

**CHAPTER 49**

**ADMINISTRATION MANUAL**

**Authority**

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

**Source and Effective Date**

R.1997 d.354, effective August 8, 1997.  
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

**Executive Order No. 66(1978) Expiration Date**

Chapter 49, Administrative Manual, expires on August 8, 2002.

**Chapter Historical Note**

Chapter 44, Administration, was filed and became effective prior to September 1, 1969. Subchapters 1 through 6 were amended by R.1977 d.213, effective July 1, 1977. See: 9 N.J.R. 123(b), 9 N.J.R. 342(c).

Pursuant to Executive Order No. 66(1978), Chapter 49 was readopted as R.1990 d.390. See: 22 N.J.R. 1512(a), 22 N.J.R. 2313(a).

Chapter 49, Administration, was repealed and a new Chapter 49, Administration, was adopted by R.1992 d.317, effective August 17, 1992. See: 24 N.J.R. 1728(b), 24 N.J.R. 2837(a). Subchapter 19, Prepaid Health Care Services: Medicaid Eligibles, was repealed by R.1995 d.337, effective June 19, 1995. See: 27 N.J.R. 853(a); 27 N.J.R. 2446(b).

Pursuant to Executive Order No. 66(1978), Chapter 49 was readopted as R.1997 d.354, effective August 8, 1997. See: Source and Effective Date. As a part of R.1997 d.354, effective September 2, 1997, the name of Chapter 49, Administration, was changed to Chapter 49, Administration Manual; the name of Subchapter 2, New Jersey Medicaid Recipients, was changed to Subchapter 2, New Jersey Medicaid Beneficiaries; the name of Subchapter 9, Provider and Recipient's Rights and Responsibilities; Administrative Process, was changed to Subchapter 9, Provider and Beneficiary's Rights and Responsibilities; Administrative Process; Subchapter 17, Home and Community-Based Services Waivers, was recodified as N.J.A.C. 10:49-22, Home and Community Based Services Waiver Programs; Subchapter 18, Home Care Expansion Program, was recodified as N.J.A.C. 8:81-2, and Subchapter 18, Early and Periodic Screening, Diagnosis and Treatment (EPSDT), was adopted as new rules; Subchapter 19, HealthStart, was adopted as new rules; Subchapter 21, Pharmaceutical Assistance to the Aged and Disabled (PAAD), was recodified as N.J.A.C. 8:81-3, and Subchapter 21, The Medicaid Managed Care Program—NJ Care, was adopted as new rules; Subchapter 22, Lifeline Programs, was recodified as N.J.A.C. 8:81-4, and Subchapter 22, Home and Community-Based Services Waiver Programs, was adopted as new rules; and Subchapter 23, Hearing Aid Assistance to the Aged and Disabled, was recodified as N.J.A.C. 8:81-5, and a new Subchapter 23, Lifeline Programs, was adopted as new rules. See, also, section annotations.

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**SUBCHAPTER 1. GENERAL PROVISIONS**

**10:49-1.1 Scope and purpose**

(a) The Division of Medical Assistance and Health Services, under the Department of Human Services, is designated, in accordance with 42 C.F.R. 412.30, as the single State agency for the administration of the New Jersey Medicaid program under authority of N.J.S.A. 30:4D-5, and pursuant to N.J.S.A. 30:4D-4, the Division of Medical Assistance and Health Services is authorized to administer the Medicaid program as well as other special programs. This chapter provides general and specific information about the regular Medicaid program; special Medicaid services or programs (such as HealthStart, Prepaid Health Plans, and Waivered programs); and other special (State) funded programs.

(b) Governor Whitman's Reorganization Plan No. 001-1996 gives the Department of Health and Senior Services (DHSS) legal authority to administer several components of the Medicaid program. These components include nursing facility services, medical day care services, PreAdmission Screening (PAS) and PreAdmission Screening and Annual Resident Review (PASARR), the Community Care program for the Elderly and Disabled (CCPED) waiver, the Assisted Living/Alternate Family Care (AL/AFC) waiver, and peer grouping. Rules for these Medicaid program components are promulgated by DHSS. Accordingly, providers must contact DHSS regarding requirements for these services.

Amended by R.1997 d.354, effective September 2, 1997.  
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).  
Substantially amended section.

### 10:49-1.2 Organization

(a) Regarding the organization of the Division of Medical Assistance and Health Services, the Department of Human Services is the single State Agency for receipt of Federal funds under Title XIX (Medicaid) of the Social Security Act. The Division of Medical Assistance and Health Services, Department of Human Services, administers the New Jersey Medicaid program through its Central Office and through Medicaid District Offices (MDO) located throughout the State of New Jersey. A listing of the MDOs is provided in the chapter Appendix.

1. The program is jointly financed by the Federal and State governments and administered by the State. The New Jersey Medicaid program is conducted according to the Medicaid State Plan approved by the Secretary, United States Department of Health and Human Services, through the Health Care Financing Administration (HCFA).

Amended by R.1997 d.354, effective September 2, 1997.  
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Section name amended; former (a) recodified as N.J.A.C. 10:49-1.3; recodified former (b) as (a); in (b)1, added " through the Health Care Financing Administration (HCFA)"; and deleted (c), relating to Medicaid Program services and eligibility.

### 10:49-1.3 Definitions

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

"Aid to Families with Dependent Children (AFDC)" or "AFDC beneficiary" means the standards effective July 16, 1996 or persons meeting those eligibility standards, as contained in N.J.A.C. 10:81 and 10:82.

"Beneficiary or eligible beneficiary" means any person meeting the definition of recipient as defined below.

"County welfare agency or CWA" means that agency of county government which is charged with the responsibility for determining eligibility for public assistance programs

including Aid to Families with Dependent Children, the Food Stamp program, and Medicaid. Depending on the county, the CWA might be identified as the Board of Social Services, the Welfare Board, the Division of Welfare, or the Division of Social Services.

"Commissioner of DHS" means the Commissioner of the Department of Human Services.

"Department" or "DHS" means the Department of Human Services. The Department of Human Services is the single state agency designated by N.J.S.A. 30:4D-3 in accordance with 42 C.F.R. 412.30.

"Division" or "DMAHS" means the Division of Medical Assistance and Health Services.

"DHSS" means the Department of Health and Senior Services.

"Fiscal Agent" means an entity that processes and adjudicates provider claims on behalf of the New Jersey Medicaid Program, other Special Programs, and the Pharmaceutical Assistance to the Aged and Disabled Program.

"Health Care Financing Agency (HCFA)" means the agency of the Federal Department of Health and Human Services which is responsible for the administration of the Medicaid program in the United States.

"Medicaid" means medical assistance provided to certain persons with low income and limited resources as authorized under Title XIX (Medicaid) of the Social Security Act.

"Medicaid Agent" means, under Reorganization Plan No. 001-1996, either DHSS or DMAHS, acting as administrators of the Medicaid program.

"Prepaid health plan" means an entity that provides medical services to enrolled Medicaid eligibles under a contract with DMAHS on the basis of prepaid capitation fees but which does not necessarily qualify as an HMO. For rules concerning prepaid health care services, see N.J.A.C. 10:49-19. For a description of the State operated HMO, the Garden State Health Plan, see N.J.A.C. 10:49-20. For Medicaid Managed Care Program-New Jersey Care 2000, see N.J.A.C. 10:49-21.

"Program" means the New Jersey Medicaid program.

"Provider" means any individual, partnership, association, corporation, institution, or any other public or private entity, agency, or business concern, meeting applicable requirements and standards for participation in the New Jersey Medicaid Program, other Special programs, and where applicable, holding a current valid license, and lawfully providing medical care, services, goods and supplies authorized under N.J.S.A. 30:4D-1 et seq. and amendments thereto.

“Qualified applicant” means a person who is a resident of this State and is determined to need medical care and services as provided under the Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 et seq., and who meets one of the eligibility criteria set out therein.

“Recipient” means a qualified applicant receiving benefits under the Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 et seq.

Recodified from N.J.A.C. 10:49-1.2(a) and amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Deleted (a) designation, added “Aid to Families with Dependent Children (AFDC)”, “Beneficiary or eligible beneficiary”, “Commissioner of DHS”, “Department”, “Division”, “DHSS”, “Health Care Financing Agency”, “Medicaid Agent”, “Prepaid health plan”, “Program”, and “Qualified applicant”; changed “County welfare agency” to “County welfare agency or CWA” and amended; amended “Provider” and “recipient”; and deleted (b) and (c). Former section, “Early and Periodic Screening, Diagnosis and Treatment (EPSDT)”, repealed.

**10:49-1.4 Overview of provider manuals**

(a) The New Jersey Medicaid Program maintains New Jersey Medicaid provider manuals. Each is designed for use by a specific type of provider that provides services to Medicaid beneficiaries. Each manual is written in accordance with Federal and State laws, rules, and regulations, with the intent to ensure that such laws, rules, and regulations are uniformly applied.

(b) Each Medicaid provider manual consists of two chapters, broken down into subchapters. The first chapter is referred to as N.J.A.C. 10:49 (Administration) and outlines the general administrative policies of the New Jersey Medicaid Program and other special programs. The second chapter of each manual specifies the rules and regulations relevant to the specific provider-type and the services provided. Following the second chapter of the manuals is the Fiscal Agent Billing Supplement.

(c) Codification of manual material follows that of the New Jersey Administrative Code (N.J.A.C.). The citation for a particular section of the provider manual reflects the same material under the same citation in the N.J.A.C. The following is an example of a citation in the N.J.A.C. or a provider manual:

Citation -----	10:49-11.10
Title—Department of Human Services -----	
Chapter (Administration) -----	
Subchapter -----	
Section -----	

(d) There is an individual New Jersey Medicaid provider manual for each of the following services. These services are listed in the New Jersey Administrative Code (N.J.A.C.) under Title 10 (Department of Human Services) Chapters 10:50 through 10:64; 10:66 through 10:68, and 10:73 through 10:74 as follows:

1. 10:50—Transportation Services Manual
2. 10:51—Pharmacy Services Manual
3. 10:52—Hospital Services Manual
4. 10:53—(Reserved)
5. 10:53A—Hospice Services Manual
6. 10:54—Physician Services Manual
7. 10:55—Prosthetic and Orthotic Services Manual
8. 10:56—Dental Services Manual
9. 10:57—Podiatry Services Manual
10. 10:58—Nurse-Midwifery Services Manual
11. 10:58A—Certified Nurse Practitioner/Clinical Nurse Specialist
12. 10:59—Medical Supplier Services Manual
13. 10:60—Home Care Services Manual
14. 10:61—Independent Clinical Laboratory Services Manual
15. 10:62—Vision Care Services Manual
16. 10:63—Long Term Care Services Manual
17. 10:64—Hearing Aid Services Manual
18. 10:65—Medical Day Care Services Manual
19. 10:66—Independent Clinic Services Manual
20. 10:67—Psychological Services Manual
21. 10:68—Chiropractic Services Manual
22. 10:73—Case Management Services Manual
23. 10:74—Managed Health Care Services for Medicaid Eligibles

(e) Regarding manual updates, revised pages or additions to the provider manual are issued, as required, for new policy, policy clarification, and/or revisions to the New Jersey Medicaid program. A newsletter system is utilized to distribute new or revised manual material and to provide any other pertinent information regarding manual updates. Newsletters should be filed at the back of the manual and replacement pages should be added to the manual in accordance with instructions provided. Substantive manual revisions shall be made through the rulemaking process, in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

(f) Regarding provider responsibility, this manual and all subsequent updates are distributed as a guide to assist providers in their participation in the New Jersey Medicaid program. The provider is ultimately responsible for knowing and abiding by current laws and regulations pertaining to this program.

Recodified from N.J.A.C. 10:49-1.8 and amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

In (a), substituted "The New Jersey Medicaid Program maintains" for "There are 19" and "Medicaid beneficiaries" for "Medicaid recipients"; in (d), inserted additional N.J.A.C. references; inserted new (d)5, 11 and 23; recodified former (d)5 through 9 and 10 through 20 as (d)6 through 10 and 12 through 22; and in (e), substituted "Substantive manual revisions shall be made" for "Manual revisions shall be substantially made". Former section, "HealthStart", repealed.

