

**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 49, 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Chapter 49, Administration, was repealed and a new Chapter 49, Administration, was adopted by R.1992 d.317, effective August 17, 1992.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 Subchapter 19, Prepaid Health Care Services: Medicaid Eligibles, was repealed by R.1995 d.337, effective June 19, 1995.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); the NJ KidCare program 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.

(c) Pursuant to P.L. 1997, c.272, the Division of Medical Assistance and Health Services, under the Department of Human Services, is designated as the State agency responsible for the administration of the NJ KidCare program.

(d) Unless otherwise specified, or clearly indicated otherwise in the context of the rule, the rules of the New Jersey Medicaid program and the rules of the Division of Medical Assistance and Health Services are equally applicable to the NJ KidCare program.

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.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).  
 See: 30 N.J.R. 713(a).

In (a), inserted a reference to the NJ KidCare program in the second sentence; and added (c) and (d).  
 Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.  
 See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).  
 Readopted provisions of R.1998 d.116 without change.

### 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) and Title XXI of the Social Security Act. The Division of Medical Assistance and Health Services, Department of Human Services, administers the New Jersey Medicaid and the NJ KidCare program through its Central Office and through Medicaid District Offices (MDOs) located throughout the State of New Jersey. A listing of the MDOs is provided in the chapter Appendix. The Division may also designate from time to time agencies which will assist in the administration of the NJ KidCare program.

1. The two programs are 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). The NJ KidCare program is conducted according to the Title XIX and Title XXI State Plans approved by 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.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

In (a), inserted a reference to Title XXI of the Social Security Act in the first sentence, inserted a reference to the NJ KidCare program in the second sentence and added a fourth sentence in the introductory paragraph, and substituted “two programs are” for “program is” in the first sentence and added a third sentence in 1.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 with changes, effective August 17, 1998.

### 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.

“Commissioner of DHS” means the Commissioner of the Department of Human Services.

“Copayment” means a specified dollar amount required to be paid by or on behalf of the beneficiary in connection with benefits as specified in N.J.A.C. 10:49-9.1.

“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.

“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.

“DHSS” means the Department of Health and Senior Services.

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

“Fiscal agent” means an entity that processes and adjudicates provider claims on behalf of the New Jersey Medicaid program, other Special programs, the NJ KidCare program, 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.

“NJ KidCare” means the health insurance coverage program administered by DMAHS under the provisions of Title XIX and Title XXI of the Social Security Act.

“NJ KidCare—Plan A” means the state-operated program which provides comprehensive, managed care coverage, including all benefits provided through the New Jersey Care . . . Special Medicaid Programs, to eligible children through the age of 18 with family incomes up to and including 133 percent of the Federal poverty level.

“NJ KidCare—Plan B” means the State-operated program which provides comprehensive, managed care coverage to uninsured children through the age of 18 with family incomes above 133 percent and not in excess of 150 percent of the Federal poverty level. In addition to covered managed care services, eligibles may access mental health and substance abuse services and certain other services which are paid fee-for-service.

“NJ KidCare—Plan C” means the State-operated program which provides comprehensive, managed care coverage to uninsured children through the age of 18 with family incomes above 150 percent and not in excess of 200 percent of the Federal poverty level. In addition to covered managed care services, eligibles may access mental health and substance abuse services and certain other services which are paid fee-for-service. Eligibles are required to participate in cost-sharing in the form of monthly premiums and personal contributions to care for certain services.

“NJ KidCare—Plan D” means the State-operated program which provides managed care coverage to uninsured children through the age of 18 with gross family incomes above 200 percent and not in excess of 350 percent of the Federal poverty level. In addition to covered managed care services, eligibles may access certain services including mental health and substance abuse services, with limitations, which are paid fee-for-service. Eligibles participate in cost-sharing in the form of monthly premiums and copayments for most services.

“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.

“Programs” means the New Jersey Medicaid program and the NJ KidCare 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.

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.

Recodified from N.J.A.C. 10:49-2.14 by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998). See: 30 N.J.R. 713(a).

Former N.J.A.C. 10:49-2.15, Validation form (FD 34) Validation of Eligibility, recodified to N.J.A.C. 10:49-2.16.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

### 10:49-2.16 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. 10:49-2.11(b)2).

(b) The New Jersey Medicaid and the NJ KidCare programs have 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 or NJ KidCare 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.

