CHAPTER 49

ADMINISTRATION MANUAL

Authority

N.J.S.A. 30:4D-1 et seq., specifically 6, 7 and 12, 30:4I-5, 30:4I-6, 30:4I-8 et seq., 30:6E-1 et seq., and 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

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 49, Administration Manual, expires on July 20, 2008. See: 40 N.J.R. 984(a).

Chapter Historical Note

Chapter 49, Administration, was adopted and became effective prior to September 1, 1969. Subchapters 1 through 6 were amended by R.1977 d.213, effective July 1, 1977. See: 9 N.J.R. 123(b), 9 N.J.R. 342(c).

Pursuant to Executive Order No. 66(1978), Chapter 49, Administration, was readopted as R.1990 d.390. See: 22 N.J.R. 1512(a), 22 N.J.R. 2313(a).

Chapter 49, Administration, was repealed and a new Chapter 49, Administration, was adopted by R.1992 d.317, effective August 17, 1992.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 Subchapter 19, Prepaid Health Care Services: Medicaid Eligibles, was repealed by R.1995 d.337, effective June 19, 1995.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. See: Source and Effective Date. See, also, section annotations. 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).

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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.

"Adult mental health rehabilitation services provided in/by community residence programs" means community residential mental health services provided in/by any community residential program licensed by, and under contract with, the Division of Mental Health Services (DMHS), which provides services in accordance with N.J.A.C. 10:37A. These services include assessment and evaluation; individual service coordination; training in daily living skills; residential counseling; life support services and crisis intervention services.

"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.

"Community residences for mentally ill adults" means any community residential program licensed by the Division of Mental Health Services in accordance with N.J.A.C. 10:37A. "Community residences for mentally ill adults" does not include supportive housing residences as defined at N.J.A.C. 10:37A–1.2 and 10:77A–1.2.

"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.

"Managed care service administrator" means an entity in a non-risk based financial arrangement that contracts to provide a designated set of services for an administrative fee. Services provided may include, but are not limited to: medical management, claims processing, and provider network maintenance.

"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.

"NJ FamilyCare Plan D for adults" means the State-operated program which provides a benefit package through managed care organizations, supplemented by services provided on a fee-for-service basis, to specified parents/caretakers of children enrolled in NJ FamilyCare, in accordance with N.J.A.C. 10:49–5.7, 10:78–7.1 and this chapter.

"NJ FamilyCare Plan I" means the State-operated program which provides a Plan D benefit package on a fee-for-service basis to specified parents/caretakers of children enrolled in NJ FamilyCare, in accordance with N.J.A.C. 10:78–7.1 and this chapter.

"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.

"Programs of Assertive Community Treatment (PACT)" means mental health rehabilitative services which are delivered in a self-contained treatment program, provided by a service delivery team and managed by a qualified program director, that merge clinical and rehabilitative expertise to provide mental health treatment, rehabilitation, and support services which are individualized and tailored to the unique needs and choices of the individual receiving the services.

"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.

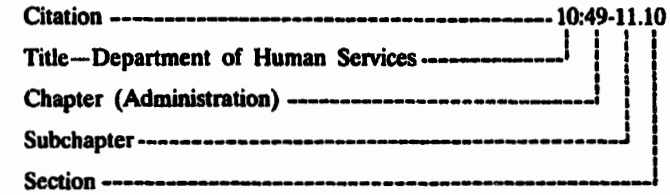
Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In "Fiscal agent" inserted a reference to the NJ KidCare program; and inserted "NJ KidCare", "NJ KidCare—Plan A", and "Programs".
Amended by R.1998 d.154, effective February 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 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.
Special amendment, R.2003 d.98, effective January 31, 2003.
See: 35 N.J.R. 1303(a).
Inserted "NJ FamilyCare Plan D for adults" and "NJ FamilyCare Plan I".
Amended by R.2003 d.89, effective March 3, 2003.
See: 34 N.J.R. 1593(a), 35 N.J.R. 1281(a).
Added "Programs of Assertive Community Treatment (PACT)".
Special amendment, R.2003 d.417, effective September 26, 2003 (operative November 1, 2003).
See: 35 N.J.R. 4913(a).
Added "Managed care service administrator".
Amended by R.2004 d.8, effective January 5, 2004.
See: 35 N.J.R. 2620(a), 35 N.J.R. 4204(a), 36 N.J.R. 189(a).
Added "Adult mental health rehabilitation services provided in/by community residence programs" and "Community residences for mentally ill adults".

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—Advanced Practice Nurse;
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).
Amended by R.2004 d.334, effective September 7, 2004.
See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).
In (d), rewrote 11.

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).

Substituted "Medicaid beneficiaries" for "Medicaid recipients" and added Home and Community-Based Services Waiver Programs category.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

10:49–2.2 Persons eligible under the New Jersey Medicaid program

(a) The eligibility rules for persons eligible under the regular New Jersey Medicaid program are included in N.J.A.C. 10:69, 10:70, 10:71, 10:72, 10:78 and 10:79.

(b) The following groups may be eligible for medical and health services covered under the New Jersey Medicaid program requirements as outlined in the second chapter of each Provider Services Manual. The list is not all inclusive but is intended to provide an overview of some of the types of individuals who may be eligible for Medicaid benefits, when provided in accordance with the requirements of N.J.A.C. 10:69, 10:70, 10:71, 10:72, 10:78 and 10:79, as appropriate.

1. Persons who are eligible to receive Supplemental Security Income (SSI) payments as determined by the Social Security Administration and those persons who meet the SSI standards but apply for the Medicaid Only program through the CBOSS. Those persons are the aged (65 and over), the blind, and the disabled;

2. A person who qualifies under the Supplemental Security Income (SSI) program as the "ineligible spouse" of an SSI beneficiary determined by the Social Security Administration;

3. For a period of one year, a child born to a woman who is a Medicaid beneficiary, so long as the woman remains eligible for Medicaid, or would remain eligible if pregnant;

4. Persons for whom adoption assistance agreements are in effect pursuant to Section 473 of the Social Security Act (42 U.S.C. § 673) or for whom foster or adoption assistance is paid under Title IV-E of the Act;

5. Persons ineligible for Supplemental Security Income (SSI) because of requirements that do not apply under Medicaid;

6. Persons receiving only mandatory State supplemental payments administered by the Social Security Administration;

7. Certain former beneficiaries of Supplemental Security Income (SSI) who would still be eligible for SSI except for entitlement to or increase in the amount of Social Security benefits;

8. Persons eligible for but not receiving TANF or an optional State benefit;

9. Children under the age of 21 years who meet the income and resource requirements for TANF but do not qualify as dependent children;

10. Persons who are in institutions for at least 30 consecutive days and who are eligible under a special income level (the Medicaid "cap") that is higher than the income level for a noninstitutionalized SSI or State supplement beneficiary;

11. Pregnant women and children up to the age one whose income is below 185 percent of the Federal poverty level, and children up to the age of six whose income is below 133 percent of the Federal poverty level, codified as 42 U.S.C. § 1396a, or 1902(*l*) of the Social Security Act;

12. Aged, blind, and disabled persons whose income is below 100 percent of the Federal poverty level and whose assets are within 200 percent of the SSI asset limits;

13. For a period lasting through the end of the month following the 60th day following delivery, women who have applied for Medicaid benefits before the last day of pregnancy and who are eligible for Medicaid on the last day of pregnancy; and

14. Refugees who are eligible under the Refugee Resettlement program.

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); and recodified former (a) as (b) and amended.
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).
In (b), deleted "regular" preceding "New Jersey Medicaid program" and amended the N.J.A.C. references in the introductory paragraph, deleted 3 through 6 and 18 and recodified former 7 through 19 as 3 through 14.

