47 Middlesex MACC

48 Middlesex MACC

51 Middlesex MACC—Menlo Park Veterans Home

51 Middlesex MACC—Vineland Veterans Home

90 MACC in county in which beneficiary resides.

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Substituted "beneficiary" for "recipient" or "resident" throughout; in (a)3 and (b), substituted "Medicaid Eligibility Identification Number" for "HSP (Medicaid) Case Number"; in (b), inserted references to beneficiaries, amended MDO references, and inserted the two 51—Middlesex references.
Recodified from N.J.A.C 10:49–2.15 by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Former N.J.A.C. 10:49–2.16, Medicaid application, recodified to N.J.A.C. 10:49–2.17.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

10:49–2.17 Medicaid application

(a) If a person has not applied for benefits, is unable to pay for services provided, and appears to meet the requirements for eligibility for the New Jersey Medicaid program, the provider shall encourage the person, or his or her representative, to apply for benefits:

1. To the CBOSS for programs such as AFDC–Related Medicaid; Medicaid Only; New Jersey Care ... Special Medicaid programs for pregnant women, children, and the aged, blind, or disabled; or for Medically Needy.

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

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

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

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

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Recodified from N.J.A.C 10:49–2.16 by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

10:49–2.18 (Reserved)

10:49–2.19 Medicaid or NJ FamilyCare eligibility—aliens

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

New Rule, R.1998 d.116, effective January 30, 1998 (operative February 1, 1998).
See: 30 N.J.R. 713(a).
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 with changes, effective August 17, 1998.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

SUBCHAPTER 3. PROVIDER PARTICIPATION

10:49–3.1 Provider types eligible to participate

(a) The following provider types shall be eligible to participate as Medicaid/NJ FamilyCare–Plan A providers:

1. Case managers;

2. Certified nurse practitioners/clinical nurse specialists;

3. Chiropractors and/or chiropractic groups;

4. Clinics (independent outpatient health care facilities);

5. Clinical laboratories;

6. Dentists and/or dentist groups;

7. Hearing aid dealers;

8. Health maintenance organizations/managed care organizations;

9. Home health agencies;

10. Homemaker agencies;

11. Hospices;

12. Hospitals;

i. General;

ii. Psychiatric; and

iii. Special;

13. Local health departments;

14. Nursing facilities, including intermediate care facilities for the mentally retarded;

15. Medical suppliers;

16. Mental health rehabilitation providers:

i. Residential child care facilities (see N.J.A.C. 10:77 and 10:127);

ii. Children's group homes (see N.J.A.C. 10:77 and 10:128);

iii. Psychiatric community residences for youth (see N.J.A.C. 10:37B and 10:77);

iv. Providers of behavioral assistance services for children/youth or young adults (see N.J.A.C. 10:77–4);

v. Mobile response agencies (see N.J.A.C. 10:77–6);

vi. Programs for Assertive Community Treatment (PACT) Agencies/Teams (see N.J.A.C. 10:37J and 10:76); and

vii. Community residences for mentally ill adults (see N.J.A.C. 10:37A and 10:77A).

17. Medical day care centers;

18. Nurse-midwives;

19. Opticians;

20. Optometrists;

21. Orthotists;

22. Pharmacies;

23. Physicians and/or physician groups;

24. Podiatrists and/or podiatric groups;

25. Prosthetists;

26. Psychologists and/or psychologist groups;

27. Residential treatment facilities;

28. Transportation providers; and

29. State and county agencies that have agreed to provide personal care assistant services.

(b) In order for professional practices to be eligible to participate in the Medicaid and NJ FamilyCare programs as specific provider entities, such practices shall comply with all applicable State licensing statutes and rules governing their ownership and direction.

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Inserted new (a)1; recodified former (a)1 through 25 as (a)2 through 26; in (a)7, inserted reference to managed care organizations.
Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In (a), inserted a reference to NJ KidCare—Plan A in the introductory paragraph.
Amended by R.1998 d.143, effective March 16, 1998.
See: 29 N.J.R. 543(a), 30 N.J.R. 1081(a).
In (a), inserted a new 12, and recodified former 12 through 26 as 13 through 27.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Amended by R.2000 d.309, effective August 7, 2000.
See: 32 N.J.R. 1342(a), 32 N.J.R. 2900(a).
In (a), inserted a new 1, and recodified former 1 through 27 as 2 through 28.
Amended by R.2001 d.144, effective May 7, 2001.
See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).
Inserted new (a)16 and recodified former (a)16 through 28 as new (a)17 through 29.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).
Added (b).
Amended by R.2003 d.89, effective March 3, 2003.
See: 34 N.J.R. 1593(a), 35 N.J.R. 1281(a).
Rewrote (a)16.
Amended by R.2003 d.479, effective December 15, 2003.
See: 35 N.J.R. 2146(a), 35 N.J.R. 5584(a).
In (a)16, inserted a new iv and recodified former iv as new v.
Amended by R.2004 d.8, effective January 5, 2004.
See: 35 N.J.R. 2620(a), 35 N.J.R. 4204(a), 36 N.J.R. 189(a).
In (a)16, added vi.
Amended by R.2005 d.68, effective February 22, 2005.
See: 36 N.J.R. 379(a), 37 N.J.R. 659(a).
In (a), added 16v, recodified existing v to vi as vi to vii.

Cross References

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

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

10:49–3.2 Enrollment process

(a) Providers shall complete a Provider Application and sign a Provider Agreement (see Appendix, N.J.A.C. 10:49) or a specialized agreement, and submit such other information or documentation, including, but not limited to, social security number and date of birth, as the program may require, depending on the nature of the services provided.

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

2. All practitioners participating in a group practice shall personally sign both the group application and the provider agreement if individual documents, or shall sign a single signature sheet if both documents are contained in a single packet.

