

CHAPTER 49

ADMINISTRATION MANUAL

Authority

N.J.S.A. 30:4D-1 et seq., specifically 6, 7 and 12; 30:6E-1 et seq.; 52:14D-1 et seq., and 42 C.F.R. 412.30.

Source and Effective Date

R.2003 d.81, effective January 22, 2003.
See: 34 N.J.R. 2647(a), 35 N.J.R. 1116(a).

Chapter Expiration Date

Chapter 49, Administration Manual, expires on January 22, 2008.

Chapter Historical Note

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

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

Chapter 49, Administration, was repealed and a new Chapter 49, Administration, was adopted by R.1992 d.317, effective August 17, 1992.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 Subchapter 19, Prepaid Health Care Services: Medicaid Eligibles, was repealed by R.1995 d.337, effective June 19, 1995.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

Pursuant to Executive Order No. 66(1978), Chapter 49, Administration, was readopted as R.1997 d.354, effective August 8, 1997. As a part of R.1997 d.354, effective September 2, 1997, Chapter 49, Administration, was renamed Chapter 49, Administration Manual; Subchapter 2, New Jersey Medicaid Recipients, was renamed Subchapter 2, New Jersey Medicaid Beneficiaries; Subchapter 9, Provider and Recipient's Rights and Responsibilities; Administrative Process, was renamed 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: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Subchapter 24, Work First New Jersey/General Assistance Claims Processing, was adopted by R.2000 d.309, effective August 7, 2000. See: 32 N.J.R. 1342(a), 32 N.J.R. 2900(a).

Chapter 49, Administration Manual, was readopted as R.2003 d.81, effective January 22, 2003. See: Source and Effective Date. See, also, section annotations. Subchapter 20, The Garden State Health Plan (GSHP), was reserved by R.2003 d.82, effective February 18, 2003. See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

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APPENDIX

SUBCHAPTER 1. GENERAL PROVISIONS

10:49-1.1 Scope and purpose

(a) The Division of Medical Assistance and Health Services, under the Department of Human Services, is designated in accordance with 42 C.F.R. 412.30, as the single State agency for the administration of the New Jersey Medicaid program. Under the authority of N.J.S.A. 30:4D-1 et seq., as amended and supplemented, N.J.S.A. 30:4D-5, and pursuant to N.J.S.A. 30:4D-4, 30:4I-1 et seq. and 30:4J-1 et seq., 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 FamilyCare programs 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 N.J.S.A. 30:4D-1 et seq., as amended and supplemented, 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 FamilyCare 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 FamilyCare 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.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

Amended N.J.S.A. reference in (a) and (c).

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 FamilyCare program through its Central Office and through Medical Assistance Customer Centers (MACCs) located throughout the State of New Jersey. A listing of the MACCs 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 FamilyCare 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 Centers for Medicare & Medicaid Services (CMS). The NJ FamilyCare program is conducted according to the Title XIX and Title XXI State Plans approved by CMS.

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.

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

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

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.

"AFDC" means the former Aid to Families with Dependent Children program.

"AFDC-related Medicaid" means medical assistance provided to families who would otherwise qualify for AFDC or would be deemed to qualify for AFDC if the program would be deemed still in existence.

"American Indian/Alaska Native (AI/AN)" means a member of a Federally recognized Indian tribe, band, or group; an Eskimo or Aleut or other Alaska Native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 C.F.R. 1601 et seq.; or a person who is considered by the Secretary of the Interior as meeting the requirements of tribal membership in accordance with 42 C.F.R. 36a.16.

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

"Centers for Medicare and Medicaid Services (CMS)" 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.

"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 board of social services (CBOSS)" means that agency of county government which is charged with the responsibility for determining eligibility for public assistance programs including AFDC-Related Medicaid, Temporary Assistance to Needy Families, the Food Stamp program and Medicaid. Depending on the county, the CBOSS might be identified as the Board of Social Services, the Welfare Board, the Division of Welfare, or the Division of Social Services.

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

"DHSS" means the Department of Health and Senior Services.

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

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

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

"Fiscal agent" means an entity that processes and adjudicates provider claims on behalf of programs administered in whole or part by the Division.

"Managed care service administrator" means an entity in a non-risk based financial arrangement that contracts to provide a designated set of services for an administrative fee. Services provided may include, but are not limited to: medical management, claims processing, and provider network maintenance.

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

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

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

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

"NJ FamilyCare-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, and adults with family incomes up to and including 133 percent of the Federal poverty level.

"NJ FamilyCare-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.

- 47 Middlesex MACC
- 48 Middlesex MACC
- 51 Middlesex MACC—Menlo Park Veterans Home
- 51 Middlesex MACC—Vineland Veterans Home
- 90 MACC 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.

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

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

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 CBOSS for programs such as AFDC—Related Medicaid; 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 MACC will be able to provide guidance in this matter (for MACC 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.

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

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

10:49-2.18 (Reserved)

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

For any alien who does not qualify for Medicaid or NJ FamilyCare—Plan A based on his or her alien status, and thus is potentially eligible for Medicaid or NJ FamilyCare—Plan A payment for emergency services only (see N.J.A.C. 10:49-5.4, Medicaid or NJ FamilyCare—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 FamilyCare—Plan A eligibility but serves only to protect the date of inquiry as an application date for Medicaid, or NJ FamilyCare—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.

