

CHAPTER 49
ADMINISTRATION

Authority

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

Source and Effective Date

R.1992 d.317, effective August 17, 1992.
See: 24 N.J.R. 1728(a), 24 N.J.R. 2837(a).

Executive Order No. 66(1978) Expiration Date

Chapter 49, Administration, expires on August 17, 1997.

Chapter Historical Note

Chapter 44, Administration, was filed and became effective prior to September 1, 1969. Amendments to subchapter 1 through 6 were filed on June 20, 1977, to become effective on July 1, 1977, as R.1977 d.213. 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 Chapter 49 was repealed by R.1992 d.317, and was replaced with new rules, effective August 17, 1992. See: Source and Effective Date.

See subchapter and section annotations for specific rulemaking activity.

Prior rulemaking activity in Chapter 49, Administration, which was repealed by R.1992 d.317, follows:

FOREWORD

Amended by R.1986 d. 236, effective June 16, 1986 (operative July 1 1986).
See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a).
Substantially amended.
Amended by R.1989 d. 498, effective September 18, 1989.
See: 21 N.J.R. 1791(a), 21 N.J.R. 2998(a).
New program provisions described.

SUBCHAPTER 1. GENERAL PROVISIONS

Authority

N.J.S.A. 30:4D-3, 6, 7, 17, 17.1; 42 CFR 431.51, 107, 301;
42 CFR 435; 42 CFR 440.

Source and Effective Date

R.1985 d. 246, effective April 29, 1985.
See: 17 N.J.R. 532(a), 17 N.J.R. 1307(a).

Historical Note

All provisions of this subchapter were filed prior to September 1, 1969. Amendments became effective May 5, 1972 as R.1972 d. 85. See: 4 N.J.R. 127(a), 4 N.J.R. 68(b). Further amendments were filed and became effective April 2, 1973 as R.1973 d. 91. See: 5 N.J.R. 43(c), 5 N.J.R. 149(a). Further amendments were filed and became effective April 17, 1973 as R.1973 d. 105. See: 5 N.J.R. 82(b), 5 N.J.R. 149(d). Further amendments were filed and became effective November 1, 1973 as R.1973 d. 313. See: 5 N.J.R. 188(c), 5 N.J.R. 415(b). Further amendments were filed and became effective January 1, 1974 as R.1973 d. 249. See: 5 N.J.R. 266(b), 5 N.J.R. 341(e). Further amendments were filed and became effective January 15, 1974 as R.1973 d. 340. See: 5 N.J.R. 377(a), 6 N.J.R. 14(b). Further amendments were filed and became effective March 1, 1974 as R.1973 d. 323. See: 5 N.J.R.

339(a), 5 N.J.R. 420(b). Further amendments were filed and became effective June 15, 1974 as R.1974 d. 112. See: 6 N.J.R. 141(c), 6 N.J.R. 245(c). Further amendments were filed and became effective June 3, 1975 as R.1975 d. 150. See: 7 N.J.R. 165(a), 7 N.J.R. 328(d). Further amendments were filed and became effective August 1, 1975 as R.1975 d. 225. See: 7 N.J.R. 317(b), 7 N.J.R. 421(a). Further amendments were filed and became effective January 1, 1976 as R.1975 d. 383. See: 7 N.J.R. 557(b), 8 N.J.R. 70(b). Further amendments were filed and became effective January 16, 1976 as R.1975 d. 380. See: 7 N.J.R. 557(a), 8 N.J.R. 70(a). Further amendments were filed and became effective March 10, 1976 as R.1976 d. 78. See: 8 N.J.R. 196(a). Further amendments were filed and became effective October 8, 1976 as R.1976 d. 314. See: 8 N.J.R. 283(a), 8 N.J.R. 516(a). Further amendments were filed and became effective January 19, 1977 as R.1977 d. 12. See: 9 N.J.R. 91(a). Further amendments were filed and became effective August 1, 1977 as R.1977 d. 243. See: 9 N.J.R. 370(e). Further amendments were filed and became effective October 26, 1977 as R.1977 d. 408. See: 9 N.J.R. 431(b), 9 N.J.R. 534(b). Further amendments were filed and became effective December 30, 1977 as R.1977 d. 490. See: 9 N.J.R. 571(b), 10 N.J.R. 65(b). Further amendments became effective March 1, 1980 as R.1980 d. 90. See: 12 N.J.R. 19(b), 12 N.J.R. 193(b). Further amendments became effective July 1, 1980 as R.1980 d.278. See: 12 N.J.R. 20(a), 12 N.J.R. 481(a). Further amendments became effective November 14, 1980 as R.1980 d. 501. See: 12 N.J.R. 581(a), 13 N.J.R. 17(a). Further amendments became effective January 1, 1981 as R.1980 d. 549. See: 12 N.J.R. 274(a), 13 N.J.R. 100(c). Further amendments became effective May 7, 1981 (operative June 15, 1981) as R.1981 d. 123. See: 12 N.J.R. 187(c), 13 N.J.R. 272(a). Further amendments became effective July 9, 1981 as R.1981 d. 246. See: 13 N.J.R. 272(b), 13 N.J.R. 412(d). Further amendments became effective September 10, 1981 as R.1981 d. 329. See: 12 N.J.R. 520(b), 12 N.J.R. 574(b). Further amendments became effective November 2, 1981 as R.1981 d. 393. See: 13 N.J.R. 496(c), 13 N.J.R. 758(c). Further amendments became effective March 1, 1982 as R.1982 d. 52. See: 13 N.J.R. 654(b), 14 N.J.R. 235(b). Further amendments became effective August 16, 1982 as R.1982 d. 261. See: 14 N.J.R. 418(a), 14 N.J.R. 917(b). Further amendments became effective December 6, 1982 (operative January 1, 1983) as R.1982 d. 415. See: 14 N.J.R. 889(a), 14 N.J.R. 1393(a). Further amendments became effective March 21, 1983 as R.1983 d. 75. See: 14 N.J.R. 1332(a), 15 N.J.R. 442(a). Further amendments became effective December 19, 1983 as R.1983 d. 583. See: 15 N.J.R. 782(a), 15 N.J.R. 2168(b). Further amendments became effective February 6, 1984 as R.1984 d. 21. See: 15 N.J.R. 1726(a), 16 N.J.R. 239(c). Further amendments became effective April 2, 1984 as R.1984 d. 91. See: 16 N.J.R. 118(a), 16 N.J.R. 727(a). Further amendments became effective February 4, 1985 as R.1985 d. 7. See: 16 N.J.R. 1933(a), 17 N.J.R. 309(a). Further amendments became effective April 15, 1985 as R.1985 d. 177. See: 16 N.J.R. 2413(a), 17 N.J.R. 966(a). This subchapter was readopted pursuant to Executive Order 66 (1978) effective April 29, 1985 (with amendments effective May 20, 1985) as R.1985 d. 246. See: 17 N.J.R. 532(a), 17 N.J.R. 1307(a). Public Notice: "Jersey Care—Special Medicaid Programs" has been changed to "New Jersey Care—Special Medicaid Programs" administratively. See: 20 N.J.R. 2478(c).

10:49-1.1 Who is eligible for Medicaid

Amended by R.1985 d. 246, effective May 20, 1985.
See: 17 N.J.R. 532(a), 17 N.J.R. 1307(a).

Substantially amended.

Amended by R.1986 d. 137, effective April 21, 1986.
See: 17 N.J.R. 2729(a), 18 N.J.R. 845(c).

Added text in (d) "(address on application) ... for public assistance."

Amended by R.1986 d. 236, effective June 16, 1986 (operative July 1, 1986).

See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a).

Substantially amended.

Emergency Amendment, R.1987 d. 312, effective June 29, 1987.
(Operative July 1, 1987, expires August 28, 1987).

See: 1324(a).

Adoption of concurrent proposal as R.1987 d. 380, effective August 27, 1987.

See: 19 N.J.R. 1324(a), 19 N.J.R. 1731(a).

Provisions of emergency amendment R.1987 d. 312 readopted with changes.

Emergency Amendment, R.1988 d. 96, effective February 2, 1988 (expires April 2, 1988).

See: 20 N.J.R. 548(a).

Added new (b)9; renumbered (b)9. to (b)10.

Amended by R.1988 d. 192, effective May 2, 1988.

See: 20 N.J.R. 367(a), 20 N.J.R. 983(a).

Substantially amended (d) and (e).

Adoption of concurrent proposal as R.1988 d. 212, effective May 16, 1988.

See: 20 N.J.R. 548(a), 20 N.J.R. 1103(a).

Amended by R.1989 d. 397, effective August 7, 1989.

See: 21 N.J.R. 965(a), 21 N.J.R. 2383(a).

Eligible persons listed at (b)3-10 deleted and new listing added at 3-21. Exceptions at (d)1 deleted and new text added at 1 and 2 to allow newborns to be billed for under the mother's number.

Amended by R.1989 d. 498, effective September 18, 1989.

See: 21 N.J.R. 1791(a), 21 N.J.R. 2998(a).

Provisions for ambulatory prenatal services from Medicaid participating providers added.

Amended by R.1989 d. 499, effective September 18, 1989.

See: 21 N.J.R. 417(b), 21 N.J.R. 3000(a).

Provisions for retroactive eligibility added at (d)3. Provisions for New Jersey Care added.

Administrative Correction: deleted (f) and (g).

See: 22 N.J.R. 1375(a).

10:49-1.2 How to identify a Medicaid recipient (an eligible person)

Emergency Adoption, R.1988 d. 96, effective March 7, 1988.

See: 20 N.J.R. 548(a).

Amended (a)3 categories.

Adopted concurrent proposal, R.1988 d. 212, effective May 16, 1988.

See: 20 N.J.R. 548(a), 20 N.J.R. 1103(a).

Amended by R.1989 d. 498, effective September 18, 1989.

See: 21 N.J.R. 1791(a), 21 N.J.R. 2998(a).

Provisions for New Jersey Care added.

EXHIBITS I THROUGH IV: VALIDATION FORMS

Amended by R.1980 d. 549, eff. January 1, 1981.

See: 12 N.J.R. 274(a), 13 N.J.R. 100(c).

Amended by R.1982 d. 261, eff. August 16, 1982.

See: 14 N.J.R. 418(a), 14 N.J.R. 917(b).

Amended by R.1985 d. 246, effective May 20, 1985.

See: 17 N.J.R. 532(a), 17 N.J.R. 1307(a).

Original text deleted and new text substituted.

EXHIBIT V: MEDICAID ELIGIBILITY IDENTIFICATION CARD

Amended by R.1985 d. 246, effective May 20, 1985.

See: 17 N.J.R. 532(a), 17 N.J.R. 1307(a).

Exhibits I through V were deleted in their entirety and new Exhibits I through IV were inserted.

Amended by R.1986 d. 236, effective June 16, 1986 (operative July 1, 1986).

See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a).

Substantially amended.

Emergency amendment R.1987 d. 312, effective June 29, 1987 (operative July 1, 1987, expires August 28, 1987).

See: 19 N.J.R. 1324(a).

Adoption of concurrent proposal as R.1987 d. 380, effective August 27, 1987.

See: 19 N.J.R. 1324(a), 19 N.J.R. 1731(a).

Provisions of emergency amendment R.1987 d. 312 readopted with changes.

Amended by R.1989 d. 498, effective September 18, 1989.

See: 21 N.J.R. 1791(a), 21 N.J.R. 2998(a).

Exhibit VI added.

10:49-1.3 Eligible Providers

EXHIBIT VI: PROVIDER AGREEMENT BETWEEN NEW JERSEY DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

As amended, R.1977 d. 490, effective December 30, 1977.

See: 9 N.J.R. 571(b), 10 N.J.R. 65(b).

As amended, R.1980 d. 90, effective March 1, 1980.

See: 12 N.J.R. 19(b), 12 N.J.R. 193(b).

As amended, R.1981 d. 393, effective November 2, 1981.

See: 13 N.J.R. 496(c), 13 N.J.R. 758(c).

(d) and (e) added.

As amended, R.1982 d. 415, effective December 6, 1982, operative January 1, 1983.

See: 14 N.J.R. 889(a), 14 N.J.R. 1393(a).

As amended, R.1984 d. 21, effective February 6, 1984.

See: 15 N.J.R. 1726(a), 16 N.J.R. 239(c).

Reference to personal care assistant services providers added.

Amended by R.1985 d. 246, effective May 20, 1985.

See: 17 N.J.R. 523(a), 17 N.J.R. 1307(a).

Section substantially amended and Exhibit V added.

Amended by R.1988 d. 62, effective February 1, 1988.

See: 19 N.J.R. 1978(a), 20 N.J.R. 278(b).

Added text in (a): "and/or such other documentation as the program may require,"

10:49-1.4 Services covered by the New Jersey Medicaid Program

As amended, R.1982 d. 415, effective December 6, 1982, operative January 1, 1983.

See: 14 N.J.R. 889(a), 14 N.J.R. 1393(a).

As amended, R.1983 d. 583, effective December 19, 1983, operative January 1, 1984.

See: 15 N.J.R. 782(a), 15 N.J.R. 2168(b).

Language added concerning initial evaluation visits and personal care assistant services.

As amended, R.1984 d. 21, effective February 6, 1984.

See: 15 N.J.R. 1726(a), 16 N.J.R. 239(c).

Personal care assistant services added.

Amended by R.1985 d. 246, effective May 20, 1985.

See: 17 N.J.R. 532(a), 17 N.J.R. 1307(a).

Section substantially amended.

Amended by R.1986 d. 59, effective March 17, 1986.

See: 17 N.J.R. 1235(a), 18 N.J.R. 559(a).

New (a)18 added. Personal Care Assistance Services was not deleted at R.1985 d. 246 by error. It has been deleted in this update.

Amended by R.1986 d. 236, effective June 16, 1986 (operative July 1, 1986).

See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a).

Old rule "Authorized services for covered persons" deleted in its entirety.

Amended by R.1988 d. 62, effective February 1, 1988.

See: 19 N.J.R. 1978(a), 20 N.J.R. 278(b).

Added new (a)7, 14 and 20 and renumbered listing accordingly.

Amended by R.1988 d. 349, effective August 1, 1988.

See: 19 N.J.R. 1388(a), 20 N.J.R. 1945(a).

Deleted (b)4 and renumbered 5.-9. as 4.-8.

10:49-1.5 General exclusions

Amended by R.1977 d. 408, effective October 26, 1977.

See: 9 N.J.R. 431(b), 9 N.J.R. 534(b).

Amended by R.1981 d. 549, effective January 1, 1981.

See: 12 N.J.R. 274(a), 13 N.J.R. 100(c).

Amendment provided for a hearing if a recipient objects in any way to the issuance of a Special Status Medicaid Card.

As amended, R.1981 d. 329, effective September 10, 1981.

See: 12 N.J.R. 520(b), 12 N.J.R. 574(b).

Amended by R.1985 d. 246, effective May 20, 1985.

See: 17 N.J.R. 532(a), 17 N.J.R. 1307(a).

Substantive changes in (a)13.

- Amended by R.1987 d. 180, effective April 20, 1987.
See: 18 N.J.R. 2411(c), 19 N.J.R. 643(a).
(a)14 added.
- Amended by R.1988 d. 62, effective February 1, 1988.
See: 19 N.J.R. 1978(a), 20 N.J.R. 278(b).
Added new (a)2; renumbered (a)2.-14. as (a)3.-15.
- 10:49-1.6 (Reserved)
Repealed by R.1988 d. 62, effective February 1, 1988.
See: 19 N.J.R. 1978(a), 20 N.J.R. 278(b).
Repealed Free Services.
- 10:49-1.7 Utilization of insurance benefits
Amended by R.1981 d. 123, effective May 7, 1981, operative June 15, 1981.
See: 12 N.J.R. 187(c), 13 N.J.R. 272(a).
Amended by R.1985 d. 7, effective February 4, 1985.
See: 16 N.J.R. 1933(a), 17 N.J.R. 309(a).
(a)5.-6. added.
Amended by R.1985 d. 246, effective May 20, 1985.
See: 17 N.J.R. 532(a), 17 N.J.R. 1307(a).
Text added "combined total of".
Amended by R.1989 d. 499, effective September 18, 1989.
See: 21 N.J.R. 417(b), 21 N.J.R. 3000(a).
Added note to alert personnel that persons with a third digit of 1, 2, 5 or 7 in their Medicaid number may have Medicare coverage.
- 10:49-1.8 Prior and retroactive authorization (general)
Amended by R.1976 d. 151, effective June 1, 1976.
See: 8 N.J.R. 194(a), 8 N.J.R. 287(c).
Amended by R.1983 d. 376, effective September 19, 1983, operative October 1, 1983.
See: 15 N.J.R. 997(a), 15 N.J.R. 1582(a).
Circumstances under which retroactive authorization is granted, added.
Amended by R.1985 d. 246, effective May 20, 1985.
See: 17 N.J.R. 532(a), 17 N.J.R. 1307(a).
"Fiscal agent" substituted for "Contractor".
Amended by R.1989 d. 499, effective September 18, 1989.
See: 21 N.J.R. 471(b), 21 N.J.R. 3000(a).
Clarification added that providers are responsible for verification of eligibility; prior authorization no guarantee of eligibility.
- 10:49-1.9 Policy on out-of-State medical care and services
As amended, R.1973 d. 105, effective April 17, 1973.
See: 5 N.J.R. 82(b), 5 N.J.R. 149(d).
As amended, R.1982 d. 52, effective March 1, 1982.
See: 13 N.J.R. 654(b), 14 N.J.R. 235(b).
Old text deleted are replaced with the new text ((a)-(b)1).
Amended by R.1985 d. 246, effective May 20, 1985.
See: 17 N.J.R. 532(a), 17 N.J.R. 1307(a).
(a)3 added.
Amended by R.1989 d. 499, effective September 18, 1989.
See: 21 N.J.R. 417(b), 21 N.J.R. 3000(a).
Stylistic changes.
- 10:49-1.10 Bureau of Claims and Accounts; Fiscal Agents
Amended by R.1985 d. 246, effective May 20, 1985.
See: 17 N.J.R. 532(a), 17 N.J.R. 1307(a).
Substantially amended.
Amended by R.1989 d. 499, effective September 18, 1989.
See: 21 N.J.R. 417(b), 21 N.J.R. 3000(a).
Clarification added that the Bureau of Claims and Accounts is responsible for processing; telephone numbers added.
Amended by R.1990 d. 326, effective July 2, 1990.
See: 22 N.J.R. 117(a), 22 N.J.R. 2009(a).
Replaced (b), concerning Prudential and Blue Cross/Blue Shield as fiscal agents.
- 10:49-1.12 Timeliness of claim submission and claim inquiry
Amended by R.1980 d. 278, effective July 1, 1980.
See: 12 N.J.R. 20(a), 12 N.J.R. 481(a).
Substantially amended.
- Amended by R.1985 d. 246, effective May 20, 1985.
See: 17 N.J.R. 532(a), 17 N.J.R. 1307(a).
Substantially amended.
New Rule, R.1987 d. 408, effective October 5, 1987.
See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).
Old rule repealed was "Timely submission of claims and claim inquiries."
Amended by R.1988 d. 541, effective November 21, 1988 (operative December 1, 1988).
See: 20 N.J.R. 1642(a), 20 N.J.R. 2915(a).
108 days changed to 365 days.
- 10:49-1.13 Prohibition of payment to factors
Amended by R.1981 d. 246, effective July 9, 1981.
See: 13 N.J.R. 272(b), 13 N.J.R. 412(d).
Old text concerning "prohibition of factoring" deleted and new text concerning "prohibition of payment to factors" substituted therefor.
- 10:49-1.14 Use of service bureau and/or management agency
Amended by R.1981 d. 246, effective July 9, 1981.
See: 13 N.J.R. 272(b), 13 N.J.R. 412(d).
Old text deleted, new text substituted therefor.
Amended by R.1985 d. 246, effective May 20, 1985.
See: 17 N.J.R. 532(a), 17 N.J.R. 1307(a).
"fiscal agent" substituted for "Contractor".
Amended by R.1989 d. 499, effective September 18, 1989.
See: 21 N.J.R. 417(b), 21 N.J.R. 3000(a).
Blue Shield added at (e)2.
- 10:49-1.16 Provisions for appeals; fair hearings
Amended by R.1984 d. 91, effective April 2, 1984.
See: 16 N.J.R. 118(a), 16 N.J.R. 727(a).
(e), added.
Amended by R.1985 d. 246, effective May 20, 1985.
See: 17 N.J.R. 532(a), 17 N.J.R. 1307(a).
"CN 712" substituted for "P.O. Box 2486".
- 10:49-1.17 Program participation
R.1972 d. 85, effective May 5, 1972.
See: 4 N.J.R. 127(a), 4 N.J.R. 68(b).
Amended by R.1975 d. 150, effective June 3, 1975.
See: 7 N.J.R. 165(a), 7 N.J.R. 328(d).
Amended by R.1975 d. 151, effective June 3, 1975.
See: 7 N.J.R. 165(c), 7 N.J.R. 329(c).
Amended by R.1980 d. 501, effective November 14, 1980.
See: 12 N.J.R. 581(a), 13 N.J.R. 17(a).
Amended by R.1981 d. 315, effective September 10, 1981 (to become operative October 1, 1981).
See: 13 N.J.R. 222(a), 13 N.J.R. 574(c).
(b)1-4 added.
Amended by R.1981 d. 393, effective November 2, 1981.
See: 13 N.J.R. 496(c), 13 N.J.R. 758(c).
(d)25 and 26 added.
Amended by R.1985 d. 246, effective May 20, 1985.
See: 17 N.J.R. 532(a), 17 N.J.R. 1307(a).
"fiscal agents" substituted for "contractors".
Amended by R.1989 d. 499, effective September 18, 1989.
See: 21 N.J.R. 417(b), 21 N.J.R. 3000(a).
Stylistic changes.
- 10:49-1.18 Civil rights
R.1973 d. 91, effective April 2, 1973.
See: 5 N.J.R. 43(c), 5 N.J.R. 149(a).
As amended, R.1974 d. 112, effective June 15, 1974.
See: 6 N.J.R. 141(c), 6 N.J.R. 245(c).
As amended, R.1980 d. 247, effective July 1, 1980.
See: 12 N.J.R. 84(a), 12 N.J.R. 418(d).
- 10:49-1.19 Observance of religious belief
R.1973 d.93, effective April 2, 1973.
See: 5 N.J.R. 43(b), 5 N.J.R. 149(c).
Amended by R.1989 d. 499, effective September 18, 1989.
See: 21 N.J.R. 417(b), 21 N.J.R. 3000(a).

Eligibility determination must follow any required physical examination.

- 10:49-1.20 Free choice by recipient and by provider
R.1973 d. 323, effective March 1, 1974.
See: 5 N.J.R. 339(a), 5 N.J.R. 420(b).
Amended by R.1985 d. 246, effective May 20, 1985.
See: 17 N.J.R. 532(a), 17 N.J.R. 1307(a).
"Medicaid district office" substituted for "local medical assistance unit".
- 10:49-1.21 Integrity of the Medicaid program
R.1973 d. 340, effective January 15, 1974.
See: 5 N.J.R. 377(a), 6 N.J.R. 14(b).
- 10:49-1.22 Confidentiality of records
R.1973 d. 313, effective November 1, 1973.
See: 5 N.J.R. 188(c), 5 N.J.R. 415(b).
Amended by R.1985 d. 246, effective May 20, 1985.
See: 17 N.J.R. 532(a), 17 N.J.R. 1307(a).
Old text deleted and new text substituted.
Amended by R.1989 d. 499, effective September 18, 1989.
See: 21 N.J.R. 417(b), 21 N.J.R. 3000(a).
Addition of text at (b)6 and 7 to conform with SSA and IRS regulations, and 42 CFR 431.305.
- 10:49-1.23 Recordkeeping and provider certification requirement
As amended, R.1980 d. 247, effective July 1, 1980.
See: 12 N.J.R. 84(a), 12 N.J.R. 418(d).
- 10:49-1.24 Individual Medicaid Practitioner (IMP) number
R.1973 d. 249, effective January 1, 1974.
See: 5 N.J.R. 266(b), 5 N.J.R. 341(l).
Amended by R.1983 d. 75, effective March 21, 1983.
See: 14 N.J.R. 1332(a), 15 N.J.R. 442(a).
Term Local Medical Assistance Unit changed to Medicaid District Offices.
Chart substantially amended.
Repealed by R.1985 d. 246, effective May 20, 1985.
See: 17 N.J.R. 532(a), 17 N.J.R. 1307(a).
Section was originally "Directory of Medicaid District Offices and the chart was recodified to Appendix A.
New Rule, R.1989 d. 499, effective September 18, 1989.
See: 21 N.J.R. 417(b), 21 N.J.R. 3000(a).
- 10:49-1.25 (Reserved)
R.1975 d. 225, effective August 1, 1975.
See: 7 N.J.R. 317(b), 7 N.J.R. 421(a).
Amended by R.1977 d. 12, effective January 19, 1977.
See: 9 N.J.R. 91(a).
Amended by R.1977 d. 243, effective August 1, 1977.
See: 9 N.J.R. 370(e).
Repealed by R.1985 d. 246, effective May 20, 1985.
See: 17 N.J.R. 532(a), 17 N.J.R. 1307(a).
Section was originally "Medicaid reimbursement for abortions".
- 10:49-1.26 Patient certification
R.1977 d. 206, eff. August 1, 1975.
See: 7 N.J.R. 365(a).
R.1981 d. 331, eff. September 10, 1981.
See: 13 N.J.R. 413(a), 13 N.J.R. 575(a).
Amended by R.1989 d. 499, effective September 18, 1989.
See: 21 N.J.R. 417(b), 21 N.J.R. 3000(a).
Stylistic changes.
- 10:49-1.27 Audits
R.1981 d. 114, eff. May 7, 1981.
See: 13 N.J.R. 133(c), 13 N.J.R. 273(a).
Amended by R.1983 d. 5, eff. February 7, 1983 (operative March 1, 1983).
See: 14 N.J.R. 1031(a), 15 N.J.R. 155(a).
Substantially amended, full text deleted and replaced.
Amended by R.1985 d. 177, effective April 15, 1985.

See: 16 N.J.R. 2413(a), 17 N.J.R. 966(a).

(a)liii added.

Correction: (a)liii was left out of code. It has been inserted.

See: 18 N.J.R. 1205(c).

- 10:49-1.28 (Reserved)
R.1975 d. 383, eff. January 1, 1976.
See: 7 N.J.R. 557(b), 8 N.J.R. 70(b).
Amended by R.1976 d. 204, eff. July 1, 1974.
See: 8 N.J.R. 385(a).
- 10:49-1.29 (Reserved)
R.1975 d. 380, eff. January 16, 1976.
See: 7 N.J.R. 557(a), 8 N.J.R. 70(a).
Amended by R.1976 d. 78, eff. March 10, 1976.
See: 8 N.J.R. 196(a).
Amended by R.1976 d. 314, eff. October 8, 1976.
See: 8 N.J.R. 283(a), 8 N.J.R. 516(a).
- 10:49-1.30 (Reserved)
R.1974 d. 202, eff. July 24, 1974.
See: 6 N.J.R. 242(b), 6 N.J.R. 313(b).
- 10:49-1.31 (Reserved)
R.1977 d. 62, eff. March 1, 1977.
See: 8 N.J.R. 120(c), 9 N.J.R. 126(e).
- 10:49-1.32 (Reserved)
R.1976 d. 189, eff. July 1, 1976.
See: 8 N.J.R. 335(b).
- 10:49-1.33 (Reserved)
R.1977 d. 36, eff. February 16, 1977.
See: 8 N.J.R. 383(a), 9 N.J.R. 125(c).

APPENDIX A: MEDICAID DISTRICT OFFICES

New Rule R.1985 d. 246, effective May 20, 1985.

See: 17 N.J.R. 532(a), 17 N.J.R. 1307(a).

Amended by R.1990 d. 390, effective August 6, 1990.

See: 22 N.J.R. 1512(a), 22 N.J.R. 2313(a).

Medicaid District office list updated.

SUBCHAPTER 2. AVAILABILITY OF PROGRAM POLICY ISSUANCES

Subchapter Historical Note

Unless otherwise expressly noted, all provisions of this subchapter were adopted pursuant to authority of N.J.S.A. 30:4D-1 et seq. and were filed and became effective prior to September 1, 1969. Amendments which repealed this subchapter were filed on June 20, 1977, as R.1977 d. 213 to become effective on July 1, 1977. See: 9 N.J.R. 123(b), 9 N.J.R. 342(c). Amendments which restored this subchapter were filed and became effective on August 15, 1978, as R.1978 d.280. See: 10 N.J.R. 399(a).

SUBCHAPTER 3. HEALTHSTART—COMPREHENSIVE MATERNITY CARE SERVICES AND COMPREHENSIVE PEDIATRIC CARE SERVICES

Authority

N.J.S.A. 30:4D-2, 30:4D-3, 30:4D-5, 30:4D-6, 30:4D-7, 30:4D-12 and 1920(a) of the Social Security Act.

Source and Effective Dates

R.1988 d.62, effective February 1, 1988.

See: 19 N.J.R. 1978(a), 20 N.J.R. 278(b), 20 N.J.R. 401(a).

- 10:49-3.19 HealthStart Maternity Care Code requirements
Public notice: Pursuant to N.J.S.A. 30:4D-2, 3, 5, 6 and 7 and the New Jersey Appropriations Act (P.L.1988, c. 47), maximum fee allowance for HealthStart Maternity Care Services in (b) increased effective October 1, 1988 and April 1, 1989.

SUBCHAPTER 5. FAIR HEARINGS

Authority

Unless otherwise expressly noted, all provisions of this subchapter were adopted pursuant to authority of N.J.S.A. 30:4D-1 et seq. and were filed and became effective on August 10, 1973, as R.1973 d. 221. See: 5 N.J.R. 145(a), 5 N.J.R. 308(b). Amendments which repealed this subchapter were filed on June 20, 1977, as R.1977 d. 213 to become effective on July 1, 1977. See: 9 N.J.R. 123(b), 9 N.J.R. 342(c). Amendments which restored this subchapter were filed and became effective on August 15, 1978, as R.1978 d. 280. See: 10 N.J.R. 399(a).

