (No change.)

4. (No change.)

(k) Vision care services (See N.J.A.C. 10:62-[4]**3**).

(l) Transportation services:

1. (No change.)

**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) [Drug treatment center] **Substance use disorder treatment** services:

[1. Methadone treatment rendered by a drug treatment center for an ACCAP-eligible individual at home, per visit: Z1830.

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.

2. Family therapy rendered by a drug treatment center for an ACCAP-eligible individual at home, per visit: Z1834.

i. Therapy with the patient and with one or more family members present. Verbal or other therapy methods are provided by a physician, or a professional counsellor under the direction of a physician, in personal involvement with the patient and the family to the exclusion of other patients and/or duties.

ii. A minimum session of one and one half hours is required with a minimum of 80 minutes personal involvement with the patient and the family and up to 10 minutes for the recording of data.

iii. The clinic may bill only for the patient and not for other family members.

3. Family conference rendered by a drug treatment center for an ACCAP-eligible individual at home, per visit: Z1835.

i. Meeting with the family or other significant persons to interpret or explain medical, psychiatric or psychological examinations and procedures, other accumulated data and/or advice to the family or other significant persons on how to assist the patient.

ii. A minimum of 50 minutes of personal involvement with the family is required. The clinic may bill only for the patient and not for other family members.]

Recodify existing 4. – 22. as **1. – 19.** (No change in text.)

(n) Miscellaneous services:

1. [Abortion] **Termination of pregnancy**: 59840 and 59841.

i. See N.J.A.C. 10:66-[2.8]**2.16**; FD-179 form shall be attached to the claim form.

ii. (No change.)

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:

[Unisys] **Molina Medicaid Solutions**

PO Box 4801

Trenton, New Jersey 08650-4801

or contact:

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