(b) All providers shall be required to complete Form HCFA–1513, Ownership and Control Interest Disclosure Statement (see Appendix, Form #10) at the time of application or reapplication. In addition, at the time of application or reapplication, all professional practices must certify that they comply with all applicable State licensing statutes and rules governing their ownership and direction (see Appendix, Form #12). Providers prior to 1973 were not required to utilize provider agreement forms; however, they shall comply with all applicable State and Federal Title XIX and Title XXI laws, policies, rules and regulations.

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

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

Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
In (a)4i, substituted a reference to Program Numbers for a reference to Medicaid Numbers.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

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

10:49–5.1 Requirements for provision of services

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

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

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
In (a), substituted "beneficiaries" for "recipients"; and in (a)1, inserted "prior" preceding "authorization".
Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In (a), inserted a reference to NJ KidCare—Plan A programs in the first sentence.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

Case Notes

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

Patient's possible Munchausen's syndrome was good cause for limiting medical services. D.S. v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 4.

10:49–5.2 Services available to beneficiaries eligible for, or children who are presumptively eligible for, the regular Medicaid and NJ FamilyCare–Plan A programs

(a) The services listed below shall be available to beneficiaries eligible for the regular Medicaid/NJ FamilyCare–Plan A programs:

1. Advanced practice nurse services;

2. Case management services (Mental Health Program);

3. Chiropractic services;

4. Religious non-medical health care services, (see Hospital Services Manual);

5. Clinic services such as services in an independent outpatient health care facility, other than hospital, that provides services such as Mental Health, Family Planning, Dental, Optometric, Ambulatory Surgery, FQHCs;

6. Dental services;

7. Environmental lead inspection services-rehabilitative services;

8. Early and Periodic Screening, Diagnosis, and Treatment for beneficiaries under age 21 (EPSDT): A preventative health care program for beneficiaries under age 21 designed for early detection, diagnosis and treatment of correctable abnormalities. This program supplements the general medical services otherwise available;

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

i. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered by the New Jersey Medicaid or NJ FamilyCare–Plan A program.

10. HealthStart maternity and pediatric care services include packages of comprehensive medical and health support services provided by independent clinics; hospital outpatient departments; local health departments meeting New Jersey Department of Health and Senior Services' improved pregnancy outcome criteria; physicians; and nurse midwives; either directly or through linkage with other HealthStart care providers. (See N.J.A.C. 10:49–19 for HealthStart services, policies and requirements for provider participation;)

11. Hearing aid services;

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

13. Hospice services including room and board services in a nursing facility (available to dually eligible Medicare/Medicaid or dually eligible Medicare/NJ FamilyCare–Plan A beneficiaries);

14. 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;

15. Hospital services—outpatient;

16. Laboratory (clinical);

17. Medical day care services;

18. Medical supplies and equipment;

19. Mental health services and mental health rehabilitation services including:

i. Residential child care facilities (see N.J.A.C. 10:77 and 10:127);

ii. Children's group homes (see N.J.A.C. 10:77 and 10:128);

iii. Psychiatric community residences for youth (see N.J.A.C. 10:37B and 10:77);

iv. Behavioral assistance services for children/youth or young adults under EPSDT (see N.J.A.C. 10:77–4);

v. Mobile response and stabilization management services for children, youth or young adults under EPSDT (see N.J.A.C. 10:77–6);

vi. Programs for Assertive Community Treatment (PACT) Services (see N.J.A.C. 10:37J and 10:76); and

vii. Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:37A and 10:77A).

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

i. Any additional Intermediate Care Facility/Mental Retardation (ICF/MR) beds or new ICF/MR facilities shall be approved by the Division of Developmental Disabilities (DDD) prior to application for reimbursement as a Medicaid/NJ FamilyCare provider;

21. Nurse-midwifery services;

22. Optometric services;

23. Optical appliances;

24. Pharmaceutical services;

25. Physician services;

26. Podiatric services;

27. Prosthetic and orthotic devices;

28. Psychological services;

29. Radiological services;

30. Rehabilitative services (Payments are made to eligible Medicaid/NJ FamilyCare–Plan A providers only. No payment is made to privately practicing therapists);

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

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

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

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

v. School based rehabilitation services under EPSDT; and

31. Transportation services which include ambulance, mobility assistance vehicle, and other transportation provided by independent clinics or through arrangements with a county board of social services.

(b) All Medicaid and NJ FamilyCare Plan A beneficiaries shall be eligible to receive all of the services specified in (a) above fee-for-service during the presumptive eligibility period, and through the time that they select and are enrolled into a managed care organization, if managed care is applicable.

Amended by R.1994 d.600, effective December 5, 1994.
See: 26 N.J.R. 3345(a), 26 N.J.R. 4762(a).
Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Amended section name; substituted "beneficiaries" for "recipients" throughout; in (a)4, inserted reference to FQHCs; in (a)8, amended Department name and N.J.A.C. reference; and in (a)28, deleted reference to livery transportation.
Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In (a), inserted references to NJ KidCare—Plan A throughout.
Amended by R.1998 d.143, effective March 16, 1998.
See: 29 N.J.R. 543(a), 30 N.J.R. 1081(a).
In (a), inserted a new 6, and recodified former 6 through 28 as 7 through 29.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.

