

**CHAPTER 49**

**ADMINISTRATION**

**Authority**

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

**Source and Effective Date**

R.1992 d.317, effective August 17, 1992.  
See: 24 N.J.R. 1728(a), 24 N.J.R. 2837(a).

**Executive Order No. 66(1978) Expiration Date**

Chapter 49, Administration, expires on August 17, 1997.

**Chapter Historical Note**

Chapter 44, Administration, was filed and became effective prior to September 1, 1969. Amendments to subchapter 1 through 6 were filed on June 20, 1977, to become effective on July 1, 1977, as R.1977 d.213. 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 Chapter 49 was repealed by R.1992 d.317, and was replaced with new rules, effective August 17, 1992. See: Source and Effective Date.

See subchapter and section annotations for specific rulemaking activity.

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## SUBCHAPTER 1. GENERAL PROVISIONS

**10:49-1.1 Scope and purpose**

The Division of Medical Assistance and Health Services, under the Department of Human Services, administers the New Jersey Medicaid Program and 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); and other special (State) funded programs.

**10:49-1.2 The Medicaid Program: definitions, organizations, services and eligibility**

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

“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.

“County welfare agency” 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 county welfare agency might be identified as the board of social services, the welfare board, the division of welfare, or the division of social services.

“Fiscal Agent” means an entity that processes and adjudicates provider claims on behalf of the New Jersey Medicaid Program, other Special Programs, and the Pharmaceutical Assistance to the Aged and Disabled 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 the Pharmaceutical Assistance to the Aged and Disabled Program, 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.

“Recipient” means a person who is a resident of the State of New Jersey and is determined to need medical care and services under N.J.S.A. 30:4D-1 et seq. and amendments thereto, and falls within the eligibility criteria set forth therein.

(b) 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) of the Social Security Act. The Division of Medical Assistance and Health Services, Department of Human Services, administers the New Jersey Medicaid Program through its Central Office and through Medicaid District Offices (MDO) located throughout the State of New Jersey. A listing of the MDOs is provided in the chapter Appendix.

1. The Program is 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.

(c) Regarding Medicaid Program services and eligibility, the New Jersey Medicaid Program became effective January 1, 1970 (P.L. 1968, c.413; codified as N.J.S.A. 30:4D-1 et seq.). The Program originally provided a broad array of medical services for individuals (aged, or blind, or disabled, or specified members of families with dependent children) categorically eligible for public assistance under the Social Security Act. Since then Medicaid coverage has been extended to the following:

1. Individuals who qualify under the Medically Needy provisions, codified as N.J.S.A. 30:4D-6(g);
2. Pregnant women and children (up to the age of six) whose income is less than 133 per cent of the Federal poverty level, codified as N.J.S.A. 30:4D-3(i)(9). These individuals are determined by the County Welfare Agency to be eligible for the New Jersey Care . . . Special Medicaid Programs;
3. Pregnant women and children (up to the age of one) whose income is less than 185 percent of the Federal poverty level, codified as N.J.S.A. 30:4D-3(i)(13); and
4. Individuals 65 years of age and older, or individuals who are blind or disabled (pursuant to Federal regulations either 42 CFR 435.530 et seq. or 42 CFR 455.540 et seq.) whose income cannot exceed 100 percent of the Federal poverty level adjusted for family size. These individuals are determined by the county welfare agency to be eligible for the New Jersey Care . . . Special Medicaid Programs, codified as N.J.S.A. 30:4D-3i(11).

**Case Notes**

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

**10:49-1.3 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)**

(a) EPSDT is a Federally mandated comprehensive child health program for Medicaid recipients from birth through 20 years of age. The Omnibus Budget Reconciliation Act

of 1989 (OBRA '89) codified EPSDT. Accordingly, the term "EPSDT Services" means the following:

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

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

**10:49-1.4 HealthStart**

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

**Case Notes**

Exclusion of Medicaid funding for abortions except where necessary to save mother's life was unconstitutional. *Right to Choose v. Byrne*, 91 N.J. 287, 450 A.2d 925 (1982).

**10:49-1.5 Prepaid health plans**

"Prepaid health plan" means an entity that provides medical services to enrolled Medicaid eligibles under a contract with the Medicaid agency on the basis of prepaid capitation fees but does not necessarily qualify as an HMO. For policies and procedures 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.

**Case Notes**

Phalloplasty was medically required treatment for gender dysphoria. *M.K. v. Division of Medical Assistance and Health Services*, 92 N.J.A.R.2d (DMA) 38.

**10:49-1.6 Waivered programs**

(a) The Division of Medical Assistance and Health Services also administers Respite and the following Home and Community-Based Services Waivers: Community Care Program for the Elderly and Disabled (CCPED); Home and Community-Based Services Waivers for Blind or Disabled Children and Adults (Medicaid Model Waivers I, II, and III); and AIDS Community Care Alternatives Program (ACCAP). An overview of these programs is provided at N.J.A.C. 10:49-17.

