

CHAPTER 49

ADMINISTRATION MANUAL

Authority

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

Source and Effective Date

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

Executive Order No. 66(1978) Expiration Date

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

Chapter Historical Note

Chapter 49, Administration, was adopted and became effective prior to September 1, 1969. Subchapters 1 through 6 were amended by R.1977 d.213, effective July 1, 1977. See: 9 N.J.R. 123(b), 9 N.J.R. 342(c).

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

Chapter 49, Administration, was repealed and a new Chapter 49, Administration, was adopted by R.1992 d.317, effective August 17, 1992.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 Subchapter 19, Prepaid Health Care Services: Medicaid Eligibles, was repealed by R.1995 d.337, effective June 19, 1995.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

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

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. GENERAL PROVISIONS

- 10:49-1.1 Scope and purpose
- 10:49-1.2 Organization
- 10:49-1.3 Definitions
- 10:49-1.4 Overview of provider manuals

SUBCHAPTER 2. NEW JERSEY MEDICAID BENEFICIARIES

- 10:49-2.1 Who is eligible for Medicaid?
- 10:49-2.2 Persons eligible under the regular New Jersey Medicaid program
- 10:49-2.3 Persons eligible under the Medically Needy program
- 10:49-2.4 Persons eligible under Home and Community-Based Services Programs
- 10:49-2.5 Persons eligible under the NJ KidCare program
- 10:49-2.6 Eligibility process (variations to routine procedure)
- 10:49-2.7 Applying for Medicaid eligibility for a newborn infant or for an inpatient upon admission to a hospital
- 10:49-2.8 Presumptive eligibility
- 10:49-2.9 Medicaid or NJ FamilyCare—Plan A retroactive eligibility
- 10:49-2.10 Verification of eligibility for Medicaid or NJ KidCare; or Pharmaceutical Assistance to the Aged and Disabled (PAAD) services
- 10:49-2.11 Recipient Eligibility Verification System (REVS)/Medicaid Eligibility Verification System (MEVS)
- 10:49-2.12 Medicaid or NJ KidCare Eligibility Identification Number
- 10:49-2.13 Forms that validate Medicaid eligibility
- 10:49-2.14 Validation form (FD-152) Department of Human Services Medicaid-ID
- 10:49-2.15 Validation form (FD-73/178) Medicaid Eligibility Identification Card (MEI Card)
- 10:49-2.16 Validation form (FD-34) Validation of Eligibility
- 10:49-2.17 Medicaid application
- 10:49-2.18 (Reserved)
- 10:49-2.19 Medicaid or NJ KidCare eligibility—aliens

SUBCHAPTER 3. PROVIDER PARTICIPATION

- 10:49-3.1 Provider types eligible to participate
- 10:49-3.2 Enrollment process
- 10:49-3.3 Providers with multi-locations
- 10:49-3.4 Medicaid or NJ KidCare provider billing number

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

- 10:49-4.1 Definitions
- 10:49-4.2 Scope
- 10:49-4.3 Registration of shared health care facilities
- 10:49-4.4 Prohibited practices; administrative requirements
- 10:49-4.5 Quality of care requirements

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

- 10:49-5.1 Requirements for provision of services
- 10:49-5.2 Services available to beneficiaries eligible for, or children who are presumptively eligible for, the regular Medicaid and NJ KidCare—Plan A programs
- 10:49-5.3 Services available to beneficiaries eligible for the Medically Needy program
- 10:49-5.4 Emergency medical services for aliens and prenatal care for specified pregnant alien women
- 10:49-5.5 Services not covered by the Medicaid or NJ KidCare—Plan A program
- 10:49-5.6 Services available to beneficiaries eligible for, or who are presumptively eligible for, NJ KidCare—Plan B or C
- 10:49-5.7 Services available to beneficiaries eligible for NJ KidCare—Plan D

SUBCHAPTER 6. AUTHORIZATIONS REQUIRED BY MEDICAID AND THE NJ KIDCARE PROGRAMS

- 10:49-6.1 Prior and retroactive authorization (general)
- 10:49-6.2 Out-of-State medical care and services

