

CHAPTER 49

ADMINISTRATION MANUAL

Authority

N.J.S.A. 30:4D-1 et seq. and 30:4J-8 et seq.

Source and Effective Date

R.2008 d.230, effective July 11, 2008.
See: 40 N.J.R. 984(a), 40 N.J.R. 4531(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1.c(2), Chapter 49, Administration Manual, expires on January 7, 2016. See: 47 N.J.R. 2039(a).

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Chapter 49, Administration, was repealed and a new Chapter 49, Administration, was adopted as R.1992 d.317, effective August 17, 1992.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 Subchapter 19, Prepaid Health Care Services: Medicaid Eligibles, was repealed by R.1995 d.337, effective June 19, 1995.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 as 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: 34 N.J.R. 2647(a), 35 N.J.R. 1116(a).

Subchapter 20, The Garden State Health Plan (GSHP), was repealed by R.2003 d.82, effective February 18, 2003. See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

Chapter 49, Administration Manual, was readopted as R.2008 d.230, effective July 11, 2008. As a part of R.2008 d.230, Subchapter 21, The Medicaid Managed Care Program—NJ Care 2000, was renamed The Medicaid/NJ FamilyCare Managed Care Program, effective August 4, 2008. See: Source and Effective Date. See, also, section annotations.

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 49, Administration Manual, was scheduled to expire on July 11, 2015. See: 43 N.J.R. 1203(a).

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. GENERAL PROVISIONS

- 10:49-1.1 Scope and purpose
- 10:49-1.2 Organization
- 10:49-1.3 Definitions
- 10:49-1.4 Overview of provider manuals
- 10:49-1.5 Compliance with the Patient Protection and Affordable Care Act, Health Care and Education Reconciliation Act of 2010, and Federal regulations
- 10:49-1.6 through 10:49-1.8 (Reserved)

SUBCHAPTER 2. NEW JERSEY MEDICAID BENEFICIARIES

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

SUBCHAPTER 3. PROVIDER PARTICIPATION

- 10:49-3.1 Provider types eligible to participate
- 10:49-3.2 Enrollment process
- 10:49-3.3 Providers with multi-locations
- 10:49-3.4 Medicaid or NJ FamilyCare provider billing number
- 10:49-3.5 One-time provider enrollment

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

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

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

- 10:49-5.1 Requirements for provision of services
- 10:49-5.2 Services available to beneficiaries eligible for, or children who are presumptively eligible for, the regular Medicaid and NJ FamilyCare-Plan A programs

- 10:49-5.3 Services available to beneficiaries eligible for the Medically Needy program
- 10:49-5.4 Emergency medical services for aliens and prenatal care for specified pregnant alien women
- 10:49-5.5 Services not covered by the Medicaid or NJ FamilyCare-Plan A program
- 10:49-5.6 Services available and unavailable to beneficiaries eligible for, or who are presumptively eligible for, NJ FamilyCare-Plan B or C
- 10:49-5.7 Services available and unavailable to beneficiaries eligible for NJ FamilyCare-Plan D and Plan D for adults
- 10:49-5.8 Services available for beneficiaries eligible for NJ FamilyCare-Plan H
- 10:49-5.9 Services available for beneficiaries eligible for NJ FamilyCare-Plan G
- 10:49-5.10 Services available to beneficiaries eligible for NJ FamilyCare-Plan I

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

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

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

- 10:49-7.1 General provisions
- 10:49-7.2 Timeliness and method of Medicaid claim or other claim submission
- 10:49-7.3 Third-party liability (TPL) benefits
- 10:49-7.4 Prohibition of payment to factors
- 10:49-7.5 Use of service bureau and/or management agency
- 10:49-7.6 Timeliness of charity care claim submission

SUBCHAPTER 8. PAYMENT FOR SERVICES PROVIDED

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

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

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

SUBCHAPTER 10. NOTICES, APPEALS AND FAIR HEARINGS

- 10:49-10.1 Definitions
- 10:49-10.2 Notices
- 10:49-10.3 Opportunity for fair hearing

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

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

- 10:49-11.1 Program participation

SUBCHAPTER 12. PROVIDER REINSTATEMENT

- 10:49-12.1 Definitions
- 10:49-12.2 Requests for reinstatement
- 10:49-12.3 Petition by debarred, disqualified or suspended person
- 10:49-12.4 Director's powers
- 10:49-12.5 Provider Reinstatement Committee
- 10:49-12.6 Criteria for reinstatement
- 10:49-12.7 Committee procedures

SUBCHAPTER 13. PROGRAM CONTROLS

- 10:49-13.1 Medical review and evaluation
- 10:49-13.2 Audits
- 10:49-13.3 Applicability to DMAHS programs of provisions relating to fraud and abuse, third-party liability and administrative and judicial remedies
- 10:49-13.4 Rewards for information relating to fraud and abuse

SUBCHAPTER 14. RECOVERY OF PAYMENTS AND SANCTIONS

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

SUBCHAPTER 15. AVAILABILITY AND MAINTENANCE OF PROGRAM POLICY ISSUANCES

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

SUBCHAPTER 16. DEMONSTRATION PROJECTS

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

SUBCHAPTER 17. (RESERVED)

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

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

law or regulation that would expand eligibility under any program to any new groups, categories, or individuals.

Repealed by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Section was "Prepaid health plans".
New Rule, R.2013 d.052, effective April 1, 2013.
See: 44 N.J.R. 2941(a), 45 N.J.R. 737(a).
Section was "Reserved".

10:49-1.6 (Reserved)

Recodified to N.J.A.C. 10:49-22.3 and amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

10:49-1.7 (Reserved)

Repealed by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Section was "State funded programs".

10:49-1.8 (Reserved)

Recodified to N.J.A.C. 10:49-1.4 and amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

SUBCHAPTER 2. NEW JERSEY MEDICAID BENEFICIARIES

10:49-2.1 Who is eligible for Medicaid?

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

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

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

Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

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

(a) The eligibility rules for persons eligible under the regular New Jersey Medicaid program are included in N.J.A.C. 10:69, 10:70, 10:71, 10:72, 10:78 and 10:79.