Case Notes

Home care visits could not be added to cost report in absence of timely claim. Long Branch Public Health Nursing Association, Inc. v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 10.

10:49–2.3 Persons eligible under the Medically Needy program

(a) The eligibility rules for persons eligible under the Medically Needy program are included in N.J.A.C. 10:70.

(b) A Medicaid beneficiary under the Medically Needy program is limited to those medical services listed in N.J.A.C. 10:49–5.3. Services shall be provided in conjunction with specific program requirements as outlined in the second chapter of the applicable Provider Services Manual.

(c) To be determined Medically Needy under the Medicaid Program, it is necessary for the person to meet categorical eligibility requirements, have income and/or resources in excess of the categorical standards, and have insufficient funds to meet his or her medical expenses. Medically Needy persons shall be in one of the following groups:

1. Pregnant women;

2. Needy children (under 21 years of age); or

3. The aged (65 years of age or older), the blind or the disabled.

(d) There are special income and resource levels established for the Medically Needy. If a person meets one of the categories listed in (c) above and has income and/or resources above categorical program levels but less than or equal to the Medically Needy income and resource levels, he or she shall be determined as Medically Needy eligible. However, if a person meets one of the categories listed in (c) above and meets the Medically Needy resource level but has income which exceeds the Medically Needy income level, eligibility may be established through the "spend-down" process.

1. "Spend-down" is the process whereby a person may apply incurred medical expenses to offset income above the Medically Needy income level, and thereby adjust his or her income to meet the Medically Needy income limit.

(e) Medically Needy eligibility for all groups, including the aged, blind and disabled, shall be determined by the CBOSS for both the retroactive and prospective period.

1. Each Medically Needy applicant/beneficiary shall reapply for benefits every six months. Eligibility may be established the first day of that six-month period or on any date during the six-month period that spend-down is met.

2. Eligibility shall be verified by providers on each visit by reviewing the Medicaid Eligibility Identification Card (MEI) (FD–73/178) (see N.J.A.C. 10:49–2.14—Validation Form). For those cards issued for the month within the six month period in which the spend-down is met, the card will reflect the date that eligibility begins after the spend-down is met.

(f) Claims for Medically Needy covered services provided during an eligible period may be submitted to the program for reimbursement using standard Medicaid procedures. Services provided prior to the effective date of eligibility shall be the client's liability, except for certain "special" claims.

1. "Special" claims are claims for Medically Needy covered services that were not used to meet the spend-down and were rendered between the first of the month in which eligibility is established and the date of eligibility that appears on the Medicaid Eligibility Identification Card.

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

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); recodified former (a) through (e) as (b) through (f); in (b) and (e)1, substituted "Medicaid beneficiary" for "Medicaid recipient"; in (d), amended internal cites; and in (e)2, amended N.J.A.C. reference.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

10:49–2.4 Persons eligible under Home and Community-Based Services Programs

(a) Individuals who may not be eligible for regular Medicaid benefits or Medical Needy may be eligible for selected services under the Home and Community-Based Services Waiver Programs under special eligibility rules. A brief overview of these programs and their rules may be found at N.J.A.C. 10:49–22.

New Rule, R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Former section recodified to N.J.A.C. 10:49–2.5.

10:49–2.5 Persons eligible under the NJ FamilyCare program

Children under the age of 19 whose family income does not exceed 133 percent of the Federal poverty level may be eligible for NJ FamilyCare—Plan A services pursuant to the eligibility rules at N.J.A.C. 10:78 and 10:79.

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. 10:49–2.5, Eligibility process (variations from routine procedure), recodified to N.J.A.C. 10:49–2.6.
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 the N.J.A.C. reference.

10:49–2.6 Eligibility process (variations to routine procedure)

There are variations to the routine procedure for determining Medicaid eligibility. These variations are relevant to applying for eligibility for a newborn infant or for an inpatient upon admission to a hospital (see N.J.A.C. 10:49–2.7); to determining presumptive eligibility for pregnant women (see N.J.A.C. 10:49–2.8); and to determining retroactive eligibility (see N.J.A.C. 10:49–2.9).

Recodified from N.J.A.C. 10:49–2.4 and amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Amended N.J.A.C. references. Former section recodified to N.J.A.C. 10:49–2.6.
Recodified from N.J.A.C 10:49–2.5 and 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).
Changed N.J.A.C. references throughout. Former N.J.A.C. 10:49–2.6, Applying for Medicaid eligibility for a newborn infant or for an inpatient upon admission to a hospital, recodified to N.J.A.C. 10:49–2.7.
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.

10:49–2.7 Applying for Medicaid eligibility for a newborn infant or for an inpatient upon admission to a hospital

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

1. Although both the mother and newborn infant may be Medicaid beneficiaries on the date of delivery, the newborn infant is not immediately assigned a Person Number (see N.J.A.C. 10:49–2.12). In order to expedite payment to any provider before this number is assigned, the provider is permitted to bill for services provided to the newborn using the mother's Medicaid Eligibility Identification Number and Person Number on the claim form.

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

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

3. The newborn's Person Number shall be used as soon as it is available to the provider. The practitioner or any other type of provider shall request the newborn's Person Number from the mother at each encounter.

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

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

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

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

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

(2) The CBOSS is responsible for establishing Medicaid eligibility for the individual who applies for AFDC–Related Medicaid (AFDC), or for the individual who is aged, blind, or disabled and applies for "Medicaid Only," or for any individual who applies for New Jersey Care ... Special Medicaid Programs.

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

i. Whether the patient is already eligible for Medicaid or whether the patient's income and/or resources meet the applicable public assistance standard; and

ii. Whether the patient falls into a category of eligibility, for example, aged, disabled, blind, pregnant under 21 years of age, or a member of a family with children under 18 years of age.

3. In the event that the date of the Medicaid eligibility which was established by the Social Security Administration or the CBOSS is later than the date of admission, the beneficiary may apply directly to the New Jersey Medicaid program for retroactive Medicaid payment of unpaid bills for allowable medical services within the three month period prior to the month of application (see N.J.A.C. 10:49–2.9).

Amended by R.1996 d.320, effective July 15, 1996.
See: 28 N.J.R. 1589(a), 28 N.J.R. 3572(a).
Recodified from N.J.A.C. 10:49–2.5 and 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", "CWA" for "county welfare agency" and "Medicaid Eligibility Identification Number" for "HSP (Medicaid) Case Number" and amended N.J.A.C references throughout; in (a)2 Example, inserted "for dates of service"; substantially amended (b)2i; rewrote (b)2ii; and deleted (b)2iii. Former section recodified to N.J.A.C. 10:49–2.7.
Recodified from N.J.A.C 10:49–2.6 and 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)1 and (b)3 changed N.J.A.C. references. Former N.J.A.C. 10:49–2.7, Presumptive eligibility, recodified to N.J.A.C. 10:49–2.8.
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).

10:49–2.8 Presumptive eligibility

(a) "Presumptive eligibility" means an expedited process whereby selected certified HealthStart Comprehensive Maternity Care providers make preliminary Medicaid eligibility determinations on behalf of pregnant women (see HealthStart in applicable Provider Services Manuals and N.J.A.C.

10:49–19). This is a preliminary process to determine presumptive eligibility prior to the determination of Medicaid eligibility or ineligibility by the CBOSS.

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

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

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

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

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

(d) A presumptively eligible pregnant woman is identified by the two messages which appear on the "Medicaid Eligibility Identification Card" (Form FD–73/178) (see Appendix, N.J.A.C. 10:49). One message is above the woman's name on the upper left side: CLIENTS: YOU MUST CONTACT THE CBOSS FOR FULL BENEFITS; P.E. IS TEMPORARY AND LIMITED. The second message, which appears in the message box on the upper right hand corner instructs the provider to call a toll-free number to verify eligibility before providing services. This card is the only document acceptable for the identification of a presumptively eligible pregnant woman.