Recodified from N.J.A.C. 10:49-2.15 by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998). See: 30 N.J.R. 713(a).

Former N.J.A.C. 10:49-2.16, Medicaid application, recodified to N.J.A.C. 10:49-2.17.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.  
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

### 10:49-2.17 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).

Recodified from N.J.A.C. 10:49-2.16 by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).  
See: 30 N.J.R. 713(a).

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

### 10:49-2.18 (Reserved)

### 10:49-2.19 Medicaid or NJ KidCare eligibility—aliens

(a) For any alien who does not qualify for Medicaid or NJ KidCare—Plan A based on his or her alien status, and thus is potentially eligible for Medicaid or NJ KidCare—Plan A payment for emergency services only (see N.J.A.C. 10:49-5.4, Medicaid or NJ KidCare—Plan A Emergency Services for Aliens) the provider of service shall complete a Form PA-1C and submit it with Certification of Treatment of Emergency Medical Condition (if necessary) to the eligibility determination agency in the county in which the individual lives. The provider shall inform the individual that a Form PA-1C does not establish Medicaid eligibility or NJ KidCare—Plan A eligibility but serves only to protect the date of inquiry as an application date for Medicaid, or NJ KidCare—Plan A if an application is filed within three months of the date that the Form PA-1C is signed. The individual should be advised to file an application with the eligibility determination agency as soon as possible.

New Rule, R.1998 d.116, effective January 30, 1998 (operative February 1, 1998).

See: 30 N.J.R. 713(a).

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 with changes, effective August 17, 1998.

## SUBCHAPTER 3. PROVIDER PARTICIPATION

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

(a) The following provider types are eligible to participate as Medicaid and NJ KidCare—Plan A 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. Local health departments;
13. Nursing facilities, including intermediate care facilities for the mentally retarded;
14. Medical suppliers;
15. Medical day care centers;
16. Nurse-midwives;
17. Opticians;
18. Optometrists;
19. Orthotists;
20. Pharmacies;
21. Physicians and/or physician groups;
22. Podiatrists and/or podiatric groups;
23. Prosthetists;

24. Psychologists and/or psychologist groups;
25. Residential treatment facilities;
26. Transportation providers; and
27. 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.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

In (a), inserted a reference to NJ KidCare—Plan A in the introductory paragraph.

Amended by R.1998 d.143, effective March 16, 1998.

See: 29 N.J.R. 543(a), 30 N.J.R. 1081(a).

In (a), inserted a new 12, and recodified former 12 through 26 as 13 through 27.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

#### 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 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 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 Title XIX and Title XXI laws, policies, rules and regulations.

1. As a condition of continued participation in the New Jersey Medicaid and NJ KidCare programs, 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 or NJ KidCare 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 or NJ KidCare 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 or NJ KidCare 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 and NJ KidCare program. An appropriate 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 and NJ KidCare program will be confirmed in writing. A provider number will be assigned and returned to the applicant along with the appropriate 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 provider number and the provider's existing record on the Provider Master File will be reactivated.

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

(g) The New Jersey Medicaid program or NJ KidCare 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".

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

Inserted references to NJ KidCare and made corresponding language changes throughout; and in (b) and (f), substituted references to Title XIX and Title XXI for references to Medicaid.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).  
Readopted provisions of R.1998 d.116 without change.

#### 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 or NJ KidCare program shall identify all locations from which they are providing services to Medicaid or NJ KidCare beneficiaries.

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

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

Inserted references to NJ KidCare throughout, and made a corresponding language change.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 with changes, effective August 17, 1998.

#### 10:49-3.4 Medicaid or NJ KidCare provider billing number

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

(b) Practitioners, as defined in (c)1 below, approved for participation, shall also be assigned a seven digit Provider Servicing Number by the Program fiscal agent. The Provider Servicing Number is an identification number which shall be entered upon all claim submittals in accordance with the instructions in the Fiscal Agent Billing Supplement.

(c) Providers who, for billing purposes, need a referring practitioner's individual Provider Servicing Number, shall contact that practitioner to obtain the number. A practitioner who does not participate in the Medicaid or NJ KidCare program will not have a Provider Servicing Number. In the absence of the referring practitioner's individual 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 or NJ KidCare program.

