

CHAPTER 49

ADMINISTRATION MANUAL

Authority

N.J.S.A. 30:4D-1 et seq., specifically 6, 7 and 12; 30:6E-1 et seq.; 52:14D-1 et seq., and 42 C.F.R. 412.30.

Source and Effective Date

R.2003 d.81, effective January 22, 2003.
See: 34 N.J.R. 2647(a), 35 N.J.R. 1116(a).

Chapter Expiration Date

Chapter 49, Administration Manual, expires on January 22, 2008.

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Chapter 49, Administration, was repealed and a new Chapter 49, Administration, was adopted by R.1992 d.317, effective August 17, 1992.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 Subchapter 19, Prepaid Health Care Services: Medicaid Eligibles, was repealed by R.1995 d.337, effective June 19, 1995.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, 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 by 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. Subchapter 20, The Garden State Health Plan (GSHP), was reserved by R.2003 d.82, effective February 18, 2003.

See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a). See: Source and Effective Date. See, also, section annotations.

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APPENDIX

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 the authority of N.J.S.A. 30:4D-1 et seq., as amended and supplemented, N.J.S.A. 30:4D-5, and pursuant to N.J.S.A. 30:4D-4, 30:4I-1 et seq. and 30:4J-1 et seq., 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); the NJ FamilyCare programs and other special (State) funded Programs.

(b) Governor Whitman's Reorganization Plan No. 001-1996 gives the Department of Health and Senior Services (DHSS) legal authority to administer several components of the Medicaid program. These components include nursing facility services, medical day care services, PreAdmission Screening (PAS) and PreAdmission Screening and Annual Resident Review (PASARR), the Community Care program for the Elderly and Disabled (CCPED) waiver, the Assisted Living/Alternate Family Care (AL/AFC) waiver,

and peer grouping. Rules for these Medicaid program components are promulgated by DHSS. Accordingly, providers must contact DHSS regarding requirements for these services.

(c) Pursuant to N.J.S.A. 30:4D-1 et seq., as amended and supplemented, the Division of Medical Assistance and Health Services, under the Department of Human Services, is designated as the State agency responsible for the administration of the NJ FamilyCare program.

(d) Unless otherwise specified, or clearly indicated otherwise in the context of the rule, the rules of the New Jersey Medicaid program and the rules of the Division of Medical Assistance and Health Services are equally applicable to the NJ FamilyCare program.

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

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

Substantially amended section.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

In (a), inserted a reference to the NJ KidCare program in the second sentence; and added (c) and (d).

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 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).

Amended N.J.S.A. reference in (a) and (c).

10:49-1.2 Organization

(a) Regarding the organization of the Division of Medical Assistance and Health Services, the Department of Human Services is the single State Agency for receipt of Federal funds under Title XIX (Medicaid) and Title XXI of the Social Security Act. The Division of Medical Assistance and Health Services, Department of Human Services, administers the New Jersey Medicaid and the NJ FamilyCare program through its Central Office and through Medical Assistance Customer Centers (MACCs) located throughout the State of New Jersey. A listing of the MACCs is provided in the chapter Appendix. The Division may also designate from time to time agencies which will assist in the administration of the NJ FamilyCare program.

1. The two programs are jointly financed by the Federal and State governments and administered by the State. The New Jersey Medicaid program is conducted according to the Medicaid State Plan approved by the Secretary, United States Department of Health and Human Services, through the Centers for Medicare & Medicaid Services (CMS). The NJ FamilyCare program is conducted according to the Title XIX and Title XXI State Plans approved by CMS.

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

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

Section name amended; former (a) recodified as N.J.A.C. 10:49-1.3; recodified former (b) as (a); in (b)1, added “, through the Health Care Financing Administration (HCFA)” and deleted (c), relating to Medicaid Program services and eligibility.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

In (a), inserted a reference to Title XXI of the Social Security Act in the first sentence, inserted a reference to the NJ KidCare program in the second sentence and added a fourth sentence in the introductory paragraph, and substituted "two programs are" for "program is" in the first sentence and added a third sentence in 1.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 with changes, effective August 17, 1998.

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

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

10:49-1.3 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"AFDC" means the former Aid to Families with Dependent Children program.

"AFDC-related Medicaid" means medical assistance provided to families who would otherwise qualify for AFDC or would be deemed to qualify for AFDC if the program would be deemed still in existence.

"American Indian/Alaska Native (AI/AN)" means a member of a Federally recognized Indian tribe, band, or group; an Eskimo or Aleut or other Alaska Native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 C.F.R. 1601 et seq.; or a person who is considered by the Secretary of the Interior as meeting the requirements of tribal membership in accordance with 42 C.F.R. 36a.16.

"Beneficiary or eligible beneficiary" means any person meeting the definition of recipient as defined below.

"Centers for Medicare and Medicaid Services (CMS)" means the agency of the Federal Department of Health and Human Services which is responsible for the administration of the Medicaid program in the United States.

"Commissioner of DHS" means the Commissioner of the Department of Human Services.

"Copayment" means a specified dollar amount required to be paid by or on behalf of the beneficiary in connection with benefits as specified in N.J.A.C. 10:49-9.1.

"County board of social services (CBOSS)" means that agency of county government which is charged with the responsibility for determining eligibility for public assistance programs including AFDC-Related Medicaid, Temporary Assistance to Needy Families, the Food Stamp program and Medicaid. Depending on the county, the CBOSS might be identified as the Board of Social Services, the Welfare Board, the Division of Welfare, or the Division of Social Services.

"Department" or "DHS" means the Department of Human Services. The Department of Human Services is the single state agency designated by N.J.S.A. 30:4D-3 in accordance with 42 C.F.R. 412.30.

"DHSS" means the Department of Health and Senior Services.

"Division" or "DMAHS" means the Division of Medical Assistance and Health Services.

"DMHS" means the Division of Mental Health Services within the New Jersey Department of Human Services.

"DYFS" means the Division of Youth and Family Services within the New Jersey Department of Human Services.

"Fiscal agent" means an entity that processes and adjudicates provider claims on behalf of programs administered in whole or part by the Division.

"Medicaid" means medical assistance provided to certain persons with low income and limited resources as authorized under Title XIX (Medicaid) of the Social Security Act.

"Medicaid Agent" means, under Reorganization Plan No. 001-1996, either DHSS or DMAHS, acting as administrators of the Medicaid program.

"Mental health rehabilitation services" means psychiatric and psychological services, including emotional and/or behavioral treatment, drug and alcohol dependency treatment, psychiatric treatment, psychotherapy and related nursing services.

"NJ FamilyCare" means the health insurance coverage program administered by DMAHS under the provisions of Title XIX and Title XXI of the Social Security Act.

"NJ FamilyCare-Plan A" means the State-operated program which provides comprehensive, managed care coverage, including all benefits provided through the New Jersey Care . . . Special Medicaid Programs, to eligible children through the age of 18, and adults with family incomes up to and including 133 percent of the Federal poverty level.

"NJ FamilyCare-Plan B" means the State-operated program which provides comprehensive, managed care coverage to uninsured children through the age of 18 with family incomes above 133 percent and not in excess of 150 percent of the Federal poverty level. In addition to covered managed care services, eligibles may access mental health and substance abuse services and certain other services which are paid fee-for-service.

"NJ FamilyCare-Plan C" means the State-operated program which provides comprehensive, managed care coverage to uninsured children through the age of 18 with family incomes above 150 percent and not in excess of 200 percent of the Federal poverty level. In addition to covered managed care services, eligibles may access mental health and substance abuse services and certain other services which are paid fee-for-service. Eligibles are required to participate in cost-sharing in the form of monthly premiums and personal contributions to care for certain services.

“NJ FamilyCare–Plan D” means the State-operated program which provides managed care coverage to uninsured children through the age of 18 and adults with gross family incomes above 200 percent and not in excess of 350 percent of the Federal poverty level. In addition to covered managed care services, eligibles may access certain services including mental health and substance abuse services, with limitations, which are paid fee-for-service. Eligibles participate in cost-sharing in the form of monthly premiums and copayments for most services.

“Prepaid health plan” means an entity that provides medical services to enrollees under a contract with DMAHS on the basis of prepaid capitation fees but which does not necessarily qualify as an HMO. For rules concerning prepaid health care services, see N.J.A.C. 10:49-1.1. For Medicaid Managed Care Program—New Jersey Care 2000, see N.J.A.C. 10:49-21.

“Program” means the New Jersey Medicaid program.

“Programs” means the New Jersey Medicaid program and the NJ FamilyCare program.

“Provider” means any individual, partnership, association, corporation, institution, or any other public or private entity, agency, or business concern, meeting applicable requirements and standards for participation in the New Jersey Medicaid Program, other Special programs, and where applicable, holding a current valid license, and lawfully providing medical care, services, goods and supplies authorized under N.J.S.A. 30:4D-1 et seq. and amendments thereto.

“Qualified applicant” means a person who is a resident of this State and is determined to need medical care and services as provided under the Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 et seq., and who meets one of the eligibility criteria set out therein.

“Recipient” means a qualified applicant receiving benefits under the Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 et seq.