- 10:49-5.3 Opportunity for fair hearing
As amended, R.1976 d. 136, effective May 25, 1976.
See: 8 N.J.R. 183(d), 8 N.J.R. 286(c).
As amended, R.1980 d. 512, effective November 24, 1980.
See: 12 N.J.R. 581(b), 13 N.J.R. 17(f).
See: 20 N.J.R. 2101(a).
Administrative Correction: Deleted the price of \$521.00 Maximum fee allowance for WM in W9030WM; claim form changed from MC-19 to MC-14.
See: 20 N.J.R. 2400(f).

- 10:49-3.20 HealthStart Pediatric Care Codes
Public notice: Pursuant to N.J.S.A. 30:4D-2, 3, 5, 6 and 7 and the New Jersey Appropriations Act (P.L.1988, c.47), maximum fee allowance for HealthStart Pediatric Care Services in (e) increased effective October 1, 1988 and April 1, 1989.
See: 20 N.J.R. 2101(a).

- 10:49-5.4 Advance notice of intent to terminate, reduce or suspend assistance
As amended, R.1980 d. 512, effective November 24, 1980.
See: 12 N.J.R. 581(b), 13 N.J.R. 17(f).
- 10:49-5.5 Location of the hearing
As amended, R.1980 d. 33, effective January 17, 1980.
See: 11 N.J.R. 623(c), 12 N.J.R. 86(f).
- 10:49-5.6 Impartiality of official conducting the hearing
As amended, R.1980 d. 512, effective November 20, 1980.
See: 12 N.J.R. 581(b), 13 N.J.R. 17(f).

SUBCHAPTER 6. ADMINISTRATIVE PROVISIONS

Subchapter Historical Note

Unless otherwise expressly noted, all provisions of this subchapter were adopted pursuant to authority of N.J.S.A. 30:4D-1 et seq. and were filed and became effective on July 29, 1971, as R.1971 d. 128. See: 3 N.J.R. 133(b), 3 N.J.R. 178(b). Amendments which repealed this subchapter were filed on June 20, 1977, as R.1977 d. 213 to become effective on July 1, 1977. See: 9 N.J.R. 123(b), 9 N.J.R. 342(c). Amendments adopting new text for this subchapter was filed and became effective on August 15, 1978, as R.1978 d. 280. See: 10 N.J.R. 399(a).

- 10:49-6.4 (Reserved)
Repealed by R.1983 d. 349, effective September 6, 1983.
See: 15 N.J.R. 1475(c), 16 N.J.R. 1075(a).
Section was "Rules governing reimbursement of Medicaid approved acute care general hospitals".
- 10:49-6.5 Recovery of payments correctly made
As amended R.1982 d. 147, effective May 3, 1982.
See: 14 N.J.R. 80(a), 14 N.J.R. 427(c).
Deleted existing text and replaced with (a)-(c).
- 10:49-6.6 Recoveries involving county welfare agencies/boards of social services
Repealed by R.1983 d. 349, effective September 6, 1983.
See: 15 N.J.R. 1075(a), 15 N.J.R. 1475(c).

New Rule: R.1991 d. 135, effective March 18, 1991.
See: 22 N.J.R. 2672(a), 23 N.J.R. 856(a).

This section formerly contained rules entitled "New Jersey Medical Formulary". They were no longer necessary due to the enactment of Drug Price Quality Stabilization Act (P.L.1977 c. 240, N.J.S.A. 24:6E-1). Replaced by R.1983 d. 349, effective September 6, 1983. See: 15 N.J.R. 1075(a), 15 N.J.R. 1475(c).

- 10:49-6.7 Contracts with county welfare agencies
As amended, R.1983 d. 349, effective September 6, 1983.
See: 15 N.J.R. 1075(a), 15 N.J.R. 1475(c).
Phrase "welfare agency" replaced "welfare board", language limiting reimbursement deleted.
- 10:49-6.8 Authority to adjust, comprise, settle or waive claims, liens and certificates of debt
R.1980 d. 502, effective November 14, 1980.
See: 12 N.J.R. 582(a), 13 N.J.R. 17(b).
As amended, R.1983 d. 349, effective September 6, 1983.
See: 15 N.J.R. 1075(a), 15 N.J.R. 1475(c).
References to Chief Creditor deleted, slight reconfiguration.
- 10:49-6.9 Administrative charges/service fees
New Rule, R.1988 d. 446, effective September 19, 1988.
See: 20 N.J.R. 518(a), 20 N.J.R. 2387(a).

SUBCHAPTER 7. PROVIDER REINSTATEMENT

Subchapter Historical Note

All provisions of this subchapter became effective September 3, 1980 as R.1980 d. 378. See: 12 N.J.R. 409(a), 12 N.J.R. 599(a). This subchapter was readopted pursuant to Executive Order 66(1978) effective August 12, 1985 as R.1985 d.463. See: 17 N.J.R. 1519(a), 17 N.J.R. 2139(a). See chapter and section levels for further amendments.

SUBCHAPTER 8. DEMONSTRATION PROJECTS

Subchapter Historical Note

Unless otherwise expressly noted, all provisions of this subchapter were adopted pursuant to authority of N.J.S.A. 30:4D-1 et seq. and were filed and became effective on July 21, 1976, as R.1976 d. 234. See: 8 N.J.R. 67(a), 8 N.J.R. 386(a).

SUBCHAPTER 9. REQUIREMENTS APPLICABLE TO SHARED HEALTH CARE FACILITIES

Subchapter Historical Note

Unless otherwise expressly noted, all provisions of this subchapter were adopted pursuant to authority of N.J.S.A. 30:4D-1 et seq. and were filed and became effective on March 2, 1977, as R.1977 d. 65. See: 8 N.J.R. 120(b), 9 N.J.R. 176(c).

SUBCHAPTER 10. PREPAID HEALTH CARE SERVICES: TITLE XIX ELIGIBLES

Authority

N.J.S.A. 30:4D-3b; 30:4D-6b(17), 30:4D-7, 7a, b and c, r; 30:4D-12; 42 CFR 434

Source and Effective Date

R.1992 d. 167, effective April 6, 1992.
See: 24 N.J.R. 64(a), 24 N.J.R. 1342(a).

Subchapter Historical Note

Subchapter 10, Prepaid Health Care Services; Title XIX Eligibles, was filed and became effective as R.1979 d. 231, effective June 13, 1979. See: 10 N.J.R. 394(a), 11 N.J.R. 346(b). Pursuant to Executive Order No. 66(1978), Subchapter 10 was readopted by R.1984 d. 211, effective May 18, 1984. See: 16 N.J.R. 675(a), 16 N.J.R. 1348(a). Pursuant to Executive Order No. 66(1978), Chapter 49 and its subchapters were readopted by R.1990 d. 390, effective July 13, 1990. See: 22 N.J.R. 1512(a), 22 N.J.R. 2313(a).

Subchapter 10 was repealed and replaced by new rules by R.1992 d. 167, effective April 6, 1992. See: 24 N.J.R. 64(a), 24 N.J.R. 1342(a).

Section annotations for prior rulemaking activity are as follows.

- 10:49-10.1 Definitions
Amended by R.1984 d. 211, effective May 18, 1984. See: 16 N.J.R. 675(a), 16 N.J.R. 1348(a).
Definitions added: "Federally qualified HMO"; "Nonrisk"; "Prepaid health plan" and "Risk" or "underwriting risk".
- 10:49-10.2 Criteria for contracting with the Department
Amended by R.1984 d. 211, effective May 18, 1984. See: 16 N.J.R. 675(a), 16 N.J.R. 1348(a).
(b) added.
- 10:49-10.3 Benefits
Amended by R.1984 d.211, effective May 18, 1984. See: 16 N.J.R. 675(a), 16 N.J.R. 1348(a).
Revised section.

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R.1977 d.409, effective October 27, 1977.
See: 9 N.J. 534(c).

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“Recipient” means a person who is a resident of the State of New Jersey and is determined to need medical care and services under N.J.S.A. 30:4D-1 et seq. and amendments thereto, and falls within the eligibility criteria set forth therein.

(b) 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.

(c) Regarding Medicaid Program services and eligibility, the New Jersey Medicaid Program became effective January 1, 1970 (P.L. 1968, c.413; codified as N.J.S.A. 30:4D-1 et seq.). The Program originally provided a broad array of medical services for individuals (aged, or blind, or disabled, or specified members of families with dependent children) categorically eligible for public assistance under the Social Security Act. Since then Medicaid coverage has been extended to the following:

1. Individuals who qualify under the Medically Needy provisions, codified as N.J.S.A. 30:4D-6(g);

2. Pregnant women and children (up to the age of six) whose income is less than 133 per cent of the Federal poverty level, codified as N.J.S.A. 30:4D-3(i)(9). These individuals are determined by the County Welfare Agency to be eligible for the New Jersey Care . . . Special Medicaid Programs;

3. Pregnant women and children (up to the age of one) whose income is less than 185 percent of the Federal poverty level, codified as N.J.S.A. 30:4D-3(i)(13); and

4. Individuals 65 years of age and older, or individuals who are blind or disabled (pursuant to Federal regulations either 42 CFR 435.530 et seq. or 42 CFR 455.540 et seq.) whose income cannot exceed 100 percent of the Federal poverty level adjusted for family size. These individuals are determined by the county welfare agency to be eligible for the New Jersey Care . . . Special Medicaid Programs, codified as N.J.S.A. 30:4D-3i(11).

10:49-1.3 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

(a) EPSDT is a Federally mandated comprehensive child health program for Medicaid recipients from birth through 20 years of age. The Omnibus Budget Reconciliation Act of 1989 (OBRA '89) codified EPSDT. Accordingly, the term “EPSDT Services” means the following:

SUBCHAPTER 1. GENERAL PROVISIONS

10:49-1.1 Scope and purpose

The Division of Medical Assistance and Health Services, under the Department of Human Services, administers the New Jersey Medicaid Program and 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.

10:49-1.2 The Medicaid Program: definitions, organizations, services and eligibility

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

“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.

“County welfare agency” 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 county welfare agency might be identified as the board of social services, the welfare board, the division of welfare, or the division of social 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.

“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 the Pharmaceutical Assistance to the Aged and Disabled Program, 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.

1. EPSDT Screening Services;
2. Vision Services;
3. Dental Services;
4. Hearing Services; and
5. Such necessary health care diagnostic services, treatment and other measures to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.

(b) A physician, independent clinic, or hospital outpatient department may provide EPSDT screening services.

10:49-1.4 HealthStart

HealthStart is a program to provide comprehensive maternity care services for all pregnant women (including those determined to be presumptively eligible) and child health care services for children (through two years of age) who are eligible for Medicaid benefits. Detailed information about this program is included in the Physician Services Manual or N.J.A.C. 10:54, Independent Clinic Services Manual or N.J.A.C. 10:66, Nurse-Midwifery Services Manual or N.J.A.C. 10:58 and the Hospital Services Manual or N.J.A.C. 10:52.

Case Notes

Exclusion of Medicaid funding for abortions except where necessary to save mother's life was unconstitutional. *Right to Choose v. Byrne*, 91 N.J. 287, 450 A.2d 925 (1982).

10:49-1.5 Prepaid health plans

"Prepaid health plan" means an entity that provides medical services to enrolled Medicaid eligibles under a contract with the Medicaid agency on the basis of prepaid capitation fees but does not necessarily qualify as an HMO. For policies and procedures 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.

10:49-1.6 Waivered programs

(a) The Division of Medical Assistance and Health Services also administers Respite and the following Home and Community-Based Services Waivers: Community Care Program for the Elderly and Disabled (CCPED); Home and Community-Based Services Waivers for Blind or Disabled Children and Adults (Medicaid Model Waivers I, II, and III); and AIDS Community Care Alternatives Program (ACCAP). An overview of these programs is provided at N.J.A.C. 10:49-17.

(b) The Division also provides oversight to the Division of Developmental Disabilities in its administration of its Home and Community-Based Services Waiver for developmentally disabled individuals.

10:49-1.7 State-funded programs

(a) In addition to the New Jersey Medicaid Program, the Division of Medical Assistance and Health Services also administers the following four State-funded programs:

1. Pharmaceutical Assistance to the Aged and Disabled Program (PAAD), see N.J.A.C. 10:49-21;
2. Lifeline Programs (utility assistance programs), see N.J.A.C. 10:49-22;
3. Hearing Aid Assistance for the Aged and Disabled, see N.J.A.C. 10:49-23; and
4. The Home Care Expansion Program, see N.J.A.C. 10:49-18.

Case Notes

Medical service not funded by Medicare or other insurance would be funded by Medicaid. *Monmouth Medical Center v. Harris*, 646 F.2d 74 (3rd Cir.1981).

10:49-1.8 Overview of provider manuals

(a) There are 19 New Jersey Medicaid provider manuals. Each is designed for use by a specific type provider that provides services to Medicaid recipients. 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 10:68, and 10:73, 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. 10:54—Physician Services Manual
6. 10:55—Prosthetic and Orthotic Services Manual
7. 10:56—Dental Services Manual
8. 10:57—Podiatry Services Manual
9. 10:58—Nurse—Midwifery Services Manual
10. 10:59—Medical Supplier Services Manual
11. 10:60—Home Care Services Manual
12. 10:61—Independent Clinical Laboratory Services Manual
13. 10:62—Vision Care Services Manual
14. 10:63—Long Term Care Services Manual
15. 10:64—Hearing Aid Services Manual
16. 10:65—Medical Day Care Services Manual
17. 10:66—Independent Clinic Services Manual
18. 10:67—Psychological Services Manual
19. 10:68—Chiropractic Services Manual
20. 10:73—Case Management Services Manual

(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. Manual revisions shall be substantially 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.

SUBCHAPTER 2. NEW JERSEY MEDICAID RECIPIENTS

10:49-2.1 Who is eligible for Medicaid?

Medicaid recipients are divided into two categories: those eligible for all services under the regular New Jersey Medicaid Program (see N.J.A.C. 10:49-2.2); and those eligible for a limited range of services under the Medically Needy Program (see N.J.A.C. 10:49-2.3).

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

(a) The following groups are eligible for medical and health services covered under the regular New Jersey Medicaid Program when provided in conjunction with specific Program requirements as outlined in the second chapter of each Provider Services Manual. The list is not all-inclusive.

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 county welfare agency. 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 recipient 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 12 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 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 recipient, 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 recipients 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 non-institutionalized SSI or State supplement recipient;

15. Pregnant women and children up to the age of 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(1) 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 of 60 days, 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.

10:49-2.3 Persons eligible under the Medically Needy Program

(a) A Medicaid recipient 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.

(b) 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.

(c) There are special income and resource levels established for the Medically Needy. If a person meets one of the categories listed in (b) 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 (b) 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.

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

1. Each Medically Needy applicant/recipient 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. 10:49-2.13—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.

(e) 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 county welfare agency 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.

10:49-2.4 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. 10:49-2.5); to determining presumptive eligibility for pregnant women (see N.J.A.C. 10:49-2.6); and to determining retroactive eligibility (see N.J.A.C. 10:49-2.7).

10:49-2.5 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 recipient. The policy and procedures follow:

1. Although both the mother and newborn infant may be Medicaid recipients on the date of delivery, the newborn infant is not immediately assigned a Person Number (see N.J.A.C. 10:49-2.10). 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 HSP (Medicaid) Case 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 county welfare agency. 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 HSP (Medicaid) Case 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 through March 31st using the mother's HSP (Medicaid) Case 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 HSP (Medicaid) Case 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 county welfare agency 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 county welfare agency 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 or not the patient is already eligible for Medicaid;

ii. Whether or not the patient has health insurance to cover the cost of hospital care and treatment; and

iii. Whether or not the person has sufficient income and/or resources to meet the cost of hospital care.

3. In the event that the date of the Medicaid eligibility which was established by the Social Security Administration or the county welfare agency is later than the date of admission, the recipient 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. 10:49-2.7).

10:49-2.6 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). This is a preliminary process to determine presumptive eligibility prior to the determination of Medicaid eligibility or ineligibility by the county welfare agency.

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 county welfare agency, 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 county welfare agency, 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 county welfare agency.

(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: **PRESUMPTIVELY ELIGIBLE PREGNANT WOMAN**. The second message appears in the message box on the upper right hand corner: **PROVIDERS ONLY: CALL 1-800-328-0065 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, 1-800-328-0065, during normal business hours (Monday through Friday, 8:30 A.M.-4:30 P.M.) or as soon as possible if the services are delivered other than during normal business hours.

3. When the provider requests verification for presumptive eligibility, he or she is required to provide the individual's name and HSP (Medicaid) Case Number, including the Person Number, to the operator.

4. The operator will advise the provider of the presumptive eligibility status on the date service is delivered and furnish him or her with an authorization number. The authorization number documents the verification of the Medicaid presumptive eligibility status for the provider.

5. Payment for services rendered without presumptive eligibility verification may be denied if the provider did not secure the required authorization number which verified the eligibility status, as noted in (d)4 above.

10:49-2.7 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(e)), 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, CN-712-10, Trenton, New Jersey 08625.

1. An application for retroactive eligibility may be obtained by the applicant, or his or her authorized agent, from the county welfare agency, 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 recipient, a retroactive eligibility determination shall be completed by the county welfare agency (see N.J.A.C. 10:49-2.3, Persons eligible under the Medically Needy Program).

10:49-2.8 Verification of eligibility for Medicaid services

(a) Each Medicaid recipient, except Nursing Facility recipients, has an HSP (Medicaid) Case Number printed on a Medicaid form that validates eligibility. The recipient 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. 10:49-2.10 for a description and information about the HSP (Medicaid) Case Number and see N.J.A.C. 10:49-2.11 for information about the Medicaid forms that are used to validate eligibility. The Recipient Eligibility Verification System (REVS) can be used, in some instances, as an alternative to viewing a form used to validate eligibility (see N.J.A.C. 10:49-2.9).

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.

10:49-2.9 Recipient Eligibility Verification System (REVS)

In the event a recipient is unable to produce a form that validates Medicaid eligibility (see N.J.A.C. 10:49-2.11) and the recipient's HSP (Medicaid) Case 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 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 of each Provider Services Manual.

10:49-2.10 HSP (Medicaid) Case Number

(a) An HSP (Medicaid) Case Number consists of 12 digits, which includes a two-digit Person Number. The components of an HSP (Medicaid) Case Number as it is initially assigned to a recipient 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 recipients (that is, the Medicaid Only Program and New Jersey Care . . . Special Medicaid Programs for Aged, Blind, and Disabled) the first two digits of the HSP (Medicaid) Case Number designate the county of residence where eligibility was originally determined but not necessarily the location where the recipient is currently residing. In these instances, when the recipient moves to another county, the recipient retains the HSP (Medicaid) Case Number of the original county of application. However, the eligibility identification card will indicate the current address.

2. For recipients in certain State or county facilities, the first two digits of the HSP (Medicaid) Case Number designate the facility where the recipient 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 serving that facility. For those facilities below marked by an asterisk(*), it should be noted that when the first two digits of an HSP (Medicaid) Case 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 recipient.

i. Identification of State and County Psychiatric Facilities

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

ii. Identification of Intermediate Care Facilities/Mental Retardation

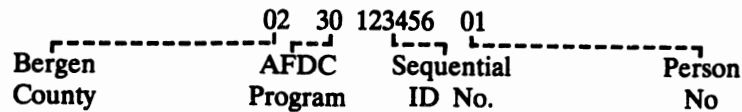
- *34—(800,000 series) Ancora Development Center (Camden MDO).
- 35—North Princeton Development Center (Hunterdon MDO)
- 41—Vineland Developmental Center (Cumberland MDO)
- 42—North Jersey Developmental Center (Totowa) (Passaic MDO)
- 43—Greenbrook Regional Center (Hunterdon MDO)
- 44—Woodbine Developmental Center (Cumberland MDO)
- 45—New Lisbon Developmental Center (Burlington MDO)
- 46—E. R. Johnstone Training and Research Center (Middlesex MDO)
- 47—Woodbridge Developmental Center (Middlesex MDO)
- 48—Hunterdon Developmental Center (Hunterdon MDO)

iii. 51—Soldiers Homes (Unit Dose Drugs) (MDO in county in which home is located)

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

(c) The third and fourth of the 12-digit HSP (Medicaid) Case Number designate the category under which a person was determined eligible for the New Jersey Medicaid Program. For some adult recipients (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 HSP (Medicaid) Case 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 recipients reach age 65.

10—Aged—SSI related (65 years of age or older)



10:49-2.11 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 four forms:

1. Department of Human Services—"Medicaid-ID" (FD-152) (see N.J.A.C. 10:49-2.12);

- 15—Aged—Medically Needy (65 years of age or older)
- 20—Disabled—SSI related (under 65 years of age)
- 25—Disabled—Medically Needy (under 65 years of age)
- 30—Aid to Families with Dependent Children (AFDC). New Jersey Care . . . Special Medicaid Programs 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 under the Institutional Services Section of the Division of Medical Assistance and Health Services).
- 70—Medical Assistance for Aged—A New Jersey State Program
- 80—Refugee Program

(d) The fifth through tenth digits of the HSP (Medicaid) Case Number designate the sequential identification number of the Medicaid recipient.

(e) The 11th and 12th digits of the HSP (Medicaid) Case Number designate the specific Person Number assigned to each recipient.

- 01-04 Adult (any age)
- 05 Pregnant Women
- 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 recipient (caretaker/parent) from Bergen County receiving assistance under Aid to Families with Dependent Children (AFDC) Program could have the following HSP (Medicaid) Case Number:

2. "Medicaid Eligibility Identification Card" (FD-73/178) (see N.J.A.C. 10:49-2.13);

3. "Validation for Health Services Program" (DYFS 16-36) (see N.J.A.C. 10:49-2.14); or

4. "Validation of Eligibility" (FD-34) (see N.J.A.C. 10:49-2.15).

10:49-2.12 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 recipient to whom it is issued.

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

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

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

3. One of the following three messages may be printed on the FD-152 form issued by the County Welfare Agency. 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: "HMO-CHECK GSHP ID CARD". This recipient and all members of his or her family listed on the Medicaid ID Card are enrolled in the Garden State Health Plan, a State-operated health maintenance organization. Each family member chooses a primary care physician known as a physician case manager. To obtain service, this recipient shall also present the Garden State Health Plan Identification Card. This gold colored card lists each family member and the name and telephone number of the member's physician case manager. The member's physician case manager shall either authorize or personally provide all medical services. (See N.J.A.C. 10:49-20, Garden State Health Plan.)

ii. Message Two: "RESTRICTED USE HMO-CALL (NUMBER LISTED)" or "HMO COVERAGE-CHECK HMO ID CARD". This recipient (and any member of his or her family on the AFDC grant) is enrolled in a Health Maintenance Organization (HMO). The provider shall call the telephone number listed on either the FD-152 validation card or on the HMO ID Card to determine whether the service or the item he or she is being asked to provide is provided by the HMO. If a provider provides a service available through the HMO, reimbursement will be denied by the New Jersey Medicaid Program, except in medical emergencies.

iii. Message Three: "OTHER COVERAGE"—There will be an asterisk (*) before the name of the recipient(s) 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).

10:49-2.13 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 or quarterly as indicated in (a)1 and 2 below.

1. The MEI Card is issued monthly to:

i. 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;

ii. Persons determined by the county welfare agency to be eligible for the New Jersey Care ... Special Medicaid Programs and the Medically Needy Program; and

iii. Recipients in the Special Status Program (see (e)2 below); and

2. The MEI card is issued quarterly for 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 recipient. However, several special programs list all eligible persons in the family; for example, for New Jersey Care ... Special Medicaid Programs all Medicaid recipients in the family are listed on the MEI card; the Special Status Program also identifies all recipients in the family on the MEI card.

1. When the MEI Card is issued to the Medically Needy, more than one recipient 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 recipient 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 recipients.

(d) The MEI Card is valid only when signed by the Medicaid recipient or his or 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 Waivers (see N.J.A.C. 10:49-17); Home Care Expansion Program (see N.J.A.C. 10:49-18); and Garden State Health Plan (see 10:49-20).

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

2. The MEI Card for the Medicaid "Special Status Program" either restricts the Medicaid recipient(s) listed on the MEI Card to a single provider, except in a medical emergency, or warns providers that the recipient'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 recipient 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 recipient. The service code will enable the provider to determine which services are available to each Medically Needy recipient (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.

10:49-2.14 Validation Form (DYFS-16-36) Validation for Health Services Program (Medicaid)

(a) The DYFS-16-36 Validation Form (see Appendix, N.J.A.C. 10:49) is issued by the Division of Youth and Family Services (DYFS) to certain eligible children (Medicaid recipients). This form indicates eligibility for covered health services during the months shown on the form itself.

1. The validation form shall be retained by the recipient to whom it is issued.

2. The form is the indicator of eligibility for this group of children.

- i. Any Medicaid recipient enrolled in a HMO shall also be required to show his or her HMO ID Card.
- ii. The HSP (Medicaid) Case Number shall be entered exactly as it appears on the validation form on all requests for authorization of services and when submitting claim forms.

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 recipient 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 recipient (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 resident.

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

3. The Medicaid resident or patient of a State or county institution receiving covered health services in the community is identified by the 12-digit HSP (Medicaid) Case 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 from each institution and family care residents who are under the jurisdiction of the Division of Developmental Disabilities. If the patient/resident's HSP (Medicaid) Case Number begins with any of the following numbers, providers shall contact the Medicaid District Office (MDO) indicated (for MDO Directory, see Appendix at N.J.A.C. 10:49).

- 31—Morris MDO
- 32—Mercer MDO
- 32—Hunterdon MDO (Applicable only to 600,000 series)
- 33—Monmouth MDO
- 34—Camden MDO
- 35—Hunterdon MDO
- 36—Monmouth MDO
- 37—Bergen MDO
- 37—Hudson MDO (Applicable only to 600,000 series)
- 38—Essex—Suburban MDO

- 39—Camden MDO
- 41—Cumberland MDO
- 42—Passaic MDO
- 43—Hunterdon MDO
- 44—Cumberland MDO
- 45—Burlington MDO
- 46—Burlington MDO
- 47—Middlesex MDO
- 48—Hunterdon MDO
- 90—MDO in county in which recipient resides.

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 county welfare agency 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 1-800-321-BABY.

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. Chiropractors and/or chiropractic groups;

2. Clinics (independent outpatient health care facilities);
3. Clinical laboratories;
4. Dentists and/or dentist groups;
5. Hearing aid dealers;
6. Health maintenance organizations;
7. Home health agencies;
8. Homemaker agencies;
9. Hospices;
10. Hospitals;
 - i. General;
 - ii. Psychiatric; and
 - iii. Special;
11. Nursing facilities, including intermediate care facilities for the mentally retarded;
12. Medical suppliers;
13. Medical day care centers;
14. Nurse-midwives;
15. Opticians;
16. Optometrists;
17. Orthotists;
18. Pharmacies;
19. Physicians and/or physician groups;
20. Podiatrists and/or podiatrist groups;
21. Prosthetists;
22. Psychologists and/or psychologist groups;
23. Residential treatment facilities;
24. Transportation providers; and
25. State and county agencies that have agreed to provide personal care assistant services.

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.

10:49-3.2 Enrollment process

(a) Providers shall be required to complete a Medicaid Provider Application and sign a Provider Agreement (see Appendix, 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 N.J.A.C. 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 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 to enroll 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 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 Division 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 Division 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.

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) The New Jersey Medicaid Program requires that all providers (except independent clinical laboratories, nursing facilities, and pharmacies) applying to participate in the Program or presently participating in the Program, identify each and every branch or satellite location from which they shall provide services to Medicaid recipients.

(b) Each separate location shall meet all required standards for participation in the New Jersey Medicaid Program and shall be uniquely identified, if approved for participation. Services rendered to Medicaid recipients at an unapproved satellite shall not be billed and will not be paid under the approved parent organization's provider number.

(c) Billing through a central location for approved multi-location providers shall be allowed; however, providers shall utilize the preaddressed claims for each office location as the claims reflect the proper address and provider number for that location. Selection of central or localized billing shall be left to providers, who shall state their preference on the application.

10:49-3.4 Medicaid Provider Billing Number

(a) Each Medicaid provider is assigned a Medicaid Provider Billing Number. The seven digit provider billing number is required on all Medicaid claim forms as a condition of payment.

(b) Certain Medicaid providers are also assigned an individual Medicaid Provider Services Number which must also appear on certain claim forms as detailed in the Medicaid Fiscal Agent Billing Supplement.

(c) Providers who, for billing purposes, need a referring practitioner's individual Medicaid Provider Services 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 Services Number. In the absence of the referring practitioner's individual Medicaid Provider Services 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 mid-wife, chiropractor, dentist, optometrist, podiatrist, or psychologist) shall supply his or her individual Medicaid Provider Services Number to other providers when referring a Medicaid recipient 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 Services Number on the claim form (see Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

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.

"Department" means the Department of Human Services.

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

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

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

"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, 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.

"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;
 - iii. Treatment rooms;
 - iv. Equipment;
 - v. Supporting staff;
 - vi. Common records; and
2. One or more of whom receives payment on a fee-for-service basis, and where the gross Medicaid income for the facility meets or exceeds \$80,000 per year.

"Specialty" means a health care practice within a discipline such as pediatrics, obstetrics/gynecology, orthodontics, periodontics, and so forth.

10:49-4.2 Scope

(a) This subchapter shall apply to shared health care facilities as defined herein and to providers located in a specific health care facility.

(b) This subchapter shall apply to purveyors, whether or not located in a building which houses a shared health care facility.

(c) Nothing in this subchapter shall apply to an association of health care providers delivering health services on other than a fee-for-service basis.

