

CHAPTER 49

ADMINISTRATION MANUAL

Authority

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

Source and Effective Date

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

Executive Order No. 66(1978) Expiration Date

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

Chapter Historical Note

Chapter 44, Administration, was filed and became effective prior to September 1, 1969. Subchapters 1 through 6 were amended by R.1977 d.213, effective July 1, 1977. See: 9 N.J.R. 123(b), 9 N.J.R. 342(c).

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

Chapter 49, Administration, was repealed and a new Chapter 49, Administration, was adopted by R.1992 d.317, effective August 17, 1992.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 Subchapter 19, Prepaid Health Care Services: Medicaid Eligibles, was repealed by R.1995 d.337, effective June 19, 1995.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

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

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SUBCHAPTER 1. GENERAL PROVISIONS

10:49-1.1 Scope and purpose

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

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

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

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

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

Substantially amended section.
Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).

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

10:49-1.2 Organization

(a) Regarding the organization of the Division of Medical Assistance and Health Services, the Department of Human Services is the single State Agency for receipt of Federal

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

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

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

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

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

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

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

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

10:49-1.3 Definitions

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

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

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

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

"Commissioner of DHS" means the Commissioner of the Department of Human Services.

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

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

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

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

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

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

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

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

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

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

“Program” means the New Jersey Medicaid program.

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

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

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

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

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

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

Deleted (a) designation, added “Aid to Families with Dependent Children (AFDC)”, “Beneficiary or eligible beneficiary”, “Commissioner of DHS”, “Department”, “Division”, “DHSS”, “Health Care Financing Agency”, “Medicaid Agent”, “Prepaid health plan”, “Program”, and “Qualified applicant”; changed “County welfare agency” to “County welfare agency or CWA” and amended; amended “Provider” and “recipient”; and deleted (b) and (c). Former section, “Early and Periodic Screening, Diagnosis and Treatment (EPSDT)”, repealed. Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

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

In “Fiscal agent” inserted a reference to the NJ KidCare program; and inserted “NJ KidCare”, “NJ KidCare—Plan A”, and “Programs”.

10:49-1.4 Overview of provider manuals

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

(b) Each provider manual consists of two chapters, broken down into subchapters. The first chapter is referred to as N.J.A.C. 10:49 (Administration) and outlines the general administrative policies of the New Jersey Medicaid program and other special programs including NJ KidCare. The second chapter of each manual specifies the rules and regulations relevant to the specific provider-type and the services provided. Following the second chapter of the manuals is the Fiscal Agent Billing Supplement.

(c) Codification of manual material follows that of the New Jersey Administrative Code (N.J.A.C.). The citation for a particular section of the provider manual reflects the same material under the same citation in the N.J.A.C. The following is an example of a citation in the N.J.A.C. or a provider manual:

10:49-2.8 Presumptive eligibility

(a) "Presumptive eligibility" means an expedited process whereby selected certified HealthStart Comprehensive Maternity Care providers make preliminary Medicaid eligibility determinations on behalf of pregnant women (see HealthStart in applicable Provider Services Manuals and N.J.A.C. 10:49-19). This is a preliminary process to determine presumptive eligibility prior to the determination of Medicaid eligibility or ineligibility by the CWA.

1. Approved HealthStart Maternity Care providers (independent clinics and hospital outpatient departments) may determine presumptive eligibility for pregnant women who require ambulatory prenatal services from Medicaid participating providers.

(b) A presumptively eligible pregnant woman is entitled to all Medicaid covered services with the exception of inpatient hospital and nursing facility care services. Although Medicaid HealthStart services must be provided only by a HealthStart provider, other Medicaid covered services may be provided to a presumptively eligible pregnant woman by any appropriate Medicaid provider.

(c) A presumptively eligible pregnant woman is eligible for a period of time which will end:

1. If the woman has not filed an application with the CWA, on or before the last day of the month subsequent to the date of the presumptive eligibility determination; or

2. If the woman has filed an application with the CWA, on the last day of the month subsequent to the month in which she was determined presumptively eligible, or on the day eligibility or ineligibility for Medicaid benefits is determined by the CWA.

(d) A presumptively eligible pregnant woman is identified by the two messages which appear on the "Medicaid Eligibility Identification Card" (Form FD-73/178) (see Appendix, N.J.A.C. 10:49). One message is above the woman's name on the upper left side: CLIENTS: YOU MUST CONTACT THE CWA FOR FULL BENEFITS; P.E. IS TEMPORARY AND LIMITED. The second message, which appears in the message box on the upper right hand corner instructs the provider to call a toll-free number to verify eligibility before providing services. This card is the only document acceptable for the identification of a presumptively eligible pregnant woman.

1. As part of the presumptive eligibility process, a presumptively eligible pregnant woman will be given an FD-334 Form, Certification of Presumptive Eligibility (see Appendix, N.J.A.C. 10:49). This is not valid proof of eligibility for Medicaid and should not be used by the provider for presumptive eligibility purposes. A request for reimbursement based solely upon the presentation of the FD-334 form does not guarantee payment.

2. Even with the identification through the MEI Card, each time a service is rendered the provider shall verify the presumptive eligibility status of a pregnant woman, prior to the delivery of ambulatory services, by calling the toll free telephone number listed on the MEI Card which is available seven days a week, 24 hours a day.

3. A provider's failure to verify eligibility prior to the delivery of services shall result in the denial of payment for those services if the individual was not eligible at that time. The provider should note that a pregnant woman's presumptive eligibility may be terminated at any time.

Amended by R.1996 d.320, effective July 15, 1996.

See: 28 N.J.R. 1589(a), 28 N.J.R. 3572(a).

Recodified from N.J.A.C. 10:49-2.6 and amended by R.1997 d.354, effective September 2, 1997.

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

Substituted "CWA" for "county welfare agency" throughout; and in (a), inserted N.J.A.C. references. Former section recodified to N.J.A.C. 10:49-2.8.

Recodified from N.J.A.C. 10:49-2.7 by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

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

Former N.J.A.C. 10:49-2.8, Medicaid retroactive eligibility, recodified as N.J.A.C. 10:49-2.9.

10:49-2.9 Medicaid or NJ KidCare—Plan A retroactive eligibility

(a) Any person applying for Medicaid or NJ KidCare—Plan A benefits shall be asked if he or she has unpaid medical bills incurred within the three month period immediately prior to the month of application for Medicaid or NJ KidCare—Plan A. Except for a Medically Needy applicant (see N.J.A.C. 10:49-2.3(f) and application processed by the Statewide eligibility determination agency, an individual indicating that there are such bills, may complete an FD-74 Form, Application for Payment of Unpaid Medical Bills (see Appendix, N.J.A.C. 10:49) and forward the application with all outstanding unpaid medical bills to the Medicaid Retroactive Eligibility Unit, Division of Medical Assistance and Health Services, PO Box 712, Mail Code #10, Trenton, New Jersey 08625-0712.

1. An application for retroactive eligibility may be obtained by the applicant, or his or her authorized agent, from the CWA, the Medicaid District Office, the Social Security Administration District Office, or from the Retroactive Eligibility Unit, Division of Medical Assistance and Health Services. The application shall be submitted within six months from the date of application for public assistance.

2. In addition to (a)1 above, applications for NJ KidCare—Plan A retroactive eligibility may be obtained from the agency they used for their NJ KidCare eligibility determination.

3. Applications for retroactive unpaid medical bills cannot be processed for services rendered prior to the effective date of the program. For NJ KidCare—Plan A, children eligible under N.J.A.C. 10:79-3.4(b) the effective date is February 1, 1998.

(b) If the Division of Medical Assistance and Health Services determines that the person was eligible for Medicaid or NJ KidCare—Plan A at the time the service was provided, providers shall be notified directly that the unpaid bills for any service covered by the New Jersey Medicaid program or NJ KidCare—Plan A may be reimbursable in accordance with standard Medicaid and NJ KidCare reimbursement procedures.

1. The provider shall then complete the appropriate claim form and submit it to the Fiscal Agent for consideration and authorization of payment.

2. For any Medically Needy beneficiary, a retroactive eligibility determination shall be completed by the CWA (see N.J.A.C. 10:49-2.3—Persons eligible under the Medically Needy program).

Recodified from N.J.A.C. 10:49-2.7 and amended by R.1997 d.354, effective September 2, 1997.

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

In (a) amended N.J.A.C. reference and mailing address; in (a)1 and (b)2, substituted "CWA" for "county welfare agency"; and in (b)2, substituted "beneficiary" for "recipient". Former section recodified to N.J.A.C. 10:49-2.9.

Recodified from N.J.A.C. 10:49-2.8 and amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

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

Inserted references to NJ KidCare—Plan A throughout; in (a), inserted "and application processed by the Statewide eligibility determination agency" following "N.J.A.C. 10:492.3(f)" in the second sentence, and added 2 and 3; and in (b), inserted a reference to NJ KidCare reimbursement procedures in the first sentence, and deleted "Medicaid" following "appropriate" and substituted a reference to the Fiscal Agent for a reference to the Retroactive Eligibility Unit in 1. Former N.J.A.C. 10:49-2.9, Verification of eligibility for Medicaid/Pharmaceutical Assistance to the Aged and Disabled (PAAD) services, recodified to N.J.A.C. 10:49-2.10.

Case Notes

Provider failing to meet regulatory time lines for cross-over Medicaid/Medicare reimbursement claims was not entitled to reimbursement. In the Matter of Bergen Pines County Hospital, 96 N.J.A.R.2d (DMA) 15.

Unique circumstances excused hospitalized applicant from complying with requirement that application for retroactive Medicaid be submitted within six months of date of application for public assistance. J.R. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 57.

Untimely application for three months retroactive benefits under Medicaid program was not waived and was properly denied. Estate of G.K. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 27.

Application for Medicaid, though filed after six-month deadline, was nevertheless sufficient to meet three month requirement for retroactive eligibility. A.D. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 11.

Spouse of Supplemental Security Income recipient was not entitled to retroactive Medicaid coverage. M.L. v. Union County Board of Social Services, 94 N.J.A.R.2d (DMA) 24.

10:49-2.10 Verification of eligibility for Medicaid or NJ Kid Care; or Pharmaceutical Assistance to the Aged and Disabled (PAAD) services

(a) Each Medicaid or NJ KidCare beneficiary, except Nursing Facility beneficiaries, has a Medicaid or NJ KidCare Eligibility Identification Number printed on a form that validates eligibility. The beneficiary shall present this form to the provider, as a proof of eligibility, every time a service is to be provided. See N.J.A.C. 10:49-2.12 for a description and information about the Medicaid Eligibility Identification Number and see N.J.A.C. 10:49-2.13 for information about the Medicaid and NJ KidCare forms that are used to validate eligibility. The Recipient Eligibility Verification System (REVS) or Medicaid Eligibility Verification System (MEVS) can be used, in some instances, as an alternative to viewing a form used to validate eligibility (see N.J.A.C. 10:49-2.11).

1. When extended plans of treatment have been approved, it is especially important to review the validation of eligibility form each time a service is provided.

i. Medical authorization or approval of a service by the Division shall not be construed as a guarantee that a person is eligible for the Medicaid or NJ KidCare program.

ii. There shall be no reimbursement for services performed after termination of eligibility, except as noted in N.J.A.C. 10:49-5.5(a)9.