1. As part of the presumptive eligibility process, a presumptively eligible pregnant woman will be given an FD–334 Form, Certification of Presumptive Eligibility (see Appendix, N.J.A.C. 10:49). This is not valid proof of eligibility for Medicaid and should not be used by the provider for presumptive eligibility purposes. A request for reimbursement based solely upon the presentation of the FD–334 form does not guarantee payment.

2. Even with the identification through the MEI Card, each time a service is rendered the provider shall verify the presumptive eligibility status of a pregnant woman, prior to the delivery of ambulatory services, by calling the toll free telephone number listed on the MEI Card which is available seven days a week, 24 hours a day.

3. A provider's failure to verify eligibility prior to the delivery of services shall result in the denial of payment for those services if the individual was not eligible at that time. The provider should note that a pregnant woman's presumptive eligibility may be terminated at any time.

Amended by R.1996 d.320, effective July 15, 1996.
See: 28 N.J.R. 1589(a). 28 N.J.R. 3572(a).
Recodified from N.J.A.C. 10:49–2.6 and amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a). 29 N.J.R. 3856(a).
Substituted "CWA" for "county welfare agency" throughout; and in (a), inserted N.J.A.C references. Former section recodified to N.J.A.C. 10:49–2.8.
Recodified from N.J.A.C 10:49–2.7 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. 10:49–2.8, Medicaid retroactive eligibility, recodified as N.J.A.C. 10:49–2.9.
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).

10:49–2.9 Medicaid or NJ FamilyCare–Plan A retroactive eligibility

(a) Any person applying for Medicaid or NJ FamilyCare–Plan A benefits shall be asked if he or she has unpaid medical bills incurred within the three month period immediately prior to the month of application for Medicaid or NJ FamilyCare–Plan A.

1. Medically Needy applicants (see N.J.A.C. 10:49–2.3(f)) shall be evaluated for retroactive eligibility by the county board of social services (CBOSS) when they apply for the Medically Needy program.

2. An applicant for NJ FamilyCare–Plan A whose application was processed by the Statewide eligibility determination agency has his or her retroactive eligibility processed by that agency. The applicant must indicate on his or her NJ FamilyCare–Plan A application that unpaid medical bills exist in the retroactive period or shall contact the Statewide eligibility determination agency within six months of his or her application date for NJ FamilyCare–Plan A.

3. Applicants who applied for Medicaid or NJ FamilyCare–Plan A at a CBOSS other than Essex, Hunterdon or Warren Counties, shall have their retroactive eligibility evaluated and processed at that CBOSS when they apply for Medicaid or NJ FamilyCare–Plan A. If the applicant does not indicate to the CBOSS that unpaid medical bills exist at the time of application, the applicant shall provide that information to the CBOSS within six months of the date of application. If retroactive eligibility is not requested from the CBOSS within six months from the date of application, retroactive eligibility will not be established.

4. Medicaid or NJ FamilyCare–Plan A Applicants who applied for benefits at the CBOSS in Essex, Hunterdon or Warren counties or who applied for Supplemental Security Income (SSI) may complete an FD–74 Form, Application for Payment of Unpaid Medical Bills (see Appendix, N.J.A.C. 10:49) and forward the application with required verification and all outstanding unpaid medical bills to the Medicaid Retroactive Eligibility Unit, Division of Medical Assistance and Health Services, PO Box 712, Mail Code #10, Trenton, New Jersey 08625–0712. An application for retroactive eligibility may be obtained by the applicant, or his or her authorized agent, from the CBOSS, the Medical Assistance Customer Center (MACC), the Social Security Administration District Office, or from the Retroactive Eligibility Unit, Division of Medical Assistance and Health Services. The application shall be received by the Retroactive Eligibility Unit within six months from the date of application for public assistance.

5. Applications for retroactive unpaid medical bills cannot be processed for services rendered prior to the effective date of the program. For NJ FamilyCare–Plan A, children eligible under N.J.A.C. 10:79–3.4(b), the effective date is February 1, 1998. For NJ FamilyCare parents, the effective date is September 6, 2000.

(b) If the Division of Medical Assistance and Health Services Retroactive Eligibility Unit determines that the person was eligible for Medicaid or NJ FamilyCare–Plan A at the time the service was provided, providers shall be notified directly that the unpaid bills for any service covered by the New Jersey Medicaid program or NJ FamilyCare–Plan A may be reimbursable in accordance with standard Medicaid and NJ FamilyCare reimbursement procedures.

1. The provider shall then complete the appropriate claim and submit it to the Fiscal Agent for consideration and authorization of payment within 90 days of the date the provider is notified in writing of the retroactive eligibility.

2. When the Retroactive Eligibility Unit approves retroactive eligibility more than one year after the date(s) of service, the Retroactive Eligibility Unit will send a special notification letter to the provider. The provider shall attach the original notification letter to the claim and shall manually submit the claim to the Medicaid fiscal agent at the address listed on the letter. The claim and the attached letter must be received by the Medicaid fiscal agent within 90 calendar days of the date on the special notification letter.

3. For any Medically Needy beneficiary, a retroactive eligibility determination shall be completed by the CBOSS (see N.J.A.C. 10:49–2.3 Persons eligible under the Medically Needy program).

Recodified from N.J.A.C. 10:49–2.7 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) amended N.J.A.C reference and mailing address; in (a)1 and (b)2, substituted "CWA" for "county welfare agency"; and in (b)2, substituted "beneficiary" for "recipient". Former section recodified to N.J.A.C. 10:49–2.9.
Recodified from N.J.A.C 10:49–2.8 and 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—Plan A throughout; in (a), inserted "and application processed by the Statewide eligibility determination agency" following "N.J.A.C. 10:492.3(f)" in the second sentence, and added 2 and 3; and in (b), inserted a reference to NJ KidCare reimbursement procedures in the first sentence, and deleted "Medicaid" following "appropriate" and substituted a reference to the Fiscal Agent for a reference to the Retroactive Eligibility Unit in 1. Former N.J.A.C. 10:49–2.9, Verification of eligibility for Medicaid/Pharmaceutical Assistance to the Aged and Disabled (PAAD) services, recodified to N.J.A.C. 10:49–2.10.
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).
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.2001 d.329, effective September 17, 2001.
See: 33 N.J.R. 1889(a), 33 N.J.R. 3334(a).
In (b)1, deleted "form" after "appropriate claim", and added "within 90 days of the date the provider is notified in writing of the retroactive eligibility".
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).
Rewrote the section.

Case Notes

Provider failing to meet regulatory time lines for cross-over Medicaid/Medicare reimbursement claims was not entitled to reimbursement. In the Matter of Bergen Pines County Hospital, 96 N.J.A.R.2d (DMA) 15.

Unique circumstances excused hospitalized applicant from complying with requirement that application for retroactive Medicaid be submitted within six months of date of application for public assistance. J.R. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 57.

Untimely application for three months retroactive benefits under Medicaid program was not waived and was properly denied. Estate of G.K. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 27.

Application for Medicaid, though filed after six-month deadline, was nevertheless sufficient to meet three month requirement for retroactive eligibility. A.D. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 11.

Spouse of Supplemental Security Income recipient was not entitled to retroactive Medicaid coverage. M.L. v. Union County Board of Social Services, 94 N.J.A.R.2d (DMA) 24.