“Temporary Assistance to Needy Families (TANF)” means that program administered by the Division of Family Development within the Department of Human Services in accordance with N.J.A.C. 10:90.

Recodified from N.J.A.C. 10:49-1.2(a) and 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) designation, added “Aid to Families with Dependent Children (AFDC)”, “Beneficiary or eligible beneficiary”, “Commissioner of DHS”, “Department”, “Division”, “DHSS”, “Health Care Financing Agency”, “Medicaid Agent”, “Prepaid health plan”, “Program”, and “Qualified applicant”; changed “County welfare agency” to “County welfare agency or CWA” and amended; amended “Provider” and “recipient”; and deleted (b) and (c). Former section, “Early and Periodic Screening, Diagnosis and Treatment (EPSDT)”, repealed. Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).

In “Fiscal agent” inserted a reference to the NJ KidCare program; and inserted “NJ KidCare”, “NJ KidCare—Plan A”, and “Programs”. 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 “NJ KidCare–Plan B” and “NJ KidCare–Plan C”.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

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.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).

Added definitions of “Copayment” and “NJ KidCare–Plan D”.

Amended by R.2001 d.144, effective May 7, 2001.

See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).

Inserted “DMHS”, “DYFS” and “Mental health rehabilitation services”.

Amended by R.2002 d.371, effective November 18, 2002.

See: 34 N.J.R. 2244(a), 34 N.J.R. 2549(b), 34 N.J.R. 3978(a).

Added “American Indian/Alaska Native (AI/AN)”.

Amended by R.2003 d.81 and d.82, effective February 18, 2003.

See: 34 N.J.R. 2647(a), 2650(a), 35 N.J.R. 1116(a), 1118(a).

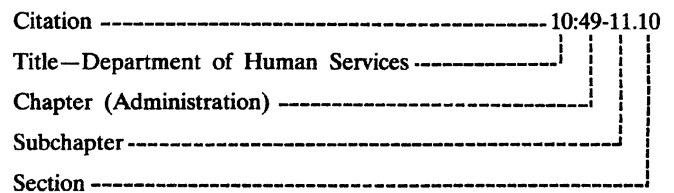
Rewrote the section.

10:49-1.4 Overview of provider manuals

(a) The Medicaid Fiscal Agent and the Division of Medical Assistance and Health Services maintain New Jersey Medicaid and NJ FamilyCare provider manuals. Each is designed for use by a specific type of provider that provides services to Medicaid and/or NJ FamilyCare beneficiaries. Each manual is written in accordance with Federal and State laws, rules, and regulations, with the intent to ensure that such laws, rules, and regulations are uniformly applied.

(b) Each provider manual consists of two chapters, broken down into subchapters. The first chapter is referred to as N.J.A.C. 10:49, Administration Manual, and outlines the general administrative policies of the New Jersey Medicaid program and other special programs including NJ FamilyCare. The second chapter of each manual specifies the rules and regulations relevant to the specific provider-type and the services provided. Following the second chapter of the manuals is the Fiscal Agent Billing Supplement.

(c) Codification of manual material follows that of the New Jersey Administrative Code (N.J.A.C.). The citation for a particular section of the provider manual reflects the same material under the same citation in the N.J.A.C. The following is an example of a citation in the N.J.A.C. or a provider manual:



(d) There is an individual Program provider manual for each of the following services. These services are listed in

the New Jersey Administrative Code (N.J.A.C.) under Title 10 (Department of Human Services) Chapters 10:50 through 10:75, and 10:77 through 10:79 as follows:

1. 10:50—Transportation Services Manual
2. 10:51—Pharmacy Services Manual
3. 10:52—Hospital Services Manual
4. 10:53—(Reserved)
5. 10:53A—Hospice Services Manual
6. 10:54—Physician Services Manual
7. 10:55—Prosthetic and Orthotic Services Manual
8. 10:56—Dental Services Manual
9. 10:57—Podiatry Services Manual
10. 10:58—Nurse-Midwifery Services Manual
11. 10:58A—Certified Nurse Practitioner/Clinical Nurse Specialist
12. 10:59—Medical Supplier Services Manual
13. 10:60—Home Care Services Manual
14. 10:61—Independent Clinical Laboratory Services Manual
15. 10:62—Vision Care Services Manual
16. 10:63—Long Term Care Services Manual
17. 10:64—Hearing Aid Services Manual
18. 10:65—Medical Day Care Services Manual
19. 10:66—Independent Clinic Services Manual
20. 10:67—Psychological Services Manual
21. 10:68—Chiropractic Services Manual
22. 10:69 AFDC—Related Medicaid
23. 10:70 Medically Needy Manual
24. 10:71 Medicaid Only Manual
25. 10:72 New Jersey Care ... Special Medicaid Programs Manual
26. 10:73—Case Management Services Manual
27. 10:74—Managed Health Care Services for Medicaid Eligibles
28. 10:75 Programs of Assertive Community Treatment
29. (Reserved)
30. 10:77 Rehabilitation Services Manual
31. 10:78 NJ FamilyCare Manual
32. 10:79 NJ KidCare Manual

(e) Manual updates, revised pages or additions to the provider manual are issued, as required, for new policy, policy clarification, and/or revisions to the New Jersey Medicaid or NJ FamilyCare program. A newsletter system is utilized to distribute new or revised manual material and to provide any other pertinent information regarding manual updates. Newsletters should be filed at the back of the manual and replacement pages should be added to the manual in accordance with instructions provided. Substantive manual revisions shall be made through the rulemaking process, in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

(f) This manual and all subsequent updates are distributed as a guide to assist providers in their participation in the New Jersey Medicaid or NJ FamilyCare program. The provider is ultimately responsible for knowing and abiding by current Federal and State laws and regulations pertaining to this program.

Recodified from N.J.A.C. 10:49-1.8 and 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 "The New Jersey Medicaid Program maintains" for "There are 19" and "Medicaid beneficiaries" for "Medicaid recipients"; in (d), inserted additional N.J.A.C. references; inserted new (d)5, 11 and 23; recodified former (d)5 through 9 and 10 through 20 as (d)6 through 10 and 12 through 22; and in (e), substituted "Substantive manual revisions shall be made" for "Manual revisions shall be substantially made". Former section, "HealthStart", repealed.
Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).

Inserted references to NJ KidCare and made corresponding language changes throughout; and in (a), substituted a reference to the Medicaid Agent and the Division of Medical Assistance and Health Services for a reference to the New Jersey Medicaid Program in the first sentence. Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 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 (d).

Case Notes

Extended care facility could not be reimbursed for care for Medicaid-ineligible patient. V.F. v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 29.

10:49-1.5 (Reserved)

Repealed by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Section was "Prepaid health plans".

10:49-1.6 (Reserved)

Recodified to N.J.A.C. 10:49-22.3 and amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

10:49-1.7 (Reserved)

Repealed by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Section was "State funded programs".

10:49-1.8 (Reserved)

Recodified to N.J.A.C. 10:49-1.4 and amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

SUBCHAPTER 2. NEW JERSEY MEDICAID BENEFICIARIES

10:49-2.1 Who is eligible for Medicaid?

Medicaid beneficiaries are: those eligible for all services under the regular New Jersey Medicaid program (see N.J.A.C. 10:49-2.2 below); those eligible for a limited range of services under the Medically Needy program (see N.J.A.C. 10:49-2.3 below) and those eligible for a limited range of services under the Home and Community-Based Services Waiver Programs, in accordance with N.J.A.C. 10:49-22.

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

- 47 Middlesex MACC
- 48 Middlesex MACC
- 51 Middlesex MACC—Menlo Park Veterans Home
- 51 Middlesex MACC—Vineland Veterans Home
- 90 MACC in county in which beneficiary resides.

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” or “resident” throughout; in (a)3 and (b), substituted “Medicaid Eligibility Identification Number” for “HSP (Medicaid) Case Number”; in (b), inserted references to beneficiaries, amended MDO references, and inserted the two 51—Middlesex references.

Recodified from N.J.A.C 10:49-2.15 by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).

Former N.J.A.C. 10:49-2.16, Medicaid application, recodified to N.J.A.C. 10:49-2.17.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 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).

10:49-2.17 Medicaid application

(a) If a person has not applied for benefits, is unable to pay for services provided, and appears to meet the requirements for eligibility for the New Jersey Medicaid program, the provider shall encourage the person, or his or her representative, to apply for benefits:

1. To the CBOSS for programs such as AFDC-Related Medicaid; Medicaid Only; New Jersey Care . . . Special Medicaid programs for pregnant women, children, and the aged, blind, or disabled; or for Medically Needy.
2. To the Social Security Administration for Supplemental Security Income benefits for the aged, blind, and disabled; or
3. In certain cases, to the New Jersey Division of Youth and Family Services, Department of Human Services.

(b) If it is not known which agency is responsible for determining eligibility or which program might be applicable, the MACC will be able to provide guidance in this matter (for MACC Directory, see Appendix N.J.A.C. 10:49).

