

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

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

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

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

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

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

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

In (a), inserted a reference to the NJ KidCare program in 1, and inserted a reference to DMAHS in 3.

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998. See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

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

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

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

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

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

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

concerning a claim or claim related information received outside the prescribed time periods.

ii. For retroactive eligibility cases, a claim associated with a retroactive eligibility application will be considered as received on the date of receipt of the application on behalf of the applicant. For information about retroactive eligibility, see N.J.A.C. 10:49-2.9.

(b) 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 FamilyCare claim are as follows (Under Federal regulations this applies only to Medicare/Medicaid or Medicare/NJ FamilyCare claims and does not extend to claims involving any other third party insurance.):

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

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

(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 30 days after the end of the timely submission period.

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

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

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

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

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

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

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

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

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

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

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

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

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

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

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

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

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

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

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

Case Notes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Contracting practitioners: No program payments shall be made when the third party calls for a contracting

or participating practitioner to accept the TPL as payment in full.

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

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

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

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

4. For NJ KidCare-Plan D enrollee's required copayment.

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

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

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

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

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

(h) TPL may be exhausted, but is not required to be, before a claim is submitted for Medicaid or NJ KidCare 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 or NJ KidCare has been billed and has made payment, the provider must reimburse the Medicaid or NJ KidCare payment to the Medicaid or NJ KidCare program and not to the Medicaid or NJ KidCare 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 or NJ KidCare reimbursement must be received by the Fiscal Agent within the time frames specified in N.J.A.C. 10:49-7.2, Timeliness of claim submission.

(k) Any individual who undertakes to legally represent any Medicaid or NJ KidCare 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". Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

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

Inserted references to NJ KidCare throughout; in (d)1, inserted " , as amended and supplemented," following "et seq." and added 3; and in (e), inserted a reference to NJ KidCare-Plan A beneficiaries in the first sentence.

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

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

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

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

Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).

See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).

10:49-7.4 Prohibition of payment to factors

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

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

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

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

In (b), substituted "beneficiary" for "recipient".

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

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

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

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

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

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

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 or NJ KidCare program.

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

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

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

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

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

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

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

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

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

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

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

Inserted references to NJ KidCare throughout.

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

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

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

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.

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

1. When the claim invoice or retroactive adjustment is paid to a provider reimbursed under a retrospective payment system;
2. For a Medicare/Medicaid claim or Medicare/NJ KidCare claim, timely filed, payment may be made for services within six months after the program or provider receives notice of the Medicare claim disposition for a timely filed Medicare/Medicaid or Medicare/NJ KidCare claim;
3. For claims from providers under investigation for fraud or abuse; or

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

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

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

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

In (a), inserted reference to charity care claims pricing.
Amended by R.2001 d.329, effective September 17, 2001.
See: 33 N.J.R. 1889(a), 33 N.J.R. 3334(a).

Added (d).

Case Notes

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

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

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

10:49-8.3 Adjustments following payment of claims

(a) If a claim is incorrectly paid and the provider receives an overpayment or underpayment, 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 NJ KidCare-Plan C personal contribution to care and Plan D copayments

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

1. Outpatient hospital clinic services: \$5.00 personal contribution to care for outpatient visits. No personal contribution to care shall be charged for well-child visits in accordance with the schedule recommended by the American Academy of Pediatrics; lead screening and

treatment; age-appropriate immunizations; prenatal care; preventive services; family planning services; or substance abuse treatment services. Specific policies are set forth at N.J.A.C. 10:52-4.7.

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

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

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

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

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

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

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

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

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

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

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

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

(c) Under NJ KidCare-Plan D, copayments in the amounts indicated below shall be collected by the provider for services as follows:

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

i. Primary care provider office visit;

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

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

ii. Specialist and other practitioner office visit;

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

iv. Hospital outpatient department visits and diagnostic testing;

v. Routine eye examinations;

vi. Prescription drugs;

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

vii. Outpatient substance abuse services for detoxification;

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

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

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

4. No copayment shall be charged for the following services:

- i. Emergency ambulance services;
- ii. Outpatient surgery;
- iii. Home health services;
- iv. Hospice services;
- v. Inpatient hospital services;
- vi. Inpatient mental health services;
- vii. Inpatient substance abuse detoxification services; or
- viii. Skilled nursing facility services.

(d) Personal contributions to care under NJ KidCare-Plan C and copayments under NJ KidCare-Plan D shall be effective upon date of enrollment.

1. Exception: A personal contribution to care or copayment shall not apply to services rendered to a newborn until the newborn is enrolled in a managed care program.

(e) No personal contribution to care under NJ KidCare-Plan C shall be charged for well-child visits in accordance with the schedule recommended by the American Academy of Pediatrics; lead screening and treatment; age-appropriate immunizations; preventive dental services; prenatal care; for family planning services; or for substance abuse treatment services.

(f) No copayment under NJ KidCare-Plan D will be charged for well-child visits in accordance with the schedule recommended by the American Academy of Pediatrics; nor for lead screening and treatment; for age-appropriate immunizations; or for preventive dental services.

(g) No cost sharing shall be imposed on children who are American Indians/Alaska Natives. Proof of Federally recognized AI/AN tribal status shall be provided in the form of a tribal card or letter, in accordance with 42 C.F.R. 36a.16.

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

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

Former N.J.A.C. 10:49-9.1, Civil Rights, recodified to N.J.A.C. 10:49-9.4.

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998. See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

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

Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).

See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).

Added a new (c); recodified former (c) and (d) as (d) and (e); added (f).

Amended by R.2002 d.371, effective November 18, 2002.

See: 34 N.J.R. 2244(a), 34 N.J.R. 2549(b), 34 N.J.R. 3978(c).

Added (g).

10:49-9.2 NJ KidCare-Plan C and D Premiums

(a) For children in families with income at or below 150 percent of the Federal poverty limit, there shall be no premiums under NJ KidCare-Plan B.

(b) For children in families with gross income above 150 percent and at or below 200 percent of the Federal poverty level (NJ KidCare-Plan C), a monthly premium shall be required to be paid for enrollment. There shall be a single premium of \$15.00 per family per month that applies to all families, regardless of income and regardless of the number of children in the family.

(c) Under NJ KidCare-Plan D, the following premiums shall apply:

1. For children in families with gross income above 200 percent and at or below 250 percent of the Federal poverty level, a single monthly premium of \$30.00 per family per month that applies to all families, regardless of the number of children in the family.

2. For children in families with gross income above 250 percent and at or below 300 percent of the Federal poverty level, a single monthly premium of \$60.00 per family per month that applies to all families, regardless of the number of children in the family.

3. For children in families with gross income above 300 percent and at or below 350 percent of the Federal poverty level, a single monthly premium of \$100.00 per family per month that applies to all families, regardless of the number of children in the family.

(d) Families shall be billed in advance of the coverage month. Failure to submit the full contribution will result in termination of coverage for the month following the coverage month that the premium has not been received by the NJ KidCare program.

(e) No cost sharing shall be imposed on children who are American Indians/Alaska Natives. Proof of Federally recognized AI/AN tribal status shall be provided in the form of a tribal card or letter, in accordance with 42 C.F.R. 36a.16.

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

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

Former N.J.A.C. 10:49-9.2, Observance of religious belief, recodified to N.J.A.C. 10:49-9.5.

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998. See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

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

Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).

See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).

Added a new (c); recodified former (c) as (d).

Amended by R.2002 d.371, effective November 18, 2002.

See: 34 N.J.R. 2244(a), 34 N.J.R. 2549(b), 34 N.J.R. 3978(c).

Added (e).

10:49-9.3 Limitation on cost sharing—Plan C

(a) There shall be a family limit on cost-sharing equal to 5 percent of household income for Plan C beneficiaries.

(b) The cost-sharing limit shall be calculated annually starting with the date of initial enrollment of any children in

the family or the annual reenrollment date. For ease of administration, the annual premium should be calculated by the Statewide eligibility determination agency and used to reduce the family cost from the first day of enrollment.

(c) Once the limits have been met, the Statewide eligibility determination agency shall issue a certification indicating that the Plan C member has met their cost share limit, and the provider shall not collect a personal contribution to care until further notice.

(d) No cost sharing shall be imposed on children who are American Indians/Alaska Natives. Proof of Federally recognized AI/AN tribal status shall be provided in the form of a tribal card or letter, in accordance with 42 C.F.R. 36a.16.

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

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

Former N.J.A.C. 10:49-9.3, Free choice of beneficiary and provider, recodified to N.J.A.C. 10:49-9.6.

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

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

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

Amended by R.2002 d.371, effective November 18, 2002.

See: 34 N.J.R. 2244(a), 34 N.J.R. 2549(b), 34 N.J.R. 3978(c).

Added (d).

10:49-9.4 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".

Recodified from N.J.A.C. 10:49-9.1 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

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

Former N.J.A.C. 10:49-9.4, Confidentiality of records, recodified to N.J.A.C. 10:49-9.7.

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

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

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

10:49-9.5 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".

Recodified from N.J.A.C. 10:49-9.2 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

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

Former N.J.A.C. 10:49-9.5, Provider certification and recordkeeping, recodified to N.J.A.C. 10:49-9.8.

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

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

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

10:49-9.6 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".

Recodified from N.J.A.C. 10:49-9.3 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

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

Former N.J.A.C. 10:49-9.6, Patient's (beneficiary) certification, recodified to N.J.A.C. 10:49-9.9.

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

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

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

10:49-9.7 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.

Recodified from N.J.A.C. 10:49-9.4 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998). See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:49-9.7, Integrity of the Medicaid program; gifts/gratuities prohibited, recodified to N.J.A.C. 10:49-9.10.

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998. See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

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

Case Notes

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).

10:49-9.8 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 and/or NJ Kid-Care programs;

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 or NJ KidCare beneficiary or to others on his behalf.



(c) When a Medicaid or NJ KidCare provider employs, contracts or subcontracts with a health care entity which is not an enrolled Medicaid or NJ KidCare provider, the services provided to Medicaid or NJ KidCare beneficiaries by that employee, contractor or subcontractor shall meet all the requirements of the Medicaid or NJ KidCare programs as defined at N.J.A.C. 10:49-5 and 6 and N.J.A.C. 10:49-9.8(a) and (b), and the pertinent provider chapters of the New Jersey Administrative Code, which requirements include, but are not limited to, availability of services, range of services, quality of care, licensure, and completeness of documentation. Failure to do so may result in either or both of the following consequences:

1. The Division may recover from the enrolled Medicaid or NJ KidCare provider the Medicaid or NJ KidCare reimbursement paid by the Program to the provider for any service rendered by an employee or a contractor's or subcontractor's employee not meeting such requirements; and/or
2. The provider may be subject to any applicable civil or criminal sanctions and/or penalties.

(d) A Medicaid or NJ KidCare provider shall ensure that any individuals or entities employed by a contractor or subcontractor performing services for the provider, fully satisfy all applicable State, Federal, and any other licensure and certification requirements. This shall include, but not be limited to, any equipment and/or vehicles relating to services provided to Medicaid or NJ KidCare beneficiaries. Failure to assure that all such requirements are met may result in either or both consequences specified in (c)1 and 2 above.

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".

Recodified from N.J.A.C. 10:49-9.5 and amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

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

In (b), inserted references to NJ KidCare in 4 and 6. Former N.J.A.C. 10:49-9.8, Fraud and abuse, recodified to N.J.A.C. 10:49-9.11. Amended by R.1998 d.327, effective July 6, 1998.

See: 30 N.J.R. 511(a), 30 N.J.R. 2486(a).

Added (c) and (d).

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

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

10:49-9.9 Patient's (beneficiary) certification

(a) Except as provided in (e) below, a beneficiary shall sign a certification, authorization to release information and payment request after the services identified on the claim are provided and before the provider submits a claim for payment. 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 the New Jersey Medicaid or NJ KidCare program or its authorized agents any information needed for this or a related claim.

(b) A provider shall obtain the beneficiary or representative's certification on the Medicaid or NJ KidCare hard-copy claim (appropriate to the provider), except as noted in (c) below, on the standard Patient Certification (Form FD-197) or on a similar form of the provider's choosing (referred to in this section as a certification log), as long as the form identifies the beneficiary by name and Medicaid or NJ KidCare Eligibility Identification Number, provides the date of service, contains a brief, non-technical description of the service(s) provided, and provides the certification and signature described in (a) above in a legible and readily understandable format. A provider who chooses to use Form FD-197 to obtain patient certification information shall use the column headed "Other Comments" to record the description of the service(s) provided. The provider shall keep this certification on file for each service rendered and shall make the form available upon request to representatives of the New Jersey Medicaid or NJ KidCare program. Initials instead of a signature are unacceptable on the certification form.

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

(c) Certain providers may be required to use an individualized certification form that calls for information in addition to that described in (b) above, as indicated in the specific service chapter of the Division's rules.

(d) A provider shall complete a Medicaid or NJ KidCare hard-copy claim, Patient Certification Form, or certification log before it is presented to the beneficiary for signature. A Medicaid or NJ KidCare beneficiary shall not sign a blank Medicaid or NJ KidCare hard-copy claim, Patient Certification Form, or certification log, nor shall he or she sign the form prior to receiving services or as a condition for receiving services.

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

1. An illiterate beneficiary shall make his or her mark (x), and the mark shall be witnessed by another person who signs his or her name on the Patient Certification Form (FD-197), certification log, or on the Medicaid or NJ KidCare 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 signer to the beneficiary shall be noted directly on the hard-copy claim, certification log, 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.

Recodified from N.J.A.C. 10:49-9.6 and amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

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

Inserted references to NJ KidCare throughout; deleted "Medicaid" following "standard" in (c) and (d), and deleted "Medicaid" preceding "hard-copy" in (f)3. Former N.J.A.C. 10:49-9.9, Informing individuals of their rights, recodified to N.J.A.C. 10:49-9.12.

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

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

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

Amended by R.2000 d.449, effective November 6, 2000.

See: 32 N.J.R. 2394(a), 32 N.J.R. 3991(a).

Rewrote the section.

Case Notes

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

10:49-9.10 Withholding of provider payments

(a) When the Division, in accordance with 42 C.F.R. 455.23, receives reliable evidence of fraud or willful misrepresentation by a provider, including an HMO, as well as a practitioner or entity participating in an HMO's network (whether or not the HMO practitioner or entity is also enrolled as a Medicaid or NJ KidCare provider), the Medicaid Agent or the Division shall withhold Program payments, in whole or in part, upon approval by the Division Director or the Assistant Director, Office of Program Integrity Administration, or their designee. Further, a practitioner or entity participating in an HMO's network subject to a withholding action under this section shall have any payments for services rendered to Medicaid and NJ KidCare beneficiaries withheld by the HMO.

(b) "Reliable evidence" shall include, but not necessarily be limited to:

1. Receipt of information from a Division unit or from the Department of Health and Senior Services, Department of Banking and Insurance or a law enforcement, investigatory, or prosecutorial agency that indicates fraud or willful misrepresentation has occurred or is occurring;
2. Information from any other local, county, State or Federal agency indicating fraud or willful misrepresentation has occurred or is occurring; or
3. Indications that a violation of those subsections of N.J.A.C. 10:49-11.1 that pertain to fraud or willful misrepresentation may have occurred or is occurring, including, but not necessarily limited to, overutilization or misutilization; any unexplained increase in the number of claims rejected by the claims processing system; or any other reliable grounds to believe that fraud or **willful** misrepresentation may have occurred or is occurring.

(c) Withholding may be total or partial, and if partial, may be predicated upon withholding by specific claim type, practitioner, procedure code, diagnosis, or other factors.

(d) The Division shall send notice of its withholding to the affected provider, practitioner or entity within five days of taking such action. The notice shall also be sent to all participating HMOs to enable them to identify if the affected provider, practitioner or entity is also part of their network. The HMOs shall be required to implement the provisions of this section within their network. The notice shall set forth the general allegations as to the nature of the withholding action, but need not disclose specific information concerning any ongoing civil or criminal investigation. The notice shall:

1. State that payments are being withheld in accordance with this regulation and with 42 C.F.R. 455.23;
2. State that withholding is for a period initially not to exceed six months, after which the withholding action shall be reviewed to determine if an additional period of withholding is warranted. Withholding shall be terminated when the Division determines there is insufficient evidence of fraud or willful misrepresentation, or legal proceedings relating to the fraud or willful misrepresentation are completed;
3. Specify, when appropriate, to which type or types of claims withholding is effective;
4. Inform the provider, practitioner or entity of the right to submit written evidence for consideration by the Medicaid Agent or the Division; and
5. Set forth the provider's, practitioner's or entity's right to an administrative hearing within 20 days of the provider's receipt of the withholding notice, consistent with N.J.A.C. 10:49-10.3.

