

CHAPTER 49

ADMINISTRATION MANUAL

Authority

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

Source and Effective Date

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

Chapter Expiration Date

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

Chapter Historical Note

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

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

Chapter 49, Administration, was repealed and a new Chapter 49, Administration, was adopted as R.1992 d.317, effective August 17, 1992.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 Subchapter 19, Prepaid Health Care Services: Medicaid Eligibles, was repealed by R.1995 d.337, effective June 19, 1995.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

Pursuant to Executive Order No. 66(1978), Chapter 49, Administration, was readopted as R.1997 d.354, effective August 8, 1997. As a part of R.1997 d.354, effective September 2, 1997, Chapter 49, Administration, was renamed Chapter 49, Administration Manual; Subchapter 2, New Jersey Medicaid Recipients, was renamed Subchapter 2, New Jersey Medicaid Beneficiaries; Subchapter 9, Provider and Recipient's Rights and Responsibilities; Administrative Process, was renamed Subchapter 9, Provider and Beneficiary's Rights and Responsibilities; Administrative Process; Subchapter 17, Home and Community-Based Services Waivers, was recodified as N.J.A.C. 10:49-22, Home and Community Based Services Waiver Programs; Subchapter 18, Home Care Expansion Program, was recodified as N.J.A.C. 8:81-2, and Subchapter 18, Early and Periodic Screening, Diagnosis and Treatment (EPSDT), was adopted as new rules; Subchapter 19, HealthStart, was adopted as new rules; Subchapter 21, Pharmaceutical Assistance to the Aged and Disabled (PAAD), was recodified as N.J.A.C. 8:81-3, and Subchapter 21, The Medicaid Managed Care Program—NJ Care, was adopted as new rules; Subchapter 22, Lifeline Programs, was recodified as N.J.A.C. 8:81-4, and Subchapter 22, Home and Community-Based Services Waiver Programs, was adopted as new rules; and Subchapter 23, Hearing Aid Assistance to the Aged and Disabled, was recodified as N.J.A.C. 8:81-5, and a new Subchapter 23, Lifeline Programs, was adopted as new rules. See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Subchapter 24, Work First New Jersey/General Assistance Claims Processing, was adopted as R.2000 d.309, effective August 7, 2000. See: 32 N.J.R. 1342(a), 32 N.J.R. 2900(a).

Chapter 49, Administration Manual, was readopted as R.2003 d.81, effective January 22, 2003. See: 34 N.J.R. 2647(a), 35 N.J.R. 1116(a).

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

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

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10:49-7.1 General provisions

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

1. Each Provider Services Manual has information relevant to the 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. 10:52-11, 12 and 13.
3. The rules of this subchapter shall also apply when submitting a claim for services provided to Medicaid/NJ FamilyCare beneficiaries who are enrolled in managed care programs but who are provided certain services through the regular Medicaid program. See N.J.A.C. 10:49-5 for a list of services that are eligible to be reimbursed on a fee-for-service basis when provided to Medicaid/NJ FamilyCare beneficiaries enrolled in managed care programs.

(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."

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

In (a)2, amended the N.J.A.C. references.

Amended by R.2003 d.485, effective December 15, 2003.
See: 35 N.J.R. 509(a), 35 N.J.R. 5568(a).

In (a)2, amended N.J.A.C. references.

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

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

In the introductory paragraph of (a), inserted "/NJ FamilyCare" three times and substituted "beneficiary" for "recipient" twice; and added (a)3.

10:49-7.2 Timeliness of Medicaid claim submission

(a) A Medicaid claim is defined as a request for payment from the New Jersey Medicaid program for a Medicaid reimbursable service provided to a Medicaid recipient.

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.

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

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

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

(b) "Prospective" medical bill(s) are bills submitted to the Retroactive Eligibility Unit with an Application for Retroactive Medicaid Eligibility (FD-74) on the assumption that they were incurred during the retroactive eligibility period but were actually incurred during the month of application for Medicaid or later. These bills were incurred during a time

period when Medicaid eligibility already existed or should have existed (except that the individual experienced a delayed determination of Medicaid eligibility).

