

(c) Notwithstanding any of the previous subsections, if after the screening of any nursing facility provider audit the Assistant Director, OPIA, determines with reasonable justification that an act or omission on the part of the provider requires that additional information or documentation be obtained from the provider, then a completed field audit shall, for the exclusive purpose of calculating interest, be considered reopened and interest shall again accrue for the period beginning 20 days from the date that the request for such information or documentation is received by the provider and ending on the date that all of the requested information or documentation is received by the agency making the request.

(d) Notwithstanding any of the previous subsections, if all or part of any nursing facility provider audit initiated on or after the effective date of this subsection is referred to the Division of Criminal Justice or other agency for criminal investigation:

1. In the event no criminal action results from the referral the field audit shall be considered completed one year from the date the decision was made to refer the matter for criminal investigation;

2. In the event criminal action does result from the referral, the field audit shall be considered completed on the date OPIA receives authorization to take administrative action.

Amended by R.1983 d.5, effective February 7, 1983 (operative March 1, 1983).

See: 14 N.J.R. 1031(a), 15 N.J.R. 155(a).

Amended by R.1985 d.177, effective April 15, 1985.

See: 16 N.J.R. 2413(a), 17 N.J.R. 966(a).

(a)2 added; (a)2 recodified to (a)3.

Correction: (a)3 was inadvertently omitted from code. It has been added.

See: 18 N.J.R. 1205(c).

Administrative change, recodified from N.J.A.C. 10:63-1.22.

See: 24 N.J.R. 3728(b).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

10:63-4.3 Final audited rate calculation

(a) The Division of Medical Assistance and Health Services will calculate final per diem rates based on audit adjustment reports.

(b) The final per diem rates determined based on (a) above cannot exceed the prospective rates previously paid.

(c) Settlement after final rate calculation will be for fraud and/or abuse collections or recoveries of payments when the final rate is lower than the original rate.

(d) The basis for establishing guidelines for the prospective per diem rates, and costs which may be reported, are the CARE (Cost Accounting and Rate Evaluation System) Guidelines which appear at N.J.A.C. 10:63-3.

(e) This section applies to all current, pending or future audits for rate years on or after March 20, 1995.

Amended by R.1984 d.572, effective December 16, 1984.

See: 16 N.J.R. 2335(a), 16 N.J.R. 3436(b).

Administrative change, recodified from N.J.A.C. 10:63-1.23.

See: 24 N.J.R. 3728(b).

Amended by R.1995 d.174, effective March 20, 1995 (operative April 1, 1995).

See: 27 N.J.R. 281(a), 27 N.J.R. 1307(a).

APPENDIX A

State of New Jersey
 Department of Human Services
 Division of Medical Assistance and Health Services

PROVIDER APPLICATION

1. _____
 Legal Name of Provider
2. _____
 Type of Business or Facility
- _____ Business Name, if Different From Above
3. _____
 Address (Service Location Only) Street City County State Zip Code
4. _____
 Employer ID Number
5. _____
 Telephone Number
6. _____
 Last of same as above address
7. _____
 Billing Address, if different
8. _____
 Name of Administrator, Chief Executive Officer, or other responsible official
9. Indicate legal status of your organization: Profit _____, Non-Profit _____, Private _____, Public _____, Municipal _____, State _____, Charity _____, School Nurse _____, County _____, Other _____. If other, please specify: _____
10. List the specific service(s) for which you are requesting approval for reimbursement under the Medicaid Program.

11. Do you operate from more than one location? _____ Yes _____ No. If yes, list all other subsidiary or affiliated organizations below: (Name and service address)
 1. _____
 2. _____
 3. _____
 Please attach additional sheet if necessary
12. Please indicate if you are a member of a chain organization. _____ Yes _____ No. If yes, indicate name: _____
13. Please indicate your preference to receive central or local reimbursement:
 _____ to each satellite location;
 _____ to central location at _____
 Billing through a central location is allowable and left to the provider's discretion. However, if the provider chooses to bill centrally, pre-addressed claims MUST be utilized since they reflect the proper address and provider number for that location.
14. Do you require a Certificate of Need under the Health Facilities Planning Act from the New Jersey Department of Health? _____ Yes _____ No. If yes, attach a copy of the Certificate of Need. If no, explain why you do not require a certificate. _____
15. If your business or facility requires a license/permit, indicate type _____ and number _____
 Please attach a copy of the license/permit, i.e., Independent Laboratory Certification.
16. CERTIFICATION, ACCREDITATION OR APPROVAL Specify type and attach copy. For example JCAHO (hospitals); New Jersey Department of Health (clinics); Division of Mental Health and Hospitals (mental health clinics); State Board of Dentistry (dental clinics); State Board of Pharmacy (providers offering pharmaceutical services); American Board for Certification in Prosthetics and Orthotics (Prosthetist and/or Orthotist). See Item 16.
17. Approved by Medicare? _____ Yes _____ No. If yes, please indicate Medicare provider number _____ and attach copy of your Medicare approval.
18. Are you currently or have you ever been an approved provider of services under the New Jersey Medicaid Program or the Medicaid Program of any other state or jurisdiction? _____ Yes _____ No. If Yes, list types of services provided and current status. If you were approved at one time and you no longer participate, explain the reason(s).

FD-20 (12 80)

- 19. Have any of the entities named in response to questions 1. or 11. or their officers or partners, or any of the individuals named in response to questions 8. ever been the subject of any license suspension, revocation, or other adverse licensure action in this state or any other jurisdiction? Yes No. If yes, please explain.

- 20. Have any of the entities named in response to question 1. or 11. or their officers or partners, or any of the individuals named in response to questions 8. ever been indicted, charged, convicted of, or pled guilty or no contest to any federal or state crime in this state or any other jurisdiction? Yes No. If yes, please explain.

- 21. Have any of the entities named in response to questions 1. or 11. or their officers or partners, or any of the individuals named in response to questions 8. ever been the subject of any Medicaid (Title XIX) or Medicare (Title XVIII) suspension, debarment, disqualification or recovery action in this state or any other jurisdiction? Yes No. If yes, please explain.

- 22. Do any of the entities named in response to question 1. or 11. or their officers or partners, or any of the other individuals named in response to questions 8. own or have any financial interest in any other provider participating in the New Jersey Medicaid (Title XIX) Program or the Medicaid (Title XIX) Program of any other state or jurisdiction? Yes No. If yes, please list provider name and nature of relationship.

- 23. Do you charge for goods and/or services? TO ALL . TO NONE . TO CERTAIN GROUPS ONLY
If you charge to all or only certain groups, please explain your arrangement and attach a copy of your fee schedule.

- 24. List days and hours of operation.