Amended by R.1995 d.589, effective November 20, 1995.

See: 27 N.J.R. 2851(a), 27 N.J.R. 4715(b).

Recodified from N.J.A.C. 10:49-2.8 and amended by R.1997 d.354, effective September 2, 1997.

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

In (a), substituted "beneficiary" and "beneficiaries" for "recipient" and "recipients" and "Medicaid Eligibility Identification Number" for "HSP (Medicaid) Case Number", and amended N.J.A.C. references; and deleted (b), relating to PAAD Programs. Former section recodified to N.J.A.C. 10:49-2.10.

Recodified from N.J.A.C. 10:49-2.9 and amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

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

Inserted references to NJ KidCare and made corresponding language changes, and changed N.J.A.C. references throughout. Former N.J.A.C. 10:49-2.10, Recipient Eligibility Verification System (REVS)/Medicaid Eligibility Verification System (MEVS), recodified to N.J.A.C. 10:49-2.11.

10:49-2.11 Recipient Eligibility Verification System (REVS)/ Medicaid Eligibility Verification System (MEVS)

(a) In the event a beneficiary is unable to produce a form that validates Medicaid or NJ KidCare eligibility or the provider wants more current eligibility data (see N.J.A.C. 10:49) and the beneficiary's Medicaid or NJ KidCare Eligibility Identification Number is known, the provider can verify eligibility by calling the Unisys Recipient Eligibility Verification System (REVS). REVS is accessed by dialing 1(800)676-6562 (or (609) 587-1955 in the local Trenton area). Complete instructions for using REVS can be found in the Fiscal Agent Billing Supplement following the second chapter for each Provider Services Manual.

(b) The New Jersey Medicaid/Pharmaceutical Assistance to the Aged and Disabled (PAAD) program offers providers an optional method of verifying beneficiary eligibility. The optional system is called Medicaid Eligibility Verification System (MEVS).

1. A provider can contract with a Medicaid/PAAD approved vendor which has access to the Medicaid/PAAD eligibility file. By contracting with a vendor, a provider through MEVS can obtain eligibility information by entering the Medicaid/PAAD number or, if the number is not available, the following data elements: the beneficiary's Social Security Number and date of birth.

i. For hospital providers only, name and date of birth may be used.

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

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

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

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

Recodified from N.J.A.C. 10:49-2.15 by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).

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

10:49-2.17 Medicaid application

(a) If a person has not applied for benefits, is unable to pay for services provided, and appears to meet the requirements for eligibility for the New Jersey Medicaid program,

the provider shall encourage the person, or his or her representative, to apply for benefits:

1. To the CWA for programs such as Aid to Families with Dependent Children; Medicaid Only; New Jersey Care . . . Special Medicaid programs for pregnant women, children, and the aged, blind, or disabled; or for Medically Needy.

2. To the Social Security Administration for Supplemental Security Income benefits for the aged, blind, and disabled; or

3. In certain cases, to the New Jersey Division of Youth and Family Services, Department of Human Services.

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

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

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

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

Recodified from N.J.A.C. 10:49-2.16 by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).

10:49-2.18 (Reserved)

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

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

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

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

SUBCHAPTER 3. PROVIDER PARTICIPATION

10:49-3.1 Provider types eligible to participate

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

1. Certified nurse practitioners/clinical nurse specialists;
2. Chiropractors and/or chiropractic groups;
3. Clinics (independent outpatient health care facilities);
4. Clinical laboratories;
5. Dentists and/or dentist groups;
6. Hearing aid dealers;
7. Health maintenance organizations/managed care organizations;
8. Home health agencies;
9. Homemaker agencies;
10. Hospices;
11. Hospitals;
 - i. General;
 - ii. Psychiatric; and
 - iii. Special;
12. Nursing facilities, including intermediate care facilities for the mentally retarded;
13. Medical suppliers;
14. Medical day care centers;
15. Nurse-midwives;
16. Opticians;
17. Optometrists;
18. Orthotists;
19. Pharmacies;
20. Physicians and/or physician groups;
21. Podiatrists and/or podiatric groups;
22. Prosthetists;
23. Psychologists and/or psychologist groups;
24. Residential treatment facilities;
25. Transportation providers; and
26. State and county agencies that have agreed to provide personal care assistant services.

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

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

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

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

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

Cross References

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

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

10:49-3.2 Enrollment process

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

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

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

1. As a condition of continued participation in the New Jersey Medicaid and NJ KidCare programs, a provider may, from time to time, be required to:

- i. Complete a provider reenrollment application form and sign a provider participation agreement; and/or
- ii. Complete a Form HCFA 1513, Ownership and Control Interest Disclosure Statement. This requirement shall not be applicable to individual practitioners(s) or groups of practitioners.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Cross References

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

10:49-3.3 Providers with multi-locations

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

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

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

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

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

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

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

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

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

10:49-3.4 Medicaid or NJ KidCare Provider Billing Number

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

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

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

1. Each participating practitioner (that is, physician, certified nurse midwife, certified nurse practitioner/clinical nurse specialist, chiropractor, dentist, optometrist, podiatrist, or psychologist) shall supply his or her individual

Provider Servicing Number to other providers when referring a Medicaid or NJ KidCare beneficiary for services.

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

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

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

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

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

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

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

10:49-4.1 Definitions

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

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

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

“Purveyor” means any person, firm, corporation or other entity other than a provider who, whether or not located in a building which houses a shared health care facility, directly or indirectly, engages in the business of supplying to ultimate users or providers within the shared health care facility any medical supplies, equipment and/or services for which reimbursement under the program is received, including, but not limited to, clinical laboratory services or supplies; diagnostic radiology services; sick room supplies; physical therapy services or equipment; orthopedic or surgical appliances or supplies; drugs, medication or medical supplies; eyeglasses, lenses or other optical supplies or equipment; hearing aids or devices; and any other goods, services, supplies, equipment or procedures prescribed, ordered, recommended or suggested for medical diagnosis, care or treatment, and which amount to \$10,000 per year.

“Shared health care facility” (SHCF) means four or more providers, two or more of whom are practicing within different specialties and/or disciplines, either independently or in association with each other, within a single structure; and

1. Two or more of whom share any of the following:
 - i. Common waiting areas;
 - ii. Examining rooms;

- iii. Treatment rooms;
- iv. Equipment;
- v. Supporting staff;
- vi. Common records; and

2. One or more of whom receives payment on a fee-for-service basis, and where the gross Medicaid income for the facility meets or exceeds \$80,000 per year.

“Specialty” means a health care practice within a discipline such as pediatrics, obstetrics/gynecology, orthodontics, periodontics, and so forth.

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

Amended “Discipline”, “Patient”, and “Purveyor”; and deleted ‘Department’, ‘Division’, and ‘Provider’.

10:49-4.2 Scope

(a) This subchapter shall apply to shared health care facilities as defined herein and to providers located in a specific health care facility.

(b) This subchapter shall apply to purveyors, whether or not located in a building which houses a shared health care facility.

(c) Nothing in this subchapter shall apply to an association of health care providers delivering health services on other than a fee-for-service basis.

(d) This subchapter shall not apply to hospitals participating in the Medicaid program.

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

10:49-4.3 Registration of shared health care facilities

(a) No shared health care facility shall be operated under the program unless it has been registered with the Division. The Office of Quality Management and Program Integrity, PO Box 712, Mail Code #7, Trenton, New Jersey 08625-0712 is responsible for registration.

1. Providers within the shared health care facility shall designate one provider member who shall be responsible for registration:

- i. Said responsibility and liability by the designated provider, shall be limited to timely filing of accurate reports required under this section.

(b) Registration shall be made on forms furnished by the Division and shall contain the information required therein, including, but not limited to:

- 1. The name of the owner or owners of the facility;

2. The name, residence address and professional license number of every provider and purveyor working in the shared health care facility;

3. The name, residence address and curriculum vitae of the individual designated to assume responsibility for the central coordination and management of the shared health care facility’s activities, if so designated;

4. The owner, lessor or lessee shall furnish to the Division a copy of the lease agreement upon request;

5. The name of any person, firm or corporation providing administrative, clerical or billing services to providers in shared health care facilities, other than employees of providers; and

6. The name and address of lessor of any space or equipment in the shared health care facility.

(c) The registrant shall re-register on the June 1 next following initial registration, and annually thereafter on June 1.

(d) The Division shall be notified, in writing, within 30 calendar days of any change in:

- 1. The owner or owners of the facility;
- 2. The termination of the services of the individual designated to assume responsibility for coordination and management of the shared health care facility’s activities. The Division shall also be notified within 30 calendar days of the name, residence address and professional qualifications of any new individual appointed to assume such central administrative responsibility; and

3. Any addition or termination of any provider or purveyor in the shared health care facility. Such notification shall include the name, residence address and license number of each person appointed in place of such individual.

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 name and address; and in (d) and (d)2, inserted “calendar” preceding “days”.

10:49-4.4 Prohibited practices; administrative requirements

(a) The Division shall not enter into any agreement of Medicaid participation, nor shall any payment be made to any provider in a shared health care facility where the rental fee for the letting of space or supportive professional or clerical services to a provider in a shared health care facility is calculated in whole or in part, directly or indirectly, as a percentage of earnings or billings of the provider for services rendered on the premises in which the shared health care facility is located.

(b) No purveyor or provider, whether or not located in a building which houses a shared health care facility, shall directly or indirectly offer, pay or give, or permit or cause to

be offered, paid or given to any provider or purveyor, and no provider or purveyor shall directly or indirectly solicit, request, receive or accept from any purveyor or provider any sum of money, credit or other valuable consideration for:

1. Recommending or procuring goods, services or equipment of such purveyor or provider to any other person;
2. Directing patronage or clientele to such purveyor or provider; or
3. Influencing any person to refrain from using or utilizing goods, services or equipment of any purveyor or provider.

(c) Patient referral requirements follow:

1. No provider in a shared health care facility or person employed in such facility shall refer a patient to another provider located in such a facility, unless the records of the referring provider pertaining to such patient clearly sets forth the justification for such referral;

2. Every provider practicing in a shared health care facility who treats a patient referred to him or her by another provider practicing in the same facility shall communicate in writing to the referring provider, the diagnostic evaluation and the therapy rendered. The referring provider shall incorporate such information into the patient's permanent record; and

3. The claim submitted to the program by the provider to whom such patient has been referred shall contain the full name and individual Medicaid Provider Servicing Number of the referring provider, and shall identify the medical problem that necessitated the referral.

(d) Any pharmacy maintaining a business in the same building in which a shared health care facility is located shall prominently post a notice informing patients that all pharmaceuticals prescribed in the program may be obtained at any pharmacy of the beneficiary's choice.

(e) No purveyor or provider other than a physician, dentist, podiatrist, optometrist or chiropractor, who maintains a business in the building in which a shared health care facility is located, shall maintain a door or window opening into the offices or waiting room of the shared health care facility.