10:49–2.10 Verification of eligibility for Medicaid or NJ FamilyCare; or Pharmaceutical Assistance to the Aged and Disabled (PAAD) services

(a) Each Medicaid or NJ FamilyCare beneficiary, except Nursing Facility beneficiaries, has a Medicaid or NJ FamilyCare Eligibility Identification Number printed on a form or eligibility card that validates eligibility. The beneficiary shall present this form or card to the provider, as a proof of eligibility, every time a service is to be provided. See N.J.A.C. 10:49–2.12 for a description and information about

the Medicaid Eligibility Identification Number and see N.J.A.C. 10:49–2.13 for information about the Medicaid and NJ FamilyCare forms or cards that are used to validate eligibility. The Recipient Eligibility Verification System (REVS) or Medicaid Eligibility Verification System (MEVS) can be used, in some instances, as an alternative to viewing a form or card used to validate eligibility (see N.J.A.C. 10:49–2.11).

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

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

ii. There shall be no reimbursement for services performed after termination of eligibility, except as noted in N.J.A.C. 10:49–5.5(a)9.

Amended by R.1995 d.589, effective November 20, 1995.
See: 27 N.J.R. 2851(a). 27 N.J.R. 4715(b).
Recodified from N.J.A.C. 10:49–2.8 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 "beneficiary" and "beneficiaries" for "recipient" and "recipients" and "Medicaid Eligibility Identification Number" for "HSP (Medicaid) Case Number", and amended N.J.A.C. references; and deleted (b), relating to PAAD Programs. Former section recodified to N.J.A.C. 10:49–2.10.
Recodified from N.J.A.C 10:49–2.9 and 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, and changed N.J.A.C. references throughout. Former N.J.A.C. 10:49–2.10, Recipient Eligibility Verification System (REVS)/Medicaid Eligibility Verification System (MEVS), recodified to N.J.A.C. 10:49–2.11.
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).
In (a), inserted reference to cards following forms throughout.

10:49–2.11 Recipient Eligibility Verification System (REVS)/Medicaid Eligibility Verification System (MEVS)

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

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

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

i. For hospital providers only, name and date of birth may be used.

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

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

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

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

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

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

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

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

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

iii. The applicant's documented qualifications, expertise, and experience on similar projects;

iv. The applicant's proposed staff's documented qualifications, expertise, and experience on similar projects;

v. The applicant's adherence to the requirements of the HCFA; and

vi. The fact that the prices charged by the applicant to subscribers are reasonable.

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

(d) MEVS intermediaries shall pay an initial application fee of $1,500, an annual registration fee of $1,000, and a five cents per inquiry fee.

See: 27 N.J.R. 2851(a), 27 N.J.R. 4715(b).
Recodified from N.J.A.C. 10:49–2.9 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) and (b), substituted "beneficiary" for "recipient"; in (a), substituted "Medicaid Eligibility Identification Number" for "HSP (Medicaid) Case Number", and amended N.J.A.C. reference; added (b)1i; and in (c)2v, substituted "HCFA" for "Health Care Financing Administration. Former section recodified to N.J.A.C. 10:49–2.11.
Recodified from N.J.A.C 10:49–2.10 and 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. Former N.J.A.C. 10:49–2.11, Medicaid Eligibility Identification Number, recodified to N.J.A.C. 10:49–2.12.
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).

10:49–2.12 Medicaid or NJ FamilyCare Eligibility Identification Number

(a) A Medicaid or NJ FamilyCare Eligibility Identification Number consists of 12 digits, which includes a two digit Person Number. The components of a Medicaid or NJ FamilyCare Eligibility Identification Number as it is initially assigned to a beneficiary follows:

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

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

23 and 24 Statewide eligibility determination agency.

1. Exception: 23 and 24 are limited to use by the Statewide eligibility determination agency.

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

3. For beneficiaries in certain State or county facilities, the first two digits of the Medicaid Eligibility Identification Number designate the facility where the beneficiary resides. In a few unique situations, the first two digits designate a special State program. The following list identifies the first two digits used to identify a State or County facility or a special State program. Following the name of the facility and enclosed in parentheses, is the Medical Assistance Customer Center responsible for inspection of care and periodic medical reviews in the facility and the ISS office responsible for eligibility processes serving that facility. For those facilities below marked by an asterisk (*), it should be noted that when the first two digits of a Medicaid Eligibility Identification Number are used to identify more than one facility, a specific series of numbers for the fifth through tenth digit shall be used to designate the second or third facility as well as to designate the sequential identification number of the Medicaid beneficiary.

i. Identification of State and County Psychiatric Facilities:

31 Greystone Park Psychiatric Hospital (Morris MACC)

32 Trenton Psychiatric Hospital (Burlington MACC)

*32 (300,000 series) Forensic Psychiatric Hospital (Burlington MACC)

*32 (600,000 series) Senator Garrett W. Hagedorn Center for Geriatrics—Psychiatric Section (Middlesex MACC)

34 Ancora Psychiatric Hospital (Camden MACC) (excluding 800,000 series)

36 Arthur Brisbane Child Treatment Center (Psychiatric Hospital) (Monmouth MACC)

37 Bergen Pines Psychiatric Center (Passaic MACC)

38 Essex County Hospital Center—Cedar Grove (Essex MACC)

39 Camden County Psychiatric Hospital (Camden MACC)

ii. Identification of Intermediate Care Facilities/Mental Retardation

*34 (800,000 series) Anchor Development Center (Camden MACC)

41 Vineland Developmental Center (Atlantic MACC)

42 North Jersey Developmental Center (Totowa) (Passaic MACC)

43 Greenbrook Regional Center (Middlesex MACC)

44 Woodbine Developmental Center (Atlantic MACC)

45 New Lisbon Developmental Center (Burlington MACC)

47 Woodbridge Developmental Center (Middlesex MACC)

48 Hunterdon Developmental Center (Middlesex MACC)

iii. 51 New Jersey Veteran's Home (Unit Dose Drugs) (MACC which serves the county in which the home is located)

iv. 90 Division of Developmental Disabilities Community Care Services (Waiver and Non Waiver) and Special Residential Services, statewide. (MACC which serves the county in which the beneficiary resides.)

(c) The third and fourth digits of the 12–digit Medicaid Eligibility Identification Number designate the category under which a person was determined eligible for the New Jersey Medicaid program. For some adult beneficiaries (that is, the Medicaid Only program and New Jersey Care ... Special Medicaid programs for Aged, Blind, and Disabled) the third and fourth digits of the Medicaid Eligibility Identification Number will not change from program 20 and 25 (meaning the individual is disabled and under 65 years of age) to 10 and 15 (meaning the individual is aged—65 years of age or older) when beneficiaries reach age 65.

10 Aged—SSI related (65 years of age or older)

15 Aged—Medically Needy (65 years of age or older)

20 Disabled—SSI related

25 Disabled—Medically Needy

30 AFDC-Related Medicaid. New Jersey Care ... Special Medicaid program for pregnant women and children are included in this category.

35 Medically Needy (children and pregnant women)

50 Blind—SSI related

55 Blind—Medically Needy

60 Children (If first two digits are 01 to 21, the individual is under supervision of the Division of Youth and Family Services. If the first two digits are greater than 21, the individual is institutionalized.

70 County Juvenile Residential Facilities

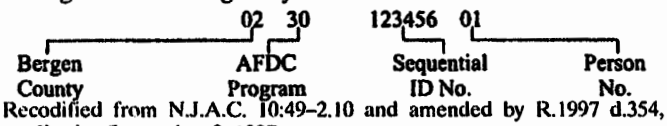
80 State Juvenile Residential Facilities

(d) The fifth through the tenth digits of the Medicaid Eligibility Identification Number designate the sequential identification number of the Medicaid beneficiary with the exception of presumptively eligible pregnant women (98–99) who are assigned those numbers.