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

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

SUBCHAPTER 3. PROVIDER PARTICIPATION

10:49-3.1 Provider types eligible to participate

(a) The following provider types are eligible to participate as Medicaid/NJ FamilyCare—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. Mental health rehabilitation providers:
 - i. Residential child care facilities (see N.J.A.C. 10:77 and 10:127);
 - ii. Children's group homes (see N.J.A.C. 10:77 and 10:128);
 - iii. Psychiatric community residences for youth (see N.J.A.C. 10:37B and 10:77); and
 - iv. Programs for Assertive Community Treatment (PACT) Agencies/Teams (see N.J.A.C. 10:37J and 10:76).
17. Medical day care centers;
18. Nurse-midwives;
19. Opticians;
20. Optometrists;
21. Orthotists;
22. Pharmacies;
23. Physicians and/or physician groups;
24. Podiatrists and/or podiatric groups;
25. Prosthetists;
26. Psychologists and/or psychologist groups;
27. Residential treatment facilities;
28. Transportation providers; and
29. State and county agencies that have agreed to provide personal care assistant services.

(b) In order for professional practices to be eligible to participate in the Medicaid and NJ FamilyCare programs as specific provider entities, such practices shall comply with all applicable State licensing statutes and rules governing their ownership and direction.

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.

Amended by R.2001 d.144, effective May 7, 2001.

See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).

Inserted new (a)16 and recodified former (a)16 through 28 as new (a)17 through 29.

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

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

Added (b).

Amended by R.2003 d.89, effective March 3, 2003.

See: 34 N.J.R. 1593(a), 35 N.J.R. 1281(a).

Rewrote (a)16.

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 complete a Provider Application and sign a Provider Agreement (see Appendix, N.J.A.C. 10:49) or a specialized agreement, and submit such other information or documentation, including, but not limited to, social security number and date of birth, 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.

2. All practitioners participating in a group practice shall personally sign both the group application and the provider agreement if individual documents, or shall sign a single signature sheet if both documents are contained in a single packet.

(b) All providers shall be required to complete Form HCFA-1513, Ownership and Control Interest Disclosure Statement (see Appendix, Form #10) at the time of application or reapplication. In addition, at the time of application or reapplication, all professional practices must certify that they comply with all applicable State licensing statutes and rules governing their ownership and direction (see Appendix, Form #12). 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 FamilyCare 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.

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

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 FAMILYCARE 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 FamilyCare–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.

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

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

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 FamilyCare–Plan A programs

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

1. Case management services (Mental Health Program);
2. Certified nurse practitioner/clinical nurse specialist services;
3. Chiropractic services;
4. Religious non-medical health care 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 FamilyCare–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 FamilyCare-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, including mental health rehabilitation services provided in:
 - i. Residential child care facilities (see N.J.A.C. 10:77 and 10:127);
 - ii. Children's group homes (see N.J.A.C. 10:77 and 10:128);
 - iii. Psychiatric community residences for youth (see N.J.A.C. 10:37B and 10:77); and
 - iv. Programs for Assertive Community Treatment (PACT) Services (see N.J.A.C. 10:37J and 10:76), except that adults with no children who are covered under NJ FamilyCare-Plan A are not eligible for PACT services. These beneficiaries are identified with a "70" as the third and fourth digits of their 12 digit NJ FamilyCare eligibility identification number.
20. Nursing facility services, including intermediate care facilities for the mentally retarded;
 - i. Any additional Intermediate Care Facility/Mental Retardation (ICF/MR) beds or new ICF/MR facilities shall be approved by the Division of Developmental Disabilities (DDD) prior to application for reimbursement as a Medicaid/NJ FamilyCare provider;
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/NJ FamilyCare-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 FamilyCare 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 FOHCs; 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.

Amended by R.2001 d.144, effective May 7, 2001.

See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).

Rewrote (a)19.

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), substituted "Religious non-medical health care services," for "Christian Science Sanatoria" in 4, added 20i.

Amended by R.2003 d.89, effective March 3, 2003.

See: 34 N.J.R. 1593(a), 35 N.J.R. 1281(a).

In (a), rewrote 19 and substituted "NJ family Care" for "or KidCare" in 30.

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.)

1. Chiropractic services are available only to pregnant women (Group A).
2. EPSDT services are not available to any Medically Needy group.
3. Hospital services (inpatient) are available only to pregnant women (Group A).
4. Nursing facility services are available to Medically Needy beneficiaries. For purposes of the Medically Needy program, nursing facility services include pharmacy services under Title XIX.
5. Medical day care services are available only to pregnant women, the aged, the blind and the disabled (Groups A and C).
6. Pharmaceutical services are available only to pregnant women and needy children (Groups A and B); and aged, blind or disabled beneficiaries who reside in Medicaid participating nursing facilities (see N.J.A.C. 10:51-2.10). Pharmaceutical services are not available to other aged, blind and disabled beneficiaries (Group C).
7. Podiatric services are available only to pregnant women, the aged, the blind and the disabled (Groups A and C).
8. Rehabilitative services are not available for reimbursement when provided through a hospital or nursing

facility, except to pregnant women as part of their inpatient hospital services.

9. Case management services for the mentally ill are available to Medically Needy pregnant women only.

10. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical or clinic), drugs, laboratory services, radiological and diagnostic services and surgical procedures are not available to the Medically Needy group.

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

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

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)4, substituted "beneficiaries" for "group" and inserted reference to pharmacy services; and in (a)6, inserted references to aged, blind or disabled beneficiaries.

Case Notes

Administrative Procedure Act notice requirement violated by freeze on Medicaid reimbursement rate increases. *Thomas Jefferson University Hospital v. Div. of Medical Assistance and Health Services*, 6 N.J.A.R. 127 (1981).

Hospital not entitled to hearing prior to decertification as Medicaid provider. *Preakness Hospital v. Div. of Medical Assistance and Health Services*, 3 N.J.A.R. 351 (1981).