(f) All provider claims submitted for services rendered at a shared health care facility shall contain the registration code (SHCF Number) of the facility at which the service was performed. The individual Medicaid Provider Servicing Number of the practitioner rendering the service must also be entered on the claim form. The practitioner who rendered the service or his or her authorized representative must sign and date the claim form.

(g) The requirements set forth in the Medicaid program Provider Services Manuals for each respective discipline shall apply to services rendered at a shared health care facility.

(h) It shall be unlawful for any provider to pay a bonus, commission or fee to any other provider based on business supplied or referred.

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

In (d), substituted "beneficiary's" for "recipient's".

10:49-4.5 Quality of care requirements

(a) To ensure quality, continuity and proper coordination of medical care, each shared health care facility shall:

1. Where feasible, designate an individual who, on a full-time basis, shall coordinate and manage the facility's activities;

2. Devise an appropriate means of insuring that patients shall be scheduled to return for appropriate follow-up care and shall be treated by a provider familiar with patient's medical history;

3. Post conspicuously the names and scheduled office hours of all providers practicing in the facility;

4. Maintain proper records. Such records shall contain at least the following information:

i. The full name, address and Medicaid Number of the patient;

ii. The dates of all visits to all providers in the shared health care facility;

iii. The chief complaint for each visit to each provider in the shared health care facility;

iv. Pertinent history and all physical examinations rendered by each provider in the shared health care facility;

v. Diagnostic impressions for each visit to any provider in the shared health care facility;

vi. All medications prescribed at each visit by any provider in the shared health care facility who is qualified to issue prescriptions;

vii. The precise dosage and prescription regimens for each medication prescribed by a provider in the shared health care facility;

viii. All x-ray, laboratory work and electrocardiograms ordered at each visit by any provider in the shared health care facility;

ix. The results of all x-ray, laboratory work and electrocardiograms ordered as in (a)4viii above;

x. All referrals by providers in the shared health care facility to other medical providers and the reason for such referrals, and date of referral; and

xi. A statement as to whether or not the patient is expected to return for further treatment.

5. The Division shall have the right to inspect the business records, patient records, leases and other contracts executed by any provider in a shared health care facility. Such inspections may be by site visits to the shared health care facility.

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

10:49-5.1 Requirements for provision of services

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

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

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

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

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

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

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

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

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 the regular Medicaid and NJ KidCare—Plan A programs

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

1. Case management services (Mental Health Program);
2. Chiropractic services;
3. Christian Science Sanatoria care and services (see Hospital Services Manual);
4. Clinic services such as services in an independent outpatient health care facility, other than hospital, that provides services such as Mental Health, Family Planning, Dental, Optometric, Ambulatory Surgery, FQHCs;
5. Dental services;
6. 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;
7. Family planning services including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling.
 - i. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered by the New Jersey Medicaid or NJ KidCare—Plan A program.
8. HealthStart maternity and pediatric care services include packages of comprehensive medical and health support services provided by independent clinics; hospital outpatient departments; local health departments meeting New Jersey Department of Health and Senior Services' improved pregnancy outcome criteria; physicians; and nurse midwives; either directly or through linkage with other HealthStart care providers. (See N.J.A.C. 10:49-19 for HealthStart services, policies and requirements for provider participation;)
9. Hearing aid services;
10. Home care services (home health care and personal care assistant services);
11. Hospice room and board services in a nursing facility (available to dually eligible Medicare/Medicaid or dually eligible Medicare/NJ KidCare—Plan A beneficiaries);
12. Hospital services—inpatient:

- i. General hospitals;
 - ii. Special hospitals;
 - iii. Psychiatric hospitals (inpatient): Limited to persons age 65 or older and children 21 years of age and under; and
 - iv. Inpatient psychiatric programs for children 21 years of age and under;
13. Hospital services—outpatient;
 14. Laboratory (clinical);
 15. Medical day care services;
 16. Medical supplies and equipment;
 17. Mental health services;
 18. Nursing facility services, including intermediate care facilities for the mentally retarded;
 19. Nurse-midwifery services;
 20. Optometric services;
 21. Optical appliances;
 22. Pharmaceutical services;
 23. Physician services;
 24. Podiatric services;
 25. Prosthetic and orthotic devices;
 26. Radiological services;
 27. Rehabilitative services (Payments are made to eligible Medicaid or NJ KidCare—Plan A providers only. No payment is made to privately practicing therapists);
 - i. Physical therapy, as provided by a home health agency, independent clinic, nursing facility, hospital outpatient department, or in a physician's office;
 - ii. Occupational therapy, as provided by a home health agency, independent clinic, nursing facility, or hospital outpatient department;
 - iii. Speech-language pathology services, as provided by a home health agency, independent clinic, nursing facility, hospital outpatient department, or in a physician's office; and
 - iv. Audiology services provided in the office of a licensed specialist in otology or otolaryngology, or as part of independent clinic or hospital outpatient services; and
 28. Transportation services which include ambulance, invalid coach, and other transportation provided by independent clinics or through arrangements with a county welfare agency.

Amended by R.1994 d.600, effective December 5, 1994.
 See: 26 N.J.R. 3345(a), 26 N.J.R. 4762(a).
 Amended by R.1997 d.354, effective September 2, 1997.

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

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

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

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

In (a), inserted references to NJ KidCare—Plan A throughout; and inserted a reference to dually eligible Medicare/NJ KidCare—Plan A beneficiaries in 11.

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

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

1. Chiropractic services are available only to pregnant women (Group A).

2. EPSDT services are not available to any Medically Needy group.

3. Hospital services (inpatient) are available only to pregnant women (Group A).

4. Nursing facility services are available to Medically Needy beneficiaries. For purposes of the Medically Needy program, nursing facility services include pharmacy services under Title XIX.

5. Medical day care services are available only to pregnant women, the aged, the blind and the disabled (Groups A and C).

6. Pharmaceutical services are available only to pregnant women and needy children (Groups A and B); and aged, blind or disabled beneficiaries who reside in Medicaid participating nursing facilities (see N.J.A.C. 10:51-2.10). Pharmaceutical services are not available to other aged, blind and disabled beneficiaries (Group C).

7. Podiatric services are available only to pregnant women, the aged, the blind and the disabled (Groups A and C).

8. Rehabilitative services are not available for reimbursement when provided through a hospital or nursing facility, except to pregnant women as part of their inpatient hospital services.

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

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

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

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

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

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

Amended section name; substituted "beneficiaries" and "beneficiary's" for "recipients" or "recipient's" throughout; in (a)4, substituted "beneficiaries" for "group" and inserted reference to pharmacy services; and in (a)6, inserted references to aged, blind or disabled beneficiaries.

Case Notes

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

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

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

10:49-5.4 Emergency NJ KidCare—Plan A services for aliens

(a) Most legal aliens who entered the United States on or after August 22, 1996 are restricted to NJ KidCare emergency services for five years from their date of entry. Undocumented aliens and temporarily documented aliens, that is, visitors, workers, and students are also restricted to emergency services.

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

- i. Placing the patient's health in serious jeopardy;
- ii. Serious impairment to bodily functions; or
- iii. Serious dysfunction of any bodily organ or part.

2. For labor and delivery services, the place of service is not limited to an acute care general hospital.

3. All diagnoses are classified as emergency or non-emergency services in accordance with the above definition of an emergency. Those diagnoses that correspond with Level I emergency care are defined as emergencies and thus do not require any authorization by the attending physician. Those diagnoses that correspond with Level II require a hard copy attachment (Certification of

Treatment of Emergency Medical Condition) signed by the attending physician confirming the emergency nature of the encounter.

i. Level I—Emergency life-threatening or organ threatening, or potentially life or organ threatening condition that requires immediate care.

ii. Level II—Urgent condition that is potentially harmful to a patient's health and determined by the physician to be medically necessary for treatment within 12 hours to prevent deterioration.

4. To be eligible for emergency services, an alien meeting the medical criteria listed in (a)1 above must also meet all financial and categorical eligibility requirements for NJ KidCare—Plan A.

(b) Lawfully admitted aliens who entered the United States prior to August 22, 1996 and other aliens who are refugees, asylees, Cuban/Haitian entrants, American Indians born in Canada, Amerasian immigrants, and aliens who are honorably discharged or are on active duty in the Armed Forces of the United States and their spouses and unmarried dependent children, may qualify for full NJ KidCare—Plan A if they meet all other NJ KidCare—Plan A eligibility requirements. These aliens should be referred to the eligibility determination agency of their choice to apply for full NJ KidCare—Plan A benefits. See N.J.A.C. 10:79-3.2(b).

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

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

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

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

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

1. Any service, admission, or item, which is not medically required for diagnosis or treatment of a disease, injury, or condition;

2. Services provided to all persons without charge; these services shall not be billed to the Medicaid program when provided for a Medicaid beneficiary. Services and items provided without charge through programs of other public or voluntary agencies (for example, New Jersey State Department of Health and Senior Services, New Jersey Heart Association, First Aid Rescue Squads, and so forth) shall be utilized to the fullest extent possible;

3. Any service or items furnished in connection with elective cosmetic procedures;

i. There are certain exceptions to this rule, but the exceptions require prior authorization. A written certification of medical necessity and a treatment plan shall

be submitted by the physician to the appropriate Medicaid District Office for consideration;

4. Private duty nursing services (except for beneficiaries under EPSDT, Model Waiver III, ACCAP and ABC programs);

5. Services or items furnished for any sickness or injury occurring while the covered person is on active duty in the military;

6. Services provided outside the United States and territories;

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

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

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

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

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

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

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

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

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

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

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

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

14. Any claim submitted by a provider for service(s) rendered, except in a medical emergency, to a Medicaid beneficiary whose Medicaid Eligibility Identification Card (FD-73/178) has a printed message restricting the beneficiary to another provider of the same service(s). (See N.J.A.C. 10:49-2.13(e)2, Special Status program);

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

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

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

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

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

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

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

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

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

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

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

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

Cross References

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

Case Notes

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

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

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

been subject to prior authorization had it not been so classified, must be supported by a practitioner's statement which describes the nature of the emergency, including relevant clinical information, and must state why the emergency services rendered were considered to be immediately necessary. To simply state that an emergency did exist is not sufficient.

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

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

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

2. Retroactive determination of eligibility;

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

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

SUBCHAPTER 6. AUTHORIZATIONS REQUIRED BY MEDICAID PROGRAM

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

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

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

2. "Medical emergency" means a critical illness or injury status for which prompt medical care may be crucial to saving life and limb or sparing the beneficiary significant or intractable pain. Services provided for a medical emergency are exempt from prior authorization. Any service classified as a medical emergency that would have

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

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

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

Case Notes

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

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

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

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

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

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

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

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

10:49-7.1 General provisions

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

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

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

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

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

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

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

Amended by R.1997 d.520, effective January 5, 1998.
See: 29 N.J.R. 1006(a), 30 N.J.R. 232(a).

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

10:49-7.2 Timeliness of claim submission and inquiry

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

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

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

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

ii. For retroactive eligibility cases, a claim associated with a retroactive eligibility application will be considered as received on the date of receipt of the application on behalf of the applicant. For information about retroactive eligibility, see 10:49-2.7.

