

CHAPTER 49

ADMINISTRATION MANUAL

Authority

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

Source and Effective Date

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

Executive Order No. 66(1978) Expiration Date

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

Chapter Historical Note

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

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

Chapter 49, Administration, was repealed and a new Chapter 49, Administration, was adopted by R.1992 d.317, effective August 17, 1992.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 Subchapter 19, Prepaid Health Care Services: Medicaid Eligibles, was repealed by R.1995 d.337, effective June 19, 1995.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

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

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SUBCHAPTER 1. GENERAL PROVISIONS

10:49-1.1 Scope and purpose

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

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

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

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

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

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

Substantially amended section.

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

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

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

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

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

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

10:49-1.2 Organization

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

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

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

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

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

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

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

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

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

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

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

10:49-1.3 Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“Program” means the New Jersey Medicaid program.

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

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

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

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

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

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

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

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.

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).

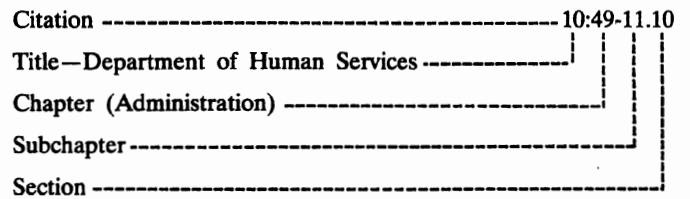
Added definitions of “Copayment” and “NJ KidCare—Plan D”.

10:49-1.4 Overview of provider manuals

(a) The Medicaid Agent and the Division of Medical Assistance and Health Services maintain New Jersey Medicaid and NJ KidCare provider manuals. Each is designed for use by a specific type of provider that provides services to Medicaid and/or NJ KidCare beneficiaries. Each manual is written in accordance with Federal and State laws, rules, and regulations, with the intent to ensure that such laws, rules, and regulations are uniformly applied.

(b) Each 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 including NJ KidCare. 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:



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

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

(e) Regarding manual updates, revised pages or additions to the provider manual are issued, as required, for new policy, policy clarification, and/or revisions to the New Jersey Medicaid or NJ KidCare program. A newsletter system is utilized to distribute new or revised manual material and to provide any other pertinent information regarding manual updates. Newsletters should be filed at the back of the manual and replacement pages should be added to the manual in accordance with instructions provided. Substantive manual revisions shall be made through the rule-making 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 or NJ KidCare program. The provider is ultimately responsible for knowing and abiding by current laws and regulations pertaining to this program.

Recodified from N.J.A.C. 10:49-1.8 and amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

In (a), substituted "The New Jersey Medicaid Program maintains" for "There are 19" and "Medicaid beneficiaries" for "Medicaid recipients"; in (d), inserted additional N.J.A.C. references; inserted new (d)5, 11 and 23; recodified former (d)5 through 9 and 10 through 20 as (d)6 through 10 and 12 through 22; and in (e), substituted "Substantive manual revisions shall be made" for "Manual revisions shall be substantially made". Former section, "HealthStart", repealed. Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

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

Inserted references to NJ KidCare and made corresponding language changes throughout; and in (a), substituted a reference to the Medicaid Agent and the Division of Medical Assistance and Health Services for a reference to the New Jersey Medicaid Program in the first sentence. Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

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

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

Case Notes

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

10:49-1.5 (Reserved)

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

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

Section was "Prepaid health plans".

10:49-1.6 (Reserved)

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

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

10:49-1.7 (Reserved)

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

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

Section was "State funded programs".

10:49-1.8 (Reserved)

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

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

SUBCHAPTER 2. NEW JERSEY MEDICAID BENEFICIARIES

10:49-2.1 Who is eligible for Medicaid?

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

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

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

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

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

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

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

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

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

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

4. Deemed recipients of AFDC including:

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

10:49-2.16 Validation form (FD-34) Validation of Eligibility

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

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

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

3. The Medicaid beneficiary or patient of a State or county institution receiving covered health services in the community is identified by the 12-digit Medicaid Eligibility Identification Number in which the first two digits identifies the institution. (See N.J.A.C. 10:49-2.11(b)2).