Agency action in enforcing its regulations to deny ambulance service claims not arbitrary, capricious and unreasonable (Division's Final Decision). *Bergen Ambulance Services v. Hudson Cty. Medical Assistance Unit*, 2 N.J.A.R. 196 (1980).

10:49-5.4 Emergency medical services for aliens and prenatal care for specified pregnant alien women

(a) Most legal aliens who entered the United States on or after August 22, 1996 are restricted in their entitlement to emergency services for five years from their date of entry. Undocumented aliens and temporarily documented aliens, that is visitors, workers, and students, are also restricted in their entitlement to emergency services. These emergency medical services are only available to individuals who, except for their alien status, would be eligible for Medicaid, Medically Needy, New Jersey Care . . . Special Medicaid Programs, AFDC-related Medicaid, or NJ FamilyCare-Plan A. Applicants who would otherwise be eligible for NJ FamilyCare-Plans B, C and D are not eligible for these emergency medical services for aliens.

1. Except as noted in (a)2 below, emergency services are defined as care provided in an acute care general hospital (emergency outpatient services and/or inpatient services) for a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- i. Placing the patient's health in serious jeopardy;

- ii. Serious impairment to bodily functions; or
- iii. Serious dysfunction of any bodily organ or part.

2. For labor and delivery services, the place of service is not limited to an acute care general hospital. Services provided in birth centers are also eligible for reimbursement under this program.

3. Diagnoses are classified as emergency or non-emergency services in accordance with the above definition of an emergency. Those diagnoses that correspond with emergency care are defined as emergencies and thus do not require any authorization by the attending physician. Those diagnoses that correspond with urgent care require a Certification of Treatment of Emergency Medical Condition signed by the attending physician confirming the emergency nature of the encounter to be attached to the claim when submitted for reimbursement.

- i. Emergency care is provided for life-threatening or organ threatening, or potentially life or organ threatening condition that requires immediate care.
- ii. Urgent care is provided for a condition that is potentially harmful to a patient's health and determined by the physician to be medically necessary for treatment within 12 hours to prevent deterioration.

4. To be eligible for emergency services, an alien meeting the medical criteria listed in (a)1 above must also meet all financial and categorical eligibility requirements for NJ FamilyCare-Plan A, Medicaid, Medically Needy, New Jersey Care ... Special Medicaid Programs or AFDC-related Medicaid.

(b) Lawfully admitted aliens who entered the United States prior to August 22, 1996 and other aliens who are refugees, asylees, Cuban/Haitian entrants, American Indians born in Canada, Amerasian immigrants, and aliens who are honorably discharged or are on active duty in the Armed Forces of the United States and their spouses and unmarried dependent children, may qualify for full NJ FamilyCare-Plan A, Medicaid, Medically Needy, New Jersey Care ... Special Medicaid Programs or AFDC-related Medicaid, if they meet all other programmatic eligibility requirements. These aliens should be referred to the appropriate eligibility determination agency of their choice to apply for full benefits. See N.J.A.C. 10:70-3.2(a), 10:71-3.3(c), 10:72-3.2(a), and 10:79-3.2(b).

(c) Legally admitted pregnant alien women who entered the United States on or after August 22, 1996, who would otherwise be eligible for New Jersey Care ... Special Medicaid Programs, except for the alien requirements are also eligible for routine prenatal care services. Prenatal care includes services provided in the outpatient hospital department, or by a physician, certified nurse practitioner or certified nurse midwife, as well as laboratory, radiological and pharmaceutical services.

New Rule, 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. 10:49-5.4., Services not covered by the Medicaid program, recodified to N.J.A.C. 10:49-5.5.

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.1999 d.253, effective August 2, 1999.

See: 31 N.J.R. 97(a), 31 N.J.R. 2203(b).

Rewrote the section.

Emergency amendment R.1999 d.254, effective July 12, 1999 (to expire September 10, 1999).

See: 31 N.J.R. 2252(a).

Rewrote the section.

Adopted concurrent proposal, R.1999 d.345, effective September 10, 1999.

See: 31 N.J.R. 2252(a), 31 N.J.R. 2880(a).

Readopted provisions of R.1999 d.254 without change.

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), inserted "in their entitlement" following "restricted" throughout.

10:49-5.5 Services not covered by the Medicaid or NJ FamilyCare-Plan A program

(a) Listed below are some general services and items excluded from payment under the New Jersey Medicaid and NJ FamilyCare-Plan A program. There are additional specific exclusions and limitations detailed in the second chapter of each Provider Services Manual. Payment is not made for the following:

1. Any service, admission, or item, which is not medically required for diagnosis or treatment of a disease, injury, or condition;
2. Services provided to all persons without charge; these services shall not be billed to the Medicaid program when provided for a Medicaid beneficiary. Services and items provided without charge through programs of other public or voluntary agencies (for example, New Jersey State Department of Health and Senior Services, New Jersey Heart Association, First Aid Rescue Squads, and so forth) shall be utilized to the fullest extent possible;
3. Any service or items furnished in connection with elective cosmetic procedures;
 - i. There are certain exceptions to this rule, but the exceptions require prior authorization. A written certification of medical necessity and a treatment plan shall be submitted by the physician to the appropriate Medicaid District Office for consideration;
4. Private duty nursing services (except for beneficiaries under EPSDT, Model Waiver III, ACCAP and ABC programs);
5. Services or items furnished for any sickness or injury occurring while the covered person is on active duty in the military;
6. Services provided outside the United States and territories;

