

(b) The restriction on the disclosure of information shall not preclude the release of statistical or summary data or information in which applicants or beneficiaries are not, and cannot be, identified; nor shall it preclude the exchange of information among providers furnishing services, Fiscal Agent of the program, and State or local government agencies, for purposes directly connected with administration of the program. Disclosure without the consent of the applicant or beneficiary shall be limited to purposes directly connected with the administration of the program in accordance with Federal and State law and regulations.

1. Purposes directly connected with the administration of the program shall include but are not limited to:

- i. Establishing eligibility;
- ii. Determining the amount of medical assistance;
- iii. Providing services for beneficiaries; and
- iv. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the program.

(c) The type of information about applicants and beneficiaries that shall be safeguarded by the program includes, but is not limited to:

1. Name and address;
2. Medical services provided;
3. Social and economic conditions or circumstances;
4. Program evaluations of personal information;
5. Medical data, including diagnosis and past history of disease or disability;
6. Any information received for verifying income eligibility and amount of medical assistance payments. Income information received from SSA or the Internal Revenue Service shall be safeguarded according to the requirements of the agency that furnished the data; and
7. Any information received in connection with the identification of legally liable third party resources as required under applicable Federal Regulations (42 C.F.R. 433.138).

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.

Recodified from N.J.A.C. 10:49-9.4 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).

Former N.J.A.C. 10:49-9.7, Integrity of the Medicaid program; gifts/gratuities prohibited, recodified to N.J.A.C. 10:49-9.10.

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

Disclosure of grand jury materials to government departments for use in civil proceedings requires strong showing of particularized need that outweighs public interest in grand jury secrecy. *State v. Doliner*, 96 N.J. 236, 475 A.2d 552 (1984).

Regulation cited as example of confidential record rule the invocation of which overrides the subpoena power of the Office of Administrative Law. *Hayes v. Gulli*, 175 N.J. Super. 294, 418 A.2d 295 (Ch.Div.1980).

10:49-9.8 Provider certification and recordkeeping

(a) All program providers, except institutional, pharmaceutical, and transportation providers, shall be required to certify that the services billed on any claim were rendered by or under his or her supervision (as defined and permitted by program regulations); and all providers shall certify that the information furnished on the claim is true, accurate, and complete.

1. All claims for covered services must be personally signed by the provider or by an authorized representative of the provider (for example, hospital, home health agency, independent clinic) unless the provider is approved for electronic media claims (EMC) submission by the Fiscal Agent. The provider must apply to the Fiscal Agent for EMC approval and sign an electronic billing certificate.

i. The following signature types are unacceptable:

- (1) Initials instead of signature;
- (2) Stamped signature; and
- (3) Automated (machine-generated) signature.

(b) Providers shall agree to the following:

1. To keep such records as are necessary to disclose fully the extent of services provided, and, as required by N.J.S.A. 30:4D-12(d), to retain individual patient records for a minimum period of five years from the date the service was rendered;

2. To furnish information for such services as the program may request;

3. That where such records do not document the extent of services billed, payment adjustments shall be necessary;

4. That the services billed on any claim and the amount charged therefore, are in accordance with the requirements of the New Jersey Medicaid and/or NJ FamilyCare programs;

5. That no part of the net amount payable under any claim has been paid, except that all available third party liability has been exhausted, in accordance with program requirements; and

6. That payment of such amount, after exhaustion of third party liability, will be accepted as payment in full without additional charge to the Medicaid or NJ FamilyCare beneficiary or to others on his behalf.

(c) When a Medicaid or NJ FamilyCare provider employs, contracts or subcontracts with an individual or entity that is not an enrolled Medicaid or NJ FamilyCare provider, the services provided to Medicaid or NJ FamilyCare beneficiaries by that employee, contractor or subcontractor shall meet all the requirements of the Medicaid or NJ FamilyCare programs as defined at N.J.A.C. 10:49-5 and 6 and 10:49-9.8(a) and (b), and the pertinent provider chapters of the New Jersey Administrative Code, which requirements include, but are not limited to, availability of services, range of services, quality of care, licensure, non-exclusion under N.J.A.C. 10:49-11.1 and completeness of documentation. Failure to do so may result in either or both of the following consequences:

1. The Division may recover from the enrolled Medicaid or NJ FamilyCare provider the Medicaid or NJ FamilyCare reimbursement paid by the Program to the provider for any service rendered by an employee, contractor, subcontractor or a contractor's or subcontractor's employee not meeting such requirements; and/or
2. The provider, contractor, subcontractor or other responsible party may be subject to any applicable civil or criminal sanctions and/or penalties.

