

CHAPTER 49

ADMINISTRATION MANUAL

Authority

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

Source and Effective Date

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

Executive Order No. 66(1978) Expiration Date

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

Chapter Historical Note

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

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

Chapter 49, Administration, was repealed and a new Chapter 49, Administration, was adopted by R.1992 d.317, effective August 17, 1992.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 Subchapter 19, Prepaid Health Care Services: Medicaid Eligibles, was repealed by R.1995 d.337, effective June 19, 1995.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

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

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. GENERAL PROVISIONS

- 10:49-1.1 Scope and purpose
- 10:49-1.2 Organization
- 10:49-1.3 Definitions
- 10:49-1.4 Overview of provider manuals

SUBCHAPTER 2. NEW JERSEY MEDICAID BENEFICIARIES

- 10:49-2.1 Who is eligible for Medicaid?
- 10:49-2.2 Persons eligible under the regular New Jersey Medicaid program
- 10:49-2.3 Persons eligible under the Medically Needy program
- 10:49-2.4 Persons eligible under Home and Community-Based Services Programs
- 10:49-2.5 Persons eligible under the NJ KidCare program
- 10:49-2.6 Eligibility process (variations to routine procedure)
- 10:49-2.7 Applying for Medicaid eligibility for a newborn infant or for an inpatient upon admission to a hospital
- 10:49-2.8 Presumptive eligibility
- 10:49-2.9 Medicaid or NJ KidCare—Plan A retroactive eligibility
- 10:49-2.10 Verification of eligibility for Medicaid or NJ KidCare; or Pharmaceutical Assistance to the Aged and Disabled (PAAD) services
- 10:49-2.11 Recipient Eligibility Verification System (REVS)/Medicaid Eligibility Verification System (MEVS)
- 10:49-2.12 Medicaid or NJ KidCare Eligibility Identification Number
- 10:49-2.13 Forms that validate Medicaid eligibility
- 10:49-2.14 Validation form (FD-152) Department of Human Services Medicaid-ID
- 10:49-2.15 Validation form (FD-73/178) Medicaid Eligibility Identification Card (MEI Card)
- 10:49-2.16 Validation form (FD-34) Validation of Eligibility
- 10:49-2.17 Medicaid application
- 10:49-2.18 (Reserved)
- 10:49-2.19 Medicaid or NJ KidCare eligibility—aliens

SUBCHAPTER 3. PROVIDER PARTICIPATION

- 10:49-3.1 Provider types eligible to participate
- 10:49-3.2 Enrollment process
- 10:49-3.3 Providers with multi-locations
- 10:49-3.4 Medicaid or NJ KidCare provider billing number

SUBCHAPTER 4. PROVIDERS' ROLE IN A SHARED HEALTH CARE FACILITY

- 10:49-4.1 Definitions
- 10:49-4.2 Scope
- 10:49-4.3 Registration of shared health care facilities
- 10:49-4.4 Prohibited practices; administrative requirements
- 10:49-4.5 Quality of care requirements

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

- 10:49-5.1 Requirements for provision of services
- 10:49-5.2 Services available to beneficiaries eligible for, or children who are presumptively eligible for, the regular Medicaid and NJ KidCare—Plan A programs
- 10:49-5.3 Services available to beneficiaries eligible for the Medically Needy program
- 10:49-5.4 Emergency medical services for aliens and prenatal care for specified pregnant alien women
- 10:49-5.5 Services not covered by the Medicaid or NJ KidCare—Plan A program
- 10:49-5.6 Services available to beneficiaries eligible for, or who are presumptively eligible for, NJ KidCare—Plan B or C
- 10:49-5.7 Services available to beneficiaries eligible for NJ KidCare—Plan D

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

- 10:49-6.1 Prior and retroactive authorization (general)
- 10:49-6.2 Out-of-State medical care and services

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

- 10:49-7.1 General provisions
- 10:49-7.2 Timeliness of claim submission and inquiry
- 10:49-7.3 Third party liability (TPL) benefits
- 10:49-7.4 Prohibition of payment to factors
- 10:49-7.5 Use of service bureau and/or management agency

SUBCHAPTER 8. PAYMENT FOR SERVICES PROVIDED

- 10:49-8.1 Fiscal Agent
- 10:49-8.2 Claims payment and pricing
- 10:49-8.3 Adjustments following payment of claims
- 10:49-8.4 Claims payment by direct deposit (electronic funds transfer or EFT)
- 10:49-8.5 Outstanding checks