7. Services or items furnished for any condition or accidental injury arising out of and in the course of employment for which any benefits are available under the provisions of any workers' compensation law, temporary disability benefits law, occupational disease law, or similar legislation, whether or not the Medicaid beneficiary claims or receives benefits thereunder, and whether or not any recovery is obtained from a third-party for resulting damages;

8. That part of any benefit which is covered or payable under any health, accident, or other insurance policy (including any benefits payable under the New Jersey no-fault automobile insurance laws), any other private or governmental health benefit system, or through any similar third-party liability, which also includes the provision of the Unsatisfied Claim and Judgment Fund;

9. Services or items furnished prior to or after the period for which the beneficiary presents evidence of eligibility for coverage.

i. Payment is made for inpatient hospital services (excluding governmental psychiatric hospitals) when ineligibility occurs after admission to hospital as an inpatient. Payment is also made for certain services that were authorized and initiated before loss of eligibility such as dental, vision care, prosthetics and orthotics, and durable medical equipment. Also, see "Retroactive Eligibility" at N.J.A.C. 10:49-2.7(c);

10. Any services or items furnished for which the provider does not normally charge;

11. Any admission, service, or item, requiring prior authorization, where 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 profes-

sional 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 recovered 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 FamilyCare-Plan A beneficiary whose Medicaid or NJ FamilyCare 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 Division. If upon audit, financial records or other acceptable evidence are unavailable for these purposes:

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

ii. Beneficiary income shall be presumed to equal the maximum income allowable for a Medicaid or NJ FamilyCare 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;

17. Claims for services, goods or supplies which are furnished, rendered, prescribed or ordered in violation of Federal or State civil or criminal statutes, or in violation of licensure statutes, rules and/or regulations; and

18. Any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the direction or on the prescription of a physician, individual or entity, during the period when such physician, individu-

al or entity is excluded from participation in the Medicaid and NJ FamilyCare programs, and when the physician, individual or entity furnishing such item or service has received written notice from the Division that the physician, individual or entity has been excluded from participation in the Medicaid and NJ FamilyCare programs.

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.

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), added 17 and 18.

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 and unavailable to beneficiaries eligible for, or who are presumptively eligible for, NJ FamilyCare-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 FamilyCare-Plan C, the services listed below are available to beneficiaries eligible for NJ FamilyCare-Plan B or C, through an HMO selected by the NJ FamilyCare-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 FamilyCare 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 FamilyCare-Plan B or C under fee-for-service:

1. Religious non-medical health care institution 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 Plan B and C are as follows:

1. Unless listed in (a) and (b) above, no other services are covered by NJ FamilyCare-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;
 - v. Lower mode transportation;
 - vi. Mental health rehabilitation services provided in residential child care facilities (as defined in N.J.A.C. 10:127 and licensed by DYFS), children's group homes (as defined in N.J.A.C. 10:128 and licensed by DYFS), or psychiatric community residences for youth (as defined in N.J.A.C. 10:37B and licensed by DMHS);
 - vii. Any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the direction or on the prescription of a physician, individual or entity, during the period when such physician, individual or entity is excluded from participation in the Medicaid and NJ FamilyCare programs, and when the physician, individual or entity furnishing such item or service has received written notice from the Division that the physician, individual or entity has been excluded from participation in the Medicaid and NJ FamilyCare programs; and
 - viii. Programs for Assertive Community Treatment (PACT) services.

(d) All presumptively eligible NJ FamilyCare-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).

Amended by R.2001 d.144, effective May 7, 2001.

See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).

Added (c)2vi.

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

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

In (b)1, substituted "Religious non-medical health care institution" for "Christian Science sanatoria"; in (c), added "for youth (as defined in N.J.A.C. 10:37B and licensed by DMHS); and" at the end of vi and added vii.

Amended by R.2003 d.89, effective March 3, 2003.

See: 34 N.J.R. 1593(a), 35 N.J.R. 1281(a).

Rewrote (c)2.

10:49-5.7 Services available and unavailable to beneficiaries eligible for NJ FamilyCare-Plan D

(a) Except as indicated at N.J.A.C. 10:79-2.5, which concerns services for newborns enrolling into NJ FamilyCare Plan C and D, the services listed below are available to beneficiaries eligible for NJ FamilyCare Plan D and Plan D for Adults, when medically necessary and provided through the network of an HMO selected by the NJ FamilyCare 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 FamilyCare 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;
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. Inpatient rehabilitative services, including physical, occupational and speech therapy for non-chronic conditions and acute illnesses and injuries;
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 FamilyCare-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. Outpatient 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 period of 60 consecutive business days per incident of illness or injury beginning with the first day of treatment per contract year, except that:

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

3. 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 FamilyCare-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. Religious non-medical health care institution 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 non-emergency 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. Nursing facility (long term care) services;

xxviii. Recreational therapy;

xxix. Sleep therapy;

- xxx. Court ordered services;
- xxxi. Thermograms and thermography;
- xxxii. Biofeedback;
- xxxiii. Radial keratotomy;

xxxiv. Mental health rehabilitation services provided in residential child care facilities (as defined in N.J.A.C. 10:127 and licensed by DYFS), children's group homes (as defined in N.J.A.C. 10:128 and licensed by DYFS), or psychiatric community residences for youth (as defined in N.J.A.C. 10:37B and licensed by DMHS); and

xxxv. Respite care;

xxxvi. Any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the direction or on the prescription of a physician, individual or entity, during the period when such physician, individual or entity is excluded from participation in the Medicaid and NJ FamilyCare programs, and when the physician, individual or entity furnishing such item or service has received written notice from the Division that the physician, individual or entity has been excluded from participation in the Medicaid and NJ FamilyCare programs; and

xxxvii. Programs for Assertive Community Treatment (PACT) services.