(d) A Medicaid or NJ FamilyCare provider shall ensure that any individuals or entities employed by or under contract to a contractor or subcontractor performing services for the provider, fully satisfy all applicable State, Federal, and any other licensure and certification requirements. This shall include, but not be limited to, any equipment and/or vehicles relating to services provided to Medicaid or NJ FamilyCare beneficiaries. Failure to assure that all such requirements are met may result in either or both consequences specified in (c)1 and 2 above.

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), deleted "form" following "furnished on the claim"; in (b)1, inserted ", and, as required ... service was rendered"; and in (b)6, substituted "beneficiary" for "recipient".

Recodified from N.J.A.C. 10:49-9.5 and 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 references to NJ KidCare in 4 and 6. Former N.J.A.C. 10:49-9.8, Fraud and abuse, recodified to N.J.A.C. 10:49-9.11.
Amended by R.1998 d.327, effective July 6, 1998.

See: 30 N.J.R. 511(a), 30 N.J.R. 2486(a).

Added (c) and (d).

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.

Amended by R.2003 d.82, effective February 18, 2003.

See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

In (b), substituted "requirements" for "regulations" in 4 and 5; in (c), substituted "an individual or" for "a health care" following "subcontracts with", inserted "non-exclusion under N.J.A.C. 10:49-11.1" following "quality of care, licensure" in the introductory paragraph and rewrote 1 and 2; in (d), inserted "or under a contract to" following "employed by".

Case Notes

Initial Decision (2005 N.J. AGEN LEXIS 1319) adopted, which concluded that a mental health service provider improperly billed full-day rates for children who did not receive the required full five hours of care and that the facility's executive officer was personally liable, within the meaning of N.J.S.A. 30:4D-7(h), for any incorrect or illegal Medicaid payments. *Hentz v. DMAHS*, OAL Dkt. No. HMA 5140-04, 2005 N.J. AGEN LEXIS 1320, Final Decision (November 18, 2005).

Executive officer of a mental health service provider was required to produce sufficient back-up for claims for partial care under Medicaid; since the officer was put on notice in June 2000 that the 1997-1999 dates of service were being questioned, the documents should have been safeguarded. *Hentz v. DMAHS*, OAL Dkt. No. HMA 5140-04, 2005 N.J. AGEN LEXIS 1320, Final Decision (November 18, 2005).

10:49-9.9 (Reserved)

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

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

Amended section name; substituted "beneficiary" and "beneficiary's" for "recipient" and "recipient's" throughout and deleted "form" following "claim" throughout.

Recodified from N.J.A.C. 10:49-9.6 and 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; deleted "Medicaid" following "standard" in (c) and (d), and deleted "Medicaid" preceding "hard-copy" in (f)3. Former N.J.A.C. 10:49-9.9, Informing individuals of their rights, recodified to N.J.A.C. 10:49-9.12.

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.

Amended by R.2000 d.449, effective November 6, 2000.

See: 32 N.J.R. 2394(a), 32 N.J.R. 3991(a).

Rewrote the section.

Amended by R.2003 d.82, effective February 18, 2003.

See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

Repealed by R.2012 d.027, effective February 6, 2012.

See: 43 N.J.R. 2641(a), 44 N.J.R. 229(a).

Section was "Patient's (beneficiary) certification".

10:49-9.10 Withholding of provider payments

(a) When the Division, in accordance with 42 C.F.R. 455.23, receives reliable evidence of fraud or willful misrepresentation by a provider, including an HMO, as well as a practitioner or entity participating in an HMO's network (whether or not the HMO practitioner or entity is also enrolled as a Medicaid or NJ FamilyCare provider), the Medicaid Agent or the Division shall withhold Program payments, in whole or in part, upon approval by the Division Director or the Assistant Director, Office of Program Integrity Administration, or their designee. Further, a practitioner or entity participating in an HMO's network subject to a withholding action under this section shall have any payments for services rendered to Medicaid and NJ FamilyCare beneficiaries withheld by the HMO.