(e) Regular, periodic meetings shall be held to review all parties from whom payments are being withheld under this section. Also, in a case involving any party against which withholding is being imposed, where circumstances indicate that the reason for the withholding may no longer exist, said case shall be brought before a committee to be comprised of staff of the Division of Medical Assistance and Health Services, or their designees, for consideration of cessation of withholding of payment, upon the request of any of the specified officials.

New Rule, R.1999 d.294, effective September 7, 1999.
See: 30 N.J.R. 2808(a), 31 N.J.R. 2635(a).

Former N.J.A.C. 10:49-9.10, Integrity of the Medicaid and NJ KidCare programs; gifts/gratuities prohibited, recodified to N.J.A.C. 10:49-9.11.

10:49-9.11 Integrity of the Medicaid and NJ KidCare programs; gifts/gratuities prohibited

The New Jersey Medicaid and NJ KidCare programs, in order to maintain the integrity of the programs, strictly prohibit their 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 programs. 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).

Recodified from N.J.A.C. 10:49-9.7 and amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

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

Inserted a reference to NJ KidCare programs. Former N.J.A.C. 10:49-9.10, Provisions for appeals; fair hearings, recodified to N.J.A.C. 10:49-9.13.

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

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

Recodified from N.J.A.C. 10:49-9.10 by R.1999 d.294, effective September 7, 1999.

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

Former N.J.A.C. 10:49-9.11, Fraud and abuse, recodified to N.J.A.C. 10:49-9.12.

10:49-9.12 Fraud and abuse

The New Jersey Medicaid and NJ KidCare programs 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.

Recodified from N.J.A.C. 10:49-9.8 and amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

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

Inserted a reference to NJ KidCare programs.

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

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

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

Recodified from N.J.A.C. 10:49-9.11 by R.1999 d.294, effective September 7, 1999.

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

Former N.J.A.C. 10:49-9.12, Informing individuals of their rights, recodified to N.J.A.C. 10:49-9.13.

10:49-9.13 Informing individuals of their rights

(a) All Medicaid and NJ KidCare-Plan A 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.

(b) NJ KidCare-Plan B, C and D enrollees are entitled to use the grievance procedure established by the Division of Medical Assistance and Health Services or the administrative law hearing process established at N.J.A.C. 10:79-6.5 and 6.6, as appropriate.

Recodified from N.J.A.C. 10:49-9.9 and amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

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

In (a), inserted "Medicaid and NJ KidCare-Plan A" following "All"; and added (b).

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

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

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

Recodified from N.J.A.C. 10:49-9.12 by R.1999 d.294, effective September 7, 1999.

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

Former N.J.A.C. 10:49-9.13, Provisions for appeals; fair hearings, recodified to N.J.A.C. 10:49-9.14.

Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).

See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).

10:49-9.14 Provisions for appeals; fair hearings

(a) Pursuant to N.J.A.C. 10:49-10, Fair Hearings, providers, Medicaid beneficiaries and NJ KidCare-Plan A beneficiaries shall have the right to file for fair hearings.

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

(c) A Medicaid or NJ KidCare Plan A beneficiary may be granted an administrative law 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. A NJ KidCare-Plan B, C and D beneficiary shall have the right to request an administrative law hearing only if they have been terminated by the program for good cause for fraud or abuse activities.

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

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

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

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

Substituted "beneficiary" and "beneficiaries" for "recipient" and "recipients" throughout; in (d), changed place to send hearing requests; and in (c), substituted "chapter" for "Manual".

Recodified from N.J.A.C. 10:49-9.10 and amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

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

Rewrote (a) and (c).

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

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

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

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

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

Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).

See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).

10:49-9.15 Advance directives

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

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

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

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

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

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

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

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

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

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

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

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

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

"Physician" means an individual licensed to practice medicine and surgery in this State.

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

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

1. Private religiously-affiliated health care institutions may develop institutional policies and practices defining circumstances under which they will decline to participate in the withholding or withdrawing of specific measures to sustain life. Such policies and practices shall be written, and shall be properly communicated to patients and their families and health care representatives before or at the time of the patient's admission or enrollment. If the institution's policies and practices appear to conflict with the legal rights of a patient wishing to forego health care, the health care institution shall attempt to resolve the conflict. If a mutually satisfactory accommodation cannot be reached, the health care institution shall take all reasonable steps to effect the appropriate, timely and respectful transfer of the patient to the care of another health care institution appropriate to the patient's needs, and shall assure that the patient is not abandoned or treated disrespectfully; and

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

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

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

1. Furnish patients with written information about their rights to accept or refuse treatment, and to formulate advance directives. This information shall also be made available on request to patients' health care representatives, families and other interested parties;

2. Note in each patient's medical record whether that patient has executed an advance directive;

3. Provide (individually or with others) for education of staff and the community on issues concerning advance directives;

4. Provide care or other services without discrimination based on whether or not the individual has executed an advance directive; and

5. Ensure compliance with State law regarding advance directives (see N.J.S.A. 26:2H-53 et seq.).

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

1. In the case of a hospital, at the time of the individual's admission as an inpatient;

2. In the case of a nursing facility, at the time of the individual's admission as a resident;

3. In the case of a provider of home health care, personal care assistant services or private duty nursing services, in advance of the individual coming under the provider's care;

4. In the case of a hospice program, at the time the individual initially receives hospice care from the program; and

5. In the case of a managed care organization, at the time the individual enrolls in the program.

(f) A physician, nurse, or other health care professional may decline to participate in the withholding or withdrawing life-sustaining treatment, in accordance with sincerely held personal or professional convictions, consistent with the provisions of N.J.S.A. 26:2H-62(b) and (c).

New Rule, R.2001 d.294, effective August 20, 2001.
See: 32 N.J.R. 2687(b), 33 N.J.R. 2808(a).

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 or Title XXI agency that may adversely affect the Medicaid or NJ KidCare-Plan A 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".

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

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

In "Notice", inserted references to Title XXI agencies and to NJ KidCare-Plan A beneficiaries.

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

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

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

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 or NJ KidCare program may print a notice of prospective policy changes affecting Medicaid or NJ KidCare 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.

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

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

In (a), inserted references to NJ KidCare in the introductory paragraph.

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

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

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

10:49-10.3 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 or NJ KidCare 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 a 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 or NJ KidCare-Plan A program has erroneously terminated, reduced or suspended their assistance. The Medicaid Agent or NJ KidCare program 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 the Medicaid Agent or NJ KidCare-Plan A program 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 or NJ KidCare program action in which to request a hearing;

4. The fair hearing shall include consideration of:

i. Any Medicaid Agent or NJ KidCare-Plan A program 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 or NJ KidCare-Plan A program'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 or DMAHS 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 or DMAHS 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 DMAHS 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. 10:49-9.12(a)3; and

7. The Medicaid Agent or DMAHS 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.

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

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

In (a), inserted a reference to NJ KidCare claims; in (b), inserted references to the NJ KidCare program, the NJ KidCare-Plan A program and DMAHS throughout; and substituted a reference to N.J.A.C. 10:49-9.12(a)3 for a reference to N.J.A.C. 10:49-9.9(a)3 in 6. Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998. See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

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

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 for Medicaid and NJ KidCare-Plan A

(a) In cases of any proposed action to terminate, reduce or suspend assistance, the Medicaid Agent or DMAHS 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 or DMAHS 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 or DMAHS promptly informs the claimant in writing that services shall be terminated or reduced pending the hearing decision.

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

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

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

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

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

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

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

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

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

Substituted reference to Medicaid Agent for reference to department throughout.

Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).

Inserted references to DMAHS throughout.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

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

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 or DMAHS' head shall specify the reasons for the decision and identify the supporting evidence or may incorporate by reference the findings, conclusions, and recommendations, contained in the initial decision.

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

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

(d) The final decision shall be promptly implemented.

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

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

Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).

Inserted references to DMAHS throughout.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

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

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

The Medicaid Agent or DMAHS shall establish and maintain a method for informing, at least in summary form, all local agencies of all fair hearing decisions by the hearing authority and the decisions shall be accessible to the public (subject to the provisions of safeguarding public assistance information).

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

Substituted "Medicaid Agent" for "Department".

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

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

Inserted a reference to DMAHS.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

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

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

Cross References

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

10:49-11.1 Program participation

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

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

1. Any individuals, including but not limited to, owners, officers, administrators, assistant administrators, employees, accountants, attorneys, and management services, who have been suspended, debarred or disqualified from participation in the Medicaid and/or NJ KidCare programs for any reason shall not be involved in any activity relating to the New Jersey Medicaid and/or NJ KidCare programs.

2. Providers reimbursed on a cost-related basis may not claim as allowable costs any amounts paid or credited

to such individuals, and such amounts shall not be reimbursed by the New Jersey Medicaid and/or NJ KidCare programs.

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 and/or NJ KidCare 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 or DMAHS:

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 DMAHS or its authorized agent, records of services provided to or payments made on behalf of Medicaid or NJ KidCare beneficiaries;

15. Failure to provide and maintain quality services to Medicaid or NJ KidCare 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 or NJ KidCare program following notification that said conduct should cease;

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

18. Overutilizing the New Jersey Medicaid or NJ KidCare 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 or NJ KidCare 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 supplemented, 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 or DMAHS 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 or NJ KidCare program of another state; or

26. Suspension or exclusion from participation in the delivery of medical care or services under Title XVIII, XIX, XX or XXI 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 DMAHS 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 or DMAHS seeks to debar a person or his or her affiliates, the Medicaid Agent or DMAHS 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 or NJ KidCare programs, except for services or supplies provided prior to the debarment. No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the program or its fiscal agent for any services or supplies provided by a person within such organization who has been debarred by the program, except for services or supplies provided prior to the debarment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In (a), inserted “, and Reorganization Plan No. 001-1996”; in (b), substituted “New Jersey Medicaid program” and “Medicaid Agent” for “Division” throughout; in (b)3, deleted “reimbursed on a fee-for-service basis”; in (c), rewrote introductory paragraph and deleted “Division”, “Fiscal Agent” and “Provider”; and in (d), substituted “beneficiary” and “beneficiaries” for “recipient” and “recipients”, reference to Medicaid Agent for references to Division, Division of Medical Assistance and Health Services, and Director, and “Program” for references to the Division of Medical Assistance and Health Services, throughout; in (d)5, deleted Public Law references: in (d)17, deleted “form” following “Medicaid claim”; in (d)20, inserted reference to Commissioner of Health and Human Services; and in (j)2, substituted “New Jersey Medicaid program” for “Division”.

Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).

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

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

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

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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. Dalgligh*, 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 or 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).

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

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

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

In "Person", inserted a reference to the NJ KidCare program.

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

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

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

10:49-12.2 Requests for reinstatement

Persons who have been debarred, disqualified or suspended from participating in the New Jersey Medicaid or the NJ KidCare 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.

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

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

Inserted a reference to the NJ KidCare program.

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

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

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

10:49-12.3 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 reinstatement 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 or the NJ KidCare 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 or the NJ KidCare 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".

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

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

In (a)1, inserted references to NJ KidCare throughout.

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

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

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

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 or 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).

In (a)9 substituted "Medicaid program" for "Division".
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).

In (a)9, inserted a reference to the NJ KidCare program.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

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

Case Notes

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 or DMAHS shall provide continuing review and evaluation of the care and services provided under the Medicaid and NJ KidCare programs. 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".

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

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

Inserted a reference to DMAHS and substituted a reference to the Medicaid and NJ KidCare programs for a reference to programs in the first sentence.

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

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

10:49-13.2 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 Program Integrity Administration (OPIA) 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, OPIA or, if the case is referred to the Legal Action Committee or the Division of Criminal Justice, the date OPIA 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, OPIA.
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, OPIA, 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, OPIA, 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 OPIA 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.
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).

Substituted references to the Office of Program Integrity Administration for references to the Office of Quality Management and Program Integrity throughout.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

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

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).

10:49-13.3 Applicability to DMAHS programs of provisions relating to fraud and abuse investigations and administrative actions, third party liability and recoveries

All of the relevant provisions pertaining to fraud and abuse investigations and administrative actions, third party liability, and recoveries which are contained in N.J.S.A. 30:4D-1 et seq. and this chapter are fully applicable to all of the programs administered in whole or in part by the Division, including, but not limited to, Plans B, C, and D of the NJ KidCare/NJ FamilyCare program, including, but not limited to, N.J.S.A. 30:4D-6c, 6f, 7h, 7i, 7k, 7l, 7.1, 12, 17(e), 17(f), 17(g), 17(i), 17.1 and 17.2, as well as N.J.A.C. 10:49-3.2, 4.1 through 4.5, 5.5, 6.1(a)3, 7.3, 7.4, 7.5, 9.6 through 9.12, 11.1, 12.1 through 12.7, 13.1, 13.4, 14.2 through 14.6 and 16.5.

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

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

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

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

Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).

See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).

Amended by R.2002 d.155, effective May 20, 2002.

See: 33 N.J.R. 3893(a), 34 N.J.R. 1852(a).

Rewrote the section.

10:49-13.4 Rewards for information relating to fraud and abuse

(a) The Division of Medical Assistance and Health Services may pay a monetary reward for information that leads to the recovery of at least \$100.00 from individuals or entities that have engaged in health care-related fraud or abuse including ineligible receipt of benefits involving the programs administered by DMAHS (including, but not limited to, the New Jersey Medicaid and NJ KidCare programs), the Pharmaceutical Assistance to the Aged and Disabled (PAAD) program administered by Department of Health and Senior Services, and/or the Work First New Jersey General Assistance (GA) program administered by Division of Family Development. The determination of whether an individual or entity meets the criteria for an award, and the amount of the award, is at the discretion of DMAHS. DMAHS shall pay a reward only if a reward is not otherwise provided for by law. When DMAHS applies the criteria specified in (b), (c) and (e) below to determine the eligibility and the amount of the reward, DMAHS shall notify the beneficiary of the reward as specified in (d) below.

(b) The following pertain to information eligible for reward.

1. In order for an individual or entity to be eligible to receive a reward, the information supplied shall relate to the activities of a specific individual or entity, and shall specify the time period of the alleged activities.

2. DMAHS shall not give a reward for information relating to an individual or entity that, at the time the information is provided, is already the subject of a review or investigation by DMAHS or its contractors; the New Jersey Department of Human Services (DHS); the New Jersey Department of Health and Senior Services; the New Jersey Department of Law and Public Safety; the Health Care Financing Administration and the Office of the Inspector General of the U.S. Department of Health and Human Services or their contractors; the U.S. Department of Justice; the Federal Bureau of Investigation; or any other Federal, State, county or municipal law enforcement agency.

(c) Any individual or entity (other than one excluded under (c)1 below) is eligible to receive a reward under this section if the information is submitted in the manner set forth in (f) below.

1. The following are excluded from eligibility to receive a reward:

i. An individual who was or is an immediate family member of an officer or employee of any of the agencies or entities listed in (b)2 above at the time he or she came into possession of, or divulged, information leading to a recovery shall not be eligible to receive a reward under this section;

ii. Any other Federal, State, county or municipal employee, contractor or grantee shall not be eligible for a reward under this section if the information submitted came to their knowledge in the course of their official duties;

iii. An individual or entity that illegally obtained the information submitted shall be excluded from receiving a reward under this section; and

iv. An individual or entity that participated in the sanctionable offense with respect to which payment would be made shall be excluded from receiving a reward under this section.

(d) After all funds have been recovered and DMAHS has determined a participant eligible to receive a reward under the provisions of this section, it shall notify the informant of his or her eligibility, by mail, at the most recent address supplied by the individual or entity. It is the individual's or entity's responsibility to ensure that the reward program has been notified of any change in their address or other relevant information (for example, change of name, phone number).