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

**10:49-1.7 State-funded programs**

(a) In addition to the New Jersey Medicaid Program, the Division of Medical Assistance and Health Services also administers the following four State-funded programs:

1. Pharmaceutical Assistance to the Aged and Disabled Program (PAAD), see N.J.A.C. 10:49-21;
2. Lifeline Programs (utility assistance programs), see N.J.A.C. 10:49-22;
3. Hearing Aid Assistance for the Aged and Disabled, see N.J.A.C. 10:49-23; and
4. The Home Care Expansion Program, see N.J.A.C. 10:49-18.

**Case Notes**

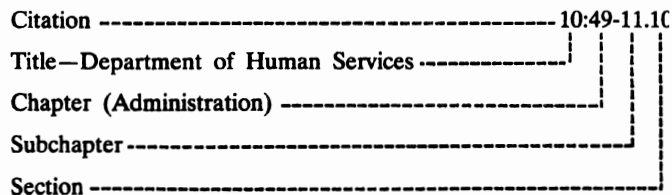
Medical service not funded by Medicare or other insurance would be funded by Medicaid. *Monmouth Medical Center v. Harris*, 646 F.2d 74 (3rd Cir.1981).

**10:49-1.8 Overview of provider manuals**

(a) There are 19 New Jersey Medicaid provider manuals. Each is designed for use by a specific type provider that provides services to Medicaid recipients. 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 Medicaid 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. 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:



2. The county welfare agency shall identify "special" claims which may be reimbursed under the Program and shall provide a Medically Needy Claim Transmittal (Form FD-311, see Appendix, N.J.A.C. 10:49). Such claims shall be submitted hard copy with Form FD-311 attached.

#### 10:49-2.4 Eligibility process (variations to routine procedure)

There are variations to the routine procedure for determining Medicaid eligibility. These variations are relevant to applying for eligibility for a newborn infant or for an inpatient upon admission to a hospital (see N.J.A.C. 10:49-2.5); to determining presumptive eligibility for pregnant women (see N.J.A.C. 10:49-2.6); and to determining retroactive eligibility (see N.J.A.C. 10:49-2.7).

#### 10:49-2.5 Applying for Medicaid eligibility for a newborn infant or for an inpatient upon admission to a hospital

(a) There are limited variations to the eligibility process for a newborn infant of a woman who is a Medicaid recipient. The policy and procedures follow:

1. Although both the mother and newborn infant may be Medicaid recipients on the date of delivery, the newborn infant is not immediately assigned a Person Number (see N.J.A.C. 10:49-2.10). In order to expedite payment to any provider before this number is assigned, the provider is permitted to bill for services provided to the newborn using the mother's HSP (Medicaid) Case Number and Person Number on the claim form.

i. Immediately after the birth of a newborn infant, the hospital shall submit a "Public Assistance Inquiry" (Form PA-1C, see Appendix, N.J.A.C. 10:49) to the county welfare agency. This will facilitate the assignment of a Person Number and addition of the newborn's name to the Medicaid eligibility file. The PA-1C Form shall include the date of birth of the newborn and the signature of the mother.

2. The period for which newborn services may be billed under the mother's HSP (Medicaid) Case Number and Person Number shall extend from the date of birth until the last day of the month in which a 60 day time frame ends, or until the newborn is assigned his or her own Person Number, whichever happens first.

Example: If a newborn's date of birth is January 5th, the 60 day period ends March 6th. Claims may be submitted through March 31st using the mother's HSP (Medicaid) Case Number and Person Number, provided the newborn has not been assigned his or her own Person Number in the meantime. Claims for services provided to the newborn after March 31st would be processed only if the required information about the newborn is used (Person Number, name, age, sex, etc.).

3. The newborn's Person Number shall be used as soon as it is available to the provider. The practitioner or

any other type of provider shall request the newborn's Person Number from the mother at each encounter.

4. Billing instructions for services provided a newborn infant under his or her mother's HSP (Medicaid) Case Number and Person Number are provided in the Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual, as applicable.

(b) The following procedures shall apply when application is made for Medicaid eligibility for an inpatient upon admission to a hospital:

1. A Hospital may submit a "Public Assistance Inquiry" (Form PA-1C, see Appendix, N.J.A.C. 10:49) when an individual is admitted to the facility and financial or medical indigency is a factor in the coverage of care. Under this arrangement, if the patient is determined to be eligible for Medicaid, the effective date of eligibility is the date of the hospital inquiry.

i. A PA-1C Form should be directed to either the Social Security Administration District Office in the area where the hospital is located or the county welfare agency as follows:

(1) The Social Security Administration is responsible for establishing Medicaid eligibility for the aged (persons 65 years and over), for the blind, and for the disabled who apply for Supplemental Security Income (SSI).

(2) The county welfare agency is responsible for establishing Medicaid eligibility for the individual who applies for Aid to Families with Dependent Children (AFDC), or for the individual who is aged, blind, or disabled and applies for "Medicaid Only," or for any individual who applies for New Jersey Care . . . Special Medicaid Programs.

2. Before preparing a PA-1C Form, the hospital shall screen the patient to determine the following:

i. Whether or not the patient is already eligible for Medicaid;

ii. Whether or not the patient has health insurance to cover the cost of hospital care and treatment; and

iii. Whether or not the person has sufficient income and/or resources to meet the cost of hospital care.