Amended by R.2000 d.266, effective July 3, 2000.
See: 32 N.J.R. 159(a), 32 N.J.R. 2493(a).
Added (b).
Amended by R.2000 d.309, effective August 7, 2000.
See: 32 N.J.R. 1342(a), 32 N.J.R. 2900(a).
In (a), inserted a new 2, recodified former 2 through 26 as 3 through 27, inserted "services including" in the new 13, inserted a new 28, recodified former 27 through 29 as 29 through 31, added v in the new 30, and substituted a reference to mobility assistance vehicles for a reference to invalid coaches and substituted a reference to county boards of social services for a reference to county welfare agencies in the new 31.
Amended by R.2001 d.144, effective May 7, 2001.
See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).
Rewrote (a)19.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).
In (a), substituted "Religious non-medical health care services," for "Christian Science Sanatoria" in 4, added 20i.
Amended by R.2003 d.89, effective March 3, 2003.
See: 34 N.J.R. 1593(a), 35 N.J.R. 1281(a).
In (a), rewrote 19 and substituted "NJ FamilyCare" for "or KidCare" in 30.
Amended by R.2003 d.479, effective December 15, 2003.
See: 35 N.J.R. 2146(a), 35 N.J.R. 5584(a).
In (a)19, inserted a new iv and recodified former iv as new v and rewrote new v.
Amended by R.2004 d.8, effective January 5, 2004.
See: 35 N.J.R. 2620(a), 35 N.J.R. 4204(a), 36 N.J.R. 189(a).
In (a)19, added vi.
Amended by R.2004 d.334, effective September 7, 2004.
See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).
In (a), added a new 1, recodified former 1 as 2, and deleted former 2.
Amended by R.2005 d.68, effective February 22, 2005.
See: 36 N.J.R. 379(a), 37 N.J.R. 659(a).
In (a), rewrote 19.

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

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

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

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

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

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

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

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

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

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

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

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

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

Case Notes

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

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

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

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

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

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

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

ii. Serious impairment to bodily functions; or

iii. Serious dysfunction of any bodily organ or part.

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

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

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

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

4. To be eligible for emergency services, an alien meeting the medical criteria listed in (a)1 above must also meet all financial and categorical eligibility requirements for NJ FamilyCare–Plan A, Medicaid, Medically Needy, New Jersey Care ... Special Medicaid Programs or AFDC-related Medicaid.

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

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

New Rule, R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Former N.J.A.C. 10:49–5.4., Services not covered by the Medicaid program, recodified to N.J.A.C. 10:49–5.5.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Amended by R.1999 d.253, effective August 2, 1999.
See: 31 N.J.R. 97(a), 31 N.J.R. 2203(b).
Rewrote the section.
Emergency amendment R.1999 d.254, effective July 12, 1999 (to expire September 10, 1999).
See: 31 N.J.R. 2252(a).
Rewrote the section.
Adopted concurrent proposal, R.1999 d.345, effective September 10, 1999.
See: 31 N.J.R. 2252(a), 31 N.J.R. 2880(a).
Readopted provisions of R.1999 d.254 without change.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).
In (a), inserted "in their entitlement" following "restricted" throughout.

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

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

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

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

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

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

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

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

6. Services provided outside the United States and territories;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17. Claims for services, goods or supplies which are furnished, rendered, prescribed or ordered in violation of Federal or State civil or criminal statutes, or in violation of licensure statutes, rules and/or regulations; and

18. Any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the direction or on the prescription of a physician, individual or entity, during the period when such physician, individual or entity is excluded from participation in the Medicaid and NJ FamilyCare programs, and when the physician, individual or entity furnishing such item or service has received written notice from the Division that the physician, individual or entity has been excluded from participation in the Medicaid and NJ FamilyCare programs.

Amended by R.1994 d.600, effective December 5, 1994.
See: 26 N.J.R. 3345(a), 26 N.J.R. 4762(a).
Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Amended section name; substituted "beneficiaries" and "beneficiary's" for "recipients" or "recipient's" throughout; in (a)2, inserted "; these services" preceding "shall not be billed" and amended Department name; in (a)4, inserted references to Model Waiver III, ACCAP and ABC programs; in (a)13iv and (a)15, substituted reference to Medicaid Agent for reference to Division.
Recodified from N.J.A.C 10:49–5.4 and amended R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
In (a), inserted a reference to the NJ KidCare-Plan A program in the first sentence, inserted a reference to NJ KidCare-Plan A beneficiaries and substituted a reference to NJ KidCare Eligibility Identification Cards for Eligibility Identification Cards in 14, inserted references to the Division throughout 15, and inserted a reference to NJ KidCare beneficiaries in 15ii.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 with changes, effective September 21, 1998.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).
In (a), added 17 and 18.

Cross References

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

Case Notes

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

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

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

10:49–5.6 Services available and unavailable to beneficiaries eligible for, or who are presumptively eligible for, NJ FamilyCare–Plan B or C

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

1. Advance practice nurse services;

2. Audiology services;

3. Chiropractic services;

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

5. Clinical nurse specialist services;

6. Dental services;

7. Durable medical equipment;

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

9. Emergency room services;

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

i. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered by the New Jersey Medicaid or NJ FamilyCare program.

11. Federally qualified health center primary care services;

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

13. Hearing aid services;

14. Home health care services;

i. Exception: personal care assistant services;

15. Hospice services;

16. Hospital services—inpatient:

i. General hospitals;

ii. Special hospitals; and

iii. Rehabilitation hospitals;

17. Hospital services—outpatient;

18. Laboratory (clinical);

19. Medical supplies and equipment;

20. Nurse-midwifery services;

21. Optometric services;

22. Optical appliances;

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

24. Prescription drug services;

25. Physician services;

26. Podiatric services;

27. Prosthetic and orthotic devices;

28. Private duty nursing;

29. Radiological services;

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

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

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

1. Religious non-medical health care institution care and services;

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

3. Elective/induced abortion services;

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

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

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

6. Hospital services—inpatient;

i. Psychiatric hospitals;

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

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

iv. Organ transplant hospital services;

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

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

i. NJ FamilyCare–Plan B and C beneficiaries under age 19 who are receiving services under the Division of Child Behavioral Health Services may be eligible for additional mental health and mental health rehabilitation services as authorized by the Contracted Systems Administrator (CSA). (See N.J.A.C. 10:49–5.6(d).)