(c) Under the circumstances in (c)1 through 3 below, the Division of Medical Assistance and Health Services' Retroactive Medicaid Eligibility Unit will generate letters to providers whose bills were included with an Application for Retroactive Medicaid Eligibility, allowing the one-year timely submission requirements to be bypassed.

1. These "prospective" claims must not have already been submitted to the Fiscal Agent within one-year of the date that services were rendered;

2. The Application for Retroactive Medicaid Eligibility that these "prospective" bills are associated with must have been received at the Retroactive Eligibility Unit within 60 days of the date of the above mentioned letter (with the original letter attached); and

3. In order for payment to be made, these claims must remain outstanding and any collection action against the Medicaid beneficiary must be withdrawn.

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

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

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

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

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

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

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

(e) A non-institutional claim is a claim submitted by all providers except a hospital, home health agency, nursing facility, intermediate care facility/mental retardation (ICF/MR),

residential treatment center, or governmental psychiatric hospital. The time requirements for submitting a non-institutional claim are as follows:

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

i. One year of the date of service;

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

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

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

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

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

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

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

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

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

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

received by Medicaid within the one year timely filing period or 90 days, whichever is later.

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

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

(g) If additional information is required in order to process a Medicaid claim, the provider shall supply the information as soon as possible but not more than 30 days after the end of the timely submission period.

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

(i) If it appears that an individual is eligible for Supplemental Security Income (SSI), the Medicaid provider or a designee should, but is not required to, assist the patient in completing and submitting an application for SSI. The application for SSI shall be submitted to the Social Security Administration (SSA) so that it is received by the SSA within the time requirements for claim submission contained in (a) through (h) above. For institutional and non-institutional claims for services provided to an individual who was not found to be eligible for Medicaid as of the date of service and who thereafter is determined to be eligible for SSI (for that date of service) by the SSA, and, therefore, also eligible for Medicaid (for that date of service), the following requirements shall apply:

1. If the individual's application for SSI is received by the SSA within the time requirements for claim submission contained in (a) through (h) above, the Medicaid provider or a designee shall file a claim for services rendered to the individual so that it is received by the State's fiscal agent within the later of the following:

i. The applicable time requirements for claim submission contained in (a) through (h) above;

ii. Six months from the date of the SSI eligibility determination; or

iii. Six months from the date that the SSI/Medicaid eligibility data appears on the New Jersey Medicaid Management Information System.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In (a)2ii, inserted "that was submitted to the Medicaid Assistance and Health Services' Retroactive Eligibility Unit" following "retroactive eligibility application"; added a new (b) and (c) and recodified existing (b) through (f) as (d) through (h).

Amended by R.2003 d.485, effective December 15, 2003.

See: 35 N.J.R. 509(a), 35 N.J.R. 5568(a).

In (a), deleted the last two sentences in the introductory paragraph; rewrote (e) and (f).

Administrative correction.

See: 36 N.J.R. 5352(b).

Amended by R.2006 d.337, effective September 18, 2006.

See: 38 N.J.R. 2002(a), 38 N.J.R. 3899(b).

Added (i).

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

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

In the introductory paragraph of (a)2, inserted a comma following "reimbursement"; in (a)2ii, deleted "that was submitted to the Medicaid Assistance and Health Services' Retroactive Eligibility Unit" following the first occurrence of "application" and inserted "at the appropriate eligibility determination agency"; and in (d)1iv and (e)1iv, substituted "Early" for "early".

Case Notes

Evidence of provider's custom or practice of mailing reimbursement claims against New Jersey Medicaid Program fund, together with other evidence, was sufficient, under preponderance of evidence standard, to

create presumption that disputed claims were mailed and received. SSI Medical Services, Inc. v. State Dept. of Human Services, Div. of Medical Assistance and Health Services, 146 N.J. 614, 685 A.2d 1 (1996).