(d) This subchapter shall not apply to hospitals participating in the Medicaid Program.

10:49-4.3 Registration of shared health care facilities

(a) No shared health care facility shall be operated under the Program unless it has been registered with the Division. The Office of Program Integrity Administration, CN-712, Trenton, New Jersey 08625 is responsible for registration.

1. Providers within the shared health care facility shall designate one provider member who shall be responsible for registration:

- i. Said responsibility and liability by the designated provider, shall be limited to timely filing of accurate reports required under this section.

(b) Registration shall be made on forms furnished by the Division and shall contain the information required therein, including, but not limited to:

1. The name of the owner or owners of the facility;

2. The name, residence address and professional license number of every provider and purveyor working in the shared health care facility;

3. The name, residence address and curriculum vitae of the individual designated to assume responsibility for the central coordination and management of the shared health care facility's activities, if so designated;

4. The owner, lessor or lessee shall furnish to the Division a copy of the lease agreement upon request;

5. The name of any person, firm or corporation providing administrative, clerical or billing services to providers in shared health care facilities, other than employees of providers; and

6. The name and address of lessor of any space or equipment in the shared health care facility.

(c) The registrant shall re-register on the June 1 next following initial registration, and annually thereafter on June 1.

(d) The Division shall be notified, in writing, within 30 days of any change in:

1. The owner or owners of the facility;

2. The termination of the services of the individual designated to assume responsibility for coordination and management of the shared health care facility's activities. The Division shall also be notified within 30 days of the name, residence address and professional qualifications of any new individual appointed to assume such central administrative responsibility; and

3. Any addition or termination of any provider or purveyor in the shared health care facility. Such notification shall include the name, residence address and license number of each person appointed in place of such individual.

10:49-4.4 Prohibited practices; administrative requirements

(a) The Division shall not enter into any agreement of Medicaid participation, nor shall any payment be made to any provider in a shared health care facility where the rental fee for the letting of space or supportive professional or clerical services to a provider in a shared health care facility is calculated in whole or in part, directly or indirectly, as a percentage of earnings or billings of the provider for services rendered on the premises in which the shared health care facility is located.

(b) No purveyor or provider, whether or not located in a building which houses a shared health care facility, shall directly or indirectly offer, pay or give, or permit or cause to be offered, paid or given to any provider or purveyor, and no provider or purveyor shall directly or indirectly solicit, request, receive or accept from any purveyor or provider any sum of money, credit or other valuable consideration for:

1. Recommending or procuring goods, services or equipment of such purveyor or provider to any other person;

2. Directing patronage or clientele to such purveyor or provider; or

3. Influencing any person to refrain from using or utilizing goods, services or equipment of any purveyor or provider.

(c) Patient referral rules require that:

1. No provider in a shared health care facility or person employed in such facility shall refer a patient to another provider located in such a facility, unless the records of the referring provider pertaining to such patient clearly sets forth the justification for such referral;

2. Every provider practicing in a shared health care facility who treats a patient referred to him or her by another provider practicing in the same facility shall communicate in writing to the referring provider, the diagnostic evaluation and the therapy rendered. The referring provider shall incorporate such information into the patient's permanent record; and

3. The claim submitted to the Program by the provider to whom such patient has been referred shall contain the full name and individual Medicaid Provider Services Number of the referring provider, and shall identify the medical problem that necessitated the referral.

(d) Any pharmacy maintaining a business in the same building in which a shared health care facility is located shall prominently post a notice informing patients that all pharmaceuticals prescribed in the Program may be obtained at any pharmacy of the recipient's choice.

(e) No purveyor or provider other than a physician, dentist, podiatrist, optometrist or chiropractor, who maintains a business in the building in which a shared health care facility is located, shall maintain a door or window opening into the offices or waiting room of the shared health care facility.

(f) All provider claims submitted for services rendered at a shared health care facility shall contain the registration code (SHCF Number) of the facility at which the service was performed. The individual Medicaid Provider Services Number of the practitioner rendering the service must also be entered on the claim form. The practitioner who rendered the service or his or her authorized representative must sign and date the claim form.

(g) The requirements set forth in the Medicaid Program Provider Services Manuals for each respective discipline shall apply to services rendered at a shared health care facility.

(h) It shall be unlawful for any provider to pay a bonus, commission or fee to any other provider based on business supplied or referred.

10:49-4.5 Quality of care requirements

(a) To ensure quality, continuity and proper coordination of medical care, each shared health care facility shall:

1. Where feasible, designate an individual who, on a full-time basis, shall coordinate and manage the facility's activities;
2. Devise an appropriate means of insuring that patients shall be scheduled to return for appropriate follow-up care and shall be treated by a provider familiar with patient's medical history;
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 Medicaid 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.

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 recipients eligible for the regular New Jersey Medicaid Program. Services available to Medically Needy recipients 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 authorization from the Program before the services are provided (see N.J.A.C. 10:49-6, Authorization Required).

10:49-5.2 Services available to recipients eligible for the regular Medicaid Program

(a) The services listed below, in alphabetical order, are available to recipients 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 (services in an independent outpatient health care facility, other than hospital, that provides services such as Mental Health, Family Planning, Dental, Optometric, Ambulatory Surgery, etc.);
5. Dental services;
6. Early and Periodic Screening, Diagnosis, and Treatment for recipients under age 21 (EPSDT): A preventative health care program for recipients 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's improved pregnancy outcome criteria; physicians; and nurse midwives; either directly or through linkage with other HealthStart care providers. (See N.J.A.C. 10:49-1.4 for applicable Provider Services Manuals regarding HealthStart services, 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 recipients);

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, livery, 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).

10:49-5.3 Services available to recipients eligible for the medically needy program

(a) Regular Medicaid services are available to Medically Needy recipients 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 recipient's name on the Medicaid Eligibility Identification Card to ascertain the Medically Needy group under which the recipient'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 not available to any Medically Needy group.

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).

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).

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 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 shall not be billed to the Medicaid Program when provided for a Medicaid recipient. Services and items provided without charge through programs of other public or voluntary agencies (for example, New Jersey State Department of Health, 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 recipients under EPSDT);

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 recipient 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 recipient 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 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 recipient'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 recipient statements.

iv. Therefore, any difference between the amount paid to the provider based on the claim submitted and the Division's value of the procedure as determined by the Division's evaluation, may be recouped by the Division of Medical Assistance and Health Services;

14. Any claim submitted by a provider for service(s) rendered, except in a medical emergency, to a Medicaid recipient whose Medicaid Eligibility Identification Card (FD-73/178) has a printed message restricting the recipient 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 recipient 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 Division. 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. Recipient income shall be presumed to equal the maximum income allowable for a Medicaid recipient for those recipients whose records relating to income are completely unavailable.

iii. The Division shall seek recovery of any resulting overpayments; and

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).

Cross References

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

Case Notes

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 (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 Manuals.

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 recipient 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 Director 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 recipient 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 recipient'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 recipient home from the hospital on a Friday evening. The recipient 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 recipient 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?"

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

(a) Services provided outside the United States and territories are not covered by the New Jersey Medicaid Program.

(b) 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.

(c) Prior authorization shall be required for all inpatient and outpatient hospital services provided outside the State of New Jersey except in the following situations:

1. Care provided in an emergency;

2. Interstate hospital transfers; and

3. Care provided to Medicaid recipients residing out-of-State at the discretion of the New Jersey Department of Human Services.

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

10:49-7.1 General provisions

(a) The following information outlines the rules 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.

(b) In addition to information in this subchapter about submitting claims for payment, a Fiscal Agent Billing Supplement is included following the second chapter of 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 crossover claims, and examples of timely submission of claims; electronic media claims (EMC) submission; Remittance Advice statements; procedure for Electronic Funds Transfer (EFT); adjustments for overpayment and underpayment 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, the latter takes precedence.

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. The claim may be submitted hard copy or by means of an approved method of automated data exchange. In order for a Medicaid claim to be considered for reimbursement, all appropriate documentation shall be included with the claim form.

1. 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; 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 recipient 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 form 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; intermediate care facility/mental retardation; residential treatment center; or 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" on the claim form.

(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, residential treatment center, or governmental psychiatric hospital. The time requirements for submitting a non-institutional claim is as follows:

1. A claim for payment of a non-institutional service provided to any Medicaid recipient 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 form if the claim form carries more than one date of service;

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

i. The claim form shall contain both the HSP (Medicaid) Case Number 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 recipient is eligible for both Medicare and Medicaid, a Medicare/Medicaid 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 crossover 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 Advise 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.

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 under this act.

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 recipient 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 recipient, subject to (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 deductible and co-insurance for certain inpatient hospital services (see (e)1i(1) below).

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 recipients 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 recipient 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 recipient by a third party on claims submitted to the third party by the provider.

(e) When a Medicaid recipient 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 coverage 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 recipient, providers shall inquire about Medicare eligibility especially if the third digit of the HSP (Medicaid) Case Number is a 1, 2, 5, or 7. Medicaid supplementation of available Medicare benefits shall be as follows:

i. Medicare (Title XVIII): For any Medicaid recipient who is covered under Medicare, responsibility for payment by the New Jersey Medicaid Program shall be limited to the unsatisfied deductible and/or co-insurance to the extent that the combined total of payments does not exceed the maximum allowable under the Medicaid Program in the absence of other coverage. The following exceptions should be noted:

(1) The Program shall pay the full amount of any unsatisfied Medicare deductible and/or co-insurance for inpatient hospital services billable to the Program in accordance with Chapter 83, P.L. 1978 (that is, inpatient hospital services subject to payment by the Program according to the New Jersey DRG reimbursement methodology).

(f) When a Medicaid recipient 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 form 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 claim forms: "(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;

2. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the Program;

3. The claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay; or

4. The claim involves a service for which HCFA has granted a waiver of the TPL cost avoidance requirements in accordance with 42 C.F.R. 433.139(e). Waivers have been granted for:

i. Pharmacy services; and

ii. Services covered by Medicare Part B which are rendered at State and county governmental psychiatric hospitals, State and private ICFs/MR and Vineland Special Hospital.

(i) In those situations where an insurance payment is received from another payer after Medicaid has been billed and has made payment, the provider must reimburse the Medicaid payment to the Medicaid Program and not the Medicaid recipient. Reimbursement must be made immediately to comply with Federal regulations. To initiate the process, providers must submit an Adjustment/Void Request Form. (See Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

(j) Regardless of the status of a provider's claim with other third parties, all claims for Medicaid reimbursement must be received by the Medicaid Fiscal Agent within the time frames specified in N.J.A.C. 10:49-7.2, Timeliness of claim submission.

(k) Any individual who undertakes to legally represent any Medicaid recipient in an action for damages against any third party when medical expenses have been paid by the Division shall be required to give written notice to the Division within 20 days of filing or commencing the action.

1. The term "legal representative" shall include, but not be limited to, an attorney, administrator/administratrix, executor/executrix, conservator, guardian or guardian ad litem.

Petition for Rulemaking.
See: 27 N.J.R. 770(b), 27 N.J.R. 1320(a).

10:49-7.4 Prohibition of payment to factors

(a) A "factor" means an individual or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provid-

er has assigned, sold or transferred to the individual organization for an added fee or deduction of a portion of the accounts receivable.

(b) Payment for any covered services furnished to any Medicaid recipient by an approved provider may not be made to or through a factor, either directly or by power-of-attorney.

10:49-7.5 Use of service bureau and/or management agency

(a) Payment may be made to a business agent, such as a billing service or an accounting firm, that furnishes statements and receives payment in the name of the provider if the agent's compensation for this service is:

1. Related to the cost of processing the billing;
2. Not related on a percentage or other basis to the amount that is billed or collected; and
3. Not dependent upon the collection of the payment.

(b) If a participating provider wishes to designate a business agent to perform management, clerical and/or other services related to the claims payment process, approval is required from the New Jersey Medicaid Program.

(c) In order to obtain approval the provider/agent shall submit a copy of the signed agreement and power-of-attorney, if any, between the provider and the agent which shall contain a detailed statement of the powers and duties of the agent (including the power to sign Medicaid claim forms on behalf of the provider and the compensation arrangement) to Provider Enrollment, New Jersey Medicaid Program.

(d) Approval shall be obtained for each provider/agent agreement. Approval of an agent agreement with one provider does not confer an automatic approval of any additional provider/agent agreement.

(e) Standard Medicaid hard-copy claim forms shall be used unless the provider has been authorized for electronic media claims submission; however, in some instances hard-copy claims are required. These instances are detailed, as applicable, in the appropriate Provider Services Manual.

1. If standard Medicaid claim forms are not utilized, the provider/agent shall obtain approval from the New Jersey Medicaid Program.

2. In order to obtain approval, the provider/agent shall submit a printer's prototype of an exact replica of the Medicaid claim form and the programming instructions for completion of the form to the Fiscal Agent.

3. The provider/agent shall assume the entire cost of printing duplicate forms at all times.

(f) The New Jersey Medicaid Program in approving any provider/agent agreement, assumes no responsibility for the performance of the provider or agent. In the event that any error of the provider/agent requires special programming to be made by the Medicaid Fiscal Agent in order to have claims paid correctly, the provider/agent shall assume the entire cost of the special program.

SUBCHAPTER 8. PAYMENT FOR SERVICES PROVIDED

10:49-8.1 Fiscal Agent

The State of New Jersey uses a fiscal agent for the processing of claims and payment to providers for all health services.

10:49-8.2 Claim payment

(a) The Fiscal Agent will process claims daily and produce provider payments and associated Remittance Advice (RA) statements once each week. The RA is the provider's account statement and reflects the status of all claims currently entered into the Medicaid Management Information System. Provider payments in the form of checks and electronic funds transfers will be released following approval by the New Jersey Medicaid Program.

1. The Remittance Advice (RA) is the major vehicle for communicating to the provider the status of all Medicaid claims received by the Fiscal Agent. All of the provider's claims are processed and supporting records are updated during each payment cycle. RA statements are generated as a result of a payment cycle. All claims processed (entered into the Medicaid Management Information System) fall into one of three classifications: paid; suspended; or denied.

i. A claim that is correctly completed for a covered service provided to a Medicaid recipient by an approved provider will be paid. The claim will appear on the RA Claims Status page, or pages, along with all other claims for which a provider is being paid in that payment cycle. If the amount differs from the billed charges, an explanation will appear on the RA.

ii. Suspended claims are those claims held for review by the Fiscal Agent. The review will result in a claim being paid, denied, or additional information being requested. If additional information is required, a Claim Correction Form (CCF) will be forwarded to the provider. (Additional billing information is provided in the Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

iii. Reasons for denial of a claim will be provided on the RA in the form of a code.

(1) Messages explaining all codes reflected on the Remittance Advice will be printed on a separate page.

(b) A unique 13 digit Internal Control Number (ICN) is assigned to each Medicaid claim received by the Fiscal Agent. The ICN is reflected on the RA and can be used to track the status of a claim. For more information about the ICN, see Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual.

(c) For each claim processed in a payment cycle, the ICN, recipient name, dates of service and other claim information is printed on the RA. On the line immediately below this information, a code is printed representing a denial reason, suspense reasons, and payment reduction reasons, if any. The only type of claim status that will not have a code is one that is paid as billed. Messages explaining all codes found on the RA will be found on a separate page following the status listing of all claims. For more information about Remittance Advice see Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual.

10:49-8.3 Adjustments following payment of claims

(a) If a claim is incorrectly paid and the provider receives an overpayment or underpayment, the provider shall notify the Fiscal Agent in writing. (For the procedure to follow, see Fiscal Agent Billing Supplement, Adjustment/Void Form, following the second chapter of each Provider Services Manual).

(b) On occasion, a claim will be paid that should not have been paid; for example, a duplicate payment. If a claim is paid in error, the provider shall notify the Fiscal Agent by requesting that the claim be voided. (For the procedure to follow, see Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual.)

(c) Any adjustment made by Medicare will not cross over to Medicaid. If Medicare makes an adjustment that results in an overpayment or underpayment by Medicaid, the provider shall notify the Fiscal Agent. (For the procedure to follow, see the Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual.)

10:49-8.4 Claims payment by direct deposit (electronic funds transfer (EFT))

(a) Through electronic funds transfer, a provider has the option of receiving claims payment automatically as a direct deposit to his or her checking account.

1. To enroll in the EFT payment program, the provider must complete an EFT Enrollment Request/Authorization form. A voided check displaying the provider's account number must accompany the complete authorization form. The enrollment form must be signed by the provider or an authorized official such as the business

manager, owner, or facility administrator. Any change to the EFT information (for example, a change of account number, ownership, or authorized official) requires the completion of a new EFT Enrollment Request/Authorization form. (For detailed instructions about enrollment in the EFT payment program, see Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

10:49-8.5 Outstanding checks

(a) After Medicaid checks are outstanding for a period of six months, a follow-up letter shall be sent to the payee. This procedure shall only apply to checks of \$5.00 or more.

(b) All Medicaid checks remaining outstanding after 12 months shall be cancelled in monthly lots rather than check by check. Listings of cancelled checks shall be in sufficient detail to identify providers and amounts of payment. These records shall be retained for audit.

SUBCHAPTER 9. PROVIDER AND RECIPIENT'S RIGHTS AND RESPONSIBILITIES; ADMINISTRATIVE PROCESS

10:49-9.1 Civil rights

Federal regulations require that services provided to any Medicaid recipient shall be given without discrimination on the basis of race, color, national origin, or handicap. Therefore, payments shall be limited to providers of service who are in compliance with the nondiscrimination requirements of Title VI of the Civil Rights Act and Section 504 of the Rehabilitation Act of 1973.

10:49-9.2 Observance of religious belief

(a) Nothing in the Medicaid Program shall be construed to require any recipient to undergo any medical screening, examination, diagnosis, or treatment, or to accept any other health care or services provided under the Program for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health) if such person or his or her parent or guardian objects thereto on religious grounds, except as specified in (b) below.

(b) If a physical examination is necessary to establish eligibility based on disability or blindness, the Medicaid Program may not find an individual eligible for Medicaid unless he or she undergoes the examination.

10:49-9.3 Free choice by recipient and provider

(a) The concept of freedom of choice shall apply to both provider and recipient.

1. A Medicaid recipient shall be free to choose providers of service who meet Program standards and who elect to participate in the Medicaid Program. The Medicaid District Office shall assist any recipient in obtaining services if the recipient cannot locate a provider. Exception: see N.J.A.C. 10:49-14.2, Special Status Programs.

2. A provider who accepts a recipient for care shall accept the Program's policies and reimbursement for all covered services and/or items provided or delivered during that period when, by mutual agreement, the recipient is under the provider's care. In the provision of professional services, the provider shall be bound by the code of ethics governing his or her profession.

10:49-9.4 Confidentiality of records

(a) All information concerning applicants and recipients acquired under this Program shall be confidential and shall not be released without the written consent of the individual or his or her authorized representative. If, because of an emergency situation, time does not permit obtaining consent before release, the Program shall notify the individual, his or her family, or authorized representative, immediately after releasing the information.

(b) The restriction on the disclosure of information shall not preclude the release of statistical or summary data or information in which applicants or recipients are not, and cannot be, identified; nor shall it preclude the exchange of information among providers furnishing services, Fiscal Agent of the Program, and State or local government agencies, for purposes directly connected with administration of the Program. Disclosure without the consent of the applicant or recipient shall be limited to purposes directly connected with the administration of the Program in accordance with Federal and State law and regulations.

1. Purposes directly connected with the administration of the Program shall include, but are not limited to:

- i. Establishing eligibility;
- ii. Determining the amount of medical assistance;
- iii. Providing services for recipients; and
- iv. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Program.

(c) The type of information about applicants and recipients that shall be safeguarded by the Program includes, but is not limited to:

1. Name and address;
2. Medical services provided;
3. Social and economic conditions or circumstances;
4. Program evaluations of personal information;

5. Medical data, including diagnosis and past history of disease or disability;

6. Any information received for verifying income eligibility and amount of medical assistance payments. Income information received from SSA or the Internal Revenue Service shall be safeguarded according to the requirements of the agency that furnished the data; and

7. Any information received in connection with the identification of legally liable third party resources as required under applicable Federal Regulations (42 C.F.R. 433.138).

Case Notes

Disclosure of grand jury materials to government departments for use in civil proceedings requires strong showing of particularized need that outweighs public interest in grand jury secrecy. *State v. Doliner*, 96 N.J. 236, 475 A.2d 552 (1984).

Regulation cited as example of confidential record rule the invocation of which overrides the subpoena power of the Office of Administrative Law. *Hayes v. Gulli*, 175 N.J. Super. 294, 418 A.2d 295 (Ch.Div. 1980).

10:49-9.5 Provider certification and recordkeeping

(a) All program providers, except institutional, pharmaceutical, and transportation providers, shall be required to certify that the services billed on any claim were rendered by or under his or her supervision (as defined and permitted by Program regulations); and all providers shall certify that the information furnished on the claim form is true, accurate, and complete.

1. All claim forms for covered services must be personally signed by the provider or by an authorized representative of the provider (for example, hospital, home health agency, independent clinic) unless the provider is approved for electronic media claims (EMC) submission by the fiscal agent. The provider must apply to the Fiscal Agent for EMC approval and sign an electronic billing certificate.

i. The following signature types are unacceptable:

- (1) Initials instead of signature;
- (2) Stamped signature; and
- (3) Automated (machine-generated) signature.

(b) Providers shall agree to the following:

1. To keep such records as are necessary to disclose fully the extent of services provided;
2. To furnish information for such services as the Program may request;
3. That where such records do not document the extent of services billed, payment adjustments shall be necessary;

4. That the services billed on any claim and the amount charged therefore are in accordance with the regulations of the New Jersey Medicaid Program;

5. That no part of the net amount payable under any claim has been paid, except that all available third party liability has been exhausted, in accordance with Program regulations; and

6. That payment of such amount, after exhaustion of third party liability, will be accepted as payment in full without additional charge to the Medicaid recipient or to others on his behalf.

10:49-9.6 Patient's (recipient) certification

(a) A recipient's certification, authorization to release information and payment request, shall, under ordinary circumstances, be signed after the services identified on the claim form are provided and before a claim for payment is submitted by the provider. The recipient is:

1. Certifying that the service(s) covered by a claim has been received;
2. Requesting payment for those services made on his or her behalf; and
3. Authorizing any holder of medical or other information to release to New Jersey Medicaid or its authorized agents any information needed for this or a related claim.

(b) A provider who is submitting claims via an approved electronic media claims submission shall request a waiver to obtain the recipient or representative's certification on the standard Patient Certification (Form FD-197) which the provider shall keep on file for each service rendered and shall make available upon request to representatives of the New Jersey Medicaid Program. Initials instead of a signature are unacceptable on the Patient Certification Form.

1. If a signed Patient Certification Form is not on file for each service, Medicaid reimbursement for the service shall be subject to recoupment.

(c) A provider who is submitting a hard-copy Medicaid claim form shall, under ordinary circumstances, obtain the recipient's certification on the Medicaid hard-copy claim form (appropriate to the provider), unless a waiver is requested to use the standard Medicaid Patient Certification (Form FD-197, see Appendix, N.J.A.C. 10:49). A waiver application may be obtained from the Fiscal Agent.

(d) For certain providers, an individualized certification form, as indicated in the specific service chapter of the appropriate provider manual, may be used in place of the standard Medicaid Patient Certification (Form FD-197).

(e) A Medicaid hard-copy claim form or a Patient Certification Form shall be completed by a provider before it is presented to the recipient for signature. A Medicaid recipi-

ent may not sign a blank Medicaid hard-copy claim or a Patient Certification Form prior to receiving services or as a condition for receiving services.

(f) When the recipient's signature is unobtainable, the following procedures may be used:

1. An illiterate recipient may make his or her mark (x), and the mark shall be witnessed by another person who signs his or her name and address on the Patient Certification Form (FD-197) or on the Medicaid hard-copy claim form.

2. If a recipient is physically or mentally incapable of signing, or is deceased, the form(s) may be signed on his or her behalf by:

- i. A parent;
- ii. A legal guardian;
- iii. A relation;
- iv. A friend;
- v. An individual provider;
- vi. A representative of an institution providing care or support;
- vii. A representative of a governmental agency providing assistance; or
- viii. An administrator or executor.

3. A brief explanation of the reason the recipient was not personally able to sign the form(s) and the relationship of the signee to the recipient shall be noted directly on the Medicaid hard-copy claim form or the Patient Certification Form (FD-197).

10:49-9.7 Integrity of the Medicaid Program

The New Jersey Medicaid Program, in order to maintain the integrity of the Program, strictly prohibits its employees from accepting gifts or gratuities of any kind and of any value from individuals, representatives of provider organizations or institutions who provide services and are reimbursed through the Program. This includes the prohibition of offers of special employment, consultation fees and all other gratuities by a provider, individual or facility.

10:49-9.8 Fraud and abuse

The New Jersey Medicaid Program shall employ methods to identify situations in which a question of fraud and/or abuse in the Program may exist. The Division shall refer to law enforcement officials situations in which there is valid reason to suspect that fraud has or may have been committed.

10:49-9.9 Informing individuals of their rights

(a) All claimants shall be informed of the following, in writing, at the time of application and at the time of any action affecting their claim:

1. Of their right to a fair hearing;
2. Of the method by which they may obtain a hearing;
3. That they may be represented by legal counsel or by a relative, friend, or other spokesperson, or they may represent themselves; and
4. Of legal services within the community from which they may receive legal aid.

10:49-9.10 Provisions for appeals; fair hearings

(a) Pursuant to N.J.A.C. 10:49-10, Fair Hearings, both providers and Medicaid recipients with the New Jersey Medicaid Program shall have the right to file for fair hearings.

(b) A provider may be granted a hearing because of the denial of a prior authorization request or issues involving the provider's status; for example, termination, debarment, suspension, and so forth, as described in N.J.A.C. 10:49-11.1, or issues arising out of the claims payment process.

(c) A Medicaid recipient may be granted a hearing because his or her claim for medical assistance is denied or is not acted upon with reasonable promptness, or because the recipient is aggrieved by any other agency action resulting in non-eligibility, denial, termination, reduction or suspension of such assistance.

(d) In order to obtain a fair hearing, the provider or the recipient shall submit a request in writing to the Fair Hearing Unit, Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625, outlining the reason for the request.

(e) Any nursing facility whose certification or Medicaid Provider Agreement is denied, terminated, or not renewed, may request a hearing in accordance with the appeals procedure described in the Nursing Facilities Services Manual.

SUBCHAPTER 10. NOTICES, APPEALS AND FAIR HEARINGS
10:49-10.1 Definitions

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

"Applicant" means any person who has made application for purpose of becoming a "qualified applicant."

"Claimant," when used within these rules, means applicant, qualified applicant or recipient as defined in this section.

"Department" means the Department of Human Services, the single State agency responsible for administering the New Jersey Medicaid Program and other special programs through the Division of Medical Assistance and Health Services.

"Notice" means an announcement of a policy decision by the Title XIX agency that may adversely affect the Medicaid recipient.

"Provider" means any person, public or private institution, agency or business concern lawfully providing medical care, services, goods and supplies authorized under N.J.S.A. 30:4D-1 et seq. and amendments thereto, holding, where applicable, a current valid license to provide such services or to dispense such goods or supplies.

"Qualified applicant" means any person who is determined to be eligible to receive benefits in accordance with N.J.S.A. 30:4D-1 et seq. and amendments thereto.

"Recipient" means a person who is a resident of this State and is determined to need medical care and services under N.J.S.A. 30:40-1 et seq. and amendments thereto, and falls within the eligibility criteria set forth therein.

10:49-10.2 Notices

(a) The Department/Division may print a notice of prospective policy changes affecting Medicaid recipients generally in one or more newspapers in New Jersey.

1. This public notice will be accompanied by a proposed rulemaking on the subject of the notice in the New Jersey Register.
2. The public notice may precede or be subsequent to the Register publication.
3. The Department of Human Services may proceed to adopt the regulatory changes pursuant to N.J.S.A. 52:14B-4 without providing further notice.

10:49-10.3 Opportunity for fair hearing

(a) An opportunity for a fair hearing may be granted to any provider requesting a hearing on any valid complaint or issue arising out of the claims payment process.

1. Such issues shall include, but not be limited to, denials of prior authorization and denial of claims submitted for payment.
2. Such requests for hearing shall be made in writing within 20 days from the date of the notice of the agency action giving rise to said complaint or issue.

3. For claim denial or payment adjustment, the 20 days' notice starts from the date in the right hand corner of the Remittance Advice Claims Status returned to providers with the Remittance Advice cover page (see Fiscal Agent Billing Supplement following the second chapter of each Providers Services Manual regarding the Remittance Advice cover page and Claims Status explanations and examples). Providers should include a photocopy of the applicable Claims Status page, highlighting the recipient and applicable edit code(s) when submitting a hearing request.

(b) An opportunity for fair hearing shall be granted to all claimants requesting a hearing because their claims for medical assistance are denied or are not acted upon with reasonable promptness, or because they believe the agency has erroneously terminated, reduced or suspended their assistance. The agency need not grant a hearing if the sole issue is one of a Federal or State law requiring an automatic termination, reduction or suspension of assistance affecting some or all claimants. Under this requirement:

1. A request for hearing shall be defined as any clear expression (submitted in writing) by claimants (or someone authorized to act on behalf of claimants) to the effect that they desire the opportunity to present their case to higher authority;

2. The freedom to make such a request shall not be limited or interfered with in any way, and departmental emphasis shall be on helping claimants to submit and process their case if needed;

3. Claimants shall have 20 days from the date of notice of departmental action in which to request a hearing;

4. The fair hearing shall include consideration of:

i. Any departmental action, or failure to act with reasonable promptness, on a claim for medical assistance, which includes undue delay in reaching a decision on eligibility, suspension of assistance or denial of such assistance in whole or in part;

ii. Department decision regarding:

(1) Eligibility for medical assistance in both initial and subsequent determinations;

(2) Amount of medical assistance or change in such assistance;

5. The Department may respond to a series of individual requests for fair hearings by arranging for a single group hearing. A consolidation of cases by the Department may be allowed only in cases which the sole issue involved is one of federal or State law or policy;

6. In all group hearings, whether initiated by the Department or by claimants, the policies governing fair hearings shall be followed. Thus, each individual claimant shall be permitted to present his or her own case and be represented in accordance with the provisions of N.J.A.C. 10:49-9.9(a)3; and

7. The Department shall not deny or dismiss a request for a hearing except where it has been withdrawn by claimant in writing or abandoned.