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

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

10. Substance abuse services provided by practitioners, including physicians, psychologists, advanced practice nurses; and

11. Targeted case management services for the chronically ill.

(c) Services not covered under Plan B and C shall be as follows:

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

2. Services not covered shall include, but shall not be limited to:

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

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

iii. Personal care services;

iv. Medical day care services;

v. Lower mode transportation;

vi. Any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the direction or on the prescription of a physician, individual or entity, during the period when such physician, individual or entity is excluded from participation in the Medicaid and NJ FamilyCare programs, and

when the physician, individual or entity furnishing such item or service has received written notice from the Division that the physician, individual or entity has been excluded from participation in the Medicaid and NJ FamilyCare programs;

vii. Programs for Assertive Community Treatment (PACT) services; and

viii. Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:37A and 10:77A).

(d) Additional mental health and mental health rehabilitation services as listed below may be available to beneficiaries under age 19 who are eligible for NJ FamilyCare–Plan B or C under fee-for-service and receiving services under the Division of Child Behavioral Health Services. All services shall first be authorized by the CSA or other agent authorized by the Department of Human Services and shall be included in an approved plan of care.

1. Care coordination by a care management organization (CMO) (see N.J.A.C. 10:73);

2. Mental health rehabilitation services provided in residential childcare facilities (as defined in N.J.A.C. 10:127 and licensed by DYFS), children's group homes (as defined in N.J.A.C. 10:128 and licensed by DYFS), or psychiatric community residences for youth (as defined in N.J.A.C. 10:37B and licensed by DMHS);

3. Behavioral assistance services for children, youth or young adults under EPSDT (see N.J.A.C. 10:77–4); and

4. Mobile response and stabilization management services for children, youth or young adults under EPSDT (see N.J.A.C. 10:77–6).

(e) All presumptively eligible NJ FamilyCare–Plan B and C beneficiaries shall be eligible to receive all the services specified in (a) and (b) above fee-for-service during the presumptive eligibility period, which shall include the services that are otherwise only available through the managed care organizations. The provision of the managed care services fee-for-service shall be limited to the presumptive eligibility period. The additional mental/behavioral health services listed in (d) above may be available to children, youth or young adults under the age of 19 who are receiving services under the Division of Child Behavioral Health Services during their period of presumptive eligibility.

New Rule, R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 with changes, effective September 21, 1998.
Amended by R.2000 d.266, effective July 3, 2000.
See: 32 N.J.R. 159(a), 32 N.J.R. 2493(a).
Added (d).
Amended by R.2001 d.144, effective May 7, 2001.
See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).
Added (c)2vi.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).
In (b)1, substituted "Religious non-medical health care institution" for "Christian Science sanatoria"; in (c), added "for youth (as defined in N.J.A.C. 10:37B and licensed by DMHS); and" at the end of vi and added vii.
Amended by R.2003 d.89, effective March 3, 2003.
See: 34 N.J.R. 1593(a), 35 N.J.R. 1281(a).
Rewrote (c)2.
Amended by R.2003 d.479, effective December 15, 2003.
See: 35 N.J.R. 2146(a), 35 N.J.R. 5584(a).
In (c)2vi, added "or behavioral assistance services for children/youth or young adults (see N.J.A.C. 10:77–4)" to the end of the paragraph.
Amended by R.2004 d.8, effective January 5, 2004.
See: 35 N.J.R. 2620(a), 35 N.J.R. 4204(a), 36 N.J.R. 189(a).
In (c)2, added ix.
Amended by R.2004 d.334, effective September 7, 2004.
See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).
In (a), added a new 1, recodified existing 1 as 2, deleted existing 2; in (b), substituted "advanced practice nurses" for "certified nurse practitioners/clinical nurse specialists" in 7 and 10.
Amended by R.2005 d.68, effective February 22, 2005.
See: 36 N.J.R. 379(a), 37 N.J.R. 659(a).
In (b), added 7i; rewrote (c)2; added (d); recodified existing (d) as (e) and added the third sentence.

10:49–5.7 Services available and unavailable to beneficiaries eligible for NJ FamilyCare–Plan D and Plan D for adults

(a) Except as indicated at N.J.A.C. 10:79–2.5, which concerns services for newborns enrolling into NJ FamilyCare–Plan C and D, the services listed below are available to beneficiaries eligible for NJ FamilyCare–Plan D and Plan D for Adults, when medically necessary and provided through the network of an HMO selected by the NJ FamilyCare–Plan D beneficiary.

1. Advanced practice nurses;

2. Clinic services (services in an independent outpatient health care facility, other than hospital, that provides covered ambulatory care services);

3. Preventive dental services for children under the age of 12 years, including oral examinations, oral prophylaxis and topical application of fluorides;

4. Emergency room services;

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

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

6. Federally qualified health center primary care services;

7. Home health care services, limited to skilled nursing for a home bound beneficiary which is provided or supervised by a registered nurse, and home health aide when the purpose of the treatment is skilled care, medical social services which are necessary for the treatment of the beneficiary's medical condition and short-term physical, speech or occupation therapy with the same limitations described in (a)22 below;

i. Personal care assistant services are not covered;

8. Hospice services;

9. Hospital services—inpatient;

10. Hospital services—outpatient;

11. Laboratory (clinical);

12. Nurse-midwifery services;

13. Optometric services, including one routine eye examination per year;

14. Optical appliances, limited to one pair of glasses or contact lenses per 24 month period;

15. Organ transplant services which are non-experimental or non-investigational;

16. Prescription drug services;

i. Exception: Over-the-counter drugs are not covered;

17. Physician services;

18. Podiatric services;

i. Exception: Coverage excludes routine foot care;

19. Prosthetic appliances, limited to initial provision of prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defect;

i. Coverage includes repair and replacement when due to congenital growth;

20. Outpatient surgery;

21. Radiological services;

22. Inpatient rehabilitative services, including physical, occupational and speech therapy for non-chronic conditions and acute illnesses and injuries;

23. Transportation services, limited to ambulance for medical emergency only;

24. Well child care including immunizations, lead screening and treatments;

25. Maternity and related newborn care; and

26. Diabetic supplies and equipment.

(b) The services listed below shall be available to beneficiaries eligible for NJ FamilyCare–Plan D under fee-for-service.