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

- 10:49-7.1 General provisions
- 10:49-7.2 Timeliness of claim submission
- 10:49-7.3 Third party liability (TPL) benefits
- 10:49-7.4 Prohibition of payment to factors
- 10:49-7.5 Use of service bureau and/or management agency

SUBCHAPTER 8. PAYMENT FOR SERVICES PROVIDED

- 10:49-8.1 Fiscal Agent
- 10:49-8.2 Claims payment and pricing
- 10:49-8.3 Adjustments following payment of claims
- 10:49-8.4 Claims payment by direct deposit (electronic funds transfer or EFT)
- 10:49-8.5 Outstanding checks

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

- 10:49-9.1 NJ KidCare—Plan C personal contribution to care and Plan D copayments
- 10:49-9.2 NJ KidCare—Plan C and D—premiums
- 10:49-9.3 Limitation on cost sharing—Plan C
- 10:49-9.4 Civil rights
- 10:49-9.5 Observance of religious belief
- 10:49-9.6 Free choice by beneficiary and provider
- 10:49-9.7 Confidentiality of records
- 10:49-9.8 Provider certification and recordkeeping
- 10:49-9.9 Patient's (beneficiary) certification
- 10:49-9.10 Withholding of provider payments
- 10:49-9.11 Integrity of the Medicaid and NJ KidCare programs; gifts/gratuities prohibited
- 10:49-9.12 Fraud and abuse
- 10:49-9.13 Informing individuals of their rights
- 10:49-9.14 Provisions for appeals; fair hearings
- 10:49-9.15 Advance directives

SUBCHAPTER 10. NOTICES, APPEALS AND FAIR HEARINGS

- 10:49-10.1 Definitions
- 10:49-10.2 Notices
- 10:49-10.3 Opportunity for fair hearing
- 10:49-10.4 Advance notice of intent to terminate, reduce, or suspend assistance for Medicaid and NJ KidCare—Plan A
- 10:49-10.5 Location of hearing
- 10:49-10.6 Impartiality of official conducting the hearing
- 10:49-10.7 Beneficiary's right to different medical assessment
- 10:49-10.8 Hearing procedures
- 10:49-10.9 Prompt, definitive and final action
- 10:49-10.10 Notification to claimants
- 10:49-10.11 Action upon favorable decision to claimants
- 10:49-10.12 Hearing decision
- 10:49-10.13 Accessibility of hearing decisions to local agencies and the public

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

- 10:49-11.1 Program participation

SUBCHAPTER 12. PROVIDER REINSTATEMENT

- 10:49-12.1 Definitions
- 10:49-12.2 Requests for reinstatement
- 10:49-12.3 Petition by debarred, disqualified or suspended person
- 10:49-12.4 Director's powers
- 10:49-12.5 Provider Reinstatement Committee

- 10:49-12.6 Criteria for reinstatement
- 10:49-12.7 Committee procedures

SUBCHAPTER 13. PROGRAM CONTROLS

- 10:49-13.1 Medical review and evaluation
- 10:49-13.2 Audits
- 10:49-13.3 Applicability to NJ KidCare—Plans B, C and D of provisions relating to fraud and abuse investigations and administrative actions, third party liability and recoveries
- 10:49-13.4 Rewards for information relating to fraud and abuse

SUBCHAPTER 14. RECOVERY OF PAYMENTS AND SANCTIONS

- 10:49-14.1 Recovery of payments correctly made
- 10:49-14.2 Sanctions—Special Status Program
- 10:49-14.3 Authority to adjust, compromise, settle or waive claims, liens, and certificates of debt
- 10:49-14.4 Recoveries involving county welfare agencies
- 10:49-14.5 Administrative charges/service fees
- 10:49-14.6 Contracts with county welfare agencies

SUBCHAPTER 15. AVAILABILITY AND MAINTENANCE OF PROGRAM POLICY ISSUANCES

- 10:49-15.1 Maintenance of public policy issuances
- 10:49-15.2 Availability of material
- 10:49-15.3 Reproduction of policy material

SUBCHAPTER 16. DEMONSTRATION PROJECTS

- 10:49-16.1 Purpose
- 10:49-16.2 Definitions
- 10:49-16.3 Implementation of projects
- 10:49-16.4 Necessary criteria for a demonstration project
- 10:49-16.5 Sanctions related to demonstration projects

