CHAPTER 49

ADMINISTRATION MANUAL

Authority

N.J.S.A. 30:4D-1 et seq. and 30:4J-8 et seq.

Source and Effective Date

R.2008 d.230, effective July 11, 2008.
See: 40 N.J.R. 984(a), 40 N.J.R. 4531(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 49, Administration Manual, expires on July 11, 2015. See: 43 N.J.R. 1203(a).

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Chapter 49, Administration, was repealed and a new Chapter 49, Administration, was adopted as R.1992 d.317, effective August 17, 1992.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 Subchapter 19, Prepaid Health Care Services: Medicaid Eligibles, was repealed by R.1995 d.337, effective June 19, 1995.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. As a part of R.1997 d.354, effective September 2, 1997, Chapter 49, Administration, was renamed Chapter 49, Administration Manual; Subchapter 2, New Jersey Medicaid Recipients, was renamed Subchapter 2, New Jersey Medicaid Beneficiaries; Subchapter 9, Provider and Recipient's Rights and Responsibilities; Administrative Process, was renamed 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: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Subchapter 24, Work First New Jersey/General Assistance Claims Processing, was adopted as R.2000 d.309, effective August 7, 2000. See: 32 N.J.R. 1342(a), 32 N.J.R. 2900(a).

Chapter 49, Administration Manual, was readopted as R.2003 d.81, effective January 22, 2003. See: 34 N.J.R. 2647(a), 35 N.J.R. 1116(a).

Subchapter 20, The Garden State Health Plan (GSHP), was repealed by R.2003 d.82, effective February 18, 2003. See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

Chapter 49, Administration Manual, was readopted as R.2008 d.230, effective July 11, 2008. As a part of R.2008 d.230, Subchapter 21, The Medicaid Managed Care Program—NJ Care 2000, was renamed The Medicaid/NJ FamilyCare Managed Care Program, effective August 4, 2008. See: Source and Effective Date. See, also, section annotations.

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(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 Patient's (beneficiary) certification

(a) Except as provided in (e) below, a beneficiary shall sign a certification, authorization to release information and payment request after the services identified on the claim are provided and before the provider submits a claim for payment. The beneficiary is:

1. Certifying that the service(s) covered by a claim has been received;

2. Requesting payment for those services made on his or her behalf; and

3. Authorizing any holder of medical or other information to release to the New Jersey Medicaid or NJ FamilyCare program or its authorized agents any information needed for this or a related claim.

(b) A provider shall obtain the beneficiary or representative's certification on the Medicaid or NJ FamilyCare hard-copy claim (appropriate to the provider), except as noted in (c) below, on the standard Patient Certification (Form FD-197) or on a similar form of the provider's choosing (referred to in this section as a certification log), as long as the form identifies the beneficiary by name and Medicaid or NJ FamilyCare Eligibility Identification Number, provides the date of service, contains a brief, non-technical description of the service(s) provided, and provides the certification and signature described in (a) above in a legible and readily understandable format. A provider who chooses to use Form FD-197 to obtain patient certification information shall use the column headed "Other Comments" to record the description of the service(s) provided. The provider shall keep this certification on file for each service rendered and shall make the form available upon request to representatives of the New Jersey Medicaid or NJ FamilyCare program. Initials instead of a signature are unacceptable on the certification form.

1. If a signed Patient Certification Form is not on file for each service, Medicaid and/or NJ FamilyCare reimbursement for the service shall be subject to recoupment.

(c) Certain providers may be required to use an individualized certification form that calls for information in addition to that described in (b) above, as indicated in the specific service chapter of the Division's rules.

(d) A provider shall complete a Medicaid or NJ FamilyCare hard-copy claim, Patient Certification Form, or certification log before it is presented to the beneficiary for signature.

A Medicaid or NJ FamilyCare beneficiary shall not sign a blank Medicaid or NJ FamilyCare hard-copy claim, Patient Certification Form, or certification log, nor shall he or she sign the form prior to receiving services or as a condition for receiving services.

(e) When the beneficiary's signature is unobtainable, the following procedures shall be used:

1. An illiterate beneficiary shall make his or her mark (x), and the mark shall be witnessed by another person who signs his or her name on the Patient Certification Form (FD-197), certification log, or on the Medicaid or NJ FamilyCare hard-copy claim.

2. If a beneficiary is physically or mentally incapable of signing, or is deceased, the form(s) may be signed on his or her behalf by:

i. A parent;

ii. A legal guardian;

iii. A relation;

iv. A friend;

v. An individual provider;

vi. A representative of an institution providing care or support;

vii. A representative of a governmental agency providing assistance; or

viii. An administrator or executor.

3. A brief explanation of the reason the beneficiary was not personally able to sign the form(s) and the relationship of the signer to the beneficiary shall be noted directly on the hard-copy claim, certification log, or the Patient Certification Form (FD-197).

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).

Case Notes

Recoupment of claims made for prescriptions warranted. Plains Pharmacy, Inc. v. DMAHS, 93 N.J.A.R.2d (DMA) 121.

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;

2. Information from any other local, county, State or Federal agency indicating fraud or willful misrepresentation has occurred or is occurring; or

3. Indications that a violation of those subsections of N.J.A.C. 10:49-11.1 that pertain to fraud or willful misrepresentation may have occurred or is occurring, including, but not necessarily limited to, overutilization or misutilization; any unexplained increase in the number of claims rejected by the claims processing system; or any other reliable grounds to believe that fraud or willful misrepresentation may have occurred or is occurring.