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).

Amended by R.2001 d.144, effective May 7, 2001.

See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).

Added (c)2xxxiv.

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

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

In (c)2, substituted "Religious non-medical health care institution" for "Christian science sanatoria" in xi and added xxxiv.

Special amendment, R.2003 d.98, effective January 31, 2003.

See: 35 N.J.R. 1303(a).

Rewrote (c)2.

Amended by R.2003 d.89, effective March 3, 2003.

See: 34 N.J.R. 1593(a), 35 N.J.R. 1281(a).

In (c)2, added xxxvi and xxxvii.

10:49-5.8 Services available for beneficiaries eligible for NJ FamilyCare Plan H

(a) Childless adults whose income is below 100 percent of the Federal poverty level and who do not qualify for WFNJ/GA and who are enrolled in NJ FamilyCare on July 1, 2002 shall be eligible to receive the NJ FamilyCare Plan H service package.

(b) Restricted alien parents who are enrolled in NJ FamilyCare on November 1, 2003, shall receive the Plan H service package.

(c) Out-of-plan community-based mental health services shall be limited to 60 service days per calendar year and shall be eligible for payment on a fee-for-service basis.

(d) No behavioral health out-of-plan service of any kind, where the place of service is a hospital, shall be a covered service.

(e) The services listed below shall be available to beneficiaries eligible for NJ FamilyCare Plan H, when medically necessary and when provided through the network of a managed care service administrator selected by the beneficiary:

1. Ambulance—medical emergency only;
2. Ambulatory surgery in an outpatient hospital setting only;
3. Certified nurse practitioner/clinical nurse specialist;
4. Clinic services (free standing)—ambulatory;
5. Diabetic supplies/equipment;
6. Durable Medical equipment-limited benefit, only covered when a medically necessary part of the beneficiary's inpatient hospital discharge plan;
7. Emergency room services;
8. Federally qualified health centers (FQHC) primary care services;
9. Home health care services (limited benefits);
10. Inpatient hospital (non-behavioral health related);
11. Laboratory services;
12. Outpatient hospital (non-mental health related);
13. Physician services;
14. Prescription drugs (excludes over the counter medications; and
15. Radiological services.

(f) The following services shall be available to NJ FamilyCare Plan H beneficiaries on a fee-for-service basis:

1. Abortion (elective/induced); and
2. Mental health services in the community, including psychological services, up to a maximum of 60 days per calendar year.

Special New Rule, R.2002 d.214, effective June 10, 2002.

See: 34 N.J.R. 2338(a).

Special amendment, R.2003 d.417, effective September 26, 2003 (operative November 1, 2003).

See: 35 N.J.R. 4913(a).

Rewrote the section.

10:49-5.9 Services available for beneficiaries eligible for NJ FamilyCare Plan G

General Assistance-eligible individuals shall receive Plan G services, which shall be those services delineated at N.J.A.C. 10:49-24.3.

Special New Rule, R.2002 d.214, effective June 10, 2002.

See: 34 N.J.R. 2338(a).

10:49-5.10 Services available to beneficiaries eligible for NJ FamilyCare Plan I

(a) The services listed below are available to beneficiaries eligible for NJ FamilyCare Plan I, on a fee-for-service basis, when medically necessary:

1. Certified nurse practitioner and clinical nurse specialist services;

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

3. Emergency room services;

4. 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 shall not be covered by the NJ FamilyCare program;

5. Federally qualified health center primary care services;

6. 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 aid services 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)21 below;

i. Personal care assistant services are not covered;

7. Hospice services;

8. Hospital services—inpatient;

9. Hospital services—outpatient;

10. Laboratory (clinical);

11. Nurse-midwifery services;

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

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

14. Organ transplant services which are non-experimental or non-investigational;

15. Prescription drug services, except that over-the-counter drugs are not covered;

16. Physician services;

17. Podiatric services, except that routine foot care is not covered;

18. 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;

19. Outpatient surgery;

20. Radiological services;

21. Outpatient 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 period of 60 consecutive business days per incident of illness or injury beginning with the first day of treatment, except that:

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

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

23. Maternity and related newborn care;

24. Diabetic supplies and equipment;

25. 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. When authorized by the Division of Medical Assistance and Health Services, inpatient benefit exchanges are allowed, as follows:

(1) One mental health inpatient day may be exchanged for up to four home health visits or 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 outpatient visits.

(2) 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; and

26. Elective/induced abortion services.

(b) Unless listed in (a) above, no other services shall be covered by NJ FamilyCare Plan I. Services which shall not be covered include, but shall not be limited to:

1. Services that are not medically necessary;
2. Private duty nursing, unless prior authorized by the Division;
3. Intermediate care facilities for mental retardation (ICF/MR);
4. Personal care assistant services;
5. Medical day care services;
6. Chiropractic services;
7. Dental services;
8. Orthotic devices;
9. Targeted case management for the chronically ill;
10. Christian Science sanatoria care and services;
11. Durable medical equipment;
12. Routine transportation, including non-emergency ambulance, invalid coach and lower mode (car, taxi, bus) transportation;
13. Hearing aid services;
14. Blood and blood plasma, except that administration, processing of blood, processing fees and fees related to autologous blood donations shall be covered;
15. Cosmetic services;
16. Nursing facility (long term care) services;
17. Special and remedial educational services;
18. Experimental and investigational services;
19. Infertility services;
20. Medical supplies, except that diabetic supplies shall be a covered service;
21. Rehabilitative services for substance abuse (methadone maintenance is not covered);
22. Weight reduction programs or dietary supplements;
23. Acupuncture and acupuncture therapy, except when performed as a form of anesthesia in connection with covered surgery;
24. Temporomandibular joint disorder (TMJ) treatment, including treatment performed by prosthesis placed directly in the teeth;
25. Recreational therapy;
26. Sleep therapy;
27. Court ordered services;
28. Thermograms and thermography;
29. Biofeedback;
30. Radial keratotomy;
31. Respite care;
32. Custodial care; and
33. EPSDT services.

