

4. NF placement approval: The Medicaid RSN shall verbally advise the hospital discharge planner and/or social worker and patient and/or family of the assessment decision.

i. For a Track I or II determination, the Medicaid RSN shall leave a copy of the HSDP and signed approval letter with the discharge planner/social worker. For individuals requiring Level II Specialized Service Screens, the signed approval letter shall be forwarded only after the determination has been made that no specialized services are required.

ii. For a Track III determination, the Medicaid RSN shall leave a copy of the HSDP and signed approval letter with the discharge planner and/or social worker to forward to the home care provider. The discharge planner and/or social worker shall arrange needed home health services and forward a copy of the HSDP and signed approval letter to the home care agency. A Track III determination shall not be an authorization for NF services.

iii. The original approval letter signed by the Medicaid RSN shall be sent by the MDO to the patient and/or family with copies to the county welfare agency (CWA).

iv. A copy of the HSDP that was left with the hospital discharge planner and/or social worker by the Medicaid RSN, shall be attached to the hospital discharge material and forwarded with the patient to the admitting NF.

(1) If the patient being transferred will be eligible for Medicare benefits, the transfer shall be made to a Medicare participating NF.

5. NF placement denial: The Medicaid RSN shall verbally advise the hospital discharge planner and/or social worker and patient and/or family of the assessment decision. The Medicaid RSN shall leave a signed copy of the NF placement denial letter with the discharge planner/social worker. The original denial letter, signed by the Medicaid RSN, shall be sent to the patient and/or family by the MDO, with copies to the CWA.

(e) The hospital discharge planner and/or social work staff shall be responsible for identifying a Medicaid recipient inpatient or a Medicaid applicant inpatient who may be at risk of NF placement.

1. The identification process shall also include any inpatient in need of NF care who may become a Medicaid recipient within six months after NF admission and individuals meeting PASARR Level I criteria. (See N.J.A.C. 10:52-1.8(c).) These patients shall be referred by the hospital to the MDO and the CWA on the basis of the "At-Risk Criteria for Nursing Facility Placement and Referral to the Medicaid Office for PAS Evaluation" in (f) below. Medicaid recipients already residing in Medicaid participating facilities who are transferred to an acute

care hospital and who are returning to either the same or a different NF, shall not require PAS authorization.

i. Within one working day of identifying an inpatient as being at risk for NF placement, the Hospital Discharge Planner and/or Social Worker shall:

(1) Make a telephone or FAX referral to the MDO and the CWA; and,

(2) If not already a Medicaid recipient, generate a Public Assistance Inquiry (PA-1C) to initiate the application process for Medicaid.

(3) Within two working days of the telephone referral to the MDO and CWA, the Hospital Discharge Planning Office shall forward the completed "Hospital Pre-Admission Screening Referral (PAS-5, 2/90)" to the MDO, unless it was "faxed" on the day of the referral.

2. The PASARR Level II Specialized Service Screens shall be performed by a Board eligible or Board certified psychiatrist for final determination, as follows:

i. The hospital discharge planning unit and/or social services department shall immediately arrange through the individual's attending physician, a consultation by a Board eligible or Board certified psychiatrist to complete the "Psychiatric Evaluation (DMH & H, 1994) form. (The "Psychiatric Evaluation" form shall not be completed until such time as the Medicaid RSN has approved Medicaid-certified NF placement.)

ii. Within 48 hours of the psychiatrist's review of the recipient or potential Medicaid recipient, the completed "Psychiatric Evaluation" form shall be sent to the Division of Mental Health and Hospitals, CN-727, Trenton, New Jersey 08625-0727, Attention: PASARR Coordinator.

(1) A supply of the "Psychiatric Evaluation" form may be ordered from the PASARR Coordinator in the Division of Mental Health and Hospitals.

iii. The MDO shall contact the appropriate Regional Office of the Division of Developmental Disabilities (DDD) agency to advise them of the need for a MR Level II Specialized Service Screen. The MR Level II Specialized Service Screen will be completed by the DDD staff within three working days of the MDO contact.

iv. The final determination of the specialized services review by the DMH & H and/or DDD agencies shall be communicated to the Medicaid District Office who, in turn, shall provide the hospital discharge planning unit and/or social services department with the approval or denial decision for placement in a Medicaid NF.