(c) For purposes of these rules, the right to a hearing is considered abandoned if claimants or their representative fail to appear at a scheduled hearing and, within five days after receipt of an inquiry as to whether they desire any further action on their request, no reply is received. Refusal of acceptance of a registered letter inquiring into contemplated further action by claimants shall constitute abandonment effective the date of refusal.

Case Notes

Opportunity for prompt posttermination hearing provided physician in connection with termination of his right to participate in state medical assistance program satisfied due process (also cited as N.J.A.C. 10:49-63). *Greenspan v. Klein*, 442 F.Supp. 860 (D.N.J.1977), (See *Greenspan v. Klein*, 550 F.2d 856 (3rd Cir.1977)).

10:49-10.4 Advance notice of intent to terminate, reduce, or suspend assistance

(a) In cases of any proposed action to terminate, reduce or suspend assistance, the Department shall give the claimant timely and adequate notice detailing the reasons for the proposed action. Under these requirements:

1. "Timely" means that the notice is dated at least 10 days before the action is to be taken; and

2. "Adequate advance notice" means a written notice that includes a statement of the action the Department intends to take, reasons for the proposed departmental action, the specific regulations that support, or the change in Federal or State law that requires, the action, the claimant's right to request a fair hearing, or in cases of a departmental action based on a change in law, the circumstances under which a hearing shall be granted, and the circumstances under which assistance shall be continued if a fair hearing is requested.

(b) In cases in which there is a request for a fair hearing within the advance notice period:

1. Assistance shall be continued until a decision is rendered unless:

i. It is determined at the hearing that the sole issue is one of Federal or State law or policy; and

ii. The Department promptly informs the claimant in writing that services shall be terminated or reduced pending the hearing decision.

2. If the Department's action is sustained by the hearing decision, the Department may institute recovery procedures against claimants to recoup the cost of any services furnished claimants to the extent the services were furnished solely by reason of this section.

(c) The Department may reinstate services if a claimant requests a hearing not more than 10 days after the effective date of the termination, suspension or reduction of eligibility or covered services.

1. If services are reinstated, they shall continue until a hearing decision is made unless it shall be determined at the hearing that the sole issue is one of Federal or State law or policy.

(d) The Department shall reinstate and continue services until a decision is rendered after a hearing if:

1. An action is taken to terminate, suspend or reduce eligibility or covered services without affording claimants adequate advance notice as defined herein;

2. Claimants request a hearing within 10 days of the date of the notice of action; and

3. The Department determines that the action to terminate, reduce or suspend assistance resulted from reasons other than the application of federal or State law or policy.

(e) If a claimant's whereabouts are unknown, as indicated by the return of unforwardable departmental mail directed to them, any discontinued services shall be reinstated if their whereabouts become known during the time they are eligible for services.

Cross References

Notification of approval or denial of nursing facility services by Medicaid District Office as under this section, see N.J.A.C. 10:63-1.8.

10:49-10.5 Location of hearing

The hearing shall be conducted at a reasonable time, date and place after adequate written notice of the hearing is given.

10:49-10.6 Impartiality of official conducting the hearing

The hearing shall be conducted by an Administrative Law Judge from the Office of Administrative Law or by other persons eligible to conduct hearings pursuant to the New Jersey Administrative Procedure Act, set forth in N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq.

10:49-10.7 Recipient's right to different medical assessment

When the hearing involves medical issues, such as those concerning a diagnosis or an examining physician's report or the medical review team's decision, and if the hearing officer considers it necessary to have a medical assessment other than that of the person or persons involved in making the original decision, such medical assessment shall be obtained at Departmental expense from a source satisfactory to the claimant and shall be made part of the record.

10:49-10.8 Hearing procedures

The hearing shall be conducted pursuant to the procedures set forth in the Administrative Procedures Act, and the Uniform Administrative Procedure Rules (N.J.A.C. 1:1). The Special Hearing Rules set forth at N.J.A.C. 1:10B apply to claimant (recipient) hearings. (See 42 C.F.R. 431.200, Subpart E).

10:49-10.9 Prompt, definitive and final action

Prompt, definitive and final administrative action shall be taken within 90 days from the date of the request for a fair hearing, except where claimant requests an adjournment.

10:49-10.10 Notification to claimants

Claimants shall receive a written final decision, in the name of the Department and shall be notified of their right to judicial review.

10:49-10.11 Action upon favorable decision to claimants

When the final hearing decision is favorable to claimants or when the Department decides in favor of claimants prior to the hearing, the Department shall make corrective payments retroactively to the date the incorrect action was taken or such earlier date as may be provided under State policy.

10:49-10.12 Hearing decision

(a) A final decision by the agency head shall specify the reasons for the decision and identify the supporting evidence or may incorporate by reference the findings, conclusions, and recommendations, contained in the initial decision.

(b) Final decisions shall be binding on the Department.

(c) Under this rule, no person who participated in the local decision being appealed shall participate in a final administrative decision on such a case; the Department shall be responsible for seeing that the decision is carried out promptly.

(d) The final decision shall be promptly implemented.

10:49-10.13 Accessibility of hearing decisions to local agencies and the public

The Department shall establish and maintain a method for informing, at least in summary form, all local agencies of all fair hearing decisions by the hearing authority and the decisions shall be accessible to the public (subject to the provisions of safeguarding public assistance information).

SUBCHAPTER 11. EXCLUSION FROM PARTICIPATION IN THE NEW JERSEY MEDICAID PROGRAM (SUSPENSION, DEBARMENT, AND DISQUALIFICATION)

Cross References

Termination of nursing facility provider agreement, good cause as under this section, see N.J.A.C. 10:63-1.6.

10:49-11.1 Program participation

(a) The provisions of this section were adopted and issued pursuant to Executive Order No. 34, dated March 29, 1976, and the authority vested in the Division of Medical Assistance and Health Services to implement the New Jersey Medicaid Program by rules and regulations set forth in N.J.S.A. 30:4D-5, and by N.J.S.A. 30:4D-17.1a and c.

(b) Suspension, debarment, and disqualification are measures which shall be invoked by the Division of Medical Assistance and Health Services to exclude or render ineligible certain persons from participation in contracts and subcontracts with the Division, or in projects or contracts performed with the assistance of and subject to the approval of the Division, on the basis of a lack of responsibility. These measures shall be used for the purpose of protecting the interests of the Division and not for punishment. To assure the Division the benefits to be derived from the full and free competition between and among such persons and to maximize the opportunity for honest competition and performance, these measures shall not be invoked for any time longer than deemed necessary to protect the interests of the Division.

1. Any individuals, including, but not limited to, owners, officers, administrators, assistant administrators, employees, accountants, attorneys, and management services, who have been suspended, debarred or disqualified from participation in the Medicaid Program for any reason shall not be involved in any activity relating to the New Jersey Medicaid Program.

2. Providers reimbursed on a cost-related basis may not claim as allowable costs any amounts paid or credited to such individuals, and such amounts shall not be reimbursed by the New Jersey Medicaid Program.

3. Providers reimbursed on a fee-for-service basis may not submit claims and shall not be reimbursed for any goods supplied or services rendered by such individuals.

4. The above policy shall apply only for the period during which such individuals are suspended, debarred or disqualified from Medicaid participation.

(c) Definitions, as used in this section, shall include the following:

“Affiliates” means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

“Debarment” means an exclusion from State contracting, on the basis of a lack of responsibility evidenced by an offense, failure or inadequacy of performance, for a reasonable period of time commensurate with the seriousness of the offense, failure or inadequacy of performance.

“Disqualification” means a debarment or a suspension which denies or revokes a qualification to bid or otherwise

engage in State contracting which has been granted or applied for pursuant to statute, or rules and regulations.

“Division” means the Division of Medical Assistance and Health Services, which administers Medicaid, Federally waived programs (see N.J.A.C. 10:49-1.6) and state funded programs (see N.J.A.C. 10:49-1.7).

“Fiscal Agent” means an entity which processes and pays claims on behalf of the State of New Jersey.

“Person” means any natural person, company, firm, association, corporation or other entity.

“Provider” means any person, public or private institution, agency or business concern lawfully providing medical care, services, goods and supplies authorized under the New Jersey Medicaid Program P.L. 1968, c.413 (N.J.S.A. 30:4D-1 et seq.), as amended, holding, where applicable, a current valid license to provide such services or to dispense such goods or supplies.

“State” means the State of New Jersey or any of the departments or agencies in the executive branch of government with the lawful authority to engage in contracting.

“State contracting” means any arrangement giving rise to an obligation to supply anything to or perform any service for the State, other than by virtue of State employment, or to supply anything to or perform any service for a private person where the State provides substantial financial assistance and retains the right to approve or disapprove the nature or quality of the goods or service or the persons who may supply or perform the same.

“Suspension” means an exclusion from State contracting for a temporary period of time, pending the completion of an investigation or legal proceedings.

(d) Any of the following, among other things, shall constitute a good cause for suspension, debarment, or disqualification of a person engaged in State contracting, as defined herein, by the Division of Medical Assistance and Health Services:

1. Commission of a criminal offense as an incident to obtaining or attempting to obtain a public or private contract, or subcontract thereunder, or in the performance of such contract or subcontract;

2. Violation of the Federal Organized Crime Control Act of 1970, or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, perjury, false swearing, receiving stolen property, obstruction of justice or any other offense indicating a lack of business integrity or honesty;

3. Violation of the Federal or State antitrust statutes, or of the anti-kickback provisions of the Social Security Act at 42 U.S.C. 1320a-7b (b), subject to the exceptions set forth in 42 CFR 1001.952;

4. Violations of any of the laws governing the conduct or elections of the State of New Jersey or of its political subdivisions;

5. Violation of the "Law Against Discrimination" (P.L. 1945, c.169, N.J.S.A. 10:5-1 et seq. as supplemented by P.L. 1975, c.127), or of the "Act Banning Discrimination in Public Works Employment" (N.J.S.A. 10:2-1 et seq.) or of the "Act Prohibiting Discrimination by Industries Engaged in Defense Work in the Employment of Persons Therein" (P.L. 1942, c.114, N.J.S.A. 10:1-10 et seq.);

6. Violations of any laws governing hours of labor, minimum wage standards, prevailing wage standards, discrimination in wages, or child labor;

7. Violations of any laws, regulations or code of ethics governing the conduct of occupations or professions or regulated industries;

8. Willful failure to perform in accordance with contract specifications or within contractual time limits;

9. A record of failure to perform or of unsatisfactory performance in accordance with the terms of one or more contracts, provided that such failure or unsatisfactory performance has occurred within a reasonable time preceding the determination to debar and was caused by acts within the control of the person debarred;

10. Violations of contractual or statutory provisions regulating contingent fees;

11. Presentment for allowance or payment of any false or fraudulent claim for services or merchandise;

12. Submitting false information for the purpose of obtaining greater compensation than that to which the person is legally entitled;

13. Submitting false information for the purpose of obtaining authorization requirements;

14. Failure to disclose or make available to the Division of Medical Assistance and Health Services or its authorized agent, records of services provided to or payments made on behalf of Medicaid recipients;

15. Failure to provide and maintain quality services to Medicaid recipients within accepted medical community standards as adjudged by a body of peers;

16. Engaging in a course of conduct or performing an act deemed improper or abusive of the New Jersey Medicaid Program following notification that said conduct should cease;

17. Breach of the terms of the Medicaid provider agreement entered into with the Division or failure to comply with the terms of the provider certification on the Medicaid claim form;

18. Overutilizing the New Jersey Medicaid Program by inducing, furnishing or otherwise causing an individual to receive service(s) or merchandise not otherwise required or requested by the recipient;

19. Rebating or accepting a fee or portion of a fee or charge for a Medicaid recipient referral;

20. Violating any provision of N.J.S.A. 30:4D-1 et seq. (New Jersey Medical Assistance and Health Services Act) as amended, or any rule or regulation promulgated by the Commissioner of Human Services pursuant thereto;

21. Conviction of any crime involving moral turpitude;

22. Submission of a false or fraudulent application for provider status to the Division or to its fiscal Agent;

23. Any other cause affecting responsibility as a State contractor of such serious and compelling nature as may be determined by the Division to warrant debarment, including such conduct as may be proscribed by the laws or contracts enumerated in this subsection, even if such conduct has not been or may not be prosecuted as violations of such laws or contracts;

24. Debarment by some other department or agency in the executive branch;

25. Suspension, debarment, disqualification or exclusion from participation in the Medicaid Program of another state; or

26. Suspension or exclusion from participation in the delivery of medical care or services under Title XVIII, XIX or XX of the Federal Social Security Act by the Secretary of the United States Department of Health and Human Services.

(e) Conditions for debarment shall be as follows:

1. Debarment shall be made only upon approval of the Director of the Division, except as otherwise provided by law.

2. The existence of any of the causes set forth in (d) above shall not necessarily require that a person be debarred. In each instance, the decision to debar shall be made within the discretion of the Director of the Division unless otherwise required by law, and shall be rendered in the best interests of the Division.

3. All mitigating factors shall be considered in determining the seriousness of the offense, failure or inadequacy of performance and in deciding whether debarment is warranted.

4. The existence of a cause set forth in (d)1 through 7 above shall be established upon the rendering of a final judgment or conviction by a court of competent jurisdiction or by an administrative agency empowered to render such judgment. In the event an appeal taken from such judgment or conviction results in reversal thereof, the debarment shall be removed upon the request of the debarred person unless other cause for debarment exists.

5. The existence of a cause set forth in (d)8, 9, 10 and 23 above shall be established by evidence which the Division or agency determines to be clear and convincing in nature.

6. The existence of a cause set forth in (d)1 through 7, 11 through 22, and 24 above shall be established by a preponderance of the believable evidence.

7. Debarment for the cause set forth in (d)24 above shall be proper, provided that one of the causes set forth in (d)1 through 23 above was the basis for debarment by the original debarring agency. Such debarment may be based entirely on the record of facts obtained by the original debarring agency, or upon a combination of such facts and additional facts.

(f) If the Division seeks to debar a person or his or her affiliates, the Division shall furnish such party with a written notice stating that debarment is being considered, setting forth the reasons for the proposed debarment and indicating that such party will be afforded an opportunity for a hearing if he or she so requests within a stated period of time. All such hearings shall be conducted in accordance with the provisions of the Administrative Procedure Act. However, where one department or agency has imposed debarment upon a party, a second department or agency may also impose a similar debarment without affording an opportunity for a hearing, provided that the second agency furnishes notice of the proposed similar debarment to that party and affords that party an opportunity to present information in his or her behalf to explain why the proposed similar debarment should not be imposed in whole or in part.

(g) Debarment shall be a reasonable, definitely stated period of time which as a general rule shall not exceed five years. Debarment for an additional period shall be permitted provided that notice thereof is furnished and the party is accorded an opportunity to present information in his or her behalf to explain why the additional period of debarment should not be imposed.

(h) Scope of debarment rules shall be as follows:

1. Except as otherwise provided by law, a debarment may be removed or the period thereof may be reduced at the discretion of the debarring agency upon the submission of a good faith application under oath, supported by documentary evidence, setting forth substantial and appropriate grounds for the granting of relief, such as newly discovered material evidence, reversal of a conviction or judgment, actual change of ownership, management or control, or the elimination of the causes for which the debarment was imposed.

2. A debarment may include all known affiliates of a person, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The offense, failure or inadequacy of performance of an individual may be imputed to a person with whom he or she is affiliated,

where such conduct was accomplished within the course of his or her official duty or was effected by him or her with the knowledge or approval of such person.

3. Debarment by the Director of any provider of service shall preclude such provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association to the Division of Medical Assistance and Health Services or its Fiscal Agent for any services or supplies he or she has provided under the New Jersey Medicaid Program, except for services or supplies provided prior to the debarment. No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the Division or its Fiscal Agent for any services or supplies provided by a person within such organization who has been debarred by the Director, except for services or supplies provided prior to the debarment.

4. When the provisions of this section are violated by a provider of service which is a clinic, group, corporation or other association, the Director may debar such organization and/or any individual person within said organization who is responsible for such violation.

(i) The Division may suspend a person in the public interest for any cause specified in (d) above, or upon a reasonable suspicion that such cause exists, or when, in the opinion of the Director, such action is necessary to protect the public welfare and the interests of the medical assistance Program.

(j) Conditions for suspension shall be as follows:

1. Suspension shall be imposed only upon approval of the Director of the Division and upon approval of the Attorney General, except as otherwise provided by law.

2. The existence of any cause for suspension shall not require that a suspension be imposed, and a decision to suspend shall be made at the discretion of the Director of the Division and of the Attorney General, and shall be rendered in the best interests of the Division.

3. Suspension shall not be based upon unsupported accusation, but upon adequate evidence that cause exists or upon evidence adequate to create a reasonable suspicion that cause exists.

4. In assessing whether adequate evidence exists, consideration shall be given to the amount of credible evidence which is available, to the existence or absence of corroboration as to important allegations, and to inferences which may properly be drawn from the existence or absence of affirmative facts.

5. Reasonable suspicion of the existence of a cause described in (d) above may be established by a judgment or order of an administrative agency, or court of competent jurisdiction, or by a judgment of conviction, grand jury indictment, accusation, arrest, or by evidence that such violations of civil or criminal law did in fact occur.

6. A suspension invoked by the Division for any of the causes described in (d) above may be the basis for the imposition of a concurrent suspension by another agency, which may impose such suspension without the approval of the Attorney General.

(k) The Division may suspend a person or his affiliates provided that within 10 days after the effective date of the suspension, the Division provides such party with a written notice stating that a suspension has been imposed and its effective date, setting forth the reasons for the suspension to the extent that the Attorney General determines that such reasons may be properly disclosed, stating that the suspension is for a temporary period pending the completion of an investigation and such legal proceedings as may ensue, and indicating that, if such legal proceedings are not commenced or the suspension removed within 60 days of the date of such notice, the party shall be given either a statement of the reasons for the suspension and an opportunity for a hearing, if he so requests, or a statement declining to give such reasons and setting forth the agency's position regarding the continuation of the suspension. Where a suspension by the Division has been the basis for suspension by another agency, the latter shall note that fact as a reason for its suspension.

(l) A suspension shall not continue beyond 18 months from its effective date unless civil or criminal action regarding the alleged violation shall have been initiated within that period, or unless debarment action has been commenced. Whenever prosecution or debarment action has been initiated, the suspension may continue until the legal proceedings are completed.

(m) Scope of suspension rules are as follows:

1. A suspension may include all known affiliates of a person, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The offense, failure or inadequacy of performance of an individual may be imputed to a person with whom he or she is affiliated, where such conduct was accomplished within the course of his official duty or was effectuated by him or her with the knowledge or approval of such person.

2. Suspension, by the Director, of any provider of service shall preclude such provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association to the Division of Medical Assistance and Health Services or its Fiscal Agent for any services or supplies he or she has provided under the New Jersey Medicaid Program, except for services or supplies provided prior to the suspension. No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the Division or its Fiscal Agent for any services or supplies provided by a person within such organization who has been suspended by the Director, except for services or supplies provided prior to the suspension.

3. When the provisions of this section are violated by a provider of service which is a clinic, group, corporation or other association, the Director may suspend such organization and/or any individual person within said organization who is responsible for such violation.

(n) Exclusion from State contracting by virtue of debarment, suspension or disqualification shall extend to all State contracting and subcontracting within the control or jurisdiction of the Division. However, when it is determined essential to the public interest by the Director of the Division, and upon filing of a finding thereof with the Attorney General, an exception from total exclusion may be made with respect to a particular State contract.

(o) Insofar as practicable, prior notice shall be given to the Attorney General and the Treasurer of any proposed debarment or suspension.

(p) The Division shall provide the State Treasurer with the names of all persons suspended or debarred and the effective date and term thereof, if any.

(q) This section shall be applicable to all persons, providers, contractors, Fiscal Agent, and their affiliates who engage in State contracting with the Division as defined in this section.

Law Review and Journal Commentaries

Defense of Health Care Fraud, Abuse Charges. Richard L. Friedman, 133 N.J.L.J. No. 7, 10 (1993).

Case Notes

Division alone could suspend provider's participation in Medicaid for crime possession of controlled dangerous substance and possession with intent to distribute. (Director's Final Decision). Div. of Medical Assistance and Health Services v. Kares, 8 N.J.A.R. 517 (1983).

Suspension of provider privileges upon indictment involving moral turpitude affirmed pending conclusion of proceedings. (Director's Final Decision). Div. of Medical Assistance and Health Services v. Rednor, 5 N.J.A.R. 430 (1981).

Suspension of Medicaid provider reserved as indicated crime (unauthorized wiretap) does not constitute a crime of moral turpitude. (Division's Final Decision). Div. of Medical Assistance and Health Services v. Dalglish, 3 N.J.A.R. 23 (1981), affirmed Dfk. No. A-4941-79 (App.Div.1982).

SUBCHAPTER 12. PROVIDER REINSTATEMENT

10:49-12.1 Definitions

As used in this subchapter, the following words shall have the following meanings, unless the context clearly indicates otherwise:

“Committee” means the Provider Reinstatement Committee.

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

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

“Person” means any natural person, company, firm, corporation, professional association, partnership, or other entity, who has been excluded from participation in the New Jersey Medicaid Program.

10:49-12.2 Requests for reinstatement

Persons who have been debarred, disqualified or suspended from participating in the New Jersey Medicaid Program or programs administered by the Division shall petition the Director for reinstatement in writing.

10:49-12.3 Petition by debarred, disqualified or suspended person

(a) Persons debarred or disqualified for a definitely stated period of time may petition the Director for reinstatement 90 days prior to the expiration of the period of debarment or disqualification.

(b) Persons disqualified for an indefinitely stated period of time may petition the Director for reinstatement after a disqualification period of eight years.

(c) Persons who have been suspended, debarred or disqualified as the result of an indictment, conviction or license revocation may immediately petition the Director for reinstatement upon acquittal, reversal of the conviction upon appeal or restoration of the license, whichever is applicable.

10:49-12.4 Director's powers

The Director may on his or her own motion order the reinstatement of debarred, disqualified or suspended persons or may refer the matter to the Provider Reinstatement Committee.

10:49-12.5 Provider Reinstatement Committee

(a) The Provider Reinstatement Committee shall be a non-standing committee that is convened for the purpose of evaluating requests for reinstatement.

1. The Committee shall be composed of three impartial officials of the Division appointed by the Director.

i. Under this requirement, the Committee members shall not have been directly involved in the debarment, disqualification or suspension of persons requesting reinstatement.

ii. The Chairperson of the Committee shall be an attorney from the Office of Legal and Regulatory Liaison/Division of Medical Assistance and Health Services.

iii. Whenever possible, the associate members of the Committee shall be one member of the Division staff from the same discipline as the debarred, disqualified or suspended persons and one member from the general administrative staff of the Division.

10:49-12.6 Criteria for reinstatement

(a) Reinstatement will not be granted unless it is reasonably certain that the causes which led to the debarment, disqualification or suspension shall not be repeated. In determining a person's fitness for reinstatement, the Committee and the Director may consider, among other factors:

1. Statements from debarred, disqualified or suspended persons setting forth the reasons why they should be reinstated;

2. Statements from private health insurers, indicating whether there have been any questionable claims submitted during the period of exclusion from Program participation;

3. Statements from peer review bodies, probation or parole officers or professional associates, attesting to their belief, supported by facts, that the causes which led to the debarment, disqualification or suspension shall not be repeated;

4. The absence of any pending criminal, licensing, or professional disciplinary proceedings;

5. Full restitution and the payment of any criminal fines imposed;

6. Full satisfaction of any civil penalties imposed;

7. Full satisfaction of interest payments;

8. Compliance with the terms and conditions of Consent Orders or Court Orders; and

9. Satisfaction of any conditions or requirements previously imposed by the Division.

Case Notes

A disqualified Medicaid provider must apply for reinstatement and satisfy all requirements of subchapter. *Div. of Medical Assistance and Health Services v. Kares*, 8 N.J.A.R. 517 (1983).

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

10:49-12.7 Committee procedures

(a) The Committee shall meet at the Division's central offices.

(b) Persons requesting reinstatement and/or their representative shall be notified, in writing, as to the time, date and place of the meeting.

(c) All correspondence concerning the meeting shall be directed to the Chairperson of the Committee.

(d) Persons requesting reinstatement may appear on their own behalf or be represented by counsel.

(e) The Committee shall be governed by the New Jersey Administrative Procedure Act concerning admissibility of evidence at the meeting.

(f) The Chairperson of the Committee shall rule on all procedural questions and objections that may be raised at the meeting.

(g) Persons requesting reinstatement shall have the burden of providing their fitness for reinstatement by a preponderance of the evidence.

(h) Persons may present evidence of their fitness for reinstatement by the testimony of witnesses under oath or by documentary evidence, or both.

(i) After reviewing the testimony and documentation presented, the Committee shall prepare a written report which discusses the testimony, contains findings of facts and recommended disposition.

(j) At least two members of the Committee shall concur in the recommended disposition.

(k) Copies of the Committee's report shall be sent to all parties at the meeting. Upon receipt of the Committee's report, the parties shall have the opportunity to submit written objections or exceptions to said report within the time period specified by the committee.

(l) After the expiration of the time period prescribed for the filing of the exceptions, the Committee's report, exceptions or objections thereto, evidence and any transcripts shall be forwarded to the Director.

(m) The Director shall have final decisional authority and may adopt, reverse or modify the Committee's recommended determination. The Director may also, for cause, remand the matter back to the Committee for further testimony.

SUBCHAPTER 13. PROGRAM CONTROLS

10:49-13.1 Medical review and evaluation

Under the provisions of Federal and State law, the Division of Medical Assistance and Health Services shall provide continuing review and evaluation of the care and services provided under the Program. This includes review of utilization of services of practitioners and other providers.

10:49-13.2 Audits

(a) A field audit shall be subject to the following:

1. "Completion of the field audit" for nursing facility providers for purposes of N.J.S.A. 30:4D-17(f) shall be defined in the following manner:

i. For all such audits and audit recovery cases pending on March 1, 1983, it shall mean the date that field work is completed, or the date information requested from the provider during the course of that field work is received, whichever is later.

ii. For all such audits and audit recovery cases pending on March 1, 1983, which are, have been or will be referred either to the Legal Action Committee, or to the Division of Criminal Justice or other agency for criminal investigation, it means the date the Office of Program Integrity Administration (OPIA) receives authorization to take administrative action.

iii. For all such audits initiated on or after March 1, 1983, it means the date the exit conference is completed or the date information requested from the provider during the course of the exit conference is received, whichever is later.

2. "Completion of the field audit" for all other providers for purposes of N.J.S.A. 30:4D-17(f) shall be defined in the following manner:

i. For all such audits and audit recovery cases pending on March 1, 1983, it means the date of final screening of the case file by the Assistant Director, Office of Program Integrity Administration (OPIA) or, if the case is referred to the Legal Action Committee or the Division of Criminal Justice, the date OPIA receives authorization to take administrative action;

ii. For all such audits initiated on or after March 1, 1983, it means the date of final screening of the case file by the Assistant Director, OPIA.

3. Notwithstanding any of the previous subsections, if after the screening of any provider audit initiated on or after March 1, 1983, the Assistant Director, OPIA, determines with reasonable justification that an act or omission on the part of the provider requires additional field work, the field audit shall be considered completed when the additional field work is completed.

4. Notwithstanding any of the previous subsections, if after the screening of any provider audit initiated on or after March 1, 1983, the Assistant Director, OPIA, determines with reasonable justification that an act or omission on the part of the provider requires that additional information or documentation be obtained from the provider, then a completed field audit shall be considered reopened and interest shall again accrue for the period beginning 20 days from the date the request for such information or documentation is received by the provider and ending on the date that all of the requested information or documentation is received by the agency making the request.

5. Notwithstanding any of the previous paragraphs, if all or part of any provider audit initiated on or after March 1, 1983, is referred to the Division of Criminal Justice or other agency for criminal investigation:

i. In the event no criminal action results from the referral the field audit shall be considered completed one year from the date the decision was made to refer the matter for criminal investigation; and

ii. In the event criminal action does result from the referral, the field audit shall be considered completed on the date OPIA receives authorization to take administrative action.

(b) "Final audit," for purposes of N.J.S.A. 30:4D-7m only, means that point in the audit process when the Division issues to the provider an audit report specifically designated as the "final audit" for a specified period audited.

Case Notes

Audit pending on effective date of regulation comes within purview of regulation. *Bridgeton Nursing Center, Inc. v. Div. of Medical Assistance and Health Services*, 8 N.J.A.R. 217 (1983), affirmed per curiam Dkt. No. A-165-83 (App.Div.1984).

SUBCHAPTER 14. RECOVERY OF PAYMENTS AND SANCTIONS

10:49-14.1 Recovery of payments correctly made

(a) Correctly paid benefits shall only be recoverable from the estate of an individual who was 65 years of age or older when he or she received medical assistance if:

1. The individual leaves no surviving spouse;
2. For estates coming into being between February 1984 and October 20, 1992, the individual leaves no surviving child;
3. For estates coming into being on or after October 21, 1992, the individual leaves no surviving child who is under the age of 21 or any surviving blind or permanently and totally disabled children;
4. The amount to be recovered is in excess of \$500.00; and
5. The gross estate is in excess of \$3,000.

(b) Paragraphs (a)4 and 5 above shall apply to recoveries from the estates of individuals who died on or after July 20, 1981, the effective date of P.L. 1981, c.217 (N.J.S.A. 30:4D-7.2a).