(c) All providers are encouraged to refer pregnant women who may be eligible for Medicaid to a provider authorized to determine presumptive eligibility. The names and addresses of these providers may be obtained by calling the HOT LINE at 1-800-328-3838.

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 10:49-2.16 by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 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).

10:49-2.18 (Reserved)

10:49-2.19 Medicaid or NJ FamilyCare eligibility—aliens

For any alien who does not qualify for Medicaid or NJ FamilyCare-Plan A based on his or her alien status, and thus is potentially eligible for Medicaid or NJ FamilyCare-Plan A payment for emergency services only (see N.J.A.C. 10:49-5.4, Medicaid or NJ FamilyCare-Plan A Emergency Services for Aliens) the provider of service shall complete a Form PA-1C and submit it with Certification of Treatment of Emergency Medical Condition (if necessary) to the eligibility determination agency in the county in which the individual lives. The provider shall inform the individual that a Form PA-1C does not establish Medicaid eligibility or NJ FamilyCare-Plan A eligibility but serves only to protect the date of inquiry as an application date for Medicaid, or NJ FamilyCare-Plan A if an application is filed within three months of the date that the Form PA-1C is signed. The individual should be advised to file an application with the eligibility determination agency as soon as possible.

New Rule, R.1998 d.116, effective January 30, 1998 (operative February 1, 1998).

See: 30 N.J.R. 713(a).

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 with changes, effective August 17, 1998.

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

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

SUBCHAPTER 3. PROVIDER PARTICIPATION

10:49-3.1 Provider types eligible to participate

(a) The following provider types are eligible to participate as Medicaid and NJ FamilyCare-Plan A providers:

1. Case managers;
2. Certified nurse practitioners/clinical nurse specialists;
3. Chiropractors and/or chiropractic groups;
4. Clinics (independent outpatient health care facilities);
5. Clinical laboratories;
6. Dentists and/or dentist groups;
7. Hearing aid dealers;
8. Health maintenance organizations/managed care organizations;
9. Home health agencies;

10. Homemaker agencies;
11. Hospices;
12. Hospitals;
 - i. General;
 - ii. Psychiatric; and
 - iii. Special;
13. Local health departments;
14. Nursing facilities, including intermediate care facilities for the mentally retarded;
15. Medical suppliers;
16. Mental health rehabilitation providers;
17. Medical day care centers;
18. Nurse-midwives;
19. Opticians;
20. Optometrists;
21. Orthotists;
22. Pharmacies;
23. Physicians and/or physician groups;
24. Podiatrists and/or podiatric groups;
25. Prosthetists;
26. Psychologists and/or psychologist groups;
27. Residential treatment facilities;
28. Transportation providers; and
29. State and county agencies that have agreed to provide personal care assistant services.

(b) In order for professional practices to be eligible to participate in the Medicaid and NJ FamilyCare programs as specific provider entities, such practices shall comply with all applicable State licensing statutes and rules governing their ownership and direction.

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

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

Inserted new (a)1; recodified former (a)1 through 25 as (a)2 through 26; in (a)7, inserted reference to managed care organizations.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

In (a), inserted a reference to NJ KidCare—Plan A in the introductory paragraph.

Amended by R.1998 d.143, effective March 16, 1998.

See: 29 N.J.R. 543(a), 30 N.J.R. 1081(a).

In (a), inserted a new 12, and recodified former 12 through 26 as 13 through 27.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

Amended by R.2000 d.309, effective August 7, 2000.

See: 32 N.J.R. 1342(a), 32 N.J.R. 2900(a).

In (a), inserted a new 1, and recodified former 1 through 27 as 2 through 28.

Amended by R.2001 d.144, effective May 7, 2001.

See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).

Inserted new (a)16 and recodified former (a)16 through 28 as new (a)17 through 29.

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

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

Added (b).

Cross References

Regional Perinatal Centers and Community Perinatal Centers, providing services in accordance with this section, see N.J.A.C. 8:33C-4.2.

Case Management Program/Mental Health, providing services in accordance with this section, see N.J.A.C. 10:73-2.4.

10:49-3.2 Enrollment process

(a) Providers shall complete a Provider Application and sign a Provider Agreement (see Appendix, N.J.A.C. 10:49) or a specialized agreement, and submit such other information or documentation, including, but not limited to, social security number and date of birth, as the program may require, depending on the nature of the services provided.

1. Policies and rules pertaining to shared health care facilities are outlined in N.J.A.C. 10:49-4.

2. All practitioners participating in a group practice shall personally sign both the group application and the provider agreement if individual documents, or shall sign a single signature sheet if both documents are contained in a single packet.

(b) All providers shall be required to complete Form HCFA-1513, Ownership and Control Interest Disclosure Statement (see Appendix, Form #10) at the time of application or reapplication. In addition, at the time of application or reapplication, all professional practices must certify that they comply with all applicable State licensing statutes and rules governing their ownership and direction (see Appendix, Form #12). Providers prior to 1973 were not required to utilize provider agreement forms; however, they shall comply with all applicable State and Federal Title XIX and Title XXI laws, policies, rules and regulations.

1. As a condition of continued participation in the New Jersey Medicaid and NJ FamilyCare programs, a provider may, from time to time, be required to:

i. Complete a provider reenrollment application form and sign a provider participation agreement; and/or

ii. Complete a Form HCFA 1513, Ownership and Control Interest Disclosure Statement.

2. The New Jersey Medicaid program or NJ FamilyCare program shall terminate any existing agreement or contract if the provider fails to disclose information required by (b)1ii above.

xi. A statement as to whether or not the patient is expected to return for further treatment.

5. The Division shall have the right to inspect the business records, patient records, leases and other contracts executed by any provider in a shared health care facility. Such inspections may be by site visits to the shared health care facility.

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)4i, substituted a reference to Program Numbers for a reference to Medicaid Numbers.

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.

SUBCHAPTER 5. SERVICES COVERED BY MEDICAID AND THE NJ FAMILYCARE PROGRAMS

10:49-5.1 Requirements for provision of services

(a) The services listed in N.J.A.C. 10:49-5.2 are available to beneficiaries eligible for the regular New Jersey Medicaid or the NJ FamilyCare-Plan A programs. Services available to Medically Needy beneficiaries are listed in N.J.A.C. 10:49-5.3. The services listed in N.J.A.C. 10:49-5.2 and 5.3 shall be provided in conjunction with program requirements specifically outlined in the second chapter of each Provider Services Manual.

1. Any service limitations imposed will be consistent with the medical necessity of the patient's condition as determined by the attending physician or other practitioner and in accordance with standards generally recognized by health professionals and promulgated through the New Jersey Medicaid program. Some services require prior authorization from the program before the services are provided (see N.J.A.C. 10:49-6—Authorization Required).

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 "beneficiaries" for "recipients"; and in (a)1, inserted "prior" preceding "authorization".

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

In (a), inserted a reference to NJ KidCare—Plan A programs in the first sentence.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 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).

Case Notes

Phalloplasty was medically required treatment for gender dysphoria. M.K. v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 38.

Patient's possible Munchausen's syndrome was good cause for limiting medical services. D.S. v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 4.

10:49-5.2 Services available to beneficiaries eligible for, or children who are presumptively eligible for, the Medicaid and NJ FamilyCare-Plan A programs

(a) The services listed below are available to beneficiaries eligible for the Medicaid or NJ FamilyCare-Plan A program:

1. Case management services (Mental Health Program);
2. Certified nurse practitioner/clinical nurse specialist services;
3. Chiropractic services;
4. Religious non-medical health care services, (see Hospital Services Manual);
5. Clinic services such as services in an independent outpatient health care facility, other than hospital, that provides services such as Mental Health, Family Planning, Dental, Optometric, Ambulatory Surgery, FQHCs;
6. Dental services;
7. Environmental lead inspection services-rehabilitative services;
8. Early and Periodic Screening, Diagnosis, and Treatment for beneficiaries under age 21 (EPSDT): A preventative health care program for beneficiaries under age 21 designed for early detection, diagnosis and treatment of correctable abnormalities. This program supplements the general medical services otherwise available;
9. Family planning services including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling.
 - i. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered by the New Jersey Medicaid or NJ FamilyCare-Plan A program.
10. HealthStart maternity and pediatric care services include packages of comprehensive medical and health support services provided by independent clinics; hospital outpatient departments; local health departments meeting New Jersey Department of Health and Senior Services' improved pregnancy outcome criteria; physicians; and nurse midwives; either directly or through linkage with other HealthStart care providers. (See N.J.A.C. 10:49-19 for HealthStart services, policies and requirements for provider participation;)
11. Hearing aid services;