1. If the individual or entity has relocated to an unknown address, the individual or entity or their legal representative may claim the reward by contacting DMAHS within one year from the date on which DMAHS first attempted to notify the individual or entity about a reward. DMAHS does not consider the individual or entity or their legal representative eligible for a reward more than one year after the date on which it first attempted to give notice. DMAHS does not pay interest on rewards that are not immediately claimed.

2. If an individual has become incapacitated or has died, an executor, administrator, or other legal representative may claim the reward on behalf of the individual or the individual's estate. The claimant shall submit certified copies of the letters testamentary, letters of administration, or other similar evidence to show his or her authority to claim the reward. The claim shall be filed within one year from the date, on which DMAHS first gave or attempted to give notice of the reward.

(e) The following pertain to the amount and payment of a reward:

1. In determining whether it shall pay a reward and, if so, the amount of the reward, DMAHS shall take into account all relevant factors, including the significance of the information furnished in relation to the ultimate resolution of the case and the recovery.

2. The amount of the reward represents what DMAHS considers to be adequate compensation in the particular case, not to exceed 10 percent of the overpayments recovered in the case, or \$1,000, whichever is less.

3. If more than one individual or entity is eligible to receive a reward in a particular case, DMAHS shall

allocate the total reward amount (not to exceed 10 percent of the overpayments recovered in that case, or \$1,000, whichever is less) among the participants.

4. DMAHS bases rewards only on recovered overpayments, not on amounts collected as interest, penalties and/or fines, and not on estimates of cost savings or cost avoidance.

5. DMAHS shall make payments as promptly as the circumstances of the case permit, but not until it has collected all overpayments, interest, penalties and fines.

6. No Division employee may make any offer or promise or otherwise bind DMAHS or DHS with respect to the payment or any reward under this subsection or the amount of the reward.

(f) An individual or entity may submit information on persons or entities engaging in, or that have engaged in, health care-related fraud and/or abuse against the programs listed in (a) above to Bureau of Program Integrity, Division of Medical Assistance and Health Services, PO Box 712, Trenton, NJ 08625-0712, or by calling the DMAHS Fraud and Abuse Hotline at 1-888-9 FRAUD-5 (1-888-937-2835).

1. A participant interested in receiving a reward shall provide his or her name, address, telephone number, and any other requested identifying information so that he or she may be contacted, if necessary, for additional information and, when applicable, for the payment of a reward upon resolution of the case.

(g) DMAHS shall not reveal a participant's identity to any person, except as required by law.

(h) If, after a reward is accepted, DMAHS finds that the awardee was ineligible to receive the reward, neither DMAHS nor DHS shall be liable for the reward, and the awardee shall refund all monies received.

(i) Receipt of a reward under this section by any applicant for, or beneficiary of, benefits under any program administered in whole or in part by the Division of Medical Assistance and Health Services, including, but not limited to, Medically Needy (N.J.A.C. 10:70), Medicaid Only (N.J.A.C. 10:71), New Jersey Care . . . Special Medicaid Programs (N.J.A.C. 10:72), NJ FamilyCare (N.J.A.C. 10:78) and NJ KidCare (N.J.A.C. 10:79), Pharmaceutical Assistance to the Aged and Disabled, Work First New Jersey/General Assistance or AFDC-Related Medicaid shall not affect that individual's eligibility or continued eligibility for those benefits.

New Rule, R.2000 d.288, effective July 17, 2000.
See: 31 N.J.R. 2673(b), 32 N.J.R. 2613(a).
Amended by R.2002 d.124, effective April 15, 2002.
See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).
Rewrote (i).

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 the individual received medical assistance if:

1. The individual leaves no surviving spouse;

2. For estates of individuals who died between February 1, 1984 and October 20, 1992, the individual left no surviving child;

3. For estates of individuals who died 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, but prior to December 22, 1995.

(c) For estates of individuals who died on or after April 1, 1995, in addition to the recoveries authorized under (a) and (b) above, any Medicaid payments correctly made on or after October 1, 1993, on behalf of individuals who received services on or after age 55 but prior to age 65, are recoverable from the estates of those individuals, subject to the conditions set forth in (a)1, 3, 4 and 5 and (b) above.

(d) Effective for estates created on or after October 4, 1999, the Division shall file any claim or lien against an estate under this section within 90 days after receiving actual written notice from the personal representative of the estate or any other interested party of the death of the Medicaid beneficiary.

(e) For estates of individuals who died on or after December 22, 1995, Medicaid claims under this section shall be deemed preferred claims, with a priority equivalent to that under subsection c. of N.J.S.A. 3B:22-2, that is, debts and taxes with preference under Federal or State law.

(f) The personal representative of the estate of a deceased Medicaid beneficiary or any other interested party, upon request to the Division, may obtain a "payoff statement" on the amount due under the claim, if that information is available to the Division at the time the request is received.

(g) Effective for estates pending on or created after October 4, 1999, if a family member of a deceased Medicaid beneficiary has, prior to the beneficiary's death, continuously resided in a home owned by the beneficiary at the time of the beneficiary's death, and that home was the beneficiary's primary residence, and was and remains the family member's primary residence, the Division may record a lien against the property, but will not enforce the lien until the property is voluntarily sold, or the resident family member either dies or vacates the property.

(h) For estates of individuals who died on or after October 1, 1993, which are subject to a recovery claim under this section which was either pending on or initiated after March 1, 1995, the estate representative may apply to the Division for a waiver or compromise of the claim based upon grounds of undue hardship, subject to the following policies and procedures:

1. Undue hardship can be demonstrated only if the estate subject to recovery is or would become the sole income-producing asset of the survivors, and pursuit of recovery is likely to result in one or more of those survivors becoming eligible for public assistance and/or Medicaid benefits.

2. There shall be a rebuttable presumption that no undue hardship exists if the hardship resulted from estate planning methods under which assets were divested in order to avoid estate recovery.

3. Upon receipt of written notice that the estate is subject to a recovery claim by the Division, the estate representative shall have 20 days from the date of receipt of the notice to file a request for a waiver or compromise of the Division's claim based upon undue hardship, together with evidence in support of the request. If that request is not received by the Division within the time limit specified, the Division shall not grant a waiver or compromise based upon undue hardship. Upon receipt of a timely request, the Division shall evaluate the request and the evidence submitted, and shall notify the applicant in writing of its decision within 45 days from the date that the request was received. If the estate representative wishes to contest the Division's decision, a written request for a hearing shall be submitted to the Division within 20 days from the date of receipt of that decision, in accordance with the provisions of N.J.A.C. 10:49-10. This request shall be forwarded by the Division to the Office of Administrative Law (OAL), which shall notify the parties of the hearing date and venue, and shall provide a description of the hearing process. Subsequent to the hearing, the formal decision of the OAL shall include a description of the process leading to the final agency decision and the appeal rights available to both parties.

(i) The Division may elect not to pursue a claim under this section against the estate of an individual who died on or after December 22, 1995, if it determines, in its sole discretion, that to do so would not be cost-effective.

(j) For all estate recoveries pending on or initiated after October 4, 1999, no lien of any kind, inchoate or otherwise, and no right of recovery can either exist or be pursued until all of the conditions set forth in N.J.S.A. 30:4D-7.2a are met, including the absence of any surviving spouse or of any minor, blind, or permanently and totally disabled children.

(k) For all estate recoveries pending on or initiated on or after October 4, 1999, even when the statutory conditions for lien filing and recovery are met, recovery shall not be pursued against property held by any bona fide purchaser who has paid fair market value for the property, but shall be sought from the estate.

(l) For purposes of this section, the term "estate" with respect to a deceased Medicaid beneficiary shall include:

1. All real and personal property and other assets included within the individual's estate, as defined in N.J.S.A. 3B:1-1; and

2. For individuals who died on or after April 1, 1995, the term "estate" shall also include any other real and personal property and other assets in which the Medicaid beneficiary had any legal title or interest at the time of death, to the extent of that interest, including assets conveyed to a survivor, heir or assign of the beneficiary through joint tenancy, tenancy in common, survivorship, life estate, living trust or other arrangement, as well as any proceeds from the sale of any such property which remain in the estate of the survivor, heir or assign of the beneficiary, to the extent of the beneficiary's interest;

i. Effective for future estates or estate recoveries pending on or after October 4, 1999, for purposes of this subsection, the term "life estate" shall mean a life estate created upon the death of a beneficiary;

ii. Effective for future estates or estate recoveries pending on or after October 4, 1999, for purposes of this subsection, the term "other arrangement" shall include, but not be limited to, any trust or annuity in which the beneficiary had an interest at the time of death, including a trust or annuity established by a third party, subject to the exclusions discussed in (n) below.

(m) Any lien filed on or after October 4, 1999 against an estate as described in (l)2 above shall describe the extent of the deceased Medicaid beneficiary's interest covered by the lien, if known to the Division at the time the lien is filed. For example, if a deceased Medicaid beneficiary at the time of his death owned real property as a tenant-in-common with another individual, the lien should state that it encumbers only 50 percent of the equity in the real property. If the deceased Medicaid beneficiary held a tenancy-by-the-entirety or joint tenancy with a right of survivorship, then the lien shall state that it encumbers all of the property. If the Division is not aware of the extent of the beneficiary's interest at the time that the lien is filed, the full amount of the Division's claim shall be listed on the lien.

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

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

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

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

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

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

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

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

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

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

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

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

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

Case Notes

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

10:49-14.2 Sanctions—Special Status Program

(a) The "Special Status Program" either restricts the Medicaid or NJ KidCare beneficiary(s) listed on the Eligibility Identification (EI) 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 or NJ KidCare beneficiary for additional identification or to take other appropriate action.

1. The restrictive card is issued to Medicaid or NJ KidCare beneficiaries determined to have misused, abused or overutilized their Medicaid or NJ KidCare benefits. Overutilization occurs when a beneficiary has utilized Medicaid or NJ KidCare 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 (EI) Card shall create a presumption that the beneficiaries listed on the (EI) Card were responsible for such actions. If this presumption is successfully rebutted by the Medicaid or NJ KidCare 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 or NJ KidCare beneficiaries determined to have had their EI 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 (EI) 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 or NJ KidCare beneficiary for additional identification or to take other appropriate action. A determination that an (EI) Card has been used by an unauthorized person or for an unauthorized purpose shall create a presumption that the beneficiaries listed on the (EI) 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.

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

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

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

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Case Notes

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

10:49-14.4 Recoveries involving 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 or NJ KidCare 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 beneficiary free of any agency claim are to be remitted to the beneficiary as promptly as possible or otherwise disbursed at the beneficiary's instruction. The CWA will promptly reevaluate eligibility following such distribution, taking into consideration any voluntary repayment to the New Jersey Medicaid or NJ KidCare 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 representa-

tive 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 or NJ KidCare program. If the claim of the New Jersey Medicaid or NJ KidCare 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 or NJ KidCare 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 DMAHS 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 or DMAHS 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 or NJ KidCare 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 or DMAHS. 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.

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

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

In (c), (d), (e) and (f), inserted references to NJ KidCare throughout; in (e)2iv, inserted a second reference to DMAHS; and in (e)3 and (f), inserted references to DMAHS.

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

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

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

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 or NJ KidCare 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.

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

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

In (a), inserted a reference to NJ KidCare.

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

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

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

10:49-14.6 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 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).

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

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

Inserted a reference to NJ KidCare.

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

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

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

SUBCHAPTER 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:

i. The project shall demonstrate, to the satisfaction of the Commissioner of Human Services or the Commissioner of Health and Senior Services, the capability to provide for and/or arrange for the provision of those services which are required as components of the project;

ii. All individuals receiving services funded under Title XIX of the Social Security Act shall be informed in a simple, brief statement of their rights to a fair hearing;

iii. The project shall develop and establish grievance procedures for beneficiaries in addition to fair hearing procedures established pursuant to this paragraph;

iv. The project shall take steps to insure that it is rendering services that are consistent with and utilizes existing related Federal and State programs such as the EPSDT;

v. The project shall insure that there will be periodic peer review and quality of care audits;

vi. The project shall utilize eligibility criteria for eligibles to receive services as defined by the Department, and the Department shall insure, by a review process, that the project is in conformance with these criteria;

vii. The project shall take appropriate action to insure that the eligibility criteria provided per (a)15vi above is faithfully executed;

viii. The project shall obtain written approval from the Commissioner of Human Services and the Commissioner of Health and Senior Services prior to implementing the following:

(1) The methods of enrollment and enrollment forms to be used to enroll beneficiaries;

(2) The form and content of informational and instructional materials to be distributed to beneficiaries outlining the nature and scope of covered services provided by the project;

(3) The form and content of informational and instructional materials to be distributed to inform enrollees of changes in program scope or administration; and

(4) Provider claim forms and instructions for their use where such claim forms are unique to this contract;

ix. The project shall provide to the Medicaid Agent, for written approval prior to use, the form and content of all public information releases pertaining to the project; and

x. The project shall insure that all marketing representatives have received instruction, as appropriate, from the Medicaid Agent, on acceptable enrollment practices.

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; inserted references to Commissioner of Health and Senior Services and substituted "Medicaid Agent" for "Department" throughout; in (a)5, inserted "all projects"; and in (a)15iii, substituted "beneficiaries" for "recipients".

10:49-16.5 Sanctions related to demonstration projects

The Commissioner of Human Services and the Commissioner of Health and Senior Services, in addition to any and all other authority, shall have the authority to totally suspend or partially reduce payment in order to enforce compliance with this subchapter.

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; inserted reference to Commissioner of Health and Senior Services.

SUBCHAPTER 17. (RESERVED)

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

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

(a) EPSDT is a federally mandated comprehensive child health program for Medicaid beneficiaries from birth through 20 years of age. The Omnibus Budget Reconciliation Act of 1989 (OBRA '89) codified EPSDT. Accordingly, the term "EPSDT Services" means the following:

1. EPSDT Screening Services;
2. Vision Services;
3. Dental Services;
4. Hearing Services; and
5. Such necessary health care diagnostic services, treatment and other measures to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.

(b) A physician, independent clinic, or hospital outpatient department may provide EPSDT screening services.

SUBCHAPTER 19. HEALTHSTART

10:49-19.1 HealthStart

HealthStart is a program which provides comprehensive maternity care services for all pregnant women (including

those determined to be presumptively eligible) and child health care services for children (through two years of age) who are eligible for Medicaid benefits. Detailed information about this program is included in the Physician Services Manual or N.J.A.C. 10:54, Independent Clinic Services Manual or N.J.A.C. 10:66, Nurse-Midwifery Services Manual or N.J.A.C. 10:58, and the Hospital Services Manual or N.J.A.C. 10:52.

SUBCHAPTER 20. THE GARDEN STATE HEALTH PLAN (GSHP)

Cross References

Optical appliance services, prior authorization for inclusion in benefits package, see N.J.A.C. 10:62-2.5.

10:49-20.1 Introduction

The GSHP is a State-operated health maintenance organization (HMO) with a Certificate of Authority from the New Jersey State Department of Health to operate in selected counties. It was formerly a Federal demonstration project known as the Medicaid Personal Physician Plan.

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

10:49-20.2 Physician case manager (PCM)

(a) The primary component of the GSHP is the medical case management system whereby the PCM is responsible for the provision of all primary care services and for the management of referral, ancillary and inpatient services. Participating providers who are acting as PCMs can be in solo practice, group practice, professional corporation or association, health maintenance organization (HMO), independent free-standing clinic, or in a hospital affiliated entity which allows for primary care services and is not subject to DRG reimbursement principles.

(b) The PCM must review and approve all medical services and expenditures on behalf of the patient (including referrals for ancillary services, specialty care, and inpatient hospital care) and provide or arrange for the provision of 24-hour, seven-day-a-week medical coverage.

(c) Participation by physicians in the GSHP is voluntary and on a contractual basis. A physician can participate in both the GSHP and the Medicaid fee-for-service program. A physician, however, must be a Medicaid approved provider before he or she can participate in the GSHP.

(d) The PCM must submit a claim form for each encounter with a patient who is included in his or her panel for GSHP members. The form is required for utilization data, quality assurance and reporting, not for billing purposes. Information on the claim is the same as that which is required on a regular fee-for-service claim. See the Fiscal Agent Billing Supplement for instructions to complete the claim form.