Amended by R.1994 d.524, effective October 17, 1994.
See: 26 N.J.R. 2757(a), 26 N.J.R. 4184(b).

Case Notes

Retroactive application of statute for recovery of Medicaid overpayments did not violate due process. In re: *Kaplan*, 178 N.J.Super. 487, 429 A.2d 590 (App.Div.1981).

10:49-14.2 Sanctions—Special Status Program

(a) The "Special Status Program" either restricts the Medicaid recipient(s) listed on the Medicaid Eligibility Identification (MEI) Card to a single provider, except in a medical emergency, or warns providers that the recipient'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 recipient for additional identification or to take other appropriate action.

1. The restrictive card is issued to Medicaid recipients determined to have misused, abused or overutilized their Medicaid benefits. Overutilization occurs when a recipient has utilized Medicaid services or items at a frequency or amount that is not medically necessary. Examples of misuse or abuse include, but are not limited to, medically harmful or inappropriate use of different drugs or provider services and forgery or alteration of prescriptions. A determination that there has been misuse, abuse or overutilization of benefits obtained by use of an MEI Card shall create a presumption that the recipients listed on the MEI Card were responsible for such actions. If this presumption is successfully rebutted by the Medicaid recipient, he or she shall not be enrolled in the Special Status Program.

i. A recipient shall be permitted to change the designated provider upon demonstration of good cause and the Division may grant the request.

ii. The Division may change the provider to which the recipient is restricted if a pattern of continued misuse, abuse or overutilization is evident.

iii. The recipient may request a contested case hearing in the following situations:

(1) If the recipient objects to being included in the special status program;

(2) If the recipient requests a change and the request is denied;

(3) If the agency causes undue delay in responding to the recipient's request for change.

2. The warning card is issued to Medicaid recipients determined to have had their MEI Card used by an unauthorized person or persons, or for an unauthorized purpose. The purpose of the warning card is to notify providers that the recipient's MEI Card has been used by an unauthorized person or persons, or for an unauthorized purpose. A message will be printed on the card alerting the provider to ask the Medicaid recipient for additional identification or to take other appropriate action. A determination that an MEI Card has been used by an unauthorized person or for an unauthorized purpose shall create a presumption that the recipients listed on the MEI Card were responsible for such actions. If this presumption is successfully rebutted by the recipient, the recipient shall not be issued a warning card.

10:49-14.3 Authority to adjust, compromise, settle or waive claims, liens, and certificates of debt

(a) The Commissioner, Department of Human Services; Director, Division of Medical Assistance and Health Services; Assistant Director, Office of Program Integrity Administration; or anyone serving in an acting capacity in any of those positions shall have the authority to adjust, compromise, settle or waive any claim, lien or certificate of debt arising under this act (N.J.S.A. 30:4D-1 et seq.), and to execute an appropriate release or document of discharge with respect to that claim, lien or certificate of debt.

(b) Such authority may be exercised by other officials only in the following limited circumstances:

1. The Chief of the Bureau of Administrative Control may compromise, settle or waive any claim or lien not arising under N.J.S.A. 30:4D-7(h) within the dollar limits specified by the Director, Division of Medical Assistance and Health Services; and

2. The Fiscal Agent may compromise, settle or waive claims arising under N.J.S.A. 30:4D-7(h) within the dollar limits specified by the Director, Division of Medical Assistance and Health Services.

10:49-14.4 Recoveries involving county welfare agencies

(a) The purpose of this section is to define areas of responsibility and establish basic principles and procedures in those collection activities in which the Division of Medical Assistance and Health Services (DMAHS), the Division of Economic Assistance (DEA) and/or a county welfare agency (CWA) may be involved. It is intended that maximum conservation of public funds be effected without duplication of effort. It is recognized that certain situations may fall into more than one of the following categories. Any such matter will be processed in accordance with the provisions of the first occurring applicable category.

(b) The following pertain to incorrectly granted assistance (cash and/or medical assistance):

1. In instances involving incorrect eligibility for medical assistance, whether or not in combination with cash assistance, the CWA shall determine the period(s) of ineligibility and ascertain from DMAHS the amount of medical assistance incorrectly granted. The CWA shall then attempt recovery of medical assistance incorrectly granted either by administrative collection, or by way of restitution in a criminal or disorderly persons proceeding.

i. Recoveries or attempts at recoveries can be made from those persons specified in N.J.S.A. 30:4D-7i.

2. When recovery cannot be obtained by these methods in a case generated by the Internal Revenue Service (IRS) unearned income component of the Income and Eligibility Verification System (IEVS), the case shall be referred by the CWA to DMAHS for possible initiation of recovery proceedings.

3. When in any other case not generated by IEVS, recovery cannot be obtained by these methods, the CWA is authorized after securing DMAHS approval to initiate recovery proceedings as DMAHS' agent. If the CWA does not initiate such recovery proceedings, it shall refer the case to DMAHS for possible initiation of recovery proceedings.

4. When collection occurs in a case involving both cash assistance and medical assistance, the CWA shall, in the absence of court instruction to the contrary, apply the net proceeds, after deducting identifiable costs of collection such as filing fees and advertising costs but not including such costs as CWA staff time, supplies, counsel fees or overhead, to the repayment of cash assistance and the reimbursement of DMAHS.

5. When in any other case a CWA recovers only medical assistance improperly granted, the CWA shall reimburse itself for those cash expenses directly related to the recovery such as filing fees and advertising costs but not including costs such as CWA staff time, supplies, counsel fees or overhead. In addition, the CWA shall retain 10 percent of the gross amount of the recovery up to \$250.00. The CWA shall remit the remaining proceeds to DMAHS. The reimbursement shall be payable to the Treasurer, State of New Jersey.

6. When any CWA action, whether alone or in combination with DMAHS, results in a recovery of improperly granted medical assistance from a case generated by the Internal Revenue Service (IRS) unearned income component of the IEVS match, all funds recovered shall be remitted to DMAHS, payable to the Treasurer, State of New Jersey, which shall then reimburse the CWA in the amount of 25 percent of the gross recovery on a periodic basis to be determined by DMAHS.

(c) The following pertain to third party liability claims in tort actions:

1. Whenever either a CWA or DMAHS learns of a situation in any case in which the other may have a claim it will notify the other.

2. Unless the individual case circumstances intervene, the first claim after settlement or judgment is for any payments by DMAHS arising from the occurrence notwithstanding any CWA claim for recovery of cash assistance. The next claim is that which the CWA may assert in accordance with an agreement to repay or similar document. The DMAHS and the CWA will, insofar as their controls allow, maintain priority of payment in the above order.

(d) The following pertain to liquidation of potential resources:

1. The CWA will participate in the liquidation of potential resources according to the Program requirements under which eligibility has been established, regardless of whether cash assistance is being granted. Notification of the potential resource to be liquidated shall be forwarded to DMAHS, enabling it to seek a voluntary contribution. Sale of real property to which title is held by a CWA is subject to DEA approval in all instances regardless of the proposed distribution of the proceeds.

2. All funds arising from the liquidation of resources and which, by action of law, regulation, or agreement with the owner, fall under the jurisdiction of either a CWA or DMAHS for distribution will, insofar as possible, be allocated as follows:

i. Proceeds will be first applied to the cash costs of liquidation, such as advertising costs and filing fees but not including costs such as CWA staff time, supplies, counsel fees or overhead.

ii. Proceeds will be next applied to any claims superior to that of the CWA (for example, taxes).

iii. Proceeds will be next applied to any funds owing to and collectible by the CWA.

iv. Any residue remaining after the above payments are allocated would, in the absence of circumstances to the contrary, be the property of the client and thereby subject to (d)3 below.

3. All funds properly belonging to a client free of any agency claim are to be remitted to the client as promptly as possible or otherwise disbursed at the client's instruction. The CWA will promptly reevaluate eligibility following such distribution, taking into consideration any voluntary repayment to DMAHS.

(e) The following pertains to recovery from estates of deceased clients:

1. The CWA shall normally undertake recovery activity as agent for DMAHS in any case in which the CWA is or will be undertaking activities on its own account. However, in those cases where the recovery of medical assistance is possible and where the entire CWA claim is for burial expenses only, DMAHS shall initiate recovery activity inclusive of CWA burial costs. DMAHS may, in certain cases, assume direct jurisdiction in recovery of its claim concurrent with CWA activity. DMAHS shall make the CWA aware of its activity in such cases.

2. CWA recoveries and distribution shall be in accord with the following procedures:

i. From the proceeds of liquidation, the CWA shall first recover the amount necessary to satisfy its own claim, including costs of liquidation and the claims of other New Jersey CWAs. The CWA shall recover funds from the clearing account in the order in which

the funds were received in the clearing account. If any part of any remaining surplus has been received from the proceeds of assigned life insurance for which there was a named beneficiary other than the client's estate, that surplus or the policy benefit, whichever is less, is the property of the beneficiary and should be so directed.

ii. All other surplus funds are part of (or the entire) the client's estate and are payable to the legally designated representative of the estate. If the representative of the estate is unknown or if no representative has been appointed and there are no known next of kin, the CWA shall forward to the DMAHS an amount not to exceed the amount of the proper medical assistance claim as determined by communication with the Chief, Bureau of Administrative Control, DMAHS. Any remaining funds will escheat to the State of New Jersey.

iii. When there are known next of kin, the CWA shall request the next of kin to take appropriate legal action to be appointed administrator if the amount to be disbursed is greater than the claim of DMAHS. If the claim of DMAHS will equal or exceed the estate, the CWA shall request the next of kin to sign a consent to transfer his or her rights to DMAHS and, upon receipt of such signed consent, the CWA shall forward the funds to DMAHS.

iv. When the next of kin will not sign a consent to transfer his or her right to DMAHS and will not file to become the administrator, the CWA may, at its option, arrange for someone to file to become administrator or the CWA may refer the information to DMAHS for action.

v. In any questions or dispute among two or more claimants on surplus funds, the CWA shall withhold payment pending resolution by mutual consent of all claimants or by court order.

3. DMAHS recoveries and distribution shall be in accordance with the following procedures:

i. DMAHS shall undertake recovery activity in medical assistance payment cases in which no CWA shall be submitting a claim. However, should information from the CWA be necessary to such DMAHS activity, the CWA shall communicate with DMAHS, supplying such material as may be required.

ii. In cases in which DMAHS is acting for a CWA in collection of burial expenses, DMAHS shall accord payment of the burial claim priority over its own recovery.

(f) The CWA may at any time accept an offer of voluntary repayment, either on its own behalf or on behalf of DMAHS, up to but not in excess of the amount of assistance granted. To any inquiry as to amount granted, the CWA shall supply the appropriate information, identifying the respective amounts granted by the CWA and DMAHS. In the absence of instruction from the payer, the CWA will reimburse cash assistance first and then remit any balance to DMAHS.

(g) Regarding compromise settlements:

1. Compromise settlements of cash assistance are subject to DEA approval.
2. Compromise settlements of medical assistance are subject to DMAHS approval.

(h) This section shall apply to all pending and future recovery cases, except that (b)6 above shall apply to all IEVS-related recoveries received on or after July 1, 1989 by either DMAHS or the CWA, whichever agency is handling the recovery.

10:49-14.5 Administrative charges/service fees

(a) A provider shall not pay nor require payment of an administrative charge or service fee for the privilege of doing business with another provider or for services for which reimbursement is included as part of the Medicaid fee.

1. An example of a prohibited practice is that a nursing facility may not require a pharmacy to pay an administrative charge or service fee to the facility for handling of the nursing facility resident's medications, drugs and/or related pharmaceutical records.

2. An administrative charge may be made for the collection of a copayment on behalf of pharmacies from beneficiaries of the Pharmaceutical Assistance to the Aged and Disabled (PAAD) Program who are residents in nursing facilities. Such administrative charges may not exceed 10 percent of the billed amount, or \$2.00, whichever is less.

10:49-14.6 Contracts with county welfare agencies

Payment shall be made by the Department of Human Services/Division of Medical Assistance and Health Services to county welfare agencies for conducting investigations and for determining whether applicants qualify for benefits under the New Jersey Medicaid Program.

SUBCHAPTER 15. AVAILABILITY AND MAINTENANCE OF PROGRAM POLICY ISSUANCES

10:49-15.1 Maintenance of public policy issuances

Program manuals and other policy issuances which affect the public, including the Divisions' rules and regulations governing eligibility, need and amount of assistance, recipient's rights and responsibilities, and services offered by the agency, shall be maintained in the State office and in each Medicaid District Office for examination during regular workdays and regular office hours by individuals, and upon request, for study or reproduction by such individuals. These manuals and other policy issuances are also distributed to entities which serve as custodians such as the State Library, County Welfare Agencies, and regional legal services offices.

10:49-15.2 Availability of material

(a) In order to facilitate public access, a current copy of material described in N.J.A.C. 10:49-15.1 shall be made available without charge to custodians who request the material for this purpose.

(b) Custodians shall meet the following requirements:

1. They shall be centrally located and publicly accessible to a substantial number of the recipient population they serve; and
2. They shall agree to accept responsibility for filing all amendments forwarded by the agency.

10:49-15.3 Reproduction of policy material

(a) The specific policy materials necessary for an applicant or recipient (or his or her representative) to determine whether a fair hearing should be requested, or to prepare for a fair hearing, shall be reproduced without charge upon request.

(b) The Division may impose a charge for copying or reproducing materials. If a charge is imposed, it shall be computed pursuant to N.J.S.A. 47:1A-1.

SUBCHAPTER 16. DEMONSTRATION PROJECTS

10:49-16.1 Purpose

This subchapter sets forth the basic parameters for demonstration projects established pursuant to N.J.S.A. 30:4D-1 et seq., as amended, and Section 1115 of the Social Security Act. Any time a demonstration project is implemented, New Jersey Medicaid providers will receive information and instructions if the project is relevant to the services they provide.

10:49-16.2 Definitions

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

"Beneficiary" means any person certified eligible for receipt of services in accordance with Title XIX of the Social Security Act and Chapter 413 of the Public Laws of New Jersey, including those persons who are covered by virtue of the waiver granted under Section 1115 of the Social Security Act.

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

"Department" means the Department of Human Services.

“Eligible beneficiaries” means those beneficiaries who meet the requirements to become a recipient.

“Principal” means all management personnel.

“Project” means any demonstration project authorized through a waiver of certain requirements under Title XIX of the Social Security Act as provided under Section 1115 of the Social Security Act.

“Provider” means providers of medical and health services under a project.

“Recipient” means any beneficiary who receives services from the project.

“Services” means medical or health services rendered as an integral part of the project.

10:49-16.3 Implementation of projects

The Department may implement projects directly or through contractual arrangements with any legal entity, including, but not limited to, corporations organized pursuant to Title 14A, New Jersey statutes (N.J.S.A. 14A:1-1 et seq.) and Title 15 revised statutes (R.S. 15:1-1 et seq.), as well as boards, groups, agencies, persons and other public or private entities.

10:49-16.4 Necessary criteria for a project

(a) The following shall apply to all projects implemented under this subchapter:

1. All projects shall have approval from the United States Department of Health and Human Services;
2. All projects entered into under this subchapter shall be subject to all relevant State and Federal statutes and regulations, except to the extent that appropriate waivers shall have been granted;
3. The Commissioner shall have the authority to review and approve in writing arrangements and agreements, whether formal or otherwise, between all projects and third parties prior to the execution thereof;
4. All projects in their hiring policies shall not discriminate against any individual on the basis of race, sex, religion, ethnicity or age, and shall comply with all the requirements of Title VI of the Civil Rights Act of 1964, as amended, and other applicable Federal and State laws or regulations pertaining to the civil rights of individuals;
5. No project shall deny services to any eligible person on the basis of race, sex, religion, ethnicity or age, and shall comply with all the requirements of Title VI of the Civil Rights Act of 1964, as amended, pertaining to the civil rights of individuals;
6. All projects shall institute procedures for safeguarding of information in compliance with applicable Federal and State regulations and shall strictly adhere to same;

7. All projects shall collect and report data relevant to the project on a periodic basis, in a manner and fashion prescribed by the Department, including, but not limited to, the following:

- i. Financial data, such as line item expenditure statements and audit reports;
- ii. Data necessary to the project regarding the characteristics of the population involved in the project and the control population, if any; and
- iii. Program data, such as number and type of service rendered;

8. All projects shall furnish to the Department, in a manner and fashion prescribed by the Department, periodic progress reports;

9. The Department, at its option, may require receipt of copies of all project reports;

10. Any project entered into under this subchapter may include components fundable from sources other than that authorized by Section 1115 of the Social Security Act. These funds cannot be matched under the provisions of Section 1115 if they are Federal funds or if these funds are not otherwise matchable;

11. Nothing herein shall abridge the Commissioner's statutory authority to implement and administer demonstration programs under Section 1115 of Title XIX of the Social Security Act and N.J.S.A. 30:4D-7, as amended;

12. Each project shall have the organizational and administrative capabilities to carry out its duties and responsibilities under the contract. This shall include as a minimum the following:

- i. A full-time administrator to manage the day-to-day business activities of the project;
- ii. Data reporting capabilities sufficient to provide necessary and timely reports to the Department;
- iii. Financial reports and books of accounts maintained in accordance with general accepted accounting principles, which are sufficient to fully disclose the disposition of all program funds received; and
- iv. An annual independent audit arranged for by the project;

13. Each project director shall advise the Department of the project's administrative organization and changes thereto. This includes the functions and responsibilities of each principal. An organization chart, and a list of all personnel, and providers used either directly by the project or through contractual arrangements. For each principal and each provider, not previously reported, the following information shall be included:

- i. Full name;
- ii. Business address;

- iii. Date and place of birth;
- iv. Social Security Account Number;
- v. IRS employer number;
- vi. Professional license number (when applicable); and
- vii. Medical specialty (when applicable);

14. Each project director shall submit to the Commissioner for written approval a manual of administrative procedures which shall include personnel, purchasing and internal fiscal procedures. This manual shall be in conformance with approved management procedure; and

15. In those instances where a project involves the delivery of services, the following shall apply where appropriate and necessary:

i. The project shall demonstrate, to the satisfaction of the Commissioner, the capability to provide for and/or arrange for the provision of those services which are required as components of the project;

ii. All individuals receiving services funded under Title XIX of the Social Security Act shall be informed in a simple, brief statement of their rights to a fair hearing;

iii. The project shall develop and establish grievance procedures for recipients in addition to fair hearing procedures established pursuant to this paragraph;

iv. The project shall take steps to insure that it is rendering services that are consistent with and utilizes existing related Federal and State programs such as the EPSDT;

v. The project shall insure that there will be periodic peer review and quality of care audits;

vi. The project shall utilize eligibility criteria for eligibles to receive services as defined by the Department, and the Department shall insure, by a review process, that the project is in conformance with these criteria;

vii. The project shall take appropriate action to insure that the eligibility criteria provided per (a)15vi above is faithfully executed;

viii. The project shall obtain written approval from the Commissioner prior to implementing the following:

(1) The methods of enrollment and enrollment forms to be used to enroll beneficiaries;

(2) The form and content of informational and instructional materials to be distributed to beneficiaries outlining the nature and scope of covered services provided by the project;

(3) The form and content of informational and instructional materials to be distributed to inform enrollees of changes in program scope or administration; and

(4) Provider claim forms and instructions for their use where such claim forms are unique to this contract;

ix. The project shall provide to the Department, for written approval prior to use, the form and content of all public information releases pertaining to the project; and

x. The project shall insure that all marketing representatives have received instruction, as appropriate, from the Department, on acceptable enrollment practices.

10:49-16.5 Sanctions

The Commissioner, in addition to any and all other authority, shall have the authority to totally suspend or partially reduce payment in order to enforce compliance with this subchapter.

SUBCHAPTER 17. HOME AND COMMUNITY-BASED SERVICES WAIVERS

10:49-17.1 Introduction

(a) Home and Community-Based Services Waivers are five-year, renewable Federal waiver programs, prepared by the Division of Medical Assistance and Health Services in response to the Omnibus Budget Reconciliation Act of 1981 (Section 2176, Public Law 97-35 and amendments under P.L. 99-509). These Home and Community-Based Services Waivers were submitted to the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services. The purpose of these programs is to help eligible individuals remain in the community, or return to the community, rather than be cared for in a nursing facility or hospital setting.

(b) Retroactive eligibility is not available to waiver program recipients; no waiver service received prior to the date of enrollment shall be considered for reimbursement.

(c) Total program costs are restricted by limits on the number of community care slots and on per-person costs. The case manager is responsible for the development of the service plan with the client/family, with input from provider agencies, and for monitoring the cost of the service package.

(d) Any questions regarding Home and Community-Based Services Waivers may be directed to the Office of Home Care Programs, located in the Division of Medical Assistance and Health Services' Central Office, telephone number (609) 588-2620.

(e) The Division administers the following six Statewide waivers that are described in N.J.A.C. 10:49-17.2, 17.3, 17.4 and 17.5 respectively:

1. Community Care Program for the Elderly and Disabled (CCPED);
2. Home and Community-Based Services Waivers for Blind or Disabled Children and Adults (Medicaid's Model Waivers I, II, and III);
3. AIDS Community Care Alternatives Program (AC-CAP); and
4. Traumatic Brain Injury Program.

Amended by R.1994 d.426, effective August 15, 1994.
See: 26 N.J.R. 1566(a), 26 N.J.R. 3466(b).

10:49-17.2 Community Care Program for the Elderly and Disabled (CCPED)

(a) CCPED became effective October 1, 1983. The program allows for community care slots, allocated on a county basis in accordance with the needs of the county.

(b) The seven services listed below are available under CCPED. Other Medicaid (Title XIX) services are not available to the waived population. There is a cost cap on each individual service package.

1. Case management;
2. Home Health;
3. Homemaker;
4. Medical day care;
5. Medical transportation (non-emergency);
6. Respite care; and
7. Social day care.

(c) Eligibility requirements for CCPED are as follows:

1. All individuals must be assessed to be in need of nursing facility care.
2. Individuals age 65 or over must be eligible for Medicare or have other health insurance coverage which includes hospital and physician coverage.
3. Individuals under 65 must be determined disabled by the Federal Social Security Administration and be eligible for Medicare or be determined disabled by the Division of Medical Assistance and Health Services' Disability Review Section and have other health insurance, including hospital and physician coverage.
4. An individual's own income must exceed the SSI community standard up to the institutional cap or be ineligible in the community because of SSI Deeming Rules. An individual's resources may not exceed those required in the institutional program. A spouse's income also is not considered. While the spouse's resources are

considered in the determination of eligibility, up to one-half of the couple's total resources are protected for the use of the spouse.

5. In order to be enrolled in the program, a waiver slot must be available.

10:49-17.3 Medicaid's Model Waivers—I, II and III

(a) The Model Waivers are Home and Community-Based Services Waivers for Blind or Disabled Children and Adults. Included are Model Waiver I (effective September 1, 1983), Model Waiver II (effective April 1, 1985) and Model Waiver III (effective April 1, 1986).

1. Model Waivers I and II serve a maximum of 50 individuals each. Model Waiver III serves 150. There are no geographic limitations nor limitations on the number of individuals who can be served within any one county.

(b) The Model Waiver programs offer, with the exception of nursing facility services, all New Jersey Medicaid (Title XIX) services, plus case management. Model Waiver III also offers private-duty nursing. "Private duty nursing" means individual and continuous care, in contrast to part-time or intermittent care, provided by licensed nurses. Private duty nursing is limited to a maximum of sixteen hours per day per person and will be provided only when there is a live-in primary caregiver (adult relative or significant other adult) who accepts 24-hour responsibility for the health and welfare of the recipient.

1. Each individual's service package must be no more than the cost of institutional care, determined at a projected weighted cost of hospital care or net average cost of nursing facility care.

(c) Eligibility requirements for the Model Waivers are as follows:

1. Individuals must be in need of institutional care and meet the minimum nursing facility (NF) level of care criteria. Model Waiver III also requires that individuals need private-duty nursing service.
2. For Model Waivers I and II, individuals must meet optional categorically needy standards. Total income must exceed the SSI community standard up to the institutional CAP, or the individual must be ineligible in the community because of SSI Deeming Rules. Parental income or resources are not considered in determining eligibility. While a spouse's income is not considered towards eligibility, up to one-half of the couple's total resources are protected for the use of the spouse.
3. Model Waiver III applicants can either be optional categorically eligible or categorical eligible. In other words, MW III also serves individuals who are eligible under SSI, DYFS or AFDC programs.

4. Individuals must be blind or disabled children and adults. Individuals who have not been determined disabled under the Social Security Act must be determined disabled by the Division of Medical Assistance and Health Services' Disability Review Section.

5. In order to be enrolled in the program, a waiver slot must be available.

10:49-17.4 AIDS Community Care Alternatives Program (ACCAP)

(a) ACCAP became effective March 1, 1987. The program allows for an allocation of a specific number of slots in accordance with the needs of each county in the State.

(b) ACCAP offers, with the exception of nursing facility services, all New Jersey Medicaid (Title XIX) services, plus those listed in (a)1 through 7 below. Total program costs are restricted by the number of community care slots each year and on per-person costs. Each individual's service package must be no more than the cost of institutional care, determined at a projected weighted cost of hospital care or net average cost of nursing facility care.

1. Case management;
2. For children:
 - i. Intensive supervision to children who reside in Division of Youth and Family Services' foster homes; and
 - ii. Specialized group foster home;
3. Hospice care services at home;
4. Medical day care (specialized);
5. (Certain) Narcotic and drug abuse treatments at home;
6. Personal care assistant services (no limitation on the number of hours); and
7. Private-duty nursing.

(c) Eligibility requirements for ACCAP are as follows:

1. Individuals must be in need of institutional care and meet, at a minimum, the nursing facility level of care criteria.
2. Individuals must be diagnosed as having AIDS or ARC. Children under the age of five may also be diagnosed HIV positive.
3. Individuals who are categorically needy or optional categorically needy are served under the program.
4. There is no deeming or parental income or resources in the determination of eligibility. A spouse's income also is not considered. While the spouse's resources are considered in the determination of eligibility, up to one-half of the couple's total resources are protected for the use of the spouse.

5. Optionally categorically eligibles under age 65 must be determined disabled by the Social Security Administration (SSA) or by the Disability Review Section, Division of Medical Assistance and Health Services.

6. In order to be enrolled in the program, a waiver slot must be available.

10:49-17.5 Traumatic Brain Injury Program

(a) The Traumatic Brain Injury (TBI) Program is a renewable Federal waiver program under Section 1915(c) of the Social Security Act, 42 U.S.C. 1396n, which offers home and community-based services to a recipient with an acquired traumatic brain injury. The purpose of the TBI program is to help eligible recipients to remain in the community, or to return to the community rather than be cared for in a nursing facility.

(b) The waiver, prepared by the Division of Medical Assistance and Health Services (DMAHS), encourages the development of community-based services in lieu of institutionalization.

(c) The Program is Statewide, with slots allocated as individuals, ages 18 through 65, are admitted to the program.

(d) The Division administers the overall program, and has the responsibility for assessing an applicant's need for care and, for determining which applicants will be served by the program.

(e) Program oversight shall be provided by the Division of Medical Assistance and Health Services through the Office of Home Care Programs (OHCP) and the Surveillance Utilization Review Subsystem (SURS). The delivery of home care services to TBI Waiver recipients will be subject to a post-payment utilization review by professional staff of the Medicaid District Offices in accordance with N.J.A.C. 10:63-1.15

(f) Applicants for participation in the TBI waiver program shall meet the following medical and financial eligibility criteria:

1. Be not less than 18 nor more than 65 years of age at the time of enrollment;
2. Have a diagnosis of acquired brain injury which occurred after the age of 16;
3. Exhibit medical, emotional, behavioral and/or cognitive deficits;
4. Meet the Division's nursing facility standard care criteria for Pre-Admission Screening (PAS), at N.J.A.C. 10:60-1.2;
5. Have a rating of at least four on the Rancho Los Amigos Levels of Cognitive Functioning Scale (see N.J.A.C. 10:60, Appendix I);

6. Be blind, disabled, or a child under the supervision of the Division of Youth and Family Services (DYFS) and be eligible for Medicaid in the community or be eligible for Medicaid if institutionalized. Persons eligible for the Medically Needy segment of New Jersey Care . . . Special Medicaid Programs, or enrolled in Garden State Health Plan, or private Health Maintenance Organizations serving Medicaid recipients are not eligible for this program.

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 recipient'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 recipients 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 Office of Home Care Programs (OHCP) 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) recipients 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 recipient's county of residence; and

3. Individuals who are not currently Medicaid eligible shall be referred by OHCP 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 determination 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 OHCP of the recipient'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 recipient 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 recipient 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).

SUBCHAPTER 18. HOME CARE EXPANSION PROGRAM

10:49-18.1 Introduction

(a) The Home Care Expansion Program (HCEP) (P.L. 1988, c.92), as set forth in N.J.S.A. 30:4E-6, is a Casino Revenue funded program. The intent of the legislation is to offer home care services to elderly and disabled persons in New Jersey who are at risk of institutionalization and whose income and resources exceed the financial requirements for Medicaid or the Community Care Program for the Elderly and Disabled (CCPED). It is anticipated that the provision of home care service will delay or prevent institutionalization. HCEP is available Statewide. Program slots are allocated to each county.

(b) The Division of Medical Assistance and Health Services has the responsibility for overall administration of the program and for monitoring the case management sites. The determination of eligibility and cost-share billing and collection is the responsibility of the Division's Bureau of Pharmaceutical Assistance to the Aged and Disabled (PAAD).

10:49-18.2 Services

(a) HCEP can provide payment for a limited package of services including:

1. Case management services;
 - i. Case management is provided by a nurse or social worker. Case managers are responsible for assessing need for care, planning, locating, coordinating and monitoring the services designed to meet individual needs of persons being served. Case management services, provided by a variety of agencies, also include responsibility for the development of a service plan with input from the client/family, attending physician and provider agencies, and for monitoring the cost of the service package, and calculating cost-share liability;
2. Home health care over and above what Medicare allows;
3. Homemaker services;
4. Medical day care;
5. Non-emergency medical transportation;
6. Respite care to relieve caregiver for short periods of time; and
7. Social day care.

