

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

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

Chapter 49, Administration, was repealed and a new Chapter 49, Administration, was adopted by R.1992 d.317, effective August 17, 1992.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 Subchapter 19, Prepaid Health Care Services: Medicaid Eligibles, was repealed by R.1995 d.337, effective June 19, 1995.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

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

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**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); and other special (State) funded programs.

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”.

#### 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 rules of the New Jersey Medicaid program that the provider shall adhere to when submitting a claim and requesting payment for services provided to a New Jersey Medicaid beneficiary. (To identify a Medicaid beneficiary see N.J.A.C. 10:49-2.)

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

(b) In addition to information in this subchapter about submitting claims for payment, a Fiscal Agent Billing Supplement is included following the second chapter of each Provider Services Manual. Included in the Supplement are prior authorization forms and instructions; information for the proper completion and submission of claims; the procedure to follow when claims are rejected and returned to the provider by the Fiscal Agent during the adjudication process; third party liability verification, procedure for submitting crossover claims, and examples of timely submission of claims; electronic media claims (EMC) submission; Remittance Advice statements; procedure for Electronic Funds Transfer (EFT); adjustments for overpayment and underpayment of claims, and adjustments by Medicare; procedure to follow when a claim is paid in error (voids); procedure for inquiries about claims; procedure for ordering forms; information about provider services; and item-by-item instructions for completing the claim and other forms.

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

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”.

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

1. It is the responsibility of the provider to ensure that each Medicaid claim submitted by that provider is re-

ceived 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 claim are as follows (Under Federal regulations this applies only to Medicare/Medicaid claims and does not extend to claims involving any other third party insurance.):

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

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

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

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

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

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

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.

#### 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).

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 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 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 beneficiary, subject to the exceptions listed in (h) below.

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

1. Medicare: The program will make payment in the full amount of the Medicare Part A deductible and co-insurance for inpatient hospital services, and Part B ambulatory care.

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

(d) Medicaid participating providers are prohibited from billing Medicaid 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.) if the beneficiary elected to receive the services, goods, or supplies with the knowledge that they were not covered or authorized; or

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

(e) When a Medicaid 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 claim processing.

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

(f) When a Medicaid beneficiary has benefits available, such as those described above or from any other liable third party, an approved Medicaid provider shall be authorized to sign an insurance claim 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 program from a liable third-party, the Commissioner shall authorize the Director or his designee(s) to sign the recovery demand.

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

1. The TPL benefits are derived from a parent whose obligation to pay support is being enforced by the State Title IV-D agency;

2. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the program;

3. The claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay;

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 has been billed and has made payment, the provider must reimburse the Medicaid payment to the Medicaid program and not the Medicaid 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 reimbursement must be received by the Medicaid Fiscal Agent within the time frames specified in N.J.A.C. 10:49-7.2, Timeliness of claim submission.

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

#### 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 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".

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

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

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

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

(c) In order to obtain approval the provider/agent shall submit a copy of the signed agreement and power-of-attorney, if any, between the provider and the agent which shall contain a detailed statement of the powers and duties of the agent (including the power to sign Medicaid claims

on behalf of the provider and the compensation arrangement) to Provider Enrollment, New Jersey Medicaid program.

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

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

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

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

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

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

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

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

#### Case Notes

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

## SUBCHAPTER 8. PAYMENT FOR SERVICES PROVIDED

### 10:49-8.1 Fiscal Agent

The State of New Jersey uses a fiscal agent for the processing of claims and payment to providers for all health services.

### 10:49-8.2 Claim payment

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

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

#### 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.)