SUBCHAPTER 17. (RESERVED)**SUBCHAPTER 18. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)**

- 10:49-18.1 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

SUBCHAPTER 19. HEALTHSTART

- 10:49-19.1 HealthStart

SUBCHAPTER 20. THE GARDEN STATE HEALTH PLAN (GSHP)

- 10:49-20.1 Introduction
- 10:49-20.2 Physician case manager (PCM)
- 10:49-20.3 Capitation payment system
- 10:49-20.4 Medicaid beneficiary
- 10:49-20.5 Action required by providers
- 10:49-20.6 GSHP services
- 10:49-20.7 Emergency medical care situations for GSHP members
- 10:49-20.8 GSHP reimbursement policy for emergency services
- 10:49-20.9 Exception Payment Request Form (GSHP-16)

SUBCHAPTER 21. THE MEDICAID MANAGED CARE PROGRAM—NJ CARE 2000

- 10:49-21.1 Purpose and scope
- 10:49-21.2 Capitation payment system
- 10:49-21.3 Medicaid beneficiaries
- 10:49-21.4 Medicaid Managed Care Program—New Jersey Care 2000 Services

SUBCHAPTER 22. HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAMS

- 10:49-22.1 Introduction
- 10:49-22.2 Approved Waivers
- 10:49-22.3 Administration of waived persons
- 10:49-22.4 Home and Community-Based Services Waivers
- 10:49-22.5 Community Care Program for the Elderly and Disabled (CCPED)
- 10:49-22.6 Medicaid's Model Waivers—I, II, and III
- 10:49-22.7 AIDS Community Care Alternatives Program (ACCAP)
- 10:49-22.8 Traumatic Brain Injury Program

SUBCHAPTER 23. LIFELINE PROGRAMS

- 10:49-23.1 Purpose and scope
- 10:49-23.2 Applications

SUBCHAPTER 24. WORK FIRST NEW JERSEY/GENERAL ASSISTANCE CLAIMS PROCESSING

- 10:49-24.1 Introduction
- 10:49-24.2 Administrative provisions
- 10:49-24.3 Services available under the Work First New Jersey/ General Assistance (WFNJ/GA) program which shall be processed by the fiscal agent
- 10:49-24.4 Services that shall not be processed by the fiscal agent
- 10:49-24.5 Basis for reimbursement

APPENDIX

SUBCHAPTER 1. GENERAL PROVISIONS

10:49-1.1 Scope and purpose

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

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

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

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

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

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

Substantially amended section.

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

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

In (a), inserted a reference to the NJ KidCare program in the second sentence; and added (c) and (d).

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

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

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

10:49-1.2 Organization

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

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

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

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

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

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

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

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

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

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

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

10:49-1.3 Definitions

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

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

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

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

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

“County welfare agency or CWA” means that agency of county government which is charged with the responsibility for determining eligibility for public assistance programs including Aid to Families with Dependent Children, the Food Stamp program, and Medicaid. Depending on the county, the CWA might be identified as the Board of Social Services, the Welfare Board, the Division of Welfare, or the Division of Social Services.

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

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

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

“DMHS” means the Division of Mental Health Services within the New Jersey Department of Human Services.

“DYFS” means the Division of Youth and Family Services within the New Jersey Department of Human Services.

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

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

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

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

“Mental health rehabilitation services” means psychiatric and psychological services, including emotional and/or behavioral treatment, drug and alcohol dependency treatment, psychiatric treatment, psychotherapy and related nursing services.