(b) The New Jersey Medicaid and the NJ KidCare programs have designated specific Medicaid District Offices to handle prior authorization requests for services for patients/residents/beneficiaries from each institution and family care residents/beneficiaries who are under the jurisdiction of the Division of Developmental Disabilities. If the patient/beneficiary's Medicaid or NJ KidCare Eligibility Identification Number begins with any of the following numbers, providers shall contact the Medicaid District Office (MDO) indicated (for MDO Directory, see Appendix N.J.A.C. 10:49).

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

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

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

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

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

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

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

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

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

10:49-2.17 Medicaid application

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

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

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

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

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

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

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

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

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

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

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

10:49-2.18 (Reserved)

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

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

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

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

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

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

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

SUBCHAPTER 3. PROVIDER PARTICIPATION

10:49-3.1 Provider types eligible to participate

(a) The following provider types are eligible to participate as Medicaid and NJ KidCare Plan A providers:

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

24. Prosthetists;
25. Psychologists and/or psychologist groups;
26. Residential treatment facilities;
27. Transportation providers; and
28. State and county agencies that have agreed to provide personal care assistant services.

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

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

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

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

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

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

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

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

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

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

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

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

Amended by R.2000 d.309, effective August 7, 2000.

See: 32 N.J.R. 1342(a), 32 N.J.R. 2900(a).

In (a), inserted a new 1, and recodified former 1 through 27 as 2 through 28.

Cross References

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

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

10:49-3.2 Enrollment process

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

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

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

1. As a condition of continued participation in the New Jersey Medicaid and NJ KidCare programs, a provider may, from time to time, be required to:
 - i. Complete a provider reenrollment application form and sign a provider participation agreement; and/or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Cross References

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

10:49-3.3 Providers with multi-locations

(a) All providers (except independent clinical laboratories, nursing facilities, and pharmacies) participating in the Medicaid or NJ KidCare program shall identify all locations from which they are providing services to Medicaid or NJ KidCare beneficiaries.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10:49-4.1 Definitions

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

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

“Patient” means anyone eligible to receive benefits from the program.

3. Post conspicuously the names and scheduled office hours of all providers practicing in the facility;
4. Maintain proper records. Such records shall contain at least the following information:
 - i. The full name, address and Program Number of the patient;
 - ii. The dates of all visits to all providers in the shared health care facility;
 - iii. The chief complaint for each visit to each provider in the shared health care facility;
 - iv. Pertinent history and all physical examinations rendered by each provider in the shared health care facility;
 - v. Diagnostic impressions for each visit to any provider in the shared health care facility;
 - vi. All medications prescribed at each visit by any provider in the shared health care facility who is qualified to issue prescriptions;
 - vii. The precise dosage and prescription regimens for each medication prescribed by a provider in the shared health care facility;
 - viii. All x-ray, laboratory work and electrocardiograms ordered at each visit by any provider in the shared health care facility;
 - ix. The results of all x-ray, laboratory work and electrocardiograms ordered as in (a)4viii above;
 - x. All referrals by providers in the shared health care facility to other medical providers and the reason for such referrals, and date of referral; and
 - xi. A statement as to whether or not the patient is expected to return for further treatment.

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.

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

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

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

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

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

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

10:49-5.1 Requirements for provision of services

(a) The services listed in N.J.A.C. 10:49-5.2 are available to beneficiaries eligible for the regular New Jersey Medicaid

or the NJ KidCare—Plan A programs. Services available to Medically Needy beneficiaries are listed in N.J.A.C. 10:49-5.3. The services listed in N.J.A.C. 10:49-5.2 and 5.3 shall be provided in conjunction with program requirements specifically outlined in the second chapter of each Provider Services Manual.

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

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

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

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

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

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

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

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

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

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

Case Notes

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

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

10:49-5.2 Services available to beneficiaries eligible for, or children who are presumptively eligible for, the regular Medicaid and NJ KidCare-Plan A programs

(a) The services listed below are available to beneficiaries eligible for the regular Medicaid or NJ KidCare—Plan A program:

1. Case management services (Mental Health Program);
2. Certified nurse practitioner/clinical nurse specialist services;
3. Chiropractic services;
4. Christian Science Sanatoria care and services (see Hospital Services Manual);
5. Clinic services such as services in an independent outpatient health care facility, other than hospital, that provides services such as Mental Health, Family Planning, Dental, Optometric, Ambulatory Surgery, FQHCs;
6. Dental services;

7. Environmental lead inspection services-rehabilitative services;

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

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

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

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

11. Hearing aid services;

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

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

14. 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;