3. In the event that the date of the Medicaid eligibility which was established by the Social Security Administration or the county welfare agency is later than the date of admission, the recipient may apply directly to the New Jersey Medicaid Program for retroactive Medicaid payment of unpaid bills for allowable medical services within the three month period prior to the month of application (see N.J.A.C. 10:49-2.7).

**10:49-2.6 Presumptive eligibility**

(a) "Presumptive eligibility" means an expedited process whereby selected certified HealthStart Comprehensive Maternity Care providers make preliminary Medicaid eligibility determinations on behalf of pregnant women (see HealthStart in applicable Provider Services Manuals). This is a preliminary process to determine presumptive eligibility prior to the determination of Medicaid eligibility or ineligibility by the county welfare agency.

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

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

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

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

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

(d) A presumptively eligible pregnant woman is identified by the two messages which appear on the "Medicaid Eligibility Identification Card" (Form FD-73/178) (see Appendix, N.J.A.C. 10:49). One message is above the woman's name on the upper left side: **PRESUMPTIVELY ELIGIBLE PREGNANT WOMAN**. The second message appears in the message box on the upper right hand corner: **PROVIDERS ONLY: CALL 1-800-328-0065 TO VERIFY ELIGIBILITY BEFORE PROVIDING SERVICES**. This card is the only document acceptable for the identification of a presumptively eligible pregnant woman.

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

2. Even with the identification through the MEI card, each time a service is rendered the provider shall verify the presumptive eligibility status of a pregnant woman, prior to the delivery of ambulatory services, by calling the toll free telephone number, 1-800-328-0065, during normal business hours (Monday through Friday, 8:30 A.M.-4:30 P.M.) or as soon as possible if the services are delivered other than during normal business hours.

3. When the provider requests verification for presumptive eligibility, he or she is required to provide the individual's name and HSP (Medicaid) Case Number, including the Person Number, to the operator.

4. The operator will advise the provider of the presumptive eligibility status on the date service is delivered and furnish him or her with an authorization number. The authorization number documents the verification of the Medicaid presumptive eligibility status for the provider.

5. Payment for services rendered without presumptive eligibility verification may be denied if the provider did not secure the required authorization number which verified the eligibility status, as noted in (d)4 above.

**10:49-2.7 Medicaid Retroactive Eligibility**

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

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

(b) If the New Jersey Medicaid Program determines that the person was eligible for Medicaid at the time the service was provided, providers shall be notified directly that the unpaid bills for any service covered by the New Jersey Medicaid Program may be reimbursable in accordance with standard Medicaid reimbursement procedures.

1. The provider shall then complete the appropriate Medicaid claim form and submit it to the Retroactive Eligibility Unit for consideration and authorization of payment.

2. For any Medically Needy recipient, a retroactive eligibility determination shall be completed by the county welfare agency (see N.J.A.C. 10:49-2.3, Persons eligible under the Medically Needy Program).

#### Case Notes

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

#### 10:49-2.8 Verification of eligibility for Medicaid/Pharmaceutical Assistance to the Aged and Disabled (PAAD) services

(a) Each Medicaid recipient, except Nursing Facility recipients, has an HSP (Medicaid) Case Number printed on a Medicaid form that validates eligibility. The recipient shall present this form to the provider, as a proof of Medicaid eligibility, every time a service is to be provided. See N.J.A.C. 10:49-2.10 for a description and information about the HSP (Medicaid) Case Number and see N.J.A.C. 10:49-2.11 for information about the Medicaid forms that are used to validate eligibility. The Recipient Eligibility Verification System (REVS) can be used, in some instances, as an alternative to viewing a form used to validate eligibility (see N.J.A.C. 10:49-2.9).

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

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

ii. There shall be no reimbursement for services performed after termination of eligibility except as noted in N.J.A.C. 10:49-5.4(a)9.

(b) The New Jersey Medicaid/Pharmaceutical Assistance to the Aged and Disabled (PAAD) Programs, through an intermediary vendor which will have access to the Medicaid and PAAD eligibility file, offers providers an optional method of verifying recipient eligibility. The optional system is called Medicaid Eligibility Verification System (MEVS).

1. A provider can obtain eligibility information by entering the Medicaid/PAAD number or, if the number is not available, the following data elements: the recipient's Social Security Number and date of birth.

2. MEVS will contain current information on eligibility but is no guarantee of eligibility. The Medicaid eligibility card remains the only guarantee of eligibility.

#### 10:49-2.9 Recipient Eligibility Verification System (REVS)/Medicaid Eligibility Verification System (MEVS)

(a) In the event a recipient is unable to produce a form that validates Medicaid eligibility or the provider wants more current eligibility data (see N.J.A.C. 10:49-2.11) and the recipient's HSP (Medicaid) Case Number is known, the provider can verify eligibility by calling the Unisys Recipient Eligibility Verification System (REVS). REVS is accessed by dialing 1-800-676-6562 (or (609) 587-1955 in the local Trenton area). Complete instructions for using REVS can be found in the Fiscal Agent Billing Supplement following the second chapter for each Provider Services Manual.

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

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

2. MEVS will contain current information on eligibility but is no guarantee of eligibility. The Medicaid eligibility card remains the only guarantee of eligibility.