(b) "Reliable evidence" shall include, but not necessarily be limited to:

1. Receipt of information from a Division unit or from the Department of Health and Senior Services, Department of Banking and Insurance or a law enforcement, investigatory, or prosecutorial agency that indicates fraud or willful misrepresentation has occurred or is occurring;

1. Except as otherwise provided by law, a debarment may be removed or the period thereof may be reduced at the discretion of the debarring agency upon the submission of a good faith application under oath, supported by documentary evidence, setting forth substantial and appropriate grounds for the granting of relief, such as newly discovered material evidence, reversal of a conviction or judgment, actual change of ownership, management or control, or the elimination of the causes for which the debarment was imposed.

2. A debarment may include all known affiliates of a person, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The offense, failure or inadequacy of performance of an individual may be imputed to a person with whom he or she is affiliated, where such conduct was accomplished within the course of his or her official duty or was effected by him or her with the knowledge or approval of such person.

3. Debarment by the Director of any provider of service shall preclude such provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association to the Program or its fiscal agent for any services or supplies he or she has provided under the New Jersey Medicaid or NJ FamilyCare programs, except for services or supplies provided prior to the debarment. No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the program or its fiscal agent for any services or supplies provided by a person within such organization who has been debarred by the program, except for services or supplies provided prior to the debarment.

4. When the provisions of this section are violated by a provider of service which is a clinic, group, corporation or other association, the Director may debar such organization and/or any individual person within said organization who is responsible for such violation.

(i) The Medicaid Agent or DMAHS may suspend a person in the public interest for any cause specified in (d) above, or upon a reasonable suspicion that such cause exists, or when, in the opinion of the Medicaid Agent or DMAHS, such action is necessary to protect the public welfare and the interests of the Medicaid or NJ FamilyCare program.

(j) Conditions for suspension shall be as follows:

1. Suspension shall be imposed only upon approval of the Director of the Division and upon approval of the Attorney General, except as otherwise provided by law.

2. The existence of any cause for suspension shall not require that a suspension be imposed, and a decision to suspend shall be made at the discretion of the Director of the Division and of the Attorney General, and shall be ren-

dered in the best interests of the New Jersey Medicaid and NJ FamilyCare programs.

3. Suspension shall not be based upon unsupported accusation, but upon adequate evidence that cause exists or upon evidence adequate to create a reasonable suspicion that cause exists.

4. In assessing whether adequate evidence exists, consideration shall be given to the amount of credible evidence which is available, to the existence or absence of corroboration as to important allegations, and to inferences which may properly be drawn from the existence or absence of affirmative facts.

5. Reasonable suspicion of the existence of a cause described in (d) above may be established by a judgment or order of an administrative agency, or court of competent jurisdiction, or by a judgment of conviction, grand jury indictment, accusation, arrest, or by evidence that such violations of civil or criminal law did in fact occur.

6. A suspension invoked by the Medicaid Agent or DMAHS for any of the causes described in (d) above may be the basis for the imposition of a concurrent suspension by another agency, which may impose such suspension without the approval of the Attorney General.

(k) The Medicaid Agent or DMAHS may suspend a person or his affiliates provided that within 10 days after the effective date of the suspension, the Medicaid Agent or DMAHS provides such party with a written notice stating that a suspension has been imposed and its effective date, setting forth the reasons for the suspension to the extent that the Attorney General determines that such reasons may be properly disclosed, stating that the suspension is for a temporary period pending the completion of an investigation and such legal proceedings as may ensue, and indicating that, if such legal proceedings are not commenced or the suspension removed within 60 days of the date of such notice, the party shall be given either a statement of the reasons for the suspension and an opportunity for a hearing, if he so requests, or a statement declining to give such reasons and setting forth the agency's position regarding the continuation of the suspension. Where a suspension by the Medicaid Agent or DMAHS has been the basis for suspension by another agency, the latter shall note that fact as a reason for its suspension.