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

10:49-20.3 Capitation payment system

(a) PCMs participating in the GSHP are reimbursed through a capitation payment system. The capitation payment system is divided into three funds:

1. The Monthly Prepayment Fund;
2. The Referral Services Fund; and
3. The Inpatient Services Fund.

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

10:49-20.4 Medicaid beneficiary

(a) The GSHP is offered to the Medicaid beneficiary as an alternative to the existing Medicaid fee-for-service program. Participation by the Medicaid beneficiary is voluntary.

(b) A Medicaid beneficiary who joins the Plan is guaranteed up to 12 months of Medicaid eligibility. This guarantee is granted in six month segments and the individual must be Medicaid eligible the first day of each six month period.

(c) A Medicaid beneficiary who enrolls in the Plan selects a PCM from a list provided by the enrolling agent. Each Medicaid eligible has his or her own PCM. Each family member may have the same PCM or may choose a different physician. A Medicaid eligible family may enroll in the GSHP only if all the Medicaid eligible family (case) members join.

(d) When a Medicaid beneficiary enrolls in GSHP, the enrolling agent completes a GSHP Enrollment Application which the Medicaid beneficiary signs. The beneficiary is then given a copy of the application, a GSHP Conditions of Membership form, and a GSHP Information Sheet at the time of application. (See Appendix, N.J.A.C. 10:49).

(e) Beginning on the effective date of enrollment in the GSHP, a message is printed on the Medicaid ID card (FD-152 Form, see N.J.A.C. 10:49-2.12 and Appendix, N.J.A.C. 10:49). The message states "HMO—CHECK GSHP ID CARD." This message alerts providers to ask the member for his or her GSHP identification card. The GSHP ID card lists each family member and his or her PCM's name and telephone number.

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 changed; and substituted "beneficiary" for "recipient" throughout.

10:49-20.5 Action required by providers

(a) When providing services and requesting payment for services rendered GSHP members, providers are required to:

1. Check the Medicaid eligibility card for GSHP message;
2. Ask to see the GSHP Member Identification card for PCM's name and telephone number;
3. Contact the PCM to receive prior authorization to provide services; and
4. Follow billing instructions in the Fiscal Agent Billing Supplement.

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

10:49-20.6 GSHP Services

(a) The following services are covered under the GSHP. Those services in (a)18 through 23 below do not require prior authorization from a PCM.

1. Chiropractic services;
2. Clinical laboratory services;
3. Clinic services at free-standing clinics;
4. Drugs (prescription);
5. EPSDT;
6. Hearing aids;
7. Home health services;
8. Hospital services, including
 - i. Emergency room service;
 - (1) True life- or organ-threatening conditions may be treated, with notification to the PCM as soon as possible;
 - ii. Inpatient hospitalization; and
 - iii. Outpatient clinic;
9. Medical equipment;
10. Medical supplies;
11. Mental health services including psychologist services: only one mental health service every six months (requires prior authorization by the PCM);
12. Optical appliances;
13. Optometric services;
14. Physician services, including inpatient physician services;
15. Podiatric services;
16. Radiological services;
17. Rehabilitative services (physical therapy, occupational therapy, audiology and speech-language pathology services);
18. Second surgical opinion consultations;
19. Physician fee for routine in-hospital newborn care;
20. Pediatrician attendance at at-risk vaginal deliveries or caesarian sections;
21. Practitioner fee for normal prenatal, delivery and post partum services;
22. Certified nurse midwife services; and
23. Certified nurse practitioner/Clinical nurse specialist.

(b) The following services are non-covered services under the GSHP. Non-covered GSHP services are still available to the GSHP client, outside of the Plan, as long as the beneficiary retains his/her Medicaid eligibility. Such services must be provided in accordance with policies described in the appropriate manual.

1. Dental services;
2. Medical day care;
3. Nursing facility care;
4. Prosthetics and orthotics; and
5. Transportation services.

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

Added (a)23 and made conforming amendments; and in (b), substituted "beneficiary" for "client".

10:49-20.7 Emergency medical care situations for GSHP members

(a) Emergency medical care is available to all GSHP members on a 24-hour, seven-day-a-week basis. Listed below are the guidelines for assessing (for reimbursement and reconciliation purposes) the levels of care in an emergent, urgent or routine situation. These guidelines can be applied to any setting.

1. Level I—Emergency life-threatening or organ-threatening or potentially life-or-organ-threatening condition that requires immediate care. The treating provider must notify the PCM as soon as possible after stabilizing the patient.
2. Level II—Urgent condition that is potentially harmful to a patient's health and determined by the physician to be medically necessary for medical treatment within 12 hours to prevent deterioration. The PCM must be called by the treating provider for authorization of the services before providing treatment.
3. Level III—Routine medical care (non-emergent/urgent—that which would have no adverse effects if not treated within 24 hours or could be treated in a less acute setting (for example, physician's office) or by the patient himself or herself. The PCM must be called by the treating provider for authorization of the services before providing treatment.

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

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

10:49-20.8 GSHP reimbursement policy for emergency services

(a) Level I emergency care will be reimbursed without the requirement of the PCM's prior authorization. However, the PCM must be notified as soon as the patient is stabilized. The GSHP office shall be contacted for exception for payment processing (telephone 1-800-525-0047).

(b) Services classified under Levels II and III will be reimbursed only when prior authorized by the PCM. If the PCM is contacted for authorization and he or she does grant his or her approval, the provider may then treat the patient and when billing for the service, include the PCM's authorization number in the appropriate portion of the claim form. The completed claim can then be submitted directly to the Fiscal Agent for payment.

1. In situations for services classified under Levels II and III where the provider and PCM do not agree and the provider renders service without authorization but feels reimbursement is warranted, the provider may request of the Plan Office payment consideration by stating and documenting his or her reasons for treatment on the GSHP 16 form, "Exception Payment Request Form" (obtained through the Plan Office). To receive consideration for reimbursement, it will be necessary for the provider to submit the completed GSHP-16 and a hard copy claim to the GSHP office.

i. The New Jersey Medicaid program's policy on timeliness of claim submission and inquiry applies to the GSHP; thus, the GSHP-16 must be submitted to and received by the GSHP, in accordance with time frames stated in N.J.A.C. 10:49-7.2.

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

10:49-20.9 Exception Payment Request Form (GSHP-16)

(a) If due to unusual circumstances a provider failed to obtain authorization from the PCM before rendering a service, he or she may request a review by and retroactive approval from the PCM.

(b) After contacting the PCM, the provider will either be sent the authorization by the PCM, or will be refused. The PCM does have the right to refuse a request for a retroactive approval.

1. If retroactive authorization is refused by the PCM and the provider feels the care was appropriately rendered, he or she may request an Exception Payment Request Form (GSHP-16), for each occurrence, from the GSHP Office, DMAHS, CN-712, Trenton, N.J. 08625-0712. Detailed information about the nature of the service as well as the circumstances of the failure to obtain prior approval will be required. For more information, providers may contact the Plan office at 1-800-525-0047.

SUBCHAPTER 21. THE MEDICAID MANAGED CARE PROGRAM—NJ CARE 2000

10:49-21.1 Purpose and scope

The Medicaid Managed Care Program—New Jersey Care 2000 is a program under which Health Maintenance Organizations (HMOs) contract with the Department of Human Services to provide health care services to Medicaid beneficiaries. Requirements governing HMO providers and services are codified at N.J.A.C. 10:49-74. For more information, providers may contact the Medicaid Managed Care Hotline at 1-800-356-1561.

10:49-21.2 Capitation payment system

Under the Medicaid Managed Care Program—New Jersey Care 2000, HMOs are reimbursed through a capitation payment system whereby DMAHS pays an HMO a set amount for the services it provides to beneficiaries, as described in N.J.A.C. 10:74.

10:49-21.3 Medicaid beneficiaries

(a) The Medicaid Managed Care Program—New Jersey Care 2000 is a mandatory enrollment program for AFDC and AFDC related New Jersey Care pregnant women and children and is offered to the SSI Medicaid beneficiary as an alternative to the existing Medicaid fee-for-service program.

(b) Medicaid beneficiaries enrolled in HMOs receive two identification cards.

1. One card is issued by the HMO and appropriate toll-free telephone numbers are indicated on the card. These telephone numbers allow the provider to inquire whether a service the provider intends to perform will be covered or if the provider needs a prior approval.

2. The second card issued is the same Medicaid Eligibility Identification card issued to all beneficiaries. However, on the card, the words "ENROLLED IN HMO XYZ, 1-800-XXX-XXXX" is imprinted (see Appendix Form #7). This card also provides the toll-free telephone number of the HMO in which the beneficiary is enrolled so that the provider can verify HMO membership. Questions about covered services should be referred to this number.

10:49-21.4 Medicaid Managed Care Program—New Jersey Care 2000 Services

(a) The following services are provided under the Medicaid Managed Care Program—New Jersey Care 2000:

1. Primary and specialist care (Preventive health care and counseling, EPSDT);
2. Inpatient and outpatient hospital services;
3. Emergency medical care;
4. Laboratory and radiology services;

5. Prescription drugs (Legend and non-legend drugs);
6. Family planning services
7. Podiatrist services;
8. Chiropractor services;
9. Optometrist services;
10. Optical and hearing appliances;
11. Home health agency services;
12. Medical supplies and durable medical equipment;
13. Dental services;
14. Ambulance, Mobile Intensive Care Unit (MICU) and invalid coach transportation services;
15. Prosthetic and orthotic services;
16. Rehabilitation services (Outpatient rehabilitation therapies—physical therapy, occupational therapy, speech/language, audiology, 60 days/therapy/year.);
17. Hospice services; and
18. Private duty nursing agency services.

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

1. Medical day care;
2. Elective/induced abortion services;
3. Lower mode transportation;
4. Psychiatric inpatient hospital services;
5. Residential treatment center care services;
6. Intermediate care facility/mental retardation services;
7. Rehabilitation services in excess of 60 days per year;
8. Services to beneficiaries participating in waiver or demonstration programs;
9. Personal care assistant services;
10. Nursing facility care;
11. Substance abuse services—diagnosis, treatment and detoxification costs for methadone and its administration; and
12. Mental health services.

(c) Certain services provided to beneficiaries who are enrolled in an HMO will no longer be reimbursed on a fee-for-services basis. If the beneficiary is enrolled in an HMO, and the HMO restricts payment to providers who have agreed to contract with it, a provider who is not a contractor with the HMO, or who fails to obtain authorization from the HMO, may not be reimbursed. It is therefore incumbent

upon the provider to check the identification card of the Medicaid beneficiary prior to the provision of any service, even if the provider has received prior authorization from a Medicaid District Office or Medicaid's Central Dental Services Unit. Failure to do so could result in a claim being rejected by both the Division's fiscal agent, Unisys, and the member's HMO.

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

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

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

SUBCHAPTER 22. HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAMS

10:49-22.1 Introduction

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

the community, or return to the community, rather than be cared for in a nursing facility or hospital setting.

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

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

Amended by R.1994 d.426, effective August 15, 1994.

See: 26 N.J.R. 1566(a), 26 N.J.R. 3466(b).

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

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

In (b), substituted "beneficiary" for "client"; deleted (d); and recodified (e) as N.J.A.C. 10:49-22.2.

10:49-22.2 Approved Waivers

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

1. Community Care Program for the Elderly and Disabled (CCPED);

2. Home and Community-Based Services Waivers for Blind or Disabled Children and Adults (Medicaid's Model Waivers I, II, and III);

3. AIDS Community Care Alternatives Program (ACCAP);

4. Traumatic Brain Injury Program;

5. Home and Community-Based Services Waiver Program for Developmentally Disabled Individuals;

6. Home and Community-Based Services Waiver Program for Children (ABC); and

7. Assisted Living/Alternative Family Care (AL/AFC) Waivers.

Amended by R.1994 d.426, effective August 15, 1994.

See: 26 N.J.R. 1566(a), 26 N.J.R. 3466(b).

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

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

Section recodified from N.J.A.C. 10:49-17.1(e); rewrote introductory paragraph and added (a)5 through 7.

10:49-22.3 Administration of waived programs

(a) The Division of Medical Assistance and Health Services administers the following Home and Community-Based Services Waivers: Home and Community-Based Services Waivers for Blind or Disabled Children and Adults Medicaid Model Waivers I, II, and III; AIDS Community Care Alternatives Program (ACCAP) and Traumatic Brain Injury Waiver.

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

(c) The Division provides oversight to the Division of Youth and Family Services (DYFS) in its administration of Home and Community-Based Services Waiver for Children.

(d) The Department of Health and Senior Services administers the Community Care program for the Elderly and Disabled (CCPED) waiver, and the Assisted Living/Alternative Family Care (AL/AFC) waiver.

Amended by R.1994 d.426, effective August 15, 1994.

See: 26 N.J.R. 1566(a), 26 N.J.R. 3466(b).

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

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

Section was recodified from N.J.A.C. 10:49-1.6; in (a), inserted "and Traumatic Brain Injury Waiver; and added (c) and (d).

10:49-22.4 Home and Community-Based Services Waivers

(a) Any questions regarding Home and Community-Based Services Waiver programs described in N.J.A.C. 10:49-22.2(a)2, 3, 4, 5, or 6, may be directed to the Bureau of Home Care Services (BHCS), located in the Division of Medical Assistance and Health Services' Central Office, telephone number (609) 588-2620.

(b) Any questions regarding Home and Community-Based Services Waiver programs described in N.J.A.C. 10:49-22.2(a)1 or 7 may be directed to DHSS, Division of Consumer Support Services, telephone (609) 588-2611.

Amended by R.1994 d.426, effective August 15, 1994.

See: 26 N.J.R. 1566(a), 26 N.J.R. 3466(b).

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

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

Section recodified from N.J.A.C. 10:49-17.1(d); substantially amended (a), and added (b).

10:49-22.5 Community Care Program for the Elderly and Disabled (CCPED)

(a) CCPED became effective October 1, 1983. The program allows for community care slots, allocated on a county basis in accordance with the needs of the county.

(b) The seven services listed below are available under CCPED. Other Medicaid (Title XIX) services are not available to the waived population. There is a cost cap on each individual service package.

1. Case management;
2. Home Health;
3. Homemaker;
4. Medical day care;
5. Medical transportation (non-emergency);
6. Respite care; and

7. Social day care.

(c) Eligibility requirements for CCPED are as follows:

1. All individuals must be assessed to be in need of nursing facility care.

2. Individuals age 65 or over must be eligible for Medicare or have other health insurance coverage which includes hospital and physician coverage.

3. Individuals under 65 must be determined disabled by the Federal Social Security Administration and be eligible for Medicare or be determined disabled by the Division of Medical Assistance and Health Services' Disability Review Section and have other health insurance, including hospital and physician coverage.

4. An individual's own income must exceed the SSI community standard up to the institutional cap or be ineligible in the community because of SSI Deeming Rules. An individual's resources may not exceed those required in the institutional program. A spouse's income also is not considered. While the spouse's resources are considered in the determination of eligibility, up to one-half of the couple's total resources are protected for the use of the spouse.

5. In order to be enrolled in the program, a waiver slot must be available.

10:49-22.6 Medicaid's Model Waivers—I, II, and III

(a) The Model Waivers are Home and Community-Based Services Waiver programs for Blind or Disabled Children and Adults. Included are Model Waiver I (effective September 1, 1983), Model Waiver II (effective April 1, 1985) and Model Waiver III (effective April 1, 1986).

1. Model Waivers I and II serve a maximum of 50 individuals each. Model Waiver III serves 150. There are no geographic limitations nor limitations on the number of individuals who can be served within any one county.

(b) The Model Waiver programs offer, with the exception of nursing facility services, all New Jersey Medicaid (Title XIX) services, plus case management. Model Waiver III also offers private-duty nursing. "Private duty nursing" means individual and continuous care, in contrast to part-time or intermittent care, provided by licensed nurses. Private duty nursing is limited to a maximum of sixteen hours per day per person and will be provided only when there is a live-in primary caregiver (adult relative or significant other adult) who accepts 24-hour responsibility for the health and welfare of the beneficiary.