12. Home care services (home health care and personal care assistant services);
13. Hospice services including room and board services in a nursing facility (available to dually eligible Medicare/Medicaid or dually eligible Medicare/NJ FamilyCare-Plan A beneficiaries);
14. Hospital services—inpatient:
 - i. General hospitals;
 - ii. Special hospitals;
 - iii. Psychiatric hospitals (inpatient): Limited to persons age 65 or older and children 21 years of age and under; and
 - iv. Inpatient psychiatric programs for children 21 years of age and under;
15. Hospital services—outpatient;
16. Laboratory (clinical);
17. Medical day care services;
18. Medical supplies and equipment;
19. Mental health services, including mental health rehabilitation services provided in residential child care facilities (as defined in N.J.A.C. 10:127 and licensed by DYFS), children's group homes (as defined in N.J.A.C. 10:128 and licensed by DYFS), or psychiatric community residences for youth (as defined in N.J.A.C. 10:37B and licensed by DMHS);
20. Nursing facility services, including intermediate care facilities for the mentally retarded;
 - i. Any additional Intermediate Care Facility/Mental Retardation (ICF/MR) beds or new ICF/MR facilities shall be approved by the Division of Developmental Disabilities (DDD) prior to application for reimbursement as a Medicaid/NJ FamilyCare provider;
21. Nurse-midwifery services;
22. Optometric services;
23. Optical appliances;
24. Pharmaceutical services;
25. Physician services;
26. Podiatric services;
27. Prosthetic and orthotic devices;
28. Psychological services;
29. Radiological services;
30. Rehabilitative services (Payments are made to eligible Medicaid or NJ FamilyCare-Plan A providers only. No payment is made to privately practicing therapists);

- i. Physical therapy, as provided by a home health agency, independent clinic, nursing facility, hospital outpatient department, or in a physician's office;
- ii. Occupational therapy, as provided by a home health agency, independent clinic, nursing facility, or hospital outpatient department;
- iii. Speech-language pathology services, as provided by a home health agency, independent clinic, nursing facility, hospital outpatient department, or in a physician's office;
- iv. Audiology services provided in the office of a licensed specialist in otology or otolaryngology, or as part of independent clinic or hospital outpatient services; and
- v. School based rehabilitation services under EPSDT; and

31. Transportation services which include ambulance, mobility assistance vehicle, and other transportation provided by independent clinics or through arrangements with a county board of social services.

(b) All Medicaid and NJ FamilyCare Plan A beneficiaries shall be eligible to receive all of the services specified in (a) above fee-for-service during the presumptive eligibility period, and through the time that they select and are enrolled into a managed care organization, if managed care is applicable.

Amended by R.1994 d.600, effective December 5, 1994.

See: 26 N.J.R. 3345(a), 26 N.J.R. 4762(a).

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 "beneficiaries" for "recipients" throughout; in (a)4, inserted reference to FOHCs; in (a)8, amended Department name and N.J.A.C. reference; and in (a)28, deleted reference to livery transportation.

Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

In (a), inserted references to NJ KidCare—Plan A throughout.

Amended by R.1998 d.143, effective March 16, 1998.

See: 29 N.J.R. 543(a), 30 N.J.R. 1081(a).

In (a), inserted a new 6, and recodified former 6 through 28 as 7 through 29.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

Amended by R.2000 d.266, effective July 3, 2000.

See: 32 N.J.R. 159(a), 32 N.J.R. 2493(a).

Added (b).

Amended by R.2000 d.309, effective August 7, 2000.

See: 32 N.J.R. 1342(a), 32 N.J.R. 2900(a).

In (a), inserted a new 2, recodified former 2 through 26 as 3 through 27, inserted "services including" in the new 13, inserted a new 28, recodified former 27 through 29 as 29 through 31, added v in the new 30, and substituted a reference to mobility assistance vehicles for a reference to invalid coaches and substituted a reference to county boards of social services for a reference to county welfare agencies in the new 31.

Amended by R.2001 d.144, effective May 7, 2001.

See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).

Rewrote (a)19.

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

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

In (a), substituted "Religious non-medical health care services," for "Christian Science Sanatoria" in 4, added 20i.

10:49-5.3 Services available to beneficiaries eligible for the Medically Needy program

(a) Regular Medicaid services are available to Medically Needy beneficiaries except for the following services which are not available or are only available to certain eligible Medically Needy groups: (See the service code next to the beneficiary's name on the Medicaid Eligibility Identification Card to ascertain the Medically Needy group under which the beneficiary's eligibility was established; that is, Group A—pregnant women, Group B—needy children, and Group C—aged, blind and disabled.)

1. Chiropractic services are available only to pregnant women (Group A).
2. EPSDT services are not available to any Medically Needy group.
3. Hospital services (inpatient) are available only to pregnant women (Group A).
4. Nursing facility services are available to Medically Needy beneficiaries. For purposes of the Medically Needy program, nursing facility services include pharmacy services under Title XIX.
5. Medical day care services are available only to pregnant women, the aged, the blind and the disabled (Groups A and C).
6. Pharmaceutical services are available only to pregnant women and needy children (Groups A and B); and aged, blind or disabled beneficiaries who reside in Medicaid participating nursing facilities (see N.J.A.C. 10:51-2.10). Pharmaceutical services are not available to other aged, blind and disabled beneficiaries (Group C).
7. Podiatric services are available only to pregnant women, the aged, the blind and the disabled (Groups A and C).
8. Rehabilitative services are not available for reimbursement when provided through a hospital or nursing facility, except to pregnant women as part of their inpatient hospital services.
9. Case management services for the mentally ill are available to Medically Needy pregnant women only.
10. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical or clinic), drugs, laboratory services, radiological and diagnostic services and surgical procedures are not available to the Medically Needy group.

Amended by R.1994 d.600, effective December 5, 1994.

See: 26 N.J.R. 3345(a), 26 N.J.R. 4762(a).

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 "beneficiaries" and "beneficiary's" for "recipients" or "recipient's" throughout; in (a)4, substituted "beneficiaries" for "group" and inserted reference to pharmacy services; and in (a)6, inserted references to aged, blind or disabled beneficiaries.

Case Notes

Administrative Procedure Act notice requirement violated by freeze on Medicaid reimbursement rate increases. *Thomas Jefferson University Hospital v. Div. of Medical Assistance and Health Services*, 6 N.J.A.R. 127 (1981).

Hospital not entitled to hearing prior to decertification as Medicaid provider. *Preakness Hospital v. Div. of Medical Assistance and Health Services*, 3 N.J.A.R. 351 (1981).

Agency action in enforcing its regulations to deny ambulance service claims not arbitrary, capricious and unreasonable (Division's Final Decision). *Bergen Ambulance Services v. Hudson Cty. Medical Assistance Unit*, 2 N.J.A.R. 196 (1980).

10:49-5.4 Emergency medical services for aliens and prenatal care for specified pregnant alien women

(a) Most legal aliens who entered the United States on or after August 22, 1996 are restricted in their entitlement to emergency services for five years from their date of entry. Undocumented aliens and temporarily documented aliens, that is visitors, workers, and students, are also restricted in their entitlement to emergency services. These emergency medical services are only available to individuals who, except for their alien status, would be eligible for Medicaid, Medically Needy, New Jersey Care . . . Special Medicaid Programs, AFDC-related Medicaid, or NJ FamilyCare—Plan A. Applicants who would otherwise be eligible for NJ FamilyCare—Plans B, C and D are not eligible for these emergency medical services for aliens.

1. Except as noted in (a)2 below, emergency services are defined as care provided in an acute care general hospital (emergency outpatient services and/or inpatient services) for a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
 - i. Placing the patient's health in serious jeopardy;
 - ii. Serious impairment to bodily functions; or
 - iii. Serious dysfunction of any bodily organ or part.
2. For labor and delivery services, the place of service is not limited to an acute care general hospital. Services provided in birth centers are also eligible for reimbursement under this program.
3. Diagnoses are classified as emergency or non-emergency services in accordance with the above definition of an emergency. Those diagnoses that correspond with emergency care are defined as emergencies and thus do not require any authorization by the attending physician. Those diagnoses that correspond with urgent care require a Certification of Treatment of Emergency Medical Con-

dition signed by the attending physician confirming the emergency nature of the encounter to be attached to the claim when submitted for reimbursement.

i. Emergency care is provided for life-threatening or organ threatening, or potentially life or organ threatening condition that requires immediate care.

ii. Urgent care is provided for a condition that is potentially harmful to a patient's health and determined by the physician to be medically necessary for treatment within 12 hours to prevent deterioration.

4. To be eligible for emergency services, an alien meeting the medical criteria listed in (a)1 above must also meet all financial and categorical eligibility requirements for NJ FamilyCare-Plan A, Medicaid, Medically Needy, New Jersey Care . . . Special Medicaid Programs or AFDC-related Medicaid.

(b) Lawfully admitted aliens who entered the United States prior to August 22, 1996 and other aliens who are refugees, asylees, Cuban/Haitian entrants, American Indians born in Canada, Amerasian immigrants, and aliens who are honorably discharged or are on active duty in the Armed Forces of the United States and their spouses and unmarried dependent children, may qualify for full NJ FamilyCare-Plan A, Medicaid, Medically Needy, New Jersey Care . . . Special Medicaid Programs or AFDC-related Medicaid, if they meet all other programmatic eligibility requirements. These aliens should be referred to the appropriate eligibility determination agency of their choice to apply for full benefits. See N.J.A.C. 10:70-3.2(a), 10:71-3.3(c), 10:72-3.2(a), and 10:79-3.2(b).