(e) The 11th and 12th digits of the Medicaid Eligibility Identification Number designate the specific Person Number assigned to each beneficiary.

01–04 Adult (any age)
05 Pregnant woman
06–09 Adult (any age)
10–19 Ineligible spouse
20–39 Children under 19
40–49 Medicaid special (Children under 21 but not under 19)

(f) For example, an adult Medicaid beneficiary (caretaker/parent) from Bergen County receiving assistance under the AFDC–Related Medicaid program could have the following Medicaid Eligibility Identification Number:



Recodified from N.J.A.C. 10:49–2.10 and amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Changed section name; substituted "beneficiary" and "beneficiaries" for "recipient" and "recipients" and "Medicaid Eligibility Identification Number" for "HSP (Medicaid) Case Number" throughout; in (b)2, inserted "responsible for inspection ... for eligibility processes"; in (b)2i. amended several MDO references and in 34 added "(excluding 800.000 series)"; in (b)2ii, amended several MDO references and deleted 46 (E.R. Johnstone Training and Research Center); in (b)2iii, substituted "New Jersey Veteran's Home" for "Soldier's Homes"; in (c), in 20 and 25 deleted "(under 65 years of age)", in 70 substituted "County Juvenile Residential Facilities" for "Medical Assistance for Aged—A New Jersey State Program", and in 80, substituted "State Juvenile Residential Facilities" for "Refugee Program"; and in (d), inserted reference to exception for presumptively pregnant women. Former section recodified to N.J.A.C. 10:49–2.12.
Recodified from N.J.A.C 10:49–2.11 and 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; in (b), inserted "23 and 24—Statewide eligibility determination agency", inserted a new 1, and recodified former 1 and 2 as 2 and 3. Former N.J.A.C. 10:49–2.12, Forms that validate Medicaid eligibility, recodified to N.J.A.C. 10:49–2.13.
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).

10:49–2.13 Forms that validate Medicaid eligibility

(a) A New Jersey Medicaid provider may verify a person's Medicaid eligibility by means of one of the following three forms:

1. Department of Human Services—"Medicaid-ID" (FD–152) (see N.J.A.C. 10:49–2.14);

2. "Medicaid Eligibility Identification Card" (FD–73/178) (see N.J.A.C. 10:49–2.15); or

3. "Validation of Eligibility" (FD–34) (see N.J.A.C. 10:49–2.16).

Recodified from N.J.A.C. 10:49–2.11 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 reference to validation for Health Services Program form and made conforming amendments. Former section recodified to N.J.A.C. 10:49–2.13.
Recodified from N.J.A.C 10:49–2.12 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. 10:49–2.13, Validation form (FD 152) Department of Human Services Medicaid ID, recodified to N.J.A.C. 10:49–2.14.
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.

10:49–2.14 Validation form (FD–152) Department of Human Services Medicaid ID

(a) The validation Form FD–152 (see Appendix, N.J.A.C. 10:49) is issued monthly to persons eligible for AFDC-related Medicaid and to persons eligible under the Refugee and Community Medicaid Only programs. The form indicates that the persons are currently eligible for coverage for the month shown on the form—"VALID ONLY FOR THE MONTH OF _____." The validation form shall be retained by the Medicaid beneficiary to whom it is issued.

1. This form is the indicator of Medicaid eligibility for the Medicaid beneficiary(s) listed on the form.

i. Any Medicaid beneficiary enrolled in an HMO shall also be required to show his or her HMO ID Card.

2. Providers shall enter the name, Medicaid Eligibility Identification Number, including the Person Number, exactly as it appears on Form FD–152 when requesting authorization for services or submitting a claim form.

3. Messages printed on Form FD–152: One of the following two messages may be printed on the FD–152 form issued by the CBOSS. Only one message will appear on the form. If more than one applies, however, the message printed is chosen in the order of priority listed below. Providers shall be requested to take the specific action for the message which appears.

i. Message One: Enrolled in HMO (name) and phone number.

ii. Message Two: "OTHER COVERAGE"—There will be an asterisk (*) before the name of the beneficiary(ies) covered by another health insurer. The provider shall determine the insurer and the policy number (see N.J.A.C. 10:49–7.3—Third Party Liability).

Recodified from N.J.A.C. 10:49–2.12 and amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Substituted references to beneficiary for references to recipient throughout; in (a)2, substituted "Medicaid Eligibility Identification Number" for "IISP (Medicaid) Case Number"; in (a)3, substituted "two messages" for "three messages" and "CWA" for "county welfare agency"; in (a)3i, rewrote Message One; deleted (a)3ii; and recodified former (a)3iii as (a)3ii and made conforming amendments. Former section recodified to N.J.A.C. 10:49–2.14.
Recodified from N.J.A.C 10:49–2.13 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. 10:49–2.14, Validation form (FD 73/178) Medicaid Eligibility Identification Card (MEI Card), recodified to N.J.A.C. 10:49–2.15.
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).

10:49–2.15 Validation form (FD–73/178) Medicaid Eligibility Identification Card (MEI Card)

(a) The MEI Card, Validation Form FD–73/178 (see Appendix, N.J.A.C. 10:49) is issued monthly to:

1. Persons (aged, blind and disabled) determined by the Social Security Administration to be eligible for Supplemental Security Income (SSI) and their spouses, if eligible as an essential person;

2. Persons determined by the CBOSS to be eligible for the New Jersey Care ... Special Medicaid Programs and the Medically Needy program;

3. Beneficiaries in the Special Status program (see (e)2 below); and

4. Children (Medicaid recipients) under the supervision of the Division of Youth and Family Services (DYFS).

(b) The MEI Card usually identifies eligibility for only one beneficiary. However, several special programs list all eligible persons in the family; for example, for New Jersey Care ... Special Medicaid Programs, all Medicaid beneficiaries in the family are listed on the MEI Card; the Special Status Program also identifies all beneficiaries in the family on the MEI Card.

1. When the MEI Card is issued to the Medically Needy, more than one beneficiary may be listed with a service code indicated next to each name.

(c) The information on the MEI Card includes an address, date of birth, Social Security Account Number and the availability of any third-party health insurance; however, for the Medically Needy program, the date of birth and Social Security Account Number are omitted and the words "Medically Needy" are printed in this space.

1. If the Medicaid beneficiary has health insurance, the name of the other insurer will be printed together with a corresponding policy number. Additionally, Medicare coverage and the HIC (Medicare) Number will be printed on the MEI Card for all Medicare/Medicaid beneficiaries.

(d) The MEI Card is valid only when signed by the Medicaid beneficiary or his/her representative payee/legal guardian.

(e) A message printed on the MEI card will indicate the cardholder's enrollment in any waivered or special programs such as Home and Community-Based Services Waiver Pro-

grams (see N.J.A.C. 10:49–22); or in another managed care program (see N.J.A.C. 10:49–20 through 21).

1. The MEI Card for the Medicaid "Special Status program" either restricts the Medicaid beneficiary(ies) listed on the MEI Card to a single provider, except in a medical emergency, or warns providers that the beneficiary's card has been used by an unauthorized person or persons, or for an unauthorized purpose. If a warning card is issued, a message will be printed on the card alerting the provider to ask the Medicaid beneficiary for additional identification or to take other appropriate action. (See N.J.A.C. 10:49–14.2—Sanctions—Special Status program).