1. Each individual's service package must be no more than the cost of institutional care, determined at a projected weighted cost of hospital care or net average cost of nursing facility care.

(c) Eligibility requirements for the Model Waivers are as follows:

1. Individuals must be in need of institutional care and meet the minimum nursing facility (NF) level of care criteria in accordance with N.J.A.C. 10:63-2.1 and 2.2. Model Waiver III also requires that individuals be in need private-duty nursing service, in accordance with N.J.A.C. 10:60-1.12(b).

2. For Model Waivers I and II, individuals must meet optional categorically needy standards, in accordance with N.J.A.C. 10:71 and 10:72. Total income must exceed the SSI community standard up to the institutional CAP, or the individual must be ineligible in the community because of SSI Deeming Rules. Parental income or resources are not considered in determining eligibility. While a spouse's income is not considered towards eligibility, up to one-half of the couple's total resources are protected for the use of the spouse.

3. Model Waiver III applicants can either be optional categorically eligible or categorically eligible. In other words, MW III also serves individuals who are eligible under SSI, DYFS or AFDC programs.

4. Individuals must be blind or disabled children and adults. Individuals who have not been determined disabled under the Social Security Act must be determined disabled by the Division of Medical Assistance and Health Services' Disability Review Section, in accordance with N.J.A.C. 10:71-3.12.

5. In order for an individual to be enrolled in the program, a waiver slot must be available.

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

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

Section recodified from N.J.A.C. 10:49-17.3; in (b), substituted "beneficiary" for "recipient"; in (c)1, 2 and 4 inserted N.J.A.C. references; and in (c)5, inserted "for an individual".

Case Notes

Quadriplegic's death mooted appeal from denial of her application for home health care. J.C. v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 42.

10:49-22.7 AIDS Community Care Alternatives Program (ACCAP)

(a) ACCAP became effective March 1, 1987. The program allows for an allocation of a specific number of slots in accordance with the needs of each county in the State.

(b) Total program costs are restricted by the number of community care slots each year and on per-person costs. Each individual's service package must be no more than the cost of institutional care, determined at a projected weighted cost of hospital care or net average cost of nursing facility care. ACCAP offers, with the exception of nursing facility services, all New Jersey Medicaid services, plus those listed in (b)1 through 7 below.

1. Case management;
2. For children:
 - i. Intensive supervision to children who reside in Division of Youth and Family Services' foster homes; and
 - ii. Specialized group foster home;
3. Hospice care services at home;
4. Medical day care (specialized);
5. (Certain) Narcotic and drug abuse treatments at home;
6. Personal care assistant services (no limitation on the number of hours); and
7. Private-duty nursing.

(c) Eligibility requirements for ACCAP are as follows

1. Individuals must be in need of institutional care and meet, at a minimum, the nursing facility level of care criteria.
2. Individuals must be diagnosed as having AIDS or ARC. Children under the age of 13 may also be diagnosed HIV positive.
3. Individuals who are categorically needy or optional categorically needy are served under the program.
4. There is no deeming of parental income or resources in the determination of eligibility. A spouse's income also is not considered. While the spouse's resources are considered in the determination of eligibility, up to one-half of the couple's total resources are protected for the use of the spouse.
5. Individuals under the age of 65 who are eligible for coverage as optional categorically needy must be determined disabled by the Social Security Administration (SSA) or by the Disability Review Section, Division of Medical Assistance and Health Services.
6. In order for an individual to be enrolled in the program, a waiver slot must be available.

Amended by R.1997 d.323, effective August 4, 1997.
See: 29 N.J.R. 403(b), 29 N.J.R. 3487(a).

In (b), amended internal cite; in (c)2, substituted "age of 13" for "age of five"; in (c)5, substituted "Individuals under the age of . . . categorically needy" for "Optionally categorically eligibles under age 65".

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

Section recodified from N.J.A.C. 10:49-17.4; in (c)6, inserted "for an individual".

10:49-22.8 Traumatic Brain Injury Program

(a) The Traumatic Brain Injury (TBI) Program is a renewable Federal waiver program under Section 1915(c) of the Social Security Act, 42 U.S.C. § 1396n, which offers home and community-based services to a beneficiary with an acquired traumatic brain injury. The purpose of the TBI program is to help eligible beneficiaries to remain in the community, or to return to the community rather than be cared for in a nursing facility.

(b) The waiver, prepared by the Division of Medical Assistance and Health Services (DMAHS), encourages the development of community-based services in lieu of institutionalization.

(c) The Program is Statewide, with slots allocated as individuals, ages 18 through 65, are admitted to the program.

(d) The Division administers the overall program, and has the responsibility for assessing an applicant's need for care and, for determining which applicants will be served by the program.

(e) Program oversight shall be provided by the Division of Medical Assistance and Health Services through the Bureau of Home Care Services (BHCS) and the Surveillance Utilization Review Subsystem (SURS). The delivery of home care services to TBI Waiver beneficiaries will be subject to a post-payment utilization review by professional staff of the Medicaid District Offices in accordance with N.J.A.C. 10:63-1.15.

(f) Applicants for participation in the TBI waiver program shall meet the following medical and financial eligibility criteria:

1. Be not less than 18 nor more than 65 years of age at the time of enrollment;
2. Have a diagnosis of acquired brain injury which occurred after the age of 16;
3. Exhibit medical, emotional, behavioral and/or cognitive deficits;
4. Meet the Division's nursing facility standard care criteria for Pre-Admission Screening (PAS), at N.J.A.C. 10:60-1.2;
5. Have a rating of at least four on the Rancho Los Amigos Levels of Cognitive Functioning Scale (see N.J.A.C. 10:60, Appendix I);
6. Be blind, disabled, or a child under the supervision of the Division of Youth and Family Services (DYFS) and be eligible for Medicaid in the community or be eligible for Medicaid if institutionalized. Persons eligible for the Medically Needy segment of New Jersey Care . . . Special Medicaid Programs, or enrolled in Garden State Health Plan, or private Health Maintenance Organizations serving Medicaid beneficiaries are not eligible for this program.

i. There is no deeming of spousal income in the determination of eligibility for this program. While spousal resources are considered in the determination of eligibility, up to one-half of the total resources are protected for the use of the spouse; and

7. Be determined disabled by the Social Security Administration (SSA) or by the Disability Review Unit of the Division, using the SSA disability criteria.

(g) If the individual is dually diagnosed, for example, with a head injury and psychiatric illness or developmental disability or substance abuse addiction, a determination will be made during the initial review as to the most appropriate service system to manage the beneficiary's care. This decision will be made based on clinical evidence as of onset of injury, and professional evaluation.

(h) Retroactive eligibility shall not be available to waiver beneficiaries for those Medicaid services provided only by virtue of enrollment in the waiver program. Those individuals who are not eligible for Medicaid services in the community prior to enrollment in the TBI Waiver are not eligible for retroactive Medicaid eligibility.

(i) All applicants determined eligible for the TBI Waiver shall be issued a Medicaid Eligibility identification (MEI) Card.

(j) In order for an applicant to be enrolled in the program, a waiver slot must be available.

(k) Prior to formal application for the TBI waiver, a referral shall be submitted to the Bureau of Home Care Services (BHCS) of the Division, which shall review the referral to determine if the individual meets the basic criteria for the program. If it is determined that the individual referred is a potential candidate for the TBI waiver, the following shall occur:

1. Supplemental Security Income (SSI) beneficiaries shall be referred to the appropriate Medicaid District Office serving their county of residence;

2. Children under the supervision of the Division of Youth and Family Services (DYFS) shall be referred to DYFS for the initiation of the formal application, which includes the determination of disability, and shall then be referred to the appropriate Medicaid District Office (MDO) serving the beneficiary's county of residence; and

3. Individuals who are not currently Medicaid eligible shall be referred by (BHCS) to the county welfare agency (CWA) located in the county where the individual resides, for a determination of financial eligibility, including the referral for determination of disability.

(l) After the applicant has been determined financially eligible, he or she shall be referred to the Medicaid District Office (MDO) of the applicant's residence for a determina-

tion of medical eligibility by the Regional Staff Nurse (RSN).

(m) When the applicant is judged financially and medically eligible for the TBI waiver program, the MDO shall assign the case to a case management site and notify the (BHCS) of the beneficiary's approval for participation in the program.

(n) The MDO shall review and approve the plan of care prepared by the case manager initially, and at six month intervals.

(o) If a waiver beneficiary is categorically eligible for Medicaid services under the State Plan and no waiver services are required as a part of the plan of care, the beneficiary shall be terminated from the TBI program.

(p) All approved services under the New Jersey Medicaid program, except for nursing facility services, are available under the TBI Waiver from approved Medicaid providers in accord with an individualized plan of care. (See N.J.A.C. 10:60-5.5 for a description of services.)

(q) An individual shall be terminated from the TBI Waiver Program for the following reasons:

1. He or she no longer meets the income and resource requirements for Medicaid;

2. He or she no longer exhibits medical, emotional, behavioral and/or cognitive deficits which would qualify the individual for nursing facility care;

3. He or she attains a Level 8 or above on the Rancho Los Amigos Levels of Cognitive Functioning Scale;

4. He or she refuses to accept case management services; or

5. He or she is categorically eligible for Medicaid State Plan services and does not require waiver services as part of the plan of care.

(r) Where termination is sought pursuant to (q) above, an individual shall be afforded the opportunity to request a hearing pursuant to N.J.A.C. 10:49-9.10.

New Rule, R.1994 d.426, effective August 15, 1994.

See: 26 N.J.R. 1566(a), 26 N.J.R. 3466(b).

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

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

Section recodified from N.J.A.C. 10:49-17.5; substituted references to beneficiary for references to recipient and references to BHCS for references to OHCP throughout.

SUBCHAPTER 23. LIFELINE PROGRAMS

10:49-23.1 Purpose and scope

Lifeline Programs provide an annual benefit to eligible persons toward the cost of electricity and natural gas. The

Lifeline Credit Program (LCP) and the Tenants Lifeline Assistance Program (TLAP) are administered by the Department of Health and Senior Services. The rules for these programs are promulgated by the Department of Health and Senior Services. Although the Department of Health and Senior Services also administers the Lifeline benefit, because Supplemental Security Income (SSI) beneficiaries receive the benefit as a Special Utility Supplement (SUS) in their monthly SSI checks, DMAHS is responsible for establishing the policies and procedures for eligibility for this benefit as part of their SSI income eligibility for the Medicaid program.

10:49-23.2 Applications

(a) Applications for the Lifeline Programs are sent automatically to persons benefiting from the following Medicaid programs:

1. Medical Assistance to the Aged (MAA);
2. Medical Assistance Only (MAO); and
3. New Jersey Care . . . Special Medicaid Programs.

SUBCHAPTER 24. WORK FIRST NEW JERSEY/GENERAL ASSISTANCE CLAIMS PROCESSING

Authority

N.J.S.A. 30:4D-7 and P.L. 1999, c.309.

Source and Effective Date

R.2000 d.309, effective August 7, 2000.
See: 32 N.J.R. 1342(a), 32 N.J.R. 2900(a).

10:49-24.1 Introduction

(a) Effective for services rendered on or after February 1, 1997, consistent with N.J.A.C. 10:90-13, the Division's fiscal agent shall process Work First New Jersey/General Assistance (WFNJ/GA) claims. N.J.A.C. 10:49-24.3 describes the covered services that shall be processed by the fiscal agent. N.J.A.C. 10:49-24.4 describes services that shall not be processed by the fiscal agent. N.J.A.C. 10:49-24.5 indicates that payment for services shall be made using existing Medicaid reimbursement methodology.

(b) The information in this subsection is provided to assist providers in identifying a WFNJ/GA beneficiary. Consistent with N.J.A.C. 10:90-13.2, each municipal welfare department (MWD) or county board of social services (CBOSS) provides a validation card or letter for each client which is used to obtain medical services. The validation card or letter is supplied to each WFNJ/GA beneficiary at the time of opening or reopening of the case and monthly thereafter to ensure validity through all periods of assistance and eligibility. Each card or letter shall contain, at a minimum:

1. The name, address, and telephone number of the MWD and the agency's four-digit municipality code;
 - i. The four-digit codes range from 5001 to 5099 and from 5200 to 5786;
2. The first and last name(s) of the WFNJ/GA client(s) to whom the card or letter applies;
3. A six-digit client case number;
 - i. If the case number assigned to a WFNJ/GA client is less than six digits, the MWD/CBOSS shall add zeros (example: 000411);
4. A two digit person number; and
5. The effective date and expiration date of the card or letter.
 - i. Validation cards or letters shall not be valid for more than one month.

(c) Providers may contact the local MWD/CBOSS that assists the WFNJ/GA client if there are questions regarding eligibility. Questions regarding WFNJ/GA requirements or coverage of services should be directed to DMAHS. Only questions related to claim processing should be directed to the fiscal agent.

(d) Dispute resolution requirements related to a client's eligibility for WFNJ/GA are contained in N.J.A.C. 10:90-9. Individuals shall contact the county or municipal agency to resolve any questions, consistent with the requirements contained in N.J.A.C. 10:90-9.

10:49-24.2 Administrative provisions

(a) Any provider of services shall meet Medicaid requirements and be enrolled as a Medicaid provider. Requirements regarding enrollment and provision of service are set forth in the appropriate chapters of the New Jersey Administrative Code.

(b) The administrative requirements of the Medicaid program shall apply to these claims. The requirements contained in this chapter include, but are not limited to, N.J.A.C. 10:49-1, General Provisions; N.J.A.C. 10:49-3, Provider Participation; N.J.A.C. 10:49-4, Providers' Role in a Shared Health Care Facility; N.J.A.C. 10:49-5.5, Services not covered by the Medicaid or NJ KidCare-Plan A program; N.J.A.C. 10:49-6, Authorizations Required by Medicaid and NJ Kid Care Programs; N.J.A.C. 10:49-7, Submitting Claims for Payment (Policies and Regulations); N.J.A.C. 10:49-8, Payment for Services Provided; N.J.A.C. 10:49-11, Exclusion from Participation in the New Jersey Medicaid and NJ KidCare Programs (Suspension, Debarment, and Disqualification); N.J.A.C. 10:49-12, Provider Reinstatement; N.J.A.C. 10:49-13, Program Controls; N.J.A.C. 10:49-14.2, Sanctions—Special Status Program; N.J.A.C. 10:49-14.3, Authority to adjust, compromise, settle or waive claims, liens and certificates of debt; and N.J.A.C. 10:49-14.5, Administrative charges/service fees.

1. WFNJ/GA claims processed by the Division's fiscal agent are not subject to the fair hearing processes described at N.J.A.C. 10:49–9.14.

10: -24.3 Services available under the Work First New Jersey/General Assistance (WFNJ/GA) program

(a) The Medicaid fiscal agent shall reimburse only those WFNJ/GA program covered services listed below in this subsection when provided in an ambulatory setting, except as specified in N.J.A.C. 10:49–24.4(a)14. These services include:

1. Abortion (elective/induced);
2. Acupuncture;
3. ADDP covered anti-retroviral drugs;
4. Ambulance;
5. Ambulatory surgery;
6. Blood and blood plasma;
7. Case management services for the chronically mentally ill (for specific information, see N.J.A.C. 10:73);
8. Certified nurse practitioner/clinical nurse specialist services (for specific information, see N.J.A.C. 10:58A);
9. Chiropractic services (for specific information, see N.J.A.C. 10:68);
10. Clinic services (services in an independent outpatient health care facility, ambulatory care facility, ambulatory surgical center, ambulatory care/family planning/surgical facility, drug treatment center, Federally qualified health center, free-standing end-stage renal dialysis facility), such as dental, family planning, laboratory, mental health, minor surgery, personal care assistance, podiatry, radiology, rehabilitation, or vision care (for specific information, see N.J.A.C. 10:66), except that:
 - i. Professional services provided by a residential alcohol or drug abuse treatment facility to an individual residing in the facility shall not be processed;
11. Dental services, including dentures (for specific information, see N.J.A.C. 10:56);
12. Durable medical equipment;
13. 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, except that:
 - i. Services provided primarily for the diagnoses and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures shall not be processed.