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

Where (1) a convalescent center provided services to a patient during January and February 1999, claims for which were initially denied while the local board of social services conducted its semi-annual review of the patient's eligibility for Medicaid benefits, (2) the patient was determined in April 1999 to be eligible for continued Medicaid benefits, and (3) the convalescent center mistakenly believed it would be automatically paid without the need to resubmit the claims, the center's resubmission of its claims for reimbursement for the January and February 1999 services in May 2001 was properly denied as being filed out of time. Medcenter Neptune v. N.J. Dep't of Health & Senior Services, OAL Dkt. No. HLT 4363-01, 2005 N.J. AGEN LEXIS 567, Initial Decision (October 3, 2005).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Medicare: The program will make payment in the full amount of the Medicare Part A deductible and co-insurance for inpatient hospital services, and for Part B outpatient hospital services. For services rendered on or after July 20, 1998, payment for Part B coinsurance and deductible for other non-hospital services shall be paid only up to the Medicaid or NJ FamilyCare 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 FamilyCare participating providers are prohibited from billing Medicaid or NJ FamilyCare beneficiaries for any amount, except:

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

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

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

4. For NJ FamilyCare-Plan D enrollee's required co-payment.

(e) When a Medicaid or NJ FamilyCare-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 FamilyCare 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 FamilyCare 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 FamilyCare supplementation of available Medicare benefits shall be as follows:

i. Medicare (Title XVIII): For any Medicaid or NJ FamilyCare beneficiary who is covered under Medicare, responsibility for payment by the New Jersey Medicaid Agent or the NJ FamilyCare 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 FamilyCare program in the absence of other coverage for services rendered on or after July 20, 1998.

(f) When a Medicaid or NJ FamilyCare beneficiary has benefits available, such as those described above or from any other liable third party, an approved Medicaid or NJ FamilyCare 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 FamilyCare 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 FamilyCare 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 CMS 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 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 FamilyCare has been billed and has made payment, the provider must reimburse the Medicaid or NJ FamilyCare payment to the Medicaid or NJ FamilyCare program and not to the Medicaid or NJ FamilyCare beneficiary. Reimbursement must be made immediately to comply with Federal regulations. In the event a provider is apprised or otherwise is on notice that a duplicate or excessive payment has been made by the Division as a result of the provider's receipt of a Medicare or health insurance payment, the provider shall have 60 days to refund such overpayments to the Division. 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).

1. In situations involving tort matters where liability has not been established at the time of billing, providers may elect to bill the Medicaid program. However, if they choose to do so, they are precluded from returning Medicaid payments for their services, and may not seek reimbursement from any proceeds resulting from the tort matter. Conversely, providers may elect not to bill the Medicaid program, and await the outcome of the tort matter. However, should the tort matter not result in an award to the beneficiary, and the deadline for timely filing of a Medicaid claim by the provider passes, the provider shall not bill either the Medicaid program or the beneficiary.

2. This subsection in no way precludes the Division from seeking reimbursement for Medicaid payments made on behalf of the beneficiary or from any third party liability source, including a tort liability recovery, which may be awarded the beneficiary.

(j) Regardless of the status of a provider's claim with other third parties, all claims for Medicaid or NJ FamilyCare 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 FamilyCare 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 "IISP (Medicaid) Case Number"; deleted (e)1i and (e)1i(1); added (h)5; and in (i), substituted "a health insurance payment is received" for "an insurance payment is received from another payer" and "MMIS Claim Adjustment Request Form" for "Adjustment/Void Request Form". Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

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

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

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

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

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

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

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

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

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

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

In (h)4, deleted i; rewrote (i).