Special New Rule, R.2003 d.98, effective January 31, 2003.
See: 35 N.J.R. 1303(a).

SUBCHAPTER 6. AUTHORIZATIONS REQUIRED BY MEDICAID AND THE NJ FAMILYCARE 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 FamilyCare 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.

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

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

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 the 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. 10:52-11, 12 and 13.

(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."

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)2, amended the N.J.A.C. references.

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 each provider to ensure that each Medicaid/NJ FamilyCare-Plan A claim submitted by that provider is received by the New Jersey Medicaid/NJ FamilyCare program's Fiscal Agent within the time periods indicated in this section. Providers shall reconcile their claims submission records with the Remittance Advice they receive from the Division's Fiscal Agent in order to verify that the Division's Fiscal Agent has received their claims. Providers shall resubmit any claims for reimbursement which the provider determines have been submitted previously, but which do not appear on the Remittance Advice.

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

ii. For retroactive eligibility cases, a claim associated with a retroactive eligibility application, that was submitted to the Medicaid Assistance and Health Services' Retroactive Eligibility Unit will be considered as received on the date of receipt of the application on behalf of the applicant. For information about retroactive eligibility, see N.J.A.C. 10:49-2.9.

(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 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 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).

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) 17.

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.

1. Medicare is a health insurance program which covers certain aged and disabled persons. When rendering Medicare-covered services to any Medicaid or NJ FamilyCare beneficiary, providers shall inquire about Medicare eligibility especially if the third digit of the Eligibility

Identification Number is a 1, 2, 5, or 7. Medicaid or FamilyCare supplementation of available Medicare benefits shall be as follows:

i. Medicare (Title XVIII): For any Medicaid or NJ FamilyCare beneficiary who is covered under Medicare, responsibility for payment by the New Jersey Medicaid Agent or the NJ FamilyCare program for non-hospital Part B services shall be limited to the unsatisfied deductible and/or coinsurance to the extent that the combined total of payments does not exceed the maximum allowable under the Medicaid or NJ FamilyCare program in the absence of other coverage for services rendered on or after July 20, 1998.

(f) When a Medicaid or NJ FamilyCare beneficiary has benefits available, such as those described above or from any other liable third party, an approved Medicaid or NJ FamilyCare provider shall be authorized to sign an insurance claim for the Commissioner, based on the third party assignment of rights, in order to receive direct payment from the insurer. This is done pursuant to N.J.S.A. 30:4D-7.1(c). The following language shall be used by the provider when completing insurance claims: "(signature of authorized provider), Assignee for the Commissioner, New Jersey Department of Human Services."

(g) When recovery of benefits is sought by the Medicaid or NJ FamilyCare program from a liable third-party, the Commissioner shall authorize the Director or his designee(s) to sign the recovery demand.

(h) TPL may be exhausted, but is not required to be, before a claim is submitted for Medicaid or NJ FamilyCare payment in any of the following circumstances:

1. The TPL benefits are derived from a parent whose obligation to pay support is being enforced by the State Title IV-D agency;
2. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the program;
3. The claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay;
4. The claim involves a service for which CMS has granted a waiver of the TPL cost avoidance requirements in accordance with 42 C.F.R. 433.139(e). Waivers have been granted for services covered by Medicare Part B which are rendered at State and county governmental psychiatric hospitals, State and private ICFs/MR, and Vineland Special Hospital; or
5. Rehabilitation services provided by a local school district under a child's Individualized Education Program (IEP).

(i) In those situations where a health insurance payment is received after Medicaid or NJ FamilyCare has been billed and has made payment, the provider must reimburse the Medicaid or NJ FamilyCare payment to the Medicaid or NJ FamilyCare beneficiary. Reimbursement must be made immediately to comply with Federal regulations. In the event a provider is apprised or otherwise is on notice that a duplicate or excessive payment has been made by the Division as a result of the provider's receipt of a Medicare or health insurance payment, the provider shall have 60 days to refund such overpayments to the Division. To initiate the process, providers must submit an MMIS Claim Adjustment Request Form. (See Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

1. In situations involving tort matters where liability has not been established at the time of billing, providers may elect to bill the Medicaid program. However, if they choose to do so, they are precluded from returning Medicaid payments for their services, and may not seek reimbursement from any proceeds resulting from the tort matter. Conversely, providers may elect not to bill the Medicaid program, and await the outcome of the tort matter. However, should the tort matter not result in an award to the beneficiary, and the deadline for timely filing of a Medicaid claim by the provider passes, the provider shall not bill either the Medicaid program or the beneficiary.

2. This subsection in no way precludes the Division from seeking reimbursement for Medicaid payments made on behalf of the beneficiary or from any third party liability source, including a tort liability recovery, which may be awarded the beneficiary.