14. Hearing aid services (for specific information, see N.J.A.C. 10:64);

15. Home care services, including home health care (for specific information, see N.J.A.C. 10:60);

16. Hospice services, except those provided in a nursing home facility (for specific information, see N.J.A.C. 10:53A);

i. The following hospice services, with corresponding HCPCS, shall be processed under the WFNJ/GA program:

- (1) Y6333 Routine home care rate;
- (2) Y6334 Continuous home care rate; and
- (3) Y6343 Drugs and biologicals co-payment (rendered in places other than long term care facilities).

ii. The following hospice services, with corresponding HCPCS, shall not be processed under the WFNJ/GA program:

- (1) Y6335 Inpatient respite care rate;
- (2) Y6336 General inpatient care;
- (3) Y6337 Therapeutic leave days;
- (4) Y6338 Bed hold days;
- (5) Y6339 Hospice Respite Care; and
- (6) Z2015 Room and board;

17. Laboratory (clinical) services (for specific information, see N.J.A.C. 10:61);

18. Medical supplies and equipment (for specific information, see N.J.A.C. 10:59);

19. Mental health services (for specific information, see N.J.A.C. 10:66);

20. Non-maternity nurse-midwifery services, such as family planning (for specific information, see N.J.A.C. 10:58);

21. Optometric services (for specific information, see N.J.A.C. 10:62);

22. Optical appliances (for specific information, see N.J.A.C. 10:62);

23. Personal care assistant;

24. Thermograms;

25. Thermography;

26. Pharmaceutical services (for specific information, see N.J.A.C. 10:51);

i. Prior authorization shall be required where patterns of medically harmful or inappropriate use of specific drugs, therapeutic drug classes, enteral nutritional supplements, needles and syringes have been

identified, or for claims originating in certain municipalities where such patterns have been identified; and

ii. Effective with claims for dates of service on or after August 7, 2000, the Division's processing of claims for certain antiretroviral drugs shall be accomplished under the AIDS Drug Distribution Program (ADDP), administered by the Department of Health and Senior Services (DHSS), except for emergency supplies as authorized under WFNJ/GA to avert a lapse in treatment. These drugs shall include, but may not be limited to: thymidine nucleosides, thymidine analogs, protease inhibitors, nucleoside analog reverse transcriptase inhibitors, non-nucleoside reverse transcriptase inhibitors, carbocyclic nucleoside analogs, purine nucleoside analogs of deoxyadenosine, and pyrimidine nucleoside analogs;

27. Physician services (for specific information, see N.J.A.C. 10:54);

28. Podiatric services (for specific information, see N.J.A.C. 10:57);

29. Prosthetic and orthotic devices (for specific information, see N.J.A.C. 10:55);

30. Psychological service (for specific information, see N.J.A.C. 10:67);

31. Radiological services (for specific information, see N.J.A.C. 10:54);

32. Rehabilitative services (for specific information, see N.J.A.C. 10:66). Payments shall be made to eligible Medicaid providers only. No payment shall be made to privately practicing therapists who are not Medicaid providers. Rehabilitative services include:

- i. Physical therapy;
- ii. Occupational therapy;
- iii. Speech-language pathology services; and
- iv. Audiology services;

33. Transportation services which include ambulance and mobility assistance vehicle (for specific information, see N.J.A.C. 10:50 and 10:66);

34. Medicare coinsurance and/or deductible for services specified in (a)1 through 23 above, if otherwise reimbursed by the New Jersey Medicaid program; and

35. Inpatient services provided by Mt. Carmel Guild Hospital located in Newark, New Jersey.

Special amendment, R.2002 d.214, effective June 10, 2002.
See: 34 N.J.R. 2338(a).
Rewrote the section.

10:49-24.4 Services that shall not be processed by the fiscal agent

(a) Consistent with N.J.A.C. 10:90-13.1(a)2, the following services shall not be processed by the fiscal agent:

1. Case management for early intervention services;
2. Early and periodic screening, diagnosis, and treatment (EPSDT) screenings, and any other EPSDT services needed to ameliorate a defect if the services are otherwise not covered by the WFNJ/GA program;
3. EPSDT school-based or early intervention rehabilitation services;
4. Federally qualified health center encounter rates;
5. For individuals dually eligible for Medicaid and WFNJ/GA, any services that should have been, but were not, covered by an HMO to which the Medicaid program has made a payment, shall be provided or covered as a medical service;
6. HealthStart maternity and pediatric care services;
7. Inpatient or outpatient services/care provided by an enrolled hospital provider, either in-State or out-of-State, including, but not limited to, psychiatric hospitals, acute care hospitals, special hospitals, rehabilitation hospitals, non-religious medical institutions and county or State hospitals, except that:
 - i. Inpatient services provided by Mt. Carmel Guild Hospital located in Newark, New Jersey shall be processed by the fiscal agent; and
 - ii. Services provided by a hospital when that facility is not providing them as hospital services and is not enrolled as a hospital, including, but not limited to, hospital-based home health agency services, dental clinic services, end-stage renal dialysis services, hospital-based transportation services, and case management services for the chronically mentally ill, shall be processed;
8. Intermediate care facility for the mentally retarded (ICF/MR) services;
9. Managed care services;
10. Maternity services, including prenatal, delivery and postpartum services (through two months), provided by any type provider, including, but not limited to, physicians, certified nurse specialists/clinical nurse practitioners, certified nurse-midwives and clinics;
11. Nursing facility per diems;
12. Medical day care services;
13. Methadone maintenance services, identified by HCPCS Z2006, as set forth at N.J.A.C. 10:66-6.3(m);

14. Physician, clinical laboratory, or other professional medical services provided while a WFNJ/GA eligible individual is a patient in a hospital, including an acute care hospital, special hospital, rehabilitation hospital, non-religious medical institution, ICF/MR, an inpatient psychiatric hospital, an inpatient psychiatric program for children under the age of 21 (residential treatment centers) or services provided to a WFNJ/GA eligible individual while in an outpatient hospital department or a hospital emergency room;

15. Professional services rendered to beneficiaries residing in a residential treatment facility for drug or alcohol abuse;

16. Services provided under a home and community based services waiver under section 1915(c) of the Social Security Act, 42 U.S.C. § 1396;

17. Services that would otherwise be covered under other health insurance coverage, including services that should have been, but were not, provided by an HMO that the WFNJ/GA eligible individual is enrolled in; and

18. Transportation services provided under contract with a vendor or through a contract with the county board of social services.

10:49-24.5 Basis for reimbursement

Except as noted under N.J.A.C. 10:49-24.3(a)16ii, payment for services shall be based upon the Medicaid reimbursement methodology for the respective service. (See specific provider chapter(s) for reimbursement methodology and requirements.)



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

MEDICALLY NEEDY CLAIM TRANSMITTAL

RECIPIENT INFORMATION

HSP (Medicaid) CASE NO. _____
NAME _____
ADDRESS _____

PROVIDER INFORMATION

PROVIDER NO. _____
PROVIDER NAME _____
PROVIDER ADDRESS _____

TYPE OF SERVICE	DATE OF SERVICE	CHARGE	PAYMENT FROM OTHER SOURCE	CLIENT OBLIGATION	TOTAL FROM OTHER SOURCES
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

Provider Instructions and Information:

- The services listed above were provided to the identified individual during a covered retroactive period.
- This transmittal does not guarantee payment. Your claim will be processed in accordance with current Medicaid and Medically Needy regulations.
- Each claim form submitted for payment for services listed above must be attached to this document.
- Please enter your provider number in the appropriate space in the upper right corner.
- Any amount listed in the column entitled "Client Obligation" is the responsibility of the client and should be paid by the client directly to you.

NUMBER OF ITEMS _____

SIGNATURE _____
Authorized Representative

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
PUBLIC ASSISTANCE INQUIRY

Referral for: [] SSI [] New Jersey Care [] Medicaid Only [] AFDC [] Newborn (complete items 1,2,4,11a,15 only)

TO: FROM:
(SSA / DO)
(County Welfare Agency) Hospital

Date

1. Name: (Last) (First) (Middle) Sex [] M [] F
(For newborn referral, enter name and sex of parent.)

2. Social Security Account Number: - - - - -

3. Permanent Home Address: Telephone:

4. Marital Status: (Check one) Married [] Single [] Divorced [] Separated [] Widowed [] Unknown []

5. Date of Admission: Date of Birth:

6. Address From Which Admitted: Telephone:

7. Diagnosis:

8. Prognosis: (For SSI disability, blindness and AFDC incapacity)

9. Referring Physician: Telephone:

10. Spouse: Name: Age: Telephone:
Address:

11. Minor Children (First Names and Ages):

(a) Newborn Data: Name: Date of Birth: Sex [] M [] F
Mother's HSP (Medicaid) Case No.: - - - - -

12. Next of Kin (If other than Spouse or Children):
Address: Telephone:

13. Gross Monthly Income of Patient: Source:

14. Gross Monthly Income of Family Members:

15. Hospital Insurance: Blue Cross [] I.D. No.: Medicare [] H.I.C. No.:
(a) Applicable to Newborn? Yes [] No []

Other [] Carrier Name: Policy No.:

16. Employer's Name: Address:

17. Name of Spouse's Employer: Address:

PA 11 (rev. 7-85)

Form #3

18. What inquiries have been made regarding financial responsibility for the hospital bill?

What were the results? _____

19. Does patient, patient's authorized agent, or relatives know that an inquiry is being made for the previously checked program?

Yes No

20. Whereabouts:

Is client still in hospital? Yes No

If YES, anticipated address upon discharge: _____

If NO, date of discharge: _____

Present address if known: _____

21. Other Comments: _____

22. The above patient is being cared for in the hospital since _____ on a ward service or general service
Date basis as to professional and other personal services and I believe that such a patient may be eligible for the previously checked program.

Signature: _____ Title: _____ Date: _____

23. Signature of Patient or Relative: _____ Date: _____

PLEASE READ CAREFULLY BEFORE SIGNING

I understand that I must furnish certain information to the SSA/DO or the County Welfare Agency to establish eligibility and extent of need for Supplemental Security Income Benefits or public assistance, and that the appropriate agency will help to secure this information and verify it. I will supply complete and accurate information, within my knowledge, to representatives of the SSA/DO or the County Welfare Agency. I hereby authorize and direct my relatives, physician, hospital, employers, bankers, and any other person having information concerning the persons named above to furnish complete details to the appropriate agency investigating my application for such assistance. I understand that the information obtained will be used only in connection with the application for or receipt of assistance.

"I further authorize the Social Security Administration to release benefit information and entitlement dates to the hospital whose name appears on the reverse of this form. I understand the hospital will only use this information for purposes of establishing my eligibility to Medicaid."

Signature: _____ Relationship: _____ Date: _____

IF NOT SIGNED BY PATIENT, EXPLAIN WHY: _____

NOTICE TO THE SSA/DO OR CWA INITIALLY RECEIVING THIS INQUIRY. WHEN IT IS NECESSARY TO REFER THE APPLICANT TO ANOTHER PUBLIC ASSISTANCE AGENCY, INCLUDE AT LEAST A COPY OF THIS PA-1C FORM.

DMAHS USE ONLY

PROVIDER USE ONLY



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

CERTIFICATION OF PRESUMPTIVE ELIGIBILITY

CLIENT INFORMATION:				
Name: _____		County of Residence _____		
Address: _____		Birth Date: _____		
_____		Social Security No. _____		
Telephone No.: () _____		Household Unit: _____ (No. of persons in household)		
<i>(Check appropriate boxes below.)</i>				
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> Oriental <input type="checkbox"/> Hispanic <input type="checkbox"/> Other				
Does client have a pending AFDC, SSI, Medicaid application? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, circle program.)</i>				
Client is: <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Alien admitted for permanent residence				
<input type="checkbox"/> Alien admitted for temporary residence <input type="checkbox"/> Undocumented alien				
Medicare Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, HIC Number: _____				
Other Insurance Company: _____		Other Insurance Policy No.: _____		
INCOME INFORMATION:				
Total Household Income:	Income	Frequency	Gross Monthly Amt.	Source
Gross Earnings				
Gross Earnings				
Gross Unearned Amount				
Gross Unearned Amount				
Gross Unearned Amount				
Gross Child Support Amount				
Gross Alimony Amount				
Total Monthly Gross Income	\$ _____			
Child Care Expense Amount:	_____ Weekly	_____ BiWeekly	_____ Monthly	
PREGNANCY INFORMATION:				
Date of L.M.P. _____		Pregnancy Due Date: _____		
CERTIFICATION STATEMENT:				
I, _____ attest that I have read and agree to the above statements and fully realize that the county welfare agency relies upon the truth and accuracy of my statements. I have received a copy and understand the Patient Guidelines.				
_____ <i>Applicant Signature</i>		_____ <i>Date</i>		
I certify the above applicant is pregnant and presumptively eligible for limited Medicaid benefits in accordance with N.J.A.C. 10:72-6.1 et seq.				
_____ <i>Provider Agency Name</i>		_____ <i>Address</i>	_____ <i>Telephone</i>	
_____ <i>Provider Signature</i>		_____ <i>Date</i>		

IMPORTANT: THE ORIGINAL FORM MUST BE FORWARDED TO THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, ISS SECTION, AREA #3, PRESUMPTIVE ELIGIBILITY RECORDS, CN-712, TRENTON, NJ 08625, WITHIN TWO (2) DAYS OF COMPLETION.

Form #4 FD 324



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

**APPLICATION FOR PAYMENT OF UNPAID MEDICAL BILLS
NEW JERSEY HEALTH SERVICES PROGRAM (MEDICAID)**

NOTE: THIS FORM (FD-74) IS GIVEN ONLY TO APPLICANTS WHO INDICATE THEY HAVE UNPAID BILLS FOR MEDICAL SERVICES RECEIVED DURING THE THREE (3) MONTHS PRIOR TO APPLICATION FOR PUBLIC ASSISTANCE OR SUPPLEMENTAL SECURITY INCOME. THE FD-74 MUST BE SUBMITTED WITHIN SIX (6) MONTHS FROM THE DATE OF APPLICATION FOR PUBLIC ASSISTANCE OR SUPPLEMENTAL SECURITY INCOME.

The New Jersey Medicaid Program will evaluate this application to determine whether or not payment can be made by the program for covered Medicaid services received by the applicant and/or eligible person(s) living in the same household during the specified period. This refers only to those services for which bills remain unpaid. The Medicaid Program will not consider payment of bills that have already been paid.

PART I - APPLICANT INFORMATION

1. _____ 2. _____ 3. _____
Name of Applicant Applicant's HSP (Medicaid) Case No Applicant's Birthdate

4. _____
Street Address - Apartment Number City State Zip

_____ Telephone Number (area code) _____ Social Security Account Number _____ County of Residence

5. _____ 6. _____
Date of Application for Public Assistance or Supplemental Security Income Name and address of Agency processing application for Public Assistance or Supplemental Security Income (i.e., County Welfare Agency or Social Security Office, etc.)

7. If the applicant has applied for Aid to Families with Dependent Children (AFDC) or Assistance to Families of the Working Poor (AFWP), list the full names, ages and relationship of each dependent child or eligible person(s) living with applicant.

PART II - MEDICAL INFORMATION

- A. PLEASE COMPLETE ALL QUESTIONS LISTED ON REVERSE SIDE AS ACCURATELY AS POSSIBLE.
- B. YOU MUST ATTACH COPIES OF ALL UNPAID MEDICAL BILLS TO THIS APPLICATION.

8. List all unpaid medical bills and the dates incurred during the three (3) months before application for assistance.

Type of Services (Hospital, Physician, Etc.) Name of Hospital, Physician Etc.	Patient	Date(s) of Service	Total Amount Due

SEE OTHER SIDE

PART III - FINANCIAL INFORMATION

9 Are any of the medical bills listed on this application the result of a job related injury, auto or other accident? Yes () No ()
 If yes, explain and indicate the name of the insurance company and your legal representative.

10. What were your income and resources at the time the medical bills were incurred for the three month period before your application for Public Assistance or Supplemental Security Income? If you had no income or resources during the three (3) months prior, please specify in the spaces provided. If you were under 18 years old, you must indicate your parent's income and resources.

Please check below the type of income you received and in which month(s) received. Also, please submit verification of your income (copies of checks, pay stubs, etc.) with your application.