(l) A suspension shall not continue beyond 18 months from its effective date unless civil or criminal action regarding the alleged violation shall have been initiated within that period, or unless debarment action has been commenced. Whenever prosecution or debarment action has been initiated, the suspension may continue until the legal proceedings are completed.

(m) Scope of suspension rules shall be as follows:

1. A suspension may include all known affiliates of a person, provided that each decision to include an affiliate is

made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The offense, failure or inadequacy of performance of an individual may be imputed to a person with whom he or she is affiliated, where such conduct was accomplished within the course of his official duty or was effectuated by him or her with the knowledge or approval of such person.

2. Suspension, by the Medicaid Agent or DMAHS, of any provider of service shall preclude such provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association to the Program or its Fiscal Agent or DMAHS for any services or supplies he or she has provided under the New Jersey Medicaid or NJ FamilyCare program, except for services or supplies provided prior to the suspension. No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the Program or its Fiscal Agent for any services or supplies provided by a person within such organization who has been suspended by the Medicaid Agent or DMAHS, except for services or supplies provided prior to the suspension.

3. When the provisions of this section are violated by a provider of service which is a clinic, group, corporation or other association, the Director may suspend such organization and/or any individual person within said organization who is responsible for such violation.

(n) Exclusion from State contracting by virtue of debarment, suspension or disqualification shall extend to all State contracting and subcontracting within the control or jurisdiction of the Medicaid Agent or DMAHS. However, when it is determined essential to the public interest by the Director of the Division, and upon filing of a finding thereof with the Attorney General, an exception from total exclusion may be made with respect to a particular State contract.

(o) Insofar as practicable, prior notice shall be given to the Attorney General and the Treasurer of any proposed debarment or suspension.

(p) The Medicaid Agent or DMAHS shall provide the State Treasurer with the names of all persons suspended or debarred and the effective date and term thereof, if any.

(q) This section shall be applicable to all persons, providers, contractors, Fiscal Agent, and their affiliates who engage in State contracting with the Medicaid Agent or DMAHS as defined in this section.

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), inserted “, and Reorganization Plan No. 001-1996”; in (b), substituted “New Jersey Medicaid program” and “Medicaid Agent” for “Division” throughout; in (b)3, deleted “reimbursed on a fee-for-service basis”; in (c), rewrote introductory paragraph and deleted “Division”, “Fiscal Agent” and “Provider”; and in (d), substituted “beneficiary” and “beneficiaries” for “recipient” and “recipients”, reference to Medicaid Agent for references to Division, Division of Medical Assistance and Health Services, and Director, and “Program” for references to the

Division of Medical Assistance and Health Services, throughout; in (d)5, deleted Public Law references: in (d)17, deleted “form” following “Medicaid claim”; in (d)20, inserted reference to Commissioner of Health and Human Services; and in (j)2, substituted “New Jersey Medicaid program” for “Division”.

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 reference to NJ KidCare and to DMAHS throughout; in (a), added a reference to P.L. 1997, c.272; in (d), inserted “or supplemented” following “amended” in 20, and inserted a reference to Title XXI in 26; in (e), substituted “DMAHS” for “agency” following “Agent or” in 5; and in (i), substituted “Medicaid or NJ KidCare program” for “medical assistance Program” at the end.

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.
Amended by R.2003 d.82, effective February 18, 2003.

See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).
Rewrote the section.

Law Review and Journal Commentaries

Defense of Health Care Fraud, Abuse Charges. Richard L. Friedman, 133 N.J.L.J. No. 7, 10 (1993).

Case Notes

Good cause justified termination of provider of mental health and drug and alcohol counseling services as a Medicaid provider where substantial evidence showed that provider violated the state’s anti-kickback statute, N.J.S.A. 30:4D-17(c), by giving away over \$179,000.00 in Pathmark gift vouchers in order to induce Medicaid beneficiaries into its facility. Statements obtained from DMAHS investigators confirmed that clients returned to the facility every day in order to obtain these vouchers, and provider’s owner himself advised an investigator that clients came on a daily basis for the vouchers, not for the services (adopting Initial Decision, 2008 N.J. AGEN LEXIS 1001). Bloomfield Health Pavilion v. DMAHS, OAL Dkt. No. HMA 03095-08, 2009 N.J. AGEN LEXIS 55, Final Decision (January 15, 2009).