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

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

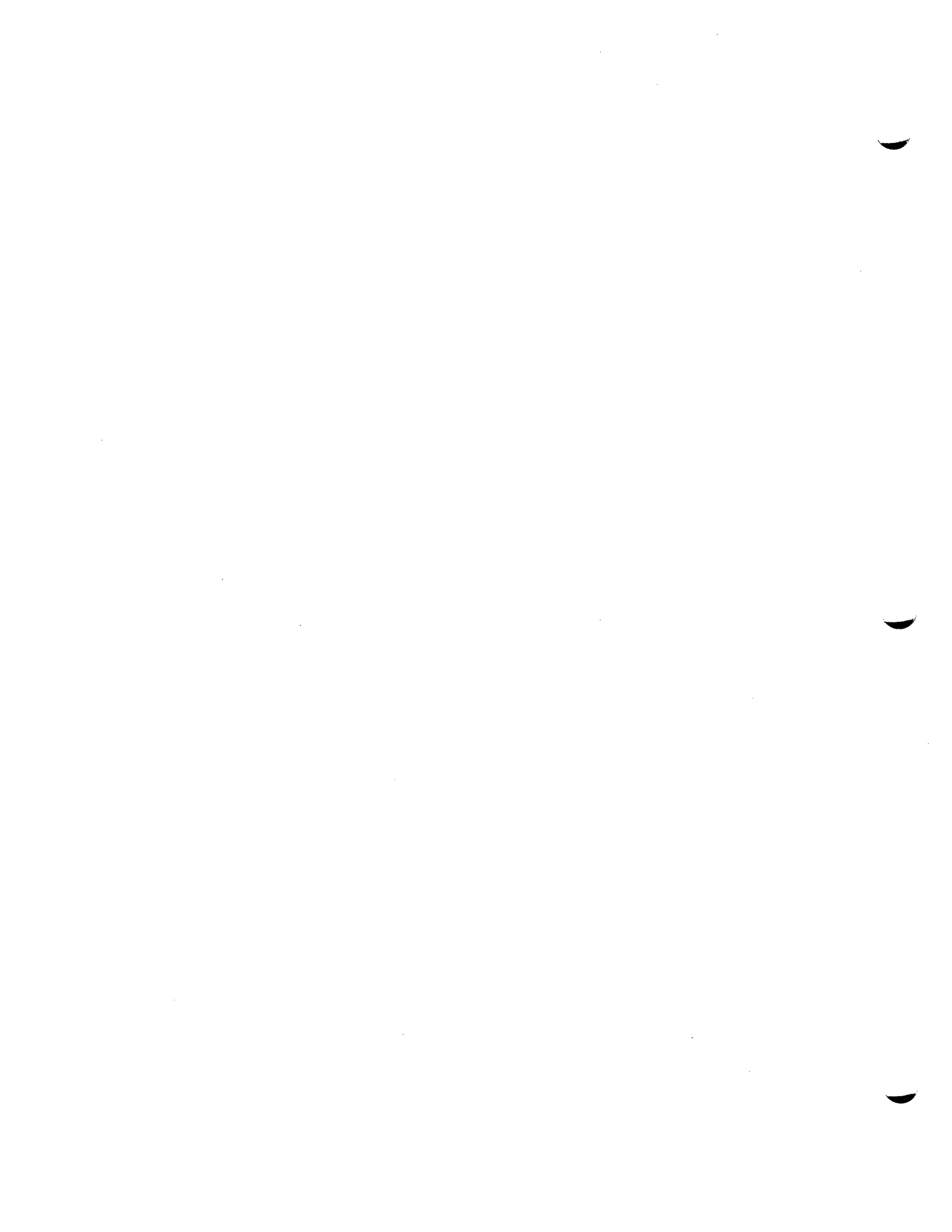
“NJ KidCare—Plan B” means the State-operated program which provides comprehensive, managed care coverage to uninsured children through the age of 18 with family incomes above 133 percent and not in excess of 150 percent of the Federal poverty level. In addition to covered managed care services, eligibles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

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

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

“Prepaid health plan” means an entity that provides medical services to enrolled Medicaid eligibles under a contract with DMAHS on the basis of prepaid capitation fees but which does not necessarily qualify as an HMO. For rules concerning prepaid health care services, see N.J.A.C.

10:49-19. For a description of the State operated HMO, the Garden State Health Plan, see N.J.A.C. 10:49-20. For Medicaid Managed Care Program—New Jersey Care 2000, see N.J.A.C. 10:49-21.



9. Satisfaction of any conditions or requirements previously imposed by the Medicaid or the NJ KidCare program.

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

In (a)9 substituted "Medicaid program" for "Division".
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).