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

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

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

Petition for Rulemaking.
See: 27 N.J.R. 770(b), 27 N.J.R. 1320(a).
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" and "beneficiaries" for "recipient" and "recipients" throughout; in (a), substituted "by the Medicaid program" for "under this act"; in (b), inserted "the exceptions listed in"; in (c)1, substituted "Medicaid Eligibility Identification Number" for "HSP (Medicaid) Case Number"; deleted (c)1i and (c)1i(1); added (h)5; and in (i), substituted "a health insurance payment is received" for "an insurance payment is received from another payer" and "MMIS Claim Adjustment Request Form" for "Adjustment/Void Request Form". 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 references to NJ KidCare throughout; in (d)1, inserted "as amended and supplemented," following "et seq." and added 3; and in (c), inserted a reference to NJ KidCare-Plan A beneficiaries in the first sentence.

Amended by R.1998 d.382, effective July 20, 1998.

See: 30 N.J.R. 1255(b), 30 N.J.R. 2646(b).

In (c), inserted a reference to the NJ KidCare Program in the introductory paragraph and rewrote 1; and in (c), added a new 1i, and inserted references to NJ KidCare, Medicare and Medicaid throughout. Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998. See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 with changes, effective September 21, 1998.

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).

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

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

In (h)4, deleted i; rewrote (i).

10:49-7.4 Prohibition of payment to factors

(a) A "factor" means an individual or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the individual organization for an added fee or deduction of a portion of the accounts receivable.

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

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), substituted "beneficiary" for "recipient".

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 (b), inserted a reference to NJ KidCare beneficiaries.

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.2003 d.82, effective February 18, 2003.

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

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

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

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

3. Not dependent upon the collection of the payment.

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

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

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

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

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

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

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

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

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

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

Inserted references to NJ KidCare throughout.

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

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

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

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

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

Case Notes

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.

SUBCHAPTER 8. PAYMENT FOR SERVICES PROVIDED

10:49-8.1 Fiscal Agent

The State of New Jersey uses a fiscal agent for the processing of Medicaid claims, the pricing of charity care claims, and payment to providers.

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

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

Inserted language referencing Medicaid claims, charity care claims, and provider payments.

10:49-8.2 Claims payment and pricing

(a) The Fiscal Agent will process claims daily and produce provider payments and associated Remittance Advice (RA) statements once each week. The RA is the provider's account statement and reflects the status of all claims currently entered into the Medicaid Management Information System. Provider payments in the form of checks and electronic funds transfers will be released following approval by the New Jersey Medicaid program. For charity care claims pricing information, see N.J.A.C. 10:52-11, 12 and 13.

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

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

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

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

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

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

(c) For each claim processed in a payment cycle, the ICN, beneficiary name, dates of service and other claim information is printed on the RA. On the line immediately below this information, a code is printed representing a denial reason, and other information that might be useful to the provider and payment reduction reasons, if any. Messages explaining all codes found on the RA will be found on a separate page following the status listing of all claims. For more information about Remittance Advice see the Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual.

(d) Claims may be paid beyond 12 months of the date of receipt with Federal financial participation (FFP) in the following situations:

1. When the claim invoice or retroactive adjustment is paid to a provider reimbursed under a retrospective payment system;

2. For a Medicare/Medicaid claim or Medicare/NJ KidCare claim, timely filed, payment may be made for services within six months after the program or provider receives notice of the Medicare claim disposition for a timely filed Medicare/Medicaid or Medicare/NJ KidCare claim;

3. For claims from providers under investigation for fraud or abuse; or

4. For claims associated with administrative or legal actions pursuant to a hearing action or agency corrective action mandate, whether for an eligible individual or for all those eligibles affected in a similar manner.

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)1 and (a)1ii, substituted "in process" for "suspended"; in (a)1i and (c), substituted "beneficiary" for "recipient"; in (a)1iii, substituted "an error/edit code" for "a code"; and in (c), deleted "suspense reasons," following "a denial reason," inserted "other information that might be useful to the provider and", and deleted reference that only a claim status paid as a bill will not have a code.

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

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

In (a), inserted reference to charity care claims pricing.

Amended by R.2001 d.329, effective September 17, 2001.

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

Added (d).

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), amended the N.J.A.C. references in the introductory paragraph and rewrote 1ii.

Case Notes

In computing hospital's charity care subsidy, the Department of Health and Senior Services acted within its discretion in using data provided by contractor that processed charity care claims, rather than using quarterly lists of charity care claims created by hospital, which had previously been used; hospital failed to identify any error in contractor's calculation of documented charity care costs. *University of Medicine and Dentistry of New Jersey v. Grant*, 778 A.2d 473 (2001).

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.

Resubmission of an incorrectly filed Medicare claim is permissible. *Leader Nursing and Rehabilitation Center v. DMAHS*, 94 N.J.A.R.2d (DMA) 4.

10:49-8.3 Adjustments following payment of claims

(a) If a claim is incorrectly paid and the provider receives an overpayment or underpayment, within 60 days of such receipt, the provider shall notify the Fiscal Agent in writing. (For the procedure to follow, see Fiscal Agent Billing Supplement, MMIS Claim Adjustment Request Form, (FD-999(9/91) following the second chapter of each Provider Services Manual).

(b) On occasion, a claim will be paid that should not have been paid. If a claim is paid in error, within 60 days of such receipt, the provider shall notify the Fiscal Agent by requesting that the claim be voided. (For the procedure to follow, see the Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual.)

(c) Any adjustment made by Medicare will not cross over to Medicaid. If Medicare makes an adjustment that results in an overpayment or underpayment by Medicaid, within 60 days of receipt of any such overpayment or under payment, the provider shall notify the Fiscal Agent. (For the procedure to follow, see the Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

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 "MMIS Claim Adjustment Request Form" for "Adjustment/Void Request Form" and inserted "(FD-999(9/91))".