(c) The MEVS intermediary shall be a person, business, corporation, etc., that has been approved by and contracted with the Division to provide eligibility information to providers.

1. Applications to be an MEVS intermediary can be submitted to the Division at any time. If an application is approved, based on the evaluation criteria in (c)2 below, the Division shall enter into a contract with the vendor. The application must:

i. Describe the prospective vendor's approach and plans for accomplishing the work required;

ii. Demonstrate and describe the effort, skills and understanding of the project necessary to satisfactorily provide the services; and

iii. Contain all pertinent information relating to the prospective vendor's organization, personnel, and experience, and be signed by an authorized representative of the applying firm.

2. The Division shall consider the following in evaluating an application:

i. The applicant's general approach and plans to meet the requirements of the MEVS project;

Amended by R.1995 d.589, effective November 20, 1995.  
See: 27 N.J.R. 2851(a), 27 N.J.R. 4715(b).

- ii. The applicant's detailed approach and plans to meet the requirements of the MEVS project;
- iii. The applicant's documented qualifications, expertise, and experience on similar projects;
- iv. The applicant's proposed staff's documented qualifications, expertise, and experience on similar projects;
- v. The applicant's adherence to the requirements of the Health Care Financing Administration; and
- vi. The fact that the prices charged by the applicant to subscribers are reasonable.

3. If a request for approval as a MEVS intermediary is denied or approval withdrawn, the applicant/intermediary may request an administrative hearing pursuant to N.J.A.C. 10:49-10.1 and 10.3.

(d) The Division shall pay for the development and operational cost at Unisys. MEVS intermediaries shall pay an initial application fee of \$1,500, an annual registration fee of \$1,000, and a five cents per inquiry fee to Unisys. These fees will be forwarded to the State, which will allow it to be reimbursed a portion of its costs in this project.

Amended by R.1995 d.589, effective November 20, 1995.  
See: 27 N.J.R. 2851(a), 27 N.J.R. 4715(b).

#### 10:49-2.10 HSP (Medicaid) Case Number

(a) An HSP (Medicaid) Case Number consists of 12 digits, which includes a two-digit Person Number. The components of an HSP (Medicaid) Case Number as it is initially assigned to a recipient follows.

(b) The first two digits usually designate the county of residence as follows.

01 Atlantic	08 Gloucester	15 Ocean
02 Bergen	09 Hudson	16 Passaic
03 Burlington	10 Hunterdon	17 Salem
04 Camden	11 Mercer	18 Somerset
05 Cape May	12 Middlesex	19 Sussex
06 Cumberland	13 Monmouth	20 Union
07 Essex	14 Morris	21 Warren

1. For some adult recipients (that is, the Medicaid Only Program and New Jersey Care . . . Special Medicaid Programs for Aged, Blind, and Disabled) the first two digits of the HSP (Medicaid) Case Number designate the county of residence where eligibility was originally determined but not necessarily the location where the recipient is currently residing. In these instances, when the recipient moves to another county, the recipient retains the HSP (Medicaid) Case Number of the original county of application. However, the eligibility identification card will indicate the current address.

2. For recipients in certain State or county facilities, the first two digits of the HSP (Medicaid) Case Number designate the facility where the recipient resides. In a few unique situations the first two digits designate a special State program. The following list identifies the first two digits used to identify a State or county facility or a special State program. Following the name of the facility and enclosed in parentheses, is the Medicaid District Office serving that facility. For those facilities below marked by an asterisk(\*), it should be noted that when the first two digits of an HSP (Medicaid) Case Number are used to identify more than one facility, a specific series of numbers for the fifth through tenth digit shall be used to designate the second or third facility as well as to designate the sequential identification number of the Medicaid recipient.

#### i. Identification of State and County Psychiatric Facilities

- 31—Greystone Park Psychiatric Hospital (Morris MDO)
- 32—Trenton Psychiatric Hospital (Mercer MDO)
- \*32—(300,000 series) Forensic Psychiatric Hospital (Mercer MDO)
- \*32—(600,000 series) Senator Garrett W. Hagedorn Center for Geriatrics—Psychiatric Section (Hunterdon MDO)
- 33—Marlboro Psychiatric Hospital (Monmouth MDO)
- 34—Ancora Psychiatric Hospital (Camden MDO)
- 36—Arthur Brisbane Child Treatment Center (Psychiatric Hospital) (Monmouth MDO)
- 37—Bergen Pines Psychiatric Center (Bergen MDO)
- 38—Essex County Hospital Center—Cedar Grove (Essex—Suburban MDO)
- 39—Camden County Psychiatric Hospital (Camden MDO)

#### ii. Identification of Intermediate Care Facilities/Mental Retardation

- \*34—(800,000 series) Ancora Development Center (Camden MDO).
- 35—North Princeton Development Center (Hunterdon MDO)
- 41—Vineland Developmental Center (Cumberland MDO)
- 42—North Jersey Developmental Center (Totowa) (Passaic MDO)
- 43—Greenbrook Regional Center (Hunterdon MDO)
- 44—Woodbine Developmental Center (Cumberland MDO)
- 45—New Lisbon Developmental Center (Burlington MDO)