In (a)9, inserted a reference to the NJ KidCare program.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

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

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 in consultation with the Commissioner of Health and Senior Services, where appropriate, 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.

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

In (m), inserted reference to consultation with Commissioner.

SUBCHAPTER 13. PROGRAM CONTROLS

10:49-13.1 Medical review and evaluation

Under the provisions of Federal and State law, the Medicaid Agent or DMAHS shall provide continuing review and evaluation of the care and services provided under the Medicaid and NJ KidCare programs. This includes review of utilization of services of practitioners and other providers.

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

Substituted "Medicaid Agent" for "Division of Medical Assistance and Health Services".

Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).

Inserted a reference to DMAHS and substituted a reference to the Medicaid and NJ KidCare programs for a reference to programs in the first sentence.

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

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

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, 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.

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

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

Amended Office references throughout.

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

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

Substituted references to the Office of Program Integrity Administration for references to the Office of Quality Management and Program Integrity throughout.

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

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

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

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).

10:49-13.3 Applicability to NJ KidCare-Plans B, C and D of provisions relating to fraud and abuse investigations and administrative actions, third party liability and recoveries

All of the relevant provisions pertaining to fraud and abuse investigations and administrative actions, third party liability, and recoveries which are contained in N.J.S.A. 30:4D-1 et seq. and this chapter are fully applicable to the NJ KidCare program, including, but not limited to, N.J.S.A. 30:4D-6c, 6f, 7h, 7i, 7k, 7l, 7.1, 12, 17(f), 17(g), 17(i), 17.1 and 17.2, as well as N.J.A.C. 10:49-3.2, 4.1 through 4.5, 5.4, 6.1(a)3, 7.3, 7.4, 7.5, 9.5 through 9.8, 11.1, 12.1 through 12.7, 13.1, 14.2 through 14.6 and 16.5.

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

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

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

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

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

Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).

See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).

10:49-13.4 Rewards for information relating to fraud and abuse

(a) The Division of Medical Assistance and Health Services may pay a monetary reward for information that leads to the recovery of at least \$100.00 from individuals or entities that have engaged in health care-related fraud or abuse including ineligible receipt of benefits involving the programs administered by DMAHS (including, but not limited to, the New Jersey Medicaid and NJ KidCare programs), the Pharmaceutical Assistance to the Aged and Disabled (PAAD) program administered by Department of Health and Senior Services, and/or the Work First New Jersey General Assistance (GA) program administered by Division of Family Development. The determination of whether an individual or entity meets the criteria for an award, and the amount of the award, is at the discretion of DMAHS. DMAHS shall pay a reward only if a reward is not otherwise provided for by law. When DMAHS applies the criteria specified in (b), (c) and (e) below to determine the eligibility and the amount of the reward, DMAHS shall notify the beneficiary of the reward as specified in (d) below.

(b) The following pertain to information eligible for reward.

1. In order for an individual or entity to be eligible to receive a reward, the information supplied shall relate to the activities of a specific individual or entity, and shall specify the time period of the alleged activities.

2. DMAHS shall not give a reward for information relating to an individual or entity that, at the time the information is provided, is already the subject of a review or investigation by DMAHS or its contractors; the New Jersey Department of Human Services (DHS); the New Jersey Department of Health and Senior Services; the New Jersey Department of Law and Public Safety; the Health Care Financing Administration and the Office of the Inspector General of the U.S. Department of Health and Human Services or their contractors; the U.S. Department of Justice; the Federal Bureau of Investigation; or any other Federal, State, county or municipal law enforcement agency.

(c) Any individual or entity (other than one excluded under (c)1 below) is eligible to receive a reward under this section if the information is submitted in the manner set forth in (f) below.

1. The following are excluded from eligibility to receive a reward:

i. An individual who was or is an immediate family member of an officer or employee of any of the agencies or entities listed in (b)2 above at the time he or she came into possession of, or divulged, information leading to a recovery shall not be eligible to receive a reward under this section;

ii. Any other Federal, State, county or municipal employee, contractor or grantee shall not be eligible for a reward under this section if the information submitted came to their knowledge in the course of their official duties;

iii. An individual or entity that illegally obtained the information submitted shall be excluded from receiving a reward under this section; and

iv. An individual or entity that participated in the sanctionable offense with respect to which payment would be made shall be excluded from receiving a reward under this section.