(f) The "At-Risk Criteria for Nursing Facility Placement and Referral to the Medicaid Office for PAS" shall be

utilized by the hospital in determining if a referral for long term care services, either in an NF or in the community, is indicated, as follows:

i. The medical criteria are as follows. Has the patient experienced any of the following:

(1) Catastrophic illness requiring major changes in lifestyle and/or living conditions, that is, multiple sclerosis, stroke, multiple trauma, AIDS, amputation, neurological disease, cancer, birth defect(s), and end stage renal disease.

(2) Debilitation and/or chronic illness causing progressive deterioration of self-care skills, that is, severe chronic disease, spina bifida, progressive pulmonary disease or diabetes.

(3) Multiple hospital admissions within the past six months. (Do not refer patients admitted directly from NFs.)

(4) Previous NFs admissions within the past two years.

(5) Major health needs, that is, tube feedings, special equipment or treatments, rehabilitation/restorative services.

ii. The social criteria are as follows: In addition to the medical criteria, does the patient meet any of the following social situations:

(1) Homeless;

(2) Lives alone and/or has no immediate support system;

(3) Primary caregiver is not able to provide required care services; or

(4) Lack of adequate support systems.

iii. The financial criteria are as follows. Does the patient meet any of the income and asset tests:

(1) Currently eligible for Medicaid;

(2) Monthly income at/or below the current institutional specified at N.J.A.C. 10:71-5.6.

(A) Has no spouse in the community and resources no greater than those specified at N.J.A.C. 10:71-4.4 and 4.5;

(B) Has no spouse in the community and resources at/or below \$26,000. (This is an indication that the patient may become Medicaid eligible within the next six months by spending down assets in an NF as private pay); or

(C) Has a spouse in the community with combined countable resources at or below \$52,000. (This allows for calculation of the community spouse's resources under Medicare Catastrophic Coverage Act of 1988.)

(3) Monthly income at/or below the current New Jersey Care Special Medicaid programs maximum monthly income limit specified at N.J.A.C. 10:72-4.1 and:

(A) Has no spouse in the community and resources no greater than those specified at N.J.A.C. 10:71-4.4 and 4.5;

(B) Has no spouse in the community and resources at/or below \$28,000. (This is an indication that the patient may become Medicaid eligible within the next six months by spending down assets in a NF as private pay; or

(C) Has a spouse in the community with combined countable resources and/or below \$56,000. (This allows for calculation of community spouse's resources under the Medicare Catastrophic Coverage Act of 1988.)

(g) The hospital discharge planner and/or social worker shall be responsible for the discharge or placement arrangements of the patient.

1. For each hospital patient referred for PAS, the hospital shall complete and send to the MDO a "Hospital Pre-Admission Screening Discharge form (PAS-6, 2/90)".

i. For any patient discharged to a NF, a Discharge Package (HSDP, discharge paper work, MDO approval letter, hospital transfer sheet, and PASARR documentation including the documentation which supports a diagnosis of Alzheimer's disease or related organic dementia) shall be compiled to accompany the patient to the NF.

(1) If the patient being transferred to a NF is eligible for Medicare benefits, the transfer shall be made to a Medicare participating NF.

ii. For those recipients discharged to community locations, the hospital social worker and/or discharge planner shall be responsible for the implementation of the HSDP by securing home care services.

10:52-1.10 Recordkeeping

Hospitals shall be required to keep legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services. This information shall be available upon the request of the Division or its agents.

10:52-1.11 Second Opinion Program for Elective Surgical Procedures

(a) A second opinion shall be obtained for any elective surgical procedures listed under (b) below. The outcome of the second opinion shall have no bearing on payment. Once the second opinion is rendered, the recipient shall retain the right to decide whether or not to proceed with the surgery; however, failure to obtain a second opinion for these procedures shall result in a denial of the hospital claim.

1. If the operating physician determines that the need for surgery is urgent or is an emergency, no second opinion shall be required. "Urgent" or "emergency" includes any situation in which a delay in performing surgery in order to meet the second opinion requirement could result in a significant threat to the patient's health or life.

i. Reimbursement for urgent or emergency surgery shall be made only if a specific statement is attached to the claim form by the operating physician certifying that the second opinion requirement was not met and substantiating the urgent or emergency nature of the surgery.

2. If a Medicaid recipient is covered by another health insurance carrier (except Medicare) which makes only partial payment on the claim, the fiscal agent shall not make supplementary payment unless the second opinion requirement has been met. However, the fiscal agent shall make payment on the claim if the hospital receives documentation that a second opinion was arranged for and paid for by another health insurance carrier. A copy of this documentation must be attached to the Medicaid claim form.