(b) The following groups may be eligible for medical and health services covered under the New Jersey Medicaid program requirements as outlined in the second chapter of each Provider Services Manual. The list is not all inclusive but is intended to provide an overview of some of the types of individuals who may be eligible for Medicaid benefits, when

provided in accordance with the requirements of N.J.A.C. 10:69, 10:70, 10:71, 10:72, 10:78 and 10:79, as appropriate.

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

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

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

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

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

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

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

8. Persons eligible for but not receiving TANF or an optional State benefit;

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

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

11. Pregnant women and children up to the age of one whose income is below 185 percent of the Federal poverty level, and children up to the age of six whose income is below 133 percent of the Federal poverty level, codified as 42 U.S.C. § 1396a, or 1902(I) of the Social Security Act;

12. Aged, blind, and disabled persons whose income is below 100 percent of the Federal poverty level and whose assets are within 200 percent of the SSI asset limits;

13. For a period lasting through the end of the month following the 60th day following delivery, women who

have applied for Medicaid benefits before the last day of pregnancy and who are eligible for Medicaid on the last day of pregnancy; and

14. Refugees who are eligible under the Refugee Resettlement program.

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); and recodified former (a) as (b) and amended.

Amended by R.2003 d.81 and 82, effective February 18, 2003.

See: 34 N.J.R. 2647(a), 2650(d), 35 N.J.R. 1116(a), 1118(a).

In (b), deleted "regular" preceding "New Jersey Medicaid program" and amended the N.J.A.C. references in the introductory paragraph, deleted 3 through 6 and 18 and recodified former 7 through 19 as 3 through 14.

Amended by R.2008 d.230, effective August 4, 2008.

See: 40 N.J.R. 984(a), 40 N.J.R. 4531(a).

In (b)1, substituted "CWA" for "CBOSS"; and in (b)11, inserted "of" preceding "one" and substituted "§1396a" for "§ 1396a".

Case Notes

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.

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

(a) The eligibility rules for persons eligible under the Medically Needy program are included in N.J.A.C. 10:70.

(b) A Medicaid beneficiary under the Medically Needy program is limited to those medical services listed in N.J.A.C. 10:49-5.3. Services shall be provided in conjunction with specific program requirements as outlined in the second chapter of the applicable Provider Services Manual.

(c) To be determined Medically Needy under the Medicaid Program, it is necessary for the person to meet categorical eligibility requirements, have income and/or resources in excess of the categorical standards, and have insufficient funds to meet his or her medical expenses. Medically Needy persons shall be in one of the following groups:

1. Pregnant women;
2. Needy children (under 21 years of age); or
3. The aged (65 years of age or older), the blind or the disabled.

(d) There are special income and resource levels established for the Medically Needy. If a person meets one of the categories listed in (c) above and has income and/or resources above categorical program levels but less than or equal to the Medically Needy income and resource levels, he or she shall be determined as Medically Needy eligible. However, if a person meets one of the categories listed in (c) above and meets the Medically Needy resource level but has income

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 shall be provided under the managed care program:

1. Advanced practice nurse services;
2. Chiropractic services;
3. Clinic services in an independent outpatient health care facility, other than hospital, that provides Family Planning, Dental, Optometric, Ambulatory Surgery services, or FQHCs;
4. Dental services;
5. 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;
6. 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.
7. Hearing aid services;
8. Home care services (home health care except for the Aged, Blind and Disabled population (ABD));
9. 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);
10. Hospital services—inpatient:
 - i. General acute care hospitals;
 - ii. Special hospitals; and
 - iii. Rehabilitation hospitals;
11. Hospital services—outpatient;
12. Laboratory (clinical);
13. Medical supplies and durable medical equipment;
14. Mental health and substance abuse services for clients of the Division of Developmental Disabilities (DDD), excluding partial care and partial hospitalization services;

15. Nurse-midwifery services;
 16. Optometric services;
 17. Optical appliances;
 18. Prescription drugs (except for ABD and all other dual eligible beneficiaries);
 19. Physician services;
 20. Podiatric services;
 21. Prosthetic and orthotic devices;
 22. Radiological services;
 23. Non-lower mode transportation services, which include ambulance, mobility assistance vehicle, and mobile intensive care units;
 24. Audiology services;
 25. Organ transplants, recipient and donor costs;
 26. Emergency medical care; and
 27. Treatment for conditions categorized as altering the mental status of an individual and that are organic in nature.
- (b) The following services are available on a fee-for-service basis:
1. Case management services (Mental Health Program);
 2. Religious non-medical health care services, (see Hospital Services Manual);
 3. Environmental lead inspection services-rehabilitative services;
 4. Medical day care services;
 5. Mental health services, including partial care and partial hospitalization services;
 6. Mental health rehabilitation services including:
 - 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);
 - iv. Behavioral assistance services for children, youth or young adults under EPSDT (see N.J.A.C. 10:77-4);
 - v. Mobile response and stabilization management services for children, youth or young adults under EPSDT (see N.J.A.C. 10:77-6);
 - vi. Intensive in-community mental health rehabilitation services for children, youth or young adults under EPSDT (see N.J.A.C. 10:77-5);
 - vii. Programs for Assertive Community Treatment (PACT) Services (see N.J.A.C. 10:37J and 10:76); and
 - viii. Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:37A and 10:77A);
 7. 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;
 8. 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. School based rehabilitation services under EPSDT;
 9. Personal care assistance services;
 10. Elective, induced abortions and related services;
 11. Lower mode transportation services;
 12. Sex abuse examinations;
 13. Family planning services and supplies when furnished by a non-HMO, that is a Medicaid/NJ FamilyCare participating provider;
 14. Home health care services for the ABD population;
 15. Prescription drugs (legend and non-legend) covered by the Medicaid program) for the ABD population and all other dual eligible individuals;
 16. Mental health services for enrollees who are not clients of the Division of Developmental Disabilities (DDD), including atypical antipsychotic medications;
 17. Substance abuse services, including diagnosis, treatment, detoxification;

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).