1. Services for mental health or behavioral conditions;

i. Inpatient hospital services, including psychiatric hospitals, limited to 35 days per year;

(1) A NJ FamilyCare–Plan D beneficiary under age 21 who is receiving services under the Division of Child Behavioral Health Services may secure additional inpatient psychiatric services provided in a psychiatric hospital, if authorized by the Contracted Systems Administrator (CSA) or other agent designated by the Department of Human Services (see N.J.A.C. 10:77–5.7(d));

ii. Outpatient benefits for short-term, outpatient evaluative and crisis intervention or home health mental health services, limited to 20 visits per year;

(1) When authorized by the Division of Medical Assistance and Health Services, inpatient benefit exchanges are allowed. One mental health inpatient day may be exchanged for up to four outpatient services, including partial care. This is limited to an exchange of up to a maximum of 10 inpatient days for a maximum of 40 additional out patient visits.

(2) When authorized by the Division of Medical Assistance and Health Services, inpatient benefit exchanges are allowed. One mental health inpatient day may be exchanged for two days of treatment in partial hospitalization up to the maximum number of covered inpatient days.

(3) A NJ FamilyCare–Plan D beneficiary under age 21 who is receiving services under the Division of Child Behavioral Health Services may secure additional outpatient mental health services, if authorized by the Contracted Systems Administrator (CSA) or other agent designated by the Department of Human Services (see N.J.A.C. 10:77–5.7(d));

iii. Inpatient and outpatient services for substance abuse are limited to detoxification;

2. Outpatient rehabilitative services, including physical, occupational and speech therapy for non-chronic conditions and acute illnesses and injuries. Outpatient rehabilitation benefits are limited to treatment over a period of 60 consecutive business days per incident of illness or injury beginning with the first day of treatment per contract year, except that:

i. Speech therapy services rendered for treatment of delays in speech development, unless resulting from disease, injury or congenital defects are not covered; and

3. Elective/induced abortion services.

(c) Services not covered under Plan D are as follows:

1. Unless listed in (a) and (b) above, no other services are covered by NJ FamilyCare–Plan D.

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

i. Services that are not medically necessary;

ii. Private duty nursing unless authorized by the HMO;

iii. Intermediate care facilities for mental retardation (ICF/MR);

iv. Personal care assistant services;

v. Medical day care services;

vi. Chiropractic services;

vii. Dental services except for preventive dentistry for children under age 12;

viii. Orthotic devices;

ix. Targeted case management for the chronically ill;

x. Inpatient psychiatric programs for children age 19 years and under, unless the beneficiary is also receiving services under the Division of Child Behavioral Health Services and is receiving services as part of a plan of care authorized by the Contracted Systems Administrator or other agent authorized by the Department of Human Services;

xi. Religious non-medical health care institution care and services;

xii. Durable medical equipment;

xiii. EPSDT services;

(1) Refer to (a)24 above concerning the coverage of well child care including immunizations, lead screening and treatments;

xiv. Routine transportation, including nonemergency ambulance, invalid coach and lower mode transportation;

xv. Hearing aid services;

xvi. Blood and blood plasma;

(1) Administration, processing of blood, processing fees and fees related to autologous blood donations are covered;

xvii. Cosmetic services;

xviii. Custodial care;

xix. Special and remedial educational services;

xx. Experimental and investigational services;

xxi. Infertility services;

xxii. Medical supplies;

(1) Diabetic supplies are a covered service;

xxiii. Rehabilitative services for substance abuse;

xxiv. Weight reduction programs or dietary supplements;

(1) Surgical operations, procedures or treatment of obesity, shall not be covered, except when specifically approved by the HMO;

xxv. Acupuncture and acupuncture therapy, except when performed as a form of anesthesia in connection with covered surgery;

xxvi. Temporomandibular joint disorder (TMJ) treatment, including treatment performed by prosthesis placed directly in the teeth;

xxvii. Nursing facility (long term care) services;

xxviii. Recreational therapy;

xxix. Sleep therapy;

xxx. Court ordered services;

xxxi. Thermograms and thermography;

xxxii. Biofeedback;

xxxiii. Radial keratotomy;

xxxiv. Respite care;

xxxv. Any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the direction or on the prescription of a physician, individual or entity, during the period when such physician, individual or entity is excluded from participation in the Medicaid and NJ FamilyCare programs, and when the physician, individual or entity furnishing such item or service has received written notice from the Division that the physician, individual or entity has been excluded from participation in the Medicaid and NJ FamilyCare programs;

xxxvi. Programs for Assertive Community Treatment (PACT) services; and

xxxvii. Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:37A and 10:77A).

(d) Additional mental health and mental health rehabilitation services as listed below may be available to beneficiaries under age 21 who are eligible for NJ FamilyCare–Plan D under fee-for-service who are receiving services under the Division of Child Behavioral Health Services. All services shall first be authorized by the Contracted Systems Administrator or other agent authorized by the Department of Human Services and shall be included in an approved plan of care.