2. The MEI Card issued for the Medically Needy program will have the following message printed on the top of the card: "Medically Needy Eligible, Check Provider Manual for Authorized Services." It is important for the provider to always review the eligibility dates and to be aware that eligibility is not always established for an entire month. Coverage may begin on any day during the month. Also, a provider shall always review the "service code" for each Medically Needy beneficiary. The service code will enable the provider to determine which services are available to each Medically Needy beneficiary (see N.J.A.C. 10:49–2.3 and 10:49–5.3 for service exceptions). The service codes for the three groups under Medically Needy are:

(A) Group A—Pregnant women,

(B) Group B—Needy children,

(C) Group C—Aged, blind and disabled.

Recodified from N.J.A.C. 10:49–2.13 and amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Substituted references to beneficiary for references to recipient throughout; in (a), deleted reference to quarterly issuance of MEI card and made conforming amendments; in (e), amended Program references; and in (e)1, substituted "Enrolled in HMO, etc." for "HMO-Check-GSHP ID Card". Former section "Validation form (DYFS–16–36) 'Validation for Health Services program' (Medicaid)" was repealed.
Recodified from N.J.A.C 10:49–2.14 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. 10:49–2.15, Validation form (FD 34) Validation of Eligibility, recodified to N.J.A.C. 10:49–2.16.
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).

10:49–2.16 Validation form (FD–34) Validation of Eligibility

(a) The FD–34 Form, Validation of Eligibility (see Appendix, N.J.A.C. 10:49) identifies a Medicaid beneficiary who resides in a State or county institution.

1. The validation form shall be prepared and completed by the authorized Medicaid representative at the State or County institution. It is valid for the calendar month it is issued (up to a period of 31 days) to a Medicaid beneficiary (patient/resident) in a State or county governmental psychiatric hospital or an intermediate care facility/mental retardation, and is used to obtain Medicaid covered services outside of the institutional setting. The form shall be returned with the Medicaid beneficiary.

2. Form FD–34 requires the signature, title, and telephone number of the authorized representative at the institution.

3. The Medicaid beneficiary or patient of a State or county institution receiving covered health services in the community is identified by the 12–digit Medicaid Eligibility Identification Number in which the first two digits identifies the institution. (See N.J.A.C. 10:49–2.11(b)2).

(b) The New Jersey Medicaid and the NJ FamilyCare programs have designated specific Medical Assistance Customer Centers (MACCs) to handle prior authorization requests for services for patients/residents/beneficiaries from each institution and family care residents/beneficiaries who are under the jurisdiction of the Division of Developmental Disabilities. If the patient/beneficiary's Medicaid or NJ FamilyCare Eligibility Identification Number begins with any of the following numbers, providers shall contact the MACC indicated (for MACC Directory, see Appendix N.J.A.C. 10:49).

31 Morris MACC

32 Burlington MACC

33 Monmouth MACC

34 Camden MACC

35 Middlesex MACC

36 Monmouth MACC

37 Passaic MACC

37 Hudson MACC (Applicable only to 600,000 series)

38 Essex MACC

39 Camden MACC

41 Atlantic MACC

42 Passaic MACC

43 Middlesex MACC

44 Atlantic MACC

45 Burlington MACC

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) Effective July 1, 2006, P.L. 2006, c. 45 requires the Division to institute a moratorium on new Medicaid/NJ FamilyCare providers of chiropractic services, medical supplies, partial care services, pharmaceutical services and podiatry services.

1. Any provider that was not an approved Medicaid or NJ FamilyCare fee-for-service provider of chiropractic services, medical supplies, partial care services, pharmaceutical services or podiatry services prior to July 1, 2006 is ineligible to become an approved fee-for-service provider of such services for Medicaid or NJ FamilyCare, unless the Division affirmatively determines that the provider's services are necessary to meet special needs.

2. Situations not subject to the moratorium for fee-for-service providers of pharmacy services or medical supply services are as follows:

i. A change of ownership only;

ii. A change of location only. A provider that has not changed ownership on or after July 1, 2006, which changes location on or after July 1, 2006, and continues to operate as a Medicaid or NJ FamilyCare provider at the new location, continues to provide the same level of services and delivery and meets all applicable State and Federal rules and regulations; and

iii. Medicare as the primary payer. Situations in which Medicare is the primary payer and the provider bills for cross-over claims and wraparound Medicare Part D payments.

(b) Subject to the moratorium set forth in (a) above, the following provider types shall be eligible to apply to participate as Medicaid/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:

i. Residential child care facilities (see N.J.A.C. 10:77 and 10:127);

ii. Children's group homes (see N.J.A.C. 10:77 and 10:128);

iii. Psychiatric community residences for youth (see N.J.A.C. 10:37B and 10:77);

iv. Providers of behavioral assistance services for children/youth or young adults (see N.J.A.C. 10:77-4);

v. Mobile response agencies (see N.J.A.C. 10:77-6);

vi. Providers of intensive in-community mental health rehabilitation services (see N.J.A.C. 10:77-5);

vii. Programs for Assertive Community Treatment (PACT) Agencies/Teams (see N.J.A.C. 10:37J and 10:76); and

viii. Community residences for mentally ill adults (see N.J.A.C. 10:37A and 10:77A).

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.

(c) 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).
Amended by R.2003 d.89, effective March 3, 2003.
See: 34 N.J.R. 1593(a), 35 N.J.R. 1281(a).
Rewrote (a)16.
Amended by R.2003 d.479, effective December 15, 2003.
See: 35 N.J.R. 2146(a), 35 N.J.R. 5584(a).
In (a)16, inserted a new iv and recodified former iv as new v.
Amended by R.2004 d.8, effective January 5, 2004.
See: 35 N.J.R. 2620(a), 35 N.J.R. 4204(a), 36 N.J.R. 189(a).
In (a)16, added vi.
Amended by R.2005 d.68, effective February 22, 2005.
See: 36 N.J.R. 379(a), 37 N.J.R. 659(a).
In (a), added 16v, recodified existing v to vi as vi to vii.
Amended by R.2005 d.98, effective April 4, 2005.
See: 36 N.J.R. 1158(a), 37 N.J.R. 1022(a).
In (a), added a new vi, recodified existing vi, vii as vii, viii in 16.
Amended by R.2007 d.238, effective August 6, 2007.
See: 39 N.J.R. 1388(a), 39 N.J.R. 3377(a).
Added new (a), recodified former (a) and (b) as (b) and (c); and in the introductory paragraph of (b), substituted "Subject to the moratorium set forth in (a) above, the" for "The" and inserted "apply to".

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.

Case Notes

Provider participation in programs such as Medicaid is conditioned upon a provider's fitness, i.e., integrity, honesty, and responsibility. Participation is contractual; there is no right to participation as a Medicaid provider, and a provider must comply with federal and state laws. Farhat v. DMAHS, OAL Dkt. No. HMA 11600-05, 2006 N.J. AGEN LEXIS 457, Initial Decision (July 13, 2006).

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 CMS-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 statutes and rules governing their ownership and direction (see Appendix, Form #12). Out-of-State providers shall certify that they comply with the requirements of the state in which the facility is located. 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 CMS-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.

3. Enrollment documentation requested by the New Jersey Medicaid or NJ FamilyCare program shall be furnished within 35 calendar days of the date of the written request.

(c) An out-of-State provider shall have a current, approved provider agreement with the New Jersey Medicaid or NJ FamilyCare program and hold a current, valid certification and/or license from the appropriate agency under the laws of the respective state in which the provider is located.

(d) A provider application may be requested from the fiscal agent of the New Jersey Medicaid and NJ FamilyCare program. An appropriate program enrollment package will be mailed to the requesting provider. The enrollment application must be completed in full and returned to the fiscal agent, along with all the necessary attachments.

1. The applicant's eligibility to participate in the New Jersey Medicaid and NJ FamilyCare program will be confirmed in writing. A provider number will be assigned and returned to the applicant along with the appropriate program Provider Manual.