(b) Cost limitations/requirements for HCEP are as follows:

1. Total costs for HCEP are restricted by the amount of money appropriated to the Division of Medical Assistance and Health Services from the Casino Revenue Fund. The number of HCEP slots and the per person costs are limited in order to stay within these appropriated monies. The cost for care for each individual is limited to a percentage of the cost of nursing home care which will be determined periodically. There is no payment for services provided before enrollment in the program.

2. Clients may be required to share in the cost of their care. The amount of this cost-share is determined by the individual's income, the cost of the services, and the additional medical or remedial care received. Non-payment of this cost-share will result in termination from the program.

10:49-18.3 Eligibility requirements

(a) To qualify for HCEP services, an individual 65 or over must:

1. Need long-term home care services which are medically necessary to avoid or delay institutionalization;
2. Be eligible for Medicare or have other health care insurance which includes hospital and physician coverage; and
3. Have an annual income of less than \$18,000 if single, or if married, less than \$21,000 in combination with that of his/her spouse. Liquid resources must be less than \$15,000 for single or married persons.

(b) To qualify for HCEP services, an individual under 65 must also:

1. Be receiving Social Security disability benefits; or
2. Be determined disabled by the Social Security Administration, or the New Jersey Division of Medical Assistance and Health Services, Disability Review Section; and also
3. Be eligible for Medicare or have other health care insurance which includes hospital and physician coverage.

10:49-18.4 Application

Application for HCEP can be made to PAAD, by calling the toll-free number, 1-800-792-9745. Inquiries about the program should be directed to the Division's Office of Home Care Programs at (609) 588-2620.

SUBCHAPTER 19. PREPAID HEALTH CARE SERVICES: MEDICAID ELIGIBLES

Cross References

Optical appliance services, prior authorization for inclusion in benefits package, see N.J.A.C. 10:62-2.5.

10:49-19.1 Definitions

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

“Benefits” means medical, psychiatric and related health services which the contractor has agreed to provide, arrange for and be held fiscally responsible for under the negotiated contract. The benefit package that shall be provided by the contractor under the terms of the contract is specified in N.J.A.C. 10:49-19.3.

“Capitation rate” means a stated sum due the contractor for a stated group of services for each enrollee for a period of time specified in the contract.

“Commissioner” means the Commissioner of the Department of Human Services or a duly authorized representative.

“Contractor” means a health maintenance organization or prepaid health plan as defined herein which contracts with the Department for the provision of comprehensive health care services to Medicaid enrollees on a prepayment basis.

“CWA” means county welfare agency, that agency of county government which is charged with the responsibility for determining eligibility for certain public assistance programs.

“Department” means the Department of Human Services.

“Director” means the Director of the Division of Medical Assistance and Health Services or a duly authorized representative.

“Disenrollment” means the process of removal of an enrollee from the contractor’s plan, not from the Medicaid Program.

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

“Emergency services” means those services required to treat a life-threatening or organ-threatening condition or potentially life or organ-threatening condition of such immediate nature that any unusual delay in treatment would be dangerous to the health or well-being of the enrollee.

“Enrollee” or “enrolled recipient” means an individual who is eligible for Medicaid residing within the defined market area, who elects or has had elected on his or her behalf by an authorized person, in writing, to participate in the contractor’s plan and meets specific Medicaid eligibility requirements for Plan enrollment agreed by the Department and the contractor.

“Enrollment” means the process by which individuals eligible for Medicaid voluntarily contract to utilize prepaid health care services in lieu of standard Medicaid benefits.

“Enrollment area” means the boundaries established by Zip Code, within which the HMO shall limit their enrollment.

“EPSDT” means Early, Periodic, Screening, Diagnosis, and Treatment mandated by Title XIX of the Social Security Act.

“Federally qualified HMO” means an HMO that has been determined by the Public Health Service (PHS) to be a qualified HMO under section 1310(d) of the PHS Act.

“Health maintenance organization” or “HMO” means a public or private organization, organized under State law which:

1. Is a Federally qualified HMO (defined above); or
2. Meets the State Plan’s definition of an HMO which includes at a minimum the following requirements:
 - i. Is organized primarily for the purpose of providing health care services;
 - ii. Makes the services it provides to its Medicaid enrollees as accessible to them (in terms of timeliness, amount, duration, and scope) as those services are to non-enrolled Medicaid eligible individuals within the area served by the HMO;
 - iii. Makes provision, satisfactory to the Division, against risk of insolvency, and assures that Medicaid enrollees will not be liable for the HMO’s debts if it does become insolvent; and
 - iv. Has a Certificate of Authority granted by the State of New Jersey to operate in all or selected counties in New Jersey.

“HHS” or “DHHS” means the Department of Health and Human Services of the Federal government.

“IPN” means Independent Practitioner Network which is one of the types of HMO operation. Services are provided for enrollees in the individual offices of the contracting physician case managers (PCMs).

“Market area” means the defined geographic area within which all potential enrollees shall reside.

“Marketing” means any presentation by or on behalf of an HMO for enrollment purposes.

“Medicaid” refers to the program funded under Title XIX of the Social Security Act administered by the Department.

"Medicaid recipient" means an individual eligible to receive services under the New Jersey Medicaid Program as authorized by State and Federal law and amendments thereto.

"Non-covered HMO services" means services not covered in the contractor's benefits package included under the terms of the Medicaid contract.

"Non-covered Medicaid services" means all services not covered under the New Jersey State Plan for the Medicaid Program.

"Nonrisk" means that the contractor is not at financial risk for changes in the cost or utilization of services provided for in the payment rate agreed upon at the beginning of the contract period. Under a nonrisk contract, the State agency may make retroactive adjustments during and at the end of the contract period so that the contractor is reimbursed for costs actually incurred, subject to the upper limit of payment established in 42 CFR 447.362 or any lower limit specified in the contract.

"PCM" means physician case manager which is the primary care physician.

"Plan" means all services and responsibilities undertaken by the contractor pursuant to this contract.

"Prepaid health plan (php)" means an entity that provides medical services to enrollees, under a contract with the Medicaid agency and on the basis of prepaid capitation fees, but does not necessarily qualify as an HMO.

"Primary care physician" means a physician who has the responsibility for general care and treatment and for initiating referrals for specialist care and for maintaining continuity of patient care. In general, the primary care physician is a general or family practitioner, internist, pediatrician or obstetrician/gynecologist.

"Referral services" means those health care services rendered outside of the contractor's facilities or IPN when ordered and approved by the contractor.

"Risk" or "underwriting risk" means the possibility that a contractor may incur a loss because the cost of providing services may exceed the payments made by the agency to the contractor for services covered under the contract.

"Service area" means the geographic area in which the contractor is obligated to provide covered services for its Medicaid enrollees under its contract.

"Subcontract" means any written agreement between the contractor and a third party to perform a specified part of the contractor's obligations under the contract.

"Subcontractor" means any third party who has a written agreement with the contractor to perform a specified part of the contractor's obligations, and is subject to the same terms, rights, and duties as the contractor.

"Target population" means the population from which the initial number of enrollees, not to exceed any limit specified in the contract, will be drawn; that is, individuals eligible for Medicaid residing within the stated market area and belonging to one of the categories of eligibility for Medicaid to be covered under the contract.

"Termination" means the loss of Medicaid eligibility and therefore automatic disenrollment from the HMO if beyond the guaranteed eligibility period.

Emergency Amendment, R.1993 d.525, effective October 4, 1993 (to expire December 3, 1993).

See: 25 N.J.R. 4793(a).

Adopted Concurrent Proposal, R.1994 d.4, effective December 2, 1993.

See: 25 N.J.R. 4793(a), 26 N.J.R. 224(a).

10:49-19.2 Criteria for contracting with the Department

(a) The contractor shall:

1. Comply with the requirements of the New Jersey Certificate of Authority (P.L. 1973, c.337, N.J.S.A. 26:2J-1 et seq.) statutes and regulations;

2. Provide to the Division of Medical Assistance and Health Services, Department of Human Services, a copy of the Department of Health approved Certificate of Authority and application document on request;

3. Furnish the Department with such information and reports that the Department finds necessary and maintain records as required by the Department, State and Federal governments;

4. Enroll individuals and provide services without reference to race, sex, age, religion, creed, color, national origin, ancestry or on the basis of health status or need for health services other than those services specifically excluded from coverage by the contract;

5. Comply with the requirements of having any contract resulting from a proposal be approved by the Health Care Financing Administration (HCFA) and the appropriate State control agencies before it shall become effective;

6. Have the organizational and administrative capabilities to carry out its duties and responsibilities under the contract. This shall include at a minimum, the following:

i. A full time administrator to manage day-to-day business activities of the contractor and who is the responsible contract officer. (This does not require a full time administrator to be dedicated solely to the Medicaid contract.);

ii. Data reporting capabilities sufficient to provide necessary reports and to assure orderly and timely flow of reports to the Department;

iii. Financial records and books of accounts maintained in accordance with generally accepted accounting principles which are sufficient to disclose fully the disposition of all program funds received; and

iv. An annual independent audit arranged for by the contractor and which shall be performed by a certified public accountant;

7. Advise the Department of its administrative organization and changes thereto. This includes the functions and responsibilities of each principal, an organizational chart and list of all personnel and providers used either directly by the contractor or through subcontractual arrangements. For each principal and each provider not previously reported, include the following information:

- i. Full name;
- ii. Business address;
- iii. Date of birth;
- iv. Social Security Number;
- v. IRS employer number;
- vi. Professional license number (when applicable); and
- vii. Medical specialty (when applicable);

8. Comply with eligibility requirements of the program which, for example, include but are not limited to: contractor shall only enroll individuals who are covered under specified Medicaid categories of assistance and who reside in the agreed upon market area;

9. Identify and provide financial disclosure of subcontractors with whom it has had business transactions in excess of \$25,000 per year, and any significant business transactions with such subcontractors. Transactions that shall be reported include:

- i. Any sale, exchange or leasing of property;
- ii. Any furnishing for consideration of goods, services, or facilities (but not employee salaries); and
- iii. Any loans or extensions of credit;

10. Make available any information reported to the State, and upon request, to the Secretary of the U.S. Department of Health and Human Services, the Office of the Inspector General, the Comptroller General and to its enrollees. The State or Secretary may request that the information be in the form of a consolidated financial statement;

11. Disclose to the Division the identity of each person with a controlling interest or ownership of five percent or more; and

12. The contractor may not employ or contract with:

i. Any individual or entity excluded from Medicaid participation under Sections 1128 or 1128A of the Social Security Act for the provision of health care, utilization review, medical social work, or administrative services; or

ii. Any entity for the provision of such services (directly or indirectly) through an excluded individual or entity.

(b) The contractor shall also comply with the Federal regulations governing HMOs or PHPs, as currently exist or hereinafter may be amended. The federal regulations governing prepaid health care services may be found in the Code of Federal Regulations at 42 CFR 434 and 42 CFR 110.

10:49-19.3 Benefits

(a) Rules on the scope of benefits require that:

1. The Division shall be responsible for providing all non-HMO covered services that are Medicaid benefits to Medicaid enrollees. This means that any service or item normally provided under the New Jersey Medicaid Program shall be provided to members if it is not covered under the terms of the contract with the HMO or PHP. The same limitations, such as prior authorization and medical necessity, shall still be applicable for Medicaid services provided outside the contract.

2. The benefits available under a nonrisk contract shall be those services and/or items that are specified in the contract.

3. The benefits available under a risk contract shall be those services and/or items that are specified in the contract.

4. Pursuant to Federal regulations (42 CFR 434.21), risk comprehensive contracts are risk contracts for furnishing comprehensive services, which shall include inpatient hospital services and any of the following services, or any three or more of the following services or groups of services:

- i. Outpatient hospital services;
- ii. Other laboratory and x-ray services;
- iii. Covered long-term care services provided in nursing facilities, early and periodic screening, diagnosis and treatment (EPSDT), and family planning;
- iv. Physicians' services;
- v. Home Health services.

(b) Responsibilities of the contractor are as follows:

1. The contractor shall make available emergency services, as defined in N.J.A.C. 10:49-19.1, on a 24-hour-a-day, seven-day-a-week basis.

2. The contractor shall offer health education services as an integral part of its health care delivery system to its enrollees in order to assure appropriate use of health care services and to promote the maintenance of health.

3. The contractor shall provide EPSDT equivalent services for all Medicaid enrollees under 21 years of age in accordance with the protocols approved by the Division.

i. Initial physical examinations shall be provided. All further treatments indicated shall be provided in an appropriate and timely manner and shall be appropriately documented as specified by EPSDT requirements. The above shall be in accordance with EPSDT regulations.

(1) The Division shall monitor the EPSDT equivalent through periodic audits.

4. The contractor shall provide or arrange to have provided all covered necessary health care services in a manner that is prompt, appropriate, and of a quality that conforms to generally acceptable professional standards as set forth in the Federal Social Security Act, 42 U.S.C. 1302 et seq., and all other applicable Federal and State laws.

(c) Limitations on services in an HMO setting are as follows:

1. The following service limitations are consistent with those of the fee-for-service Medicaid Program and are not included in the contractual service package or capitation payments even if provided by the HMO:

i. Services of podiatrists shall be provided with the exceptions of routine foot care and treatment of flat foot conditions, unless medical necessity determines otherwise.

ii. Physical therapy, occupational therapy, and treatment for speech, language or hearing disorders are provided but limited to such services when provided to an enrollee by a nursing facility, by an approved home health agency, hospital outpatient department, independent outpatient clinic, or at Contractor's facilities. Services provided by privately practicing therapists shall not be eligible for payment under the capitation rate unless:

(1) The Physical therapist holds a current license to practice in New Jersey;

(2) The physical therapist is under contract with the contractor and will abide by the provisions of the contract; and

(3) The costs of these services are specifically identified in the contractor's proposed capitation rate.

iii. Abortions are not covered under an HMO program but will continue to be paid on a fee-for-service basis by the Medicaid Program.

(d) Exclusions: The following are not covered services:

1. All claims arising directly or indirectly from services provided by or in institutions owned or operated by the Federal government;

2. Elective cosmetic surgery;

3. Rest cures and custodial or domiciliary care;

4. Personal comfort and convenience items; services and supplies not directly related to the care of the patient, including but not limited to guest meals and accommodations, telephone charges, travel expenses other than those services which may be specifically covered under the contract (such as ambulance services), take-home supplies and similar costs;

5. Services involving the use of equipment in facilities, the purchase, rental or construction of which has not been approved by applicable laws of the State of New Jersey and regulations issued pursuant thereto;

6. All services not provided, approved, or arranged by the HMO physician except in emergency services as defined in N.J.A.C. 10:49-19.1;

7. Services provided in an inpatient psychiatric institution that is not an acute care hospital to individuals under 65 years of age and over 21 years of age; and

8. Private duty nursing.

(e) Availability of services rules require that:

1. Each contractor shall demonstrate the availability and accessibility of sufficient numbers of institutional facilities and professional, allied and supporting paramedical personnel to perform adequately the agreed-upon services;

2. Each contractor shall insure that no distinctions will be made with regard to quality of service or availability of benefits between Medicaid enrollees under this subchapter and any other parties served by the contractor;

3. To the extent feasible and appropriate, each Medicaid enrollee shall be given the choice of a primary care physician who will supervise and coordinate his or her care; and

4. Generally, the contractor shall have only one market area for all Medicaid parties served, including those served under these regulations. Modifications of such market area for purposes of contracting under this subchapter shall be subject to approval by the Division.

10:49-19.4 Marketing and enrollment

(a) The following pertain to marketing:

1. The contractor shall obtain written approval from the Division prior to implementing the following:

- i. The form and content of informational and instructional materials to be distributed to Medicaid enrollees, outlining the scope and nature of benefits provided by the contractor;
- ii. The form and content of informational and instructional materials to be distributed to inform Medicaid enrollees of changes in program scope or administration; and
- iii. The form and content of all public information releases pertaining to the enrollment of Medicaid individuals in the contractor's plan.

2. The contractor shall insure that:

- i. All marketing presentations accurately and clearly represent the benefits and limitations of the contractor's plan;
- ii. The marketing representatives have received sufficient instructions and training to be capable of performing such marketing activities;
- iii. The marketing representatives shall only represent themselves as agents of the contractor involved in marketing;
- iv. That all marketing presentations make clear that HMO enrollment is voluntary; and
- v. The marketing representatives shall be prohibited from offering or giving any form of compensation or reward as an inducement to a Medicaid recipient to enroll in the contractor's plan.

(b) The following pertain to information provided to enrollees:

1. At such time as a Medicaid recipient signs an enrollment application of an HMO or prepaid health plan, the contractor shall inform the eligible that:

- i. There is normally a minimum 30 to 45-day processing period between the date of application and the effective date of enrollment;
- ii. During this interim period, the Medicaid enrollee may continue to receive health care services under his or her current arrangement as long as he or she retains Medicaid eligibility; and
- iii. Subject to the disenrollment rules in (d) below and the termination provisions in the contract between the contractor and the Department, enrollment shall be for a period of six months at a time;

2. Within 10 days after the effective date of coverage, or as specified in the contract, the contractor shall provide in writing to a new enrollee:

- i. Notification of his or her effective date of enrollment;

- ii. An identification card clearly indicating that the bearer is an enrollee in the HMO or prepaid health plan;

- iii. Specific written details on benefits, limitations, exclusions, and availability and location of services and facilities. Thereafter, such notification shall be provided at least annually;

- iv. An explanation of the procedure for obtaining benefits including the address and telephone number of primary care physicians, the hours and days facilities are open, and accepted appointment procedures;

- v. Information regarding continued enrollment in the contractor's plan including patient's rights and patient's responsibilities, and the reasons a person may lose eligibility for the plan and what should be done if this occurs;

- vi. Procedures for resolving complaints;

- vii. Information giving reasons and procedures for disenrollment;

- viii. Any other information essential to the proper use of the plan as may be required by the Division;

- ix. An explanation of where and how 24 hour a day emergency medical care and out-of-area coverage is available; and

- x. An explanation of how to obtain non-covered HMO services that are Medicaid benefits.

3. Information as required by (b)2 above shall be supplied whenever there are significant changes in the services provided or the locations where they can be obtained, or other changes in program nature and administration. Such information shall be provided to each enrolled family household at least 10 days prior to such change.

(c) The following pertain to enrollment:

1. The contractor shall enroll Medicaid recipients in the order in which they apply, without restrictions, up to contract limits.

2. Enrollment shall be accomplished by the Medicaid eligible individual's voluntary signing of an enrollment application agreeing to utilize only the health care services provided or arranged by the contractor, and completion of the enrollment procedures specified by the Division.

3. Enrollment shall be for the entire Medicaid case (family household). The contractor may not enroll a partial case except at the Director's discretion.

4. Enrollment shall be for periods of six months and in accordance with Federal statute, Section 1903(m)(2)(F) of the Social Security Act with the exceptions indicated in (d) below. This fact shall be clearly stated on the enrollment application.

5. At any time during the first 30 days of each six month enrollment period, the enrollee may elect to disenroll from the contractor's plan, upon written notification to the contractor, without stating a cause and with cause thereafter. The contractor may terminate an enrollee's enrollment for reasonable cause, through a grievance process which is consistent with applicable State and Federal regulations and is approved by the Division.

i. There is an exception for State-defined HMOs as found in N.J.A.C. 10:49-19.11.

6. The contractor shall obtain written approval from the Director prior to implementing a method of enrollment and enrollment forms to be used to enroll Medicaid recipients.

7. For any person who applies for participation in the Plan and who is hospitalized at the time this coverage becomes effective, such coverage shall not commence until the date such person is discharged from the hospital.

(d) The following pertain to disenrollment:

1. Disenrollment of an enrollee from the plan will occur:

i. Whenever the enrollee is no longer qualified to receive Medicaid services, unless otherwise specified in the contract;

ii. Whenever the enrollee moves outside of the market area boundaries;

iii. Whenever the contract between the Department and the contractor is terminated; or

iv. Through formal grievance.

2. Provision shall also be made for an enrollee's voluntary disenrollment from the contractor's plan in accordance with Section 1903(m)(2)(F) of the Federal Social Security Act.

3. Until such time as the enrollee's termination of coverage becomes effective, the contractor shall remain liable for all contracted services. If an enrollee is hospitalized at the time of disenrollment or termination, the contractor shall be liable for all inpatient hospital charges (if a contracted service).

Emergency Amendment, R.1993 d.525, effective October 4, 1993 (to expire December 3, 1993).

See: 25 N.J.R. 4793(a).

Adopted Concurrent Proposal, R.1994 d.4, effective December 2, 1993.
See: 25 N.J.R. 4793(a), 26 N.J.R. 224(a).

10:49-19.5 Medical records; peer review; quality assurance

(a) The following pertain to medical records:

1. Each contractor shall maintain a medical record on each member who has received medical services while enrolled in the contractor's plan.

2. Each enrollee's medical records shall be kept in detail consistent with Federal and State requirements and good medical and professional practice based on the service provided. Furthermore, each contractor shall conform to the standards of confidentiality of information mandated for Federal and State officials (Section 1902(a)(7) of the Federal Social Security Act, 42 CFR 431.300, N.J.S.A. 30:4D-7(g), and N.J.A.C. 10:49-9.4 and 9.5).

3. Medical records of enrollees shall be sufficiently complete to permit subsequent peer review or medical audit. All required records, either originals or reproductions thereof, shall be maintained in legible form and readily available to appropriate Division professional staff upon request for review and evaluation by professional medical and nursing staff.

4. The contractor shall release medical records of enrollees, as may be directed by authorized personnel of the Division, appropriate agencies of the State of New Jersey or the U.S. Government and shall be consistent with the provisions of confidentiality. (Section 1902(a)(7) of the Federal Social Security Act, 42 CFR 431.300, N.J.S.A. 30:4D-7(g), and N.J.A.C. 10:49-9.6).

5. All records shall be retained in accordance with the record retention requirements of 45 CFR Part 74 and appropriate State law.

6. The Division has the right to conduct audits according to appropriate Federal and State statutes and regulations.

(b) The following pertain to peer review:

1. Each contractor shall submit a description of its system of internal peer review to the Division for approval to assure that acceptable professional practice shall be followed by the contractor as well as its subcontractors.

2. There shall also be an explanation of how such peer review procedures will relate to the applicable peer review organization (PRO) should such exist.

3. The number of cases reviewed and summaries of the actions taken by the peer review system shall be reported annually to the Division.

(c) The following pertain to quality assurance:

1. The Division and the U.S. Department of Health and Human Services shall have the right to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under this contract in accordance with State and Federal requirements.

2. The contractor shall offer assurances that all health care services required by its enrollees shall meet quality standards within the acceptable medical practice of care consistent with the medical community standards of care.

3. The contractor shall submit a detailed plan for establishing and maintaining an internal quality assurance system to the Division for approval to assure that acceptable professional practice shall be followed by the organization and its subcontractors. This shall include a proposed system for continuing performance review and health care evaluation, that is, explanation of the methods which the contractor proposes to follow in guaranteeing that the services provided each enrollee shall meet criteria required by appropriate Federal and State statutes and regulations (42 CFR 434.34).

4. The contractor shall agree to medical audits relating to its standard of medical practice and the quality, appropriateness and timeliness of health care services provided all members, as may be required by the Division. The medical audit shall include, at a minimum, the review of:

- i. The delivery system for patient care;
- ii. Utilization data and medical evaluation of care provided and patient outcomes for specific enrollees as well as for a statistical representative sample of enrollee records.
- iii. The peer review system and reports; and
- iv. The grievances relating to medical care including their disposition.

5. The results of the medical audits may be disclosed to the public on a need-to-know basis by the State, consistent with State and Federal law.

6. The contractor shall agree to release the comprehensive medical records of enrollees upon termination of their coverage, as may be directed by the member, authorized personnel of the Division, appropriate agencies of the State of New Jersey, or the United States Government.

10:49-19.6 Grievance procedure

(a) The contractor shall establish a grievance procedure for the receipt and adjudication of any and all complaints from enrollees relating to quality, scope, nature and delivery of services. Such grievance procedure shall be communicated to the enrollee in writing to provide for expeditious resolution of grievances by the contractor's personnel at a decision-making level with authority to require corrective action. The contractor shall also review the complaint procedure at reasonable intervals, but no less than annually, for the purpose of amending same, with the prior written approval of the Division in order to improve said system and procedure.

(b) The contractor shall insure that all enrollees receiving services funded under Title XIX of the Social Security Act shall be informed in a simple, brief statement of their rights to a fair hearing and of the contractor's grievance review procedures. This may be accomplished by an annual mail-

ing as noted in N.J.A.C. 10:49-19.4, a member handbook, or any other method approved by the Division.

(c) The contractor shall report all completed grievances to the Division with a brief statement of the problem and resulting outcome on a quarterly basis.

10:49-19.7 Financial arrangements

(a) The contractor shall submit for Division approval information in sufficient detail to describe:

1. The exact capitation rate requested for each category of medical assistance covered under the contract;
2. The major cost components that constitute each capitation rate, including at a minimum the projected costs of hospital services, physician services, administration, and other components as approved by the Division; and
3. A detailed description of the underlying assumptions and procedures followed by the contractor in determining its rate.

(b) The annual capitation rate for any contractor may not exceed the expected per capita, fee-for-service cost for similar services provided to an actuarially equivalent non-enrolled population who reside in the contractor's market area.

(c) Capitation rates shall be subject to negotiation before the contract renewal, but shall not be revised more often than annually.

(d) Any capitation rates paid to the contractor shall not include payment for recoupment of losses incurred by the contractor from prior years.

(e) The Division does not provide stop loss for risk contracts.

(f) The contractor is responsible for payment of all contracted covered services, including emergency services as defined in the contract, rendered to an enrollee whether or not such services are provided at the contractor's facilities.

(g) The contractor shall make available to the Division, for inspection and audit, any financial records of the contractor or its subcontractors in accordance with 42 C.F.R. 434.38 and as specified by the Division.

(h) If third party liability exists for an enrollee, for example, by health insurance contract, subrogation or tort, the Division shall require the contractor to recover, or attempt to recover, all appropriate payments from any and all liable third party sources for services provided to enrollees. Likewise, the Division shall require that the contractor use its best efforts to insure that its subcontractors utilize these same payment sources.

1. It is the contractor's responsibility to recover monies from liable third parties and any monies so recovered are the property of the contractor.

2. The contractor shall include in its periodic reporting to the Division a complete disclosure demonstrating its efforts to obtain payment from liable third parties and the amount and nature of third party payments recovered for Title XIX members including, but not limited to, services, and conditions which are:

- i. Employment related injuries or illnesses;
- ii. Related to motor vehicle accidents, whether injured as pedestrians, drivers, passengers or bicyclists; or
- iii. Contained in Diagnosis Codes 800 through 999 (ICD-9-CM) with the exception of Code 994.6.

3. The Division shall thereafter pursue a policy of deducting an amount actuarially determined to be representative of the availability of third party coverage from the capitation rate, unless the capitation rate already includes an allowance for the recovery of third party payments.

Emergency Amendment, R.1993 d.525, effective October 4, 1993 (to expire December 3, 1993).

See: 25 N.J.R. 4793(a).

Adopted Concurrent Proposal, R.1994 d.4, effective December 2, 1993.
See: 25 N.J.R. 4793(a), 26 N.J.R. 224(a).

10:49-19.8 Capitation payments to contractors

(a) For Medicaid enrollees enrolled in accordance with N.J.A.C. 10.49-19.4(c)2, the Division shall pay the capitation rate no later than the 15th day of the month in which that individual will be eligible to receive services.

(b) The Division shall make monthly payments to the contractor based upon the total number of certified enrollees and negotiated capitation rate(s).

10:49-19.9 General reporting requirements

(a) Each contractor shall furnish such timely information and reports as the Division may find necessary, and on such forms or in such format as the Division may prescribe. Such reports shall include information sufficient for Division management and evaluation purposes in at least the following areas:

1. Marketing and enrollment performance;
2. Enrollee identification data, such as age, sex, and residence;
3. Utilization data for covered services provided under the contract;
4. Financial data; and
5. Third party payment recoveries for enrollees.

(b) The contractor shall submit to the Division at least annually information specified by the Division on non-Medicaid enrollees for purposes of comparative analyses of services use and cost patterns.

(c) Each contractor shall maintain records in accordance with 45 C.F.R. 74, and applicable law, and make available to authorized personnel of the Division all records created pursuant to the contracts entered into under this subchapter.

(d) All significant changes that may affect the contractor's performance under the contract shall be immediately reported to the Division.

(e) The contractor, with the prior written approval of the Division as to form and content, shall arrange for the distribution of informational materials to all subcontractors providing services to enrollees, outlining the nature, scope and contract requirements.

10:49-19.10 Contract sanctions

(a) If the Division finds that a contractor fails to comply with any of the appropriate laws, regulations or terms of the contract, or for other good cause, the Division may impose one or all of the following:

1. A letter of admonishment to the contractor indicating that continued violations may lead to the imposition sanctions listed in (a)2, 3 or 4 below;
2. A suspension of further enrollments and one or more marketing activities;
3. A withholding of all or part of the capitation payments; and/or
4. Termination of the contract.

(b) The Division shall give reasonable written notice of its intention to impose sanctions to the contractor, and if necessary as determined by the Division, to enrollees and others who may be directly interested. Such written notice shall state the effective date of, and the reason for, the sanctions.

(c) The contractor or Division shall have the right to terminate the contract with at least 90 days written notice to the other party, or as otherwise stated in the contract.