1. Care coordination by a care management organization (CMO) (see N.J.A.C. 10:73);

2. Mental health rehabilitation services provided in residential childcare facilities (as defined in N.J.A.C. 10:127 and licensed by DYFS), children's group homes (as defined in N.J.A.C. 10:128 and licensed by DYFS), or psychiatric community residences for youth (as defined in N.J.A.C. 10:37B and licensed by DMHS);

3. Behavioral assistance services for children, youth or young adults (see N.J.A.C. 10:77–4); and

4. Mobile response and stabilization management services for children, youth or young adults (see N.J.A.C. 10:77–6).

New Rule, R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).
See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).
Amended by R.2001 d.144, effective May 7, 2001.
See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).
Added (c)2xxxiv.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).
In (c)2, substituted "Religious non-medical health care institution" for "Christian science sanatoria" in xi and added xxxiv.
Special amendment, R.2003 d.98, effective January 31, 2003.
See: 35 N.J.R. 1303(a).
Rewrote (c)2.
Amended by R.2003 d.89, effective March 3, 2003.
See: 34 N.J.R. 1593(a), 35 N.J.R. 1281(a).
In (c)2, added xxxvi and xxxvii.
Amended by R.2003 d.479, effective December 15, 2003.
See: 35 N.J.R. 2146(a), 35 N.J.R. 5584(a).
In (c)2xxxiv, inserted "or behavioral assistance services for children/youth or young adults (see N.J.A.C. 10:77–4)" at the end of the paragraph.
Amended by R.2004 d.8, effective January 5, 2004.
See: 35 N.J.R. 2620(a), 35 N.J.R. 4204(a), 36 N.J.R. 189(a).
In (c)2, added xxxviii.
Amended by R.2004 d.334, effective September 7, 2004.
See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).
In (a), rewrote 1.
Amended by R.2005 d.68, effective February 22, 2005.
See: 36 N.J.R. 379(a), 37 N.J.R. 659(a).
In (b), added 1i(1) and 1ii(3); rewrote (c); added (d).

10:49–5.8 Services available for beneficiaries eligible for NJ FamilyCare–Plan H

(a) Childless adults whose income is below 100 percent of the Federal poverty level and who do not qualify for WFNJ/GA and who were enrolled in NJ FamilyCare on July 1, 2002 shall be eligible to receive the NJ FamilyCare Plan H service package.

(b) Restricted alien parents who are enrolled in NJ FamilyCare on November 1, 2003, shall receive the Plan H service package.

(c) Out-of-plan community-based mental health services shall be limited to 60 service days per calendar year and shall be eligible for payment on a fee-for-service basis.

1. Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:77A) shall not be eligible for payment under NJ FamilyCare–Plan H.

2. NJ FamilyCare–Plan H beneficiaries under age 21 who are receiving services under the Division of Child Behavioral Health Services may secure additional mental health services if the services are authorized by the Contracted Systems Administrator or other agent authorized by the Department of Human Services and included in a plan of care.

(d) No behavioral health out-of-plan service of any kind, where the place of service is a hospital, shall be a covered service, unless provided in an approved psychiatric hospital to a beneficiary who is receiving services under the Division of Child Behavioral Health Services.

(e) The services listed below shall be available to beneficiaries eligible for NJ FamilyCare–Plan H, when medically necessary and when provided through the network of an HMO selected by the beneficiary.

1. Advanced practice nurse services;

2. Ambulance—medical emergency only;

3. Ambulatory surgery in an outpatient hospital setting only;

4. Clinic services (free standing)—ambulatory;

5. Diabetic supplies/equipment;

6. Durable Medical equipment-limited benefit, only covered when a medically necessary part of the beneficiary's inpatient hospital discharge plan;

7. Emergency room services;

8. Federally qualified health centers (FQHC) primary care services;

9. Home health care services (limited benefits);

10. Inpatient hospital (non-behavioral health related);

11. Laboratory services;

12. Outpatient hospital (non-mental health related);

13. Physician services;

14. Prescription drugs (excludes over the counter medications); and

15. Radiological services.

(f) The following services shall be available to NJ FamilyCare–Plan H beneficiaries on a fee-for-service basis:

1. Abortion (elective/induced); and

2. Mental health services in the community, including psychological services, up to a maximum of 60 days per calendar year;

i. Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:77A) are not eligible for payment under NJ FamilyCare–Plan H.

ii. NJ FamilyCare–Plan H beneficiaries under age 21 who are receiving services under the Division of Child Behavioral Health Services may be eligible for additional mental health and mental health rehabilitation services as authorized by the Contracted Systems Administrator. (See N.J.A.C. 10:49–5.8(d)).

(g) Additional mental health and mental health rehabilitation services as listed below may be available to beneficiaries under age 21 who are eligible for NJ FamilyCare–Plan H under fee-for-service and are receiving services under the Division of Child Behavioral Health Services. All services shall first be authorized by the Contracted Systems Administrator, the Division of Medical Assistance and Health Services or other agent authorized by the Department of Human Services and shall be included in an approved plan of care.

1. Care coordination by a care management organization (CMO) (see N.J.A.C. 10:73);

2. Psychiatric services provided in an inpatient psychiatric hospital setting (see N.J.A.C. 10:52);

3. Mental health rehabilitation services provided in residential childcare facilities (as defined in N.J.A.C. 10:127 and licensed by DYFS), children's group homes (as defined in N.J.A.C. 10:128 and licensed by DYFS), or psychiatric community residences for youth (as defined in N.J.A.C. 10:37B and licensed by DMHS);

4. Behavioral assistance services for children, youth or young adults (see N.J.A.C. 10:77–4); and

5. Mobile response and stabilization management services for children, youth or young adults under EPSDT (see N.J.A.C. 10:77–6).