Regulations do not require that a provider intended to deceive, manipulate, or defraud Medicaid, in order to be excluded from the program; simply offering gift vouchers to Medicaid beneficiaries is prohibited under the plain language of the anti-kickback statute and is grounds for exclusion, and it is well within the Division of Medical Assistance and Health Services’ discretion to take action against a provider who has clearly violated the statutory prohibition against offering a bribe or an incentive to a Medicaid client in order to influence program participation. Bloomfield Health Pavilion v. DMAHS, OAL Dkt. No. HMA 03095-08, 2009 N.J. AGEN LEXIS 55, Final Decision (January 15, 2009).

DMAHS properly denied a pharmacy’s application for participation in the New Jersey Medicaid program because the pharmacist-in-charge, who was a 50% owner, answered “No” to the question about criminal charges despite the fact that the pharmacist had previously pled guilty to criminal trespass and completed the Pre-Trial Intervention program. Neither alleged confusion regarding the obligation to disclose Pre-Trial Intervention charges nor the fact that the pharmacist was no longer associated with the pharmacy required a different result. Mi Farmacia v. DMAHS, OAL Dkt. No. HMA 9969-06, 2008 N.J. AGEN LEXIS 354, Initial Decision (April 30, 2008).

N.J.A.C. 10:49-11.1(d) does not require that a false statement be made willfully in order to deny an application. Mi Farmacia v. DMAHS, OAL Dkt. No. HMA 9969-06, 2008 N.J. AGEN LEXIS 354, Initial Decision (April 30, 2008).

Where a registered nurse anesthetist administered 2,000 times the recommended dose of a narcotic anesthetic to three patients, and submitted false answers on applications, good cause existed for debarment from participation in New Jersey Medicaid and Division-administered programs, and the mitigating factors presented by the anesthetist,

including the provider's interest in compensation from the Medicaid program, were superseded by the Division's "overriding public interest in the proper administration of the Medicaid program in New Jersey." *Frimpong v. DMAHS*, OAL Dkt. No. HMA 05200-04, 2007 N.J. AGEN LEXIS 752, Initial Decision (November 20, 2007).

Suspension, debarment, and disqualification are measures invoked by the Division to exclude or render ineligible certain persons from participation in contracts and subcontracts with the New Jersey Medicaid or New Jersey FamilyCare programs, the Medicaid Agent, or DMAHS on the basis of a lack of responsibility; the purpose of sanctions is not to punish the person, but rather to protect the interests of Medicaid and New Jersey FamilyCare programs. *Frimpong v. DMAHS*, OAL Dkt. No. HMA 05200-04, 2007 N.J. AGEN LEXIS 752, Initial Decision (November 20, 2007).

Initial Decision (2007 N.J. AGEN LEXIS 210) adopted, which concluded that while the word "shall" in N.J.A.C. 10:49-3.2(b)(3) creates a mandatory time limit of 35 days within which a Medicaid provider applicant is to supply enrollment information requested by the Division, there is no regulatory basis for the Division to deny an application for

failure to meet the deadline. The applicant's failure to provide requested enrollment information within 35 days could not be placed within the rubric of N.J.A.C. 10:49-11.1, which sanctions are stated to be for the purposes of protecting the interests of the New Jersey Medicaid program, and not for punishment. *Grace Pharmacy v. DMAHS*, OAL Dkt. No. HMA 6904-06, 2007 N.J. AGEN LEXIS 528, Final Decision (June 5, 2007).

Initial Decision (2006 N.J. AGEN LEXIS 751) adopted, which concluded that a pharmacy's application to be a Medicaid provider was correctly denied pursuant to N.J.A.C. 10:49-11.1(d)22 because the pharmacy owner willfully or by inexcusably irresponsible omission provided false information on the application concerning the criminal history of the pharmacist-in-charge and then lied about whether the person was still an employee. *Surgi-Med Pharmacy v. DMAHS*, OAL Dkt. No. HMA 3635-06, 2006 N.J. AGEN LEXIS 934, Final Decision (October 1, 2006).

Pharmaceutical provider submitted a false answer on the application by failing to reveal the adverse action taken against it in Colorado, and