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

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

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

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

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

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

2. For claims submitted by a nursing facility; an intermediate care facility for the mentally retarded; a residential treatment center; or a governmental psychiatric hospital, a claim for payment for services shall be received by the fiscal agent no later than one year after the "from date of service" as indicated on the claim.

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

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

i. One year of the date of service;

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

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

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

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

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

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

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

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

ii. For combination Medicare/Medicaid claims received by the Medicare Intermediary/Carrier within the applicable Medicaid timely submission period and where Medicare adjudication occurs beyond the one year of the date of service, the provider shall submit a claim to be received by the Medicaid Fiscal Agent within 90 days of the date of the Medicare adjudication.

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

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

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

(e) If additional information is required in order to process a claim, the provider shall supply the information as soon as possible, but not more than 90 days after the end of the applicable timely submission period.

(f) Regarding an adjudicated claim inquiry, a provider may inquire about a claim that has been paid or denied but shall make the inquiry within 90 days of the date of adjudication as indicated on the Remittance Advice Statement.

(g) Regarding a non-adjudicated claim inquiry, a provider may inquire about the status of a claim for which neither payment nor denial has been received. The inquiry may be made at any time after the claim is received, but not more than 90 days after the end of the applicable timely submission period.

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

1. When the claim invoice or retroactive adjustment is paid to a provider reimbursed under a retrospective payment system;
2. For a Medicare/Medicaid claim, timely filed, Medicaid payment may be made for services within six months after the program or provider receives notice of the Medicare claim disposition for a timely filed Medicare/Medicaid claim;
3. For claims from providers under investigation for fraud or abuse; or
4. For claims associated with administrative or legal actions pursuant to a hearing action or agency corrective action mandate, whether for an eligible individual or for all those eligibles affected in a similar manner.

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

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

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

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

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

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

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

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

Case Notes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Medicare: The program will make payment in the full amount of the Medicare Part A deductible and co-insurance for inpatient hospital services, and Part B ambulatory care.

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

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

1. For services, goods, or supplies not covered or authorized by the New Jersey Medical Assistance and Health Services Act (N.J.S.A. 30:4D-1 et seq.) if the

beneficiary elected to receive the services, goods, or supplies with the knowledge that they were not covered or authorized; or

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

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

1. Medicare is a health insurance program which covers certain aged and disabled persons. When rendering Medicare-covered services to any Medicaid beneficiary, providers shall inquire about Medicare eligibility especially if the third digit of the Medicaid Eligibility Identification Number is a 1, 2, 5, or 7.

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

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

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

1. The TPL benefits are derived from a parent whose obligation to pay support is being enforced by the State Title IV-D agency;

2. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the program;

3. The claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay;

4. The claim involves a service for which HCFA has granted a waiver of the TPL cost avoidance requirements in accordance with 42 C.F.R. 433.139(e). Waivers have been granted for:

- i. Pharmacy services; and
- ii. Services covered by Medicare Part B which are rendered at State and county governmental psychiatric hospitals, State and private ICFs/MR, and Vineland Special Hospital; or

5. Rehabilitation services provided by a local school district under a child's Individualized Education Program (IEP).

(i) In those situations where a health insurance payment is received after Medicaid has been billed and has made payment, the provider must reimburse the Medicaid payment to the Medicaid program and not the Medicaid beneficiary. Reimbursement must be made immediately to comply with Federal regulations. To initiate the process, providers must submit an MMIS Claim Adjustment Request Form. (See Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

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

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

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

Petition for Rulemaking.

See: 27 N.J.R. 770(b), 27 N.J.R. 1320(a).

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

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

Substituted "beneficiary" and "beneficiaries" for "recipient" and "recipients" throughout; in (a), substituted "by the Medicaid program" for "under this act"; in (b), inserted "the exceptions listed in"; in (e)1, substituted "Medicaid Eligibility Identification Number" for "HSP (Medicaid) Case Number"; deleted (e)1i and (e)1i(1); added (h)5; and in (i), substituted "a health insurance payment is received" for "an insurance payment is received from another payer" and "MMIS Claim Adjustment Request Form" for "Adjustment/Void Request Form".

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 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".

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

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

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

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

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

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

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

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

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

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

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

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

Case Notes

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

SUBCHAPTER 8. PAYMENT FOR SERVICES PROVIDED

10:49-8.1 Fiscal Agent

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

Amended by R.1997 d.520, effective January 5, 1998.
See: 29 N.J.R. 1006(a), 30 N.J.R. 232(a).

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

10:49-8.2 Claims payment and pricing

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

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

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

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

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

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

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

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

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

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

Amended by R.1997 d.520, effective January 5, 1998.
See: 29 N.J.R. 1006(a), 30 N.J.R. 232(a).

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

Case Notes

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

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

10:49-8.3 Adjustments following payment of claims

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

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

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

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

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

Case Notes

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

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

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

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

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

10:49-8.5 Outstanding checks

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

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

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

10:49-9.1 Civil rights

Federal regulations require that services provided to any Medicaid beneficiary shall be given without discrimination on the basis of race, color, national origin, or handicap. Therefore, payments shall be limited to providers of service who are in compliance with the nondiscrimination requirements of Title VI of the Civil Rights Act and Section 504 of the Rehabilitation Act of 1973.

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".

10:49-9.2 Observance of religious belief

(a) Nothing in the Medicaid program shall be construed to require any beneficiary to undergo any medical screening, examination, diagnosis, or treatment, or to accept any other health care or services provided under the program for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health) if such person or his or her parent or guardian objects thereto on religious grounds, except as specified in (b) below.

(b) If a physical examination is necessary to establish eligibility based on disability or blindness, the Medicaid Program may not find an individual eligible for Medicaid unless he or she undergoes the examination.

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
In (a), substituted "beneficiary" for "recipient".

10:49-9.3 Free choice by beneficiary and provider

(a) The concept of freedom of choice shall apply to both provider and beneficiary.

1. A Medicaid fee-for-service beneficiary shall be free to choose providers of service who meet program standards and who elect to participate in the Medicaid program. The Medicaid District Office shall assist any beneficiary in obtaining services if the beneficiary cannot locate a provider. Exception: See N.J.A.C. 10:49-14.2, Special Status programs.

2. A Medicaid provider who accepts a Medicaid beneficiary as a patient under the Medicaid program shall accept the program's policies and reimbursement for all covered services and/or items provided or delivered during that period when, by mutual agreement, the beneficiary is under the provider's care. In the provision of professional services, the provider shall be bound by the code of ethics governing his or her profession.

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

Amended section name; substituted "beneficiary" for "recipient" throughout; in (a)1, substituted "fee-for-service beneficiary" for "recipient"; and in (a)2, substituted "a Medicaid provider who accepts a Medicaid beneficiary as a patient under the Medicaid program" for "A provider who accepts a recipient for care".

10:49-9.4 Confidentiality of records

(a) All information concerning applicants and beneficiaries acquired under this program shall be confidential and shall not be released without the written consent of the individual or his or her authorized representative. If, because of an emergency situation, time does not permit obtaining consent before release, the program shall notify the individual, his or her family, or authorized representative, immediately after releasing the information.

(b) The restriction on the disclosure of information shall not preclude the release of statistical or summary data or information in which applicants or beneficiaries are not, and cannot be, identified; nor shall it preclude the exchange of information among providers furnishing services, Fiscal Agent of the program, and State or local government agencies, for purposes directly connected with administration of the program. Disclosure without the consent of the applicant or beneficiary shall be limited to purposes directly connected with the administration of the program in accordance with Federal and State law and regulations.

1. Purposes directly connected with the administration of the program shall include but are not limited to:

- i. Establishing eligibility;
- ii. Determining the amount of medical assistance;
- iii. Providing services for beneficiaries; and
- iv. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the program.

(c) The type of information about applicants and beneficiaries that shall be safeguarded by the program includes, but is not limited to:

1. Name and address;
2. Medical services provided;
3. Social and economic conditions or circumstances;
4. Program evaluations of personal information;
5. Medical data, including diagnosis and past history of disease or disability;
6. Any information received for verifying income eligibility and amount of medical assistance payments. Income information received from SSA or the Internal Revenue Service shall be safeguarded according to the requirements of the agency that furnished the data; and
7. Any information received in connection with the identification of legally liable third party resources as required under applicable Federal Regulations (42 C.F.R. 433.138).

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.

Case Notes

Disclosure of grand jury materials to government departments for use in civil proceedings requires strong showing of particularized need that outweighs public interest in grand jury secrecy. *State v. Doliner*, 96 N.J. 236, 475 A.2d 552 (1984).

Regulation cited as example of confidential record rule the invocation of which overrides the subpoena power of the Office of Administrative Law. *Hayes v. Gulli*, 175 N.J.Super. 294, 418 A.2d 295 (Ch.Div. 1980).

10:49-9.5 Provider certification and recordkeeping

(a) All program providers, except institutional, pharmaceutical, and transportation providers, shall be required to certify that the services billed on any claim were rendered by or under his or her supervision (as defined and permitted by program regulations); and all providers shall certify that the information furnished on the claim is true, accurate, and complete.

1. All claims for covered services must be personally signed by the provider or by an authorized representative of the provider (for example, hospital, home health agency, independent clinic) unless the provider is approved for electronic media claims (EMC) submission by the Fiscal Agent. The provider must apply to the Fiscal Agent for EMC approval and sign an electronic billing certificate.

i. The following signature types are unacceptable:

- (1) Initials instead of signature;
- (2) Stamped signature; and
- (3) Automated (machine-generated) signature.

(b) Providers shall agree to the following:

1. To keep such records as are necessary to disclose fully the extent of services provided, and, as required by N.J.S.A. 30:4D-12(d), to retain individual patient records for a minimum period of five years from the date the service was rendered;

2. To furnish information for such services as the program may request;

3. That where such records do not document the extent of services billed, payment adjustments shall be necessary;

4. That the services billed on any claim and the amount charged therefore are in accordance with the regulations of the New Jersey Medicaid program;

5. That no part of the net amount payable under any claim has been paid, except that all available third party liability has been exhausted, in accordance with program regulations; and

6. That payment of such amount, after exhaustion of third party liability, will be accepted as payment in full without additional charge to the Medicaid beneficiary or to others on his behalf.

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), deleted "form" following "furnished on the claim"; in (b)1, inserted ", and, as required . . . service was rendered"; and in (b)6, substituted "beneficiary" for "recipient".

10:49-9.6 Patient's (beneficiary) certification

(a) A beneficiary's certification, authorization to release information and payment request, shall, under ordinary circumstances, be signed after the services identified on the claim are provided and before a claim for payment is submitted by the provider. The beneficiary is:

1. Certifying that the service(s) covered by a claim has been received;
2. Requesting payment for those services made on his or her behalf; and
3. Authorizing any holder of medical or other information to release to New Jersey Medicaid or its authorized agents any information needed for this or a related claim.

(b) A provider who is submitting claims via an approved electronic media claims submission shall request a waiver to obtain the beneficiary or representative's certification on the standard Patient Certification (Form FD-197) which the provider shall keep on file for each service rendered and shall make available upon request to representatives of the New Jersey Medicaid program. Initials instead of a signature are unacceptable on the Patient Certification Form.