Special New Rule, R.2002 d.214, effective June 10, 2002.
See: 34 N.J.R. 2338(a).
Special amendment, R.2003 d.417, effective September 26, 2003 (operative November 1, 2003).
See: 35 N.J.R. 4913(a).
Rewrote the section.
Amended by R.2004 d.8, effective January 5, 2004.
See: 35 N.J.R. 2620(a), 35 N.J.R. 4204(a), 36 N.J.R. 189(a).
In (c), added 1; in (f), added 2i.
Amended by R.2004 d.334, effective September 7, 2004.
See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).
In (e), added new 1, recodified existing 1, 2 as 2, 3, deleted existing 3.
Amended by R.2005 d.68, effective February 22, 2005.
See: 36 N.J.R. 379(a), 37 N.J.R. 659(a).
Rewrote the section.

10:49–5.9 Services available for beneficiaries eligible for NJ FamilyCare–Plan G

(a) General assistance-eligible individuals shall receive Plan G services, which shall be those services delineated at N.J.A.C. 10:49–24.3.

(b) The mental health and mental health rehabilitation services listed below may be available to beneficiaries under 21 years of age who are eligible for NJ FamilyCare–Plan G if they are receiving services under the Division of Child Behavioral Health Services. All services shall first be authorized by the Contracted Systems Administrator, the Division of Medical Assistance and Health Services or other agent authorized by the Department of Human Services and shall be included in an approved plan of care.

1. Care coordination by a care management organization (CMO) (see N.J.A.C. 10:73);

2. Psychiatric services provided in an inpatient psychiatric hospital setting (see N.J.A.C. 10:52);

3. Mental health rehabilitation services provided in residential childcare facilities (as defined in N.J.A.C. 10:127 and licensed by DYFS), children's group homes (as defined in N.J.A.C. 10:128 and licensed by DYFS), or psychiatric community residences for youth (as defined in N.J.A.C. 10:37B and licensed by DMHS);

4. Behavioral assistance services for children, youth or young adults (see N.J.A.C. 10:77–4); and

5. Mobile response and stabilization management services for children, youth or young adults under EPSDT (see N.J.A.C. 10:77–6).

Special New Rule, R.2002 d.214, effective June 10, 2002.
See: 34 N.J.R. 2338(a).
Amended by R.2005 d.68, effective February 22, 2005.
See: 36 N.J.R. 379(a), 37 N.J.R. 659(a).
Rewrote the section.

10:49–5.10 Services available to beneficiaries eligible for NJ FamilyCare–Plan I

(a) The services listed below are available to beneficiaries eligible for NJ FamilyCare–Plan I, on a fee-for-service basis, when medically necessary:

1. Certified nurse practitioner and clinical nurse specialist services;

2. Clinic services (services in an independent outpatient health care facility, other than a hospital, that provides covered ambulatory care services);

3. Emergency room services;

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

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

5. Federally qualified health center primary care services;

6. Home health care services, limited to skilled nursing for a home bound beneficiary which is provided or supervised by a registered nurse, and home health aid services when the purpose of the treatment is skilled care; medical social services which are necessary for the treatment of the beneficiary's medical condition; and short-term physical, speech or occupation therapy with the same limitations described in (a)21 below;

i. Personal care assistant services are not covered;

7. Hospice services;

8. Hospital services—inpatient;

9. Hospital services—outpatient;

10. Laboratory (clinical);

11. Nurse-midwifery services;

12. Optometric services, including one routine eye examination per year;

13. Optical appliances, limited to one pair of glasses or contact lenses per 24 month period;

14. Organ transplant services which are non-experimental or non-investigational;

15. Prescription drug services, except that over-the-counter drugs are not covered;

16. Physician services;

17. Podiatric services, except that routine foot care is not covered;

18. Prosthetic appliances, limited to initial provision of prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defect;

i. Coverage includes repair and replacement when due to congenital growth;

19. Outpatient surgery;

20. Radiological services;

21. Outpatient rehabilitative services, including physical, occupational and speech therapy for non-chronic conditions and acute illnesses and injuries. Outpatient rehabilitation benefits are limited to treatment over a period of 60 consecutive business days per incident of illness or injury beginning with the first day of treatment, except that:

i. Speech therapy services rendered for treatment of delays in speech development, unless resulting from disease, injury or congenital defects are not covered;

22. Transportation services, limited to ambulance for medical emergency only;

23. Maternity and related newborn care;

24. Diabetic supplies and equipment;

25. Services for mental health or behavioral conditions;

i. Inpatient hospital services, including psychiatric hospitals, limited to 35 days per year;

ii. Outpatient benefits for short-term, outpatient evaluative and crisis intervention or home health mental health services, limited to 20 visits per year. When authorized by the Division of Medical Assistance and Health Services, inpatient benefit exchanges are allowed, as follows:

(1) One mental health inpatient day may be exchanged for up to four home health visits or four outpatient services, including partial care. This is limited to an exchange of up to a maximum of 10 inpatient days for a maximum of 40 additional outpatient visits.