15. Hospital services—outpatient;

16. Laboratory (clinical);

17. Medical day care services;

18. Medical supplies and equipment;

19. Mental health services;

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

21. Nurse-midwifery services;

22. Optometric services;

23. Optical appliances;

24. Pharmaceutical services;

25. Physician services;

26. Podiatric services;

27. Prosthetic and orthotic devices;

28. Psychological services;

29. Radiological services;

30. Rehabilitative services (Payments are made to eligible Medicaid or NJ KidCare-Plan A providers only. No payment is made to privately practicing therapists);

i. Physical therapy, as provided by a home health agency, independent clinic, nursing facility, hospital outpatient department, or in a physician's office;

ii. Occupational therapy, as provided by a home health agency, independent clinic, nursing facility, or hospital outpatient department;

iii. Speech-language pathology services, as provided by a home health agency, independent clinic, nursing facility, hospital outpatient department, or in a physician's office;

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

v. School based rehabilitation services under EPSDT; and

31. Transportation services which include ambulance, mobility assistance vehicle, and other transportation provided by independent clinics or through arrangements with a county board of social services.

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

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

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

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

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

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

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

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

In (a), inserted references to NJ KidCare—Plan A throughout.
Amended by R.1998 d.143, effective March 16, 1998.

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

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

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

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

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

Amended by R.2000 d.266, effective July 3, 2000.

See: 32 N.J.R. 159(a), 32 N.J.R. 2493(a).

Added (b).

Amended by R.2000 d.309, effective August 7, 2000.

See: 32 N.J.R. 1342(a), 32 N.J.R. 2900(a).

In (a), inserted a new 2, recodified former 2 through 26 as 3 through 27, inserted "services including" in the new 13, inserted a new 28, recodified former 27 through 29 as 29 through 31, added v in the new 30, and substituted a reference to mobility assistance vehicles for a reference to invalid coaches and substituted a reference to county

boards of social services for a reference to county welfare agencies in the new 31.

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

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

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

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

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

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

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

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

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

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

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

sion. If upon audit, financial records or other acceptable evidence are unavailable for these purposes:

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

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

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

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

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

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

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

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

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

Recodified from N.J.A.C. 10:49-5.4 and amended R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

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

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), inserted a reference to the NJ KidCare-Plan A program in the first sentence, inserted a reference to NJ KidCare-Plan A beneficiaries and substituted a reference to NJ KidCare Eligibility Identification Cards for Eligibility Identification Cards in 14, inserted references to the Division throughout 15, and inserted a reference to NJ KidCare beneficiaries in 15ii.

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.

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 with changes, effective September 21, 1998.

Cross References

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

Case Notes

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

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

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

10:49-5.6 Services available to beneficiaries eligible for, or who are presumptively eligible for, NJ KidCare—Plan B or C

(a) Except for the exceptions at N.J.A.C. 10:79-6.5, which concern services for newborns enrolling into NJ KidCare—Plan C, the services listed below are available to beneficiaries eligible for NJ KidCare—Plan B or C, through an HMO selected by the NJ KidCare—Plan B or C beneficiary.

1. Audiology services;
2. Certified nurse practitioner services;
3. Chiropractic services;
4. Clinic services (services in an independent outpatient health care facility, other than hospital, that provides services such as, dental, optometric, ambulatory surgery, etc.);
5. Clinical nurse specialist services;
6. Dental services;
7. Durable medical equipment;
8. Early and periodic screening, and diagnosis examinations, dental, vision and hearing services. Includes only those treatment services identified through the examination that are available under the HMO contract or covered fee-for-service program;
9. Emergency room services;
10. Family planning services including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling;
 - i. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered by the New Jersey Medicaid or NJ KidCare program.
11. Federally qualified health center primary care services;
12. HealthStart maternity services, which is a package of comprehensive medical and health support services provided by the HMO;
13. Hearing aid services;
14. Home health care services;
 - i. Exception: personal care assistant services;
15. Hospice services;
16. Hospital services—inpatient:
 - i. General hospitals;
 - ii. Special hospitals; and

- iii. Rehabilitation hospitals;
17. Hospital services—outpatient;
18. Laboratory (clinical);
19. Medical supplies and equipment;
20. Nurse-midwifery services;
21. Optometric services;
22. Optical appliances;
23. Organ transplant services, except the inpatient hospital services. Inpatient hospital services for organ transplants are covered fee-for-service;
24. Prescription drug services;
25. Physician services;
26. Podiatric services;
27. Prosthetic and orthotic devices;
28. Private duty nursing;
29. Radiological services;
30. Rehabilitative services, including physical, occupational and speech therapy, limited to 60 days per type of therapy per year; and
31. Transportation services, limited to ambulance, MICU's and invalid coach.