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

- 10:49-9.1 NJ KidCare—Plan C personal contribution to care and Plan D copayments
- 10:49-9.2 NJ KidCare—Plan C and D—premiums
- 10:49-9.3 Limitation on cost sharing—Plan C
- 10:49-9.4 Civil rights
- 10:49-9.5 Observance of religious belief
- 10:49-9.6 Free choice by beneficiary and provider
- 10:49-9.7 Confidentiality of records
- 10:49-9.8 Provider certification and recordkeeping
- 10:49-9.9 Patient's (beneficiary) certification
- 10:49-9.10 Withholding of provider payments
- 10:49-9.11 Integrity of the Medicaid and NJ KidCare programs; gifts/gratuities prohibited
- 10:49-9.12 Fraud and abuse
- 10:49-9.13 Informing individuals of their rights
- 10:49-9.14 Provisions for appeals; fair hearings
- 10:49-9.15 Advance directives

SUBCHAPTER 10. NOTICES, APPEALS AND FAIR HEARINGS

- 10:49-10.1 Definitions
- 10:49-10.2 Notices
- 10:49-10.3 Opportunity for fair hearing
- 10:49-10.4 Advance notice of intent to terminate, reduce, or suspend assistance for Medicaid and NJ KidCare—Plan A
- 10:49-10.5 Location of hearing
- 10:49-10.6 Impartiality of official conducting the hearing
- 10:49-10.7 Beneficiary's right to different medical assessment
- 10:49-10.8 Hearing procedures
- 10:49-10.9 Prompt, definitive and final action
- 10:49-10.10 Notification to claimants
- 10:49-10.11 Action upon favorable decision to claimants
- 10:49-10.12 Hearing decision
- 10:49-10.13 Accessibility of hearing decisions to local agencies and the public

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

- 10:49-11.1 Program participation

SUBCHAPTER 12. PROVIDER REINSTATEMENT

- 10:49-12.1 Definitions
- 10:49-12.2 Requests for reinstatement
- 10:49-12.3 Petition by debarred, disqualified or suspended person
- 10:49-12.4 Director's powers
- 10:49-12.5 Provider Reinstatement Committee

- 10:49-12.6 Criteria for reinstatement
- 10:49-12.7 Committee procedures

SUBCHAPTER 13. PROGRAM CONTROLS

- 10:49-13.1 Medical review and evaluation
- 10:49-13.2 Audits
- 10:49-13.3 Applicability to NJ KidCare—Plans B, C and D of provisions relating to fraud and abuse investigations and administrative actions, third party liability and recoveries
- 10:49-13.4 Rewards for information relating to fraud and abuse

SUBCHAPTER 14. RECOVERY OF PAYMENTS AND SANCTIONS

- 10:49-14.1 Recovery of payments correctly made
- 10:49-14.2 Sanctions—Special Status Program
- 10:49-14.3 Authority to adjust, compromise, settle or waive claims, liens, and certificates of debt
- 10:49-14.4 Recoveries involving county welfare agencies
- 10:49-14.5 Administrative charges/service fees
- 10:49-14.6 Contracts with county welfare agencies

SUBCHAPTER 15. AVAILABILITY AND MAINTENANCE OF PROGRAM POLICY ISSUANCES

- 10:49-15.1 Maintenance of public policy issuances
- 10:49-15.2 Availability of material
- 10:49-15.3 Reproduction of policy material

SUBCHAPTER 16. DEMONSTRATION PROJECTS

- 10:49-16.1 Purpose
- 10:49-16.2 Definitions
- 10:49-16.3 Implementation of projects
- 10:49-16.4 Necessary criteria for a demonstration project
- 10:49-16.5 Sanctions related to demonstration projects

SUBCHAPTER 17. (RESERVED)**SUBCHAPTER 18. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)**

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

SUBCHAPTER 19. HEALTHSTART

- 10:49-19.1 HealthStart

SUBCHAPTER 20. THE GARDEN STATE HEALTH PLAN (GSHP)

- 10:49-20.1 Introduction
- 10:49-20.2 Physician case manager (PCM)
- 10:49-20.3 Capitation payment system
- 10:49-20.4 Medicaid beneficiary
- 10:49-20.5 Action required by providers
- 10:49-20.6 GSHP services
- 10:49-20.7 Emergency medical care situations for GSHP members
- 10:49-20.8 GSHP reimbursement policy for emergency services
- 10:49-20.9 Exception Payment Request Form (GSHP-16)