Amended by R.2014 d.030, effective February 3, 2014.

See: 45 N.J.R. 103(a), 46 N.J.R. 295(a).

Section was "Third party liability (TPL) benefits". Rewrote the section.

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;

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

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

Amended by R.2008 d.230, effective August 4, 2008.

See: 40 N.J.R. 984(a), 40 N.J.R. 4531(a).

In the introductory paragraph of (a), inserted “and NJ FamilyCare Plan D parents with incomes up to 133 percent of the Federal poverty level”; and in (b), inserted “all other Plan”.

10:49-9.14 Provisions for appeals; fair hearings

(a) Pursuant to N.J.A.C. 10:49-10, Notices, Appeals, and Fair Hearings, providers, Medicaid beneficiaries and NJ FamilyCare-Plan A beneficiaries and NJ FamilyCare Plan D parents with incomes up to 133 percent of the Federal poverty level shall have the right to file for fair hearings.

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

(c) A Medicaid or NJ FamilyCare-Plan A beneficiary and NJ FamilyCare Plan D parents with incomes up to 133 percent of the Federal poverty level may be granted a fair hearing in accordance with N.J.A.C. 10:49-10 if his or her claim for medical assistance is denied or is not acted upon with reasonable promptness, or because the beneficiary is aggrieved by any other agency action resulting in non-eligibility, denial, termination, reduction or suspension of such assistance. NJ FamilyCare-Plan B, C and all other Plan D beneficiaries shall be afforded the opportunity for grievance review in accordance with N.J.A.C. 10:78-8.

(d) In order to obtain a fair hearing, the provider or the beneficiary shall submit a request in writing to the Medicaid Agent at the address as specified in the notice.

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

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 (d), changed place to send hearing requests; and in (c), substituted “chapter” for “Manual”.

Recodified from N.J.A.C. 10:49-9.10 and 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).

Rewrote (a) and (c).

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.

Recodified from N.J.A.C. 10:49-9.13 by R.1999 d.294, effective September 7, 1999.

See: 30 N.J.R. 2808(a), 31 N.J.R. 2635(a).

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 (a), inserted “Notices, Appeals, and “ preceding “Fair Hearings”; rewrote (c).

Amended by R.2008 d.230, effective August 4, 2008.

See: 40 N.J.R. 984(a), 40 N.J.R. 4531(a).

In (a) and (c), inserted “and NJ FamilyCare Plan D parents with incomes up to 133 percent of the Federal poverty level”; and in (c), deleted “A” preceding “NJ FamilyCare-Plan B,”; inserted “all other Plan” and substituted “beneficiaries” for the final occurrence of “beneficiary”.

10:49-9.15 Advance directives

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

“Advance directive” means a written expression of a patient’s preferences regarding the provision, withholding or withdrawal of a medical service, treatment or procedure in the event that the patient subsequently lacks decision making capacity. An advance directive may include a proxy directive or an instruction directive, or both.

“Decision making capacity” means a patient’s ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of each, and alternatives to any proposed health care, and to reach an informed decision. A patient’s decision making capacity is evaluated relative to the demands of a particular health care decision.

“Declarant” means a competent adult 18 years of age or older who executes an advance directive.

“Health care decision” means a decision to accept or to refuse any treatment, service or procedure used to diagnose, treat or care for a patient’s physical or mental condition, including life-sustaining treatment. “Health care decision” also means a decision to accept or to refuse the services of a particular physician, nurse, other health care professional or health care institution, including a decision to accept or to refuse a transfer of care.

“Health care institution” means institutions, facilities, and agencies licensed, certified, or otherwise authorized by State law to administer health care in the ordinary course of business, including hospitals, nursing homes, residential health care facilities, home health care agencies, personal care service agencies, and hospice programs operating in this State, mental health institutions, facilities or agencies, or institutions, facilities and agencies for the developmentally disabled. For purposes of this section, “health care institution” also means a managed care organization contracted pursuant to N.J.A.C. 10:74 to provide medical services to beneficiaries of the New Jersey Medicaid/NJ KidCare/NJ FamilyCare program.

“Health care professional” means an individual, as opposed to a health care institution, licensed by this State to administer health care in the ordinary course of business or practice of a profession.

“Health care representative” means the individual designated by a declarant pursuant to the proxy directive part of an advance directive for the purpose of making health care decisions on the declarant’s behalf, and includes an individual designated as an alternate health care representative who is acting as the declarant’s health care representative in accordance with the terms and order of priority stated in an advance directive.

“Instruction directive” means a writing which provides instructions and direction regarding the declarant’s wishes for health care in the event that the declarant subsequently lacks decision making capacity.

“Life-sustaining treatment” means the use of any medical device or procedure, artificially provided fluids and nutrition, drugs, surgery or therapy that uses mechanical or other artificial means to sustain, restore or supplant a vital bodily function, and thereby increase the expected life span of a patient.

“Nurse” means a person currently licensed to practice as a registered professional nurse who is certified by the New Jersey State Board of Nursing in accordance with N.J.A.C. 13:37-7, and with N.J.S.A. 45:11-23 et seq., or similarly licensed and certified by a comparable agency of the state in which he or she practices.

“Other health care professionals” means licensed health care professionals other than physicians and nurses.

“Patient” means an individual who is under the care of a physician, nurse or other health care professional.

“Physician” means an individual (M.D. or D.O.) licensed to practice medicine and surgery in this State.

“Proxy directive” means a writing which designates a health care representative in the event the declarant subsequently lacks decision making capacity.