8. HealthStart maternity and pediatric care services include packages of comprehensive medical and health support services provided by independent clinics; hospital outpatient departments; local health departments meeting New Jersey Department of Health's improved pregnancy outcome criteria; physicians; and nurse midwives; either directly or through linkage with other HealthStart care providers. (See N.J.A.C. 10:49-1.4 for applicable Provider Services Manuals regarding HealthStart services, and requirements for provider participation);

9. Hearing aid services;

10. Home care services (home health care and personal care assistant services);

11. Hospice room and board services in a nursing facility (available to dually eligible Medicare/Medicaid recipients);

12. Hospital services—inpatient:

i. General hospitals;

ii. Special hospitals;

iii. Psychiatric hospitals (inpatient): Limited to persons age 65 or older and children 21 years of age and under; and

iv. Inpatient psychiatric programs for children 21 years of age and under;

13. Hospital services—outpatient;

14. Laboratory (clinical);

15. Medical day care services;

16. Medical supplies and equipment;

17. Mental health services;

18. Nursing facility services, including intermediate care facilities for the mentally retarded;

19. Nurse-midwifery services;

20. Optometric services;

21. Optical appliances;

22. Pharmaceutical services;

23. Physician services;

24. Podiatric services;

25. Prosthetic and orthotic devices;

26. Radiological services;

27. Rehabilitative services (Payments are made to eligible Medicaid providers only. No payment is made to privately practicing therapists);

i. Physical therapy, as provided by a home health agency, independent clinic, nursing facility, hospital outpatient department, or in a physician's office;

ii. Occupational therapy, as provided by a home health agency, independent clinic, nursing facility, or hospital outpatient department;

iii. Speech-language pathology services, as provided by a home health agency, independent clinic, nursing facility, hospital outpatient department, or in a physician's office; and

iv. Audiology services provided in the office of a licensed specialist in otology or otolaryngology, or as part of independent clinic or hospital outpatient services; and

28. Transportation services which include ambulance, invalid coach, livery, and other transportation provided by independent clinics or through arrangements with a county welfare agency.

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

#### **10:49-5.3 Services available to recipients eligible for the medically needy program**

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

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

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

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

4. Nursing facility services are not available to any Medically Needy group.

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).

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).

#### 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 Services not covered by Medicaid Program

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

1. Any service, admission, or item, which is not medically required for diagnosis or treatment of a disease, injury, or condition;
2. Services provided to all persons without charge shall not be billed to the Medicaid Program when provided for a Medicaid recipient. Services and items provided without charge through programs of other public or voluntary agencies (for example, New Jersey State Department of Health, 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 recipients under EPSDT);
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 recipient 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 recipient 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 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 recipient'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 recipient statements.

iv. Therefore, any difference between the amount paid to the provider based on the claim submitted and the Division's value of the procedure as determined by the Division's evaluation, may be recouped by the Division of Medical Assistance and Health Services;

14. Any claim submitted by a provider for service(s) rendered, except in a medical emergency, to a Medicaid recipient whose Medicaid Eligibility Identification Card (FD-73/178) has a printed message restricting the recipient 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 recipient 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 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. Recipient income shall be presumed to equal the maximum income allowable for a Medicaid recipient for those recipients whose records relating to income are completely unavailable.

iii. The Division shall seek recovery of any resulting overpayments; and

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).

#### Cross References

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

#### Case Notes

Extended care facility could not be reimbursed for care for Medicaid-eligible 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. *Prekness Hospital v. Div. of Medical Assistance and Health Services*, 3 N.J.A.R. 351 (1982).

## SUBCHAPTER 6. AUTHORIZATIONS REQUIRED BY MEDICAID PROGRAM

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

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

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

2. "Medical emergency" means a critical illness or injury status for which prompt medical care may be crucial to saving life and limb or sparing the recipient 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 Director 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 recipient 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 recipient'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 recipient home from the hospital on a Friday evening. The recipient 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 recipient 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?"

#### Case Notes

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) Services provided outside the United States and territories are not covered by the New Jersey Medicaid Program.

(b) 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.

(c) Prior authorization shall be required for all inpatient and outpatient hospital services provided outside the State of New Jersey except in the following situations:

1. Care provided in an emergency;

2. Interstate hospital transfers; and

3. Care provided to Medicaid recipients residing out-of-State at the discretion of the New Jersey Department of Human Services.

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

##### 10:49-7.1 General provisions

(a) The following information outlines the rules 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.

(b) In addition to information in this subchapter about submitting claims for payment, a Fiscal Agent Billing Supplement is included following the second chapter of 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; procedure for Electronic Funds Transfer (EFT); adjustments for overpayment and underpayment 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, the latter takes precedence.

##### 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. The claim may be submitted hard copy or by means of an approved method of automated data exchange. In order for a Medicaid claim to be considered for reimbursement, all appropriate documentation shall be included with the claim form.

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

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

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

(b) An institutional claim is a claim submitted by a hospital; home health agency; nursing facility; intermediate care facility/mental retardation; 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 recipient 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 form 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; intermediate care facility/mental retardation; residential treatment center; or government 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" on the claim form.