(d) Pursuant to 42 U.S.C. 1396b(m)(5)(A), the Secretary of the U.S. Department of Health and Human Services may impose substantial civil money penalties on the contractor if:

1. It has failed to substantially provide required medically necessary items and services if that failure has adversely affected the enrollees or has substantial likelihood of adversely affecting the enrollees;
2. It imposes premiums on enrollees in excess of the premiums allowed by the law;

3. It discriminates among enrollees on the basis of their health status or requirements for health care services by expulsion or refusal to re-enroll an enrollee or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment by eligible persons whose medical condition or history indicates a need for substantial future medical services; or

4. It misrepresents or falsifies information that is furnished to:

i. Secretary of the Department of Health and Human Services or the State; or

ii. To any person or to any other entity under this subsection.

(e) The Secretary may provide, in addition to any other remedies available under law, for any of the following remedies:

1. Civil money penalties of not more than \$25,000 for each determination under (d) above, or, with respect to a determination under (d)3 or (d)4i of not more than \$100,000 for each such determination, plus, with respect to a determination under (d)2 above, double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under (d)3 above, \$15,000 for each individual not enrolled as a result of a practice described in such paragraph.

10:49-19.11 State-defined HMOs

(a) A State-defined HMO is subject to all of the requirements of N.J.A.C. 10:49-19.1 through 19.10 with the following exceptions noted:

1. A guarantee of Medicaid eligibility cannot be offered to enrollees of a State defined HMO. (1902(e)(2)(A) of the Social Security Act)

2. The State may not restrict the period for requests for termination of enrollment without cause to the first month of each period of enrollment for enrollees of a State-defined HMO. (1903(m)(2)(F) of the Social Security Act)

(b) Medicaid members of a State defined HMO receive all Medicaid services for as long as they remain Medicaid eligible.

1. Out-of-plan services are reimbursed through fee-for-service and do not require prior authorization by the HMO.

Emergency New Rule, R.1993 d.525, effective October 4, 1993 (to expire December 3, 1993).

See: 25 N.J.R. 4793(a).

Adopted Concurrent Proposal, R.1994 d.4, effective December 2, 1993.

See: 25 N.J.R. 4793(a), 26 N.J.R. 224(a).

SUBCHAPTER 20. THE GARDEN STATE HEALTH PLAN (GSHP)

Cross References

Optical appliance services, prior authorization for inclusion in benefits package, see N.J.A.C. 10:62-2.5.

10:49-20.1 Introduction

The Garden State Health Plan (GSHP) is a State-operated health maintenance organization (HMO) with a Certificate of Authority from the New Jersey State Department of Health to operate in selected counties. It was formerly a Federal demonstration project known as the Medicaid Personal Physician Plan.

10:49-20.2 Physician case manager (PCM)

(a) The primary component of the Garden State Health Plan is the medical case management system whereby the physician case manager (PCM) is responsible for the provision of all primary care services and for the management of referral, ancillary and inpatient services. Participating providers who are acting as PCMs can be in solo practice; group practice; professional corporation or association; health maintenance organization (HMO); independent, free-standing clinic; or in a hospital affiliated entity which allows for primary care services and is not subject to DRG reimbursement principles.

(b) The PCM must review and approve all medical services and expenditures on behalf of the patient (including referrals for ancillary services, specialty care, and inpatient hospital care) and provide or arrange for the provision of 24-hour, seven-day-a-week medical coverage.

(c) Participation by physicians in the Garden State Health Plan is voluntary and on a contractual basis. A physician can participate in both the Garden State Health Plan and the Medicaid fee-for-service program. A Physician, however, must be a Medicaid approved provider before he or she can participate in the Garden State Health Plan.

(d) The physician case manager must submit a claim form for each encounter with a patient who is included in his or her panel for GSHP members. The form is required for utilization data, quality assurance and reporting, not for billing purposes. Information on the claim is the same as that which is required on a regular fee-for-service claim. See the Fiscal Agent Billing Supplement for instructions to complete the claim form.

10:49-20.3 Capitation payment system

(a) Physician case managers (PCMs) participating in the Garden State Health Plan are reimbursed through a capitation payment system. The capitation payment system is divided into three funds:

1. The Monthly Prepayment Fund;
2. The Referral Services Fund; and
3. The Inpatient Services Fund.

10:49-20.4 Medicaid recipient

(a) The Garden State Health Plan is offered to the Medicaid recipient as an alternative to the existing Medicaid fee-for-service program. Participation by the Medicaid recipient is voluntary.

(b) A Medicaid recipient who joins the Plan is guaranteed up to 12 months of Medicaid eligibility. This guarantee is granted in six month segments and the individual must be Medicaid eligible the first day of each six month period.

(c) A Medicaid recipient who enrolls in the Plan selects a physician case manager from a list provided by the enrolling agent. Each Medicaid eligible has his or her own PCM. Each family member may have the same PCM or may choose a different physician. A Medicaid eligible family may enroll in the GSHP only if all the Medicaid eligible family (case) members join.

(d) When a Medicaid recipient enrolls in GSHP, the enrolling agent completes a GSHP Enrollment Application which the Medicaid recipient signs. The recipient is then given a copy of the application, a GSHP Conditions of Membership form and a GSHP Information Sheet at the time of application. (See Appendix, N.J.A.C. 10:49).

(e) Beginning on the effective date of enrollment in the GSHP, a message is printed on the Medicaid ID card (FD-152 Form, see N.J.A.C. 10:49-2.12 and Appendix, N.J.A.C. 10:49). The message states "HMO-CHECK GSHP ID CARD." This message alerts providers to ask the member for his or her GSHP identification card. The GSHP ID card lists each family member and his or her physician case manager's name and telephone number.

10:49-20.5 Action required by providers

(a) When providing services and requesting payment for services rendered GSHP members, providers are required to:

1. Check the Medicaid eligibility card for GSHP message;
2. Ask to see the GSHP Member Identification card for physician case manager's name and telephone number;
3. Contact the physician case manager to receive prior authorization to provide services; and
4. Follow billing instructions in the Fiscal Agent Billing Supplement.

10:49-20.6 GSHP services

(a) The following services are covered under the GSHP. Those services in (a)18 through 22 below do not require prior authorization from a physician case manager.

1. Chiropractic services;
2. Clinical laboratory services;
3. Clinic services at free-standing clinics;
4. Drugs (prescription);
5. EPSDT;
6. Hearing aids;
7. Home health services;
8. Hospital services, including
 - i. Emergency room service;
 - (1) True life- or organ-threatening conditions may be treated, with notification to the PCM as soon as possible;
 - ii. Inpatient hospitalization; and
 - iii. Outpatient clinic;
9. Medical equipment;
10. Medical supplies;
11. Mental health services including psychologist services; only one mental health service every six months (requires prior authorization by the physician case manager);
12. Optical appliances;
13. Optometric services;
14. Physician services, including inpatient physician services;
15. Podiatric services;
16. Radiological services;
17. Rehabilitative services (physical therapy, occupational therapy, audiology and speech-language pathology services);
18. Second surgical opinion consultations;
19. Physician fee for routine in-hospital newborn care;
20. Pediatrician attendance at at-risk vaginal deliveries or caesarian sections;
21. Practitioner fee for normal prenatal, delivery and post partum services; and
22. Certified nurse midwife services.

(b) The following services are non-covered services under the GSHP. Non-covered GSHP services are still available to the GSHP client, outside of the Plan, as long as the client retains his or her Medicaid eligibility. Such services must be provided in accordance with policies described in the appropriate manual.

1. Dental services;
2. Medical day care;
3. Nursing facility care;
4. Prosthetics and orthotics; and
5. Transportation services.

10:49-20.7 Emergency medical care situations for GSHP members

(a) Emergency medical care is available to all GSHP members on a 24-hour, seven-day-a-week basis. Listed below are the guidelines for assessing (for reimbursement and reconciliation purposes) the levels of care in an emergent, urgent or routine situation. These guidelines can be applied to any setting.

1. Level I—Emergency life-threatening or organ-threatening or potentially life-or-organ-threatening condition that requires immediate care. The treating provider must notify the physician case manager as soon as possible after stabilizing the patient.

2. Level II—Urgent condition that is potentially harmful to a patient's health and determined by the physician to be medically necessary for medical treatment within 12 hours to prevent deterioration. The PCM must be called by the treating provider for authorization of the services before providing treatment.

3. Level III—Routine medical care (non-emergent/urgent)—that which would have no adverse effects if not treated within 24 hours or could be treated in a less acute setting (for example, physician's office) or by the patient himself or herself. The physician case manager must be called by the treating provider for authorization of the services before providing treatment.

10:49-20.8 GSHP reimbursement policy for emergency services

(a) Level I emergency care will be reimbursed without the requirement of the PCM's prior authorization. However, the PCM must be notified as soon as the patient is stabilized. The GSHP office shall be contacted for exception for payment processing (telephone 1-800-525-0047).

(b) Services classified under Levels II and III will be reimbursed only when prior authorized by the PCM. If the PCM is contacted for authorization and he or she does grant his or her approval, the provider may then treat the patient and when billing for the service, include the PCM's authorization number in the appropriate portion of the claim form. The completed claim can then be submitted directly to the Fiscal Agent for payment.

1. In situations for services classified under Levels II and III where the provider and PCM do not agree and the provider renders service without authorization but feels reimbursement is warranted, the provider may request of the Plan Office payment consideration by stating and documenting his or her reasons for treatment on the GSHP 16 form, "Exception Payment Request Form" (obtained through the Plan Office). To receive consideration for reimbursement, it will be necessary for the provider to submit the completed GSHP-16 and a hard copy claim to the Garden State Health Plan Office.

i. The New Jersey Medicaid Program's policy on timeliness of claim submission and inquiry applies to the Garden State Health Plan; thus, the GSHP-16 must be submitted to and received by the Garden State Health Plan, in accordance with time frames stated in N.J.A.C. 10:49-7.2.

10:49-20.9 Exception Payment Request Form (GSHP-16)

(a) If due to unusual circumstances a provider failed to obtain authorization from the PCM before rendering a service, he or she may request a review by and retroactive approval from the PCM.

(b) After contacting the PCM, the provider will either be sent the authorization by the PCM, or will be refused. The PCM does have the right to refuse a request for a retroactive approval.

1. If retroactive authorization is refused by the PCM and the provider feels the care was appropriately rendered, he or she may request an Exception Payment Request Form (GSHP-16), for each occurrence, from the GSHP Office, DMAHS, CN-712, Trenton, N.J. 08625-0712. Detailed information about the nature of the service as well as the circumstances of the failure to obtain prior approval will be required. For more information, providers may contact the Plan office at 1-800-525-0047.

SUBCHAPTER 21. PHARMACEUTICAL ASSISTANCE TO THE AGED AND DISABLED (PAAD)

10:49-21.1 Introduction

(a) Pharmaceutical Assistance to the Aged and Disabled (PAAD) is a unique State-funded program to help certain New Jersey residents pay for prescription medicines and certain pharmacy items. A person who applies and is approved will receive a PAAD Eligibility Card (see Appendix, N.J.A.C. 10:49). A PAAD eligible person must pay a \$2.00 copayment for each prescribed drug to the pharmacy. PAAD pays the rest.

1. Legend drugs, insulin, insulin syringes and needles and certain diabetic testing materials are covered. Drugs that the Food and Drug Administration determines to be proven not effective are not covered.

10:49-21.2 Eligibility requirements

(a) To qualify for PAAD, a person:

1. Must have been a New Jersey resident at a permanent address for at least 30 days before applying. Residence must not be seasonal or temporary but a legally established residence; and

2. Must meet the annual income criteria established by the New Jersey State Legislature for a single individual and/or married couples; and

3. Must be 65 years of age or older; or

4. Must be receiving Federal Social Security Disability benefits and be at least 18 years of age and under 65; and

5. Must not have any other health insurance or retirement benefits which provide prescription coverage, equal to, or better than, PAAD benefits, or may not be receiving Medicaid prescription benefits.

(b) A person under age 65 receiving Federal Social Security Disability benefits on behalf of someone else is not eligible for PAAD.

(c) A person in a nursing facility is eligible if he or she meets all the other standards. A person, whether married or single, who has been in a nursing facility for more than 30 days, can receive benefits if his or her own individual income is within the established income limit for single persons and if this income goes directly to the nursing facility. The single income limit similarly applies to the husband or wife of the patient who is not in a nursing facility but who would otherwise be eligible. For a stay of less than 30 days, the established limit for married couples applies.

10:49-21.3 Eligibility renewal

(a) The PAAD beneficiary must renew his or her eligibility every year unless his or her income is below the established biennial income eligibility limit. In that case, he or she would receive an updated eligibility card automatically for the second year, and would complete a renewal application every two years.

(b) Approximately four months prior to his or her expiration date, PAAD will notify the beneficiary if he or she is eligible for biennial eligibility or if he or she must complete a renewal form. Renewal applications must be returned to the PAAD Bureau by the beneficiary at least 45 days prior to the expiration date to ensure continuous coverage.

(c) Under the PAAD Quality Control Program, a person's name may be chosen at random for a review of eligibility. Selection of a person's name does not mean that a problem exists with that person's eligibility.

10:49-21.4 Loss of eligibility

(a) A person will be considered ineligible and PAAD will no longer pay for prescription drugs if:

1. Eligibility is not renewed;

2. The participant moves outside the State of New Jersey;

3. The participant's income increases above the established income limits;

4. A change occurs in a participant's marital status (for example, through divorce, death, remarriage) that increases his or her income above the allowable income limits; or if a spouse is discharged from a nursing home to the community altering a person's income eligibility;

5. The participant loses his or her Federal Social Security Disability benefits;

6. False information is submitted on or with the application; or

7. The participant obtains other health insurance or retirement benefits which provide prescription coverage equal to, or better than, PAAD benefits.

(b) By law, any changes that will affect a person's eligibility must be promptly reported to PAAD. If for any reason a person becomes ineligible, the PAAD card must be returned to PAAD immediately.

10:49-21.5 Applications

Applications for PAAD may be obtained from local pharmacies, senior citizens centers, Medicaid District Offices, County Offices on Aging or directly from PAAD. All documents of proof required must be submitted with the application. If married, and both husband and wife wish to apply, each must file separate applications, even though the joint income appears on both applications.

10:49-21.6 Inquiries

(a) Questions regarding PAAD may be directed to:

PAAD, CN 715, TRENTON, N.J. 08625

1. A toll-free number is also available: 1-800-792-9745.

2. A special teletypewriter telephone (TTY) is available for the hearing impaired by calling: (609) 588-7180. This is not a toll-free number.

SUBCHAPTER 22. LIFELINE PROGRAMS

10:49-22.1 Introduction

Lifeline Programs provide an annual benefit to eligible persons toward the cost of electricity and natural gas. The Lifeline Credit Program (LCP) provides the benefit as a credit on recipients' gas and/or electric bills. The Tenants Lifeline Assistance Program (TLAP) provides the benefit check to tenants whose utility costs are included in their rent. Supplemental Security Income (SSI) beneficiaries receive the benefit as a Special Utility Supplement (SUS) in their monthly SSI checks. For additional information, refer to N.J.A.C. 10:69B.

10:49-22.2 Eligibility requirements

(a) To qualify for Lifeline, a person must:

1. Be a New Jersey resident; and
2. Have annual income within the requirements established by the New Jersey Legislature; and
3. Be at least 65 years old; or receive Federal Social Security disability benefits from the month of July of one year through the month of January of the next year; and
4. Receive electric and/or gas bills in his or her name; or be a tenant who does not receive utility bills but has the cost of utilities included in the rent; or
5. Be eligible for or receiving benefits under the Federal Supplemental Security Income (SSI) program.

10:49-22.3 Lifeline Credit Program

(a) The credit is granted to utility customers as follows:

1. If the customer pays utility bills directly to a single utility company, a \$225.00 credit will appear on the customer's utility bill. If the customer receives utility service from two different companies, (gas and electric), the credit will be divided and \$112.50 applied to each company's bill. (A Special Utility Supplement (SUS) payment will be made to SSI beneficiaries instead of a Lifeline credit. See N.J.A.C. 10:49-22.5.)

(b) When a customer is billed directly:

1. The customer's application must apply to his or her primary place of residence, meaning the home where the customer lives most of the time during the year. Seasonal or temporary residence in New Jersey is not considered the primary residence.
2. When two or more related or unrelated persons live in a single household, Lifeline will accept only one application from that household. The application must be in the name of the person (or his or her spouse) whose name appears on the utility bills.

3. If the customer pays utility bills to two different companies and one bill is in the customer's name and the other in the spouse's name, the customer should report this at the time the application is made. In this instance, the credit would be divided with \$112.50 applied to each of the two accounts.

10:49-22.4 Tenants Lifeline Assistance Program (TLAP)

(a) The benefit is granted to tenants as follows:

1. Tenants who do not pay utility bills directly receive a check for \$225.00 toward the cost of utilities. Only one tenant in a household is entitled to the payment. (A Special Utility Supplement (SUS) payment is made to SSI beneficiaries instead of a TLAP payment. See N.J.A.C. 10:49-22.5.)

(b) When utilities are included in the rent:

1. The tenant's rental must be for his or her primary residence and not for seasonal or temporary rental.
2. A "residential tenant" means a person renting or leasing real property, including a mobile home park site as a personal residence, a net lease residential tenant, as well as a person who is a resident shareholder in a non-profit residential cooperative or mutual housing corporation, or an owner of a condominium, as defined by law.
3. Only one application may be filed per household. When two or more related or unrelated persons live in the same rented household, the person whose name is on the lease or who is the primary tenant or head of household should complete the form.

10:49-22.5 Lifeline for Supplemental Security Income (SSI) beneficiaries

(a) The benefit is granted to SSI beneficiaries as follows:

1. Recipients of Supplemental Security Income (SSI) receive the benefit as Special Utility Supplement (SUS) which is added to their monthly SSI checks. At the end of the fiscal year, those SUS recipients who did not receive the full benefit are sent a check for the difference.

(b) Eligibility for the Special Utility Supplement (SUS) is as follows:

1. Persons receiving SSI benefits who are not in a nursing facility or hospital may receive the SUS.
2. SSI beneficiaries will not receive an application and should not apply. The Lifeline benefit is automatically included in the SSI check. Persons who do not receive the full annual benefit in a year, receive a 13th payment for the balance not received through their SSI checks.

10:49-22.6 Review of eligibility for Lifeline

(a) Eligibility for participation in the Lifeline Programs will be reviewed.

1. If any person is found ineligible for Lifeline or became eligible by providing false or incorrect information, he or she will be required by law to repay the State of New Jersey the full amount of any payment made to, or credit made on his or her behalf.

2. A Lifeline representative may contact a person about his or her eligibility and application if additional information is required.

3. Under the Lifeline Quality Control Program, a person's name may be chosen at random for a review of eligibility. Selection of a person's name does not mean that a problem exists with that person's eligibility.

4. Refusal to be interviewed could result in recovery of a person's Lifeline benefit by the State of New Jersey.

10:49-22.7 Applications

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

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

10:49-22.8 Inquiries

(a) Persons who have not received an application in the mail may call the Lifeline toll-free number: 1-800-792-9745.

1. A special teletypewriter telephone (TTY) is available for the hearing and/or speech impaired (609) 588-7180. This is not a toll-free number.

SUBCHAPTER 23. HEARING AID ASSISTANCE TO THE AGED AND DISABLED**10:49-23.1 Introduction**

The Hearing Aid Assistance to the Aged and Disabled Program (HAAAD) is a New Jersey program which provides a \$100.00 reimbursement to eligible residents who purchase a hearing aid during a calendar year. Purchases made in subsequent calendar years may be reimbursed upon reapplication. Medicaid recipients or persons who have other health insurance coverage or retirement benefits that provide full hearing aid coverage are not eligible. However, individuals who have only limited or partial coverage are eligible for a supplementary payment.

10:49-23.2 Eligibility requirements

(a) To meet the requirements for eligibility an individual must:

1. Have purchased a hearing aid;
2. Have been a New Jersey resident at a permanent address for at least 30 days;
3. Have gross income within the requirements established by the New Jersey Legislature; and
4. Be 65 years of age or older; or
5. Be receiving Social Security disability benefits.

10:49-23.3 Administration and application

(a) Applications may be obtained by calling the following toll-free number: 1-800-792-9745.

(b) Individuals not currently enrolled in the Pharmaceutical Assistance to the Aged and Disabled (PAAD) Program, should complete a PAAD Eligibility Application (AP-2). Those having a current PAAD card should complete a Hearing Aid Assistance to the Aged and Disabled (HA-1) Application (see Appendix, N.J.A.C. 10:49).

(c) A special teletypewriter telephone (TTY) is available for the hearing impaired by calling: 609-588-7180. This is not a toll-free number.

APPENDIX

Medicaid Eligibility Identification Card (FD-73/178)
 Medically Needy Claim Transmittal (FD-311)
 Public Assistance Inquiry (PA-1C)
 Certification of Presumptive Eligibility (FD-334)
 Application for Payment of Unpaid Medical Bills (FD-74)
 Department of Human Services Medicaid ID (FD-152)
 DYFS Validation for Health Services Program (DYFS-16-36)
 Validation of Eligibility (FD-34)

Form # 1
 Form # 2
 Form # 3
 Form # 4
 Form # 5
 Form # 6
 Form # 7
 Form # 8

Provider Application (FD-20)
 Provider Agreement (FD-62)
 Disclosure of Ownership and Control Statement (HCFA-1513)
 Patient Certification Form (FD-197)
 Garden State Health Plan Information Sheet
 Garden State Health Plan Conditions for Membership (GSHP-4(a))
 Hearing Aid Assistance Application (HA-1)
 PAAD Eligibility Card
 Medicaid District Office Directory

Form # 9
 Form # 10
 Form # 11
 Form # 12
 Form # 13
 Form # 14
 Form # 15
 Form # 16
 Form # 17

STATE OF NEW JERSEY
 DEPARTMENT OF
 HUMAN SERVICES
 DIVISION OF
 MEDICAL ASSISTANCE
 AND
 HEALTH SERVICES

MEDICAID ELIGIBILITY IDENTIFICATION CARD 1939902

[Empty box for Additional Health Insurance]

[Empty box for HSP (Medicaid) Case No. Person No.]

ADDITIONAL HEALTH INSURANCE*

HSP (MEDICAID) CASE NO. PERSON NO.

VALID FROM TO

SOC. SEC. ACCT. NO. DATE OF BIRTH



FD-73/178 (REV. 3/81)

USE THIS CARD WHEN YOU NEED MEDICAL SERVICES

RECIPENT'S SIGNATURE

[Large empty box for Recipient's Signature]



Form #1

IMPORTANT NOTICE

You must sign the front of this card on the line above the Recipient's Signature. If you are unable to sign the card, the individual representing you must sign your name, initial the card and explain his/her relationship to you.

Immediately notify the Medicaid District Office or the Division of Youth and Family Services case manager or the County Welfare Agency (as appropriate):

1. if you have Medicare coverage or other health insurance not listed or incorrectly listed; or
2. if any changes are necessary to the front of this card; or
3. if you have any questions regarding the use of this card; or
4. if this card is lost or stolen. (Unless the report of the loss or theft can be documented at the appropriate agency, you may be liable to repay Medicaid for any benefits obtained through its unauthorized use).

FEDERAL and STATE LAW make it a crime and set the punishment for persons who have been found guilty of making any false statement or representation of a material fact to receive any benefit or payment under the Medicaid Program. The Department of Human Services is required to make you aware of this law and to warn you against making any false statement in an application or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended.

THIS CARD IS NON-TRANSFERABLE UNDER PENALTY OF LAW. NOTICE TO PROVIDER

The printed name which appears directly above the line for Recipient's Signature on this card is the MEDICAID eligible person. This name identifies that person ONLY (except AFDC can include spouse/child(ren) listed with PERSON NUMBERS) as being eligible for MEDICAID benefits within the time period shown. If the name of a "REPRESENTATIVE PAYEE" appears on this card, that individual is not eligible for Medicaid benefits.

* Ask the cardholder if there is Medicare coverage or other health insurance not listed. Please indicate this information in the appropriate area on the claim form. Prior to billing Medicaid you are to bill other third party payers in accordance with N.J.A.C. 10:49.



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
MEDICALLY NEEDEY CLAIM TRANSMITTAL

RECIPIENT INFORMATION

HSP (Medicaid) CASE NO. _____
NAME _____
ADDRESS _____

PROVIDER INFORMATION

PROVIDER NO. _____
PROVIDER NAME _____
PROVIDER ADDRESS _____

TYPE OF SERVICE	DATE OF SERVICE	CHARGE	PAYMENT FROM OTHER SOURCE	CLIENT OBLIGATION	TOTAL FROM OTHER SOURCES
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

Provider Instructions and Information:

- The services listed above were provided to the identified individual during a covered retroactive period.
- This transmittal does not guarantee payment. Your claim will be processed in accordance with current Medicaid and Medically Needy regulations.
- Each claim form submitted for payment for services listed above must be attached to this document.
- Please enter your provider number in the appropriate space in the upper right corner.
- Any amount listed in the column entitled "Client Obligation" is the responsibility of the client and should be paid by the client directly to you.

NUMBER OF ITEMS _____

SIGNATURE _____
Authorized Representative

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
PUBLIC ASSISTANCE INQUIRY

Referral for: SSI New Jersey Care Medicaid Only AFDC Newborn (complete items 1,2,4,11a,15 only)

TO: FROM:
(SSA / DO)
(County Welfare Agency) Hospital

Date

1. Name: (Last) (First) (Middle) Sex M F
(For newborn referral, enter name and sex of parent.)

2. Social Security Account Number:

3. Permanent Home Address: Telephone:

4. Marital Status: (Check one) Married Single Divorced Separated Widowed Unknown

5. Date of Admission: Date of Birth:

6. Address From Which Admitted: Telephone:

7. Diagnosis:

8. Prognosis: (For SSI disability, blindness and AFDC inapplicable)

9. Referring Physician: Telephone:

10. Spouse: Name: Age: Telephone:
Address:

11. Minor Children (First Names and Ages):
(a) Newborn Data: Name: Date of Birth: Sex M F
Mother's HSP (Medicaid) Case No.:

12. Next of Kin (If other than Spouse or Children):
Address: Telephone:

13. Gross Monthly Income of Patient: Source:

14. Gross Monthly Income of Family Members:

15. Hospital Insurance: Blue Cross I.D. No.: Medicare H.I.C. No.:
(a) Applicable to Newborn? Yes No
Other Carrier Name: Policy No.:

16. Employer's Name: Address:

17. Name of Spouse's Employer: Address:

PA 11 (Rev. 7-89)

Form #3

18. What inquiries have been made regarding financial responsibility for the hospital bill?

What were the results? _____

19. Does patient, patient's authorized agent, or relatives know that an inquiry is being made for the previously checked program?

Yes No

20. Whereabouts:

Is client still in hospital? Yes No

If YES, anticipated address upon discharge: _____

If NO, date of discharge: _____

Present address if known: _____

21. Other Comments: _____

22. The above patient is being cared for in the hospital since _____ on a ward service or general service
Date
basis as to professional and other personal services and I believe that such a patient may be eligible for the previously checked program.

Signature: _____ Title: _____ Date: _____

23. Signature of Patient or Relative: _____ Date: _____

PLEASE READ CAREFULLY BEFORE SIGNING

I understand that I must furnish certain information to the SSA/DO or the County Welfare Agency to establish eligibility and extent of need for Supplemental Security Income Benefits or public assistance, and that the appropriate agency will help to secure this information and verify it. I will supply complete and accurate information, within my knowledge, to representatives of the SSA, DO or the County Welfare Agency. I hereby authorize and direct my relatives, physician, hospital, employers, bankers, and any other person having information concerning the persons named above to furnish complete details to the appropriate agency investigating my application for such assistance. I understand that the information obtained will be used only in connection with the application for or receipt of assistance.

"I further authorize the Social Security Administration to release benefit information and entitlement dates to the hospital whose name appears on the reverse of this form. I understand the hospital will only use this information for purposes of establishing my eligibility to Medicaid."

Signature: _____ Relationship: _____ Date: _____

IF NOT SIGNED BY PATIENT, EXPLAIN WHY: _____

NOTICE TO THE SSA/DO OR CWA INITIALLY RECEIVING THIS INQUIRY. WHEN IT IS NECESSARY TO REFER THE APPLICANT TO ANOTHER PUBLIC ASSISTANCE AGENCY, INCLUDE AT LEAST A COPY OF THIS PA-IC FORM.

DMAHS USE ONLY

PROVIDER USE ONLY



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

CERTIFICATION OF PRESUMPTIVE ELIGIBILITY

CLIENT INFORMATION:

Name: _____ County of Residence _____
 Address: _____ Birth Date: _____
 _____ Social Security No. _____
 Telephone No.: () _____ Household Unit: _____ (No. of persons in household)

(Check appropriate boxes below.)
 Marital Status: Single Married Separated Divorced Widowed
 Race: White Black American Indian Oriental Hispanic Other
 Does client have a pending AFDC, SSI, Medicaid application? Yes No *(If yes, circle program.)*
 Client is: U.S. Citizen Alien admitted for permanent residence
 Alien admitted for temporary residence Undocumented alien

Medicare Coverage: Yes No If Yes, HIC Number: _____
 Other Insurance Company: _____ Other Insurance Policy No.: _____

INCOME INFORMATION:

Total Household Income:	Income	Frequency	Gross Monthly Amt.	Source
Gross Earnings				
Gross Earnings				
Gross Unearned Amount				
Gross Unearned Amount				
Gross Unearned Amount				
Gross Child Support Amount				
Gross Alimony Amount				
Total Monthly Gross Income	\$ _____			
Child Care Expense Amount:	_____ Weekly	_____ BiWeekly	_____ Monthly	

PREGNANCY INFORMATION:

Date of L.M.P. _____ Pregnancy Due Date: _____

CERTIFICATION STATEMENT:

I, _____ attest that I have read and agree to the above statements and fully realize that the county welfare agency relies upon the truth and accuracy of my statements. I have received a copy and understand the Patient Guidelines.