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

- 10:49-21.1 Purpose and scope
- 10:49-21.2 Capitation payment system
- 10:49-21.3 Medicaid beneficiaries
- 10:49-21.4 Medicaid Managed Care Program—New Jersey Care 2000 Services

SUBCHAPTER 22. HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAMS

- 10:49-22.1 Introduction
- 10:49-22.2 Approved Waivers
- 10:49-22.3 Administration of waived persons
- 10:49-22.4 Home and Community-Based Services Waivers
- 10:49-22.5 Community Care Program for the Elderly and Disabled (CCPED)
- 10:49-22.6 Medicaid's Model Waivers—I, II, and III
- 10:49-22.7 AIDS Community Care Alternatives Program (ACCAP)
- 10:49-22.8 Traumatic Brain Injury Program

SUBCHAPTER 23. LIFELINE PROGRAMS

- 10:49-23.1 Purpose and scope
- 10:49-23.2 Applications

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

- 10:49-24.1 Introduction
- 10:49-24.2 Administrative provisions
- 10:49-24.3 Services available under the Work First New Jersey/ General Assistance (WFNJ/GA) program which shall be processed by the fiscal agent
- 10:49-24.4 Services that shall not be processed by the fiscal agent
- 10:49-24.5 Basis for reimbursement

APPENDIX

SUBCHAPTER 1. GENERAL PROVISIONS

10:49-1.1 Scope and purpose

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

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

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

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

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

Substantially amended section.

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

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

In (a), inserted a reference to the NJ KidCare program in the second sentence; and added (c) and (d).

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

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

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

10:49-1.2 Organization

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

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

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

Section name amended; former (a) recodified as N.J.A.C. 10:49-1.3; recodified former (b) as (a); in (b)1, added " , through the Health Care Financing Administration (HCFA)"; and deleted (c), relating to Medicaid Program services and eligibility.

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

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

In (a), inserted a reference to Title XXI of the Social Security Act in the first sentence, inserted a reference to the NJ KidCare program in the second sentence and added a fourth sentence in the introductory paragraph, and substituted "two programs are" for "program is" in the first sentence and added a third sentence in 1.

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

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

Readopted provisions of R.1998 d.116 with changes, effective August 17, 1998.

10:49-1.3 Definitions

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

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

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

“Commissioner of DHS” means the Commissioner of the Department of Human Services.

“Copayment” means a specified dollar amount required to be paid by or on behalf of the beneficiary in connection with benefits as specified in N.J.A.C. 10:49-9.1.

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

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

“DHSS” means the Department of Health and Senior Services.

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

“DMHS” means the Division of Mental Health Services within the New Jersey Department of Human Services.

“DYFS” means the Division of Youth and Family Services within the New Jersey Department of Human Services.

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

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

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

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

“Mental health rehabilitation services” means psychiatric and psychological services, including emotional and/or behavioral treatment, drug and alcohol dependency treatment, psychiatric treatment, psychotherapy and related nursing services.

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

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

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

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

“NJ KidCare—Plan D” means the State-operated program which provides managed care coverage to uninsured children through the age of 18 with gross family incomes above 200 percent and not in excess of 350 percent of the Federal poverty level. In addition to covered managed care services, eligibles may access certain services including mental health and substance abuse services, with limitations, which are paid fee-for-service. Eligibles participate in cost-sharing in the form of monthly premiums and copayments for most services.

“Prepaid health plan” means an entity that provides medical services to enrolled Medicaid eligibles under a contract with DMAHS on the basis of prepaid capitation fees but which does not necessarily qualify as an HMO. For rules concerning prepaid health care services, see N.J.A.C.

10:49-19. For a description of the State operated HMO, the Garden State Health Plan, see N.J.A.C. 10:49-20. For Medicaid Managed Care Program–New Jersey Care 2000, see N.J.A.C. 10:49-21.



(2) The CWA 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 the patient is already eligible for Medicaid or whether the patient's income and/or resources meet the applicable public assistance standard; and

ii. Whether the patient falls into a category of eligibility, for example, aged, disabled, blind, pregnant under 21 years of age, or a member of a family with children under 18 years of age.

3. In the event that the date of the Medicaid eligibility which was established by the Social Security Administration or the CWA is later than the date of admission, the beneficiary 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. 10:49-2.9).