_____ EMPLOYMENT	WHEN RECEIVED:	TOTAL MONTHLY AMOUNT RECEIVED:
_____ UNEMPLOYMENT	_____ 1st MONTH BEFORE APPLICATION	\$ _____
_____ DISABILITY	_____ 2nd MONTH BEFORE APPLICATION	\$ _____
_____ SOCIAL SECURITY	_____ 3rd MONTH BEFORE APPLICATION	\$ _____
_____ ALIMONY		
_____ CHILD SUPPORT	HOW OFTEN RECEIVED:	
_____ OTHER: _____	_____ WEEKLY _____ BI-WEEKLY _____ MONTHLY	
_____ NO INCOME RECEIVED DURING THE THREE MONTHS BEFORE APPLYING FOR PUBLIC ASSISTANCE OR SUPPLEMENTAL SECURITY INCOME.		

What resources did you have during this same time period?

_____ CHECKING ACCOUNT \$ _____	_____ STOCKS, BONDS, ETC. \$ _____
_____ SAVINGS ACCOUNT \$ _____	_____ SPECIFY: _____
_____ AUTOMOBILE: 1. Year 19 ____ make _____	_____ OTHER: _____
_____ 2. Year 19 ____ make _____	
_____ INSURANCE POLICY 1. Face Value \$ _____ Cash Value \$ _____	
_____ 2. Face Value \$ _____ Cash Value \$ _____	
_____ NO RESOURCE OF ANY KIND	

11. Did you have any type of Medical or Health Insurance coverage, such as Blue Cross or Medicare? Yes () No ()
 (If yes, explain below.)

NAME OF INSURANCE COMPANY OR PROGRAM	POLICY NUMBER OR MEDICARE NUMBER	NAME OF INSURED

12. I certify that the above information is true and correct to the best of my knowledge and that no facts have knowingly been omitted. I understand that my application may be investigated and I agree to cooperate in such an investigation. I further understand that the law provides for fine or imprisonment, or both, for a person hiding facts or not telling the truth.

Signature of Applicant _____ Relationship to Applicant _____ Date _____
 NOTE: This application must be signed by the applicant, or relative, or legal guardian or friend acting on behalf of the applicant. This application must not be signed by the applicant's physician or anyone representing a hospital or collection agency.

MAIL THIS COMPLETED APPLICATION, TOGETHER WITH COPIES OF ALL UNPAID MEDICAL BILLS, TO THE RETRO-ACTIVE ELIGIBILITY UNIT, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, CN-712-10, TRENTON, NJ 08625.

DEPARTMENT OF HUMAN SERVICES
MEDICAID-ID

7841006

VALID ONLY FOR THE MONTH OF
MEDICAID HSP #

NOTICE TO PROVIDER

ELIGIBLE PERSONS	PER #	ELIGIBLE PERSONS	PER #
	11		
	12		
	13		
	14		
	15		
	16		
	17		
	18		
	19		
	20		
	21		
	22		

VOID

REQUEST PERSONAL IDENTIFICATION IF YOU DO NOT KNOW THE PATIENT

PLEASE REPORT THE CASE NAME, CASE NUMBER, AND PERSON NUMBER ACCURATELY ON ALL CLAIM FORMS AND OTHER COMMUNICATIONS RELATING TO THE CLAIM.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES
MEDICAID ELIGIBILITY IDENTIFICATION

CARRY THIS CARD AT ALL TIMES

Present it to the pharmacy, hospital, physician or other providers for medical services rendered in behalf of eligible persons

RECIPIENT'S SIGNATURE REQUIRED

No es válida si no está firmada. Entréguela a la farmacia, hospital, médico u otros proveedores de servicios médicos prestados a personas que reúnen las condiciones necesarias para poder usar Medicaid.

NOTICE

Federal law makes it a crime and sets punishment for persons who have been found guilty of making any false statement or representation of a material fact to receive any benefit or payment under the medical assistance program. This Department is required to make you aware of this law and to warn you against making any false statement in an application or in a fact used in determining the right to a benefit or converting a benefit to the use of any person other than one for whom it was intended.

NON-TRANSFERABLE UNDER PENALTY OF LAW

AVISO

De acuerdo con la ley federal es un delito hacer una declaración falsa a fin de recibir un beneficio o pago bajo el programa de asistencia médica, y dicha ley fija pena a las personas que la infrinjan. Este Departamento le tiene que informar de dicha ley y le tiene que advertir que no haga ninguna falsa declaración en una solicitud para determinar su derecho a un beneficio, o para convertir el beneficio al uso de otra persona que no sea la destinada a recibir el mismo.

INTRASFERIBLE BAJO PENA DE LA LEY

Form #6



STATE OF NEW JERSEY
 DEPARTMENT OF HUMAN SERVICES
 DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

VALIDATION OF ELJGIBILITY

Last Name	First Name	Mi	Health Services Program Case No.	Person Number
-----------	------------	----	-------------------------------------	---------------

NOTICE TO PROVIDERS

This form identifies the person listed above as eligible for authorized services under the New Jersey Health Services Program (Medicaid).

This form also serves as a validation of eligibility for up to 31 days from date of issue. All policies and procedures specified in the appropriate New Jersey Health Services Program Provider Manual are to be followed by providers when rendering services to this person.

The signature, title and telephone number of an authorized representative of the State Institution listed below must be included to validate this form.

THIS FORM IS THE PROPERTY OF THE STATE OF NEW JERSEY AND MUST BE RETURNED WITH THE PATIENT.

Signature and Title of State Institution Representative	Date of Issue
--	------------------

Name of State Institution	Telephone No.
---------------------------	---------------

FD-34 (rev. 5/83)

Form #7

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

PROVIDER APPLICATION

1 _____ 2 _____
 Legal Name of Provider Type of Business or Facility

 Business Name if Different From Above

3 _____ 4 _____ 5 _____ 6 _____
 Address - Service Location Units Street City County State Zip Code
 Employer ID Number Telephone Number Length of time at above address

7 _____ 8 _____
 Billing Address, if different Name of Administrator, Chief Executive Officer, or other responsible official

9 Indicate legal status of your organization: Profit _____, Non-Profit _____, Private _____, Public _____, Municipal _____
 State _____, Charity _____, School Nurse _____, County _____, Other _____ If other, please specify _____

10 List the specific service(s) for which you are requesting approval for reimbursement under the Medicaid Program

11 Do you operate from more than one location? _____ Yes _____ No If yes, list all other subsidiary or affiliated organizations below (Name and service address)

1 _____
 2 _____
 3 _____
 Please attach additional sheets if necessary.

12 Please indicate if you are a member of a chain organization. _____ Yes _____ No. If yes, indicate name _____

13 Please indicate your preference to receive central or local reimbursement.

_____ to each satellite location;
 _____ to central location at _____

Billing through a central location is allowable and left to the provider's discretion. However, if the provider chooses to bill centrally, pre-addressed claims MUST be utilized since they reflect the proper address and provider number for that location

14 Do you require a Certificate of Need under the Health Facilities Planning Act from the New Jersey Department of Health? _____ Yes _____ No If yes, attach a copy of the Certificate of Need. If no, explain why you do not require a certificate.

15 If your business or facility requires a license permit, indicate type _____ and number _____
 Please attach a copy of the license permit, i.e., Independent Laboratory Certification.

16 CERTIFICATION, ACCREDITATION OR APPROVAL Specify type and attach copy For example JCAHO (hospitals), New Jersey Department of Health (clinics), Division of Mental Health and Hospitals (mental health clinics), State Board of Dentistry (dental clinics), State Board of Pharmacy (providers offering pharmaceutical services), American Board for Certification in Prosthetics and Orthotics (Prosthetist and/or Orthotist). See Item 16.

17 Approved by Medicare? _____ Yes _____ No. If yes, please indicate Medicare provider number _____ and attach copy of your Medicare approval.

18 Are you currently or have you ever been an approved provider of services under the New Jersey Medicaid Program or the Medicaid Program of any other state or jurisdiction? _____ Yes _____ No. If Yes, list types of services provided and current status. If you were approved at one time and you no longer participate, explain the reason(s)

FD-30 (12-80)

Form #8

- 19 Have any of the entities named in response to questions 1, or 11 or their officers or partners, or any of the individuals named in response to questions 8 ever been the subject of any license suspension, revocation, or other adverse licensure action in this state or any other jurisdiction? _____ Yes _____ No If yes, please explain _____
- 20 Have any of the entities named in response to question 1 or 11 or their officers or partners, or any of the individuals named in response to questions 8 ever been indicted, charged, convicted of, or pled guilty or no contest to any federal or state crime in this state or any other jurisdiction? _____ Yes _____ No If yes, please explain _____
- 21 Have any of the entities named in response to questions 1 or 11 or their officers or partners, or any of the individuals named in response to questions 8 ever been the subject of any Medicaid (Title XIX) or Medicare (Title XVIII) suspension, debarment, disqualification or recovery action in this state or any other jurisdiction? _____ Yes _____ No If yes, please explain _____
- 22 Do any of the entities named in response to question 1 or 11 or their officers or partners, or any of the other individuals named in response to questions 8 own or have any financial interest in any other provider participating in the New Jersey Medicaid (Title XIX) Program or the Medicaid (Title XIX) Program of any other state or jurisdiction? _____ Yes _____ No If yes, please list provider name and nature of relationship _____
- 23 Do you charge for goods and/or services? TO ALL _____, TO NONE _____, TO CERTAIN GROUPS ONLY _____
If you charge to all or only certain groups, please explain your arrangement and attach a copy of your fee schedule _____
- 24 List days and hours of operation _____



STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

NEW JERSEY HEALTH SERVICES PROGRAM
TITLE XIX (MEDICAID)

PROVIDER AGREEMENT
BETWEEN
NEW JERSEY DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
AND

PROVIDER

PROVIDER AGREES:

1. To comply with all applicable State and Federal Medicaid laws and policy, and rules and regulations promulgated pursuant thereto;
2. To keep such records as are necessary to fully disclose the extent of services provided to individuals receiving assistance under the Medicaid Program;
3. To furnish the Division of Medical Assistance and Health Services, the Secretary of Health and Human Services and the Medicaid Fraud Section, Division of Criminal Justice with such information as may be requested from time to time, regarding any payments claimed for providing services under the Medicaid Program;
4. To comply with the requirements of Title VI of the Civil Rights Acts of 1964 and Section 504 of the Rehabilitation Act of 1973 and any amendments thereto; and Section 1909 of P.L. 92-603, Section 242 (c) which makes it a crime and sets the punishment for persons who have been found guilty of making any false statement or representation of a material fact in order to receive any benefit or payment under the Medical Assistance Program. (The Department of Human Services is required by Federal regulation to make this law known and to warn against false statements in an application/agreement or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended).
5. To comply with the disclosure requirements specified in 42 CFR 455.100 through 42 CFR 455.106.

The provider may, on thirty days written notice to the Division, terminate this Agreement.

DATE

SIGNATURE OF PROVIDER

TITLE

FD-62 (rev. 6/86)

Medicaid 3031-M Ed. 6/86

Form #9

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0086

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

(a). Name of Entity	D/B/A	Provider No.	Vendor No.	Telephone No.
Street Address		City, County, State		Zip Code

(b) (To be completed by HCFA Regional Office) Chain Affiliate No. LB1

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued

A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

Yes No LB2

B. Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

Yes No LB3

C. Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only)

Yes No LB4

III (a) List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on Page 2 if more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks

Name	Address	EIN

LB5

(b) Type of Entity: Sole Proprietorship Partnership Corporation Unincorporated Associations Other (Specify)

LB6

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks

Check appropriate box for each of the following questions

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers

Yes No LB7

Name	Address	Provider Number

Form HCFA-1513

Form #10

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0086

IV (a) Has there been a change in ownership or control within the last year?
If yes, give date Yes No LB8

(b) Do you anticipate any change of ownership or control within the year?
If yes, when? Yes No LB9

(c) Do you anticipate filing for bankruptcy within the year?
If yes, when? Yes No LB10

V Is this facility operated by a management company, or leased in whole or part by another organization?
If yes, give date of change in operations Yes No LB11

VI Has there been a change in Administrator, Director of Nursing or Medical Director within the last year?
 Yes No LB12

VII (a) Is this facility chain affiliated? (If yes, list name, address of Corporation and EIN)
Name EIN # Yes No LB13

Address LB14

VII (b) If the answer to Question VII a is No, was the facility ever affiliated with a chain?
(If YES, list Name, Address of Corporation and EIN) Name EIN # Yes No LB18

Address LB19

VIII Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years?
If yes, give year of change Yes No LB15

Current beds LB16 Prior beds LB17

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Name of Authorized Representative (Typed)		Title
Signature		Date
Remarks		

Form HCFA-1513



**YOUR PRESCRIPTION FOR
GOOD HEALTH**

WELCOME TO THE GARDEN STATE HEALTH PLAN

Thank you for applying for membership in the Garden State Health Plan (GSHP). After your eligibility for enrollment is verified, the GSHP will process your enrollment, which usually takes forty-five days. Your membership, therefore, should begin on . . . You will know when your membership begins when the message, "HMO-Check GSHP-ID Card," is printed on your Medicaid Identification (ID) Card which you receive each month.

A few weeks before your membership begins, you will receive a gold Garden State Health Plan Membership Card. When your GSHP membership begins, you must show both your Medicaid ID Card and your GSHP gold card each time you receive medical care.

T100

Also, as a Plan member, it is important that you establish and maintain a close relationship with your primary care physician. Remember, all medical services you receive will be coordinated by your primary care physician. You must, therefore, call your physician for authorization before you go to any other health provider, such as an eye doctor, for X-rays, or to have a prescription filled, etc.

The Garden State Health Plan operates a toll-free number: 1-800-525-0047. Please call if you have any questions or problems. Our goal is to keep each GSHP member healthy and satisfied. In addition, please notify our office immediately if you do not receive your gold card within 45 days of your application.

The Garden State Health Plan physician case manager(s) you have chosen is/are:

Name of Family Member	Physician	Telephone	Address
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SU RECETA PARA LA BUENA SALUD

UNA CORDIAL BIENVENIDA AL GARDEN STATE HEALTH PLAN

Le agradecemos su solicitud para afiliarse al Garden State Health Plan (GSHP). Después de que se compruebe su elegibilidad para la inscripción, el GSHP tramitará su inscripción, lo que normalmente toma 45 días. Por consiguiente, su afiliación comenzará el día que el mensaje "HMO-CHECK GSHP-ID CARD" esté impreso en su tarjeta de identificación de Medicaid, que recibirá mensualmente.

Unas semanas antes de que se inicie su afiliación, usted recibirá una Tarjeta dorada de Identificación como Miembro del Garden State Health Plan. Cuando se inicie su afiliación en el GSHP, cada vez que reciba atención médica usted deberá presentar su tarjeta de identificación de Medicaid junto con su tarjeta dorada del GSHP.

Además, como miembro del Plan, es importante que usted establezca y mantenga unas relaciones estrechas con su médico de atención primaria. Tenga presente que todos los servicios médicos que usted reciba serán coordinados por su médico de atención primaria. Por consiguiente, usted deberá llamar a su médico para obtener autorización antes de acudir a cualquier proveedor de salud distinto, tal como el oculista, para radiografías o para que se le dispense una receta.

El Garden State Health Plan mantiene un número de teléfono gratis de tarifa: 1-800-525-0047. Le rogamos que llame si tiene preguntas o problemas. Nuestro objetivo es el de mantener sano y satisfecho a cada uno de los miembros del GSHP. Además, le rogamos que avise a nuestra oficina si no recibe su tarjeta dorada en un plazo de 45 días de remitir su solicitud.