Applicant Signature _____
Date

I certify the above applicant is pregnant and presumptively eligible for limited Medicaid benefits in accordance with N.J.A.C. 10:72-6.1 et seq.

Provider Agency Name _____
Address _____
Telephone

Provider Signature _____
Date

IMPORTANT: THE ORIGINAL FORM MUST BE FORWARDED TO THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, ISS SECTION, AREA #3, PRESUMPTIVE ELIGIBILITY RECORDS, CN-712, TRENTON, NJ 08625, WITHIN TWO (2) DAYS OF COMPLETION.

Form #4 10 334

DEPARTMENT OF HUMAN SERVICES
MEDICAID-ID

7841.006

VALID ONLY FOR THE MONTH OF
MEDICAID HSP #

NOTICE TO PROVIDER

ELIGIBLE PERSONS		PER	ELIGIBLE PERSONS		PER
1		11			
2		12			
3		13			
4		14			
5		15			
6		16			
7		17			
8		18			
9		19			
10		20			
11		21			
12		22			

VOID

REQUEST PERSONAL IDENTIFICATION IF YOU DO NOT KNOW THE PATIENT

PLEASE REPORT THE CASE NAME, CASE NUMBER, AND PERSON NUMBER ACCURATELY ON ALL CLAIM FORMS AND OTHER COMMUNICATIONS RELATING TO THE CLAIM.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES
MEDICAID ELIGIBILITY IDENTIFICATION

CARRY THIS CARD AT ALL TIMES

Present it to the pharmacy, hospital, physician or other providers for medical services rendered in behalf of eligible persons

RECIPIENT'S SIGNATURE REQUIRED

No es válida si no está firmada. Entréguela a la farmacia, hospital, médico u otros proveedores de servicios médicos prestados a personas que reúnen las condiciones necesarias para poder usar Medicaid.

NOTICE

Federal law makes it a crime and sets punishment for persons who have been found guilty of making any false statement or representation of a material fact to receive any benefit or payment under the medical assistance program. This Department is required to make you aware of this law and to warn you against making any false statement in an application or in a fact used in determining the right to a benefit or converting a benefit to the use of any person other than one for whom it was intended.

NON-TRANSFERABLE UNDER PENALTY OF LAW

AVISO

De acuerdo con la ley federal es un delito hacer una declaración falsa a fin de recibir un beneficio o pago bajo el programa de asistencia médica, y dicha ley fija pena a las personas que la infrinjan. Este Departamento le tiene que informar de dicha ley y le tiene que advertir que no haga ninguna falsa declaración en una solicitud para determinar su derecho a un beneficio, o para convertir el beneficio al uso de otra persona que no sea la destinada a recibir el mismo.

INTRANSFERIBLE BAJO PENA DE LA LEY

Form #6

NOTICE TO CLIENT

THIS VALIDATION FORM INDICATES ELIGIBILITY FOR AUTHORIZED HEALTH SERVICES PROVIDED UNDER THE NEW JERSEY HEALTH SERVICES PROGRAM.

THIS VALIDATION MUST BE PRESENTED TO THE DOCTOR, HOSPITAL OR OTHER MEDICAL SERVICES PROVIDER WHEN SERVICES ARE RENDERED.

NOTICE TO PROVIDER OF MEDICAL SERVICES

YOUR CLAIM FOR PAYMENT OF HEALTH SERVICES IS TO BE SUBMITTED TO THE APPROPRIATE CONTRACTOR FOR THE STATE OF NEW JERSEY ON THE REQUIRED VENDOR CLAIM FORM.

PLEASE REPORT THE CASE NAME, CASE NUMBER AND PERSON NUMBER ACCURATELY ON ALL CLAIM FORMS AND OTHER COMMUNICATIONS RELATING TO THE CLAIM.

PLEASE CONTACT THE MEDICAID DISTRICT OFFICE SERVING YOUR AREA IF YOU HAVE QUESTIONS ABOUT THE MEDICAID PROGRAM.

Child's Medicaid No. Name Case No.

VALID ONLY FOR DATES OF

PLACEMENT REFERENCE

STATE OF NEW JERSEY
DIVISION OF YOUTH AND FAMILY SERVICES

VALIDATION
FOR HEALTH SERVICES PROGRAM

DYFS 16-36
(rev. 10/85)

Form #7



STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

VALIDATION OF ELIGIBILITY

Last Name	First Name	Mi	Health Services Program Case No.	Person Number
-----------	------------	----	-------------------------------------	---------------

NOTICE TO PROVIDERS

This form identifies the person listed above as eligible for authorized services under the New Jersey Health Services Program (Medicaid).

This form also serves as a validation of eligibility for up to 31 days from date of issue. All policies and procedures specified in the appropriate New Jersey Health Services Program Provider Manual are to be followed by providers when rendering services to this person.

The signature, title and telephone number of an authorized representative of the State Institution listed below must be included to validate this form.

THIS FORM IS THE PROPERTY OF THE STATE OF NEW JERSEY AND MUST BE RETURNED WITH THE PATIENT.

Signature and Title of State Institution Representative	Date of Issue
--	------------------

Name of State Institution	Telephone No.
---------------------------	---------------

FD-34 (rev. 5/83)

Form #8

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

PROVIDER APPLICATION

1 _____ 2 _____
 Legal Name of Provider Type of Business or Facility

 Business Name (if Different From Above)

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____
 Address - Service Location (Street) Street City County State Zip Code

4 _____ 5 _____ 6 _____
 Employer ID Number Telephone Number Length of Time at Above Address

7 _____ 8 _____
 Billing Address (if different) Name of Administrator, Chief Executive Officer, or other responsible official

9 Indicate legal status of your organization Profit _____ Non-Profit _____ Private _____ Public _____ Municipal _____
 State _____ Charity _____ School Nurse _____ County _____ Other _____ If other, please specify _____

10 List the specific service(s) for which you are requesting approval for reimbursement under the Medicaid Program

11 Do you operate from more than one location? _____ Yes _____ No If yes, list all other subsidiary or affiliated organizations below (Name and service address)
 1 _____
 2 _____
 3 _____
 Please attach additional sheets if necessary.

12 Please indicate if you are a member of a chain organization. _____ Yes _____ No. If yes, indicate name _____

13 Please indicate your preference to receive central or local reimbursement
 _____ to each satellite location;
 _____ to central location at _____
 Billing through a central location is allowable and left to the provider's discretion. However, if the provider chooses to bill centrally, pre-addressed claims MUST be utilized since they reflect the proper address and provider number for that location.

14 Do you require a Certificate of Need under the Health Facilities Planning Act from the New Jersey Department of Health? _____ Yes _____ No If yes, attach a copy of the Certificate of Need. If no, explain why you do not require a certificate _____

15 If your business or facility requires a license permit, indicate type _____ and number _____
 Please attach a copy of the license permit, i.e., Independent Laboratory Certification.

16 CERTIFICATION, ACCREDITATION OR APPROVAL Specify type and attach copy For example JCAHO (hospitals), New Jersey Department of Health (clinics), Division of Mental Health and Hospitals (mental health clinics), State Board of Dentistry (dental clinics), State Board of Pharmacy (providers offering pharmaceutical services), American Board for Certification in Prosthetics and Orthotics (Prosthetist and/or Orthotist) See Item 16.

17 Approved by Medicare? _____ Yes _____ No. If yes, please indicate Medicare provider number _____ and attach copy of your Medicare approval.

18 Are you currently or have you ever been an approved provider of services under the New Jersey Medicaid Program or the Medicaid Program of any other state or jurisdiction? _____ Yes _____ No If Yes, list types of services provided and current status (If you were approved at one time and you no longer participate, explain the reason(s)) _____

FD-20-112-90

Form #9

- 19 Have any of the entities named in response to questions I, or II, or their officers or partners, or any of the individuals named in response to questions 8 ever been the subject of any license suspension, revocation, or other adverse licensure action in this state or any other jurisdiction? Yes No If yes, please explain _____
- 20 Have any of the entities named in response to question I or II, or their officers or partners, or any of the individuals named in response to questions 8 ever been indicted, charged, convicted of, or pled guilty or no contest to any federal or state crime in this state or any other jurisdiction? Yes No If yes, please explain _____
- 21 Have any of the entities named in response to questions I or II, or their officers or partners, or any of the individuals named in response to questions 8 ever been the subject of any Medicaid (Title XIX) or Medicare (Title XVIII) suspension, debarment, disqualification or recovery action in this state or any other jurisdiction? Yes No If yes, please explain _____
- 22 Do any of the entities named in response to question I or II, or their officers or partners, or any of the other individuals named in response to questions 8 own or have any financial interest in any other provider participating in the New Jersey Medicaid (Title XIX) Program or the Medicaid (Title XIX) Program of any other state or jurisdiction? Yes No If yes, please list provider name and nature of relationship _____
- 23 Do you charge for goods and/or services? TO ALL TO NONE TO CERTAIN GROUPS ONLY
If you charge to all or only certain groups, please explain your arrangement and attach a copy of your fee schedule _____
- 24 List days and hours of operation _____



STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
NEW JERSEY HEALTH SERVICES PROGRAM
TITLE XIX (MEDICAID)

PROVIDER AGREEMENT
BETWEEN
NEW JERSEY DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
AND

PROVIDER

PROVIDER AGREES:

1. To comply with all applicable State and Federal Medicaid laws and policy, and rules and regulations promulgated pursuant thereto;
2. To keep such records as are necessary to fully disclose the extent of services provided to individuals receiving assistance under the Medicaid Program;
3. To furnish the Division of Medical Assistance and Health Services, the Secretary of Health and Human Services and the Medicaid Fraud Section, Division of Criminal Justice with such information as may be requested from time to time, regarding any payments claimed for providing services under the Medicaid Program;
4. To comply with the requirements of Title VI of the Civil Rights Acts of 1964 and Section 504 of the Rehabilitation Act of 1973 and any amendments thereto; and Section 1909 of P.L. 92-603, Section 242 (c) which makes it a crime and sets the punishment for persons who have been found guilty of making any false statement or representation of a material fact in order to receive any benefit or payment under the Medical Assistance Program. (The Department of Human Services is required by Federal regulation to make this law known and to warn against false statements in an application/agreement or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended).
5. To comply with the disclosure requirements specified in 42 CFR 455.100 through 42 CFR 455.106.

The provider may, on thirty days written notice to the Division, terminate this Agreement.

DATE

SIGNATURE OF PROVIDER

TITLE

FD-62 (REV. 6/86)

MEDICAID 3031-M Ed. 6/86

Form #10

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0086

IV (a) Has there been a change in ownership or control within the last year?
If yes, give date _____ Yes No LB8

(b) Do you anticipate any change of ownership or control within the year?
If yes, when? _____ Yes No LB9

(c) Do you anticipate filing for bankruptcy within the year?
If yes, when? _____ Yes No LB10

V Is this facility operated by a management company, or leased in whole or part by another organization?
If yes, give date of change in operations _____ Yes No LB11

VI Has there been a change in Administrator, Director of Nursing or Medical Director within the last year?
 Yes No LB12

VII (a) Is this facility chain affiliated? (If yes, list name, address of Corporation and EIN)
Name _____ EIN # _____ Yes No LB13

Address _____ LB14

VII (b) If the answer to Question VII.a. is No, was the facility ever affiliated with a chain?
(If YES, list Name, Address of Corporation and EIN)
Name _____ EIN # _____ Yes No LB18

Address _____ LB19

VIII Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years?
 Yes No LB15

If yes, give year of change _____
Current beds _____ LB16 Prior beds _____ LB17

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Name of Authorized Representative (Typed)		Title
Signature		Date
Remarks		



**YOUR PRESCRIPTION FOR
GOOD HEALTH**

WELCOME TO THE GARDEN STATE HEALTH PLAN

Thank you for applying for membership in the Garden State Health Plan (GSHP). After your eligibility for enrollment is verified, the GSHP will process your enrollment, which usually takes forty-five days. Your membership, therefore, should begin on [blank]. You will know when your membership begins when the message, "HMO-Check GSHP-ID Card," is printed on your Medicaid Identification (ID) Card which you receive each month.

A few weeks before your membership begins, you will receive a gold Garden State Health Plan Membership Card. When your GSHP membership begins, you must show both your Medicaid ID Card and your GSHP gold card each time you receive medical care.

Also, as a Plan member, it is important that you establish and maintain a close relationship with your primary care physician. Remember, all medical services you receive will be coordinated by your primary care physician. You must, therefore, call your physician for authorization before you go to any other health provider, such as an eye doctor, for X-rays, or to have a prescription filled, etc.

The Garden State Health Plan operates a toll-free number: 1-800-525-0047. Please call if you have any questions or problems. Our goal is to keep each GSHP member healthy and satisfied. In addition, please notify our office immediately if you do not receive your gold card within 45 days of your application.

The Garden State Health Plan physician case manager(s) you have chosen is/are:

Name of Family Member	Physician	Telephone	Address
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SU RECETA PARA LA BUENA SALUD

UNA CORDIAL BIENVENIDA AL GARDEN STATE HEALTH PLAN

Le agradecemos su solicitud para afiliarse al Garden State Health Plan (GSHP). Después de que se compruebe su elegibilidad para la inscripción, el GSHP tramitará su inscripción, lo que normalmente toma 45 días. Por consiguiente, su afiliación comenzará el [blank]. Usted sabrá la fecha del inicio de su afiliación cuando el mensaje "HMO-CHECK GSHP-ID CARD" esté impreso en su tarjeta de identificación de Medicaid, que recibirá mensualmente.

Unas semanas antes de que se inicie su afiliación, usted recibirá una Tarjeta dorada de Identificación como Miembro del Garden State Health Plan. Cuando se inicie su afiliación en el GSHP, cada vez que reciba atención médica usted deberá presentar su tarjeta de identificación de Medicaid junto con su tarjeta dorada del GSHP.

Además, como miembro del Plan, es importante que usted establezca y mantenga unas relaciones estrechas con su médico de atención primaria. Tenga presente que todos los servicios médicos que usted reciba serán coordinados por su médico de atención primaria. Por consiguiente, usted deberá llamar a su médico para obtener autorización antes de acudir a cualquier proveedor de salud distinto, tal como el oculista, para radiografías o para que se le dispense una receta.

T El Garden State Health Plan mantiene un número de teléfono gratis de tarifa: 1-800-525-0047. Le rogamos que llame si tiene preguntas o problemas. Nuestro objetivo es el de mantener sano y satisfecho a cada uno de los miembros del GSHP. Además, le rogamos que avise a nuestra oficina si no recibe su tarjeta dorada en un plazo de 45 días de remitir su solicitud.

El o los gerentes médicos para casos del Garden State Health Plan que usted seleccionó son:

Nombre del familiar	Medico	Teléfono	Dirección
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services

GARDEN STATE HEALTH PLAN (GSHP)
CONDITIONS FOR MEMBERSHIP

1. I have applied for membership in the Garden State Health Plan (GSHP). I have accepted no money nor rewards to enroll in the Plan, nor have I been forced by anyone to join the Plan.
2. I understand that I may choose my Physician Case Manager (PCM) from a list of participating physicians in my area according to the type of practice and availability of openings for that PCM.
3. I understand that I am eligible for all Medicaid services as a Plan member and I will not lose any Medicaid benefits by enrolling in this plan.
4. I understand and agree, as a Plan member, to *only* go to the doctor I have chosen for *all* medical services no matter what the problem. If an emergency occurs and my doctor cannot be contacted right away, I may go to a hospital emergency room and my PCM will be notified. I *will not* go to the hospital emergency room or to any other doctor if it is not an emergency situation.
5. I understand that the PCM I have chosen will send me for other health services whenever necessary. I will *only* use another physician's services or other health care provider's services (e.g. optometrist, chiropractor, etc.) if I have been sent by or have the approval of my PCM. Only my PCM will write any necessary prescriptions for me or will authorize another physician to write a prescription for me.
6. I understand that if I use any health services (for example, using the hospital emergency room for non-emergency or routine care) without the approval of my PCM, the Medicaid Program will not pay for these unauthorized services and I may become responsible for paying the bills.
7. I understand that my Plan participation begins when I receive my validation stub with the following message, "HMO—Check GSHP ID Card," printed on the stub. My membership in the Plan will automatically continue until my eligibility is terminated or my disenrollment is authorized. If I want to disenroll from the Plan or choose another PCM, I *must* contact the Plan Office listed below. Under certain circumstances, I may be guaranteed twelve (12) months of Medicaid eligibility upon enrollment which has been explained to me.
8. I understand that I am enrolling for six (6) month periods and that I may change my Physician Case Manager for any reason during the first thirty (30) days of membership in the Plan (which begins the first month the Plan message appears on my Medicaid Validation Card) and during the first thirty (30) days of each successive six (6) month period of membership.
9. I understand that in order to participate in the Plan I must be Medicaid eligible on the effective date of my enrollment in the Plan. If I should lose my Medicaid eligibility, my membership becomes null and void.
10. I understand that if I am currently receiving long-range medical services, (such as mental health counseling) or am under a "plan of care" of another physician, I will discuss this matter with my PCM as soon as possible. If there is any disagreement about continuing that care, I may call the designated Plan Office at the toll free number to discuss a possible solution.
11. I understand that under certain circumstances the County Welfare Agency (AFDC clients only) has the right and obligation to invalidate my twelve (12) month guarantee of eligibility if I fail to comply with public law which affect my eligibility for public assistance benefits.

Any questions or complaints about my Plan membership should be directed to:

Office of the Garden State Health Plan

Address: CN 712, Trenton, New Jersey 08625

Toll Free Telephone Number: 1 - 800 - 525 - 0047
(This number can also be found on your GSHP Membership Card.)

GSHP-4(a)

Form #14

CONDICIONES DE MIEMBRO

1. He solicitado ser miembro del Plan de Salud del Estado del Jardín. No he aceptado ningún dinero o recompensa para inscribirme al Plan, ni se me ha obligado a unirme al Plan.
2. Tengo entendido que puedo escoger mi Gerente Médico para Casos (GMC) de un listado de médicos participantes en mi área, de acuerdo al tipo de práctica y a la disponibilidad de plazas existentes para ese GMC.
3. Tengo entendido que soy elegible para todos los servicios de Medicaid como miembro del Plan y que no voy a perder ningún beneficio de Medicaid al participar en este plan.
4. Tengo entendido y estoy de acuerdo que, como miembro del Plan, visitaré para *todos* los servicios médicos *solamente* al médico que haya escogido, independientemente del problema. En caso de emergencia y no poder comunicarme con mi médico inmediatamente, puedo ir a la sala de emergencia de un hospital y se notificará a mi GMC. *No* iré a la sala de emergencia de un hospital o a ningún otro médico, a menos que sea una emergencia.
5. Tengo entendido que al GMC que haya escogido me enviará a otros servicios de salud cuando sea necesario. *Solamente* recurriré a los servicios de otro médico o de algún otro proveedor de servicios de salud (p.e. optómetra, quiropráctico, etc.), siempre y cuando me haya enviado y tenga la aprobación de mi GMC. Mi GMC será el único que podrá suministrarme las recetas necesarias o autorizar a otro médico a hacerlo.
6. Tengo entendido que si utilizo cualquier servicio de salud (por ejemplo, la utilización de la sala de emergencia hospitalaria para casos que no son de urgencia o para cuidado rutinario) sin la aprobación de mi GMC, el programa de Medicaid no pagará dichos servicios y puede que yo sea responsable de cubrir los gastos incurridos.
7. Tengo entendido que mi Plan de participación comienza en el momento en que reciba mi tarjeta de validación impresa con el siguiente mensaje: "HMO — Check GSHP ID Card," (HMO—Factue la tarjeta de identificación del Plan). Mi participación en el Plan continuará automáticamente hasta que termine mi elegibilidad o hasta que se autorice mi disociación. En caso de que desee disociarme del Plan o escoger a otro GMC, *deberé* comunicarme con la oficina del Plan cuyo nombre aparece al pie de la página. Bajo ciertas circunstancias, se me podrán garantizar doce (12) meses de elegibilidad con Medicaid, lo cual me fue explicado al momento de la inscripción.
8. Tengo entendido que alisto para un periodo de seis meses y que puedo cambiar de Gerente Médico para Casos por la razón que sea durante los primeros treinta (30) días de participación en el Plan (el cual comienza a partir del primer mes en que aparezca en mi tarjeta de validación de Medicaid el mensaje de Plan) y durante los primeros treinta (30) días de cada periodo sucesivo de seis meses de participación.
9. Tengo entendido que para participar en el Plan debo ser elegible para Medicaid en la fecha efectiva de mi subscripción al Plan. Si perdiera mi elegibilidad de Medicaid, mi membresía será nula e inválida.
10. Tengo entendido que si actualmente estoy recibiendo servicios médicos a largo plazo, (tales como consejería de salud mental) o estoy bajo un "plan de cuidado" de otro médico, discutiré este asunto con mi GMC lo más pronto posible. En caso de surgir algún desacuerdo sobre la continuación de dicha atención, podré comunicarme con la oficina del Plan para discutir una posible solución.
11. Tengo entendido que bajo ciertas circunstancias la Agencia de Bienestar del Condado (solamente para clientes del AFDC) tiene el derecho y la obligación de invalidar mi garantía de elegibilidad de doce (12) meses, en caso de que no cumpla con las leyes que gobiernan mi elegibilidad para los beneficios de asistencia pública.

Cualquier pregunta o queja sobre mi membresía al Plan deberá dirigirse al:

Oficina del Plan de Salud del Estado del Jardín

Dirección: CN 712, Trenton, New Jersey 08625

Número del Teléfono Libre de Tarifa: 1-800-525-0047
(Este número del teléfono lo puede encontrar en su tarjeta de miembro de GSHP)

Form #14

State of New Jersey 10:49-Appendix-FORM #15 Address reply to
 Department of Human Services HAAAD Program
 Division of Medical Assistance and Health Services Cn-715
 Trenton, NJ 08625-0715

**ELIGIBILITY APPLICATION
 HEARING AID ASSISTANCE TO THE AGED AND DISABLED (HAAAD)**

Last Name	First Name	MI
Street Address		
City	State	Zip Code
Applicant's Social Security Number		Applicant's Pharmaceutical Assistance to the Aged and Disabled Number
<p>The following documentation must accompany this application:</p> <ol style="list-style-type: none"> 1. A receipt for the purchase of the hearing aid. 2. A written statement from your physician attesting to the medical necessity for obtaining a hearing aid. You may obtain your physician's signature below or attach a copy of the prescription for the hearing aid. 		
<p>TO BE COMPLETED BY YOUR PHYSICIAN</p> <p>I have examined this applicant and have determined the medical necessity for obtaining a hearing aid.</p>		
Physician's Signature	Name & Address of Physician (PLEASE PRINT)	
<p>Applicant's Certification and Waiver: I certify that the information above is true and accurate to the best of my knowledge. I understand that if it is determined that HAAAD benefits have been improperly issued to me, I will be required to repay such benefits. I understand that to verify my eligibility for HAAAD, it may be necessary to obtain certain information from records of the Pharmaceutical Assistance to the Aged and Disabled (PAAD) Program, and I authorize the release of that information. I hereby assign to the State of New Jersey any right to hearing aid coverage to which I may be entitled under any other plan of assistance or insurance or from any other liable third party.</p>		
Applicant's Signature	Date	
<p>HA-1 (rev 4/91) Form #15</p>		

What Is Hearing Aid Assistance to the Aged and Disabled?

This is a State of New Jersey program which provides a \$100 reimbursement to eligible residents who purchase a hearing aid.

How Do I Apply?

If you are currently enrolled in the Pharmaceutical Assistance to the Aged and Disabled Program (PAAD), you must complete a HAAAD application and submit the following documentation:

1. A receipt for the purchase of your hearing aid.
2. A written statement from your physician attesting to the medical necessity for obtaining a hearing aid.

If you are not currently enrolled in the PAAD program, you must complete a PAAD application as well. This is needed to verify your age or disability status, state residency, and annual income.

Applications may be obtained by calling the toll-free number:

1-800-792-9745

How Is The Term "Hearing Aid" Defined For The Purpose Of This Program?

"Hearing aid" means a custom-fitted ear-level or body-worn electronic device to enhance communication for the hearing impaired.

How Often May I Receive The HAAAD Benefit?

You may receive one \$100 payment during a calendar year. If you purchase another hearing aid during a subsequent calendar year, you may reapply.

How Soon Will I Get My \$100 Payment After I Apply?

Once your application has been approved, you should receive your payment in approximately six to eight weeks.

Would I Be Eligible If I Have Other Hearing Aid Coverage?

If you are a Medicaid recipient or have other health insurance coverage or retirement benefits that provide full hearing aid coverage, you would not be eligible. If you have only limited or partial coverage, you would be eligible for a supplementary payment.

How Do I Know If I Am Eligible?

You must be at least 65 years of age, or receiving Social Security Disability benefits.

You must be a New Jersey resident

You must have an annual gross income of less than \$15,700 if you are single, or less than \$19,250 if you are married

If you have any questions about HAAAD, write to:

**HAAAD
CN-715
Trenton, NJ 08625-0715**

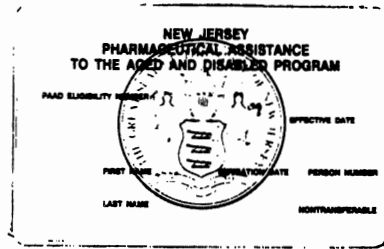
or telephone the toll-free number
1-800-792-9745

A special Teletypewriter Telephone (TTY) is available for the hearing impaired by calling
609-588-7180*

***NOTE:
This is NOT a toll-free number.**

STATE OF NEW JERSEY
 PHARMACEUTICAL ASSISTANCE TO THE AGED AND DISABLED

Your plastic PAAD Identification card is attached. Persons violating any provision of the PAAD ACT shall be subject to applicable civil and criminal penalties in N.J.S.A. 30:40-1 Et Seq. and as may hereafter be amended, and to suspension of their eligibility for one year for a first offense and permanent revocation of their eligibility for a second offense. Names can have no more than 7 letters in the first and 12 in the last.



You must return your eligibility card to PAAD, CN 715, Trenton, New Jersey 08625 if:

1. Your annual income exceeds the limits set by law.
2. You move out of the State of New Jersey.
3. You become eligible for Medicaid or any plan that offers coverage equal to PAAD pharmaceutical services.
4. You are under age 65 and your Social Security Disability benefits are terminated.

Use of your PAAD card if ineligible is a violation of law and will result in your owing the State for benefits paid, plus civil and criminal penalties.

You must notify PAAD if:

1. You change your address.
2. Your marital status changes.

Include your PAAD eligibility number on all correspondence.
 250 (3-90)

Form #16



STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Form #17

MEDICAID DISTRICT OFFICE	DIRECTOR & PHONE NUMBER	ADDRESS
(01) Atlantic	William Underland, Director Tel. 609-441-3620 Fax #1-609-344-2268	1601 Atlantic Avenue, 7th Floor Atlantic City, NJ 08401
(02) Bergen	Kate Buckley, Director Tel. 201-996-8084 Fax #1-201-996-8084	171-173 Main Street Hackensack, NJ 07601
(03) Burlington	Eileen Calabro, Acting Director Tel. 609-261-0448 Fax #1-609-265-0095	50 Rancocas Road Mt. Holly, NJ 08060
(04) Camden	Daniel Cooperston, Director Tel. 609-757-4626 Fax #1-609-757-4626	101 Haddon Avenue, 5th Floor Camden, NJ 08103
Ronald Coppola, Regional Director		
(05) Cape May	Barbara Dills, Director Tel. 609-696-6560 Fax #1-609-794-2586	108 Landis Avenue Vineland, NJ 08360
(06) Cumberland	Diane West, Director Tel. 201-648-2470 Fax #1-201-642-6468	153 Halsey Street, 4th Floor Newark, NJ 07102
(07) Essex	Joan Suleskey, Acting Director Tel. 609-853-4177 Fax #1-609-845-0444	251 N. Delsea Drive Deptwood Center Deptford, NJ 08096-1930
(08) Gloucester	William Underland, Director Tel. 201-433-7544 Fax #1-201-433-7544	2815 Kennedy Boulevard, 2nd Floor Jersey City, NJ 07306
(09) Hudson	Caroline Krajewski, Director Tel. 908-782-1130 Fax #1-90-782-7899	84 Park Avenue, 2nd Floor Flemington, NJ 08822
(10) Hunterdon	Eileen Calabro, Acting Director Tel. 609-599-4627 Fax #1-609-599-4627	314-316 E. State Street Trenton, NJ 08608
(11) Mercer	Colleen DeMarks, Director Tel. 908-906-8275 Fax #1-908-906-8275	Bldg. B, Suite 5 & 6 25 S. Main Street Edison, NJ 08837
(12) Middlesex	John Russell, Regional Director Tel. 908-308-1159 Fax #1-908-409-6446	1003 Route 9 North-Suite 200 Howell, NJ 07731-1113
(13) Monmouth	Marie Grubin, Director Tel. 201-631-6440 Fax #1-201-631-6440	10 Park Place, 4th Floor Morristown, NJ 07960
(14) Morris	Gail Dempsey, Acting Director Tel. 908-255-0743 Fax #1-908-255-0743	1510 Hooper Avenue Toms River, NJ 08753
(15) Sussex	Kathleen Lohrey, Acting Director Tel. 201-977-4077 Fax #1-201-684-8182	66 Hamilton Street Paterson, NJ 07505
(16) Warren	Director Tel. 908-820-3135 Fax #1-908-353-5340	24-52 Rahway Avenue, 3rd Floor United Jersey Bank Bldg. Elizabeth, NJ 07201
(17) Ocean	Thomas Rafferty Acting Regional Director Tel. 201-977-4541 Fax #1-201-684-7769	100 Hamilton Plaza Room 601, Box 2 Paterson, NJ 07505
(18) Passaic		
(19) Union		
(20) Northern Regional Medicaid Office		

Rev. 7/92