(b) Participating health care institutions shall establish written policies and procedures concerning the rights of patients to make decisions regarding their medical care and their right to execute advance directives. In addition to policies affirming patients’ rights:

1. Private religiously-affiliated health care institutions may develop institutional policies and practices defining circumstances under which they will decline to participate in the withholding or withdrawing of specific measures to sustain life. Such policies and practices shall be written, and shall be properly communicated to patients and their families and health care representatives before or at the time of the patient’s admission or enrollment. If the institution’s policies and practices appear to conflict with the legal rights of a patient wishing to forego health care, the health care institution shall attempt to resolve the conflict. If a mutually satisfactory accommodation cannot be reached, the health care institution shall take all reason-

able steps to effect the appropriate, timely and respectful transfer of the patient to the care of another health care institution appropriate to the patient’s needs, and shall assure that the patient is not abandoned or treated disrespectfully; and

2. Health care institutions shall include in their policies a statement informing physicians, nurses and other health care professionals of their rights and responsibilities, to assure that such rights and responsibilities are understood, including the right to decline to participate in withholding or withdrawing life-sustaining treatment, in accordance with sincerely held personal or professional convictions, and to provide a forum for discussion and consultation on the subject of such rights.

(c) Nothing in this section shall be construed as restricting, modifying or replacing the requirements established for health care institutions by the Department of Health and Senior Services (see N.J.A.C. 8:36, 8:39, 8:42, 8:43, 8:43C and 8:43G for specific requirements).

(d) In addition to developing the written policies referred to in (b) above, health care institutions shall:

1. Furnish patients with written information about their rights to accept or refuse treatment, and to formulate advance directives. This information shall also be made available on request to patients’ health care representatives, families and other interested parties;
2. Note in each patient’s medical record whether that patient has executed an advance directive;
3. Provide (individually or with others) for education of staff and the community on issues concerning advance directives;
4. Provide care or other services without discrimination based on whether or not the individual has executed an advance directive; and
5. Ensure compliance with State law regarding advance directives (see N.J.S.A. 26:2H-53 et seq.).

(e) Health care institutions shall distribute written information concerning advance directives to individuals:

1. In the case of a hospital, at the time of the individual’s admission as an inpatient;
2. In the case of a nursing facility, at the time of the individual’s admission as a resident;
3. In the case of a provider of home health care, personal care assistant services or private duty nursing services, in advance of the individual coming under the provider’s care;
4. In the case of a hospice program, at the time the individual initially receives hospice care from the program; and

cases of a departmental action based on a change in law, the circumstances under which a hearing shall be granted, and the circumstances under which assistance shall be continued if a fair hearing is requested.

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

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

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

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

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

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

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

(d) The Medicaid Agent or DMAHS shall reinstate and continue services until a decision is rendered after a hearing if:

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

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

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

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

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

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

Substituted reference to Medicaid Agent for reference to department throughout.

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

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

Inserted references to DMAHS 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).

Amended by R.2008 d.230, effective August 4, 2008.

See: 40 N.J.R. 984(a), 40 N.J.R. 4531(a).

Section was "Advance notice of intent to terminate, reduce, or suspend assistance for Medicaid and NJ FamilyCare-Plan A".

Cross References

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

Case Notes

Initial Decision (2005 N.J. AGEN LEXIS 496) adopted, which concluded that no deprivation of due process had resulted from deficiencies in the notice informing petitioners of a reduction in private duty nursing service hours provided by Medicaid, because petitioners had constructive notice of the grounds of denial at the time the appeal was initiated, the hearing before the ALJ provided due process, and the services had not been terminated but had been maintained pending the outcome of the hearing. *N.S. v. AmeriChoice of N.J., Inc.*, OAL Dkt. No. HMA 6759-04, 2005 N.J. AGEN LEXIS 1112, Final Decision (December 8, 2005).

10:49-10.5 Location of hearing

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

10:49-10.6 Impartiality of official conducting the hearing

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

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

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

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.

10:49-10.8 Hearing procedures

The hearing shall be conducted pursuant to the procedures set forth in the Administrative Procedure Act and the Uniform Administrative Procedure Rules (N.J.A.C. 1:1). The Special Hearing Rules set forth in N.J.A.C. 1:10B apply to

claimant (beneficiary) hearings. (See 42 C.F.R. 431.200, Subpart E).

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".

10:49-10.9 Prompt, definitive and final action

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

10:49-10.10 Notification to claimants

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

10:49-10.11 Action upon favorable decision to claimants

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

10:49-10.12 Hearing decision

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

(b) Final decisions shall be binding on the Medicaid Agent or DMAHS.

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

(d) The final decision shall be promptly implemented.

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

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

Substituted references to Medicaid Agent for references to agency and department throughout.

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

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

Inserted references to DMAHS 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.

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

The Medicaid Agent or DMAHS shall establish and maintain a method for informing, at least in summary form, all local agencies of all fair hearing decisions by the hearing

authority and the decisions shall be accessible to the public (subject to the provisions of safeguarding public assistance information).

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

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

Substituted "Medicaid Agent" for "Department".

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

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

Inserted a reference to DMAHS.

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

Cross References

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

10:49-11.1 Program participation

(a) The provisions of this section were adopted and issued pursuant to Executive Order No. 34, dated March 29, 1976, and the authority vested in the Division of Medical Assistance and Health Services to implement the New Jersey Medicaid and NJ FamilyCare programs by rules and regulations set forth in N.J.S.A. 30:4D-5, N.J.S.A. 30:4D-17.1 a and c, Reorganization Plan No. 001-1996 and P.L. 1997, c.272.

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

1. Any individuals, including but not limited to, owners, officers, administrators, assistant administrators, employees, accountants, attorneys, and management services, who have been suspended, debarred or disqualified from participation in the Medicaid and/or NJ FamilyCare

programs for any reason shall not be involved in any activity relating to the New Jersey Medicaid and/or NJ FamilyCare programs.

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

3. Providers may not submit claims and shall not be reimbursed for any goods supplied or services rendered by such individuals.

4. The requirement in (b)3 above shall apply only for the period during which such individuals are suspended, debarred or disqualified from Medicaid and/or NJ FamilyCare participation.

5. Claims shall not be submitted and claims shall not be reimbursable for 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, an individual or entity, during the period when such individual, entity or physician is excluded from participation in the Medicaid and NJ FamilyCare programs, and when the individual or entity furnishing such item or service has received written notice from the Division that the entity, individual or physician has been excluded from participation in the Medicaid and NJ FamilyCare programs.