(b) The following elective surgical procedures fall under the Second Opinion Program:

1. Hernia Repair (Unilateral or bilateral including common abdominal wall type) for any herniorrhaphy involving an adult (over 18 years of age).

2. Hysterectomy (See also N.J.A.C. 10:52-2.13(e));

3. Laminectomy;

4. Spinal fusion;

i. A second opinion shall not be required for spinal fusion for scoliosis in a child or young adult 18 years of age or under.

5. Tonsillectomy/Adenoidectomy;

i. A second opinion is required for all tonsillectomy/adenoidectomy procedures except for primary adenoidectomy for children under 12 years of age.

(c) A second opinion shall be arranged through the Medicaid Second Opinion Referral Services of the Provider Services Unit at the fiscal agent.

1. A consultation ordered by a physician shall not meet the Program's definition of a second opinion and no "Authorization for Payment" shall be granted based on such a consultation. The only exception to this policy involves second opinions arranged and paid for by other health insurance carriers. (See (a)2 above.)

2. In order to prevent claim denial as a result of a situation in which one of the elective surgical procedures is scheduled and performed before the second opinion requirement is met, it is suggested that the elective sur-

gery not be scheduled until after the second opinion has been rendered.

(d) Neither the physician claim nor hospital claim associated with one of the second opinion procedures shall be paid unless attached to the hard copy claim is an "Authorization for Payment", or documentation of a second opinion arranged through another health insurance carrier, or a specific statement from the operating physician certifying that the second opinion requirement was not met and substantiating the urgent or emergency nature of the surgery.

1. Reimbursement shall not be made for a second opinion rendered to an individual who is not a Medicaid recipient. The issuance of a "Medicaid Second Opinion Referral Form" to the recipient by the Medicaid Second Opinion Referral Services of the Provider Services Unit shall not guarantee the individual's eligibility on the date of the second opinion or subsequent surgery. The individual's Medicaid eligibility shall be verified by checking the individual's current New Jersey Medicaid Validation Form before rendering any service (See N.J.A.C. 10:49-2.3, Administration—How to Identify a Medicaid Recipient).

(e) For physician requirements regarding Second Opinion procedures, see N.J.A.C. 10:54, Physician Services.

10:52-1.12 Social Necessity Days

(a) Payment for "Social Necessity Days" shall be made to hospitals for a maximum of 12 calendar days per hospitalization for a Medicaid recipient child admitted with the diagnosis of child abuse or suspected child abuse, if special circumstances (social necessity) prevent the discharge or transfer of the patient and the hospital has taken effective action to initiate discharge or transfer of the patient.

1. For these cases, it is not necessary for the day of admission to be at the acute level of care.

2. Effective action is defined as telephone notification to the County Welfare Agency (CWA), or Division of Youth and Family Services (DYFS) district office, or other responsible officials as may be designated, within 48 hours of the time that the stay is determined to be no longer medically necessary. This telephone contact shall then be confirmed in writing within three working days. A copy of the written notification shall be submitted with all claims for which reimbursement is claimed for special circumstances (social necessity).

3. Medicaid reimbursement for social necessity shall be made to hospitals paid in accordance with the DRG rate setting methodology in N.J.A.C. 10:52-5 through 9.

10:52-1.13 Utilization control (inpatient services)

(a) This section provides information on the requirements for utilization control for inpatient services for approved acute general hospitals, special hospitals, and private

psychiatric hospitals. EXCEPTION: For inpatient psychiatric hospital services for individuals under the age of 21, refer to N.J.A.C. 10:52-1.14.

(b) For the purposes of this rule, the following words and terms shall have the following meanings:

“Utilization Control” means an approved program instituted, implemented and operated by or under the authorization of a utilization review organization (URO) which effectively safeguards against unnecessary or inappropriate Medicaid services and assesses the quality of those services to Medicaid recipients.

“Utilization Review Organization (URO)” means an organization designated and certified by the New Jersey State Department of Health, that has review authority over hospitals for specific functions for utilization review and quality assurance for all admissions to and continued lengths of stay at general hospitals in New Jersey. The review may be delegated or non-delegated and billed to the hospital under N.J.A.C. 8:31B-3.81.