2. If the application is denied, the applicant will receive a notification which explains the decision to deny and the applicant's right to appeal the decision (see N.J.A.C. 10:49-10).

(e) If a provider is found to be currently enrolled, but has been inactive for at least two (2) years, the applicant will be required to complete a new application. If the application is approved, the provider's existing record on the Provider Master File will be reactivated.

(f) The New Jersey Medicaid program or NJ FamilyCare program may refuse to enter into or to renew a provider participation agreement with any applicant or provider who has been suspended, debarred, disqualified, or excluded by the Title XIX or Title XXI program of another state. The program may terminate any existing agreement with a

provider, if good cause for exclusion of the provider from program participation exists under any of the provisions of N.J.A.C. 10:49-11.1(d)1 through 27.

(g) The New Jersey Medicaid program or NJ FamilyCare program shall not enter into a provider participation agreement with an applicant who has been suspended or excluded from participation in the delivery of medical care or services under Medicare (Title XVIII), Medicaid (Title XIX), or the Social Services Block Grant Act (Title XX) of the Federal Social Security Act, by the Secretary of the United States Department of Health and Human Services.

(h) The Division may place a moratorium on the enrollment of new providers for particular provider types and/or in particular geographic areas if it determines that beneficiary access to services would not be adversely affected, and:

1. That the number of providers already enrolled is sufficient to adequately serve beneficiaries;

2. That a moratorium is necessary in order to address fraud and/or abuse; or

3. That other compelling reasons warrant a moratorium.

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
In (b)1i, inserted "reenrollment"; and in (f) and (g), substituted "New Jersey Medicaid program" for "Division".
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 (b) and (f), substituted references to Title XIX and Title XXI for references to Medicaid.
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 the section.
Amended by R.2006 d.25, effective January 17, 2006.
See: 37 N.J.R. 3176(a), 38 N.J.R. 802(a).
In (b), substituted "CMS-" for "HCFA" throughout, deleted "licensing" preceding "statutes," and added "Out-of-State providers shall certify that they comply with the requirements of the state in which the facility is located."

Cross References

Eye care providers, fulfillment of enrollment process as under this section, see N.J.A.C. 10:62-2.3.

Case Notes

Initial Decision (2007 N.J. AGEN LEXIS 789) adopted, which concluded that applicants' request for their 11-year-old child to be placed at a New Mexico school and treatment facility was correctly denied as a matter of law because the facility did not satisfy the pertinent federal and State regulations necessary to provide services to a New Jersey Medicaid beneficiary, where: (1) the facility was not licensed as a health care provider or provider of inpatient psychiatric services in New Mexico; (2) the facility was not an approved provider of inpatient psychiatric services for children in the New Mexico Medicaid program; (3) the facility was not accredited by JCAHO; and (4) the facility's therapy included physical restraint of children who were not at that time a danger to themselves or others. R.C. and C.M. ex rel. C.G. v. DMAHS, OAL Dkt. No. HMA 4414-06, 2008 N.J. AGEN LEXIS 274, Final Decision (January 8, 2008).

Initial Decision (2007 N.J. AGEN LEXIS 210) adopted, which concluded that while the word "shall" in N.J.A.C. 10:49-3.2(b)(3) creates a mandatory time limit of 35 days within which a Medicaid provider applicant is to supply enrollment information requested by the Division, there is no regulatory basis for the Division to deny an application for failure to meet the deadline. Grace Pharmacy v. DMAHS, OAL Dkt. No. HMA 6904-06, 2007 N.J. AGEN LEXIS 528, Final Decision (June 5, 2007).

10:49-3.3 Providers with multi-locations

(a) All providers participating in the Medicaid or NJ FamilyCare program shall identify all locations from which they are providing services to Medicaid or NJ FamilyCare beneficiaries.

(b) Each location shall comply with provider participation requirements and shall be assigned a separate provider number. Services rendered to Medicaid or NJ FamilyCare beneficiaries at a location not approved for participation are not eligible for Medicaid or NJ FamilyCare reimbursement.

(c) Billing through a central location for approved multi-location providers shall be allowed; however, providers shall utilize the applicable provider number for each service location. Selection of central or localized billing shall be left to providers, who shall state their preference on the application. The program reserves the right to assign unique provider numbers to maintain the accountability and integrity of the New Jersey Medicaid Management Information System (NJMMIS) and the New Jersey Medicaid or 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).
Rewrote (a) and (b); and substantially amended (c).
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 made a corresponding language change.
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).

10:49-3.4 Medicaid or NJ FamilyCare provider billing number

(a) A seven digit Provider Billing Number shall be assigned by the fiscal agent to all providers approved for participation. The Provider Billing Number shall be entered upon all claims submitted in accordance with the instructions in the Fiscal Agent Billing Supplement. The Provider Billing Number should also be referenced in all written and telephone inquiries.

(b) Practitioners, as defined in (c)1 below, approved for participation, shall also be assigned a seven digit Provider

Servicing Number by the Program fiscal agent. The Provider Servicing Number is an identification number which shall be entered upon all claim submittals in accordance with the instructions in the Fiscal Agent Billing Supplement.

(c) Providers who, for billing purposes, need a referring, ordering or prescribing practitioner's individual Provider Servicing Number, shall contact that practitioner or the fiscal agent, or shall access the Provider Servicing Number Directory, to obtain the number. A practitioner who does not participate in the Medicaid or NJ FamilyCare program will not have a Provider Servicing Number. In the absence of the referring, ordering or prescribing practitioner's individual Provider Servicing Number, providers must enter seven fives (5's) for non-participating out-of-State providers or seven sixes (6's) for non-participating in-State providers to indicate non-participation in the New Jersey Medicaid or NJ FamilyCare program. Providers may contact the Medicaid/NJ FamilyCare Fiscal Agent for a copy of the participating provider directory. In addition, providers may obtain servicing and prescribing numbers at www.njmmis.com.

1. Each participating practitioner (that is, physician, certified nurse midwife, advanced practice nurse, chiropractor, dentist, optometrist, podiatrist, or psychologist) shall supply his or her individual Provider Servicing Number to other providers when referring a Medicaid or NJ FamilyCare beneficiary for services, or ordering or prescribing on his behalf.

(d) A shared health care facility (SHCF) (see N.J.A.C. 10:49-4.1) is assigned a registration code (Shared Health Care Facility Number), which must appear on a claim form submitted to the fiscal agent by every member of the SHCF. In addition, each practitioner rendering a service in a shared health care facility must indicate his or her Provider Billing Number and individual Provider Servicing Number on the claim form (see 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).
Rewrote (a) and (b); and in (c)1, inserted reference to certified nurse practitioner/clinical nurse specialist.
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.
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).
Rewrote (c).
Amended by R.2004 d.334, effective September 7, 2004.
See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).
In (c), substituted "advanced practice nurse" for "certified nurse practitioner/clinical nurse specialist" in 1.

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 regular Medicaid and NJ FamilyCare–Plan A programs

(a) The services listed below shall be available to beneficiaries eligible for the regular Medicaid/NJ FamilyCare–Plan A programs:

1. Advanced practice nurse services;

2. Case management services (Mental Health Program);

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 and mental health rehabilitation services including:

i. Residential child care facilities (see N.J.A.C. 10:77 and 10:127);

ii. Children's group homes (see N.J.A.C. 10:77 and 10:128);

iii. Psychiatric community residences for youth (see N.J.A.C. 10:37B and 10:77);

iv. Behavioral assistance services for children, youth or young adults under EPSDT (see N.J.A.C. 10:77–4);

v. Mobile response and stabilization management services for children, youth or young adults under EPSDT (see N.J.A.C. 10:77–6);

vi. Intensive in-community mental health rehabilitation services for children, youth or young adults under EPSDT (see N.J.A.C. 10:77–5);

vii. Programs for Assertive Community Treatment (PACT) Services (see N.J.A.C. 10:37J and 10:76); and

viii. Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:37A and 10:77A).