(c) The following words and terms, as used in this section, shall have the following meanings:

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

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

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

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

(i) The Medicaid Agent or DMAHS may suspend a person in the public interest for any cause specified in (d) above, or upon a reasonable suspicion that such cause exists, or when, in the opinion of the Medicaid Agent or DMAHS, such action is necessary to protect the public welfare and the interests of the Medicaid or NJ FamilyCare program.

(j) Conditions for suspension shall be as follows:

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

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

dered in the best interests of the New Jersey Medicaid and NJ FamilyCare programs.

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

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

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

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

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

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

(m) Scope of suspension rules shall be as follows:

1. A suspension may include all known affiliates of a person, provided that each decision to include an affiliate is

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

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

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

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

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

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

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

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), inserted “, and Reorganization Plan No. 001-1996”; in (b), substituted “New Jersey Medicaid program” and “Medicaid Agent” for “Division” throughout; in (b)3, deleted “reimbursed on a fee-for-service basis”; in (c), rewrote introductory paragraph and deleted “Division”, “Fiscal Agent” and “Provider”; and in (d), substituted “beneficiary” and “beneficiaries” for “recipient” and “recipients”, reference to Medicaid Agent for references to Division, Division of Medical Assistance and Health Services, and Director, and “Program” for references to the

Division of Medical Assistance and Health Services, throughout; in (d)5, deleted Public Law references; in (d)17, deleted “form” following “Medicaid claim”; in (d)20, inserted reference to Commissioner of Health and Human Services; and in (j)2, substituted “New Jersey Medicaid program” for “Division”.

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

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

Inserted reference to NJ KidCare and to DMAHS throughout; in (a), added a reference to P.L. 1997, c.272; in (d), inserted “or supplemented” following “amended” in 20, and inserted a reference to Title XXI in 26; in (e), substituted “DMAHS” for “agency” following “Agent or” in 5; and in (i), substituted “Medicaid or NJ KidCare program” for “medical assistance Program” at the end.

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).

Rewrote the section.

Law Review and Journal Commentaries

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

Case Notes

Good cause existed to deny petitioner’s application as a Medicaid pharmacy services provider because the application contained false statements, including failing to disclose the fact that petitioner had violated Board of Pharmacy regulations for outdated prescriptions, mis-branded medication, over-filled containers of medications in the active drug stock inventory, and medication held for re-dispensing in containers not properly labeled; the mere submission of false information was grounds for denial, without regard to whether the applicant intended to deceive, manipulate, or defraud Medicaid. Oakland Pharmacy v. DMAHS, OAL Dkt. No. HMA 5062-09, 2009 N.J. AGEN LEXIS 1019, Final Decision (October 26, 2009).

Good cause existed for the denial of a petitioner’s application to be a Medicaid provider based on the submission of an application containing false information in which petitioner failed to include his name on the application as a pharmacist associated with the pharmacy and also did not disclose a penalty assessed against him for violating a Board of Pharmacy rule; the mere submission of false information was grounds for denial, without regard to whether the applicant intended to deceive, manipulate, or defraud Medicaid. Newark Pharmacy v. DMAHS, OAL Dkt. No. HMA 3323-09, 2009 N.J. AGEN LEXIS 760, Final Decision (September 16, 2009).

Good cause existed to deny a petitioner’s application as a Medicaid pharmacy services provider because the application contained false statements, including a failure to disclose prior regulatory violations for neglecting to request allergy and other chronic conditions for 60% of its filled prescriptions and not including the “use by” date on its prescription labels, as well as the failure to disclose criminal charges brought against the pharmacist-in-charge for attempting to obtain a controlled dangerous substance by presenting a forged prescription; the mere submission of false information was grounds for denial, without regard to whether the applicant intended to deceive, manipulate, or defraud Medicaid. New Lucy Pharmacy v. DMAHS, OAL Dkt. No. HMA 3090-09 and HMA 1624-09 (Consolidated), 2009 N.J. AGEN LEXIS 667, Final Decision (August 17, 2009).

Good cause justified termination of provider of mental health and drug and alcohol counseling services as a Medicaid provider where substantial evidence showed that provider violated the state’s anti-kick-back statute, N.J.S.A. 30:4D-17(c), by giving away over \$179,000.00 in Pathmark gift vouchers in order to induce Medicaid beneficiaries into its facility. Statements obtained from DMAHS investigators confirmed that clients returned to the facility every day in order to obtain these vouchers, and provider’s owner himself advised an investigator that clients came on a daily basis for the vouchers, not for the services (adopting

Initial Decision, 2008 N.J. AGEN LEXIS 1001). Bloomfield Health Pavilion v. DMAHS, OAL Dkt. No. HMA 03095-08, 2009 N.J. AGEN LEXIS 55, Final Decision (January 15, 2009).

Regulations do not require that a provider intended to deceive, manipulate, or defraud Medicaid, in order to be excluded from the program; simply offering gift vouchers to Medicaid beneficiaries is prohibited under the plain language of the anti-kickback statute and is grounds for exclusion, and it is well within the Division of Medical Assistance and Health Services' discretion to take action against a provider who has clearly violated the statutory prohibition against offering a bribe or an incentive to a Medicaid client in order to influence program participation. Bloomfield Health Pavilion v. DMAHS, OAL Dkt. No. HMA 03095-08, 2009 N.J. AGEN LEXIS 55, Final Decision (January 15, 2009).

Although an ALJ found that an applicant knowingly and intentionally provided false information on an application to be a Medicaid provider, N.J.A.C. 10:49-11.1 did not require that a provider intended to deceive, manipulate, or defraud Medicaid in order for an enrollment application to be denied. Rather, the mere submission of false information was grounds for denial. Comm-Unity, Inc. v. DMAHS, OAL Dkt. No. HMA 1721-07 and HMA 3275-07, 2008 N.J. AGEN LEXIS 1316, Final Decision (August 7, 2008).

DMAHS properly denied a pharmacy's application for participation in the New Jersey Medicaid program because the pharmacist-in-charge, who was a 50% owner, answered "No" to the question about criminal charges despite the fact that the pharmacist had previously pled guilty to criminal trespass and completed the Pre-Trial Intervention program. Neither alleged confusion regarding the obligation to disclose Pre-Trial Intervention charges nor the fact that the pharmacist was no longer associated with the pharmacy required a different result. Mi Farmacia v. DMAHS, OAL Dkt. No. HMA 9969-06, 2008 N.J. AGEN LEXIS 354, Initial Decision (April 30, 2008).