(c) Under the Social Security Act, Section 1903(g) and (h), the Division is responsible for an effective program to control the utilization of services in hospitals. (See 42 CFR Part 456, Utilization Control, Subchapters B, C, and D). Included under utilization control are: Certification and recertification of the need for inpatient care; medical, psychiatric and social evaluations; a PoC established and periodically reviewed and evaluated by a physician; and a continuous program of utilization review under which the admission of each recipient is reviewed or screened. Hospital entitlement to Medicaid payment for services rendered to a Medicaid recipient for each period of hospitalization is subject to the following requirements:

1. A physician shall certify, for each recipient or applicant, that inpatient services in the acute care or in the private psychiatric hospital are or were needed.

i. The certification shall be made at the time of admission or, if an individual applies for assistance while in a hospital, before the Medicaid program authorizes payment.

ii. The certification shall be in writing and signed, or initialed, by a physician. The signature or initials are not acceptable if they are rubber stamped unless the physician has initialed the stamped signature. The physician shall date the certification on the date he or she signs it.

iii. The certification for any Medicaid patient shall be maintained in the recipient’s medical record.

iv. Acceptable documentation for certification or recertification may be any of the following:

(1) A statement, signed and dated, by the attending physician, staff physician, and/or consultant physician who has knowledge of the case, attesting that the recipient is in need of hospital care.

(2) Physician’s orders which are signed and dated on admission and clearly attest to the need for hospital care.

(3) A medical evaluation which designates the services and which is signed and dated by a physician who has knowledge of the case.

(4) An admission review form signed and dated by an attending or staff physician who has knowledge of the case.

2. A physician shall recertify for each Medicaid recipient or applicant that inpatient services in a hospital are needed.

i. Recertification shall be made at least every 60 days after certification.

ii. The recertification shall be in writing, shall attest to the need for inpatient services, and shall be signed or initialed by a physician who has knowledge of the case.

iii. The physician shall date the recertification on the date that he or she signs it.

iv. The recertification shall demonstrate the need for the level and type of care that the recipient is receiving.

v. The recertification for any Medicaid recipient shall be maintained in the recipient’s medical record.

vi. Acceptable documentation for recertification shall include any one of the following:

(1) A signed and dated statement by the physician who has knowledge of the case, attesting that continued care of a particular level or type is needed; or,

(2) Signed and dated orders by the physician who has knowledge of the case that clearly indicated that continued care is needed; or,

(3) Signed and dated progress notes by the physician who has knowledge of the case that clearly indicate that continued care is needed; or,

(4) Signed and dated reports that a physician might use in caring for the recipient that clearly indicate that continued care is needed; or,

(5) An admission certification or recertification form signed and dated by a physician who has knowledge of the case; or

(1) Profiles are comprised of those components of a test or series of tests performed as groups or combinations (profiles) which are performed on automated multichannel equipment and are finished identifiable laboratory study(ies). Examples are: The components of an SMA (Sequential Multichannel Automated Analysis) 12/60 or other automated laboratory study. Complete blood counts (CBC) with inclusion of Hemoglobin, Hematocrit, Red Blood Cell (RBC) Counts, Red Blood Cell (RBC) indices, White Blood Cell (WBC) Counts, and Differentials, MCHs, MCVs and MCHCs, are calculations, and not billable services. If the components of a profile or panel are billed separately, reimbursement for the components of the profile shall not exceed the Medicaid fee schedule for the profile itself.

(2) Panels are laboratory tests that are associated with other organ or disease oriented areas, such as organ "panels". Examples are hepatic function panels and lipid panels. The tests listed with each panel identifies the defined components of that panel. (See also (b)2iii below.)

2. Some outpatient laboratory services which use laboratory HCPCS procedure codes that are reimbursed based on actual billed charges, are subject to the cost-to-charge ratio. These include procedure codes such as:

i. Those valid for Medicaid reimbursement but not listed on the Medicare Laboratory HCPCS Procedure Code File (see 42 U.S.C. § 1395L). They are designated as "subject to cost-to-charge" or S.C.C. in N.J.A.C. 10:52-9.2;

ii. For those HCPCS codes submitted for payment on the same claim with charges for blood products (if no blood product is provided and/or billed on the same claim, the codes are reimbursed according to the fee allowance schedule); and

iii. For some codes associated with other laboratory services such as for organ or disease oriented panels; clinical pathology consultations; unlisted chemistry or toxicology procedures; certain bone marrow testing; certain specific or unlisted hematology procedures; certain immunology testing; unlisted microbiology procedures; and certain procedures under anatomic pathology.

3. All renal dialysis services for end-stage renal disease (ESRD) are reimbursed at 100 percent of the composite rate and includes any add-on charge to the composite rate approved by Medicare.

i. Renal dialysis services provided on an emergency basis in a hospital center not approved to provide renal dialysis services for ESRD are reimbursed actual billed charges, subject to the cost-to-charge ratio.