#### Case Notes

Extended care facility could not be reimbursed for care for Medicaid-eligible patient. *V.F. v. Division of Medical Assistance and Health Services*, 92 N.J.A.R.2d (DMA) 29.

#### 10:49-1.5 (Reserved)

Repealed by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Section was "Prepaid health plans".

#### 10:49-1.6 (Reserved)

Recodified to N.J.A.C. 10:49-22.3 and amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

#### 10:49-1.7 (Reserved)

Repealed by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Section was "State funded programs".

#### 10:49-1.8 (Reserved)

Recodified to N.J.A.C. 10:49-1.4 and amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

## SUBCHAPTER 2. NEW JERSEY MEDICAID BENEFICIARIES

### 10:49-2.1 Who is eligible for Medicaid?

(a) Medicaid beneficiaries are: those eligible for all services under the regular New Jersey Medicaid program (see N.J.A.C. 10:49-2.2 below); those eligible for a limited range of services under the Medically Needy program (see N.J.A.C. 10:49-2.3 below) and those eligible for a limited range of services under the Home and Community-Based Services Waiver Programs, in accordance with N.J.A.C. 10:49-22.

Amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Substituted "Medicaid beneficiaries" for "Medicaid recipients" and added Home and Community-Based Services Waiver Programs category.

### 10:49-2.2 Persons eligible under the regular New Jersey Medicaid program

(a) The eligibility rules for persons eligible under the regular New Jersey Medicaid program are included in N.J.A.C. 10:71, 10:72, 10:81, and 10:82.

(b) The following groups may be eligible for medical and health services covered under the regular New Jersey Medicaid program requirements as outlined in the second chapter of each Provider Services Manual. The list is not all inclusive but is intended to provide an overview of some of the types of individuals who may be eligible for Medicaid benefits, when provided in accordance with the requirements of N.J.A.C. 10:71, 10:72, 10:81 and 10:82, as appropriate.

1. Persons who are eligible to receive Supplemental Security Income (SSI) payments as determined by the Social Security Administration and those persons who meet the SSI standards but apply for the Medicaid Only program through the CWA. Those persons are the aged (65 and over), the blind, and the disabled;

2. A person who qualifies under the Supplemental Security Income (SSI) program as the "ineligible spouse" of an SSI beneficiary determined by the Social Security Administration;

3. Children and caretaker relatives eligible for and receiving Aid to Families with Dependent Children (AFDC);

4. Deemed recipients of AFDC including:

i. Persons denied AFDC solely because the payment would be less than \$10.00;

ii. Persons whose AFDC payment is reduced to zero (\$0.00) because of an over-payment recovery; and

iii. For a period of four months, persons losing AFDC because of the receipt of child or spousal support;

5. For a period of up to 24 months from the first month of ineligibility, persons losing eligibility for AFDC as a result of earnings or hours of employment, or the receipt of New Jersey Unemployment or Temporary Disability Insurance benefits;

6. Persons ineligible for AFDC or Work First New Jersey because of requirements that do not apply under Medicaid;

7. For a period of one year, a child born to a woman who is a Medicaid beneficiary, so long as the woman remains eligible for Medicaid, or would remain eligible if pregnant;

8. Persons for whom adoption assistance agreements are in effect pursuant to Section 473 of the Social Security Act (42 U.S.C. § 673) or for whom foster or adoption assistance is paid under Title IV-E of the Act;

9. Persons ineligible for Supplemental Security Income (SSI) because of requirements that do not apply under Medicaid;

10. Persons receiving only mandatory State supplemental payments administered by the Social Security Administration;

11. Certain former beneficiaries of Supplemental Security Income (SSI) who would still be eligible for SSI except for entitlement to or increase in the amount of Social Security benefits;

12. Persons eligible for but not receiving AFDC or an optional State benefit;

13. Children under the age of 21 years who meet the income and resource requirements for AFDC but do not qualify as dependent children;

14. Persons who are in institutions for at least 30 consecutive days and who are eligible under a special income level (the Medicaid "cap") that is higher than the income level for a noninstitutionalized SSI or State supplement beneficiary;

15. Pregnant women and children up to the age one whose income is below 185 percent of the Federal poverty level, and children up to the age of six whose income is below 133 percent of the Federal poverty level, codified as 42 U.S.C. § 1396a, or 1902(l) of the Social Security Act;

16. Aged, blind, and disabled persons whose income is below 100 percent of the Federal poverty level and whose assets are within 200 percent of the SSI asset limits;

17. For a period lasting through the end of the month following the 60th day following delivery, women who have applied for Medicaid benefits before the last day of pregnancy and who are eligible for Medicaid on the last day of pregnancy;

18. Persons 65 years of age or older who do not meet the eligibility standards of the categorically needy or medically needy and who are eligible for the Medical Assistance to the Aged Continuance (MAA) program. (No new applications are accepted for this coverage); and

19. Refugees who are eligible under the Refugee Resettlement program.

Amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Inserted new (a); and recodified former (a) as (b) and amended.

#### Case Notes

Home care visits could not be added to cost report in absence of timely claim. Long Branch Public Health Nursing Association, Inc. v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 10.

#### 10:49-2.3 Persons eligible under the Medically Needy program

(a) The eligibility rules for persons eligible under the Medically Needy program are included in N.J.A.C. 10:70.

(b) A Medicaid beneficiary under the Medically Needy program is limited to those medical services listed in N.J.A.C. 10:49-5.3. Services shall be provided in conjunction with specific program requirements as outlined in the second chapter of the applicable Provider Services Manual.

(c) To be determined Medically Needy under the Medicaid Program, it is necessary for the person to meet categorical eligibility requirements, have income and/or resources in excess of the categorical standards, and have insufficient funds to meet his or her medical expenses. Medically Needy persons shall be in one of the following groups:

1. Pregnant women;

2. Needy children (under 21 years of age); or

3. The aged (65 years of age or older), the blind or the disabled.

(d) There are special income and resource levels established for the Medically Needy. If a person meets one of the categories listed in (c) above and has income and/or resources above categorical program levels but less than or equal to the Medically Needy income and resource levels, he or she shall be determined as Medically Needy eligible. However, if a person meets one of the categories listed in (c) above and meets the Medically Needy resource level but has income which exceeds the Medically Needy income level, eligibility may be established through the "spend-down" process.

1. "Spend-down" is the process whereby a person may apply incurred medical expenses to offset income above the Medically Needy income level, and thereby adjust his or her income to meet the Medically Needy income limit.

(e) Medically Needy eligibility for all groups, including the aged, blind and disabled, shall be determined by the CWA for both the retroactive and prospective period.

1. Each Medically Needy applicant/beneficiary shall reapply for benefits every six months. Eligibility may be established the first day of that six-month period or on any date during the six-month period that spend-down is met.

2. Eligibility shall be verified by providers on each visit by reviewing the Medicaid Eligibility Identification Card (MEI) (FD-73/178) (see N.J.A.C. 10:49-2.14—Validation Form). For those cards issued for the month within the six month period in which the spend-down is met, the card will reflect the date that eligibility begins after the spend-down is met.

(f) Claims for Medically Needy covered services provided during an eligible period may be submitted to the program for reimbursement using standard Medicaid procedures. Services provided prior to the effective date of eligibility shall be the client's liability, except for certain "special" claims.

1. "Special" claims are claims for Medically Needy covered services that were not used to meet the spend-down and were rendered between the first of the month in which eligibility is established and the date of eligibility that appears on the Medicaid Eligibility Identification Card.

2. The CWA shall identify "special" claims which may be reimbursed under the program and shall provide a Medically Needy Claim Transmittal (Form FD-311, see Appendix, N.J.A.C. 10:49). Such claims shall be submitted hard copy with Form FD-311 attached.

Amended by R.1997 d.354, effective September 2, 1997.  
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Inserted new (a); recodified former (a) through (e) as (b) through (f); in (b) and (e)1, substituted "Medicaid beneficiary" for "Medicaid recipient"; in (d), amended internal cites; and in (e)2, amended N.J.A.C. reference.

#### 10:49-2.4 Persons eligible under Home and Community-Based Services Programs

(a) Individuals who may not be eligible for regular Medicaid benefits or Medical Needy may be eligible for selected services under the Home and Community-Based Services Waiver Programs under special eligibility rules. A brief overview of these programs and their rules may be found at N.J.A.C. 10:49-22.

New Rule, R.1997 d.354, effective September 2, 1997.  
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Former section recodified to N.J.A.C. 10:49-2.5.

#### 10:49-2.5 Eligibility process (variations to routine procedure)

There are variations to the routine procedure for determining Medicaid eligibility. These variations are relevant to applying for eligibility for a newborn infant or for an inpatient upon admission to a hospital (see N.J.A.C. 10:49-2.6); to determining presumptive eligibility for pregnant women (see N.J.A.C. 10:49-2.7); and to determining retroactive eligibility (see N.J.A.C. 10:49-2.8).

Recodified from N.J.A.C. 10:49-2.4 and amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Amended N.J.A.C. references. Former section recodified to N.J.A.C. 10:49-2.6.

#### 10:49-2.6 Applying for Medicaid eligibility for a newborn infant or for an inpatient upon admission to a hospital

(a) There are limited variations to the eligibility process for a newborn infant of a woman who is a Medicaid beneficiary. The policy and procedures follow:

1. Although both the mother and newborn infant may be Medicaid beneficiaries on the date of delivery, the newborn infant is not immediately assigned a Person Number (see N.J.A.C. 10:49-2.11). In order to expedite payment to any provider before this number is assigned, the provider is permitted to bill for services provided to the newborn using the mother's Medicaid Eligibility Identification Number and Person Number on the claim form.

i. Immediately after the birth of a newborn infant, the hospital shall submit a "Public Assistance Inquiry" (Form PA-1C, see Appendix, N.J.A.C. 10:49) to the CWA. This will facilitate the assignment of a Person Number and addition of the newborn's name to the Medicaid eligibility file. The PA-1C Form shall include the date of birth of the newborn and the signature of the mother.

2. The period for which newborn services may be billed under the mother's Medicaid Eligibility Identification Number and Person Number shall extend from the date of birth until the last day of the month in which a 60 day time frame ends, or until the newborn is assigned his or her own Person Number, whichever happens first.

Example: If a newborn's date of birth is January 5th, the 60 day period ends March 6th. Claims may be submitted for dates of service through March 31st using the mother's Medicaid Eligibility Identification Number and Person Number, provided the newborn has not been assigned his or her own Person Number in the meantime. Claims for services provided to the newborn after March 31st would be processed only if the required information about the newborn is used (Person Number, name, age, sex, etc.).

3. The newborn's Person Number shall be used as soon as it is available to the provider. The practitioner or any other type of provider shall request the newborn's Person Number from the mother at each encounter.

4. Billing instructions for services provided a newborn infant under his or her mother's Medicaid Eligibility Identification Number and Person Number are provided in the Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual, as applicable.

(b) The following procedures shall apply when application is made for Medicaid eligibility for an inpatient upon admission to a hospital:

1. A hospital may submit a "Public Assistance Inquiry" (Form PA-1C, see Appendix, N.J.A.C. 10:49) when an individual is admitted to the facility and financial or medical indigency is a factor in the coverage of care. Under this arrangement, if the patient is determined to be eligible for Medicaid, the effective date of eligibility is the date of the hospital inquiry.

i. A PA-1C Form should be directed to either the Social Security Administration District Office in the

area where the hospital is located or the CWA as follows:

(1) The Social Security Administration is responsible for establishing Medicaid eligibility for the aged (persons 65 years and over), for the blind, and for the disabled who apply for Supplemental Security Income (SSI).