(b) The services listed below are available to beneficiaries eligible for NJ KidCare—Plan B or C under fee-for-service:

1. Christian Science sanatoria care and services;
2. Clinic services (services in an independent outpatient health care facility, other than hospital) for family planning services, mental health or substance abuse treatment services;
3. Elective/induced abortion services;
4. Emergency room services for treatment of mental health disorder or for substance abuse;
5. 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;
6. Hospital services—inpatient;
 - i. Psychiatric hospitals;
 - ii. Inpatient psychiatric programs for children 19 years of age and under;

iii. Acute care or special hospital services if provided for mental health or substance abuse services;

iv. Organ transplant hospital services;

(1) All other transplant services are covered by HMO;

7. Mental health services provided by practitioners, such as physicians, psychologists, and certified nurse practitioners/clinical nurse specialists;

8. Nursing facility services, limited to the Medicare Part A copayments for the first 30 days of skilled nursing care;

9. Outpatient hospital services for family planning, mental health and substance abuse treatment services;

10. Substance abuse services provided by practitioners, including physicians, psychologists, certified nurse practitioners/clinical nurse specialists; and

11. Targeted case management services for the chronically ill.

(c) Services not covered under Plans B and C are as follows:

1. Unless listed in (a) and (b) above, no other services are covered by NJ KidCare-Plan B or C.

2. Services not covered include, but are not limited to:

i. Nursing facility services, except the Medicare Part A copayments for the first 30 days of skilled nursing care;

ii. Intermediate care facilities for mental retardation (ICFs/MR);

iii. Personal care services;

iv. Medical day care services; and

v. Lower mode transportation.

(d) All presumptively eligible NJ KidCare-Plan B and C beneficiaries shall be eligible to receive all the services specified in (a) and (b) above fee-for-service during the presumptive eligibility period, which shall include the services that are otherwise only available through the managed care organizations. The provision of the managed care services fee-for-service shall be limited to the presumptive eligibility period.

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 with changes, effective September 21, 1998.

Amended by R.2000 d.266, effective July 3, 2000.

See: 32 N.J.R. 159(a), 32 N.J.R. 2493(a).

Added (d).

10:49-5.7 Services available to beneficiaries eligible for NJ KidCare-Plan D

(a) Except as indicated at N.J.A.C. 10:79-2.5, which concerns services for newborns enrolling into NJ KidCare-Plan C and D, the services listed below are available to beneficiaries eligible for NJ KidCare-Plan D, when medically necessary and provided through the network of an HMO selected by the NJ KidCare-Plan D beneficiary.

1. Certified nurse practitioner and clinical nurse specialist services;

2. Clinic services (services in an independent outpatient health care facility, other than hospital, that provides covered ambulatory care services);

3. Preventive dental services for children under the age of 12 years, including oral examinations, oral prophylaxis and topical application of fluorides;

4. Emergency room services;

5. 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 KidCare program;

6. Federally qualified health center primary care services;

7. Home health care services, limited to skilled nursing for a home bound beneficiary which is provided or supervised by a registered nurse, and home health aide when the purpose of the treatment is skilled care, medical social services which are necessary for the treatment of the beneficiary's medical condition and short-term physical, speech or occupation therapy with the same limitations described in (a)22 below;

i. Personal care assistant services are not covered;

8. Hospice services;

9. Hospital services—inpatient;

10. Hospital services—outpatient;

11. Laboratory (clinical);

12. Nurse-midwifery services;

13. Optometric services, including one routine eye examination per year;

14. Optical appliances, limited to one pair of glasses or contact lenses per 24 month period;

15. Organ transplant services which are non-experimental or non-investigational, except the inpatient hospital services. Inpatient hospital services for organ transplants are covered fee-for-service;

16. Prescription drug services;

i. Exception: Over-the-counter drugs are not covered;

17. Physician services;

18. Podiatric services;

i. Exception: Coverage excludes routine foot care;

19. Prosthetic appliances, limited to initial provision of prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defect;

i. Coverage includes repair and replacement when due to congenital growth;