4. All dental services are reimbursed in accordance with the Division Dental Fee Schedule. This fee-for-

service schedule is consistent with the Division's fees paid to the private practitioners and independent dental clinics. For information about dental services in the Outpatient Department, see N.J.A.C. 10:52-2.3.

5. All HealthStart Maternity Health Support Services and HealthStart Pediatric Continuity of Care services are reimbursed on a fee-for-service basis in the hospital outpatient department. All other HealthStart Maternity and Pediatric Care Services are reimbursed based on the cost-to-charge ratio. (For policies and procedures for HealthStart Services, see N.J.A.C. 10:52-3.10.)

6. Early Periodic Screening, Diagnosis, and Treatment services are reimbursed in the hospital outpatient department according to the specific reimbursement methodology. (See also N.J.A.C. 10:52-2.4.)

i. The physician who is allowed by the hospital to bill Medicaid separately from the hospital costs (unbundled) for EPSDT services, shall bill on the EPSDT form.

7. All deductible and coinsurance amounts for Medicare crossover claims are not subject to the cost-to-charge ratio and are reimbursed are 100 percent of the amounts.

(c) Emergency room visits for Medicaid recipients not admitted as inpatients are coded by the hospital as needing primary care or non-primary care. (See N.J.A.C. 8:31B-3.23(e)).

1. Primary care is defined as those categories described in the Physicians' Current Procedural Terminology (CPT) as either minimal, brief, or limited service.

2. Non-primary care shall be defined as those categories described in the Physicians' Current Procedural Terminology (CPT), 1994, as amended and supplemented, as either intermediate, extended, or comprehensive service.

3. Hospitals shall not refuse to provide emergency room services to any Medicaid recipient for the reason that such recipient does not require services on an emergency basis.

NOTE: The cost of emergency room services for a Medicaid recipient admitted as an inpatient is allocated to the inpatient rates and is not reimbursed through the outpatient hospital reimbursement methodology, as stated above.

Amended by R.1996 d.479, effective October 7, 1996.

See: 28 N.J.R. 3221(b), 28 N.J.R. 4479(b).

Amended by R.1997 d.396, effective September 15, 1997.

See: 29 N.J.R. 1003(a), 29 N.J.R. 4132(b).

Rewrote (a).

10:52-4.4 Basis of payment; out-of-State hospital services

(a) The Division will reimburse an out-of-State approved hospital (see N.J.A.C. 10:52-1.2—Definitions) for providing inpatient and outpatient hospital services to New Jersey Medicaid recipients if the hospital meets the requirements of the Division and the services are prior authorized pursuant to N.J.A.C. 10:52-1.6(b). Reimbursement of inpatient hospital services is outlined in (b) through (d) below; and for outpatient services, is outlined in (e) below.

(b) Reimbursement of inpatient hospital services for hospitals participating in the Medicaid program is based on the following criteria:

1. All rates in effect at the time the service is rendered shall be considered final rates by the State.

i. In Diagnosis Related Group (DRG) hospitals, interim reimbursement is 100 percent of the DRG rate approved for the provider by the State Medicaid Agency in the state in which the hospital is located and in effect at the time the service is rendered.

ii. In non-Diagnosis Related Group (DRG) hospitals, reimbursement is 95 percent of the any reimbursement methodology (per diem, charges or case rate) approved by the State Medicaid agency of the state in which the hospital is located.

3. An out-of-State hospital should provide official documentation of the Medicaid rate that has been established by the State Medicaid agency in the state in which the hospital is located.

i. An example of acceptable documentation is a copy of the letter sent by the State Medicaid Agency to the hospital specifying the Medicaid rate. The purpose of this information is to facilitate claims processing.

(c) In the event an out-of-State hospital does not participate in the Medicaid program in the state where the hospital is located or has not established a rate with the State Medicaid agency, the hospital must enter into a negotiated rate with the Division at the time of enrollment for inpatient hospital services. The rate that is established between the hospital and the Division may be reviewed periodically thereafter.

1. Reimbursement for out-of-State inpatient hospital services for organ transplantation and procurement provided to a Medicaid recipient who has been determined to be in need of, and approved for, a kidney, heart, heart-lung, liver, bone marrow transplant, or other selected medically necessary organ transplants, except for those transplants categorized as experimental because of a life-threatening situation, shall be at a rate negotiated between the New Jersey Medicaid program and the hospital performing the organ transplant. Cornea transplants, although not life-threatening, shall be reimbursed as any other out-of-State transplant service.