(c) Legally admitted pregnant alien women who entered the United States on or after August 22, 1996, who would otherwise be eligible for New Jersey Care . . . Special Medicaid Programs, except for the alien requirements are also eligible for routine prenatal care services. Prenatal care includes services provided in the outpatient hospital department, or by a physician, certified nurse practitioner or certified nurse midwife, as well as laboratory, radiological and pharmaceutical services.

New Rule, R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).

Former N.J.A.C. 10:49-5.4., Services not covered by the Medicaid program, recodified to N.J.A.C. 10:49-5.5.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

Amended by R.1999 d.253, effective August 2, 1999.

See: 31 N.J.R. 97(a), 31 N.J.R. 2203(b).

Rewrote the section.
Emergency amendment R.1999 d.254, effective July 12, 1999 (to expire September 10, 1999).

See: 31 N.J.R. 2252(a).

Rewrote the section.
Adopted concurrent proposal, R.1999 d.345, effective September 10, 1999.

See: 31 N.J.R. 2252(a), 31 N.J.R. 2880(a).

Readopted provisions of R.1999 d.254 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 (a), inserted "in their entitlement" following "restricted" throughout.

10:49-5.5 Services not covered by the Medicaid or NJ FamilyCare-Plan A program

(a) Listed below are some general services and items excluded from payment under the New Jersey Medicaid and NJ FamilyCare-Plan A program. There are additional specific exclusions and limitations detailed in the second chapter of each Provider Services Manual. Payment is not made for the following:

1. Any service, admission, or item, which is not medically required for diagnosis or treatment of a disease, injury, or condition;
2. Services provided to all persons without charge; these services shall not be billed to the Medicaid program when provided for a Medicaid beneficiary. Services and items provided without charge through programs of other public or voluntary agencies (for example, New Jersey State Department of Health and Senior Services, New Jersey Heart Association, First Aid Rescue Squads, and so forth) shall be utilized to the fullest extent possible;
3. Any service or items furnished in connection with elective cosmetic procedures;
 - i. There are certain exceptions to this rule, but the exceptions require prior authorization. A written certification of medical necessity and a treatment plan shall be submitted by the physician to the appropriate Medicaid District Office for consideration;
4. Private duty nursing services (except for beneficiaries under EPSDT, Model Waiver III, ACCAP and ABC programs);
5. Services or items furnished for any sickness or injury occurring while the covered person is on active duty in the military;
6. Services provided outside the United States and territories;
7. Services or items furnished for any condition or accidental injury arising out of and in the course of employment for which any benefits are available under the provisions of any workers' compensation law, temporary disability benefits law, occupational disease law, or similar legislation, whether or not the Medicaid beneficiary claims or receives benefits thereunder, and whether or not any recovery is obtained from a third-party for resulting damages;
8. That part of any benefit which is covered or payable under any health, accident, or other insurance policy (including any benefits payable under the New Jersey no-fault automobile insurance laws), any other private or governmental health benefit system, or through any similar third-party liability, which also includes the provision of the Unsatisfied Claim and Judgment Fund;

9. Services or items furnished prior to or after the period for which the beneficiary presents evidence of eligibility for coverage.

i. Payment is made for inpatient hospital services (excluding governmental psychiatric hospitals) when ineligibility occurs after admission to hospital as an inpatient. Payment is also made for certain services that were authorized and initiated before loss of eligibility such as dental, vision care, prosthetics and orthotics, and durable medical equipment. Also, see "Retroactive Eligibility" at N.J.A.C. 10:49-2.7(c);

10. Any services or items furnished for which the provider does not normally charge;

11. Any admission, service, or item, requiring prior authorization, where prior authorization has not been obtained or has been denied (see N.J.A.C. 10:49-6, Authorizations required);

12. Services furnished by an immediate relative or member of the Medicaid beneficiary's household;

13. Services billed for which the corresponding health care records do not adequately and legibly reflect the requirements of the procedure described or procedure code utilized by the billing provider, as specified in the Provider Services Manual;

i. Final payment shall be made in accordance with a review of those services actually documented in the provider's health care record. Further, the medical necessity for the services must be apparent and the quality of care must be acceptable as determined upon review by an appropriate and qualified health professional consultant.

ii. All such determinations will be based on rules and regulations of the New Jersey Medicaid Program, the minimum requirements described in the appropriate New Jersey Medicaid Provider Services Manual, to include those elements required to be documented in the provider's records according to the procedure code(s) utilized for payment, and on accepted professional standards. (See N.J.A.C. 10:49-9.5, Provider Certification and Recordkeeping.)

iii. Any other evidence of the performance of services shall be admissible for the purpose of proving that services were rendered only if the evidence is found to be clear and convincing. "Clear and convincing evidence" of the performance of services includes, but is not limited to, office records, hospital records, nurses notes, appointment diaries, and beneficiary statements.

iv. Therefore, any difference between the amount paid to the provider based on the claim submitted and the Medicaid Agent's value of the procedure as determined by the Medicaid Agent's evaluation, may be recouped by the Medicaid Agent.

14. Any claim submitted by a provider for service(s) rendered, except in a medical emergency, to a Medicaid or a NJ FamilyCare-Plan A beneficiary whose Medicaid or NJ FamilyCare Eligibility Identification Card has a printed message restricting the beneficiary to another provider of the same service(s). (See N.J.A.C. 10:49-2.13(e)2, Special Status program);

15. Services or items reimbursed based upon submission of a cost study when there are no acceptable records or other evidence to substantiate either the costs allegedly incurred or beneficiary income available to offset those costs. In the absence of financial records, a provider may substantiate costs or available income by means of other evidence acceptable to the Medicaid Agent or the Division. If upon audit, financial records or other acceptable evidence are unavailable for these purposes:

i. All reported costs for which financial records or other acceptable evidence are unavailable for review upon audit are deemed to be non-allowable; and/or

ii. Beneficiary income shall be presumed to equal the maximum income allowable for a Medicaid or NJ FamilyCare beneficiary for those beneficiaries whose records relating to income are completely unavailable;

iii. The Medicaid Agent or the Division shall seek recovery of any resulting overpayments;

16. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical or clinic), drugs, laboratory services, radiological and diagnostic services and surgical procedures;

17. Claims for services, goods or supplies which are furnished, rendered, prescribed or ordered in violation of Federal or State civil or criminal statutes, or in violation of licensure statutes, rules and/or regulations; and

18. Any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the direction or on the prescription of a physician, individual or entity, during the period when such physician, individual or entity is excluded from participation in the Medicaid and NJ FamilyCare programs, and when the physician, individual or entity furnishing such item or service has received written notice from the Division that the physician, individual or entity has been excluded from participation in the Medicaid and NJ FamilyCare programs.

Amended by R.1994 d.600, effective December 5, 1994.

See: 26 N.J.R. 3345(a), 26 N.J.R. 4762(a).

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 "beneficiaries" and "beneficiary's" for "recipients" or "recipient's" throughout; in (a)2, inserted "; these services" preceding "shall not be billed" and amended Department name; in (a)4, inserted references to Model Waiver III, ACCAP and ABC programs; in (a)13iv and (a)15, substituted reference to Medicaid Agent for reference to Division.

Recodified from N.J.A.C. 10:49-5.4 and amended R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).

See: 30 N.J.R. 713(a).

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 a reference to the NJ KidCare-Plan A program in the first sentence, inserted a reference to NJ KidCare-Plan A beneficiaries and substituted a reference to NJ KidCare Eligibility Identification Cards for Eligibility Identification Cards in 14, inserted references to the Division throughout 15, and inserted a reference to NJ KidCare beneficiaries in 15ii.

Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.

See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).

Readopted provisions of R.1998 d.116 without change.

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.

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

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

In (a), added 17 and 18.

Cross References

Medical Day Center, verification of recipients eligibility as under this section, see N.J.A.C. 10:65-1.6.

Case Notes

Digital scale for applicant with morbid obesity was not an item for which Medicaid funds were available. R.S. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 65.

Extended care facility could not be reimbursed for care for Medicaid-ineligible patient. V.F. v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 29.

Hospital not entitled to hearing prior to decertification as medical provider. Preakness Hospital v. Div. of Medical Assistance and Health Services, 3 N.J.A.R. 351 (1982).

10:49-5.6 Services available to beneficiaries eligible for, and who are presumptively eligible for, NJ FamilyCare-Plan B or C

(a) Except for the exceptions at N.J.A.C. 10:79-6.5, which concern services for newborns enrolling into NJ FamilyCare-Plan C, the services listed below are available to beneficiaries eligible for NJ FamilyCare-Plan B or C, through an HMO selected by the NJ FamilyCare-Plan B or C beneficiary.

1. Audiology services;
2. Certified nurse practitioner services;
3. Chiropractic services;
4. Clinic services (services in an independent outpatient health care facility, other than hospital, that provides services such as, dental, optometric, ambulatory surgery, etc.);
5. Clinical nurse specialist services;
6. Dental services;
7. Durable medical equipment;

8. Early and periodic screening, and diagnosis examinations, dental, vision and hearing services. Includes only those treatment services identified through the examination that are available under the HMO contract or covered fee-for-service program;

9. Emergency room services;

10. Family planning services including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling;

i. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered by the New Jersey Medicaid or NJ FamilyCare program.