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

1. A claim for payment of a non-institutional service provided to any Medicaid recipient 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 form if the claim form carries more than one date of service;

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

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

(d) The time requirements for submitting a combination Medicare/Medicaid claim are as follows (Under Federal regulations, this applies only to Medicare/Medicaid 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 recipient.

i. The claim form shall contain both the HSP (Medicaid) Case Number and the Medicare HIC Number.

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

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

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

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

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

3. In most cases, when a recipient is eligible for both Medicare and Medicaid, a Medicare/Medicaid claim will cross over from the Medicare Carrier/Intermediary to the

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

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

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

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

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

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

#### Case Notes

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).

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 under this act.

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 recipient because of a third party's potential liability to pay for services.

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

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

1. Medicare: The Program will make payment in the full amount of the Medicare deductible and co-insurance for certain inpatient hospital services (see (e)1i(1) below).
2. Contracting practitioners: No Program payments shall be made when the third party calls for a contracting or participating practitioner to accept the TPL as payment in full.

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

1. For services, goods, or supplies not covered or authorized by the New Jersey Medical Assistance and Health Services Act (N.J.S.A. 30:4D-1 et seq.) if the recipient elected to receive the services, goods, or supplies with the knowledge that they were not covered or authorized; or
2. For payments made to the recipient by a third party on claims submitted to the third party by the provider.

(e) When a Medicaid recipient 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 coverage services rendered by a participating or contracting practitioner with any private health coverage program where the private plan calls for the practitioner to accept that plan's payment as payment in full. When other health insurance is involved, supplementation claims shall not be filed with the Program unless accompanied by a statement of payment, Explanation of Benefits (EOB), or denial from the other carrier. Attachment of such information will expedite Medicaid claim processing.

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

- i. Medicare (Title XVIII): For any Medicaid recipient who is covered under Medicare, responsibility for payment by the New Jersey Medicaid Program shall be limited to the unsatisfied deductible and/or co-insurance to the extent that the combined total of payments does not exceed the maximum allowable under the Medicaid Program in the absence of other coverage. The following exceptions should be noted:

- (1) The Program shall pay the full amount of any unsatisfied Medicare deductible and/or co-insurance for inpatient hospital services billable to the Program in accordance with Chapter 83, P.L. 1978 (that is, inpatient hospital services subject to payment by the Program according to the New Jersey DRG reimbursement methodology).

(f) When a Medicaid recipient has benefits available, such as those described above or from any other liable third party, an approved Medicaid provider shall be authorized to sign an insurance claim form 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 claim forms: "(signature of authorized provider), Assignee for the Commissioner, New Jersey Department of Human Services."

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

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

1. The TPL benefits are derived from a parent whose obligation to pay support is being enforced by the State Title IV-D agency;
2. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the Program;
3. The claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay; or
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.

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

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

(k) Any individual who undertakes to legally represent any Medicaid recipient 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).

#### 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 recipient by an approved provider may not be made to or through a factor, either directly or by power-of-attorney.

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

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

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

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

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

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

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

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

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

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

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

### 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 claims and payment to providers for all health services.

#### 10:49-8.2 Claim payment

(a) The Fiscal Agent will process claims daily and produce provider payments and associated Remittance Advice (RA) statements once each week. The RA is the provider's account statement and reflects the status of all claims currently entered into the Medicaid Management Information System. Provider payments in the form of checks and electronic funds transfers will be released following approval by the New Jersey Medicaid Program.

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

i. A claim that is correctly completed for a covered service provided to a Medicaid recipient 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. Suspended claims are those claims held for review by the Fiscal Agent. The review will result in a claim being paid, denied, or additional information being requested. If additional information is required, a Claim Correction Form (CCF) will be forwarded to the provider. (Additional billing information is provided in the Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

iii. Reasons for denial of a claim will be provided on the RA in the form of a 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, recipient 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, suspense reasons, and payment reduction reasons, if any. The only type of claim status that will not have a code is one that is paid as billed. 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 Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual.

#### Case Notes

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

#### 10:49-8.3 Adjustments following payment of claims

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

(b) On occasion, a claim will be paid that should not have been paid; for example, a duplicate payment. If a claim is paid in error, the provider shall notify the Fiscal Agent by

requesting that the claim be voided. (For the procedure to follow, see Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual.)

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

#### 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 (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 Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

#### 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.

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

#### 10:49-9.1 Civil rights

Federal regulations require that services provided to any Medicaid recipient 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.

#### 10:49-9.2 Observance of religious belief

(a) Nothing in the Medicaid Program shall be construed to require any recipient 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.

#### 10:49-9.3 Free choice by recipient and provider

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

1. A Medicaid recipient 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 recipient in obtaining services if the recipient cannot locate a provider. Exception: see N.J.A.C. 10:49-14.2, Special Status Programs.

2. A provider who accepts a recipient for care 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 recipient 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.

#### 10:49-9.4 Confidentiality of records

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

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

1. Purposes directly connected with the administration of the Program shall include, but are not limited to:
  - i. Establishing eligibility;
  - ii. Determining the amount of medical assistance;
  - iii. Providing services for recipients; and
  - iv. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Program.