El o los gerentes médicos para casos del Garden State Health Plan que usted seleccionó son:

Nombre del familiar	Medico	Teléfono	Dirección
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Form #12



State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services

GARDEN STATE HEALTH PLAN (GSHP)
CONDITIONS FOR MEMBERSHIP

1. I have applied for membership in the Garden State Health Plan (GSHP). I have accepted no money nor rewards to enroll in the Plan, nor have I been forced by anyone to join the Plan.
2. I understand that I may choose my Physician Case Manager (PCM) from a list of participating physicians in my area according to the type of practice and availability of openings for that PCM.
3. I understand that I am eligible for all Medicaid services as a Plan member and I will not lose any Medicaid benefits by enrolling in this plan.
4. I understand and agree, as a Plan member, to *only* go to the doctor I have chosen for *all* medical services no matter what the problem. If an emergency occurs and my doctor cannot be contacted right away, I may go to a hospital emergency room and my PCM will be notified. I *will not* go to the hospital emergency room or to any other doctor if it is not an emergency situation.
5. I understand that the PCM I have chosen will send me for other health services whenever necessary. I will *only* use another physician's services or other health care provider's services (e.g. optometrist, chiropractor, etc.) if I have been sent by or have the approval of my PCM. Only my PCM will write any necessary prescriptions for me or will authorize another physician to write a prescription for me.
6. I understand that if I use any health services (for example, using the hospital emergency room for non-emergency or routine care) without the approval of my PCM, the Medicaid Program will not pay for these unauthorized services and I may become responsible for paying the bills.
7. I understand that my Plan participation begins when I receive my validation stub with the following message, "HMO—Check GSHP ID Card," printed on the stub. My membership in the Plan will automatically continue until my eligibility is terminated or my disenrollment is authorized. If I want to disenroll from the Plan or choose another PCM, I *must* contact the Plan Office listed below. Under certain circumstances, I may be guaranteed twelve (12) months of Medicaid eligibility upon enrollment which has been explained to me.
8. I understand that I am enrolling for six (6) month periods and that I may change my Physician Case Manager for any reason during the first thirty (30) days of membership in the Plan (which begins the first month the Plan message appears on my Medicaid Validation Card) and during the first thirty (30) days of each successive six (6) month period of membership.
9. I understand that in order to participate in the Plan I must be Medicaid eligible on the effective date of my enrollment in the Plan. If I should lose my Medicaid eligibility, my membership becomes null and void.
10. I understand that if I am currently receiving long-range medical services, (such as mental health counseling) or am under a "plan of care" of another physician, I will discuss this matter with my PCM as soon as possible. If there is any disagreement about continuing that care, I may call the designated Plan Office at the toll free number to discuss a possible solution.
11. I understand that under certain circumstances the County Welfare Agency (AFDC clients only) has the right and obligation to invalidate my twelve (12) month guarantee of eligibility if I fail to comply with public law which affect my eligibility for public assistance benefits.

Any questions or complaints about my Plan membership should be directed to:

Office of the Garden State Health Plan

Address: CN 712, Trenton, New Jersey 08625

Toll Free Telephone Number: 1 - 800 - 525 - 0047

(This number can also be found on your GSHP Membership Card.)

Form #13

GSHP-4(a)

CONDICIONES DE MIEMBRO

1. He solicitado ser miembro del Plan de Salud del Estado del Jardín. No he aceptado ningún dinero o recompensa para inscribirme al Plan, ni se me ha obligado a unirme al Plan.
2. Tengo entendido que puedo escoger mi Gerente Médico para Casos (GMC) de un listado de médicos participantes en mi área, de acuerdo al tipo de práctica y a la disponibilidad de plazas existentes para ese GMC.
3. Tengo entendido que soy elegible para todos los servicios de Medicaid como miembro del Plan y que no voy a perder ningún beneficio de Medicaid al participar en este plan.
4. Tengo entendido y estoy de acuerdo que, como miembro del Plan, visitaré para *todos* los servicios médicos *solamente* al médico que haya escogido, independientemente del problema. En caso de emergencia y no poder comunicarme con mi médico inmediatamente, puedo ir a la sala de emergencia de un hospital y se notificará a mi GMC. *No* iré a la sala de emergencia de un hospital o a ningún otro médico, a menos que sea una emergencia.
5. Tengo entendido que al GMC que haya escogido me enviará a otros servicios de salud cuando sea necesario. *Solamente* recurriré a los servicios de otro médico o de algún otro proveedor de servicios de salud (p.e. optómetra, quiropráctico, etc.), siempre y cuando me haya enviado y tenga la aprobación de mi GMC. Mi GMC será el único que podrá suministrarme las recetas necesarias o autorizar a otro médico a hacerlo.
6. Tengo entendido que si utilizo cualquier servicio de salud (por ejemplo, la utilización de la sala de emergencia hospitalaria para casos que no son de urgencia o para cuidado rutinario) sin la aprobación de mi GMC, el programa de Medicaid no pagará dichos servicios y puede que yo sea responsable de cubrir los gastos incurridos.
7. Tengo entendido que mi Plan de participación comienza en el momento en que reciba mi tarjeta de validación impresa con el siguiente mensaje: "HMO — Check GSHP ID Card." (HMO—Factue la tarjeta de identificación del Plan). Mi participación en el Plan continuará automáticamente hasta que termine mi elegibilidad o hasta que se autorice mi disociación. En caso de que desee disociarme del Plan o escoger a otro GMC, *deberé* comunicarme con la oficina del Plan cuyo nombre aparece al pie de la página. Bajo ciertas circunstancias, se me podrán garantizar doce (12) meses de elegibilidad con Medicaid, lo cual me fue explicado al momento de la inscripción.
8. Tengo entendido que alisto para un periodo de seis meses y que puedo cambiar de Gerente Médico para Casos por la razón que sea durante los primeros treinta (30) días de participación en el Plan (el cual comienza a partir del primer mes en que aparezca en mi tarjeta de validación de Medicaid el mensaje de Plan) y durante los primeros treinta (30) días de cada periodo sucesivo de seis meses de participación.
9. Tengo entendido que para participar en el Plan debo ser elegible para Medicaid en la fecha efectiva de mi subscripción al Plan. Si pierdiera mi elegibilidad de Medicaid, mi membresía será nula e inválida.
10. Tengo entendido que si actualmente estoy recibiendo servicios médicos a largo plazo, (tales como consejería de salud mental) o estoy bajo un "plan de cuidado" de otro médico, discutiré este asunto con mi GMC lo más pronto posible. En caso de surgir algún desacuerdo sobre la continuación de dicha atención, podré comunicarme con la oficina del Plan para discutir una posible solución.
11. Tengo entendido que bajo ciertas circunstancias la Agencia de Bienestar del Condado (solamente para clientes del AFDC) tiene el derecho y la obligación de invalidar mi garantía de elegibilidad de doce (12) meses, en caso de que no cumpla con las leyes que gobiernan mi elegibilidad para los beneficios de asistencia pública.

Cualquier pregunta o queja sobre mi membresía al Plan deberá dirigirse al:

Oficina del Plan de Salud del Estado del Jardín

Dirección: CN 712, Trenton, New Jersey 08625

Número del Teléfono Libre de Tarifa: 1-800-525-0047

(Este número del teléfono lo puede encontrar en su tarjeta de miembro de GSHP)

Form #13

FORM #14

*MEDICAID DISTRICT OFFICE DIRECTORY
BENEFICIARY AND PROVIDER SERVICES

Medicaid District Office	Director & Phone Number	Address
(01) ATLANTIC	Barbara Smith, Director	1601 Atlantic Avenue
(05) CAPE MAY	(609) 441-3620	7th Floor
(06) CUMBERLAND	FAX: #(609) 441-3152	Atlantic City, NJ 08401
(03) BURLINGTON	Eileen Calabro, Director	50 Rancocas Road
(11) MERCER	(609) 261-0448	Mt. Holly, NJ 08060
	FAX: #(609) 265-0095	
(04) CAMDEN	Bill Underland, Director	2 Port Center, Suite 401
(08) GLOUCESTER	(609) 757-2870	2 Riverside Drive
(17) SALEM	Thomas Rafferty, Regional Director	Camden, NJ 08102
	(609) 757-2699	
	FAX: #(609) 757-4626	
(07) ESSEX	Kate Buckley-Straussl, Director	153 Halsey Street
	(973) 648-3700	4th Floor
	John Russell, Regional Director	Newark, NJ 07101
	(973) 648-7186	
	FAX: #(973) 642-6468	

Medicaid District Office (09) HUDSON	Director & Phone Number Ellen Keane, Director (201) 217-7100 FAX: #(201) 217-7122	Address 438 Summit Avenue Jersey City, NJ 07306-3186
(12) MIDDLESEX (10) HUNTERDON (18) SOMERSET (20) UNION (13) MONMOUTH	Colleen DeMarks, Director (732) 603-3151 FAX: #(732) 603-5643	25 South Main Street Building B, Suite 5 & 6 Edison, NJ 08837
(14) MORRIS (19) SUSSEX (21) WARREN (15) OCEAN	France Garrett, Director (732) 308-1159 FAX: #(732) 409-6446	1003 Highway 9 North Howell, NJ 07731-3301
(16) PASSAIC (02) BERGEN	Marie Grubin, Director (973) 631-6440 FAX: #(973) 631-6448 Gail Dempsey, Director (732) 255-0731 FAX: #(732) 255-0743 Kathleen Lohrey, Director (973) 977-4077 FAX: #(973) 684-8182	10 Park Place 4th Floor Morristown, NJ 07960 1510 Hooper Avenue Suite 130 Toms River, NJ 08753 66 Hamilton Street Paterson, NJ 07505

Revised: 7/17/97*

NEW FORM #15

		*New Jersey County Welfare Agencies	
ATLANTIC	1	DR. JOHN W. COSBY, DEPT. HEAD KAREN B. ENOUS, DIVISION DIRECTOR	ATLANTIC COUNTY DEPARTMENT OF ECONOMIC ASSISTANCE & COMMUNITY DEVELOPMENT DIVISION OF ECONOMIC ASSISTANCE 1333 ATLANTIC AVE. ATLANTIC CITY, NJ 0840 609-348-3001
8:30-4:30 BERGEN	2	FAX: 609-345-4295 EDWARD TESTA, DIRECTOR	BERGEN COUNTY BOARD OF SOCIAL SERVICES 216 ROUTE 17 NORTH 17 PARK OFFICE CENTER, BLDG. A ROCHELLE PARK, NJ 07662-3300 201-368-4200
8:15-4:15 BURLINGTON	3	FAX: 201-368-8710 ANN SABOE, DIRECTOR	BURLINGTON COUNTY BOARD OF SOCIAL SERVICES HUMAN SERVICES FACILITY 795 WOODLANE RD. MOUNT HOLLY, NJ 08060-3316 609-261-1000
8:00-4:30 CAMDEN	4	FAX: 609-261-0463 ROBERT ELLIS, DIRECTOR	CAMDEN COUNTY BOARD OF SOCIAL SERVICES COUNTY ADMINISTRATION BLDG. 600 MARKET ST. CAMDEN, NJ 08101 609-225-8800
8:30-4:30 CAPE MAY	5	FAX: 609-225-5145 (DIRECTOR ONLY) FAX: 609-225-7797 JOSEPH B. FAHY, DIRECTOR	CAPE MAY COUNTY BOARD OF SOCIAL SERVICES SOCIAL SERVICES BLDG. 4005 ROUTE 9 SOUTH RIO GRANDE, NJ 08242-1911 609-886-6200
8:30-4:30 CUMBERLAND	6	FAX: 609-889-9332 GREGORY CURLISS, DIRECTOR	CUMBERLAND COUNTY BOARD OF SOCIAL SERVICES 13 NORTHEAST BLVD. VINELAND, NJ 08360 609-691-4600
8:30-4:30 ESSEX	7	FAX: 609-692-7635 JAMES WILLIAMS, DIRECTOR	ESSEX COUNTY DEPT. OF CITIZEN SERVICES DIVISION OF WELFARE 18 RECTOR ST., 9TH FL. NEWARK, NJ 07102 201-733-3000
8:30-4:00 GLOUCESTER	8	FAX: 201-643-3985 CAROL PIRROTTA, DIRECTOR	GLOUCESTER COUNTY BOARD OF SOCIAL SERVICES 400 HOLLYDELL DR. SEWELL, NJ 08080 609-582-9200
8:00-4:00 HUDSON	9	FAX: 609-582-6587 ANGELICA HARRISON, DIRECTOR	HUDSON COUNTY DIVISION OF SOCIAL SERVICES JOHN F. KENNEDY OFFICE BLDG. 100 NEWKIRK ST. JERSEY CITY, NJ 07306 201-420-3000
8:30-4:15 HUNTERDON	10	FAX: 201-420-0343 JOHN F. CAHALAN, DIRECTOR	HUNTERDON COUNTY DIVISION OF SOCIAL SERVICES COMMUNITY SERVICES CENTER 6 GAUNTT PLACE FLEMINGTON, NJ 08822 908-788-1300
8:30-4:30 MERCER	11	FAX: 908-806-4589 PATRICK J. MAGEE, DIRECTOR	MERCER COUNTY BOARD OF SOCIAL SERVICES 200 WOOLVERTON ST., PO BOX 1450 TRENTON, NJ 08650-2099 609-989-4320
8:30-4:30 MIDDLESEX	12	FAX: 609-989-0405 ANGELA MACKARONIS, DIRECTOR FAX: 908-745-4558	MIDDLESEX COUNTY BOARD OF SOCIAL SERVICES 181 HOW LANE, PO BOX 509 NEW BRUNSWICK, NJ 08903 908-745-3500
8:30-4:15 MONMOUTH	13	JOBS FAX: 908-745-4555 KATHLEEN A. BRADY, DIRECTOR FAX: 908-431-6266	MONMOUTH COUNTY DIVISION OF SOCIAL SERVICES KOZLOSKI RD., PO BOX 3000 FREEHOLD, NJ 07728 908-431-6000
8:30-4:30 MORRIS	14	JOBS FAX: 908-431-6267 ELIZABETH LEHMANN, DIRECTOR	MORRIS COUNTY BOARD OF SOCIAL SERVICES

8:30-4:30		FAX: 201-326-7251	MT. PLEASANT COMPLEX, LOBBY C	
OCEAN	15	BEVERLY J. BEARMORE, DIRECTOR	1719 ROUTE 10	
		FAX: 908-244-8075	PARSIPPANY, NJ 07054	201-326-7800
8:30-4:30		JOBS FAX: 908-473-0669	OCEAN COUNTY BOARD OF SOCIAL SERVICES	
PASSAIC	16	MARK SCHIFFER, ACTING DIRECTOR	1027 HOOPER AVE., PO BOX 547	908-349-1500
			TOMS RIVER, NJ 08754-0547	
8:30-4:30		FAX: 201-881-3232	PASSAIC COUNTY BOARD OF SOCIAL SERVICES	
SALEM	17	KENNETH HIXENBAUGH, DIRECTOR	80 HAMILTON ST.	201-881-0100
			PATERSON, NJ 07505-2057	
8:30-4:00		FAX: 609-299-3245	SALEM COUNTY BOARD OF SOCIAL SERVICES	
SOMERSET	18	MILDRED A. GAUPP, DIRECTOR	147 S. VIRGINIA AVE.	609-299-7200
			PENNS GROVE, NJ 08069	
8:15-6:00		FAX: 908-231-9010	SOMERSET COUNTY BOARD OF SOCIAL SERVICES	
SUSSEX	19	SAMUEL SEAMANS, DIRECTOR	73 E. HIGH ST., PO BOX 936	908-526-8800
			SOMERVILLE, NJ 08876	
8:30-4:30		FAX: 201-383-3627	SUSSEX COUNTY DIVISION OF WELFARE	
UNION	20	CHARLES J. GILLON, DIRECTOR	18 CHURCH ST., PO BOX 218	973-383-3600
		FAX: 908-965-2752	NEWTON, NJ 07860-0218	
8:30-4:30		JOBS FAX: 908-965-2758	UNION COUNTY BOARD OF SOCIAL SERVICES	
WARREN	21	HENRY DINGER, DIRECTOR	342 WESTMINSTER AVE.	908-965-2700
			ELIZABETH, NJ 07208-3290	
8:30-4:30		FAX: 908-475-1533	WARREN COUNTY WELFARE BOARD	
(Revised 6/24/97)*			COURT HOUSE ANNEX	
			SECOND & HARDWICK STS., PO BOX 3000	908-475-4744
			BELVIDERE, NJ 07823-3000	

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

Repealed Forms 7, 15 and 16, and recodified Forms 8 through 14, and 17, as Forms 7 through 13, and 14, respectively; and added Form 158.