(2) One mental health inpatient day may be exchanged for two days of treatment in partial hospitalization up to the maximum number of covered inpatient days.

iii. Inpatient and outpatient services for substance abuse are limited to detoxification;

iv. Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:77A) are not eligible for payment under NJ FamilyCare–Plan I; and

v. NJ FamilyCare–Plan I beneficiaries under age 21 who are receiving services under the Division of Child Behavioral Health Services may be eligible for additional mental health and mental health rehabilitation services as authorized by the Contracted Systems Administrator. (See N.J.A.C. 10:49–5.10(c)); and

26. Elective/induced abortion services.

(b) Unless listed in (a) above, no other services shall be covered by NJ FamilyCare–Plan I. Services which shall not be covered include, but shall not be limited to:

1. Services that are not medically necessary;

2. Private duty nursing, unless prior authorized by the Division;

3. Intermediate care facilities for mental retardation (ICF/MR);

4. Personal care assistant services;

5. Medical day care services;

6. Chiropractic services;

7. Dental services;

8. Orthotic devices;

9. Targeted case management for the chronically ill;

10. Christian Science sanitaria care and services;

11. Durable medical equipment;

12. Routine transportation, including non-emergency ambulance, invalid coach and lower mode (car, taxi, bus) transportation;

13. Hearing aid services;

14. Blood and blood plasma, except that administration, processing of blood, processing fees and fees related to autologous blood donations shall be covered;

15. Cosmetic services;

16. Nursing facility (long term care) services;

17. Special and remedial educational services;

18. Experimental and investigational services;

19. Infertility services;

20. Medical supplies, except that diabetic supplies shall be a covered service;

21. Rehabilitative services for substance abuse (methadone maintenance is not covered);

22. Weight reduction programs or dietary supplements;

23. Acupuncture and acupuncture therapy, except when performed as a form of anesthesia in connection with covered surgery;

24. Temporomandibular joint disorder (TMJ) treatment, including treatment performed by prosthesis placed directly in the teeth;

25. Recreational therapy;

26. Sleep therapy;

27. Court ordered services;

28. Thermograms and thermography;

29. Biofeedback;

30. Radial keratomy;

31. Respite care;

32. Custodial care;

33. EPSDT services; and

34. Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:77A).

(c) Additional mental health and mental health rehabilitation services as listed below shall be available to beneficiaries under age 21 who are eligible for NJ FamilyCare–Plan I under fee-for-service who are receiving services under the Division of Child Behavioral Health Services. All services shall first be authorized by the Contracted Systems Administrator or other agent authorized by the Department of Human Services and shall be included in an approved plan of care.

1. Care coordination by a care management organization (CMO) (see N.J.A.C. 10:73);

2. Psychiatric services provided in an inpatient psychiatric hospital setting (see N.J.A.C. 10:52);

3. Mental health rehabilitation services provided in residential childcare facilities (as defined in N.J.A.C. 10:127 and licensed by DYFS), children's group homes (as defined in N.J.A.C. 10:128 and licensed by DYFS), or psychiatric community residences for youth (as defined in N.J.A.C. 10:37B and licensed by DMHS);

4. Behavioral assistance services for children, youth or young adults (see N.J.A.C. 10:77–4); and

5. Mobile response and stabilization management services for children, youth or young adults under EPSDT (see N.J.A.C. 10:77–6).

Special New Rule, R.2003 d.98, effective January 31, 2003.
See: 35 N.J.R. 1303(a).
Amended by R.2004 d.8, effective January 5, 2004.
See: 35 N.J.R. 2620(a), 35 N.J.R. 4204(a), 36 N.J.R. 189(a).
In (a)25, added iv; in (b), added 34.
Amended by R.2005 d.68, effective February 22, 2005.
See: 36 N.J.R. 379(a), 37 N.J.R. 659(a).
In (a), added 25v; added (c).

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

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

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

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

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

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

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

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

2. Retroactive determination of eligibility;

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

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

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

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Substituted "beneficiaries" and "beneficiary's" for "recipients" or "recipient's" throughout; in (a), substituted "Provider Services Chapter" for "Provider Services Manuals"; and in (a)3, substituted "Medicaid Agent" for "Director".
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
In (a), inserted a reference to the NJ KidCare program in 1, and inserted a reference to DMAHS in 3.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 with changes, effective September 21, 1998.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

Case Notes

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

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

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

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

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

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Deleted (a) and (c); and recodified former (b) as (a).

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

10:49–7.1 General provisions

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

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

2. For requirements of the Division of Medical Assistance and Health Services and the New Jersey State Department of Health and Senior Services when submitting a claim to be considered for the charity care component of the disproportionate share subsidies for hospital services and other rules regarding eligibility for these services, see N.J.A.C. 10:52–11, 12 and 13.

(b) In addition to information in this subchapter about submitting claims for payment, a Fiscal Agent Billing Supplement is included following each Provider Services Manual. Included in the Supplement are prior authorization forms and instructions; information for the proper completion and submission of claim forms; the procedure to follow when claims are rejected and returned to the provider by the Fiscal Agent during the adjudication process; third party liability verification, procedure for submitting cross-

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

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

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
In (a), substituted "beneficiary" for "recipient"; in (b), deleted "form" or "forms" following "claim" and "claims".
Amended by R.1997 d.520, effective January 5, 1998.
See: 29 N.J.R. 1006(a), 30 N.J.R. 232(a).
Inserted (a)2; in (b), clarified precedence of Medicaid rules over Fiscal Agent Billing Supplement, and added references to "charity care program."
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).
In (a)2, amended the N.J.A.C. references.
Amended by R.2003 d.485, effective December 15, 2003.
See: 35 N.J.R. 509(a), 35 N.J.R. 5568(a).
In (a)2, amended N.J.A.C. references.

10:49–7.2 Timeliness of Medicaid claim submission

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

1. For a Medicaid claim, the claim for payment from the Medicaid program may be submitted hard copy or by means of an approved method of automated data exchange.

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

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

ii. For retroactive eligibility cases, a claim associated with a retroactive eligibility application, that was submitted to the Medicaid Assistance and Health Services' Retroactive Eligibility Unit will be considered as received on the date of receipt of the application on behalf of the applicant. For information about retroactive eligibility, see N.J.A.C. 10:49–2.9.