(d) Reimbursement for outpatient hospital services in an out-of-State approved hospital is based on the rate of reasonable covered charges (subject to a percentage reduction based upon the cost-to-charge ratio) approved by the State Medicaid Agency in the state in which the hospital is located if the hospital participates in the State's Medicaid program, or if the hospital does not participate in the State's Medicaid program, the rate negotiated by the Division with the hospital.

10:52-4.5 Medicaid reimbursement for third-party claims

On claims for hospital services rendered to Medicaid recipients who are also covered by another form of health insurance, the Division shall pay the difference between the insurer's payment amount and that of Medicaid for covered services. (See N.J.A.C. 10:49-7.3, Administration.)

10:52-4.6 Medicare/Medicaid claims

(a) Some patients may be covered under both Medicare and Medicaid. When the Medicaid recipient is covered under both programs, Item 57 on the hospital claim form shall be completed showing the Medicaid Program Case and Person Number.

(b) Reimbursement of the deductible and coinsurance for inpatient and outpatient services for Medicaid recipients having both Medicare and Medicaid coverage shall be limited to the unsatisfied deductible and coinsurance.

(c) Where benefits have been exhausted under Medicare, the charges to be billed to the Medicaid program must be itemized for the Medicare non-covered services and the HSP (Medicaid) Case Number, including Person Number, must be shown on the hospital claim form.

(d) Where prior authorization is required for Medicaid program purposes, it shall be obtained and shall be submitted with the UB-92 claim form.

10:52-4.7 Personal contribution to care requirements for NJ KidCare-Plan C

(a) General policies regarding the collection of personal contribution to care for NJ KidCare-Plan C fee-for-service are set forth at N.J.A.C. 10:49-9.

(b) Personal contribution to care for NJ KidCare-Plan C services are \$5.00 a visit for outpatient clinic visits and \$10.00 for an emergency room visit that does not result in an inpatient hospital stay.

(c) Hospitals are required to collect the personal contribution to care for the above mentioned NJ KidCare-Plan C services if the NJ KidCare Identification Card indicates that a personal contribution to care is required and the beneficiary does not have a NJ KidCare form which indicates that the beneficiary has reached their cost share limit and no further personal contributions to care are required, until further notice. Personal contribution to care charges cannot be waived.

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).

Former N.J.A.C. 10:52-4.7, Medicaid settlement, recodified to N.J.A.C. 10:52-4.8.

10:52-4.8 Medicaid settlement

(a) In the capacity of the New Jersey Medicaid Settlement Agent for hospital for all New Jersey acute care general (excluding inpatient services), special, rehabilitation, private psychiatric and county governmental psychiatric hospitals and all hospital-based home health agencies, Blue Cross and Blue Shield of New Jersey, Inc. (BCBSNJ) shall determine their amount of disbursements, recoupments, and/or changes in per diem amounts and outpatient percentages, as applicable. BCBSNJ shall inform the hospital and the Division of Medical Assistance and Health Services (Division) of the results of their review. If the BCBSNJ's review is accepted, DMAHS, through its fiscal agent for claims processing, shall perform the following processes:

1. For disbursements, payment shall be made to the hospital for the full amount due within 20 working days from the date of BCBSNJ's letter.
2. The fiscal agent shall begin recoupment for the full amount of the overpayment 30 days after the date the Division receives BCBSNJ's overpayment notification by withholding the Medicaid payments to the hospital.
3. If the withholding of the New Jersey Medicaid payment is not acceptable to the hospital, the hospital must

submit, prior to the end of the 30-day period, a proposed repayment schedule to the Division. For a repayment schedule in excess of three months, documentation (as specified in Medicare Bulletin No. 0452) shall be submitted. If an approvable repayment schedule is not received by the Division, the withholding of Medicaid payments shall be implemented to begin recoupment.

4. The proposed repayment plans should be submitted directly to the following address:

Bureau of Institutional and Provider Reimbursement
Division of Medical Assistance and Health Services
PO Box 712, Mail Code # 25
Trenton, New Jersey 08625-0712
Attention: Health Care Facilities Analyst

5. Interest shall be charged at the maximum legal rate as of the date of the repayment agreement or 30 days from the date of the BCBSNJ letter to the Division, whichever is sooner.

Recodified from N.J.A.C. 10:52-4.7 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
Sec: 30 N.J.R. 1060(a).