

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10:49-2.6 Presumptive eligibility

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

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

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

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

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

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

(d) A presumptively eligible pregnant woman is identified by the two messages which appear on the "Medicaid Eligibility Identification Card" (Form FD-73/178) (see Appendix, N.J.A.C. 10:49). One message is above the woman's name on the upper left side: 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).

10:49-2.7 Medicaid Retroactive Eligibility

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

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

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

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

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

Case Notes

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10:49-2.10 HSP (Medicaid) Case Number

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

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

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

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

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

i. Identification of State and County Psychiatric Facilities

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

ii. Identification of Intermediate Care Facilities/Mental Retardation

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