N.J.A.C. 10:49-11.1(d) does not require that a false statement be made willfully in order to deny an application. Mi Farmacia v. DMAHS, OAL Dkt. No. HMA 9969-06, 2008 N.J. AGEN LEXIS 354, Initial Decision (April 30, 2008).

Where a registered nurse anesthetist administered 2,000 times the recommended dose of a narcotic anesthetic to three patients, and submitted false answers on applications, good cause existed for debarment

from participation in New Jersey Medicaid and Division-administered programs, and the mitigating factors presented by the anesthetist, including the provider's interest in compensation from the Medicaid program, were superseded by the Division's "overriding public interest in the proper administration of the Medicaid program in New Jersey." Frimpong v. DMAHS, OAL Dkt. No. HMA 05200-04, 2007 N.J. AGEN LEXIS 752, Initial Decision (November 20, 2007).

Suspension, debarment, and disqualification are measures invoked by the Division to exclude or render ineligible certain persons from participation in contracts and subcontracts with the New Jersey Medicaid or New Jersey FamilyCare programs, the Medicaid Agent, or DMAHS on the basis of a lack of responsibility; the purpose of sanctions is not to punish the person, but rather to protect the interests of Medicaid and New Jersey FamilyCare programs. Frimpong v. DMAHS, OAL Dkt. No. HMA 05200-04, 2007 N.J. AGEN LEXIS 752, Initial Decision (November 20, 2007).

Initial Decision (2007 N.J. AGEN LEXIS 210) adopted, which concluded that while the word "shall" in N.J.A.C. 10:49-3.2(b)(3) creates a mandatory time limit of 35 days within which a Medicaid provider applicant is to supply enrollment information requested by the Division, there is no regulatory basis for the Division to deny an application for failure to meet the deadline. The applicant's failure to provide requested enrollment information within 35 days could not be placed within the rubric of N.J.A.C. 10:49-11.1, which sanctions are stated to be for the purposes of protecting the interests of the New Jersey Medicaid program, and not for punishment. Grace Pharmacy v. DMAHS, OAL Dkt. No. HMA 6904-06, 2007 N.J. AGEN LEXIS 528, Final Decision (June 5, 2007).

Initial Decision (2006 N.J. AGEN LEXIS 751) adopted, which concluded that a pharmacy's application to be a Medicaid provider was correctly denied pursuant to N.J.A.C. 10:49-11.1(d)22 because the pharmacy owner willfully or by inexcusably irresponsible omission provided false information on the application concerning the criminal history of the pharmacist-in-charge and then lied about whether the person was still an employee. Surgi-Med Pharmacy v. DMAHS, OAL Dkt. No. HMA 3635-06, 2006 N.J. AGEN LEXIS 934, Final Decision (October 1, 2006).

Pharmaceutical provider submitted a false answer on the application by failing to reveal the adverse action taken against it in Colorado, and

is not aware of the extent of the beneficiary's interest at the time that the lien is filed, the full amount of the Division's claim shall be listed on the lien.

(n) For purposes of this section, for future estates or estates pending on or after October 4, 1999, the term "estate" shall not include:

1. A life estate in which the beneficiary held an interest during his or her lifetime, but which expired upon the Medicaid beneficiary's death;

2. An inter vivos trust established by a third party for the benefit of the now-deceased Medicaid beneficiary, provided that:

i. The trust is a discretionary trust, constructed in such a way that the Medicaid beneficiary could not compel distributions from the trust; and

ii. The trust contains no assets in which the Medicaid beneficiary held any interest within either five years prior to applying for Medicaid benefits, or five years prior to the Medicaid beneficiary's death; or

3. A testamentary trust established by a third party (including the spouse of the now-deceased Medicaid beneficiary) for the benefit of the now-deceased Medicaid beneficiary, provided that:

i. The trust is a discretionary trust, constructed in such a way that the Medicaid beneficiary could not compel distributions from the trust; and

ii. The trust contains no assets in which the Medicaid beneficiary held any interest within either five years prior to applying for Medicaid benefits, or five years prior to the beneficiary's death. Assets of the community spouse which formed a part of the community spouse resource allowance shall not be considered assets of the Medicaid beneficiary. Any assets of the community spouse other than those that formed part of the community spouse resource allowance shall be considered assets of the Medicaid beneficiary if acquired from the Medicaid beneficiary within five years prior to the date of application for Medicaid benefits or five years prior to the date of death of the Medicaid beneficiary.

Amended by R.1994 d.524, effective October 17, 1994.

See: 26 N.J.R. 2757(a), 26 N.J.R. 4184(b).

Amended by R.1999 d.332, effective October 4, 1999.

See: 31 N.J.R. 242(a), 31 N.J.R. 2883(a).

In (a), in the introductory text, substituted "the individual" for "he or she", in (a)2, substituted "of individuals who died" for "coming into being", inserted "1," following "February", and substituted "left" for "leaving", in (a)3, substituted "of individuals who died" for "coming into being", in (b), substituted "but prior to December 22, 1995" for "the effective date of P.L. 1981, c.217 (N.J.S.A. 30:4D-7.2a)", and added (c) to (n).

Amended by R.2013 d.079, effective May 20, 2013.

See: 45 N.J.R. 107(a), 45 N.J.R. 1249(b).

In (d), substituted "three years" for "90 days".

Case Notes

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

10:49-14.2 Sanctions—Special Status Program

(a) The "Special Status Program" either restricts the Medicaid or NJ FamilyCare beneficiary(s) listed on the HBID Card to a single provider, except in a medical emergency, or warns providers that the beneficiary's card has been used by an unauthorized person or persons, or for an unauthorized purpose. If a warning letter is issued to a beneficiary, a message will be included in the eligibility message on the REVS/MEVS/eMEVS system alerting the provider to ask the Medicaid or NJ FamilyCare beneficiary for additional identification or to take other appropriate action.

