3. Individuals already enrolled in, or covered by, either a Medicare or commercial MCO, shall not be enrolled in a contractor's plan, unless the contractor and the Medicare or commercial MCO are the same;

4. Individuals in the Medicaid Pharmacy Lock-in, Provider Warning, or Hospice programs (see "Special Status" requirements at N.J.A.C. 10:49-14.2, and general hospice requirements at N.J.A.C. 10:53A);

5. Individuals in Medicaid eligibility categories other than those specified in N.J.A.C. 10:74-8.1;

6. Individuals eligible through the Division of Youth and Family Services who are not in foster care:

i. All individuals eligible through DYFS shall be considered a unique case and shall be issued an individual 12 digit identification number and shall be enrolled in his or her own right.

7. Children awaiting adoption through a private agency;

8. Individuals identified as having more than one active eligible Medicaid number; and

9. Dual Medicare/Medicaid eligibles.

(b) Individuals included under the same Medicaid case number where one or more of household member(s) are exempt shall be excluded from automatic assignment and shall not be allowed to voluntarily enroll in managed care.

(c) NJ FamilyCare applicants shall be exempt from automatic assignment, but they are not covered for medical services until they select and enroll in a managed care plan.

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.
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.370, effective September 18, 2000 (operative October 1, 2000).
32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
Rewrote section.
Amended by R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).
Rewrote (a)4 and (a)6; in (c), substituted "from" for "for"; substituted "FamilyCare" for "KidCare" and "MCO" for "HMO" throughout.

10:74-8.4 Reasons for exemptions from mandatory managed care

(a) Exemptions from managed care shall not apply to NJ FamilyCare non-Plan A individuals or to individuals who have been enrolled in any contractor's plan for more than 180 days. All exemption requests are reviewed by DMAHS on a case-by-case basis. Individuals may be exempted by DMAHS from enrollment in a contractor's plan for the following reasons:

1. First time Medicaid/NJ FamilyCare-Plan A applicants who are pregnant women, beyond the first trimester, who have an established relationship with an obstetrician who is not a participating provider in any contractor's plan. These individuals will be tracked and enrolled at 60 days postpartum;

2. Individuals with a terminal illness who have an established relationship with a physician who is not a participating provider in any contractor's plan;

3. Individuals with a chronic, debilitating illness or disability who have received treatment from a physician and/or team of providers with expertise in treating that illness with whom the individuals have an established relationship (greater than 12 months) and who are not participating in any contractor's plan; and there is no reasonable alternative, as determined by DMAHS at its sole discretion, on a case by case basis.

i. To request an exemption, the individuals or authorized persons shall provide written documentation identifying all of the providers who provide regular, ongoing care and who shall certify their continued involvement in the care of these individuals. Documentation shall also be provided detailing how and who will provide medical management for the individual.

ii. A temporary exemption may be granted by the Division to allow the contractor time to contract with a specific specialist needed by an enrollee with whom there is a long-standing established relationship (greater than 12 months) and there is no equivalent specialist available in the network. The contractor shall establish appropriate contractual/referral relations with any or all specialists needed to accommodate the needs of enrollees with special needs;

4. Individuals who do not speak English or Spanish (who shall not be automatically exempt from initial enrollment) and who meet the following criteria:

i. Have an illness requiring on-going treatment;

ii. Have an established relationship with a physician who speaks their primary language; and

iii. There is no available primary care provider in any of the participating managed care plans who speaks the beneficiary's language; and

5. Individuals who do not have a choice of at least two PCPs within 30 miles of their residence.

(b) Exemptions from managed care for DYFS children in foster care may be granted in the following circumstances or for the following reasons:

1. The child is in short-term placement (up to two months);

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2. The child is residing in a Special Home Service Provider (SHSP) home;

3. The child's primary care provider does not participate in any MCO;

4. There is a demonstrated disruption of the child's existing network of health care providers which would occur upon enrollment in managed care; or

5. There are no MCO providers in the foster home's area.

(c) If a beneficiary does not exercise his or her option to voluntarily select an MCO within a specified time period, the State will assign the beneficiary to an MCO.

(d) If a beneficiary is granted an exemption, he or she will continue to receive Medicaid or NJ FamilyCare-Plan A services from Medicaid providers in the fee-for-service setting.

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 (c), inserted a reference to NJ KidCare—Plan 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.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
Rewrote (a).
Amended by R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).
Rewrote section.

10:74-8.5 Coverage prior to enrollment

If the beneficiary needs Medicaid or NJ FamilyCare-Plan A covered services from the date of eligibility prior to the completion of the enrollment process, care shall be given by fee-for-service providers enrolled in the New Jersey Medicaid or NJ FamilyCare program. These providers shall bill Medicaid or NJ FamilyCare under the normal fee-for-service system, in accordance with N.J.A.C. 10:49-8.