1. Each 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 Provider Servicing Number to other providers when referring a Medicaid or NJ KidCare 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 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 Provider Billing Number and individual 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.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

Inserted references to NJ KidCare and made corresponding language changes throughout.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 with changes, effective August 17, 1998.

### 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.

3. Post conspicuously the names and scheduled office hours of all providers practicing in the facility;
4. Maintain proper records. Such records shall contain at least the following information:
  - i. The full name, address and Program Number of the patient;
  - ii. The dates of all visits to all providers in the shared health care facility;
  - iii. The chief complaint for each visit to each provider in the shared health care facility;
  - iv. Pertinent history and all physical examinations rendered by each provider in the shared health care facility;
  - v. Diagnostic impressions for each visit to any provider in the shared health care facility;
  - vi. All medications prescribed at each visit by any provider in the shared health care facility who is qualified to issue prescriptions;
  - vii. The precise dosage and prescription regimens for each medication prescribed by a provider in the shared health care facility;
  - viii. All x-ray, laboratory work and electrocardiograms ordered at each visit by any provider in the shared health care facility;
  - ix. The results of all x-ray, laboratory work and electrocardiograms ordered as in (a)4viii above;
  - 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.

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

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

In (a)4i, substituted a reference to Program Numbers for a reference to Medicaid Numbers.

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

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

Readopted the provisions of R.1998 d.154 without change.

## SUBCHAPTER 5. SERVICES COVERED BY MEDICAID AND THE NJ KIDCARE PROGRAMS

### 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

or the NJ KidCare—Plan A programs. 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".

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

In (a), inserted a reference to NJ KidCare—Plan A programs in the first sentence.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

### 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, or children who are presumptively eligible for, the regular Medicaid and NJ KidCare—Plan A programs

(a) The services listed below are available to beneficiaries eligible for the regular Medicaid or NJ KidCare—Plan A 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. Environmental lead inspection services-rehabilitative services;

7. 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;

8. 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 or NJ KidCare—Plan A program.

9. 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;)

10. Hearing aid services;

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

12. Hospice room and board services in a nursing facility (available to dually eligible Medicare/Medicaid or dually eligible Medicare/NJ KidCare—Plan A beneficiaries);

13. 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;

14. Hospital services—outpatient;

15. Laboratory (clinical);

16. Medical day care services;

17. Medical supplies and equipment;

18. Mental health services;

19. Nursing facility services, including intermediate care facilities for the mentally retarded;

20. Nurse-midwifery services;

21. Optometric services;

22. Optical appliances;

23. Pharmaceutical services;

24. Physician services;

25. Podiatric services;

26. Prosthetic and orthotic devices;

27. Radiological services;

28. Rehabilitative services (Payments are made to eligible Medicaid or NJ KidCare—Plan A 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

29. Transportation services which include ambulance, invalid coach, and other transportation provided by independent clinics or through arrangements with a county welfare agency.

(b) All Medicaid and NJ KidCare Plan A beneficiaries shall be eligible to receive all of the services specified in (a) above fee-for-service during the presumptive eligibility period, and through the time that they select and are enrolled into a managed care organization, if managed care is applicable.

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.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

In (a), inserted references to NJ KidCare—Plan A throughout.

Amended by R.1998 d.143, effective March 16, 1998.

See: 29 N.J.R. 543(a), 30 N.J.R. 1081(a).

In (a), inserted a new 6, and recodified former 6 through 28 as 7 through 29.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

Amended by R.2000 d.266, effective July 3, 2000.  
See: 32 N.J.R. 159(a), 32 N.J.R. 2493(a).  
Added (b).

**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.)

i. There is no deeming of spousal income in the determination of eligibility for this program. While spousal resources are considered in the determination of eligibility, up to one-half of the total resources are protected for the use of the spouse; and

7. Be determined disabled by the Social Security Administration (SSA) or by the Disability Review Unit of the Division, using the SSA disability criteria.

(g) If the individual is dually diagnosed, for example, with a head injury and psychiatric illness or developmental disability or substance abuse addiction, a determination will be made during the initial review as to the most appropriate service system to manage the beneficiary's care. This decision will be made based on clinical evidence as of onset of injury, and professional evaluation.