1. If a signed Patient Certification Form is not on file for each service, Medicaid reimbursement for the service shall be subject to recoupment.

(c) A provider who is submitting a hard-copy Medicaid claim shall, under ordinary circumstances, obtain the beneficiary's certification on the Medicaid hard-copy claim (appropriate to the provider), unless a waiver is requested to use the standard Medicaid Patient Certification (Form FD-197, see Appendix, N.J.A.C. 10:49). A waiver application may be obtained from the fiscal agent.

(d) For certain providers, an individualized certification form, as indicated in the specific service chapter of the appropriate provider manual, may be used in place of the standard Medicaid Patient Certification (Form FD-197).

(e) A Medicaid hard-copy claim or a Patient Certification Form shall be completed by a provider before it is presented to the beneficiary for signature. A Medicaid beneficiary may not sign a blank Medicaid hard-copy claim or a Patient Certification Form prior to receiving services or as a condition for receiving services.

(f) When the beneficiary's signature is unobtainable, the following procedures may be used:

1. An illiterate beneficiary may make his or her mark (x), and the mark shall be witnessed by another person who signs his or her name and address on the Patient Certification Form (FD-197) or on the Medicaid hard-copy claim.

2. If a beneficiary is physically or mentally incapable of signing, or is deceased, the form(s) may be signed on his or her behalf by:

- i. A parent;
- ii. A legal guardian;
- iii. A relation;
- iv. A friend;
- v. An individual provider;
- vi. A representative of an institution providing care or support;
- vii. A representative of a governmental agency providing assistance; or
- viii. An administrator or executor.

3. A brief explanation of the reason the beneficiary was not personally able to sign the form(s) and the relationship of the signee to the beneficiary shall be noted directly on the Medicaid hard-copy claim or the Patient Certification Form (FD-197).

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

Amended section name; substituted "beneficiary" and "beneficiary's" for "recipient" and "recipient's" throughout and deleted "form" following "claim" throughout.

Case Notes

Recoupment of claims made for prescriptions warranted. Plains Pharmacy, Inc. v. DMAHS, 93 N.J.A.R.2d (DMA) 121.

10:49-9.7 Integrity of the Medicaid program; gifts/gratuities prohibited

The New Jersey Medicaid program, in order to maintain the integrity of the program, strictly prohibits its employees from accepting gifts or gratuities of any kind and of any value from individuals, representatives of provider organizations or institutions who provide services and are reimbursed through the program. This includes the prohibition of offers of special employment, consultation fees and all other gratuities by a provider, individual or facility.

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

10:49-9.8 Fraud and abuse

The New Jersey Medicaid program shall employ methods to identify situations in which a question of fraud and/or abuse in the program may exist. The Division shall refer to law enforcement officials situations in which there is valid reason to suspect that fraud has or may have been committed.

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

10:49-9.9 Informing individuals of their rights

(a) All claimants shall be informed of the following, in writing, at the time of application and at the time of any action affecting their claim:

1. Of their right to a fair hearing;
2. Of the method by which they may obtain a hearing;
3. That they may be represented by legal counsel or by a relative, friend, or other spokesperson, or they may represent themselves; and
4. Of legal services within the community from which they may receive legal aid.

10:49-9.10 Provisions for appeals; fair hearings

(a) Pursuant to N.J.A.C. 10:49-10, Fair Hearings, both providers and Medicaid beneficiaries with the New Jersey Medicaid program 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 beneficiary may be granted a hearing because 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.

(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".

SUBCHAPTER 10. NOTICES, APPEALS AND FAIR HEARINGS

10:49-10.1 Definitions

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

"Applicant" means any person who has made application for purpose of becoming a "qualified applicant."

"Claimant," when used within these rules, means applicant, qualified applicant or beneficiary as defined in this section.

"Notice" means an announcement of a policy decision by the Title XIX agency that may adversely affect the Medicaid beneficiary.

"Qualified applicant" means any person who is determined to be eligible to receive benefits in accordance with N.J.S.A. 30:4D-1 et seq. and amendments thereto.

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

Amended "Claimant" and "Notice"; and deleted "Department", "Provider", and "Recipient".

Case Notes

Indictment and subsequent conviction of provider for Medicaid fraud provided good cause for suspension of license and eventual debarment. Division of Medical Assistance v. A & H Medical, 95 N.J.A.R.2d (DMA) 43.

10:49-10.2 Notices

(a) The New Jersey Medicaid program may print a notice of prospective policy changes affecting Medicaid beneficiaries or providers generally in one or more newspapers in New Jersey.

1. This public notice will be accompanied by a proposed rulemaking on the subject of the notice in the New Jersey Register.

2. The public notice may precede or be subsequent to the Register publication.

3. The Department of Human Services, or the Department of Health and Senior Services where authorized by Reorganization Plan No. 001-1996, may proceed to adopt the regulatory changes pursuant to N.J.S.A. 52:14B-4 without providing further notice.

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 "New Jersey Medicaid program" for "Department/Division" and "beneficiaries or providers" for "recipients"; and in (a)3, inserted reference to Department of Health and Senior Services.

10:49-10.3 Opportunity for fair hearing

(a) An opportunity for a fair hearing may be granted to any provider requesting a hearing on any valid complaint or issue arising out of the Medicaid claims payment process:

1. Such issues shall include, but not be limited to, denials of prior authorization and denial of claims submitted for payment.

2. Such requests for hearing shall be made in writing within 20 days from the date of the notice of the agency action giving rise to said complaint or issue.

3. For claim denial or payment adjustment, the 20 days' notice starts from the date in the right hand corner of the Remittance Advice Claims Status returned to providers with the Remittance Advice cover page (see the Fiscal Agent Billing Supplement following the second chapter of each Providers Services Manual regarding the Remittance Advice cover page and Claims Status explanations and examples). Providers should include a photocopy of the applicable Claims Status page, highlighting the beneficiary and applicable edit code(s) when submitting a hearing request.

(b) An opportunity for fair hearing shall be granted to all claimants requesting a hearing because their claims for medical assistance are denied or are not acted upon with reasonable promptness, or because they believe the Medicaid Agent has erroneously terminated, reduced or suspended their assistance. The Medicaid Agent need not grant a hearing if the sole issue is one of a Federal or State law requiring an automatic termination, reduction or suspension of assistance affecting some or all claimants. Under this requirement:

1. A request for hearing shall be defined as any clear expression (submitted in writing) by claimants (or someone authorized to act on behalf of claimants) to the effect that they desire the opportunity to present their case to higher authority;

2. The freedom to make such a request shall not be limited or interfered with in any way, and Medicaid Agent emphasis shall be on helping claimants to submit and process their case if needed;

3. Claimants shall have 20 days from the date of notice of Medicaid Agent action in which to request a hearing;

4. The fair hearing shall include consideration of:

i. Any Medicaid Agent action, or failure to act with reasonable promptness, on a claim for medical assistance, which includes undue delay in reaching a decision on eligibility, suspension of assistance or denial of such assistance in whole or in part;

ii. Medicaid Agent's decision regarding:

(1) Eligibility for medical assistance in both initial and subsequent determinations;

(2) Amount of medical assistance or change in such assistance;

5. The Medicaid Agent may respond to a series of individual requests for fair hearings by arranging for a single group hearing. A consolidation of cases by the Medicaid Agent may be allowed only in cases which the sole issue involved is one of Federal or State law or policy;

6. In all group hearings, whether initiated by the Medicaid Agent or by claimants, the policies governing fair hearings shall be followed. Thus, each individual claimant shall be permitted to present his or her own case and be represented in accordance with the provisions of N.J.A.C. 10:49-9.9 (a) 3; and

7. The Medicaid Agent shall not deny or dismiss a request for a hearing except where it has been withdrawn by claimant in writing or abandoned.

(c) For purposes of these rules, the right to a hearing is considered abandoned if claimants or their representative fail to appear at a scheduled hearing and, within five days after receipt of an inquiry as to whether they desire any further action on their request, no reply is received. Refusal of acceptance of a registered letter inquiring into contemplated further action by claimants shall constitute abandonment effective the date of refusal.

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 "Medicaid" preceding "claims payment"; in (a)3, substituted "beneficiary" for "recipient"; in (b), substituted reference to Medicaid Agent for references to agency and department throughout.

Case Notes

Opportunity for prompt posttermination hearing provided physician in connection with termination of his right to participate in state medical assistance program satisfied due process. (also cited as N.J.A.C. 10:49-63). *Greenspan v. Klein*, 442 F.Supp. 860 (D.N.J.1977), (See *Greenspan v. Klein*, 550 F.2d 856 (3rd Cir.1977).

10:49-10.4 Advance notice of intent to terminate, reduce, or suspend assistance

(a) In cases of any proposed action to terminate, reduce or suspend assistance, the Medicaid Agent shall give the claimant timely and adequate notice detailing the reasons for the proposed action. Under these requirements:

1. "Timely" means that the notice is dated at least 10 days before the action is to be taken; and

2. "Adequate advance notice" means a written notice that includes a statement of the action the Medicaid Agent intends to take, reasons for the proposed departmental action, the specific regulations that support, or the change in Federal or State law that requires the action, the claimant's right to request a fair hearing, or in 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 promptly informs the claimant in writing that services shall be terminated or reduced pending the hearing decision.

2. If the Medicaid Agent's action is sustained by the hearing decision, the Medicaid Agent 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 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 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 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.

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.

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 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.

(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 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.

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

The Medicaid Agent 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".

SUBCHAPTER 11. EXCLUSION FROM PARTICIPATION IN THE NEW JERSEY MEDICAID PROGRAM (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 program by rules and regulations set forth in N.J.S.A. 30:4D–5, and by N.J.S.A. 30:4D–17.1a and c, and Reorganization Plan No. 001–1996.

(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 program, or in projects or contracts performed with the assistance of and subject to the approval of the Medicaid Agent, 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 program and not for punishment. To assure the New Jersey Medicaid program 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 program.

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 Program for any reason shall not be involved in any activity relating to the New Jersey Medicaid Program.

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 program.

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

4. The above policy shall apply only for the period during which such individuals are suspended, debarred or disqualified from Medicaid participation.

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

“Affiliates” means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

“Debarment” means an exclusion from State contracting, on the basis of a lack of responsibility evidenced by an offense, failure or inadequacy of performance, for a reasonable period of time commensurate with the seriousness of the offense, failure or inadequacy of performance.

“Disqualification” means a debarment or a suspension which denies or revokes a qualification to bid or otherwise engage in State contracting which has been granted or applied for pursuant to statute, or rules and regulations.

“Person” means any natural person, company, firm, association, corporation or other entity.

“State” means the State of New Jersey or any of the departments or agencies in the executive branch of government with the lawful authority to engage in contracting.

“State contracting” means any arrangement giving rise to an obligation to supply anything to or perform any service for the State, other than by virtue of State employment, or to supply anything to or perform any service for a private person where the State provides substantial financial assistance and retains the right to approve or disapprove the nature or quality of the goods or service or the persons who may supply or perform the same.

“Suspension” means an exclusion from State contracting for a temporary period of time, pending the completion of an investigation or legal proceedings.