(2) The CWA is responsible for establishing Medicaid eligibility for the individual who applies for Aid to Families with Dependent Children (AFDC), or for the individual who is aged, blind, or disabled and applies for "Medicaid Only", or for any individual who applies for New Jersey Care . . . Special Medicaid Programs.

2. Before preparing a PA-1C Form, the hospital shall screen the patient to determine the following:

i. Whether the patient is already eligible for Medicaid or whether the patient's income and/or resources meet the applicable public assistance standard; and

ii. Whether the patient falls into a category of eligibility, for example, aged, disabled, blind, pregnant under 21 years of age, or a member of a family with children under 18 years of age.

3. In the event that the date of the Medicaid eligibility which was established by the Social Security Administration or the CWA is later than the date of admission, the beneficiary may apply directly to the New Jersey Medicaid program for retroactive Medicaid payment of unpaid bills for allowable medical services within the three month period prior to the month of application (see N.J.A.C. 10:49-2.8).

Amended by R.1996 d.320, effective July 15, 1996.

See: 28 N.J.R. 1589(a), 28 N.J.R. 3572(a).

Recodified from N.J.A.C. 10:49-2.5 and amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Substituted "beneficiary" for "recipient", "CWA" for "county welfare agency" and "Medicaid Eligibility Identification Number" for "HSP (Medicaid) Case Number" and amended N.J.A.C. references throughout; in (a)2 Example, inserted "for dates of service"; substantially amended (b)2i; rewrote (b)2ii; and deleted (b)2iii. Former section recodified to N.J.A.C. 10:49-2.7.

### 10:49-2.7 Presumptive eligibility

(a) "Presumptive eligibility" means an expedited process whereby selected certified HealthStart Comprehensive Maternity Care providers make preliminary Medicaid eligibility determinations on behalf of pregnant women (see HealthStart in applicable Provider Services Manuals and N.J.A.C. 10:49-19). This is a preliminary process to determine presumptive eligibility prior to the determination of Medicaid eligibility or ineligibility by the CWA.

1. Approved HealthStart Maternity Care providers (independent clinics and hospital outpatient departments) may determine presumptive eligibility for pregnant women who require ambulatory prenatal services from Medicaid participating providers.

(b) A presumptively eligible pregnant woman is entitled to all Medicaid covered services with the exception of inpatient hospital and nursing facility care services. Although Medicaid HealthStart services must be provided only by a HealthStart provider, other Medicaid covered services may be provided to a presumptively eligible pregnant woman by any appropriate Medicaid provider.

(c) A presumptively eligible pregnant woman is eligible for a period of time which will end:

1. If the woman has not filed an application with the CWA, on or before the last day of the month subsequent to the date of the presumptive eligibility determination; or

2. If the woman has filed an application with the CWA, on the last day of the month subsequent to the month in which she was determined presumptively eligible, or on the day eligibility or ineligibility for Medicaid benefits is determined by the CWA.

(d) A presumptively eligible pregnant woman is identified by the two messages which appear on the "Medicaid Eligibility Identification Card" (Form FD-73/178) (see Appendix, N.J.A.C. 10:49). One message is above the woman's name on the upper left side: CLIENTS: YOU MUST CONTACT THE CWA FOR FULL BENEFITS; P.E. IS TEMPORARY AND LIMITED. The second message, which appears in the message box on the upper right hand corner instructs the provider to call a toll-free number to verify eligibility before providing services. This card is the only document acceptable for the identification of a presumptively eligible pregnant woman.

1. As part of the presumptive eligibility process, a presumptively eligible pregnant woman will be given an FD-334 Form, Certification of Presumptive Eligibility (see Appendix, N.J.A.C. 10:49). This is not valid proof of eligibility for Medicaid and should not be used by the provider for presumptive eligibility purposes. A request for reimbursement based solely upon the presentation of the FD-334 form does not guarantee payment.

2. Even with the identification through the MEI Card, each time a service is rendered the provider shall verify the presumptive eligibility status of a pregnant woman, prior to the delivery of ambulatory services, by calling the toll free telephone number listed on the MEI Card which is available seven days a week, 24 hours a day.

3. A provider's failure to verify eligibility prior to the delivery of services shall result in the denial of payment for those services if the individual was not eligible at that time. The provider should note that a pregnant woman's presumptive eligibility may be terminated at any time.

Amended by R.1996 d.320, effective July 15, 1996.

See: 28 N.J.R. 1589(a), 28 N.J.R. 3572(a).

Recodified from N.J.A.C. 10:49-2.6 and amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Substituted "CWA" for "county welfare agency" throughout; and in (a), inserted N.J.A.C. references. Former section recodified to N.J.A.C. 10:49-2.8.

### 10:49-2.8 Medicaid retroactive eligibility

(a) Any person applying for Medicaid benefits shall be asked if he or she has unpaid medical bills incurred within the three month period immediately prior to the month of application for Medicaid. Except for a Medically Needy applicant (see N.J.A.C. 10:49-2.3(f), an individual indicating that there are such bills, may complete an FD-74 Form, Application for Payment of Unpaid Medical Bills (see Appendix, N.J.A.C. 10:49) and forward the application with all outstanding unpaid medical bills to the Medicaid Retroactive Eligibility Unit, Division of Medical Assistance and Health Services, PO Box 712, Mail Code #10, Trenton, New Jersey 08625-0712.

1. An application for retroactive eligibility may be obtained by the applicant, or his or her authorized agent, from the CWA, the Medicaid District Office, the Social Security Administration District Office, or from the Retroactive Eligibility Unit, Division of Medical Assistance and Health Services. The application shall be submitted within six months from the date of application for public assistance.

(b) If the New Jersey Medicaid program determines that the person was eligible for Medicaid at the time the service was provided, providers shall be notified directly that the unpaid bills for any service covered by the New Jersey Medicaid Program may be reimbursable in accordance with standard Medicaid reimbursement procedures.

1. The provider shall then complete the appropriate Medicaid claim form and submit it to the Retroactive Eligibility Unit for consideration and authorization of payment.

2. For any Medically Needy beneficiary, a retroactive eligibility determination shall be completed by the CWA (see N.J.A.C. 10:49-2.3—Persons eligible under the Medically Needy program).

Recodified from N.J.A.C. 10:49-2.7 and amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

In (a) amended N.J.A.C. reference and mailing address; in (a)1 and (b)2, substituted "CWA" for "county welfare agency"; and in (b)2, substituted "beneficiary" for "recipient". Former section recodified to N.J.A.C. 10:49-2.9.

#### Case Notes

Provider failing to meet regulatory time lines for cross-over Medicaid/Medicare reimbursement claims was not entitled to reimbursement. In the Matter of Bergen Pines County Hospital, 96 N.J.A.R.2d (DMA) 15.

Unique circumstances excused hospitalized applicant from complying with requirement that application for retroactive Medicaid be submitted within six months of date of application for public assistance. J.R. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 57.

Untimely application for three months retroactive benefits under Medicaid program was not waived and was properly denied. Estate of G.K. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 27.

Application for Medicaid, though filed after six-month deadline, was nevertheless sufficient to meet three month requirement for retroactive eligibility. A.D. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 11.

Spouse of Supplemental Security Income recipient was not entitled to retroactive Medicaid coverage. M.L. v. Union County Board of Social Services, 94 N.J.A.R.2d (DMA) 24.

### 10:49-2.9 Verification of eligibility for Medicaid /Pharmaceutical Assistance to the Aged and Disabled (PAAD) services

(a) Each Medicaid beneficiary, except Nursing Facility beneficiaries, has a Medicaid Eligibility Identification Number printed on a Medicaid form that validates eligibility. The beneficiary shall present this form to the provider, as a proof of Medicaid eligibility, every time a service is to be provided. See N.J.A.C. 10:49-2.11 for a description and information about the Medicaid Eligibility Identification Number and see N.J.A.C. 10:49-2.12 for information about the Medicaid forms that are used to validate eligibility. The Recipient Eligibility Verification System (REVS) or Medicaid Eligibility Verification System (MEVS) can be used, in some instances, as an alternative to viewing a form used to validate eligibility (see N.J.A.C. 10:49-2.10).

1. When extended plans of treatment have been approved, it is especially important to review the validation of eligibility form each time a service is provided.

i. Medical authorization or approval of a service by the Division shall not be construed as a guarantee that a person is eligible for the Medicaid program.

ii. There shall be no reimbursement for services performed after termination of eligibility except as noted in N.J.A.C. 10:49-5.4(a)9.

Amended by R.1995 d.589, effective November 20, 1995.

See: 27 N.J.R. 2851(a), 27 N.J.R. 4715(b).

Recodified from N.J.A.C. 10:49-2.8 and amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

In (a), substituted "beneficiary" and "beneficiaries" for "recipient" and "recipients" and "Medicaid Eligibility Identification Number" for "HSP (Medicaid) Case Number", and amended N.J.A.C. references; and deleted (b), relating to PAAD Programs. Former section recodified to N.J.A.C. 10:49-2.10.

### 10:49-2.10 Recipient Eligibility Verification System (REVS)/ Medicaid Eligibility Verification System (MEVS)

(a) In the event a beneficiary is unable to produce a form that validates Medicaid eligibility or the provider wants more current eligibility data (see N.J.A.C. 10:49) and the beneficiary's Medicaid Eligibility Identification Number is known, the provider can verify eligibility by calling the

Unisys Recipient Eligibility Verification System (REVS). REVS is accessed by dialing 1-800-676-6562 (or (609) 587-1955 in the local Trenton area). Complete instructions for using REVS can be found in the Fiscal Agent Billing Supplement following the second chapter for each Provider Services Manual.

(b) The New Jersey Medicaid/Pharmaceutical Assistance to the Aged and Disabled (PAAD) program offers providers an optional method of verifying beneficiary eligibility. The optional system is called Medicaid Eligibility Verification System (MEVS).

1. A provider can contract with a Medicaid/PAAD approved vendor which has access to the Medicaid/PAAD eligibility file. By contracting with a vendor, a provider through MEVS can obtain eligibility information by entering the Medicaid/PAAD number or, if the number is not available, the following data elements: the beneficiary's Social Security Number and date of birth.

i. For hospital providers only, name and date of birth may be used.

2. MEVS will contain current information on eligibility but is no guarantee of eligibility. The Medicaid eligibility card remains the only guarantee of eligibility.

(c) The MEVS intermediary shall be a person, business, corporation, etc., that has been approved by and contracted with the Division to provide eligibility information to providers.

1. Applications to be a MEVS intermediary can be submitted to the Division at any time. If an application is approved, based on the evaluation criteria in (c)2 below, the Division shall enter into a contract with the vendor. The application must:

i. Describe the prospective vendor's approach and plans for accomplishing the work required;

ii. Demonstrate and describe the effort, skills and understanding of the project necessary to satisfactorily provide the services; and

iii. Contain all pertinent information relating to the prospective vendor's organization, personnel, and experience, and be signed by an authorized representative of the applying firm.

2. The Division shall consider the following in evaluating an application:

i. The applicant's general approach and plans to meet the requirements of the MEVS project;

ii. The applicant's detailed approach and plans to meet the requirements of the MEVS project;

iii. The applicant's documented qualifications, expertise, and experience on similar projects;

iv. The applicant's proposed staff's documented qualifications, expertise, and experience on similar projects;

v. The applicant's adherence to the requirements of the HCFA; and

vi. The fact that the prices charged by the applicant to subscribers are reasonable.

3. If a request for approval as a MEVS intermediary is denied or approval withdrawn, the applicant/intermediary may request an administrative hearing pursuant to N.J.A.C. 10:49-10.1 and 10.3.

(d) The Division shall pay for the development and operational cost at Unisys. MEVS intermediaries shall pay an initial application fee of \$1,500, an annual registration fee of \$1,000, and a five cents per inquiry fee to Unisys. These fees will be forwarded to the State, which will allow it to be reimbursed for a portion of its costs in this project.

Amended by R.1995 d.589, effective November 20, 1995.

See: 27 N.J.R. 2851(a), 27 N.J.R. 4715(b).