(h) Retroactive eligibility shall not be available to waiver beneficiaries for those Medicaid services provided only by virtue of enrollment in the waiver program. Those individuals who are not eligible for Medicaid services in the community prior to enrollment in the TBI Waiver are not eligible for retroactive Medicaid eligibility.

(i) All applicants determined eligible for the TBI Waiver shall be issued a Medicaid Eligibility identification (MEI) Card.

(j) In order for an applicant to be enrolled in the program, a waiver slot must be available.

(k) Prior to formal application for the TBI waiver, a referral shall be submitted to the Bureau of Home Care Services (BHCS) of the Division, which shall review the referral to determine if the individual meets the basic criteria for the program. If it is determined that the individual referred is a potential candidate for the TBI waiver, the following shall occur:

1. Supplemental Security Income (SSI) beneficiaries shall be referred to the appropriate Medicaid District Office serving their county of residence;

2. Children under the supervision of the Division of Youth and Family Services (DYFS) shall be referred to DYFS for the initiation of the formal application, which includes the determination of disability, and shall then be referred to the appropriate Medicaid District Office (MDO) serving the beneficiary's county of residence; and

3. Individuals who are not currently Medicaid eligible shall be referred by (BHCS) to the county welfare agency (CWA) located in the county where the individual resides, for a determination of financial eligibility, including the referral for determination of disability.

(l) After the applicant has been determined financially eligible, he or she shall be referred to the Medicaid District Office (MDO) of the applicant's residence for a determina-

tion of medical eligibility by the Regional Staff Nurse (RSN).

(m) When the applicant is judged financially and medically eligible for the TBI waiver program, the MDO shall assign the case to a case management site and notify the (BHCS) of the beneficiary's approval for participation in the program.

(n) The MDO shall review and approve the plan of care prepared by the case manager initially, and at six month intervals.

(o) If a waiver beneficiary is categorically eligible for Medicaid services under the State Plan and no waiver services are required as a part of the plan of care, the beneficiary shall be terminated from the TBI program.

(p) All approved services under the New Jersey Medicaid program, except for nursing facility services, are available under the TBI Waiver from approved Medicaid providers in accord with an individualized plan of care. (See N.J.A.C. 10:60-5.5 for a description of services.)

(q) An individual shall be terminated from the TBI Waiver Program for the following reasons:

1. He or she no longer meets the income and resource requirements for Medicaid;

2. He or she no longer exhibits medical, emotional, behavioral and/or cognitive deficits which would qualify the individual for nursing facility care;

3. He or she attains a Level 8 or above on the Rancho Los Amigos Levels of Cognitive Functioning Scale;

4. He or she refuses to accept case management services; or

5. He or she is categorically eligible for Medicaid State Plan services and does not require waiver services as part of the plan of care.

(r) Where termination is sought pursuant to (q) above, an individual shall be afforded the opportunity to request a hearing pursuant to N.J.A.C. 10:49-9.10.

New Rule, R.1994 d.426, effective August 15, 1994.  
See: 26 N.J.R. 1566(a), 26 N.J.R. 3466(b).  
Amended by R.1997 d.354, effective September 2, 1997.  
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Section recodified from N.J.A.C. 10:49-17.5; substituted references to beneficiary for references to recipient and references to BHCS for references to OHCP throughout.

## SUBCHAPTER 23. LIFELINE PROGRAMS

### 10:49-23.1 Purpose and scope

Lifeline Programs provide an annual benefit to eligible persons toward the cost of electricity and natural gas. The

Lifeline Credit Program (LCP) and the Tenants Lifeline Assistance Program (TLAP) are administered by the Department of Health and Senior Services. The rules for these programs are promulgated by the Department of Health and Senior Services. Although the Department of Health and Senior Services also administers the Lifeline benefit, because Supplemental Security Income (SSI) beneficiaries receive the benefit as a Special Utility Supplement (SUS) in their monthly SSI checks, DMAHS is responsible for establishing the policies and procedures for eligibility for

this benefit as part of their SSI income eligibility for the Medicaid program.

**10:49-23.2 Applications**

(a) Applications for the Lifeline Programs are sent automatically to persons benefiting from the following Medicaid programs:

1. Medical Assistance to the Aged (MAA);
2. Medical Assistance Only (MAO); and
3. New Jersey Care . . . Special Medicaid Programs.