20. Outpatient surgery;

21. Radiological services;

22. Rehabilitative services, including physical, occupational and speech therapy for non-chronic conditions and acute illnesses and injuries. Outpatient rehabilitation benefits are limited to treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment per contract year;

i. Speech therapy services rendered for treatment of delays in speech development, unless resulting from disease, injury or congenital defects are not covered;

23. Transportation services, limited to ambulance for medical emergency only;

24. Well child care including immunizations, lead screening and treatments;

25. Maternity and related newborn care; and

26. Diabetic supplies and equipment.

(b) The services listed below are available to beneficiaries eligible for NJ KidCare-Plan D under fee-for-service.

1. Services for mental health or behavioral conditions;

i. Inpatient hospital services, including psychiatric hospitals, limited to 35 days per year;

ii. Outpatient benefits for short-term, outpatient evaluative and crisis intervention or home health mental health services, limited to 20 visits per year;

(1) When authorized by the Division of Medical Assistance and Health Services, inpatient benefit exchanges are allowed. One mental health inpatient day may be exchanged for up to four outpatient services, including partial care. This is limited to an exchange of up to a maximum of 10 inpatient days for a maximum of 40 additional out patient visits.

(2) When authorized by the Division of Medical Assistance and Health Services, inpatient benefit exchanges are allowed. One mental health inpatient day may be exchanged for two days of treatment in partial hospitalization up to the maximum number of covered inpatient days.

iii. Inpatient and outpatient services for substance abuse are limited to detoxification;

2. Inpatient hospital services for organ transplants that are non-experimental or non-investigational;

i. All other transplant services shall be covered by the HMO.

3. Skilled nursing facility services; and

4. Elective/induced abortion services.

(c) Services not covered under Plan D are as follows:

1. Unless listed in (a) and (b) above, no other services are covered by NJ KidCare-Plan D.

2. Services not covered include, but are not limited to:

i. Services that are not medically necessary;

ii. Private duty nursing unless authorized by the HMO;

iii. Intermediate care facilities for mental retardation (ICF/MR);

iv. Personal care assistant services;

v. Medical day care services;

vi. Chiropractic services;

vii. Dental services except for preventive dentistry for children under age 12;

viii. Orthotic devices;

ix. Targeted case management for the chronically ill;

x. Inpatient psychiatric programs for children age 19 years and under;

xi. Christian science sanatoria care and services;

xii. Durable medical equipment;

xiii. EPSDT services;

(1) Refer to (a)24 above concerning the coverage of well child care including immunizations, lead screening and treatments;

xiv. Routine transportation, including nonemergency ambulance, invalid coach and lower mode transportation;

xv. Hearing aid services;

xvi. Blood and blood plasma;

(1) Administration, processing of blood, processing fees and fees related to autologous blood donations are covered;

xvii. Cosmetic services;

xviii. Custodial care;

xix. Special and remedial educational services;

xx. Experimental and investigational services;

xxi. Infertility services;

xxii. Medical supplies;

(1) Diabetic supplies are a covered service;

xxiii. Rehabilitative services for substance abuse;

xxiv. Weight reduction programs or dietary supplements;

(1) Surgical operations, procedures or treatment of obesity, shall not be covered, except when specifically approved by the HMO;

xxv. Acupuncture and acupuncture therapy, except when performed as a form of anesthesia in connection with covered surgery;

xxvi. Temporomandibular joint disorder (TMJ) treatment, including treatment performed by prosthesis placed directly in the teeth;

xxvii. Orthotics;

xxviii. Recreational therapy;

xxix. Sleep therapy;

xxx. Court ordered services;

xxxi. Thermograms and thermography;

xxxii. Biofeedback; and

xxxiii. Radial keratotomy.

New Rule, 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).

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

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

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

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

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

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

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

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

2. Retroactive determination of eligibility;

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

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

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

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

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

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

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), inserted a reference to the NJ KidCare program in 1, and inserted a reference to DMAHS in 3.

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 with changes, effective September 21, 1998.

Case Notes

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

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

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

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

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

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

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

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

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

10:49-7.1 General provisions

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

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

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

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

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

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

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

In (a), substituted "beneficiary" for "recipient"; in (b), deleted "form" or "forms" following "claim" and "claims".

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

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

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

10:49-7.2 Timeliness of claim submission and inquiry

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

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

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

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

ing 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.

