

(b) "Prospective" medical bill(s) are bills submitted to the Retroactive Eligibility Unit with an Application for Retroactive Medicaid Eligibility (FD-74) on the assumption that they were incurred during the retroactive eligibility period but were actually incurred during the month of application for Medicaid or later. These bills were incurred during a time period when Medicaid eligibility already existed or should have existed (except that the individual experienced a delayed determination of Medicaid eligibility).

(c) Under the circumstances in (c)1 through 3 below, the Division of Medical Assistance and Health Services' Retroactive Medicaid Eligibility Unit will generate letters to providers whose bills were included with an Application for Retroactive Medicaid Eligibility, allowing the one-year timely submission requirements to be bypassed.

1. These "prospective" claims must not have already been submitted to the Fiscal Agent within one-year of the date that services were rendered;

2. The Application for Retroactive Medicaid Eligibility that these "prospective" bills are associated with must have been received at the Retroactive Eligibility Unit within 60 days of the date of the above mentioned letter (with the original letter attached); and

3. In order for payment to be made, these claims must remain outstanding and any collection action against the Medicaid beneficiary must be withdrawn.

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

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

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

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

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

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

2. For claims submitted by a nursing facility; an intermediate care facility for the mentally retarded; a residential treatment center; or a governmental psychiatric hospital, a claim for payment for services shall be received by

the fiscal agent no later than one year after the "from date of service" as indicated on the claim.

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

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

i. One year of the date of service;

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

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

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

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

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

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

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

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

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

claim to be received by the Medicaid Fiscal Agent within 90 days of the date of the Medicare adjudication.

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

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

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

(g) If additional information is required in order to process a Medicaid claim, the provider shall supply the information as soon as possible but not more than 30 days after the end of the timely submission period.

(h) Regarding a Medicaid claim submitted timely that has been adjudicated and denied, a provider may resubmit the claim within one year of the date of service or 30 days of the date of adjudication as indicated in the Remittance Advice Statement, whichever is later.

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

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

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

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

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

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

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 (d), inserted references to Medicare/NJ KidCare and to NJ KidCare, and made corresponding language changes, throughout, and inserted a reference to Medicare and NJ KidCare in the first sentence of 3.

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 (d)3, inserted a reference to Medicare/NJ KidCare approved claims in the first sentence and deleted "Medicaid" following "provider's" in the last sentence; and in (h)2, inserted references to Medicare/NJ KidCare claims throughout, and deleted "Medicaid" following "filed,".

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.2001 d.329, effective September 17, 2001.

See: 33 N.J.R. 1889(a), 33 N.J.R. 3334(a).

Rewrote (a)2; in (a)2ii, revised N.J.A.C. reference; in (d)3, substituted "KidCare may result in payment delays" with "FamilyCare will result in claim denials", and substituted "Advise" with "Advice"; in (e), substituted "30" for "90"; rewrote (f); deleted (g) and (h).

Amended by R.2003 d.82, effective February 18, 2003.

See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

In (a)2ii, inserted ". that was submitted to the Medicaid Assistance and Health Services' Retroactive Eligibility Unit" following "retroactive eligibility application"; added a new (b) and (c) and recodified existing (b) through (f) as (d) through (h).

Amended by R.2003 d.485, effective December 15, 2003.

See: 35 N.J.R. 509(a), 35 N.J.R. 5568(a).

In (a), deleted the last two sentences in the introductory paragraph; rewrote (e) and (f).

Administrative correction.

See: 36 N.J.R. 5352(b).

Case Notes

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

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

Denial of reimbursement for untimely claims affirmed. *Capital Nursing Center v. Department of Health and Senior Services*, 97 N.J.A.R.2d (HLT) 44.

Nursing facility not entitled to Medicaid reimbursement for untimely claims. *Clara Maass Continuing Care Center v. Department of Health and Senior Services*, 97 N.J.A.R.2d (HLT) 26.

Denial of reimbursement for untimely claim affirmed. In the Matter of *Bridgeton Nursing Center, Patients: W.G. and M.R.*, 97 N.J.A.R.2d (HLT) 7.

Medicaid claims submitted more than two years after services rendered rejected as untimely filed. In the Matter of *Bayview Convalescent Center*, 97 N.J.A.R.2d (HLT) 1.

Failure to make timely inquiry regarding denial of Medicaid reimbursement claim rendered nursing home ineligible for reimbursement. In the Matter of *Meadowview Nursing Home Patients*, 96 N.J.A.R.2d (DMA) 65.

Medicaid reimbursement claims were denied where insufficient proof was submitted to invoke presumption of timely receipt of claims. *SSI Medical Services, Inc. v. Medical Assistance and Health Services*, 96 N.J.A.R.2d (DMA) 47.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Medicare: The program will make payment in the full amount of the Medicare Part A deductible and co-insurance for inpatient hospital services, and for Part B outpatient hospital services. For services rendered on or after July 20, 1998, payment for Part B coinsurance and deductible for other non-hospital services shall be paid only up to the Medicaid or NJ FamilyCare maximum allowable.

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

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

1. For services, goods, or supplies not covered or authorized by the New Jersey Medical Assistance and Health Services Act (N.J.S.A. 30:4D-1 et seq.), as amended and supplemented, or not covered or authorized by the Division of Medical Assistance and Health Services under this chapter or N.J.A.C. 10:74, if the beneficiary elected to receive the services, goods, or supplies with the knowledge that they were not covered or authorized;

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

3. For NJ FamilyCare-Plan C enrollee's contribution to care responsibility; or

4. For NJ FamilyCare-Plan D enrollee's required co-payment.

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