(d) Any of the following, among other things, shall constitute a good cause for suspension, debarment, or disqualification of a person engaged in State contracting, as defined herein, by the Medicaid Agent:

1. Commission of a criminal offense as an incident to obtaining or attempting to obtain a public or private contract, or subcontract thereunder, or in the performance of such contract or subcontract;

2. Violation of the Federal Organized Crime Control Act of 1970, or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, perjury, false swearing, receiving stolen property, obstruction of justice or any other offense indicating a lack of business integrity or honesty;

3. Violation of the Federal or State antitrust statutes, or of the anti-kickback provisions of the Social Security Act at 42 U.S.C. § 1320 a–7b (b), subject to the exceptions set forth in 42 C.F.R. 1001.952;

4. Violations of any of the laws governing the conduct or elections of the State of New Jersey or of its political subdivisions;

5. Violation of the "Law Against Discrimination" (N.J.S.A. 10:5-1 et seq.), or of the "Act Banning Discrimination in Public Works Employment" (N.J.S.A. 10:2-1 et seq.) or of the "Act Prohibiting Discrimination by Industries Engaged in Defense Work in the Employment of Persons Therein" (N.J.S.A. 10:1-10 et seq.);

6. Violations of any laws governing hours of labor, minimum wage standards, prevailing wage standards, discrimination in wages, or child labor;

7. Violations of any laws, regulations or code of ethics governing the conduct of occupations or professions or regulated industries;

8. Willful failure to perform in accordance with contract specifications or within contractual time limits;

9. A record of failure to perform or of unsatisfactory performance in accordance with the terms of one or more contracts, provided that such failure or unsatisfactory performance has occurred within a reasonable time preceding the determination to debar and was caused by acts within the control of the person debarred;

10. Violations of contractual or statutory provisions regulating contingent fees;

11. Presentment for allowance or payment of any false or fraudulent claim for services or merchandise;

12. Submitting false information for the purpose of obtaining greater compensation than that to which the person is legally entitled;

13. Submitting false information for the purpose of obtaining authorization requirements;

14. Failure to disclose or make available to the Medicaid Agent or its authorized agent, records of services provided to or payments made on behalf of Medicaid beneficiaries;

15. Failure to provide and maintain quality services to Medicaid beneficiaries within accepted medical community standards as adjudged by a body of peers;

16. Engaging in a course of conduct or performing an act deemed improper or abusive of the New Jersey Medicaid program following notification that said conduct should cease;

17. Breach of the terms of the Medicaid provider agreement entered into with the Medicaid Agent for failure to comply with the terms of the provider certification on the Medicaid claim;

18. Overutilizing the New Jersey Medicaid program by inducing, furnishing or otherwise causing an individual to receive service(s) or merchandise not otherwise required or requested by the beneficiary;

19. Rebating or accepting a fee or portion of a fee or charge for a Medicaid beneficiary referral;

20. Violating any provision of N.J.S.A. 30:4D-1 et seq. (New Jersey Medical Assistance and Health Services Act) as amended, or any rule or regulation promulgated by the Commissioner of Human Services or the Commissioner of Health and Senior Services pursuant thereto;

21. Conviction of any crime involving moral turpitude;

22. Submission of a false or fraudulent application for provider status to the Program or to its Fiscal Agent;

23. Any other cause affecting responsibility as a State contractor of such serious and compelling nature as may be determined by the Medicaid Agent to warrant debarment, including such conduct as may be proscribed by the laws or contracts enumerated in this subsection, even if such conduct has not been or may not be prosecuted as violations of such laws or contracts;

24. Debarment by some other department or agency in the executive branch;

25. Suspension, debarment, disqualification or exclusion from participation in the Medicaid program of another state; or

26. Suspension or exclusion from participation in the delivery of medical care or services under Title XVIII, XIX or XX of the Federal Social Security Act by the Secretary of the United States Department of Health and Human Services.

(e) Conditions for debarment shall be as follows:

1. Debarment shall be made only upon approval of the Director of the Division, except as otherwise provided by law.

2. The existence of any of the causes set forth in (d) above, shall not necessarily require that a person be debarred. In each instance, the decision to debar shall be made within the discretion of the Director of the Division unless otherwise required by law, and shall be rendered in the best interests of the Program.

3. All mitigating factors shall be considered in determining the seriousness of the offense, failure or inadequacy of performance and in deciding whether debarment is warranted.

4. The existence of a cause set forth in (d)1 through 7 above shall be established upon the rendering of a final judgment or conviction by a court of competent jurisdiction or by an administrative agency empowered to render such judgment. In the event an appeal taken from such judgment or conviction results in reversal thereof, the debarment shall be removed upon the request of the debarred person unless other cause for debarment exists.

5. The existence of a cause set forth in (d)8, 9, 10 and 23 above shall be established by evidence which the Medicaid Agent or agency determines to be clear and convincing in nature.

6. The existence of a cause set forth in (d)1 through 7, 11 through 22, and 24 above shall be established by a preponderance of the believable evidence.

7. Debarment for the cause set forth in (d)24 above shall be proper, provided that one of the causes set forth in (d)1 through 23 above was the basis for debarment by the original debarring agency. Such debarment may be based entirely on the record of facts obtained by the original debarring agency, or upon a combination of such facts and additional facts.

(f) If the Medicaid Agent seeks to debar a person or his or her affiliates, the Medicaid Agent shall furnish such party with a written notice stating that debarment is being considered, setting forth the reasons for the proposed debarment and indicating that such party will be afforded an opportunity for a hearing if he or she so requests within a stated period of time. All such hearings shall be conducted in accordance with the provisions of the Administrative Procedure Act. However, where one department or agency has imposed debarment upon a party, a second department or agency may also impose a similar debarment without affording an opportunity for a hearing, provided that the second agency furnishes notice of the proposed similar debarment to that party and affords that party an opportunity to present information in his or her behalf to explain why the proposed similar debarment should not be imposed in whole or in part.

(g) Debarment shall be a reasonable, definitely stated period of time which as a general rule shall not exceed five years. Debarment for an additional period shall be permitted provided that notice thereof is furnished and the party is accorded an opportunity to present information in his or her behalf to explain why the additional period of debarment should not be imposed.

(h) Scope of debarment rules shall be as follows:

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 program, 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 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, such action is necessary to protect the public welfare and the interests of the medical assistance 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 rendered in the best interests of the New Jersey Medicaid program.

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 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 may suspend a person or his affiliates provided that within 10 days after the effective date of the suspension, the Medicaid Agent 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 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 are 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, 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 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, 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. 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 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 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".

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

Indictment and subsequent conviction of provider for Medicaid fraud provided good cause for suspension of license and eventual debarment. Division of Medical Assistance v. A & H Medical, 95 N.J.A.R.2d (DMA) 43.

Suspension pending resolution of criminal proceedings of Medicaid program livery transporter was proper. Division of Medical Assistance and Health Services v. Ahmed, 94 N.J.A.R.2d (DMA) 31.

It was proper to suspend physician from participation in Medicaid program pending outcome of criminal proceeding. Joachim v. DMAHS, 93 N.J.A.R.2d (DMA) 110.

Physician permanently disqualified due to engagement in illegal kickback scheme. Scollo v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 23.

Division alone could suspend provider's participation in Medicaid for crime of possession of controlled dangerous substance and possession with intent to distribute. (Director's Final Decision). Div. of Medical Assistance and Health Services v. Kares, 8 N.J.A.R. 517 (1983).

Suspension of provider privileges upon indictment involving moral turpitude affirmed pending conclusion of proceedings. (Director's Final Decision). Div. of Medical Assistance and Health Services v. Rednor, 5 N.J.A.R. 430 (1981).

Suspension of Medicaid provider reserved as indicated crime (unauthorized wiretap) does not constitute a crime of moral turpitude. (Division's Final Decision). Div. of Medical Assistance and Health Services v. Dalglish, 3 N.J.A.R. 23 (1981), affirmed Dfk. No. A-4941-79 (App.Div.1982).

SUBCHAPTER 12. PROVIDER REINSTATEMENT

10:49-12.1 Definitions

As used in this subchapter, the following words shall have the following meanings, unless the context clearly indicates otherwise:

"Committee" means the Provider Reinstatement Committee.

"Person" means any natural person, company, firm, corporation, professional association, partnership, or other entity, who has been excluded from participation in the New Jersey Medicaid program.

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

Amended "Committee" and "Person"; and deleted "Director" and "Division".

10:49-12.2 Requests for reinstatement

Persons who have been debarred, disqualified or suspended from participating in the New Jersey Medicaid program shall petition the Director for reinstatement in writing.

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

Deleted reference to programs administered by the Division.

10:49-12.3 Petition by debarred, disqualified or suspended person

(a) Persons debarred or disqualified for a definitely stated period of time may petition the Director for reinstatement 90 days prior to the expiration of the period of debarment or disqualification.

(b) Persons disqualified for an indefinitely stated period of time may petition the Director for reinstatement after a disqualification period of eight years.

(c) Persons who have been suspended, debarred or disqualified as the result of an indictment, conviction or license revocation may immediately petition the Director for rein-

statement upon acquittal, reversal of the conviction upon appeal or restoration of the license, whichever is applicable.

10:49-12.4 Director's powers

The Director may on his or her own motion order the reinstatement of debarred, disqualified or suspended persons or may refer the matter to the Provider Reinstatement Committee.

10:49-12.5 Provider Reinstatement Committee

(a) The Provider Reinstatement Committee shall be a non-standing committee that is convened for the purpose of evaluating requests for reinstatement.

1. The Committee shall be composed of three impartial officials of the New Jersey Medicaid program appointed by the Director.

i. The Committee members shall not have been directly involved in the debarment, disqualification or suspension of persons requesting reinstatement.

ii. The Chairperson of the Committee shall be an attorney from the Office of Legal and Regulatory Liaison/Division of Medical Assistance and Health Services.

iii. Whenever possible, the associate members of the Committee shall be one member of the Medicaid Agent staff from the same discipline as the debarred, disqualified or suspended persons and one member from the general administrative staff of the Division.

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

In (a)1 substituted "New Jersey Medicaid program" for "Division"; in (a)1i, deleted "Under this requirement," preceding "The committee"; and in (a)1iii, substituted "Medicaid Agent" for "Division".

10:49-12.6 Criteria for reinstatement

(a) Reinstatement will not be granted unless it is reasonably certain that the causes which led to the debarment, disqualification or suspension shall not be repeated. In determining a person's fitness for reinstatement, the Committee and the Director may consider, among other factors:

1. Statements from debarred, disqualified or suspended persons setting forth the reasons why they should be reinstated;

2. Statements from private health insurers, indicating whether there have been any questionable claims submitted during the period of exclusion from Program participation;

3. Statements from peer review bodies, probation or parole officers or professional associates, attesting to their belief, supported by facts, that the causes which led to the debarment, disqualification or suspension shall not be repeated;

4. The absence of any pending criminal, licensing, or professional disciplinary proceedings;

5. Full restitution and the payment of any criminal fines imposed;
6. Full satisfaction of any civil penalties imposed;
7. Full satisfaction of interest payments;
8. Compliance with the terms and conditions of Consent Orders or Court Orders; and
9. Satisfaction of any conditions or requirements previously imposed by the Medicaid program.