11. Federally qualified health center primary care services;

12. HealthStart maternity services, which is a package of comprehensive medical and health support services provided by the HMO;

13. Hearing aid services;

14. Home health care services;

i. Exception: personal care assistant services;

15. Hospice services;

16. Hospital services—inpatient:

i. General hospitals;

ii. Special hospitals; and

iii. Rehabilitation hospitals;

17. Hospital services—outpatient;

18. Laboratory (clinical);

19. Medical supplies and equipment;

20. Nurse-midwifery services;

21. Optometric services;

22. Optical appliances;

23. Organ transplant services, except the inpatient hospital services. Inpatient hospital services for organ transplants are covered fee-for-service;

24. Prescription drug services;

25. Physician services;

26. Podiatric services;

27. Prosthetic and orthotic devices;

28. Private duty nursing;

29. Radiological services;

30. Rehabilitative services, including physical, occupational and speech therapy, limited to 60 days per type of therapy per year; and

31. Transportation services, limited to ambulance, MICU's and invalid coach.

(b) The services listed below are available to beneficiaries eligible for NJ FamilyCare-Plan B or C under fee-for-service:

1. Religious non-medical health care institution care and services;

2. Clinic services (services in an independent outpatient health care facility, other than hospital) for family planning services, mental health or substance abuse treatment services;

3. Elective/induced abortion services;

4. Emergency room services for treatment of mental health disorder or for substance abuse;

5. Family planning services including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling;

i. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered;

6. Hospital services—inpatient;

i. Psychiatric hospitals;

ii. Inpatient psychiatric programs for children 19 years of age and under;

iii. Acute care or special hospital services if provided for mental health or substance abuse services;

iv. Organ transplant hospital services;

(1) All other transplant services are covered by HMO;

7. Mental health services provided by practitioners, such as physicians, psychologists, and certified nurse practitioners/clinical nurse specialists;

8. Nursing facility services, limited to the Medicare Part A copayments for the first 30 days of skilled nursing care;

9. Outpatient hospital services for family planning, mental health and substance abuse treatment services;

10. Substance abuse services provided by practitioners, including physicians, psychologists, certified nurse practitioners/clinical nurse specialists; and

11. Targeted case management services for the chronically ill.

(c) Services not covered under Plan B and C are as follows:

1. Unless listed in (a) and (b) above, no other services are covered by NJ FamilyCare-Plan B or C.

2. Services not covered include, but are not limited to:

i. Nursing facility services, except the Medicare Part A copayments for the first 30 days of skilled nursing care;

ii. Intermediate care facilities for mental retardation (ICFs/MR);

iii. Personal care services;

iv. Medical day care services;

v. Lower mode transportation;

vi. Mental health rehabilitation services provided in residential care facilities (as defined in N.J.A.C. 10:127 and licensed by DYFS), children's group homes (as defined in N.J.A.C. 10:128 and licensed by DYFS), or psychiatric community residences for youth (as defined in N.J.A.C. 10:37B and licensed by DMHS); and

vii. Any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the direction or on the prescription of a physician, individual or entity, during the period when such physician, individual or entity is excluded from participation in the Medicaid and NJ FamilyCare programs, and when the physician, individual or entity furnishing such item or service has received written notice from the Division that the physician, individual or entity has been excluded from participation in the Medicaid and NJ FamilyCare programs.

(d) All presumptively eligible NJ FamilyCare-Plan B and C beneficiaries shall be eligible to receive all the services specified in (a) and (b) above fee-for-service during the presumptive eligibility period, which shall include the services that are otherwise only available through the managed care organizations. The provision of the managed care services fee-for-service shall be limited to the presumptive eligibility period.

New Rule, R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

See: 30 N.J.R. 1060(a).

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.

Amended by R.2000 d.266, effective July 3, 2000.

See: 32 N.J.R. 159(a), 32 N.J.R. 2493(a).

Added (d).

Amended by R.2001 d.144, effective May 7, 2001.

See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).

Added (c)vi.

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)1, substituted "Religious non-medical health care institution" for "Christian Science sanatoria"; in (c), added "for youth (as defined in N.J.A.C. 10:37B and licensed by DMHS); and" at the end of vi and added vii.

10:49-5.7 Services available to beneficiaries eligible for NJ FamilyCare-Plan D

(a) Except as indicated at N.J.A.C. 10:79-2.5, which concerns services for newborns enrolling into NJ FamilyCare-Plan C and D, the services listed below are available to beneficiaries eligible for NJ FamilyCare-Plan D, when medically necessary and provided through the network of an HMO selected by the NJ FamilyCare-Plan D beneficiary.

1. Certified nurse practitioner and clinical nurse specialist services;
2. Clinic services (services in an independent outpatient health care facility, other than hospital, that provides covered ambulatory care services);
3. Preventive dental services for children under the age of 12 years, including oral examinations, oral prophylaxis and topical application of fluorides;
4. Emergency room services;
5. Family planning services including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling.
 - i. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered by the New Jersey FamilyCare program;
6. Federally qualified health center primary care services;
7. Home health care services, limited to skilled nursing for a home bound beneficiary which is provided or supervised by a registered nurse, and home health aide when the purpose of the treatment is skilled care, medical social services which are necessary for the treatment of the beneficiary's medical condition and short-term physical, speech or occupation therapy with the same limitations described in (a)22 below;
 - i. Personal care assistant services are not covered;
8. Hospice services;
9. Hospital services—inpatient;
10. Hospital services—outpatient;
11. Laboratory (clinical);
12. Nurse-midwifery services;

13. Optometric services, including one routine eye examination per year;

14. Optical appliances, limited to one pair of glasses or contact lenses per 24 month period;

15. Organ transplant services which are non-experimental or non-investigational, except the inpatient hospital services. Inpatient hospital services for organ transplants are covered fee-for-service;

16. Prescription drug services;

i. Exception: Over-the-counter drugs are not covered;

17. Physician services;

18. Podiatric services;

i. Exception: Coverage excludes routine foot care;

19. Prosthetic appliances, limited to initial provision of prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defect;

i. Coverage includes repair and replacement when due to congenital growth;

20. Outpatient surgery;

21. Radiological services;

22. Rehabilitative services, including physical, occupational and speech therapy for non-chronic conditions and acute illnesses and injuries. Outpatient rehabilitation benefits are limited to treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment per contract year;

i. Speech therapy services rendered for treatment of delays in speech development, unless resulting from disease, injury or congenital defects are not covered;

23. Transportation services, limited to ambulance for medical emergency only;

24. Well child care including immunizations, lead screening and treatments;

25. Maternity and related newborn care; and

26. Diabetic supplies and equipment.

(b) The services listed below are available to beneficiaries eligible for NJ FamilyCare-Plan D under fee-for-service.

1. Services for mental health or behavioral conditions;

i. Inpatient hospital services, including psychiatric hospitals, limited to 35 days per year;

ii. Outpatient benefits for short-term, outpatient evaluative and crisis intervention or home health mental health services, limited to 20 visits per year;

(1) When authorized by the Division of Medical Assistance and Health Services, inpatient benefit exchanges are allowed. One mental health inpatient day may be exchanged for up to four outpatient services, including partial care. This is limited to an exchange of up to a maximum of 10 inpatient days for a maximum of 40 additional out patient visits.

(2) When authorized by the Division of Medical Assistance and Health Services, inpatient benefit exchanges are allowed. One mental health inpatient day may be exchanged for two days of treatment in partial hospitalization up to the maximum number of covered inpatient days.

iii. Inpatient and outpatient services for substance abuse are limited to detoxification;

2. Inpatient hospital services for organ transplants that are non-experimental or non-investigational;

i. All other transplant services shall be covered by the HMO.