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), inserted "within 60 days of such receipt" following "underpayment"; in (b), inserted "within 60 days of such receipt" following "paid in error"; in (c), rewrote the second sentence.

Case Notes

Nursing home's controller personally liable for Medicare overpayments. *Division of Medical Assistance and Health Services v. Klein*, 92 N.J.A.R.2d (DMA) 16.

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

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

1. To enroll in the EFT payment program, the provider must complete an EFT Enrollment Request/Authorization form. A voided check displaying the provider's account number must accompany the complete authorization form. The enrollment form must be signed by the provider or an authorized official such as the business manager, owner, or facility administrator. Any change to the EFT information (for example, a change of account number, ownership, or authorized official) requires the completion of a new EFT Enrollment Request/Authorization form. (For detailed instructions about enrollment in the EFT payment program, see the 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).

10:49-8.5 Outstanding checks

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

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

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

10:49-9.1 NJ FamilyCare-Plan C personal contribution to care and Plan D copayments

(a) Under NJ FamilyCare-Plan C, personal contribution to care in the amounts indicated below shall be collected by the provider for the services indicated below:

1. Outpatient hospital clinic services: \$5.00 personal contribution to care for outpatient visits. No personal contribution to care shall be charged for well-child visits in accordance with the schedule recommended by the American Academy of Pediatrics; lead screening and treatment; age-appropriate immunizations; prenatal care; preventive services; family planning services; or substance abuse treatment services. Specific policies are set forth at N.J.A.C. 10:52-4.7.

2. \$10.00 personal contribution to care for each covered emergency room services visit which does not result in an inpatient hospital stay.

3. Physician services: \$5.00 personal contribution to care per visit. No personal contribution to care shall be charged for well-child visits in accordance with the schedule recommended by the American Academy of Pediatrics; lead screening and treatment; age-appropriate immunizations; prenatal care; preventive or for family planning services, or substance abuse treatment services. Policies specific to physician personal contribution to care services are set forth at N.J.A.C. 10:54-4.1.

4. Clinic services: \$5.00 personal contribution to care for clinic visits. No personal contribution to care shall be charged for well-child visits in accordance with the schedule recommended by the American Academy of Pediatrics; lead screening and treatment; age-appropriate immunizations; prenatal care; preventive or for family planning services, or substance abuse treatment services. Policies specific to clinic personal contribution to care policies are set forth at N.J.A.C. 10:66-1.6.

5. Podiatric services: \$5.00 personal contribution to care for office visits. Specific policies regarding podiatric personal contribution to care are set forth at N.J.A.C. 10:57-1.7.

6. Optometric services: \$5.00 personal contribution to care for professional vision care services. Specific policies are set forth at N.J.A.C. 10:62-1.6.

7. Chiropractic services: \$5.00 personal contribution to care. Covered for spinal manipulation only.

8. Prescription drugs: \$1.00 personal contribution to care for generics and \$5.00 for brand name drugs. Includes insulin, needles and syringes. Specific policies regarding personal contribution to care for prescription drugs are set forth at N.J.A.C. 10:51-1.12.

9. Psychological services: \$5.00 personal contribution to care. Specific policies for psychologists are set forth at N.J.A.C. 10:67-1.6.

10. Certified nurse-midwife services: \$5.00 personal contribution to care. No personal contribution to care shall be charged for prenatal care, preventive care, or for family planning services. See N.J.A.C. 10:58-1.8 for specific policies related to certified nurse-midwife services.

11. Clinical nurse practitioner: \$5.00 personal contribution to care. No personal contribution to care shall be charged for well-child visits in accordance with the schedule recommended by the American Academy of Pediatrics; lead screening and treatment; age-appropriate immunizations; prenatal care; preventive or for family planning services, or substance abuse treatment services. Specific policies are set forth at N.J.A.C. 10:58A-1.6.

12. Dental services: \$5.00 personal contribution to care applies, unless the visit is for preventive dentistry services. Specific policies are set forth at N.J.A.C. 10:57-1.7.

(b) Providers are required to collect the personal contribution to care for the NJ FamilyCare-Plan C services set forth in (a) above if the NJ FamilyCare Identification card indicates that a personal contribution to care is required and the beneficiary does not have a NJ FamilyCare letter which indicates that the beneficiary has reached his or her cost share limit and no further personal contributions to care are required until further notice. Personal contributions to care can not be waived.

(c) Under NJ FamilyCare-Plan D, copayments in the amounts indicated below shall be collected by the provider for services as follows, if copayment is indicated on the beneficiary's HMO card:

1. A \$5.00 copayment per visit shall be required for the following services:

i. Primary care provider office visit;

(1) A \$10.00 copayment shall apply for services rendered during non-office hours and for home visits.

(2) The \$5.00 copayment shall apply only to the first prenatal visit;

ii. Specialist and other practitioner office visit;

iii. Outpatient rehabilitation services, including physical therapy, occupational therapy and speech therapy;

iv. Hospital outpatient department visits and diagnostic testing;

v. Routine eye examinations;

vi. Prescription drugs;

(1) If greater than a 34-day supply of a prescription drug is dispensed, a \$10.00 copayment shall apply; and

vii. Outpatient substance abuse services for detoxification;

2. A \$25.00 copayment per visit shall be required for outpatient mental health visits; and

3. A \$35.00 copayment per visit shall be required for outpatient emergency services, including services provided in an outpatient hospital department or an urgent care facility.

i. No copayment shall be required if the beneficiary was referred to the emergency room by his or her primary care provider for services that should have been rendered in the primary care physician's office, or if the beneficiary is admitted into the hospital.