(c) Withholding may be total or partial, and if partial, may be predicated upon withholding by specific claim type, practitioner, procedure code, diagnosis, or other factors.

(d) The Division shall send notice of its withholding to the affected provider, practitioner or entity within five days of taking such action. The notice shall also be sent to all participating HMOs to enable them to identify if the affected provider, practitioner or entity is also part of their network. The HMOs shall be required to implement the provisions of this section within their network. The notice shall set forth the general allegations as to the nature of the withholding action, but need not disclose specific information concerning any ongoing civil or criminal investigation. The notice shall:

1. State that payments are being withheld in accordance with this regulation and with 42 C.F.R. 455.23;

2. State that withholding is for a period initially not to exceed six months, after which the withholding action shall be reviewed to determine if an additional period of withholding is warranted. Withholding shall be terminated when the Division determines there is insufficient evidence of fraud or willful misrepresentation, or legal proceedings relating to the fraud or willful misrepresentation are completed;

3. Specify, when appropriate, to which type or types of claims withholding is effective;

4. Inform the provider, practitioner or entity of the right to submit written evidence for consideration by the Medicaid Agent or the Division; and

5. Set forth the provider's, practitioner's or entity's right to submit to the Division, within 20 days of the pro-

vider's receipt of the withholding notice, a request for an administrative hearing, consistent with N.J.A.C. 10:49-10.3. Immediately upon receipt of such a request, the Division shall request the Office of Administrative Law to schedule a hearing on an expedited basis.

(e) Regular, periodic meetings shall be held to review all parties from whom payments are being withheld under this section. Also, in a case involving any party against which withholding is being imposed, where circumstances indicate that the reason for the withholding may no longer exist, said case shall be brought before a committee to be comprised of staff of the Division of Medical Assistance and Health Services, or their designees, for consideration of cessation of withholding of payment, upon the request of any of the specified officials.

New Rule, R.1999 d.294, effective September 7, 1999.
See: 30 N.J.R. 2808(a), 31 N.J.R. 2635(a).
Former N.J.A.C. 10:49-9.10, Integrity of the Medicaid and NJ KidCare programs; gifts/gratuities prohibited, recodified to N.J.A.C. 10:49-9.11.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).
Rewrote (d)5.

10:49-9.11 Integrity of the Medicaid and NJ FamilyCare programs; gifts/gratuities prohibited

The Division, in order to maintain the integrity of the programs it administers in whole or in part, strictly prohibits its employees, or representatives of its contractors, subcontractors or fiscal agents, from accepting gifts or gratuities of any kind and of any value from representatives of providers or provider-related individuals, entities, organizations or institutions if receipt of such gifts or gratuities would violate the rules of the New Jersey Executive Commission on Ethical Standards (N.J.A.C. 19:61), the New Jersey Conflicts of Interest Law (N.J.S.A. 52:13D-12 et seq.), Executive Order No. 189 (July 20, 1988), and/or Executive Order No. 2 (January 18, 1994). This includes the prohibition of offers of special employment, consultation fees and all other gratuities by a provider, individual or facility.

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Recodified from N.J.A.C. 10:49-9.7 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 a reference to NJ KidCare programs. Former N.J.A.C. 10:49-9.10, Provisions for appeals; fair hearings, recodified to N.J.A.C. 10:49-9.13.
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.
Recodified from N.J.A.C. 10:49-9.10 by R.1999 d.294, effective September 7, 1999.
See: 30 N.J.R. 2808(a), 31 N.J.R. 2635(a).
Former N.J.A.C. 10:49-9.11, Fraud and abuse, recodified to N.J.A.C. 10:49-9.12.
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.

10:49-9.12 Fraud and abuse

The New Jersey Medicaid and NJ FamilyCare programs shall employ methods to identify situations in which a question of fraud and/or abuse in the program may exist. The Division shall refer to law enforcement officials situations in which there is valid reason to suspect that fraud has or may have been committed.

Recodified from N.J.A.C. 10:49-9.8 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 a reference to NJ KidCare programs.
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.
Recodified from N.J.A.C. 10:49-9.11 by R.1999 d.294, effective September 7, 1999.
See: 30 N.J.R. 2808(a), 31 N.J.R. 2635(a).
Former N.J.A.C. 10:49-9.12, Informing individuals of their rights, recodified to N.J.A.C. 10:49-9.13.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

10:49-9.13 Informing individuals of their rights

(a) All Medicaid and NJ FamilyCare-Plan A claimants and NJ FamilyCare Plan D parents with incomes up to 133 percent of the Federal poverty level shall be informed of the following, in writing, at the time of application and at the time of any action affecting their claim:

1. Of their right to a fair hearing;

2. Of the method by which they may obtain a hearing;

3. That they may be represented by legal counsel or by a relative, friend, or other spokesperson, or they may represent themselves; and

4. Of legal services within the community from which they may receive legal aid.

(b) NJ FamilyCare-Plan B, C and all other Plan D enrollees are entitled to use the grievance procedure established by the Division of Medical Assistance and Health Services or the administrative law hearing process established at N.J.A.C. 10:79-6.5 and 6.6, as appropriate.

Recodified from N.J.A.C. 10:49-9.9 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 (a), inserted "Medicaid and NJ KidCare-Plan A" following "All"; and added (b).
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.
Recodified from N.J.A.C. 10:49-9.12 by R.1999 d.294, effective September 7, 1999.
See: 30 N.J.R. 2808(a), 31 N.J.R. 2635(a).
Former N.J.A.C. 10:49-9.13, Provisions for appeals; fair hearings, recodified to N.J.A.C. 10:49-9.14.
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).