3. Skilled nursing facility services; and

4. Elective/induced abortion services.

(c) Services not covered under Plan D are as follows:

1. Unless listed in (a) and (b) above, no other services are covered by NJ FamilyCare-Plan D.

2. Services not covered include, but are not limited to:

i. Services that are not medically necessary;

ii. Private duty nursing unless authorized by the HMO;

iii. Intermediate care facilities for mental retardation (ICF/MR);

iv. Personal care assistant services;

v. Medical day care services;

vi. Chiropractic services;

vii. Dental services except for preventive dentistry for children under age 12;

viii. Orthotic devices;

ix. Targeted case management for the chronically ill;

x. Inpatient psychiatric programs for children age 19 years and under;

xi. Religious non-medical health care institution care and services;

xii. Durable medical equipment;

xiii. EPSDT services;

(1) Refer to (a)24 above concerning the coverage of well child care including immunizations, lead screening and treatments;

xiv. Routine transportation, including nonemergency ambulance, invalid coach and lower mode transportation;

xv. Hearing aid services;

xvi. Blood and blood plasma;

(1) Administration, processing of blood, processing fees and fees related to autologous blood donations are covered;

xvii. Cosmetic services;

xviii. Custodial care;

xix. Special and remedial educational services;

xx. Experimental and investigational services;

xxi. Infertility services;

xxii. Medical supplies;

(1) Diabetic supplies are a covered service;

xxiii. Rehabilitative services for substance abuse;

xxiv. Weight reduction programs or dietary supplements;

(1) Surgical operations, procedures or treatment of obesity, shall not be covered, except when specifically approved by the HMO;

xxv. Acupuncture and acupuncture therapy, except when performed as a form of anesthesia in connection with covered surgery;

xxvi. Temporomandibular joint disorder (TMJ) treatment, including treatment performed by prosthesis placed directly in the teeth;

xxvii. Orthotics;

xxviii. Recreational therapy;

xxix. Sleep therapy;

xxx. Court ordered services;

xxxi. Thermograms and thermography;

xxxii. Biofeedback;

xxxiii. Radial keratotomy; and

xxxiv. Any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the direction or on the prescription of a physician, individual or entity, during the period when such physician, individual or entity is excluded from participation in the Medicaid and NJ FamilyCare programs, and when the physician, individual or entity furnishing such item or service has received written notice from the Division that the physician, individual or entity has been excluded from participation in the Medicaid and NJ FamilyCare programs.

xxxiv. Mental health rehabilitation services provided in residential child care facilities (as defined in N.J.A.C. 10:127 and licensed by DYFS), children's group homes (as defined in N.J.A.C. 10:128 and licensed by DYFS), or psychiatric community residences for youth (as defined in N.J.A.C. 10:37B and licensed by DMHS).

New Rule, 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).

Amended by R.2001 d.144, effective May 7, 2001.

See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).

Added (c)2xxxiv.

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

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

In (c)2, substituted "Religious non-medical health care institution" for "Christian science sanatoria" in xi and added xxxiv.

10:49-5.8 Services available for beneficiaries eligible for NJ FamilyCare Plan H

(a) Childless adults whose income is below 100 percent of the Federal poverty level and who do not qualify for WFNJ/GA and who are enrolled in NJ FamilyCare on July 1, 2002 shall be eligible to receive the NJ FamilyCare Plan H service package.

(b) Out-of-plan community-based mental health services shall be limited to 60 service days per calendar year and shall be eligible for payment on a fee-for-service basis.

(c) No behavioral health out-of-plan service of any kind, where the place of service is a hospital, shall be a covered service.

(d) The services listed below shall be available to beneficiaries eligible for NJ FamilyCare Plan H, when medically necessary and when provided through the network of an HMO selected by the beneficiary;

1. Ambulance—emergency;
2. Ambulatory surgery;
3. Certified nurse practitioner/clinical nurse specialist;
4. Clinic services (free standing)—ambulatory;
5. Clinic services (free standing)—ESRD;
6. Clinic services (free standing)—family planning;
7. Diabetic supplies/equipment;
8. Emergency room;
9. Family planning services;
10. Federally qualified health centers (FQHC) encounters;
11. HealthStart maternity;
12. HMO services not otherwise specified herein;
13. Home health care services (limited benefits);
14. Hospice services—non-nursing facility based;

15. Inpatient hospital (non-behavioral health related);
16. Laboratory services;
17. Maternity services;
18. Nurse midwifery—nonmaternity;
19. Nurse midwifery services—maternity;
20. Organ transplantation;
21. Outpatient hospital (non-mental health related);
22. Optometric services (limited benefits);
23. Optical appliances (limited benefits);
24. Physician services;
25. Podiatric services;
26. Prescription drugs (excludes over the counter medications);
27. Private duty nursing (when authorized);
28. Prosthetic devices (limited benefits);
29. Psychological services (up to a maximum of 60 days of mental health services per calendar year); and
30. Radiological services.

(e) The following services shall be available to NJ FamilyCare Plan H beneficiaries on a fee-for-service basis:

1. Abortion (elective/induced);
2. Mental health services in the community, including psychological services, up to a maximum of 60 days per calendar year;
3. Outpatient rehabilitative services: speech therapy, occupational therapy and physical therapy, in an office, a hospital based clinic, an independent clinic, or by a home health agency; and
4. Skilled nursing services (limited benefits).
 - i. For individuals admitted to a skilled nursing facility, managed care shall be terminated in the month of admission, which shall result in the termination of eligibility for Plan H.

Special New Rule, R.2002 d.214, effective June 10, 2002.

See: 34 N.J.R. 2338(a).

10:49-5.9 Services available for beneficiaries eligible for NJ FamilyCare Plan G

General Assistance-eligible individuals shall receive Plan G services, which shall be those services delineated at N.J.A.C. 10:49-24.3.

Special New Rule, R.2002 d.214, effective June 10, 2002.

See: 34 N.J.R. 2338(a).

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

In (a), amended the N.J.A.C. references in the introductory paragraph and rewrote lii.

Case Notes

In computing hospital's charity care subsidy, the Department of Health and Senior Services acted within its discretion in using data provided by contractor that processed charity care claims, rather than using quarterly lists of charity care claims created by hospital, which had previously been used; hospital failed to identify any error in contractor's calculation of documented charity care costs. *University of Medicine and Dentistry of New Jersey v. Grant*, 778 A.2d 473 (2001).

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, within 60 days of such receipt, 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, within 60 days of such receipt, 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, within 60 days of receipt of any such overpayment or under payment, 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))".

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

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

In (a), inserted "within 60 days of such receipt" following "underpayment"; in (b), inserted "within 60 days of such receipt" following "paid in error"; in (c), rewrote the second sentence.

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.)

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

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

10:49-8.5 Outstanding checks

(a) After Medicaid checks are outstanding for a period of six months, a follow-up letter shall be sent to the payee. This procedure shall only apply to checks of \$5.00 or more.

(b) All Medicaid checks remaining outstanding after 12 months shall be cancelled in monthly lots rather than check by check. Listings of cancelled checks shall be in sufficient detail to identify providers and amounts of payment. These records shall be retained for audit.

SUBCHAPTER 9. PROVIDER AND BENEFICIARY'S RIGHTS AND RESPONSIBILITIES; ADMINISTRATIVE PROCESS

10:49-9.1 NJ FamilyCare-Plan C personal contribution to care and Plan D copayments

(a) Under NJ FamilyCare-Plan C, personal contribution to care in the amounts indicated below shall be collected by the provider for the services indicated below:

1. Outpatient hospital clinic services: \$5.00 personal contribution to care for outpatient visits. No personal contribution to care shall be charged for well-child visits in accordance with the schedule recommended by the American Academy of Pediatrics; lead screening and treatment; age-appropriate immunizations; prenatal care; preventive services; family planning services; or substance abuse treatment services. Specific policies are set forth at N.J.A.C. 10:52-4.7.

2. \$10.00 personal contribution to care for each covered emergency room services visit which does not result in an inpatient hospital stay.

3. Physician services: \$5.00 personal contribution to care per visit. No personal contribution to care shall be charged for well-child visits in accordance with the schedule recommended by the American Academy of Pediatrics; lead screening and treatment; age-appropriate immunizations; prenatal care; preventive or for family planning services, or substance abuse treatment services. Policies specific to physician personal contribution to care services are set forth at N.J.A.C. 10:54-4.1.

4. Clinic services: \$5.00 personal contribution to care for clinic visits. No personal contribution to care shall be charged for well-child visits in accordance with the schedule recommended by the American Academy of Pediatrics; lead screening and treatment; age-appropriate immunizations; prenatal care; preventive or for family planning services, or substance abuse treatment services. Policies specific to clinic personal contribution to care policies are set forth at N.J.A.C. 10:66-1.6.

5. Podiatric services: \$5.00 personal contribution to care for office visits. Specific policies regarding podiatric personal contribution to care are set forth at N.J.A.C. 10:57-1.7.

6. Optometric services: \$5.00 personal contribution to care for professional vision care services. Specific policies are set forth at N.J.A.C. 10:62-1.6.

7. Chiropractic services: \$5.00 personal contribution to care. Covered for spinal manipulation only.

8. Prescription drugs: \$1.00 personal contribution to care for generics and \$5.00 for brand name drugs. Includes insulin, needles and syringes. Specific policies regarding personal contribution to care for prescription drugs are set forth at N.J.A.C. 10:51-1.12.

9. Psychological services: \$5.00 personal contribution to care. Specific policies for psychologists are set forth at N.J.A.C. 10:67-1.6.

10. Certified nurse-midwife services: \$5.00 personal contribution to care. No personal contribution to care shall be charged for prenatal care, preventive care, or for family planning services. See N.J.A.C. 10:58-1.8 for specific policies related to certified nurse-midwife services.

11. Clinical nurse practitioner: \$5.00 personal contribution to care. No personal contribution to care shall be charged for well-child visits in accordance with the schedule recommended by the American Academy of Pediatrics; lead screening and treatment; age-appropriate immunizations; prenatal care; preventive or for family planning services, or substance abuse treatment services. Specific policies are set forth at N.J.A.C. 10:58A-1.6.