Amended by R.1996 d.320, effective July 15, 1996.

See: 28 N.J.R. 1589(a), 28 N.J.R. 3572(a).

Recodified from N.J.A.C. 10:49-2.5 and 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", "CWA" for "county welfare agency" and "Medicaid Eligibility Identification Number" for "HSP (Medicaid) Case Number" and amended N.J.A.C. references throughout; in (a)2 Example, inserted "for dates of service"; substantially amended (b)2i; rewrote (b)2ii; and deleted (b)2iii. Former section recodified to N.J.A.C. 10:49-2.7.

Recodified from N.J.A.C. 10:49-2.6 and 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)1 and (b)3 changed N.J.A.C. references. Former N.J.A.C. 10:49-2.7, Presumptive eligibility, recodified to N.J.A.C. 10:49-2.8.

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

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

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

10:49-2.8 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 and N.J.A.C. 10:49-19). This is a preliminary process to determine presumptive eligibility prior to the determination of Medicaid eligibility or ineligibility by the CWA.

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 CWA, 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 CWA, 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 CWA.

(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: CLIENTS: YOU MUST CONTACT THE CWA FOR FULL BENEFITS; P.E. IS TEMPORARY AND LIMITED. The second message, which appears in the message box on the upper right hand corner instructs the provider to call a toll-free number 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 listed on the MEI Card which is available seven days a week, 24 hours a day.

3. A provider's failure to verify eligibility prior to the delivery of services shall result in the denial of payment for those services if the individual was not eligible at that time. The provider should note that a pregnant woman's presumptive eligibility may be terminated at any time.

Amended by R.1996 d.320, effective July 15, 1996.

See: 28 N.J.R. 1589(a), 28 N.J.R. 3572(a).

Recodified from N.J.A.C. 10:49-2.6 and amended by R.1997 d.354, effective September 2, 1997.

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

Substituted "CWA" for "county welfare agency" throughout; and in (a), inserted N.J.A.C. references. Former section recodified to N.J.A.C. 10:49-2.8.

Recodified from N.J.A.C. 10:49-2.7 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. 10:49-2.8, Medicaid retroactive eligibility, recodified as N.J.A.C. 10:49-2.9.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998. See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

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

10:49-2.9 Medicaid or NJ KidCare—Plan A retroactive eligibility

(a) Any person applying for Medicaid or NJ KidCare—Plan A 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 or NJ KidCare—Plan A. Except for a Medically Needy applicant (see N.J.A.C. 10:49-2.3(f) or an application processed by the Statewide eligibility determination agency, 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, PO Box 712, Mail Code #10, Trenton, New Jersey 08625-0712.

1. An application for retroactive eligibility may be obtained by the applicant, or his or her authorized agent, from the CWA, 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.

2. In addition to (a)1 above, applications for NJ KidCare—Plan A retroactive eligibility may be obtained from the agency they used for their NJ KidCare eligibility determination.

3. Applications for retroactive unpaid medical bills cannot be processed for services rendered prior to the effective date of the program. For NJ KidCare—Plan A, children eligible under N.J.A.C. 10:79-3.4(b) the effective date is February 1, 1998.

(b) If the Division of Medical Assistance and Health Services determines that the person was eligible for Medicaid or NJ KidCare—Plan A 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 or NJ KidCare—Plan A may be reimbursable in accordance with standard Medicaid and NJ KidCare reimbursement procedures.

1. The provider shall then complete the appropriate claim form and submit it to the Fiscal Agent for consideration and authorization of payment.

2. For any Medically Needy beneficiary, a retroactive eligibility determination shall be completed by the CWA (see N.J.A.C. 10:49-2.3—Persons eligible under the Medically Needy program).

Recodified from N.J.A.C. 10:49-2.7 and amended by R.1997 d.354, effective September 2, 1997.

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

In (a) amended N.J.A.C. reference and mailing address; in (a)1 and (b)2, substituted "CWA" for "county welfare agency"; and in (b)2, substituted "beneficiary" for "recipient". Former section recodified to N.J.A.C. 10:49-2.9.

Recodified from N.J.A.C. 10:49-2.8 and amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

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

Inserted references to NJ KidCare—Plan A throughout; in (a), inserted "and application processed by the Statewide eligibility determination agency" following "N.J.A.C. 10:492.3(f)" in the second sentence, and added 2 and 3; and in (b), inserted a reference to NJ KidCare reimbursement procedures in the first sentence, and deleted "Medicaid" following "appropriate" and substituted a reference to the Fiscal Agent for a reference to the Retroactive Eligibility Unit in 1. Former N.J.A.C. 10:49-2.9, Verification of eligibility for Medicaid/Pharmaceutical Assistance to the Aged and Disabled (PAAD) services, recodified to N.J.A.C. 10:49-2.10.