Recodified from N.J.A.C. 10:49-2.9 and amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

In (a) and (b), substituted "beneficiary" for "recipient"; in (a), substituted "Medicaid Eligibility Identification Number" for "HSP (Medicaid) Case Number", and amended N.J.A.C. reference; added (b)1i; and in (c)2v, substituted "HCFA" for "Health Care Financing Administration. Former section recodified to N.J.A.C. 10:49-2.11.

**10:49-2.11 Medicaid Eligibility Identification Number**

(a) A Medicaid Eligibility Identification Number consists of 12 digits, which includes a two digit Person Number. The components of a Medicaid Eligibility Identification Number as it is initially assigned to a beneficiary follows:

(b) The first two digits usually designate the county of residence as follows:

01—Atlantic	08—Gloucester	15—Ocean
02—Bergen	09—Hudson	16—Passaic
03—Burlington	10—Hunterdon	17—Salem
04—Camden	11—Mercer	18—Somerset
05—Cape May	12—Middlesex	19—Sussex
06—Cumberland	13—Monmouth	20—Union
07—Essex	14—Morris	21—Warren

1. For some adult beneficiaries (that is, the Medicaid Only program and New Jersey Care . . . Special Medicaid programs for Aged, Blind, and Disabled) the first two digits of the Medicaid Eligibility Identification Number designate the county of residence where eligibility was originally determined but not necessarily the location where the beneficiary is currently residing. In these instances, when the beneficiary moves to another county, the beneficiary retains the Medicaid Eligibility Identification Number of the original county of application. However, the eligibility identification card will indicate the current address.

2. For beneficiaries in certain State or county facilities, the first two digits of the Medicaid Eligibility Identification Number designate the facility where the beneficiary resides. In a few unique situations, the first two digits designate a special State program. The following list identifies the first two digits used to identify a State or County facility or a special State program. Following the name of the facility and enclosed in parentheses, is the Medicaid District Office responsible for inspection of care and periodic medical reviews in the facility and the ISS office responsible for eligibility processes serving that facility. For those facilities below marked by an asterisk (\*), it should be noted that when the first two digits of a Medicaid Eligibility Identification Number are used to identify more than one facility, a specific series of numbers for the fifth through tenth digit shall be used to designate the second or third facility as well as to designate the sequential identification number of the Medicaid beneficiary.

i. Identification of State and County Psychiatric Facilities:

- 31 Greystone Park Psychiatric Hospital (Morris MDO)
- 32 Trenton Psychiatric Hospital (Burlington MDO)
- \*32 (300,000 series) Forensic Psychiatric Hospital (Burlington MDO)
- \*32 (600,000 series) Senator Garrett W. Hagedorn Center for Geriatrics—Psychiatric Section (Middlesex MDO)
- 33 Marlboro Psychiatric Hospital (Monmouth MDO)
- 34 Ancora Psychiatric Hospital (Camden MDO) (excluding 800,000 series)
- 36 Arthur Brisbane Child Treatment Center (Psychiatric Hospital) (Monmouth MDO)
- 37 Bergen Pines Psychiatric Center (Passaic MDO)
- 38 Essex County Hospital Center—Cedar Grove (Essex MDO)
- 39 Camden County Psychiatric Hospital (Camden MDO)

ii. Identification of Intermediate Care Facilities/Mental Retardation

- \*34 (800,000 series) Ancora Development Center (Camden MDO).
- 35 North Princeton Development Center (Middlesex MDO)
- 41 Vineland Developmental Center (Atlantic MDO)
- 42 North Jersey Developmental Center (Totowa) (Passaic MDO)
- 43 Greenbrook Regional Center (Middlesex MDO)

- 44 Woodbine Developmental Center (Atlantic MDO)
- 45 New Lisbon Developmental Center (Burlington MDO)
- 47 Woodbridge Developmental Center (Middlesex MDO)
- 48 Hunterdon Developmental Center (Middlesex MDO)

iii. 51 New Jersey Veteran's Home (Unit Dose Drugs) (MDO which serves the county in which the home is located)

iv. 90 Division of Developmental Disabilities Community Care Services (Waiver and Non-Waiver) and Special Residential Services, statewide. (MDO which serves the county in which the beneficiary resides.)

(c) The third and fourth digits of the 12-digit Medicaid Eligibility Identification Number designate the category under which a person was determined eligible for the New Jersey Medicaid program. For some adult beneficiaries (that is, the Medicaid Only program and New Jersey Care ... Special Medicaid programs for Aged, Blind, and Disabled) the third and fourth digits of the Medicaid Eligibility Identification Number will not change from program 20 and 25 (meaning the individual is disabled and under 65 years of age) to 10 and 15 (meaning the individual is aged—65 years of age or older) when beneficiaries reach age 65.

- 10 Aged—SSI related (65 years of age or older)
- 15 Aged—Medically Needy (65 years of age or older)
- 20 Disabled—SSI related
- 25 Disabled—Medically Needy
- 30 Aid to Families with Dependent Children (AFDC). New Jersey Care ... Special Medicaid program for pregnant women and children are included in this category.
- 35 Medically Needy (children and pregnant women)
- 50 Blind—SSI related
- 55 Blind—Medically Needy
- 60 Children (If first two digits are 01 to 21, the individual is under supervision of the Division of Youth and Family Services. If the first two digits are greater than 21, the individual is institutionalized.)
- 70 County Juvenile Residential Facilities
- 80 State Juvenile Residential Facilities

(d) The fifth through the tenth digits of the Medicaid Eligibility Identification Number designate the sequential identification number of the Medicaid beneficiary with the exception of presumptively eligible pregnant women (98-99) who are assigned those numbers.

(e) The 11th and 12th digits of the Medicaid Eligibility Identification Number designate the specific Person Number assigned to each beneficiary.

- 01-04 Adult (any age)
- 05 Pregnant woman
- 06-09 Adult (any age)
- 10-19 Ineligible spouse
- 20-39 Children under 19
- 40-49 Medicaid special (Children under 21 but not under 19)

(f) For example, an adult Medicaid beneficiary (caretaker/parent) from Bergen County receiving assistance under Aid to Families with Dependent Children (AFDC) program could have the following Medicaid Eligibility Identification Number:

02	30	123456	01
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Bergen	AFDC	Sequential	Person
County	Program	ID No.	No

Recodified from N.J.A.C. 10:49-2.10 and amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Changed section name; substituted "beneficiary" and "beneficiaries" for "recipient" and "recipients" and "Medicaid Eligibility Identification Number" for "HSP (Medicaid) Case Number" throughout; in (b)2, inserted "responsible for inspection . . . for eligibility processes"; in (b)2i, amended several MDO references and in 34 added "(excluding 800,000 series)"; in (b)2ii, amended several MDO references and deleted 46 (E.R. Johnstone Training and Research Center); in (b)2iii, substituted "New Jersey Veteran's Home" for "Soldier's Homes"; in (c), in 20 and 25 deleted "(under 65 years of age)", in 70 substituted "County Juvenile Residential Facilities" for "Medical Assistance for Aged—A New Jersey State Program", and in 80, substituted "State Juvenile Residential Facilities" for "Refugee Program"; and in (d), inserted reference to exception for presumptively pregnant women. Former section recodified to N.J.A.C. 10:49-2.12.

#### 10:49-2.12 Forms that validate Medicaid eligibility

(a) A New Jersey Medicaid provider may verify a person's Medicaid eligibility by means of one of the following three forms:

1. Department of Human Services—"Medicaid-ID" (FD-152) (see N.J.A.C. 10:49-2.13);
2. "Medicaid Eligibility Identification Card" (FD-73/178) (see N.J.A.C. 10:49-2.14); or
3. "Validation of Eligibility" (FD-34) (see N.J.A.C. 10:49-2.15).

Recodified from N.J.A.C. 10:49-2.11 and amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Deleted reference to validation for Health Services Program form and made conforming amendments. Former section recodified to N.J.A.C. 10:49-2.13.

#### 10:49-2.13 Validation form (FD-152) Department of Human Services Medicaid-ID

(a) The validation Form FD-152 (see Appendix, N.J.A.C. 10:49) is issued monthly to persons eligible for Aid to Families with Dependent Children (AFDC) and to persons eligible under the Refugee and Community Medicaid Only programs. The form indicates that the persons are currently eligible for coverage for the month shown on the form—"VALID ONLY FOR THE MONTH OF \_\_\_\_". The validation form shall be retained by the Medicaid beneficiary to whom it is issued.

1. This form is the indicator of Medicaid eligibility for the Medicaid beneficiary(s) listed on the form.

i. Any Medicaid beneficiary enrolled in an HMO shall also be required to show his or her HMO ID Card.

2. Providers shall enter the name, Medicaid Eligibility Identification Number, including the Person Number, exactly as it appears on Form FD-152 when requesting authorization for services or submitting a claim form.

3. Messages printed on Form FD-152: One of the following two messages may be printed on the FD-152 form issued by the CWA. Only one message will appear on the form. If more than one applies, however, the message printed is chosen in the order of priority listed below. Providers shall be requested to take the specific action for the message which appears.

i. Message One: Enrolled in HMO (name) and phone number.

ii. Message Two: "OTHER COVERAGE"—There will be an asterisk (\*) before the name of the beneficiary(ies) covered by another health insurer. The provider shall determine the insurer and the policy number (see N.J.A.C. 10:49-7.3—Third Party Liability).

Recodified from N.J.A.C. 10:49-2.12 and amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Substituted references to beneficiary for references to recipient throughout; in (a)2, substituted "Medicaid Eligibility Identification Number" for "HSP (Medicaid) Case Number"; in (a)3, substituted "two messages" for "three messages" and "CWA" for "county welfare agency"; in (a)3i, rewrote Message One; deleted (a)3ii; and recodified former (a)3iii as (a)3ii and made conforming amendments. Former section recodified to N.J.A.C. 10:49-2.14.

#### 10:49-2.14 Validation form (FD-73/178) Medicaid Eligibility Identification Card (MEI Card)

(a) The MEI Card, Validation Form FD-73/178 (see Appendix, N.J.A.C. 10:49) is issued monthly to:

1. Persons (aged, blind and disabled) determined by the Social Security Administration to be eligible for Supplemental Security Income (SSI) and their spouses, if eligible as an essential person;
2. Persons determined by the CWA to be eligible for the New Jersey Care . . . Special Medicaid Programs and the Medically Needy program;
3. Beneficiaries in the Special Status program (see (e)2 below); and
4. Children (Medicaid recipients) under the supervision of the Division of Youth and Family Services (DYFS).

(b) The MEI Card usually identifies eligibility for only one beneficiary. However, several special programs list all eligible persons in the family; for example, for New Jersey Care . . . Special Medicaid Programs, all Medicaid beneficiaries in the family are listed on the MEI Card; the Special Status Program also identifies all beneficiaries in the family on the MEI Card.

1. When the MEI Card is issued to the Medically Needy, more than one beneficiary may be listed with a service code indicated next to each name.

(c) The information on the MEI Card includes an address, date of birth, Social Security Account Number and the availability of any third-party health insurance; however, for the Medically Needy program, the date of birth and Social Security Account Number are omitted and the words "Medically Needy" are printed in this space.

1. If the Medicaid beneficiary has health insurance, the name of the other insurer will be printed together with a corresponding policy number. Additionally, Medicare coverage and the HIC (Medicare) Number will be printed on the MEI Card for all Medicare/Medicaid beneficiaries.

(d) The MEI Card is valid only when signed by the Medicaid beneficiary or his/her representative payee/legal guardian.

(e) A message printed on the MEI Card will indicate the cardholder's enrollment in any waived or special programs such as Home and Community-Based Services Waiver Programs (see N.J.A.C. 10:49-22); or in another managed care program (see N.J.A.C. 10:49-20 through 21).