1. The restriction is issued to Medicaid or NJ FamilyCare beneficiaries determined to have misused, abused or overutilized their Medicaid or NJ FamilyCare benefits. Overutilization occurs when a beneficiary has utilized Medicaid or NJ FamilyCare services or items at a frequency or amount that is not medically necessary. Examples of misuse or abuse include, but are not limited to, medically harmful or inappropriate use of different drugs or provider services, obtaining or attempting to obtain early refills of prescriptions in violation of N.J.A.C. 10:51-1.19(a)5, at more than one pharmacy, and forgery or alteration of prescriptions. A determination that there has been misuse, abuse or overutilization of benefits obtained by use of an HBID Card shall create a presumption that the beneficiary listed on the HBID Card, or a person responsible for a minor listed on the HBID Card, was responsible for such actions. If this presumption is successfully rebutted by or on behalf of the Medicaid or NJ FamilyCare beneficiary, he or she shall not be enrolled in the Special Status Program.

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

ii. The Division may change the provider to which the beneficiary is restricted if a pattern of continued misuse, abuse or overutilization by the beneficiary is evident, or if it is determined that the provider has engaged in fraud or abuse, or if the Division determines that such a change is in the best interest of the beneficiary and/or the programs it administers in whole or part.

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

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

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

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

2. The warning letter is issued to Medicaid or NJ FamilyCare beneficiaries determined to have had their HBID Card used by an unauthorized person or persons, or for an unauthorized purpose. The purpose of the warning is to notify providers that the beneficiary's HBID Card has been used by an unauthorized person or persons, or for an unauthorized purpose. A message will be available on the REVS/MEVS/eMEVS system alerting the provider to ask the Medicaid or NJ FamilyCare beneficiary for additional identification or to take other appropriate action. A determination that an HBID Card has been used by an unauthorized person or for an unauthorized purpose shall create a presumption that the beneficiary listed on the HBID Card, or a person responsible for a minor listed on the HBID Card, was responsible for such actions. If this presumption is successfully rebutted by the beneficiary, the beneficiary shall not be issued a warning letter.

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

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

Substituted reference to beneficiaries for references to recipients throughout.

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

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

In (a), inserted references to NJ KidCare and substituted references to Eligibility Identification Cards for references to Medicaid Eligibility Identification Cards 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).

Rewrote (a)1.

Amended by R.2008 d.230, effective August 4, 2008.

See: 40 N.J.R. 984(a), 40 N.J.R. 4531(a).

In the introductory paragraph of (a), substituted "HBID" for "Eligibility Identification (EI)", "letter" for "card" and "included in the eligibility message on the REVS/MEVS/eMEVS system" for "printed on the card", and inserted "to a beneficiary"; in the introductory paragraph of (a)1, substituted "restriction" for "restrictive card", "HBID" for "(EI)" twice, the second occurrence of "beneficiary" for "beneficiaries", and ", or a person responsible for a minor listed on the HBID Card, was" for "were", and inserted "or on behalf of"; and in (a)2, substituted "letter" for "card" twice, "HBID" for "(EI)" four times, "available on the REVS/MEVS/eMEVS system" for "printed on the card", the second occurrence of "beneficiary" for "beneficiaries" and ", or a person responsible for a minor listed on the HBID Card, was" for "were".

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

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

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

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

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

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), amended Office reference and added reference to Commissioner and Deputy Commissioner of Department of Health and Senior Services.

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

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

Substituted a reference to the Office of Program Integrity Administration for a reference to the Office of Quality Management and Program Integrity.

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

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

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

Case Notes

Recapture of the reimbursement for pharmaceutical services; agent erroneously processed claim. South End Pharmacy, Inc. v. Division of Medical Assistance and Health Services, 94 N.J.A.R.2d (DMA) 48.

10:49-14.4 Recoveries involving a county welfare agency (CWA)

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

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

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

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

2. When recovery cannot be obtained by these methods in a case generated by the Internal Revenue Service (IRS) unearned income component of the Income and Eligibility

Amended by R.2008 d.230, effective August 4, 2008.
See: 40 N.J.R. 984(a), 40 N.J.R. 4531(a).

In (a) and the introductory paragraph of (b), inserted “NJ FamilyCare”; in (a), deleted “—New Jersey Care 2000” following “Program”, inserted “; Aged, Blind and Disabled (ABD) individuals without Medicare and NJ FamilyCare beneficiaries” and substituted “AFDC-related” for “AFDC related” and “Medicare-Medicaid dual eligible” for “SSI Medicaid”; and rewrote (b)2.

10:49-21.4 Medicaid/NJ FamilyCare Managed Care Program services

(a) The following services are provided under the Medicaid/NJ FamilyCare Managed Care Program:

1. Primary and specialist care;
2. Preventive health care and counseling;
3. Early and Periodic Screening, Diagnostic and Treatment (EPSDT);
4. Audiology Services;
5. Organ transplants, donor and recipient costs;
6. Inpatient and outpatient hospital services;
7. Emergency medical care;
8. Laboratory and radiology services;
9. Prescription drugs (Legend and non-legend drugs);
10. Family planning services
11. Podiatrist services;
12. Chiropractor services;
13. Optometrist services;
14. Optical and hearing appliances;
15. Home health agency services;
16. Medical supplies and durable medical equipment;
17. Dental services;
18. Ambulance, Mobile Intensive Care Unit (MICU) and invalid coach transportation services;
19. Prosthetic and orthotic services;
20. Hospice services; and
21. Private duty nursing agency services.