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)9 substituted "Medicaid program" for "Division".

Case Notes

A disqualified Medicaid provider must apply for reinstatement and satisfy all requirements of subchapter. Div. of Medical Assistance and Health Services v. Kares, 8 N.J.A.R. 517 (1983).

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

10:49-12.7 Committee procedures

(a) The Committee shall meet at the Division's central offices.

(b) Persons requesting reinstatement and/or their representative shall be notified, in writing, as to the time, date and place of the meeting.

(c) All correspondence concerning the meeting shall be directed to the Chairperson of the Committee.

(d) Persons requesting reinstatement may appear on their own behalf or be represented by counsel.

(e) The Committee shall be governed by the New Jersey Administrative Procedure Act concerning admissibility of evidence at the meeting.

(f) The Chairperson of the Committee shall rule on all procedural questions and objections that may be raised at the meeting.

(g) Persons requesting reinstatement shall have the burden of providing their fitness for reinstatement by a preponderance of the evidence.

(h) Persons may present evidence of their fitness for reinstatement by the testimony of witnesses under oath or by documentary evidence, or both.

(i) After reviewing the testimony and documentation presented, the Committee shall prepare a written report which discusses the testimony, contains findings of facts and recommended disposition.

(j) At least two members of the Committee shall concur in the recommended disposition.

(k) Copies of the Committee's report shall be sent to all parties at the meeting. Upon receipt of the Committee's report, the parties shall have the opportunity to submit written objections or exceptions to said report within the time period specified by the committee.

(l) After the expiration of the time period prescribed for the filing of the exceptions, the Committee's report, exceptions or objections thereto, evidence and any transcripts shall be forwarded to the Director.

(m) The Director in consultation with the Commissioner of Health and Senior Services, where appropriate, shall have final decisional authority and may adopt, reverse or modify the Committee's recommended determination. The Director may also, for cause, remand the matter back to the Committee for further testimony.

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

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

In (m), inserted reference to consultation with Commissioner.

SUBCHAPTER 13. PROGRAM CONTROLS

10:49-13.1 Medical review and evaluation

Under the provisions of Federal and State law, the Medicaid Agent shall provide continuing review and evaluation of the care and services provided under the Program. This includes review of utilization of services of practitioners and other providers.

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 "Division of Medical Assistance and Health Services".

10:49-13.2 Audits

(a) A field audit shall be subject to the following:

1. "Completion of the field audit" for nursing facility providers for purposes of N.J.S.A. 30:4D-17(f) shall be defined in the following manner:

i. For all such audits and audit recovery cases pending on March 1, 1983, it shall mean the date that field work is completed, or the date information requested from the provider during the course of that field work is received, whichever is later.

ii. For all such audits and audit recovery cases pending on March 1, 1983, which are, have been or will be referred either to the Legal Action Committee, or to the Division of Criminal Justice or other agency for criminal investigation, it means the date the Office of Quality Management and Program Integrity (OQMPI) receives authorization to take administrative action.

iii. For all such audits initiated on or after March 1, 1983, it means the date the exit conference is completed or the date information requested from the provider during the course of the exit conference is received, whichever is later.

2. "Completion of the field audit" for all other providers for purposes of N.J.S.A. 30:4D-17(f) shall be defined in the following manner:

i. For all such audits and audit recovery cases pending on March 1, 1983, it means the date of final screening of the case file by the Assistant Director, OQMPI or, if the case is referred to the Legal Action Committee or the Division of Criminal Justice, the date OQMPI receives authorization to take administrative action;

ii. For all such audits initiated on or after March 1, 1983, it means the date of final screening of the case file by the Assistant Director, OQMPI.

3. Notwithstanding any of the previous subsections, if after the screening of any provider audit initiated on or after March 1, 1983, the Assistant Director, OQMPI, determines with reasonable justification that an act or omission on the part of the provider requires additional field work, the field audit shall be considered completed when the additional field work is completed.

4. Notwithstanding any of the previous subsections, if after the screening of any provider audit initiated on or after March 1, 1983, the Assistant Director, OQMPI, determines with reasonable justification that an act or omission on the part of the provider requires that additional information or documentation be obtained from the provider, then a completed field audit shall be considered reopened and interest shall again accrue for the period beginning 20 days from the date the request for such information or documentation is received by the provider and ending on the date that all of the requested information or documentation is received by the agency making the request.

5. Notwithstanding any of the previous paragraphs, if all or part of any provider audit initiated on or after March 1, 1983, is referred to the Division of Criminal Justice or other agency for criminal investigation:

i. In the event no criminal action results from the referral the field audit shall be considered completed one year from the date the decision was made to refer the matter for criminal investigation; and

ii. In the event criminal action does result from the referral, the field audit shall be considered completed on the date OQMPI receives authorization to take administrative action.

(b) "Final audit," for purposes of N.J.S.A. 30:4D-7m only, means that point in the audit process when the Division issues to the provider an audit report specifically

designated as the "final audit" for a specified period audited.

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

Case Notes

Audit pending on effective date of regulation comes within purview of regulation. *Bridgeton Nursing Center, Inc. v. Div. of Medical Assistance and Health Services*, 8 N.J.A.R. 217 (1983), affirmed per curiam Dkt. No. A-165-83 (App.Div.1984).

SUBCHAPTER 14. RECOVERY OF PAYMENTS AND SANCTIONS

10:49-14.1 Recovery of payments correctly made

(a) Correctly paid benefits shall only be recoverable from the estate of an individual who was 65 years of age or older when he or she received medical assistance if:

1. The individual leaves no surviving spouse;
2. For estates coming into being between February 1984 and October 20, 1992, the individual leaves no surviving child;
3. For estates coming into being on or after October 21, 1992, the individual leaves no surviving child who is under the age of 21 or any surviving blind or permanently and totally disabled children;
4. The amount to be recovered is in excess of \$500.00; and
5. The gross estate is in excess of \$3,000.

(b) Paragraphs (a)4 and 5 above shall apply to recoveries from the estates of individuals who died on or after July 20, 1981, the effective date of P.L. 1981, c.217 (N.J.S.A. 30:4D-7.2a).

Amended by R.1994 d.524, effective October 17, 1994.
See: 26 N.J.R. 2757(a), 26 N.J.R. 4184(b).

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 beneficiary(s) listed on the Medicaid Eligibility Identification (MEI) 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 card is issued, a message will be printed on the card alerting the provider

to ask the Medicaid beneficiary for additional identification or to take other appropriate action.

1. The restrictive card is issued to Medicaid beneficiaries determined to have misused, abused or overutilized their Medicaid benefits. Overutilization occurs when a beneficiary has utilized Medicaid 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 and forgery or alteration of prescriptions. A determination that there has been misuse, abuse or overutilization of benefits obtained by use of an MEI Card shall create a presumption that the beneficiaries listed on the MEI Card were responsible for such actions. If this presumption is successfully rebutted by the Medicaid 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 is evident.

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 card is issued to Medicaid beneficiaries determined to have had their MEI Card used by an unauthorized person or persons, or for an unauthorized purpose. The purpose of the warning card is to notify providers that the beneficiary's MEI Card has been used by an unauthorized person or persons, or for an unauthorized purpose. A message will be printed on the card alerting the provider to ask the Medicaid beneficiary for additional identification or to take other appropriate action. A determination that an MEI Card has been used by an unauthorized person or for an unauthorized purpose shall create a presumption that the beneficiaries listed on the MEI Card were responsible for such actions. If this presumption is successfully rebutted by the beneficiary, the beneficiary shall not be issued a warning card.

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.

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 Quality Management and Program Integrity; 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.

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 county welfare agencies

(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 Verification System (IEVS), the case shall be referred by the CWA to DMAHS for possible initiation of recovery proceedings.

3. When in any other case not generated by IEVS, recovery cannot be obtained by these methods, the CWA is authorized after securing DMAHS approval to initiate recovery proceedings as DMAHS' agent. If the CWA does not initiate such recovery proceedings, it shall refer the case to DMAHS for possible initiation of recovery proceedings.

4. When collection occurs in a case involving both cash assistance and medical assistance, the CWA shall, in the absence of court instruction to the contrary, apply the proceeds to the repayment of cash assistance and the reimbursement of DMAHS for medical assistance. The reimbursement shall be made payable to the Treasurer, State of New Jersey, which shall then reimburse the CWA in the amount of 25 percent of the gross recovery on a periodic basis to be determined by DMAHS.

5. When a CWA recovers only for medical assistance improperly granted, the CWA shall remit the proceeds to DMAHS. The reimbursement shall be made payable to the Treasurer, State of New Jersey, who will then reimburse the CWA in the amount of 25 percent of the gross recovery on a periodic basis to be determined by DMAHS.

6. When any CWA action, whether alone or in combination with DMAHS, results in a recovery of improperly granted medical assistance from a case generated by the Internal Revenue Service (IRS) unearned income component of the IEVS match, all funds recovered shall be remitted to DMAHS payable to the Treasurer, State of New Jersey, which shall then reimburse the CWA in the amount of 25 percent of the gross recovery on a periodic basis to be determined by DMAHS.

(c) The following pertain to third party liability claims in tort actions:

1. Whenever either a CWA or DMAHS learns of a situation in any case in which the other may have a claim it will notify the other.

2. Unless the individual case circumstances intervene, the first claim after settlement or judgment is for any payments by New Jersey Medicaid program arising from the occurrence notwithstanding any CWA claim for recovery of cash assistance. The next claim is that which the CWA may assert in accordance with an agreement to repay or similar document. The DMAHS and the CWA will, insofar as their controls allow, maintain priority of payment in the above order.

(d) The following pertain to liquidation of potential resources:

1. The CWA will participate in the liquidation of potential resources according to the Program requirements under which eligibility has been established, regardless of whether cash assistance is being granted. Notification of the potential resource to be liquidated shall be forwarded to DHSS, enabling it to seek a voluntary contribution. Sale of real property to which title is held by a CWA is subject to DFD approval in all instances regardless of the proposed distribution of the proceeds.

2. All funds arising from the liquidation of resources and which, by action of law, regulation, or agreement with the owner, fall under the jurisdiction of either a CWA or DHSS for distribution will, insofar as possible, be allocated as follows:

i. Proceeds will be first applied to the cash costs of liquidation, such as advertising costs and filing fees but not including costs such as CWA staff time, supplies, counsel fees or overhead.

ii. Proceeds will be next applied to any claims superior to that of the CWA (for example, taxes).

iii. Proceeds will be next applied to any funds owing to and collectible by the CWA.

iv. Any residue remaining after the above payments are allocated would, in the absence of circumstances to the contrary, be the property of the client and thereby subject to (d)3 below.

3. All funds properly belonging to a client free of any agency claim are to be remitted to the client as promptly as possible or otherwise disbursed at the client's instruction. The CWA will promptly reevaluate eligibility following such distribution, taking into consideration any voluntary repayment to New Jersey Medicaid program.