1. The MEI Card for Garden State Health Plan members will have the printed message: "Enrolled in HMO, etc." under the section "Additional Health Insurance." To obtain service, this beneficiary shall also present the Garden State Health Plan Identification Card. This gold colored card lists the beneficiary and the name and telephone number of the beneficiary's physician case manager. All medical services shall be either provided by or authorized by the beneficiary's physician case manager prior to rendering a service.

2. The MEI Card for the Medicaid "Special Status program" either restricts the Medicaid beneficiary(ies) listed on the MEI Card to a single provider, except in a medical emergency, or warns providers that the beneficiary's card has been used by an unauthorized person or persons, or for an unauthorized purpose. If a warning card is issued, a message will be printed on the card alerting the provider to ask the Medicaid beneficiary for additional identification or to take other appropriate action. (See N.J.A.C. 10:49-14.2—Sanctions—Special Status program).

3. The MEI Card issued for the Medically Needy program will have the following message printed on the top of the card: "Medically Needy Eligible, Check Provider

Manual for Authorized Services." It is important for the provider to always review the eligibility dates and to be aware that eligibility is not always established for an entire month. Coverage may begin on any day during the month. Also, a provider shall always review the "service code" for each Medically Needy beneficiary. The service code will enable the provider to determine which services are available to each Medically Needy beneficiary (see N.J.A.C. 10:49-2.3 and 10:49-5.3 for service exceptions). The service codes for the three groups under Medically Needy are:

- (A) Group A—Pregnant women,
- (B) Group B—Needy children,
- (C) Group C—Aged, blind and disabled.

Recodified from N.J.A.C. 10:49-2.13 and amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Substituted references to beneficiary for references to recipient throughout; in (a), deleted reference to quarterly issuance of MEI card and made conforming amendments; in (e), amended Program references; and in (e)1, substituted "Enrolled in HMO, etc." for "HMO-Check-GSHP ID Card". Former section "Validation form (DYFS-16-36) 'Validation for Health Services program' (Medicaid)" was repealed.

#### 10:49-2.15 Validation form (FD-34) Validation of Eligibility

(a) The FD-34 Form, Validation of Eligibility (see Appendix, N.J.A.C. 10:49) identifies a Medicaid beneficiary who resides in a State or county institution.

1. The validation form shall be prepared and completed by the authorized Medicaid representative at the State or County institution. It is valid for the calendar month it is issued (up to a period of 31 days) to a Medicaid beneficiary (patient/resident) in a State or county governmental psychiatric hospital or an intermediate care facility/mental retardation, and is used to obtain Medicaid covered services outside of the institutional setting. The form shall be returned with the Medicaid beneficiary.

2. Form FD-34 requires the signature, title, and telephone number of the authorized representative at the institution.

3. The Medicaid beneficiary or patient of a State or county institution receiving covered health services in the community is identified by the 12-digit Medicaid Eligibility Identification Number in which the first two digits identifies the institution. (See N.J.A.C. 10:49-2.10(b)2).

(b) The New Jersey Medicaid program has designated specific Medicaid District Offices to handle prior authorization requests for services for patients/residents/beneficiaries from each institution and family care residents/beneficiaries who are under the jurisdiction of the Division of Developmental Disabilities. If the patient/beneficiary's Medicaid Eligibility Identification Number begins with any of the following numbers, providers shall contact the Medicaid

District Office (MDO) indicated (for MDO Directory, see Appendix N.J.A.C. 10:49).

- 31—Morris MDO
- 32—Burlington MDO
- 33—Monmouth MDO
- 34—Camden MDO
- 35—Middlesex MDO
- 36—Monmouth MDO
- 37—Passaic MDO
- 37—Hudson MDO (Applicable only to 600,000 series)
- 38—Essex MDO
- 39—Camden MDO
- 41—Atlantic MDO
- 42—Passaic MDO
- 43—Middlesex MDO
- 44—Atlantic MDO
- 45—Burlington MDO
- 47—Middlesex MDO
- 48—Middlesex MDO
- 51—Middlesex MDO—Menlo Park Veterans Home
- 51—Middlesex MDO—Vineland Veterans Home
- 90—MDO in county in which beneficiary resides.

Amended by R.1997 d.354, effective September 2, 1997.  
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Substituted "beneficiary" for "recipient" or "resident" throughout; in (a)3 and (b), substituted "Medicaid Eligibility Identification Number" for "HSP (Medicaid) Case Number"; in (b), inserted references to beneficiaries, amended MDO references, and inserted the two 51—Middlesex references.

#### 10:49-2.16 Medicaid application

(a) If a person has not applied for benefits, is unable to pay for services provided, and appears to meet the requirements for eligibility for the New Jersey Medicaid program, the provider shall encourage the person, or his or her representative, to apply for benefits:

1. To the CWA for programs such as Aid to Families with Dependent Children; Medicaid Only; New Jersey Care . . . Special Medicaid programs for pregnant women, children, and the aged, blind, or disabled; or for Medically Needy.
2. To the Social Security Administration for Supplemental Security Income benefits for the aged, blind, and disabled; or
3. In certain cases, to the New Jersey Division of Youth and Family Services, Department of Human Services.

(b) If it is not known which agency is responsible for determining eligibility or which program might be applicable, the Medicaid District Office will be able to provide guidance in this matter (for MDO Directory, see Appendix N.J.A.C. 10:49).

(c) All providers are encouraged to refer pregnant women who may be eligible for Medicaid to a provider authorized to determine presumptive eligibility. The names and addresses of these providers may be obtained by calling the HOT LINE at 1-800-328-3838.

Amended by R.1997 d.354, effective September 2, 1997.  
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

### SUBCHAPTER 3. PROVIDER PARTICIPATION

#### 10:49-3.1 Provider types eligible to participate

(a) The following provider types are eligible to participate as Medicaid providers:

1. Certified nurse practitioners/clinical nurse specialists;
2. Chiropractors and/or chiropractic groups;
3. Clinics (independent outpatient health care facilities);
4. Clinical laboratories;
5. Dentists and/or dentist groups;
6. Hearing aid dealers;
7. Health maintenance organizations/managed care organizations;
8. Home health agencies;
9. Homemaker agencies;
10. Hospices;
11. Hospitals;
  - i. General;
  - ii. Psychiatric; and
  - iii. Special;
12. Nursing facilities, including intermediate care facilities for the mentally retarded;
13. Medical suppliers;
14. Medical day care centers;
15. Nurse-midwives;
16. Opticians;
17. Optometrists;
18. Orthotists;

19. Pharmacies;
20. Physicians and/or physician groups;
21. Podiatrists and/or podiatric groups;
22. Prosthetists;
23. Psychologists and/or psychologist groups;
24. Residential treatment facilities;
25. Transportation providers; and
26. State and county agencies that have agreed to provide personal care assistant services.

Amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Inserted new (a)1; recodified former (a)1 through 25 as (a)2 through 26; in (a)7, inserted reference to managed care organizations.

#### Cross References

Regional Perinatal Centers and Community Perinatal Centers, providing services in accordance with this section, see N.J.A.C. 8:33C-4.2.

Case Management Program/Mental Health, providing services in accordance with this section, see N.J.A.C. 10:73-2.4.

#### 10:49-3.2 Enrollment process

(a) Providers shall be required to complete a Medicaid Provider Application and sign a Provider Agreement (see Appendix, N.J.A.C. 10:49) or a specialized agreement, and/or such other documentation as the program may require, depending on the nature of the services provided.

1. Policies and rules pertaining to shared health care facilities are outlined in N.J.A.C. 10:49-4.

(b) All Medicaid Providers other than an individual practitioner and/or group of practitioners shall be required to complete Form HCFA-1513, Ownership and Control Interest Disclosure Statement (see Appendix 10:49) at the time of application or reapplication. Providers prior to 1973 were not required to utilize provider agreement forms; however, they shall comply with all applicable State and federal Medicaid laws, policies, rules and regulations.

1. As a condition of continued participation in the New Jersey Medicaid program, a provider may, from time to time, be required to:

i. Complete a provider reenrollment application form and sign a provider participation agreement; and/or

ii. Complete a Form HCFA 1513, Ownership and Control Interest Disclosure Statement. This requirement shall not be applicable to individual practitioners(s) or groups of practitioners.

2. The New Jersey Medicaid program shall terminate any existing agreement or contract if the provider fails to disclose information required by (b)1ii above.

3. Enrollment documentation requested by the New Jersey Medicaid program shall be furnished within 35 calendar days of the date of the written request.

(c) An out-of-State provider shall have a current, approved provider agreement with the New Jersey Medicaid program and hold a current, valid certification and/or license from the appropriate agency under the laws of the respective state in which the provider is located.

(d) A provider application may be requested from the fiscal agent of the New Jersey Medicaid program. An appropriate Medicaid program enrollment package will be mailed to the requesting provider. The enrollment application must be completed in full and returned to the fiscal agent, along with all the necessary attachments.

1. The applicant's eligibility to participate in the New Jersey Medicaid program will be confirmed in writing. A New Jersey Medicaid provider number will be assigned and returned to the applicant along with the appropriate Medicaid program Provider Manual.

2. If the application is denied, the applicant will receive a notification which explains the decision to deny and the applicant's right to appeal the decision (see N.J.A.C. 10:49-10).

(e) If the applicant is found to be currently enrolled (for example, an inactive provider who now wants to actively participate), the applicant will be assigned an appropriate Medicaid provider number and the provider's existing record on the Provider Master File will be reactivated.

(f) The New Jersey Medicaid program may refuse to enter into a provider participation agreement with any applicant who has been suspended, debarred, disqualified, or excluded by the Medicaid program of another state.

(g) The New Jersey Medicaid program shall not enter into a provider participation agreement with an applicant who has been suspended or excluded from participation in the delivery of medical care or services under Medicare (Title XVIII), Medicaid (Title XIX), or the Social Services Block Grant Act (Title XX) of the Federal Social Security Act, by the Secretary of the United States Department of Health and Human Services.

Amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

In (b)1i, inserted "reenrollment"; and in (f) and (g), substituted "New Jersey Medicaid program" for "Division".

#### Cross References

Eye care providers, fulfillment of enrollment process as under this section, see N.J.A.C. 10:62-2.3.

#### 10:49-3.3 Providers with multi-locations

(a) All providers (except independent clinical laboratories, nursing facilities, and pharmacies) participating in the

Medicaid program shall identify all locations from which they are providing services to Medicaid beneficiaries.

(b) Each location shall comply with provider participating requirements and shall be assigned a separate provider number. Services rendered to Medicaid beneficiaries at a location not approved for participation are not eligible for Medicaid reimbursement.

(c) Billing through a central location for approved multi-location providers shall be allowed; however, providers shall utilize the applicable provider number for each service location. Selection of central or localized billing shall be left to providers, who shall state their preference on the application. The Medicaid program reserves the right to assign unique provider numbers to maintain the accountability and integrity of the New Jersey Medicaid/Management Information System (NJMMIS) and the New Jersey Medicaid program.

Amended by R.1997 d.354, effective September 2, 1997.  
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Rewrote (a) and (b); and substantially amended (c).

#### 10:49-3.4 Medicaid provider billing number

(a) A seven digit Provider Billing Number shall be assigned by the Medicaid fiscal agent to all providers approved for Medicaid participation. The Provider Billing Number shall be entered upon all claims submitted in accordance with the instructions in the Medicaid Fiscal Agent Billing Supplement. The Provider Billing Number should also be referenced in all written and telephone inquiries.

(b) Practitioners, as defined in N.J.A.C. 10:49-3.4(c)1 below, approved for Medicaid participation, shall also be assigned a seven digit Provider Servicing Number by the Medicaid fiscal agent. The Provider Servicing Number is a unique identification number which shall be entered upon all claim submittals in accordance with the instructions in the Medicaid Fiscal Agent Billing Supplement.

(c) Providers who, for billing purposes, need a referring practitioner's individual Medicaid Provider Servicing Number, shall contact that practitioner to obtain the number. A practitioner who does not participate in the Medicaid program will not have a Medicaid Provider Servicing Number. In the absence of the referring practitioner's individual Medicaid Provider Servicing Number, providers must enter seven fives (5's) for non-participating out-of-State providers or seven sixes (6's) for non-participating in-state providers to indicate non-participation in the New Jersey Medicaid program.

1. Each Medicaid participating practitioner (that is, physician, certified nurse midwife, certified nurse practitioner/clinical nurse specialist, chiropractor, dentist, optometrist, podiatrist, or psychologist) shall supply his or her individual Medicaid Provider Servicing Number to other providers when referring a Medicaid beneficiary for services.

(d) A shared health care facility (SHCF) (see N.J.A.C. 10:49-4.1) is assigned a registration code (Shared Health Care Facility Number), which must appear on a claim form submitted to the Medicaid fiscal agent by every member of the SHCF. In addition, each practitioner rendering a service in a shared health care facility must indicate his or her Medicaid Provider Billing Number and individual Medicaid Provider Servicing Number on the claim form (see Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

Amended by R.1997 d.354, effective September 2, 1997.  
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Rewrote (a) and (b); and in (c)1, inserted reference to certified nurse practitioner/clinical nurse specialist.

### SUBCHAPTER 4. PROVIDERS' ROLE IN A SHARED HEALTH CARE FACILITY

#### 10:49-4.1 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

"Discipline" means a branch of instruction or learning, such as medicine, dentistry, chiropractic, and so forth.

"Patient" means anyone eligible to receive benefits from the program.

"Purveyor" means any person, firm, corporation or other entity other than a provider who, whether or not located in a building which houses a shared health care facility, directly or indirectly, engages in the business of supplying to ultimate users or providers within the shared health care facility any medical supplies, equipment and/or services for which reimbursement under the program is received, including, but not limited to, clinical laboratory services or supplies; diagnostic radiology services; sick room supplies; physical therapy services or equipment; orthopedic or surgical appliances or supplies; drugs, medication or medical supplies; eyeglasses, lenses or other optical supplies or equipment; hearing aids or devices; and any other goods, services, supplies, equipment or procedures prescribed, ordered, recommended or suggested for medical diagnosis, care or treatment, and which amount to \$10,000 per year.

"Shared health care facility" (SHCF) means four or more providers, two or more of whom are practicing within different specialties and/or disciplines, either independently or in association with each other, within a single structure; and

1. Two or more of whom share any of the following:
  - i. Common waiting areas;
  - ii. Examining rooms;

x. All referrals by providers in the shared health care facility to other medical providers and the reason for such referrals, and date of referral; and

xi. A statement as to whether or not the patient is expected to return for further treatment.

5. The Division shall have the right to inspect the business records, patient records, leases and other contracts executed by any provider in a shared health care facility. Such inspections may be by site visits to the shared health care facility.

## SUBCHAPTER 5. SERVICES COVERED BY MEDICAID PROGRAM

### 10:49-5.1 Requirements for provision of services

(a) The services listed in N.J.A.C. 10:49-5.2 are available to beneficiaries eligible for the regular New Jersey Medicaid program. Services available to Medically Needy beneficiaries are listed in N.J.A.C. 10:49-5.3. The services listed in N.J.A.C. 10:49-5.2 and 5.3 shall be provided in conjunction with program requirements specifically outlined in the second chapter of each Provider Services Manual.

1. Any service limitations imposed will be consistent with the medical necessity of the patient's condition as determined by the attending physician or other practitioner and in accordance with standards generally recognized by health professionals and promulgated through the New Jersey Medicaid program. Some services require prior authorization from the program before the services are provided (see N.J.A.C. 10:49-6—Authorization Required).

Amended by R.1997 d.354, effective September 2, 1997.  
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

In (a), substituted "beneficiaries" for "recipients"; and in (a)1, inserted "prior" preceding "authorization".

#### Case Notes

Phalloplasty was medically required treatment for gender dysphoria. *M.K. v. Division of Medical Assistance and Health Services*, 92 N.J.A.R.2d (DMA) 38.

Patient's possible Munchausen's syndrome was good cause for limiting medical services. *D.S. v. Division of Medical Assistance and Health Services*, 92 N.J.A.R.2d (DMA) 4.

### 10:49-5.2 Services available to beneficiaries eligible for the regular Medicaid program

(a) The services listed below are available to beneficiaries eligible for the regular Medicaid program:

1. Case management services (Mental Health Program);
2. Chiropractic services;

3. Christian Science Sanatoria care and services (see Hospital Services Manual);

4. Clinic services such as services in an independent outpatient health care facility, other than hospital, that provides services such as Mental Health, Family Planning, Dental, Optometric, Ambulatory Surgery, FQHCs;

5. Dental services;

6. Early and Periodic Screening, Diagnosis, and Treatment for beneficiaries under age 21 (EPSDT): A preventative health care program for beneficiaries under age 21 designed for early detection, diagnosis and treatment of correctable abnormalities. This program supplements the general medical services otherwise available;

7. Family planning services including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling.

i. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered by the New Jersey Medicaid program.

8. HealthStart maternity and pediatric care services include packages of comprehensive medical and health support services provided by independent clinics; hospital outpatient departments; local health departments meeting New Jersey Department of Health and Senior Services' improved pregnancy outcome criteria; physicians; and nurse midwives; either directly or through linkage with other HealthStart care providers. (See N.J.A.C. 10:49-19 for HealthStart services, policies and requirements for provider participation;)

9. Hearing aid services;

10. Home care services (home health care and personal care assistant services);

11. Hospice room and board services in a nursing facility (available to dually eligible Medicare/Medicaid beneficiaries);

12. Hospital services—inpatient:

i. General hospitals;

ii. Special hospitals;

iii. Psychiatric hospitals (inpatient): Limited to persons age 65 or older and children 21 years of age and under; and

iv. Inpatient psychiatric programs for children 21 years of age and under;

13. Hospital services—outpatient;

14. Laboratory (clinical);

15. Medical day care services;
16. Medical supplies and equipment;
17. Mental health services;
18. Nursing facility services, including intermediate care facilities for the mentally retarded;
19. Nurse-midwifery services;
20. Optometric services;
21. Optical appliances;
22. Pharmaceutical services;
23. Physician services;
24. Podiatric services;
25. Prosthetic and orthotic devices;
26. Radiological services;
27. Rehabilitative services (Payments are made to eligible Medicaid providers only. No payment is made to privately practicing therapists);
  - i. Physical therapy, as provided by a home health agency, independent clinic, nursing facility, hospital outpatient department, or in a physician's office;
  - ii. Occupational therapy, as provided by a home health agency, independent clinic, nursing facility, or hospital outpatient department;
  - iii. Speech-language pathology services, as provided by a home health agency, independent clinic, nursing facility, hospital outpatient department, or in a physician's office; and
  - iv. Audiology services provided in the office of a licensed specialist in otology or otolaryngology, or as part of independent clinic or hospital outpatient services; and
28. Transportation services which include ambulance, invalid coach, and other transportation provided by independent clinics or through arrangements with a county welfare agency.

Amended by R.1994 d.600, effective December 5, 1994.

See: 26 N.J.R. 3345(a), 26 N.J.R. 4762(a).

Amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Amended section name; substituted "beneficiaries" for "recipients" throughout; in (a)4, inserted reference to FQHCs; in (a)8, amended Department name and N.J.A.C. reference; and in (a)28, deleted reference to livery transportation.

### 10:49-5.3 Services available to beneficiaries eligible for the Medically Needy program

(a) Regular Medicaid services are available to Medically Needy beneficiaries except for the following services which are not available or are only available to certain eligible Medically Needy groups: (See the service code next to the beneficiary's name on the Medicaid Eligibility Identification Card to ascertain the Medically Needy group under which the beneficiary's eligibility was established; that is, Group A—pregnant women, Group B—needy children, and Group C—aged, blind and disabled.)

1. Chiropractic services are available only to pregnant women (Group A).

2. EPSDT services are not available to any Medically Needy group.

3. Hospital services (inpatient) are available only to pregnant women (Group A).

4. Nursing facility services are available to Medically Needy beneficiaries. For purposes of the Medically Needy program, nursing facility services include pharmacy services under Title XIX.

5. Medical day care services are available only to pregnant women, the aged, the blind and the disabled (Groups A and C).

6. Pharmaceutical services are available only to pregnant women and needy children (Groups A and B); and aged, blind or disabled beneficiaries who reside in Medicaid participating nursing facilities (see N.J.A.C. 10:51-2.10). Pharmaceutical services are not available to other aged, blind and disabled beneficiaries (Group C).

7. Podiatric services are available only to pregnant women, the aged, the blind and the disabled (Groups A and C).

8. Rehabilitative services are not available for reimbursement when provided through a hospital or nursing facility, except to pregnant women as part of their inpatient hospital services.

9. Case management services for the mentally ill are available to Medically Needy pregnant women only.

10. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical or clinic), drugs, laboratory services, radiological and diagnostic services and surgical procedures are not available to the Medically Needy group.

Amended by R.1994 d.600, effective December 5, 1994.

See: 26 N.J.R. 3345(a), 26 N.J.R. 4762(a).

Amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Amended section name; substituted "beneficiaries" and "beneficiary's" for "recipients" or "recipient's" throughout; in (a)4, substituted "beneficiaries" for "group" and inserted reference to pharmacy services; and in (a)6, inserted references to aged, blind or disabled beneficiaries.

#### Case Notes

Administrative Procedure Act notice requirement violated by freeze on Medicaid reimbursement rate increases. *Thomas Jefferson University Hospital v. Div. of Medical Assistance and Health Services*, 6 N.J.A.R. 127 (1981).

Hospital not entitled to hearing prior to decertification as Medicaid provider. *Preakness Hospital v. Div. of Medical Assistance and Health Services*, 3 N.J.A.R. 351 (1981).

Agency action in enforcing its regulations to deny ambulance service claims not arbitrary, capricious and unreasonable (Division's Final Decision). *Bergen Ambulance Services v. Hudson Cty. Medical Assistance Unit*, 2 N.J.A.R. 196 (1980).

#### 10:49-5.4 Services not covered by the Medicaid program

(a) Listed below are some general services and items excluded from payment under the New Jersey Medicaid program. There are additional specific exclusions and limitations detailed in the second chapter of each Provider Services Manual. Payment is not made for the following:

1. Any service, admission, or item, which is not medically required for diagnosis or treatment of a disease, injury, or condition;

2. Services provided to all persons without charge; these services shall not be billed to the Medicaid program when provided for a Medicaid beneficiary. Services and items provided without charge through programs of other public or voluntary agencies (for example, New Jersey State Department of Health and Senior Services, New Jersey Heart Association, First Aid Rescue Squads, and so forth) shall be utilized to the fullest extent possible;

3. Any service or items furnished in connection with elective cosmetic procedures;

i. There are certain exceptions to this rule, but the exceptions require prior authorization. A written certification of medical necessity and a treatment plan shall be submitted by the physician to the appropriate Medicaid District Office for consideration;

4. Private duty nursing services (except for beneficiaries under EPSDT, Model Waiver III, ACCAP and ABC programs);

5. Services or items furnished for any sickness or injury occurring while the covered person is on active duty in the military;

6. Services provided outside the United States and territories;

7. Services or items furnished for any condition or accidental injury arising out of and in the course of employment for which any benefits are available under the provisions of any workers' compensation law, temporary disability benefits law, occupational disease law, or similar legislation, whether or not the Medicaid beneficiary claims or receives benefits thereunder, and whether or not any recovery is obtained from a third-party for resulting damages;

8. That part of any benefit which is covered or payable under any health, accident, or other insurance policy (including any benefits payable under the New Jersey no-fault automobile insurance laws), any other private or governmental health benefit system, or through any similar third-party liability, which also includes the provision of the Unsatisfied Claim and Judgment Fund;

9. Services or items furnished prior to or after the period for which the beneficiary presents evidence of eligibility for coverage.

i. Payment is made for inpatient hospital services (excluding governmental psychiatric hospitals) when ineligibility occurs after admission to hospital as an inpatient. Payment is also made for certain services that were authorized and initiated before loss of eligibility such as dental, vision care, prosthetics and orthotics, and durable medical equipment. Also, see "Retroactive Eligibility" at N.J.A.C. 10:49-2.7(c);

10. Any services or items furnished for which the provider does not normally charge;

11. Any admission, service, or item, requiring prior authorization, where prior authorization has not been obtained or has been denied (see N.J.A.C. 10:49-6, Authorizations required);

12. Services furnished by an immediate relative or member of the Medicaid beneficiary's household;

13. Services billed for which the corresponding health care records do not adequately and legibly reflect the requirements of the procedure described or procedure code utilized by the billing provider, as specified in the Provider Services Manual;

i. Final payment shall be made in accordance with a review of those services actually documented in the provider's health care record. Further, the medical necessity for the services must be apparent and the quality of care must be acceptable as determined upon review by an appropriate and qualified health professional consultant.

ii. All such determinations will be based on rules and regulations of the New Jersey Medicaid Program, the minimum requirements described in the appropriate New Jersey Medicaid Provider Services Manual, to include those elements required to be documented in the provider's records according to the procedure code(s) utilized for payment, and on accepted professional standards. (See N.J.A.C. 10:49-9.5, Provider Certification and Recordkeeping.)

iii. Any other evidence of the performance of services shall be admissible for the purpose of proving that services were rendered only if the evidence is found to be clear and convincing. "Clear and convincing evidence" of the performance of services includes, but is not limited to, office records, hospital records, nurses notes, appointment diaries, and beneficiary statements.

iv. Therefore, any difference between the amount paid to the provider based on the claim submitted and the Medicaid Agent's value of the procedure as determined by the Medicaid Agent's evaluation, may be recouped by the Medicaid Agent.

14. Any claim submitted by a provider for service(s) rendered, except in a medical emergency, to a Medicaid beneficiary whose Medicaid Eligibility Identification Card (FD-73/178) has a printed message restricting the beneficiary to another provider of the same service(s). (See N.J.A.C. 10:49-2.13(e)2, Special Status program);

15. Services or items reimbursed based upon submission of a cost study when there are no acceptable records or other evidence to substantiate either the costs allegedly incurred or beneficiary income available to offset those costs. In the absence of financial records, a provider may substantiate costs or available income by means of other evidence acceptable to the Medicaid Agent. If upon audit, financial records or other acceptable evidence are unavailable for these purposes:

i. All reported costs for which financial records or other acceptable evidence are unavailable for review upon audit are deemed to be non-allowable; and/or

ii. Beneficiary income shall be presumed to equal the maximum income allowable for a Medicaid beneficiary for those beneficiaries whose records relating to income are completely unavailable;

iii. The Medicaid Agent shall seek recovery of any resulting overpayments;

16. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical or clinic), drugs, laboratory services, radiological and diagnostic services and surgical procedures.

Amended by R.1994 d.600, effective December 5, 1994.

See: 26 N.J.R. 3345(a), 26 N.J.R. 4762(a).

Amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Amended section name; substituted "beneficiaries" and "beneficiary's" for "recipients" or "recipient's" throughout; in (a)2, inserted "these services" preceding "shall not be billed" and amended Department name; in (a)4, inserted references to Model Waiver III, ACCAP and ABC programs; in (a)13iv and (a)15, substituted reference to Medicaid Agent for reference to Division.

#### Cross References

Medical Day Center, verification of recipients eligibility as under this section, see N.J.A.C. 10:65-1.6.

#### Case Notes

Digital scale for applicant with morbid obesity was not an item for which Medicaid funds were available. R.S. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 65.

Extended care facility could not be reimbursed for care for Medicaid-ineligible patient. V.F. v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 29.

Hospital not entitled to hearing prior to decertification as medical provider. Preakness Hospital v. Div. of Medical Assistance and Health Services, 3 N.J.A.R. 351 (1982).

## SUBCHAPTER 6. AUTHORIZATIONS REQUIRED BY MEDICAID PROGRAM

### 10:49-6.1 Prior and retroactive authorization (general)

(a) Under the program, payment for certain services shall require prior authorization except in an emergency. It is the responsibility of the provider to obtain prior authorization before furnishing or rendering a service. Specific instructions are detailed in the appropriate Provider Services chapter.

1. Prior authorization should not be construed as a guarantee that a person is eligible for the New Jersey Medicaid program. At the time the service is to be provided, it is the provider's responsibility to verify eligibility.

2. "Medical emergency" means a critical illness or injury status for which prompt medical care may be crucial to saving life and limb or sparing the beneficiary significant or intractable pain. Services provided for a medical emergency are exempt from prior authorization. Any service classified as a medical emergency that would have been subject to prior authorization had it not been so classified, must be supported by a practitioner's statement which describes the nature of the emergency, including relevant clinical information, and must state why the emergency services rendered were considered to be immediately necessary. To simply state that an emergency did exist is not sufficient.

3. In addition to services that must be prior authorized under the previous subsections, a provider may be required to submit some or all services for prior authorization if in the judgment of the Medicaid Agent the provider has engaged in conduct which would constitute good cause for suspension, debarment or disqualification under N.J.A.C. 10:49-11.1(d). Prior authorization under this subsection may be imposed prior to a hearing under the same conditions applicable to suspensions under N.J.A.C. 10:49-11.1(j), except that the approval of the Attorney General shall not be necessary.

(b) Retroactive authorization may be granted under certain circumstances provided that the service is a part of continuing beneficiary care and, on the basis of medical judgment, would have been authorized at the time the service was rendered. Each case is considered on its own merit. Retroactive authorization is an exceptional measure granted only under the following unusual circumstances:

1. "Other coverage" (Medicare, Third-Party liability, other insurance, etc.) has denied or made only partial payment of a claim for services or items requiring prior authorization and it would have been unreasonable to expect the provider to have requested authorization prior to rendering the service;

2. Retroactive determination of eligibility;

3. An “administrative emergency” existed because communication between the provider and the staff of the New Jersey Medicaid program could not be established (for example, during a weekend, holiday or evening) and provision of the service should not have been delayed. This differs from a medical emergency in that the beneficiary’s condition would not be impaired if the service was not provided (see example below). In such instances, the request for retroactive authorization, including an explanation of the circumstances as well as the medical documentation supporting the services, shall be submitted to the Medicaid District Office or Central Office, as appropriate, within five calendar days after the service was provided or initiated. If verbal authorization was obtained, confirming written documentation shall follow.

Example: A physician orders a Medicaid beneficiary home from the hospital on a Friday evening. The beneficiary requires an electrical hospital bed, but the Medical Supplier is unable to contact the Medicaid District Office to obtain prior authorization. It is advantageous to the Medicaid program, the hospital and the patient to discharge the beneficiary and not wait until authorization for the bed is requested on Monday; or

4. In situations not covered by (b)1, 2, and 3 above, the New Jersey Medicaid program follows the doctrine of reasonableness which asks, “Is it reasonable to conclude that the situation presented warrants waiver of procedural rules?”

Amended by R.1997 d.354, effective September 2, 1997.  
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Substituted “beneficiaries” and “beneficiary’s” for “recipients” or “recipient’s” throughout; in (a), substituted “Provider Services Chapter” for “Provider Services Manuals”; and in (a)3, substituted “Medicaid Agent” for “Director”.

#### Case Notes

Unusual circumstances required retroactive authorization for payment of Medicaid services notwithstanding failure to obtain prior authorization. *Pendleton Bradley Hospital v. Division of Medical Assistance*, 95 N.J.A.R.2d (DMA) 23.

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

#### 10:49-6.2 Out-of-State medical care and services

(a) Any covered service that requires prior authorization as a prerequisite for reimbursement to New Jersey Medicaid providers shall also require prior authorization if it is to be provided in any other state.

1. Services which require prior authorization are described in the specific Medicaid Provider Services Manual.

Amended by R.1997 d.354, effective September 2, 1997.  
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Deleted (a) and (c); and recodified former (b) as (a).

## SUBCHAPTER 7. SUBMITTING CLAIMS FOR PAYMENT (POLICIES AND REGULATIONS)

### 10:49-7.1 General provisions

(a) The following information outlines the policies and regulations of the New Jersey Medicaid program that the provider shall adhere to when submitting a claim and requesting payment for services provided to a New Jersey Medicaid recipient. (To identify a Medicaid recipient, see N.J.A.C. 10:49-2.)

1. Each Provider Services Manual has information relevant to basis of payment for services and items of payment provided that is usually found in the second chapter of each manual.

2. For requirements of the Division of Medical Assistance and Health Services and the New Jersey State Department of Health and Senior Services when submitting a claim to be considered for the charity care component of the disproportionate share subsidies for hospital services and other rules regarding eligibility for these services, see N.J.A.C. 10:52-10 and 10A.

(b) In addition to information in this subchapter about submitting claims for payment, a Fiscal Agent Billing Supplement is included following each Provider Services Manual. Included in the Supplement are prior authorization forms and instructions; information for the proper completion and submission of claim forms; the procedure to follow when claims are rejected and returned to the provider by the Fiscal Agent during the adjudication process; third party liability verification, procedure for submitting cross-over claims, and examples of timely submission of claims; electronic media claims (EMC) submission; Remittance Advice Statements; procedures for Electronic Funds Transfer (EFT); adjustments for overpayment of claims, and adjustments by Medicare; procedure to follow when a claim is paid in error (voids); procedure for inquiries about claims; procedure for ordering forms; information about provider services; and item-by-item instructions for completing the claim form and other forms.

1. The Fiscal Agent Billing Supplement is not published in the New Jersey Administrative Code (N.J.A.C.) but is referenced as an appendix and is thus, not a legal description of the New Jersey Medicaid program’s rules. Should there be any conflict between the Fiscal Agent Billing Supplement and the pertinent laws or rules governing the Medicaid program or the charity care program, the laws and rules of the Medicaid program and the charity care program, as appropriate, take precedence.

Amended by R.1997 d.354, effective September 2, 1997.  
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

In (a), substituted “beneficiary” for “recipient”; in (b), deleted “form” or “forms” following “claim” and “claims”.  
Amended by R.1997 d.520, effective January 5, 1998.  
See: 29 N.J.R. 1006(a), 30 N.J.R. 232(a).

Inserted (a)2; in (b), clarified precedence of Medicaid rules over Fiscal Agent Billing Supplement, and added references to "charity care program."

#### 10:49-7.2 Timeliness of claim submission and inquiry

(a) A claim is defined as a request for payment from the New Jersey Medicaid program for a Medicaid reimbursable service provided to a Medicaid recipient. For disproportionate share data collection purposes only, a claim is defined as a request for the New Jersey charity care program to price the services rendered and consider those services when determining the amount of subsidy to be afforded to New Jersey hospitals. The charity care claim properly identifies the hospital, the service(s) rendered, the recipient of the service(s), the date(s) of the service, and any other data required by the State.

1. For a Medicaid claim, the claim for payment from the Medicaid program may be submitted hard copy or by means of an approved method of automated data exchange. A claim for pricing of charity care hospital services is a request to the New Jersey charity care program, which shall be submitted by an approved method of automated data exchange within 180 days of the charity care determination. In order for a Medicaid claim to be considered, all appropriate documentation shall be included with the claim form.

2. It is the responsibility of the provider to ensure that each Medicaid claim submitted by that provider is received by the New Jersey Medicaid program's Fiscal Agent within the time periods indicated in this section.

i. The New Jersey Medicaid program shall not reimburse for a claim received outside the prescribed time periods. This policy also applies to inquiries concerning a claim or claim related information received outside the prescribed time periods.

ii. For retroactive eligibility cases, a claim associated with a retroactive eligibility application will be considered as received on the date of receipt of the application on behalf of the applicant. For information about retroactive eligibility, see 10:49-2.7.

(b) An institutional claim is a claim submitted by a hospital; home health agency; nursing facility; intermediate care facility/mental retardation (ICF/MR); residential treatment center; or governmental psychiatric hospital. The time requirements for submitting an institutional claim is as follows:

1. For claims submitted by home health agencies and hospitals (excluding governmental psychiatric hospitals), a claim for payment of a service provided to any Medicaid beneficiary shall be received by the New Jersey Medicaid Fiscal Agent within:

i. One year of the date of discharge on an inpatient hospital claim;

ii. One year of the date of service entered on an outpatient hospital claim or home health claim;

iii. One year of the earliest date of service entered on an outpatient hospital claim or home health claim, if the claim carries more than one date of service; or

iv. For early and Periodic Screening, Diagnosis and Treatment (EPSDT) including pediatric HealthStart services, claims must be submitted to the Fiscal Agent within 30 days of the provision of services.

2. For claims submitted by a nursing facility; an intermediate care facility for the mentally retarded; a residential treatment center; or a governmental psychiatric hospital, a claim for payment for services shall be received by the fiscal agent no later than one year after the "from date of service" as indicated on the claim.

(c) A non-institutional claim is a claim submitted by all providers except a hospital, home health agency, nursing facility, intermediate care facility/mental retardation (ICF/MR), residential treatment center, or governmental psychiatric hospital. The time requirements for submitting a non-institutional claim are as follows:

1. A claim for payment of a non-institutional service provided to any Medicaid beneficiary shall be received by the New Jersey Medicaid Fiscal Agent within:

i. One year of the date of service;

ii. One year of the earliest date of service entered on the claim if the claim carries more than one date of service;

iii. One year (365 days) of the dispensing date on a pharmacy claim; or

iv. For early and Periodic Screening, Diagnosis and Treatment (EPSDT) including pediatric HealthStart services, claims must be submitted to the Fiscal Agent within 30 days of the provision of services.

(d) The time requirements for submitting a combination Medicare/Medicaid claim are as follows (Under Federal regulations this applies only to Medicare/Medicaid claims and does not extend to claims involving any other third party insurance.):

1. A combination Medicare/Medicaid claim is defined as a request for payment from the New Jersey Medicaid program for a medical service provided to any Medicare/Medicaid beneficiary.

i. The claim shall contain the Medicaid Eligibility Identification Number, the Medicare three digit carrier/payor code, and the Medicare HIC Number.

2. A combination Medicare/Medicaid claim shall be received by the Medicare Intermediary/Carrier within the applicable Medicaid timely submission period (see (b) and (c) above) to be considered for further payment by the New Jersey Medicaid program.

i. The provider shall continue to have one year from the date of service for a claim to be received by the Medicaid Fiscal Agent. A claim received by the Medicaid Fiscal Agent after Medicare adjudication and within one year from the date of service shall be considered timely submitted.

ii. For combination Medicare/Medicaid claims received by the Medicare Intermediary/Carrier within the applicable Medicaid timely submission period and where Medicare adjudication occurs beyond the one year of the date of service, the provider shall submit a claim to be received by the Medicaid Fiscal Agent within 90 days of the date of the Medicare adjudication.

iii. For Medicare/Medicaid claims where the Medicare adjudication occurs within one year from the date of service, but less than 90 days remain within the timely filing period, the provider shall submit the claim to be received by Medicaid within the one year timely filing period or 90 days, whichever is later.

iv. A combination Medicare/Medicaid claim received outside the applicable Medicaid timely submission period shall not be reimbursed by the New Jersey Medicaid program.

3. In most cases, when a beneficiary is eligible for both Medicare and Medicaid, a Medicare/Medicaid approved claim will cross over from the Medicare Carrier/Intermediary to the Medicaid Fiscal Agent. The provider is requested to allow 45 days from Medicare adjudication for the Medicaid program to receive and process cross-over claims. Failure to allow the 45 days for the transition from Medicare to Medicaid may result in payment delays due to duplicate claim errors. There are instances, however, where claims will not cross over from Medicare to Medicaid. In those instances, or when a Medicare/Medicaid crossover is not reflected on the provider's Medicaid Remittance Advice within 45 days of the Medicare Explanation of Benefits (EOB), the provider shall follow the billing instructions in the Fiscal Agent Billing Supplement following the second chapter of the Provider Services Manual.

(e) If additional information is required in order to process a claim, the provider shall supply the information as soon as possible, but not more than 90 days after the end of the applicable timely submission period.

(f) Regarding an adjudicated claim inquiry, a provider may inquire about a claim that has been paid or denied but shall make the inquiry within 90 days of the date of adjudication as indicated on the Remittance Advice Statement.

(g) Regarding a non-adjudicated claim inquiry, a provider may inquire about the status of a claim for which neither payment nor denial has been received. The inquiry may be made at any time after the claim is received, but not more than 90 days after the end of the applicable timely submission period.

(h) Claims may be paid beyond 12 months of the date of receipt with Federal financial participation (FFP) in the following situations:

1. When the claim invoice or retroactive adjustment is paid to a provider reimbursed under a retrospective payment system;

2. For a Medicare/Medicaid claim, timely filed, Medicaid payment may be made for services within six months after the program or provider receives notice of the Medicare claim disposition for a timely filed Medicare/Medicaid claim;

3. For claims from providers under investigation for fraud or abuse; or

4. For claims associated with administrative or legal actions pursuant to a hearing action or agency corrective action mandate, whether for an eligible individual or for all those eligibles affected in a similar manner.

Amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Substituted "beneficiary" for "recipient" and deleted "form" following "claim" throughout; and in (b)2, substituted "Medicaid Eligibility Identification Number" for "HSP (Medicaid) Case Number" and inserted reference to three digit carrier/payer.

Amended by R.1997 d.520, effective January 5, 1998.

See: 29 N.J.R. 1006(a), 30 N.J.R. 232(a).

Rewrote (a), inserted new (a)1 and recodified existing (a)1 as (a)2.

#### Case Notes

Evidence of provider's custom or practice of mailing reimbursement claims against New Jersey Medicaid Program fund, together with other evidence, was sufficient, under preponderance of evidence standard, to create presumption that disputed claims were mailed and received. SSI Medical Services, Inc. v. State Dept. of Human Services, Div. of Medical Assistance and Health Services, 146 N.J. 614, 685 A.2d 1 (1996).

Evidence supported finding that medical service provider timely submitted its Medicaid claims to fiscal agent for Division of Medical Assistance and Health Services: fiscal agent probably lost them. SSI Medical Services, Inc. v. State, Dept. of Human Services, Div. of Medical Assistance and Health Services, 284 N.J.Super. 184, 664 A.2d 505 (A.D.1995).

Delay between claim receipt and claim processing was that of agency, not that of provider and did not warrant denial of Medicaid reimbursement for untimeliness. Bergen Pines County v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 30.

Twelve-month rule not applicable; government failed to give hospital provider number. Bergen Pines County Hospital v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 54.

Billing agent's error did not provide exception from one-year period. Pan American Pharmacy, Inc. v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 32.

Mismanagement by primary insurer no reason for relaxing time frames. Newark Beth Israel Medical Center v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 27.

Failure to receive determination from primary carrier did not excuse untimely application for Medicaid. Carrier Foundation v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 17.

Medicaid claim untimely; computer-indicated error not corrected for over one year. Lincoln Park Intermediate Care Center v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 63.

Claims for Medicaid reimbursement not timely filed. *Jewish Hospital and Rehabilitation Center v. Division of Medical Assistance and Health Services*, 92 N.J.A.R.2d (DMA) 53.

Corrected copy was sufficient notice of filing of discharge in error. *Courthouse Convalescent Center v. Division of Medical Assistance and Health Services*, 92 N.J.A.R.2d (DMA) 43.

Claim for reimbursement not filed within one year of date of discharge. *Holy Name Hospital v. Division of Medical Assistance and Health Services*, 92 N.J.A.R.2d (DMA) 36.

Hospital's claims for Medicaid reimbursement were untimely. *Holy Name Hospital v. Division of Medical Assistance and Health Services*, 92 N.J.A.R.2d (DMA) 33.

Long term care facility's claim for payment was untimely. *Leisure Chateau Care Center v. Division of Medical Assistance and Health Services*, 92 N.J.A.R.2d (DMA) 31.

Medicaid reimbursement; properly completed claims timely filed after rejection of improperly submitted claims. *Leader Nursing and Rehabilitation Center v. Division of Medical Assistance and Health Services*, 92 N.J.A.R.2d (DMA) 21.

Home care visits could not be added to cost report in absence of timely claim. *Long Branch Public Health Nursing Association, Inc. v. Division of Medical Assistance and Health Services*, 92 N.J.A.R.2d (DMA) 10.

### 10:49-7.3 Third party liability (TPL) benefits

(a) "Third party liability" (TPL) exists when any person, institution, corporation, insurance company, absent parent, Medicare program, public, private, or governmental entity is or may be liable in contract, tort, or otherwise by law or equity to pay all or part of the cost of medical assistance payable by the Medicaid program.

1. It is a violation of section 1902(a)(25)(D) of the Federal Social Security Act to refuse to furnish covered services to any Medicaid beneficiary because of a third party's potential liability to pay for services.

(b) Medicaid benefits are last-payment benefits. All TPL, for example, health insurance, Medicare, CHAMPUS, prepaid health plans, workers' compensation and auto insurance, shall, if available, be used first and to the fullest extent in meeting the cost of the medical needs of the Medicaid beneficiary, subject to the exceptions listed in (h) below.

(c) The New Jersey Medicaid program will supplement the amount paid by a third party, but the combined total paid to the provider shall not exceed the total amount payable under the program in the absence of any TPL. The following exceptions should be noted:

1. Medicare: The program will make payment in the full amount of the Medicare Part A deductible and co-insurance for inpatient hospital services, and Part B ambulatory care.

2. Contracting practitioners: No program payments shall be made when the third party calls for a contracting or participating practitioner to accept the TPL as payment in full.

(d) Medicaid participating providers are prohibited from billing Medicaid beneficiaries for any amount, except:

1. For services, goods, or supplies not covered or authorized by the New Jersey Medical Assistance and Health Services Act (N.J.S.A. 30:4D-1 et seq.) if the beneficiary elected to receive the services, goods, or supplies with the knowledge that they were not covered or authorized; or

2. For payments made to the beneficiary by a third party on claims submitted to the third party by the provider.

(e) When a Medicaid beneficiary has other health insurance, the program requires that such benefits be used first and to the fullest extent, subject to the exceptions in (h) below. Supplementation may be made by the program, but the combined total paid shall not exceed the amount payable under the program in the absence of other coverage. The program shall not supplement covered services rendered by a participating or contracting practitioner with any private health coverage program where the private plan calls for the practitioner to accept that plan's payment as payment in full. When other health insurance is involved, supplementation claims shall not be filed with the program unless accompanied by a statement of payment, Explanation of Benefits (EOB), or denial from the other carrier. Attachment of such information will expedite Medicaid claim processing.

1. Medicare is a health insurance program which covers certain aged and disabled persons. When rendering Medicare-covered services to any Medicaid beneficiary, providers shall inquire about Medicare eligibility especially if the third digit of the Medicaid Eligibility Identification Number is a 1, 2, 5, or 7.

(f) When a Medicaid beneficiary has benefits available, such as those described above or from any other liable third party, an approved Medicaid provider shall be authorized to sign an insurance claim for the Commissioner, based on the third party assignment of rights, in order to receive direct payment from the insurer. This is done pursuant to N.J.S.A. 30:4D-7.1(c). The following language shall be used by the provider when completing insurance claims: "(signature of authorized provider), Assignee for the Commissioner, New Jersey Department of Human Services."

(g) When recovery of benefits is sought by the Medicaid program from a liable third-party, the Commissioner shall authorize the Director or his designee(s) to sign the recovery demand.

(h) TPL may be exhausted, but is not required to be, before a claim is submitted for Medicaid payment in any of the following circumstances:

1. The TPL benefits are derived from a parent whose obligation to pay support is being enforced by the State Title IV-D agency;