(b) The following services are not covered by an HMO, but are available to beneficiaries and are payable by the Medicaid program on a traditional fee-for-service basis:

1. Medical day care;
2. Elective/induced abortion services;
3. Lower mode transportation;
4. Psychiatric inpatient hospital services;

5. Residential treatment center care services;

6. Intermediate care facility/mental retardation services;

7. Outpatient rehabilitation services; these services for NJ FamilyCare Plan B and C beneficiaries are limited to 60 days per year;

8. Services to beneficiaries participating in waiver or demonstration programs;

9. Personal care assistant services;

10. Nursing facility care;

11. Substance abuse services—diagnosis, treatment and detoxification costs for methadone, suboxone and subutex maintenance and their administration;

12. Mental health services (except that these services are covered by the HMO for DDD clients);

13. Partial care and partial hospitalization services;

14. Sex abuse examinations;

15. Home health agency services for the Aged, Blind and Disabled (ABD) population; and

16. Prescription drugs for the ABD population and dual-eligible beneficiaries eligible for Medicaid and Medicare.

(c) Certain services provided to beneficiaries who are enrolled in an HMO will no longer be reimbursed on a fee-for-services basis. If the beneficiary is enrolled in an HMO, and the HMO restricts payment to providers who have agreed to contract with it, a provider who is not a contractor with the HMO, or who fails to obtain authorization from the HMO, may not be reimbursed. It is therefore incumbent upon the provider to check the identification card of the Medicaid beneficiary prior to the provision of any service, even if the provider has received prior authorization from a Medical Assistance Customer Center (MACC) or the Medicaid/NJ FamilyCare Central Dental Services Unit. Failure to do so could result in a claim being rejected by both the Division’s fiscal agent, Unisys, and the member’s HMO.

(d) Persons in Home or Community-based Waiver Programs, those who are in demonstration programs, those who are in long-term care facilities or residential placement facilities and those in the Medically Needy program, or presumptive eligibility program, are excluded from enrolling in an HMO. Other persons, including pregnant women past the first trimester who have an existing relationship with an obstetrician, those persons who have chronic debilitating illnesses who are under the care of a physician who will coordinate their health care needs; and individuals who are terminally ill with an established relationship with a physician or enrolled under the Hospice program, may be exempted from mandatory managed care under certain circumstances. See N.J.A.C. 10:74-8 for further information on excluded or exempted persons.

(e) A beneficiary may elect to obtain family planning services either through the HMO or through a Medicaid-participating family planning provider on a fee-for-service basis.

(f) Reimbursement for any and all drugs prescribed for the treatment of mental health and substance abuse are the responsibility of the HMO with the exception of methadone, suboxone, subutex for treatment of substance abuse and atypical antipsychotics (see N.J.A.C. 10:49-21.4(b)9). A pharmacist dispensing these drugs shall participate in the pharmacy network of the Medicaid/NJ FamilyCare beneficiary's HMO. In addition, any ambulance, MICU or invalid coach transportation provided for behavioral health services also remain the responsibility of the HMO. A transportation provider providing ambulance, MICU or invalid coach services shall participate in the transportation network of the Medicaid member's HMO.

Amended by R.2008 d.230, effective August 4, 2008.
See: 40 N.J.R. 984(a), 40 N.J.R. 4531(a).

Section was "Medicaid Managed Care Program—New Jersey Care 2000 Services". In the introductory paragraph of (a), inserted "/NJ FamilyCare" and deleted "—New Jersey Care 2000" following "Program"; in (a)1, deleted "(Preventive health care and counseling, EPSDT)" from the end; added new (a)2 through (a)5; recodified former (a)2 through (a)15 as new (a)6 through (a)19; deleted former (a)16; recodified former (a)17 and (a)18 as (a)20 and (a)21; in the introductory paragraph of (b), substituted a colon for a period at the end; rewrote (b)7; (b)11 and (b)12; added (b)13 through (b)16; in (c), substituted "Medical Assistance Customer Center (MACC)" for "Medicaid District Office" and "the Medicaid/NJ FamilyCare" for "Medicaid's"; and in (f), inserted "suboxone, subutex for treatment of substance abuse and atypical antipsychotics" and "NJ FamilyCare".

SUBCHAPTER 22. HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAMS

10:49-22.1 Introduction

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

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

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

Amended by R.1994 d.426, effective August 15, 1994.
See: 26 N.J.R. 1566(a), 26 N.J.R. 3466(b).
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 "client"; deleted (d); and recodified (e) as N.J.A.C. 10:49-22.2.
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

Contrary to the Division's contention, the applicant's mental retardation did not disqualify him from participation in the Assisted Living Waiver Program, N.J.A.C. 10:49-22.1 et seq.; the applicant was in need of nursing facility services because the assistance required by him as described by his physician met the requirements of the term "dependent" as expressed in N.J.A.C. 8:85-2.1, and even if not, the applicant's mental retardation, when combined with any appreciable medical, emotional or psychosocial condition, or Assisted Daily Living dependency, would have made him eligible under the regulation. S.B. v. DMAHS, OAL Dkt. No. HMA 6558-06, 2007 N.J. AGEN LEXIS 264, Initial Decision (April 23, 2007).

10:49-22.2 Approved Waivers

(a) The New Jersey Medicaid program has received waivers for the following programs:

1. Community Care Program for the Elderly and Disabled (CCPED);
2. Community Resources for Persons with Disability (CRPD);
3. AIDS Community Care Alternatives Program (ACCAP);
4. Traumatic Brain Injury Program;
5. Home and Community-Based Services Waiver Program for Developmentally Disabled Individuals; and
6. Assisted Living/Alternative Family Care (AL/AFC) Waivers.

Amended by R.1994 d.426, effective August 15, 1994.
See: 26 N.J.R. 1566(a), 26 N.J.R. 3466(b).
Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Section recodified from N.J.A.C. 10:49-17.1(e); rewrote introductory paragraph and added (a)5 through 7.
Amended by R.2008 d.230, effective August 4, 2008.
See: 40 N.J.R. 984(a), 40 N.J.R. 4531(a).

Rewrote (a)2; in (a)5, inserted "and" at the end; deleted former (a)6, and recodified (a)7 as new (a)6.

10:49-22.3 Administration of waived programs

(a) The Division of Medical Assistance and Health Services provides oversight to the following Home and Community-Based Services Waivers, which are administered by the Division of Disability Services (DDS): Community Resources for Persons with Disability (CRPD); AIDS Community Care Alternatives Program (ACCAP) and Traumatic Brain Injury Waiver.

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