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 throughout, and inserted a reference to NJ KidCare—Plan A covered services 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.2000 d.287, effective July 3, 2000.
See: 32 N.J.R. 1345(a), 32 N.J.R. 2498(a).
Substituted a reference to fee-for-service providers for a reference to providers.
Amended by R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).
Substituted "FamilyCare" for "KidCare" throughout, and "shall" for "should" in the last sentence.

10:74-8.6 Coverage after enrollment

(a) The MCO shall issue an identification card to the beneficiary indicating the effective enrollment date in the MCO.

(b) Beneficiaries shall consult their primary care provider (PCP)/APN for necessary medical care and services.

(c) The PCP/APN shall provide all necessary treatment or make the appropriate referral.

Amended by R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).
Substituted "MCO" for "HMO" in (a), "provider" for "physician" in (b), and "APN" for "CNP/CNS" in (b) and (c).

10:74-8.7 Protecting managed care enrollees against liability for payment

(a) If a fee-for-service or managed care provider, whether or not a participant in a program administered in whole or in part by the Division of Medical Assistance and Health Services (DMAHS), renders a covered service to a beneficiary of a program administered in whole or in part by DMAHS, including, but not limited to, the WorkFirst NJ/General Assistance, Medicaid or NJ FamilyCare program, the provider's sole recourse for payment, other than collection of any authorized cost-sharing and/or third party liability, shall be either DMAHS or the MCO with which DMAHS contracts that serves the beneficiary. A provider shall not seek payment from, and shall not institute or cause the initiation of collection proceedings or litigation against, a beneficiary, a beneficiary's family member, any legal representative of the beneficiary, or anyone else acting on the beneficiary's behalf unless (a)1 below, or (a)2 through and including 7, below, apply:

1. The beneficiary has been paid for the service by a health insurance company or other third party (as defined in N.J.S.A. 30:4D-3.m.), and the beneficiary has failed or refused to remit to the provider that portion of the third party's payment to which the provider is entitled by law; or

2. Either:

i. The service is not a covered service;

ii. The service is determined to be medically unnecessary before it is rendered; or

iii. The provider does not participate in the aforementioned programs either generally or for that service;

3. The beneficiary is informed in writing before the service is rendered that one or more of the conditions listed in (a)2 above exists and voluntarily agrees in writing before the service is rendered to pay for all or part of the provider's charges;

4. The service is not an emergency or related service covered by the provisions of 42 U.S.C. §1396u-2(b)(2)(A)(ii), 42 CFR 438.114 and/or N.J.A.C. 10:74-9.1;

5. The service is not a trauma service covered by the provisions of N.J.A.C. 8:38-6.3(a)3i;

6. The protections afforded to beneficiaries under 42 U.S.C. §1396u-2(b)(6), 42 CFR 438.106, N.J.A.C. 8:38-9.1(d)9 and/or N.J.A.C. 8:38-15.2(b)7ii do not apply; and

7. The provider has received no program payments from either DMAHS or the beneficiary's MCO for the service.

New Rule, R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).

SUBCHAPTER 9. EMERGENCY SERVICES

10:74-9.1 Emergency services

(a) The contractor shall, on a 24-hour-a-day, seven-day-a-week basis, make available emergency services, that is, those services within or outside of the contractor's enrollment area, required to be provided to an enrollee as a result of an onset of a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in placing the health of the person or others in serious jeopardy; serious impairment to such person's bodily functions; serious dysfunction of any bodily organ or part of such person, or serious disfigurement of such person. With respect to a pregnant woman who is having contractions, an emergency exists when there is inadequate time to effect a safe transfer to another hospital before delivery or when such a transfer may pose a threat to the health or safety of the woman or unborn child. Emergency services shall also include:

1. Medical examinations at an emergency room for suspected physical/child abuse and/or neglect.

2. Medical examinations at an emergency room in accordance with N.J.A.C. 10:122D-2.5(b) when a foster home placement of a child occurs after business hours.

3. In regard to post-stabilization of care, the contractor shall comply with 42 CFR 422.113(c) incorporated herein by reference, as amended and supplemented. The contractor shall cover post-stabilization services without requiring authorization and regardless of whether the enrollee obtains the services within or outside the contractor's network, if:

i. The services were pre-approved by the contractor or its providers;

ii. The services were not pre-approved by the contractor because the contractor did not respond to the provider of post-stabilization care services' request for pre-approval within one hour after being requested to approve such care; or

iii. The contractor could not be contacted for pre-approval.

(b) The contractor shall give the enrollee an explanation of where and how 24 hour a day emergency medical care and out-of-area coverage is available, and shall explain to the enrollee the procedure for obtaining treatment for emergency care.

(c) Emergency services, as distinguished at (a) above, are covered services, even if they have not been authorized by the MCO.

(d) The contractor shall be responsible for developing procedures for review and approval by DMAHS and for advising its enrollees of procedures for obtaining emergency services when it is not medically feasible for enrollees to receive emergency services from or through a participating provider or when the time required to reach the participating provider would mean risk of permanent damage to the enrollee's health. The contractor shall bear the cost of providing emergency service through non-participating providers.