10:49-7.4 Prohibition of payment to factors

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Related to the cost of processing the billing;

2. Not related on a percentage or other basis to the amount that is billed or collected; and

3. Not dependent upon the collection of the payment.

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

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

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

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

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

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

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

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

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

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

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

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

Inserted references to NJ KidCare throughout.

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

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

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

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

Case Notes

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

10:49-7.6 Timeliness of charity care claim submission

(a) A charity care claim is defined as a request for the New Jersey charity care program to price the hospital services rendered and consider those services when determining the amount of the charity care component of the disproportionate share subsidies of the Health Care Trust Fund to be allocated to each New Jersey disproportionate share hospital.

(b) In order to be priced by the Fiscal Agent, the charity care claim must be a clean charity care claim, as defined in N.J.A.C. 10:52-12.1.

New Rule, R.2003 d.485, effective December 15, 2003.
See: 35 N.J.R. 509(a), 35 N.J.R. 5568(a).

SUBCHAPTER 8. PAYMENT FOR SERVICES PROVIDED

10:49-8.1 Fiscal Agent

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

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

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

10:49-8.2 Medicaid claims payment and charity care claims pricing

(a) The Fiscal Agency will process Medicaid claims daily and produce provider payments and associated Remittance Advice (RA) statements once each week. The RA is the provider's account statement and reflects the status of all Medicaid claims currently entered into the Medicaid Management Information System. Provider payments in the form of checks and electronic funds transfers will be released following approval by the New Jersey Medicaid program. For charity care claims pricing information, see N.J.A.C. 10:52-11, 12 and 13.

1. The Remittance Advice (RA) is the major vehicle for communicating to the provider the status of all Medicaid claims received by the fiscal agent. All of the provider's claims are processed and supporting records are updated during each payment cycle. RA statements are generated as a result of a payment cycle. All claims processed (entered into the Medicaid Management Infor-

mation System) fall into one of three classifications: paid; in process; or denied.

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

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

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

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

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

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

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

1. When the claim invoice or retroactive adjustment is paid to a provider reimbursed under a retrospective payment system;

2. For a Medicare/Medicaid claim or Medicare/NJ FamilyCare claim, timely filed, payment may be made for services within six months after the program or provider receives notice of the Medicare claim disposition for a timely filed Medicare/Medicaid or Medicare/NJ Family-Care claim;

3. For claims from providers under investigation for fraud or abuse; or

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

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

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

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

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

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

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

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

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

Added (d).

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

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

In (a), amended the N.J.A.C. references in the introductory paragraph and rewrote 1ii.

Amended by R.2003 d.485, effective December 15, 2003.

See: 35 N.J.R. 509(a), 35 N.J.R. 5568(a).

In (a), amended N.J.A.C. references.

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

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

In (d)2, substituted "FamilyCare" for "KidCare" twice.

Case Notes

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

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

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

10:49-8.3 Adjustments following payment of claims

(a) If a claim is incorrectly paid and the provider receives an overpayment or underpayment, within 60 days of such receipt, the provider shall notify the Fiscal Agent in writing. (For the procedure to follow, see Fiscal Agent Billing Supplement, MMIS Claim Adjustment Request Form, (FD-999(9/91) following the second chapter of each Provider Services Manual).

(b) On occasion, a claim will be paid that should not have been paid. If a claim is paid in error, within 60 days of such receipt, the provider shall notify the Fiscal Agent by requesting that the claim be voided. (For the procedure to

follow, see the Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual.)

(c) Any adjustment made by Medicare will not cross over to Medicaid. If Medicare makes an adjustment that results in an overpayment or underpayment by Medicaid, within 60 days of receipt of any such overpayment or under payment, the provider shall notify the Fiscal Agent. (For the procedure to follow, see the Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

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

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

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

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

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

In (a), inserted "within 60 days of such receipt" following "underpayment"; in (b), inserted "within 60 days of such receipt" following "paid in error"; in (c), rewrote the second sentence.

Case Notes

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

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

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

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

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

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

10:49-8.5 Outstanding checks

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

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