(d) After all funds have been recovered and DMAHS has determined a participant eligible to receive a reward under the provisions of this section, it shall notify the informant of his or her eligibility, by mail, at the most recent address supplied by the individual or entity. It is the individual's or entity's responsibility

to ensure that the reward program has been notified of any change in their address or other relevant information (for example, change of name, phone number).

1. If the individual or entity has relocated to an unknown address, the individual or entity or their legal representative may claim the reward by contacting DMAHS within one year from the date on which DMAHS first attempted to notify the individual or entity about a reward. DMAHS does not consider the individual or entity or their legal representative eligible for a reward more than one year after the date on which it first attempted to give notice. DMAHS does not pay interest on rewards that are not immediately claimed.

2. If an individual has become incapacitated or has died, an executor, administrator, or other legal representative may claim the reward on behalf of the individual or the individual's estate. The claimant shall submit certified copies of the letters testamentary, letters of administration, or other similar evidence to show his or her authority to claim the reward. The claim shall be filed within one year from the date, on which DMAHS first gave or attempted to give notice of the reward.

(e) The following pertain to the amount and payment of a reward:

1. In determining whether it shall pay a reward and, if so, the amount of the reward, DMAHS shall take into account all relevant factors, including the significance of the information furnished in relation to the ultimate resolution of the case and the recovery.

2. The amount of the reward represents what DMAHS considers to be adequate compensation in the particular case, not to exceed 10 percent of the overpayments recovered in the case, or \$1,000, whichever is less.

3. If more than one individual or entity is eligible to receive a reward in a particular case, DMAHS shall allocate the total reward amount (not to exceed 10 percent of the overpayments recovered in that case, or \$1,000, whichever is less) among the participants.

4. DMAHS bases rewards only on recovered overpayments, not on amounts collected as interest, penalties and/or fines, and not on estimates of cost savings or cost avoidance.

5. DMAHS shall make payments as promptly as the circumstances of the case permit, but not until it has collected all overpayments, interest, penalties and fines.

6. No Division employee may make any offer or promise or otherwise bind DMAHS or DHS with respect to the payment or any reward under this subsection or the amount of the reward.

(f) An individual or entity may submit information on persons or entities engaging in, or that have engaged in, health care-related fraud and/or abuse against the programs listed in (a) above to Bureau of Program Integrity, Division of Medical Assistance and Health Services, PO Box 712, Trenton, NJ 08625-0712, or by calling the DMAHS Fraud and Abuse Hotline at 1-888-9 FRAUD-5 (1-888-937-2835).

1. A participant interested in receiving a reward shall provide his or her name, address, telephone number, and any other requested identifying information so that he or she may be contacted, if necessary, for additional information and, when applicable, for the payment of a reward upon resolution of the case.

(g) DMAHS shall not reveal a participant's identity to any person, except as required by law.

(h) If, after a reward is accepted, DMAHS finds that the awardee was ineligible to receive the reward, neither DMAHS nor DHS shall be liable for the reward, and the awardee shall refund all monies received.

(i) Receipt of a reward under this section by any applicant for, or beneficiary of, benefits under any program administered in whole or in part by the Division of Medical

Assistance and Health Services, including, but not limited to, Medically Needy (N.J.A.C. 10:70), Medicaid Only (N.J.A.C. 10:71), New Jersey Care ... Special Medicaid Programs (N.J.A.C. 10:72), NJ FamilyCare (N.J.A.C. 10:78) and NJ KidCare (N.J.A.C. 10:79), Pharmaceutical Assistance to the Aged and Disabled, Work First New Jersey/General Assistance or AFDC-Related Medicaid shall not affect that individual's eligibility or continued eligibility for those benefits.

New Rule, R.2000 d.288, effective July 17, 2000.
See: 31 N.J.R. 2673(b), 32 N.J.R. 2613(a).
Amended by R.2002 d.124, effective April 15, 2002.
See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).
Rewrote (i).

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 the individual received medical assistance if:

1. The individual leaves no surviving spouse;