(e) Prior authorization shall not be required for emergency services.

(f) The contractor shall pay for all medical screening services rendered to its members by hospitals and emergency room physicians. The amount and method of reimbursement for medical screenings shall be subject to negotiations between the contractor and the hospital and directly with non-hospital-salaried emergency room physicians and shall include reimbursement for urgent care and non-urgent care rates. Non-participating hospitals may be reimbursed for hospital costs at Medicaid rates or other mutually agreeable rates for medical screening services. Additional fees for additional services may be included at the discretion of the contractor and the hospital.

1. The managed care entity shall be liable for payment for the following emergency services provided to an enrollee:

i. If the medical screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists, the managed care entity shall pay for both the services involved in the screening examination and the services required to stabilize the patient.

ii. All emergency services which are medically necessary until the clinical emergency is stabilized. This includes all treatment that is necessary to assure, within reasonable medical probability, that material deterioration of the patient's condition is not likely to result from, or occur during, discharge of the patient or transfer of the patient to another facility. If there is a disagreement between a hospital and the contractor concerning whether the patient is stable enough for

discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the member at the treating facility shall prevail and be binding upon the contractor. The contractor may establish arrangements with hospitals whereby the contractor may send one of its own physicians with appropriate ER privileges to assume the attending physician's responsibilities to stabilize, treat, or transfer the patient.

iii. If the medical screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, but the enrollee had acute symptoms of sufficient severity at the time of presentation to warrant emergency attention under the prudent layperson standard, the MCE shall pay for all services involved in the medical screening examination.

iv. If the enrollee's PCP or other plan representative instructs the enrollee to seek emergency care in-network or out-of-network, whether or not the patient meets the prudent layperson standard.

2. The managed care entity shall not retroactively deny a claim for an emergency medical screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, was subsequently determined to be non-emergency in nature.

(g) Prior authorization for medical screenings and urgent care shall not be required. This provision shall apply to out-of-network as well as in-network providers. The hospital emergency room physician may determine the necessity to contact the PCP or the contractor for information about a patient who presents with an urgent condition. The PCP shall be called if the patient is to be admitted.

(h) The contractor's agreement with the hospital must require the hospital to notify the contractor of a hospital admission through the emergency room within 24 to 72 hours of the admission.

(i) The contractor's agreement with the hospital must require the hospital to notify the contractor of all of its members who present in the emergency room for non-emergent care who have been medically screened but not admitted as an inpatient within 24 to 72 hours of the rendered service. The contractor and the hospitals will negotiate how this notification shall occur.

(j) The contractor shall not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms.

(k) Women who arrive at any emergency room in active labor shall be considered as an emergency situation and the contractor shall reimburse providers of care accordingly.

(*l*) Non-contracted hospitals providing emergency services to Medicaid or NJ FamilyCare members enrolled in the managed care program shall accept, as payment in full, the amounts that the non-contracted hospitals would receive from Medicaid for the emergency services and/or any related hospitalization as if the beneficiary were enrolled in FFS Medicaid.

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).
Rewrote the section.
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.2000 d.370, effective September 18, 2000 (operative October 1, 2000).
32 N.J.R. 1352(a), 32 N.J.R. 3426(a).
Rewrote (a) and (f); and in (g), inserted a new second sentence.
Amended by R.2006 d.17, effective January 3, 2006.
See: 37 N.J.R. 2787(a), 38 N.J.R. 294(d).
In the introductory paragraph of (a), substituted "or when such a" for "; or the" in the second sentence; rewrote (a)2; in (a)3, corrected C.F.R. reference; in (c), substituted "MCO" for "HMO"; in (g), substituted "shall" for "must"; rewrote (j); added (*l*).

SUBCHAPTER 10. MEDICAL RECORDS; PEER REVIEW AND QUALITY ASSURANCE

10:74-10.1 Medical records

(a) Each contractor shall maintain a medical record on each member who has received medical services while enrolled in the contractor's plan, and shall retain such records in accordance with 45 CFR Part 74 and applicable Federal and State law and rule.

(b) Each enrollee's medical records shall be kept in detail consistent with applicable Federal and State requirements and good medical and professional practice, based on the service provided.

(c) Each contractor shall conform to the standards of confidentiality of information mandated for Federal and State officials (Section 1902(a)(7) of the Federal Social Security Act, 42 CFR Part 438 as included herein by reference, as amended and supplemented, N.J.S.A. 30:4D-7(g), and N.J.A.C. 10:49-9.7 and 9.8).

(d) Medical records of enrollees shall be sufficiently complete to permit subsequent peer review or medical audit. All required records, either originals or reproductions thereof, shall be maintained in legible form and readily available to appropriate Division professional staff or its agents, upon request for review, audit and evaluation by professional medical, nursing and investigative staff, in accordance with appropriate Federal and State laws, rules and regulations.

(e) The contractor shall release medical records of enrollees, as may be directed by authorized personnel of the