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

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

#### Case Notes

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

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

#### 10:49-9.5 Provider certification and recordkeeping

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

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

i. The following signature types are unacceptable:

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

(b) Providers shall agree to the following:

1. To keep such records as are necessary to disclose fully the extent of services provided;
2. To furnish information for such services as the Program may request;
3. That where such records do not document the extent of services billed, payment adjustments shall be necessary;
4. That the services billed on any claim and the amount charged therefore are in accordance with the regulations of the New Jersey Medicaid Program;
5. That no part of the net amount payable under any claim has been paid, except that all available third party liability has been exhausted, in accordance with Program regulations; and
6. That payment of such amount, after exhaustion of third party liability, will be accepted as payment in full without additional charge to the Medicaid recipient or to others on his behalf.

#### 10:49-9.6 Patient's (recipient) certification

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

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

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

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

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

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

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

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

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

2. If a recipient 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 recipient was not personally able to sign the form(s) and the relationship of the signee to the recipient shall be noted directly on the Medicaid hard-copy claim form or the Patient Certification Form (FD-197).

#### Case Notes

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

**10:49-9.7 Integrity of the Medicaid Program**

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

**10:49-9.8 Fraud and abuse**

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

**10:49-9.9 Informing individuals of their rights**

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

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

**10:49-9.10 Provisions for appeals; fair hearings**

(a) Pursuant to N.J.A.C. 10:49-10, Fair Hearings, both providers and Medicaid recipients with the New Jersey Medicaid Program shall have the right to file for fair hearings.

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

(c) A Medicaid recipient may be granted a hearing because his or her claim for medical assistance is denied or is not acted upon with reasonable promptness, or because the recipient is aggrieved by any other agency action resulting in non-eligibility, denial, termination, reduction or suspension of such assistance.

(d) In order to obtain a fair hearing, the provider or the recipient shall submit a request in writing to the Fair Hearing Unit, Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625, outlining the reason for the request.

(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 Manual.

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**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 recipient as defined in this section.

“Department” means the Department of Human Services, the single State agency responsible for administering the New Jersey Medicaid Program and other special programs through the Division of Medical Assistance and Health Services.

“Notice” means an announcement of a policy decision by the Title XIX agency that may adversely affect the Medicaid recipient.

“Provider” means any person, public or private institution, agency or business concern lawfully providing medical care, services, goods and supplies authorized under N.J.S.A. 30:4D-1 et seq. and amendments thereto, holding, where applicable, a current valid license to provide such services or to dispense such goods or supplies.

“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.

“Recipient” means a person who is a resident of this State and is determined to need medical care and services under N.J.S.A. 30:40-1 et seq. and amendments thereto, and falls within the eligibility criteria set forth therein.

**10:49-10.2 Notices**

(a) The Department/Division may print a notice of prospective policy changes affecting Medicaid recipients 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.

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

(d) The final decision shall be promptly implemented.

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

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

### SUBCHAPTER 11. EXCLUSION FROM PARTICIPATION IN THE NEW JERSEY MEDICAID PROGRAM (SUSPENSION, DEBARMENT, AND DISQUALIFICATION)

#### Cross References

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

#### 10:49-11.1 Program participation

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

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

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

2. Providers reimbursed on a cost-related basis may not claim as allowable costs any amounts paid or credited to such individuals, and such amounts shall not be reimbursed by the New Jersey Medicaid Program.

3. Providers reimbursed on a fee-for-service basis may not submit claims and shall not be reimbursed for any goods supplied or services rendered by such individuals.

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

(c) Definitions, as used in this section, shall include the following:

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

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

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

“Division” means the Division of Medical Assistance and Health Services, which administers Medicaid, Federally waived programs (see N.J.A.C. 10:49-1.6) and state funded programs (see N.J.A.C. 10:49-1.7).

“Fiscal Agent” means an entity which processes and pays claims on behalf of the State of New Jersey.

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

“Provider” means any person, public or private institution, agency or business concern lawfully providing medical care, services, goods and supplies authorized under the New Jersey Medicaid Program P.L. 1968, c.413 (N.J.S.A. 30:4D-1 et seq.), as amended, holding, where applicable, a current valid license to provide such services or to dispense such goods or supplies.

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

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

nature or quality of the goods or service or the persons who may supply or perform the same.

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

(d) Any of the following, among other things, shall constitute a good cause for suspension, debarment, or disqualification of a person engaged in State contracting, as defined herein, by the Division of Medical Assistance and Health Services:

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

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

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

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

5. Violation of the “Law Against Discrimination” (P.L. 1945, c.169, N.J.S.A. 10:5-1 et seq. as supplemented by P.L. 1975, c.127), or of the “Act Banning Discrimination in Public Works Employment” (N.J.S.A. 10:2-1 et seq.) or of the “Act Prohibiting Discrimination by Industries Engaged in Defense Work in the Employment of Persons Therein” (P.L. 1942, c.114, N.J.S.A. 10:1-10 et seq.);

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

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

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

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

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

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

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

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

14. Failure to disclose or make available to the Division of Medical Assistance and Health Services or its authorized agent, records of services provided to or payments made on behalf of Medicaid recipients;

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

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

17. Breach of the terms of the Medicaid provider agreement entered into with the Division or failure to comply with the terms of the provider certification on the Medicaid claim form;