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).

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

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

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

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

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

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

Case Notes

Provider failing to meet regulatory time lines for cross-over Medicaid/Medicare reimbursement claims was not entitled to reimbursement. In the Matter of Bergen Pines County Hospital, 96 N.J.A.R.2d (DMA) 15.

Unique circumstances excused hospitalized applicant from complying with requirement that application for retroactive Medicaid be submitted within six months of date of application for public assistance. J.R. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 57.

Untimely application for three months retroactive benefits under Medicaid program was not waived and was properly denied. Estate of G.K. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 27.

Application for Medicaid, though filed after six-month deadline, was nevertheless sufficient to meet three month requirement for retroactive eligibility. A.D. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 11.

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.

10:49-2.10 Verification of eligibility for Medicaid or NJ Kid Care; or Pharmaceutical Assistance to the Aged and Disabled (PAAD) services

(a) Each Medicaid or NJ KidCare beneficiary, except Nursing Facility beneficiaries, has a Medicaid or NJ KidCare Eligibility Identification Number printed on a form that validates eligibility. The beneficiary shall present this form to the provider, as a proof of eligibility, every time a service is to be provided. See N.J.A.C. 10:49-2.12 for a description and information about the Medicaid Eligibility Identification Number and see N.J.A.C. 10:49-2.13 for information about the Medicaid and NJ KidCare forms that are used to validate eligibility. The Recipient Eligibility Verification System (REVS) or Medicaid Eligibility Verification System (MEVS) can be used, in some instances, as an alternative to viewing a form used to validate eligibility (see N.J.A.C. 10:49-2.11).

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.

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

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

In (a), substituted "beneficiary" for "recipient"; in (b), deleted "form" or "forms" following "claim" and "claims".

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

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

Inserted (a)2; in (b), clarified precedence of Medicaid rules over Fiscal Agent Billing Supplement, and added references to "charity care program."

10:49-7.2 Timeliness of claim submission and inquiry

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

recipient of the service(s), the date(s) of the service, and any other data required by the State.

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

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

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

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

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

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

- i. One year of the date of discharge on an inpatient hospital claim;
- ii. One year of the date of service entered on an outpatient hospital claim or home health claim;
- iii. One year of the earliest date of service entered on an outpatient hospital claim or home health claim, if the claim carries more than one date of service; or
- iv. For early and Periodic Screening, Diagnosis and Treatment (EPSDT) including pediatric HealthStart services, claims must be submitted to the Fiscal Agent within 30 days of the provision of services.

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

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

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

- i. One year of the date of service;
- ii. One year of the earliest date of service entered on the claim if the claim carries more than one date of service;
- iii. One year (365 days) of the dispensing date on a pharmacy claim; or
- iv. For early and Periodic Screening, Diagnosis and Treatment (EPSDT) including pediatric HealthStart services, claims must be submitted to the Fiscal Agent within 30 days of the provision of services.

(d) The time requirements for submitting a combination Medicare/ Medicaid or Medicare/NJ KidCare claim are as follows (Under Federal regulations this applies only to Medicare/Medicaid or Medicare/NJ Kid Care claims and

does not extend to claims involving any other third party insurance.):

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

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

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

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

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

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

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

3. In most cases, when a beneficiary is eligible for both Medicare and Medicaid, or Medicare and NJ KidCare, a Medicare/Medicaid approved claim will crossover from the Medicare Carrier/Intermediary to the Program's Fiscal Agent. The provider is requested to allow 45 days from Medicare adjudication for the Medicaid or NJ KidCare program to receive and process crossover claims. Failure to allow the 45 days for the transition from Medicare to Medicaid or NJ KidCare may result in payment delays due to duplicate claim errors. There are instances, however, where claims will not cross over from Medicare. In those instances, or when a Medicare/Medicaid or Medicare/NJ KidCare 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 or Medicare/NJ KidCare claim, timely filed, payment may be made for services within six months after the program or provider receives notice of the Medicare claim disposition for a timely filed Medicare/Medicaid or Medicare/NJ KidCare claim;
3. For claims from providers under investigation for fraud or abuse; or
4. For claims associated with administrative or legal actions pursuant to a hearing action or agency corrective action mandate, whether for an eligible individual or for all those eligibles affected in a similar manner.