12. Dental services: \$5.00 personal contribution to care applies, unless the visit is for preventive dentistry services. Specific policies are set forth at N.J.A.C. 10:57-1.7.

(b) Providers are required to collect the personal contribution to care for the NJ FamilyCare-Plan C services set forth in (a) above if the NJ FamilyCare Identification card indicates that a personal contribution to care is required and the beneficiary does not have a NJ FamilyCare letter which indicates that the beneficiary has reached his or her cost share limit and no further personal contributions to care are required until further notice. Personal contributions to care can not be waived.

(c) Under NJ FamilyCare-Plan D, copayments in the amounts indicated below shall be collected by the provider for services as follows:

1. A \$5.00 copayment per visit shall be required for the following services:

i. Primary care provider office visit;

(1) A \$10.00 copayment shall apply for services rendered during non-office hours and for home visits.

(2) The \$5.00 copayment shall apply only to the first prenatal visit;

ii. Specialist and other practitioner office visit;

iii. Outpatient rehabilitation services, including physical therapy, occupational therapy and speech therapy;

iv. Hospital outpatient department visits and diagnostic testing;

v. Routine eye examinations;

vi. Prescription drugs;

(1) If greater than a 34-day supply of a prescription drug is dispensed, a \$10.00 copayment shall apply; and

vii. Outpatient substance abuse services for detoxification;

2. A \$25.00 copayment per visit shall be required for outpatient mental health visits; and

3. A \$35.00 copayment per visit shall be required for outpatient emergency services, including services provided in an outpatient hospital department or an urgent care facility.

i. No copayment shall be required if the beneficiary was referred to the emergency room by his or her primary care provider for services that should have been rendered in the primary care physician's office, or if the beneficiary is admitted into the hospital.

4. No copayment shall be charged for the following services:

- i. Emergency ambulance services;
- ii. Outpatient surgery;
- iii. Home health services;
- iv. Hospice services;
- v. Inpatient hospital services;
- vi. Inpatient mental health services;
- vii. Inpatient substance abuse detoxification services; or
- viii. Skilled nursing facility services.

(d) Personal contributions to care under NJ FamilyCare-Plan C and copayments under NJ FamilyCare-Plan D shall be effective upon date of enrollment.

1. Exception: A personal contribution to care or copayment shall not apply to services rendered to a newborn until the newborn is enrolled in a managed care program.

(e) No personal contribution to care under NJ FamilyCare-Plan C shall be charged for well-child visits in accordance with the schedule recommended by the American Academy of Pediatrics; lead screening and treatment; age-appropriate immunizations; preventive dental services; prenatal care; for family planning services; or for substance abuse treatment services.

(f) No copayment under NJ FamilyCare-Plan D will be charged for well-child visits in accordance with the schedule recommended by the American Academy of Pediatrics; nor for lead screening and treatment; for age-appropriate immunizations; or for preventive dental services.

(g) No cost sharing shall be imposed on children who are American Indians/Alaska Natives. Proof of Federally recognized AI/AN tribal status shall be provided in the form of a tribal card or letter, in accordance with 42 C.F.R. 36a.16.

New Rule, 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. 10:49-9.1, Civil Rights, recodified to N.J.A.C. 10:49-9.4.

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.

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).

Added a new (c); recodified former (c) and (d) as (d) and (e); added (f).

Amended by R.2002 d.371, effective November 18, 2002.

See: 34 N.J.R. 2244(a), 34 N.J.R. 2549(b), 34 N.J.R. 3978(c).

Added (g).

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

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

10:49-9.2 NJ FamilyCare-Plan C and D—premiums

(a) For children in families with income at or below 150 percent of the Federal poverty limit, there shall be no premiums under NJ FamilyCare-Plan B.

(b) For children in families with gross income above 150 percent and at or below 200 percent of the Federal poverty level (NJ FamilyCare-Plan C), a monthly premium shall be required to be paid for enrollment. There shall be a single premium of \$15.00 per family per month that applies to all families, regardless of income and regardless of the number of children in the family.

(c) Under NJ FamilyCare-Plan D, the following premiums shall apply:

1. For children in families with gross income above 200 percent and at or below 250 percent of the Federal poverty level, a single monthly premium of \$30.00 per family per month that applies to all families, regardless of the number of children in the family.

2. For children in families with gross income above 250 percent and at or below 300 percent of the Federal poverty level, a single monthly premium of \$60.00 per family per month that applies to all families, regardless of the number of children in the family.

3. For children in families with gross income above 300 percent and at or below 350 percent of the Federal poverty level, a single monthly premium of \$100.00 per family per month that applies to all families, regardless of the number of children in the family.

(d) Families shall be billed in advance of the coverage month. Failure to submit the full contribution will result in termination of coverage for the month following the coverage month that the premium has not been received by the NJ FamilyCare program.

(e) No cost sharing shall be imposed on children who are American Indians/Alaska Natives. Proof of Federally recognized AI/AN tribal status shall be provided in the form of a tribal card or letter, in accordance with 42 C.F.R. 36a.16.

New Rule, 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. 10:49-9.2, Observance of religious belief, recodified to N.J.A.C. 10:49-9.5.

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.

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).

Added a new (c); recodified former (c) as (d).

Amended by R.2002 d.371, effective November 18, 2002.

See: 34 N.J.R. 2244(a), 34 N.J.R. 2549(b), 34 N.J.R. 3978(c).

Added (e).

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

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

10:49-9.3 Limitation on cost sharing—Plan C

(a) There shall be a family limit on cost-sharing equal to 5 percent of household income for Plan C beneficiaries.

(b) The cost-sharing limit shall be calculated annually starting with the date of initial enrollment of any children in the family or the annual reenrollment date. For ease of administration, the annual premium should be calculated by the Statewide eligibility determination agency and used to reduce the family cost from the first day of enrollment.

(c) Once the limits have been met, the Statewide eligibility determination agency shall issue a certification indicating that the Plan C member has met their cost share limit, and the provider shall not collect a personal contribution to care until further notice.

(d) No cost sharing shall be imposed on children who are American Indians/Alaska Natives. Proof of Federally recognized AI/AN tribal status shall be provided in the form of a tribal card or letter, in accordance with 42 C.F.R. 36a.16.

New Rule, 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. 10:49-9.3, Free choice of beneficiary and provider, recodified to N.J.A.C. 10:49-9.6.

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.2002 d.371, effective November 18, 2002.

See: 34 N.J.R. 2244(a), 34 N.J.R. 2549(b), 34 N.J.R. 3978(c).

Added (d).

10:49-9.4 Civil rights

Federal regulations require that services provided to any Medicaid beneficiary shall be given without discrimination on the basis of race, color, national origin, or handicap. Therefore, payments shall be limited to providers of service who are in compliance with the nondiscrimination requirements of Title VI of the Civil Rights Act and Section 504 of the Rehabilitation Act of 1973.

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".

Recodified from N.J.A.C. 10:49-9.1 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. 10:49-9.4, Confidentiality of records, recodified to N.J.A.C. 10:49-9.7.

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.

10:49-9.5 Observance of religious belief

(a) Nothing in the Medicaid program shall be construed to require any beneficiary to undergo any medical screening, examination, diagnosis, or treatment, or to accept any other health care or services provided under the program for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health) if such person or his or her parent or guardian objects thereto on religious grounds, except as specified in (b) below.

(b) If a physical examination is necessary to establish eligibility based on disability or blindness, the Medicaid Program may not find an individual eligible for Medicaid unless he or she undergoes the examination.

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".

Recodified from N.J.A.C. 10:49-9.2 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. 10:49-9.5, Provider certification and recordkeeping, recodified to N.J.A.C. 10:49-9.8.

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.

10:49-9.6 Free choice by beneficiary and provider

(a) The concept of freedom of choice shall apply to both provider and beneficiary.

1. A Medicaid fee-for-service beneficiary shall be free to choose providers of service who meet program standards and who elect to participate in the Medicaid program. The MACC shall assist any beneficiary in obtaining services if the beneficiary cannot locate a provider. Exception: See N.J.A.C. 10:49-14.2, Special Status programs.

2. A Medicaid provider who accepts a Medicaid beneficiary as a patient under the Medicaid program shall accept the program's policies and reimbursement for all covered services and/or items provided or delivered during that period when, by mutual agreement, the beneficiary is under the provider's care. In the provision of professional services, the provider shall be bound by the code of ethics governing his or her profession.

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" for "recipient" throughout; in (a)1, substituted "fee-for-service beneficiary" for "recipient"; and in (a)2, substituted "a Medicaid provider who accepts a Medicaid beneficiary as a patient under the Medicaid program" for "A provider who accepts a recipient for care".

Recodified from N.J.A.C. 10:49-9.3 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. 10:49-9.6, Patient's (beneficiary) certification, recodified to N.J.A.C. 10:49-9.9.

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).

10:49-9.7 Confidentiality of records

(a) All information concerning applicants and beneficiaries acquired under this program shall be confidential and shall not be released without the written consent of the individual or his or her authorized representative. If, because of an emergency situation, time does not permit obtaining consent before release, the program shall notify the individual, his or her family, or authorized representative, immediately after releasing the information.