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

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

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

21. Conviction of any crime involving moral turpitude;

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

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

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

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

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

(e) Conditions for debarment shall be as follows:

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

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

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

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

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

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

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

(f) If the Division seeks to debar a person or his or her affiliates, the Division shall furnish such party with a written notice stating that debarment is being considered, setting forth the reasons for the proposed debarment and indicating that such party will be afforded an opportunity for a hearing if he or she so requests within a stated period of time. All such hearings shall be conducted in accordance with the provisions of the Administrative Procedure Act. However, where one department or agency has imposed debarment upon a party, a second department or agency may also impose a similar debarment without affording an opportunity for a hearing, provided that the second agency furnishes

notice of the proposed similar debarment to that party and affords that party an opportunity to present information in his or her behalf to explain why the proposed similar debarment should not be imposed in whole or in part.

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

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

1. Except as otherwise provided by law, a debarment may be removed or the period thereof may be reduced at the discretion of the debarring agency upon the submission of a good faith application under oath, supported by documentary evidence, setting forth substantial and appropriate grounds for the granting of relief, such as newly discovered material evidence, reversal of a conviction or judgment, actual change of ownership, management or control, or the elimination of the causes for which the debarment was imposed.

2. A debarment may include all known affiliates of a person, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The offense, failure or inadequacy of performance of an individual may be imputed to a person with whom he or she is affiliated, where such conduct was accomplished within the course of his or her official duty or was effected by him or her with the knowledge or approval of such person.

3. Debarment by the Director of any provider of service shall preclude such provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association to the Division of Medical Assistance and Health Services or its Fiscal Agent for any services or supplies he or she has provided under the New Jersey Medicaid Program, except for services or supplies provided prior to the debarment. No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the Division or its Fiscal Agent for any services or supplies provided by a person within such organization who has been debarred by the Director, except for services or supplies provided prior to the debarment.

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

(i) The Division may suspend a person in the public interest for any cause specified in (d) above, or upon a reasonable suspicion that such cause exists, or when, in the

opinion of the Director, such action is necessary to protect the public welfare and the interests of the medical assistance Program.

(j) Conditions for suspension shall be as follows:

1. Suspension shall be imposed only upon approval of the Director of the Division and upon approval of the Attorney General, except as otherwise provided by law.

2. The existence of any cause for suspension shall not require that a suspension be imposed, and a decision to suspend shall be made at the discretion of the Director of the Division and of the Attorney General, and shall be rendered in the best interests of the Division.

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

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

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

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

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

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

(m) Scope of suspension rules are as follows:

1. A suspension may include all known affiliates of a person, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The offense, failure or inadequacy of performance of an individual may be imputed to a person with whom he or she is affiliated, where such conduct was accomplished within the course of his official duty or was effectuated by him or her with the knowledge or approval of such person.

2. Suspension, by the Director, of any provider of service shall preclude such provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association to the Division of Medical Assistance and Health Services or its Fiscal Agent for any services or supplies he or she has provided under the New Jersey Medicaid Program, except for services or supplies provided prior to the suspension. No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the Division or its Fiscal Agent for any services or supplies provided by a person within such organization who has been suspended by the Director, except for services or supplies provided prior to the suspension.

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

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

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

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

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

#### Law Review and Journal Commentaries

Defense of Health Care Fraud, Abuse Charges. Richard L. Friedman, 133 N.J.L.J. No. 7, 10 (1993).

#### Case Notes

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

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

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

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

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

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

## SUBCHAPTER 12. PROVIDER REINSTATEMENT

### 10:49-12.1 Definitions

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

"Committee" means the Provider Reinstatement Committee.

"Director" means the Director of the Division of Medical Assistance and Health Services.

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

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

### 10:49-12.2 Requests for reinstatement

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

or programs administered by the Division shall petition the Director for reinstatement in writing.

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

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

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

(c) Persons who have been suspended, debarred or disqualified as the result of an indictment, conviction or license revocation may immediately petition the Director for reinstatement upon acquittal, reversal of the conviction upon appeal or restoration of the license, whichever is applicable.

### 10:49-12.4 Director's powers

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

### 10:49-12.5 Provider Reinstatement Committee

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

1. The Committee shall be composed of three impartial officials of the Division appointed by the Director.

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

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

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

### 10:49-12.6 Criteria for reinstatement

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

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

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

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

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

5. Full restitution and the payment of any criminal fines imposed;

6. Full satisfaction of any civil penalties imposed;

7. Full satisfaction of interest payments;

8. Compliance with the terms and conditions of Consent Orders or Court Orders; and

9. Satisfaction of any conditions or requirements previously imposed by the Division.

#### Case Notes

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

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

#### 10:49-12.7 Committee procedures

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

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

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

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

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

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

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

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

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

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

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

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

(m) The Director 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.

### SUBCHAPTER 13. PROGRAM CONTROLS

#### 10:49-13.1 Medical review and evaluation

Under the provisions of Federal and State law, the Division of Medical Assistance and Health Services shall provide continuing review and evaluation of the care and services provided under the Program. This includes review of utilization of services of practitioners and other providers.

#### 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.