(e) The following pertains to recovery from estates of deceased beneficiaries:

1. The CWA shall normally undertake recovery activity as agent for DMAHS in any case in which the CWA is or will be undertaking activities on its own account. However, in those cases where the recovery of medical assistance is possible and where the entire CWA claim is for burial expenses only, DMAHS shall initiate recovery activity inclusive of CWA burial costs. DMAHS may, in certain cases, assume direct jurisdiction in recovery of its claim concurrent with CWA activity. DMAHS shall make the CWA aware of its activity in such cases.

2. CWA recoveries and distribution shall be in accord with the following procedures:

i. From the proceeds of liquidation, the CWA shall first recover the amount necessary to satisfy its own claim, including costs of liquidation and the claims of other New Jersey CWAs. The CWA shall recover

funds from the clearing account in the order in which the funds were received in the clearing account. If any part of any remaining surplus has been received from the proceeds of assigned life insurance for which there was a named beneficiary other than the client's estate, that surplus or the policy benefit, whichever is less, is the property of the beneficiary and should be so directed.

ii. All other surplus funds are part of (or the entire) the client's estate and are payable to the legally designated representative of the estate. If the representative of the estate is unknown or if no representative has been appointed and there are no known next of kin, the CWA shall forward to the DMAHS an amount not to exceed the amount of the proper medical assistance claim as determined by communication with the Administrator, Bureau of Administrative Control, DMAHS. Any remaining funds will escheat to the State of New Jersey.

iii. When there are known next of kin, the CWA shall request the next of kin to take appropriate legal action to be appointed administrator if the amount to be disbursed is greater than the claim of the New Jersey Medicaid program. If the claim of the New Jersey Medicaid program will equal or exceed the estate, the CWA shall request the next of kin to sign a consent to transfer his or her rights to the New Jersey Medicaid program and, upon receipt of such signed consent, the CWA shall forward the funds to DMAHS.

iv. When the next of kin will not sign a consent to transfer his or her right to the Medicaid Agent and will not file to become the administrator, the CWA may, at its option, arrange for someone to file to become administrator or the CWA may refer the information to DMAHS for action.

v. In any questions or dispute among two or more claimants on surplus funds, the CWA shall withhold payment pending resolution by mutual consent of all claimants or by court order.

3. The Medicaid Agent recoveries and distribution shall be in accordance with the following procedures:

i. DMAHS shall undertake recovery activity in medical assistance payment cases in which no CWA shall be submitting a claim. However, should information from the CWA be necessary to such DMAHS activity, the CWA shall communicate with DMAHS, supplying such material as may be required.

ii. In cases in which DMAHS is acting for a CWA in collection of burial expenses, DMAHS shall accord payment of the burial claim priority over its own recovery.

(f) The CWA may at any time accept an offer of voluntary repayment, either on its own behalf or on behalf of the New Jersey Medicaid program, up to but not in excess of the amount of assistance granted. To any inquiry as to amount granted, the CWA shall supply the appropriate information, identifying the respective amounts granted by the CWA and the Medicaid Agent. In the absence of instruction from the payer, the CWA will reimburse cash assistance first and then remit any balance to DHSS.

1. Compromise settlements of medical assistance are subject to DHSS approval.

(g) Regarding compromise settlements:

1. Compromise settlements of cash assistance are subject to DFD approval.

2. Compromise settlements of medical assistance are subject to DMAHS approval.

(h) This section shall apply to all pending and future recovery cases, except that:

1. The 25 percent incentive payments provided for in (b)4 and 5 above shall apply to all non-IEVS incorrect payment recoveries received by the CWA on or after July 1, 1993.

2. Paragraph (b)6 above applies to all IEVS-related recoveries received on or after July 1, 1989 by either DMAHS or the CWA, whichever agency is handling the recovery.

Amended by R.1995, d.105, effective June 19, 1995.

See: 26 N.J.R. 3348(a), 27 N.J.R. 2466(a).

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 and deleted Division references and substituted "New Jersey Medicaid program" and "Medicaid Agent" for "DMAHS" throughout; and added (f)1.

10:49-14.5 Administrative charges/service fees

(a) A provider shall not pay nor require payment of an administrative charge or service fee for the privilege of doing business with another provider or for services for which reimbursement is included as part of the Medicaid fee.

1. An example of a prohibited practice is that a nursing facility may not require a pharmacy to pay an administrative charge or service fee to the facility for handling of the nursing facility resident's medications, drugs and/or related pharmaceutical records.

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

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

Deleted (a)2.

10:49-14.6 Contracts with county welfare agencies

Payment shall be made by the Department of Human Services/ Division of Medical Assistance and Health Services to county welfare agencies for conducting investigations and for determining whether applicants qualify for benefits under the New Jersey Medicaid program.

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

SUBCHAPTER 15. AVAILABILITY AND MAINTENANCE OF PROGRAM POLICY ISSUANCES

10:49-15.1 Maintenance of public policy issuances

Program manuals and other policy issuances which affect the public, including the Medicaid Agent's rules and regulations governing eligibility, need and amount of assistance, beneficiary's rights and responsibilities, and services offered by the Medicaid Agent, shall be maintained in the State or Division Central Office and in each Medicaid District Office for examination during regular workdays and regular office hours by individuals, and upon request, for study or reproduction by such individuals. These manuals and other policy issuances are also distributed to entities which serve as custodians such as the State Library, CWAs, and regional legal services offices.

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 Division and agency, and inserted reference to Division Central Office.

10:49-15.2 Availability of material

(a) In order to facilitate public access, a current copy of material described in N.J.A.C. 10:49-15.1 shall be made available without charge to custodians who request the material for this purpose.

(b) Custodians shall meet the following requirements:

1. They shall be centrally located and publicly accessible to a substantial number of the beneficiary population they serve; and
2. They shall agree to accept responsibility for filing all amendments forwarded by the Medicaid Agent.

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)1, substituted "beneficiary" for "recipient"; and in (b)2, substituted "Medicaid Agent" for "agency".

10:49-15.3 Reproduction of policy material

(a) The specific policy materials necessary for an applicant or beneficiary (or his or her representative) to determine whether a fair hearing should be requested, or to

prepare for a fair hearing, shall be reproduced without charge upon request.

(b) The Medicaid Agent may impose a charge for copying or reproducing materials. If a charge is imposed, it shall be computed pursuant to N.J.S.A. 47:1A-1.

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

In (a), substituted "beneficiary" for "recipient"; and in (b), substituted "Medicaid Agent" for "Division".

SUBCHAPTER 16. DEMONSTRATION PROJECTS

10:49-16.1 Purpose

This subchapter sets forth the basic parameters for demonstration projects established pursuant to N.J.S.A. 30:4D-1 et seq., as amended, and Section 1115 of the Social Security Act. Any time a demonstration project is implemented, New Jersey Medicaid providers will receive information and instructions if the project is relevant to the services they provide.

10:49-16.2 Definitions

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

"Principal" means all Division management personnel.

"Project" means any demonstration project authorized through a waiver by the Secretary of Health and Human Services of certain requirements under Title XIX of the Social Security Act as provided under Section 1115 of the Social Security Act.

"Provider" means providers of medical and health services under a project.

"Recipient" means any beneficiary who receives services from the project.

"Services" means medical or health services rendered as an integral part of the project.

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

Amended "Principal", "Project", "Provider" "Recipient" and "Services"; and deleted "Beneficiary", "Commissioner", "Department" and "Eligible beneficiaries".

10:49-16.3 Implementation of projects

The Medicaid Agent may implement projects directly or through contractual arrangements with any legal entity, including, but not limited to, corporations organized pursuant to Title 14A, New Jersey statutes (N.J.S.A. 14A:1-1 et seq.) and Title 15 revised statutes (R.S. 15:1-1 et seq.), as

well as boards, groups, agencies, persons and other public or private entities.

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".

10:49-16.4 Necessary criteria for a demonstration project

(a) The following shall apply to all projects implemented under this subchapter:

1. All projects shall have approval from the United States Department of Health and Human Services;
2. All projects entered into under this subchapter shall be subject to all relevant State and Federal statutes and regulations, except to the extent that appropriate waivers shall have been granted;
3. The Commissioner of Human Services or the Commissioner of Health and Senior Services shall have the authority to review and approve in writing arrangements and agreements, whether formal or otherwise, between all projects and third parties prior to the execution thereof;
4. All projects in their hiring policies shall not discriminate against any individual on the basis of race, sex, religion, ethnicity or age, and shall comply with all the requirements of Title VI of the Civil Rights Act of 1964, as amended, and other applicable Federal and State laws or regulations pertaining to the civil rights of individuals;
5. No project shall deny services to any eligible person on the basis of race, sex, religion, ethnicity or age, and all projects shall comply with all the requirements of Title VI of the Civil Rights Act of 1964, as amended, pertaining to the civil rights of individuals;
6. All projects shall institute procedures for safeguarding of information in compliance with applicable Federal and State regulations and shall strictly adhere to same;
7. All projects shall collect and report data relevant to the project on a periodic basis, in a manner and fashion prescribed by the Medicaid Agent, including but not limited to, the following:
 - i. Financial data, such as line item expenditure statements and audit reports;
 - ii. Data necessary to the project regarding the characteristics of the population involved in the project and the control population, if any; and
 - iii. Program data, such as number and type of service rendered;
8. All projects shall furnish to the Medicaid Agent, in a manner and fashion prescribed by the Medicaid Agent, periodic progress reports;
9. The Medicaid Agent at its option may require receipt of copies of all project reports;

10. Any project entered into under this subchapter may include components fundable from sources other than that authorized by Section 1115 of the Social Security Act. These funds cannot be matched under the provisions of Section 1115 if they are Federal funds or if these funds are not otherwise matchable;

11. Nothing herein shall abridge the Commissioner's statutory authority to implement and administer demonstration programs under Section 1115 of Title XIX of the Social Security Act and N.J.S.A. 30:4D-7, as amended;

12. Each project shall have the organizational and administrative capabilities to carry out its duties and responsibilities under the contract. This shall include as a minimum the following:

- i. A full-time administrator to manage the day-to-day business activities of the project;
- ii. Data reporting capabilities sufficient to provide necessary and timely reports to the Medicaid Agent;
- iii. Financial reports and books of accounts maintained in accordance with generally accepted accounting principles, which are sufficient to fully disclose the disposition of all program funds received; and
- iv. An annual independent audit arranged for by the project;

13. Each project director shall advise the Medicaid Agent of the project's administrative organization and changes thereto. This includes the functions and responsibilities of each principal, an organizational chart and a list of all personnel and providers used either directly by the project or through contractual arrangements. For each principal and each provider not previously reported, the following information shall be included:

- i. Full name;
- ii. Business address;
- iii. Date and place of birth;
- iv. Social Security Account Number;
- v. IRS employer number;
- vi. Professional license number (when applicable); and
- vii. Medical specialty (when applicable);

14. Each project director shall submit to the Commissioner of Human Services or the Commissioner of Health and Senior Services for written approval a manual of administrative procedures which shall include personnel, purchasing and internal fiscal procedures. This manual shall be in conformance with approved management procedure; and

15. In those instances where a project involves the delivery of services, the following shall apply where appropriate and necessary: