CHAPTER 49

ADMINISTRATION MANUAL

Authority

N.J.S.A. 30:4D–1 et seq.

Source and Effective Date

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

Executive Order No. 66(1978) Expiration Date

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

Chapter Historical Note

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

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

Chapter 49, Administration, was repealed and a new Chapter 49, Administration, was adopted by R.1992 d.317, effective August 17, 1992.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 Subchapter 19, Prepaid Health Care Services: Medicaid Eligibles, was repealed by R.1995 d.337, effective June 19, 1995.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

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

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 23. LIFELINE PROGRAMS

APPENDIX

SUBCHAPTER 1. GENERAL PROVISIONS

10:49–1.1 Scope and purpose

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

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

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

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

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Substantially amended section.
Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In (a), inserted a reference to the NJ KidCare program in the second sentence; and added (c) and (d).
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.

10:49–1.2 Organization

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

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

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Section name amended; former (a) recodified as N.J.A.C. 10:49–1.3; recodified former (b) as (a); in (b)1, added ", through the Health Care Financing Administration (HCFA)"; and deleted (c), relating to Medicaid Program services and eligibility.
Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In (a), inserted a reference to Title XXI of the Social Security Act in the first sentence, inserted a reference to the NJ KidCare program in the second sentence and added a fourth sentence in the introductory paragraph, and substituted "two programs are" for "program is" in the first sentence and added a third sentence in 1.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 with changes, effective August 17, 1998.

10:49–1.3 Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"NJ KidCare–Plan B" means the State-operated program which provides comprehensive, managed care coverage to uninsured children through the age of 18 with family incomes above 133 percent and not in excess of 150 percent of the Federal poverty level. In addition to covered managed care services, eligibles may access mental health and substance abuse services and certain other services which are paid fee-for-service.

"NJ KidCare–Plan C" means the State-operated program which provides comprehensive, managed care coverage to uninsured children through the age of 18 with family incomes above 150 percent and not in excess of 200 percent of the Federal poverty level. In addition to covered managed care services, eligibles may access mental health and substance abuse services and certain other services which are paid fee-for-service. Eligibles are required to participate in cost-sharing in the form of monthly premiums and personal contributions to care for certain services.

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

"Program" means the New Jersey Medicaid program.

"Programs" means the New Jersey Medicaid program and the NJ KidCare program.

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

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

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

Recodified from N.J.A.C. 10:49–1.2(a) and amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Deleted (a) designation, added "Aid to Families with Dependent Children (AFDC)", "Beneficiary or eligible beneficiary", "Commissioner of DHS", "Department", "Division", "DHSS", "Health Care Financing Agency", "Medicaid Agent", "Prepaid health plan", "Program", and "Qualified applicant"; changed "County welfare agency" to "County welfare agency or CWA" and amended; amended "Provider" and "recipient"; and deleted (b) and (c). Former section, "Early and Periodic Screening, Diagnosis and Treatment (EPSDT)", repealed.
Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In "Fiscal agent" inserted a reference to the NJ KidCare program; and inserted "NJ KidCare", "NJ KidCare—Plan A", and "Programs".
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

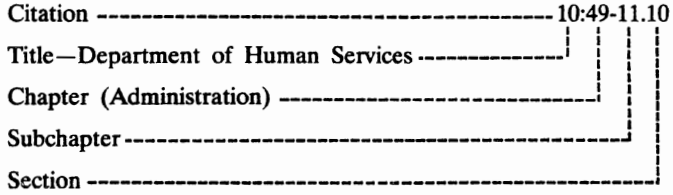
See: 30 N.J.R. 1060(a).
Inserted "NJ KidCare–Plan B" and "NJ KidCare–Plan C".
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Adopted concurrent proposal, R.1998 d.487, effective August 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.

10:49–1.4 Overview of provider manuals

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

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

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



(d) There is an individual Program provider manual for each of the following services. These services are listed in the New Jersey Administrative Code (N.J.A.C.) under Title 10 (Department of Human Services) Chapters 10:50 through 10:64, 10:66 through 10:68, and 10:73 through 10:74 as follows:

1. 10:50—Transportation Services Manual
2. 10:51—Pharmacy Services Manual
3. 10:52—Hospital Services Manual
4. 10:53—(Reserved)
5. 10:53A—Hospice Services Manual
6. 10:54—Physician Services Manual
7. 10:55—Prosthetic and Orthotic Services Manual
8. 10:56—Dental Services Manual
9. 10:57—Podiatry Services Manual
10. 10:58—Nurse-Midwifery Services Manual
11. 10:58A—Certified Nurse Practitioner/Clinical Nurse Specialist
12. 10:59—Medical Supplier Services Manual
13. 10:60—Home Care Services Manual
14. 10:61—Independent Clinical Laboratory Services Manual
15. 10:62—Vision Care Services Manual
16. 10:63—Long Term Care Services Manual
17. 10:64—Hearing Aid Services Manual
18. 10:65—Medical Day Care Services Manual
19. 10:66—Independent Clinic Services Manual
20. 10:67—Psychological Services Manual
21. 10:68—Chiropractic Services Manual
22. 10:73—Case Management Services Manual
23. 10:74—Managed Health Care Services for Medicaid Eligibles

(e) Regarding manual updates, revised pages or additions to the provider manual are issued, as required, for new policy, policy clarification, and/or revisions to the New Jersey Medicaid or NJ KidCare program. A newsletter system is utilized to distribute new or revised manual material and to provide any other pertinent information regarding manual updates. Newsletters should be filed at the back of the manual and replacement pages should be added to the manual in accordance with instructions provided. Substantive manual revisions shall be made through the rulemaking process, in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq.

(f) Regarding provider responsibility, this manual and all subsequent updates are distributed as a guide to assist providers in their participation in the New Jersey Medicaid or NJ KidCare program. The provider is ultimately responsible for knowing and abiding by current laws and regulations pertaining to this program.

Recodified from N.J.A.C. 10:49–1.8 and amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
In (a), substituted "The New Jersey Medicaid Program maintains" for "There are 19" and "Medicaid beneficiaries" for "Medicaid recipients"; in (d), inserted additional N.J.A.C. references; inserted new (d)5, 11 and 23; recodified former (d)5 through 9 and 10 through 20 as (d)6 through 10 and 12 through 22; and in (e), substituted "Substantive manual revisions shall be made" for "Manual revisions shall be substantially made". Former section, "HealthStart", repealed.
Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Inserted references to NJ KidCare and made corresponding language changes throughout; and in (a), substituted a reference to the Medicaid Agent and the Division of Medical Assistance and Health Services for a reference to the New Jersey Medicaid Program in the first sentence.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.

Case Notes

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

10:49–1.5 (Reserved)

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

10:49–1.6 (Reserved)

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

10:49–1.7 (Reserved)

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

10:49–1.8 (Reserved)

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

SUBCHAPTER 2. NEW JERSEY MEDICAID BENEFICIARIES

10:49–2.1 Who is eligible for Medicaid?

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

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Substituted "Medicaid beneficiaries" for "Medicaid recipients" and added Home and Community-Based Services Waiver Programs category.

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

(a) The eligibility rules for persons eligible under the regular New Jersey Medicaid program are included in N.J.A.C. 10:71, 10:72, 10:81, and 10:82.

(b) The following groups may be eligible for medical and health services covered under the regular New Jersey Medicaid program requirements as outlined in the second chapter of each Provider Services Manual. The list is not all inclusive but is intended to provide an overview of some of the types of individuals who may be eligible for Medicaid benefits, when provided in accordance with the requirements of N.J.A.C. 10:71, 10:72, 10:81 and 10:82, as appropriate.

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

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

3. Children and caretaker relatives eligible for and receiving Aid to Families with Dependent Children (AFDC);

4. Deemed recipients of AFDC including:

i. Persons denied AFDC solely because the payment would be less than $10.00;

ii. Persons whose AFDC payment is reduced to zero ($0.00) because of an over-payment recovery; and

iii. For a period of four months, persons losing AFDC because of the receipt of child or spousal support;

5. For a period of up to 24 months from the first month of ineligibility, persons losing eligibility for AFDC as a result of earnings or hours of employment, or the receipt of New Jersey Unemployment or Temporary Disability Insurance benefits;

6. Persons ineligible for AFDC or Work First New Jersey because of requirements that do not apply under Medicaid;

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

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

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

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

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

12. Persons eligible for but not receiving AFDC or an optional State benefit;

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

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

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

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

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

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

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

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

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

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

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

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

Amended by R.1994 d.600, effective December 5, 1994.
See: 26 N.J.R. 3345(a), 26 N.J.R. 4762(a).
Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Amended section name; substituted "beneficiaries" and "beneficiary's" for "recipients" or "recipient's" throughout; in (a)4, substituted "beneficiaries" for "group" and inserted reference to pharmacy services; and in (a)6, inserted references to aged, blind or disabled beneficiaries.

Case Notes

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

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

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

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

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

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

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

ii. Serious impairment to bodily functions; or

iii. Serious dysfunction of any bodily organ or part.

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

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

i. Emergency care is provided for life-threatening or organ threatening, or potentially life or organ threatening condition that requires immediate care.

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

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

Jersey Care ... Special Medicaid Programs or AFDC-related Medicaid.

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

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

New Rule, R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Former N.J.A.C. 10:49–5.4., Services not covered by the Medicaid program, recodified to N.J.A.C. 10:49–5.5.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Amended by R.1999 d.253, effective August 2, 1999.
See: 31 N.J.R. 97(a), 31 N.J.R. 2203(b).
Rewrote the section.
Emergency amendment R.1999 d.254, effective July 12, 1999 (to expire September 10, 1999).
See: 31 N.J.R. 2252(a).
Rewrote the section.

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

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

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

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

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

i. There are certain exceptions to this rule, but the exceptions require prior authorization. A written certification of medical necessity and a treatment plan shall be submitted by the physician to the appropriate Medicaid District Office for consideration;

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

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

6. Services provided outside the United States and territories;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Amended by R.1994 d.600, effective December 5, 1994.
See: 26 N.J.R. 3345(a), 26 N.J.R. 4762(a).
Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Amended section name; substituted "beneficiaries" and "beneficiary's" for "recipients" or "recipient's" throughout; in (a)2, inserted "; these services" preceding "shall not be billed" and amended Department name; in (a)4, inserted references to Model Waiver III, ACCAP and ABC programs; in (a)13iv and (a)15, substituted reference to Medicaid Agent for reference to Division.
Recodified from N.J.A.C 10:49–5.4 and amended R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
In (a), inserted a reference to the NJ KidCare-Plan A program in the first sentence, inserted a reference to NJ KidCare-Plan A beneficiaries and substituted a reference to NJ KidCare Eligibility Identification Cards for Eligibility Identification Cards in 14, inserted references to the Division throughout 15, and inserted a reference to NJ KidCare beneficiaries in 15ii.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 with changes, effective September 21, 1998.

Cross References

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

Case Notes

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

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

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

10:49–5.6 Services available to beneficiaries eligible for NJ KidCare–Plan B or C

(a) Except for the exceptions at N.J.A.C. 10:79–6.5, which concern services for newborns enrolling into NJ KidCare–Plan C, the services listed below are available to beneficiaries eligible for NJ KidCare–Plan B or C, through an HMO selected by the NJ KidCare–Plan B or C beneficiary.

1. Audiology services;

2. Certified nurse practitioner services;

3. Chiropractic services;

4. Clinic services (services in an independent outpatient health care facility, other than hospital, that provides services such as, dental, optometric, ambulatory surgery, etc.);

5. Clinical nurse specialist services;

6. Dental services;

7. Durable medical equipment;

8. Early and periodic screening, and diagnosis examinations, dental, vision and hearing services. Includes only those treatment services identified through the examination that are available under the HMO contract or covered fee-for-service program;

9. Emergency room services;

10. Family planning services including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling;

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

and surgical procedures are not covered by the New Jersey Medicaid or NJ KidCare program.

11. Federally qualified health center primary care services;

12. HealthStart maternity services, which is a package of comprehensive medical and health support services provided by the HMO;

13. Hearing aid services;

14. Home health care services;

i. Exception: personal care assistant services;

15. Hospice services;

16. Hospital services—inpatient:

i. General hospitals;

ii. Special hospitals; and

iii. Rehabilitation hospitals;

17. Hospital services—outpatient;

18. Laboratory (clinical);

19. Medical supplies and equipment;

20. Nurse-midwifery services;

21. Optometric services;

22. Optical appliances;

23. Organ transplant services, except the inpatient hospital services. Inpatient hospital services for organ transplants are covered fee-for-service;

24. Prescription drug services;

25. Physician services;

26. Podiatric services;

27. Prosthetic and orthotic devices;

28. Private duty nursing;

29. Radiological services;

30. Rehabilitative services, including physical, occupational and speech therapy, limited to 60 days per type of therapy per year; and

31. Transportation services, limited to ambulance, MICU's and invalid coach.

(b) The services listed below are available to beneficiaries eligible for NJ KidCare–Plan B or C under fee-for-service:

1. Christian Science sanatoria care and services;

2. Clinic services (services in an independent outpatient health care facility, other than hospital) for family planning services, mental health or substance abuse treatment services;

3. Elective/induced abortion services;

4. Emergency room services for treatment of mental health disorder or for substance abuse;

5. Family planning services including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling;

i. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered;

6. Hospital services—inpatient;

i. Psychiatric hospitals;

ii. Inpatient psychiatric programs for children 19 years of age and under;

iii. Acute care or special hospital services if provided for mental health or substance abuse services;

iv. Organ transplant hospital services;

(1) All other transplant services are covered by HMO;

7. Mental health services provided by practitioners, such as physicians, psychologists, and certified nurse practitioners/clinical nurse specialists;

8. Nursing facility services, limited to the Medicare Part A copayments for the first 30 days of skilled nursing care;

9. Outpatient hospital services for family planning, mental health and substance abuse treatment services;

10. Substance abuse services provided by practitioners, including physicians, psychologists, certified nurse practitioners/clinical nurse specialists; and

11. Targeted case management services for the chronically ill.

(c) Services not covered under Plans B and C are as follows:

1. Unless listed in (a) and (b) above, no other services are covered by NJ KidCare–Plan B or C.

2. Services not covered include, but are not limited to:

i. Nursing facility services, except the Medicare Part A copayments for the first 30 days of skilled nursing care;

ii. Intermediate care facilities for mental retardation (ICFs/MR);

iii. Personal care services;

iv. Medical day care services; and

v. Lower mode transportation.

New Rule, R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 with changes, effective September 21, 1998.

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

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

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

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

2. "Medical emergency" means a critical illness or injury status for which prompt medical care may be crucial to saving life and limb or sparing the beneficiary significant or intractable pain. Services provided for a medical emergency are exempt from prior authorization. Any service classified as a medical emergency that would have been subject to prior authorization had it not been so classified, must be supported by a practitioner's statement which describes the nature of the emergency, including relevant clinical information, and must state why the emergency services rendered were considered to be immediately necessary. To simply state that an emergency did exist is not sufficient.

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

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

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

2. Retroactive determination of eligibility;

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

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

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

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Substituted "beneficiaries" and "beneficiary's" for "recipients" or "recipient's" throughout; in (a), substituted "Provider Services Chapter" for "Provider Services Manuals"; and in (a)3, substituted "Medicaid Agent" for "Director".
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
In (a), inserted a reference to the NJ KidCare program in 1, and inserted a reference to DMAHS in 3.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 with changes, effective September 21, 1998.

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 crossover claims, and examples of timely submission of claims; electronic media claims (EMC) submission; Remittance Advice Statements; procedures for Electronic Funds Transfer (EFT); adjustments for overpayment of claims, and adjustments by Medicare; procedure to follow when a claim is paid in error (voids); procedure for inquiries about claims; procedure for ordering forms; information about provider services; and item-by-item instructions for completing the claim form and other forms.

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

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
In (a), substituted "beneficiary" for "recipient"; in (b), deleted "form" or "forms" following "claim" and "claims".
Amended by R.1997 d.520, effective January 5, 1998.
See: 29 N.J.R. 1006(a), 30 N.J.R. 232(a).
Inserted (a)2; in (b), clarified precedence of Medicaid rules over Fiscal Agent Billing Supplement, and added references to "charity care program."

10:49–7.2 Timeliness of claim submission and inquiry

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

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

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

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

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

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 coinsurance 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, 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; or

3. For NJ KidCare–Plan C enrollee's contribution to care responsibility.

(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.

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.

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

10:49–9.1 NJ KidCare–Plan C—personal contribution to care

(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) Personal contributions to care is effective upon date of enrollment.

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

(d) 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; preventive dental services; prenatal care; for family planning services; or for substance abuse treatment services.

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.

10:49–9.2 NJ KidCare–Plan C—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 C.

(b) For children in families with income above 150 percent and at or below 200 percent of the Federal poverty level, 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) 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.

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.

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.

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.

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).

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

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

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Amended section name; substituted "beneficiary" and "beneficiary's" for "recipient" and "recipient's" throughout and deleted "form" following "claim" throughout.
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.

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 and C 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.

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 and C 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).

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.

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 NJ KidCare–Plans B and C 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 the NJ KidCare program, including, but not limited to, N.J.S.A. 30:4D–6c, 6f, 7h, 7i, 7k, 7l, 7.1, 12, 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, 5.4, 6.1(a)3, 7.3, 7.4, 7.5, 9.5 through 9.8, 11.1, 12.1 through 12.7, 13.1, 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.

SUBCHAPTER 14. RECOVERY OF PAYMENTS AND SANCTIONS

10:49–14.1 Recovery of payments correctly made

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

1. The individual leaves no surviving spouse;

2. For estates coming into being between February 1984 and October 20, 1992, the individual leaves no surviving child;

3. For estates coming into being on or after October 21, 1992, the individual leaves no surviving child who is under the age of 21 or any surviving blind or permanently and totally disabled children;

4. The amount to be recovered is in excess of $500.00; and

5. The gross estate is in excess of $3,000.

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

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

Case Notes

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

10:49–14.2 Sanctions—Special Status Program

(a) The "Special Status Program" either restricts the Medicaid 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.