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

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

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

Rewrote (a), inserted new (a)1 and recodified existing (a)1 as (a)2.
Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).

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

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

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

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

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

Case Notes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

only up to the Medicaid or NJ KidCare maximum allowable.

2. Contracting practitioners: No program payments shall be made when the third party calls for a contracting or participating practitioner to accept the TPL as payment in full.

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

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

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

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

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

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

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

i. Medicare (Title XVIII): For any Medicaid or NJ KidCare beneficiary who is covered under Medicare, responsibility for payment by the New Jersey Medicaid Agent or the NJ KidCare program for non-hospital Part B services shall be limited to the unsatisfied de-

ductible and/or coinsurance to the extent that the combined total of payments does not exceed the maximum allowable under the Medicaid or NJ KidCare program in the absence of other coverage for services rendered on or after July 20, 1998.

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

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

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

1. The TPL benefits are derived from a parent whose obligation to pay support is being enforced by the State Title IV-D agency;
2. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the program;
3. The claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay;
4. The claim involves a service for which HCFA has granted a waiver of the TPL cost avoidance requirements in accordance with 42 C.F.R. 433.139(e). Waivers have been granted for:
 - i. Pharmacy services; and
 - ii. Services covered by Medicare Part B which are rendered at State and county governmental psychiatric hospitals, State and private ICFs/MR, and Vineland Special Hospital; or
5. Rehabilitation services provided by a local school district under a child's Individualized Education Program (IEP).

(i) In those situations where a health insurance payment is received after Medicaid or NJ KidCare has been billed and has made payment, the provider must reimburse the Medicaid or NJ KidCare payment to the Medicaid or NJ KidCare program and not to the Medicaid or NJ KidCare beneficiary. Reimbursement must be made immediately to comply with Federal regulations. To initiate the process, providers must submit an MMIS Claim Adjustment Request Form. (See Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

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

(k) Any individual who undertakes to legally represent any Medicaid or NJ KidCare beneficiary in an action for damages against any third party when medical expenses have been paid by the Division shall be required to give written notice to the Division within 20 days of filing or commencing the action.

1. The term "legal representative" shall include, but not be limited to, an attorney, administrator/administratrix, executor/executrix, conservator, guardian or guardian ad litem.

Petition for Rulemaking.

See: 27 N.J.R. 770(b), 27 N.J.R. 1320(a).

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

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

Substituted "beneficiary" and "beneficiaries" for "recipient" and "recipients" throughout; in (a), substituted "by the Medicaid program" for "under this act"; in (b), inserted "the exceptions listed in"; in (e)1, substituted "Medicaid Eligibility Identification Number" for "HSP (Medicaid) Case Number"; deleted (e)1i and (e)1i(1); added (h)5; and in (i), substituted "a health insurance payment is received" for "an insurance payment is received from another payer" and "MMIS Claim Adjustment Request Form" for "Adjustment/Void Request Form". Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

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

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

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

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

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

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

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

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

10:49-7.4 Prohibition of payment to factors

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

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

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

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

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

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

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

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

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

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

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

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

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

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

1. If standard Medicaid or NJ KidCare claim forms are not utilized, the provider/agent shall obtain approval from the New Jersey Medicaid or NJ KidCare program.
2. In order to obtain approval, the provider/agent shall submit a printer's prototype of an exact replica of the Medicaid or NJ KidCare claim form and the programming instructions for completion of the form to the Fiscal Agent.
3. The provider/agent shall assume the entire cost of printing duplicate forms at all times.

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

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

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

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

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

Inserted references to NJ KidCare throughout.

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

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

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

Case Notes

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

SUBCHAPTER 8. PAYMENT FOR SERVICES PROVIDED**10:49-8.1 Fiscal Agent**

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

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

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

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

10:49-8.2 Claims payment and pricing

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

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

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

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

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

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

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

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

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

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

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

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

Case Notes

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

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

10:49-8.3 Adjustments following payment of claims

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

(b) On occasion, a claim will be paid that should not have been paid. If a claim is paid in error, the provider shall notify the Fiscal Agent by requesting that the claim be voided. (For the procedure to follow, see the Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

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

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

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

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

Case Notes

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

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

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

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

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

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

10:49-8.5 Outstanding checks

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

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