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/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 FQHCs; 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.
Amended by R.2003 d.89, effective March 3, 2003.
See: 34 N.J.R. 1593(a), 35 N.J.R. 1281(a).
In (a), rewrote 19 and substituted "NJ FamilyCare" for "or KidCare" in 30.
Amended by R.2003 d.479, effective December 15, 2003.
See: 35 N.J.R. 2146(a), 35 N.J.R. 5584(a).
In (a)19, inserted a new iv and recodified former iv as new v and rewrote new v.
Amended by R.2004 d.8, effective January 5, 2004.
See: 35 N.J.R. 2620(a), 35 N.J.R. 4204(a), 36 N.J.R. 189(a).
In (a)19, added vi.
Amended by R.2004 d.334, effective September 7, 2004.
See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).
In (a), added a new 1, recodified former 1 as 2, and deleted former 2.
Amended by R.2005 d.68, effective February 22, 2005.
See: 36 N.J.R. 379(a), 37 N.J.R. 659(a).
In (a), rewrote 19.
Amended by R.2005 d.98, effective April 4, 2005.
See: 36 N.J.R. 1158(a), 37 N.J.R. 1022(a).
In (a)19, added a new vi, recodified existing vi, vii as vii, viii.

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 Condition 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 ser-

vices, 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

Testimony and evidence presented on a nursing home resident's behalf failed to articulate a proper basis for reimbursing the $29,000 cost of a specialized wheelchair since federal law requires that the Division avoid the unnecessary utilization of services, the wheelchair was not medically necessary for the diagnosis or treatment of a disease, injury, or condition in accordance with N.J.A.C. 10:49-5.5(a)1, and the Medicaid program does not cover durable medical equipment when not considered cost-effective for a beneficiary's treatment. Specifically, providing necessary assistance to the resident in the resident's current wheelchair was within the nursing staff's responsibility and was care already included in the rate the Division paid to the nursing facility as a Medicaid provider, and the resident would not have been able to leave the nursing home in the foreseeable future. J.R. v. DMAHS, OAL Dkt. No. HMA 10958-04, 2005 N.J. AGEN LEXIS 1317, Final Decision (October 14, 2005).

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 and unavailable to beneficiaries eligible for, or 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. Advance practice nurse services;

2. Audiology 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;

i. NJ FamilyCare–Plan B and C beneficiaries under age 19 who are receiving services under the Division of Child Behavioral Health Services may be eligible for additional mental health and mental health rehabilitation services as authorized by the Contracted Systems Administrator (CSA). (See N.J.A.C. 10:49–5.6(d).)

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, advanced practice nurses; and

11. Targeted case management services for the chronically ill.

(c) Services not covered under Plan B and C shall be 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 shall include, but shall not be 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. 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;

vii. Programs for Assertive Community Treatment (PACT) services; and

viii. Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:37A and 10:77A).

(d) Additional mental health and mental health rehabilitation services as listed below may be available to beneficiaries under age 19 who are eligible for NJ FamilyCare–Plan B or C under fee-for-service who are receiving services from the Division of Child Behavioral Health Services. All services shall first be authorized by the CSA or other agent authorized by the Department of Human Services and shall be included in an approved plan of care.

1. Care coordination by a care management organization (CMO) (see N.J.A.C. 10:73);

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

3. Behavioral assistance services for children, youth or young adults under EPSDT (see N.J.A.C. 10:77–4);

4. Mobil response and stabilization management services for children, youth or young adults under EPSDT (see N.J.A.C. 10:77–6); and

5. Intensive in-community mental health rehabilitation services for children, youth or young adults (see N.J.A.C. 10:77–5).

(e) All presumptively eligible NJ FamilyCare–Plan B and C beneficiaries shall be eligible to receive all the services specified in (a) and (b) above for 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. The additional mental health services listed in (d) above may be available to children, youth or young adults under the age of 19 who are receiving services from the Division of Child Behavioral Health Services during their period of presumptive eligibility.

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)2vi.
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.
Amended by R.2003 d.89, effective March 3, 2003.
See: 34 N.J.R. 1593(a), 35 N.J.R. 1281(a).
Rewrote (c)2.
Amended by R.2003 d.479, effective December 15, 2003.
See: 35 N.J.R. 2146(a), 35 N.J.R. 5584(a).
In (c)2vi, added "or behavioral assistance services for children/youth or young adults (see N.J.A.C. 10:77–4)" to the end of the paragraph.
Amended by R.2004 d.8, effective January 5, 2004.
See: 35 N.J.R. 2620(a), 35 N.J.R. 4204(a), 36 N.J.R. 189(a).
In (c)2, added ix.
Amended by R.2004 d.334, effective September 7, 2004.
See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).
In (a), added a new 1, recodified existing 1 as 2, deleted existing 2; in (b), substituted "advanced practice nurses" for "certified nurse practitioners/clinical nurse specialists" in 7 and 10.
Amended by R.2005 d.68, effective February 22, 2005.
See: 36 N.J.R. 379(a), 37 N.J.R. 659(a).
In (b), added 7i; rewrote (c)2; added (d); recodified existing (d) as (e) and added the third sentence.
Amended by R.2005 d.98, effective April 4, 2005.
See: 36 N.J.R. 1158(a), 37 N.J.R. 1022(a).
Rewrote (d) and (e).

10:49–5.7 Services available and unavailable to beneficiaries eligible for NJ FamilyCare–Plan D and Plan D for adults

(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 and Plan D for Adults, when medically necessary and provided through the network of an HMO selected by the NJ FamilyCare–Plan D beneficiary.

1. Advanced practice nurses;

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;

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. Inpatient rehabilitative services, including physical, occupational and speech therapy for non-chronic conditions and acute illnesses and injuries;

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 shall be 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;

(1) A NJ FamilyCare–Plan D beneficiary under age 21 who is receiving services under the Division of Child Behavioral Health Services may secure additional inpatient psychiatric services provided in a psychiatric hospital, if authorized by the Contracted Systems Administrator (CSA) or other agent designated by the Department of Human Services (see N.J.A.C. 10:77–5.7(d));

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.

(3) A NJ FamilyCare–Plan D beneficiary under age 21 who is receiving services under the Division of Child Behavioral Health Services may secure additional outpatient mental health services, if authorized by the Contracted Systems Administrator (CSA) or other agent designated by the Department of Human Services (see N.J.A.C. 10:77–5.7(d));

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

2. Outpatient 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 period of 60 consecutive business days per incident of illness or injury beginning with the first day of treatment per contract year, except that:

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

3. 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, unless the beneficiary is also receiving services under the Division of Child Behavioral Health Services and is receiving services as part of a plan of care authorized by the Contracted Systems Administrator or other agent authorized by the Department of Human Services;

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. Nursing facility (long term care) services;

xxviii. Recreational therapy;

xxix. Sleep therapy;

xxx. Court ordered services;

xxxi. Thermograms and thermography;

xxxii. Biofeedback;

xxxiii. Radial keratotomy;

xxxiv. Respite care;

xxxv. 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;

xxxvi. Programs for Assertive Community Treatment (PACT) services; and

xxxvii. Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:37A and 10:77A).

(d) Additional mental health and mental health rehabilitation services as listed below may be available to beneficiaries under age 21 who are eligible for NJ FamilyCare–Plan D under fee-for-service receiving services from the Division of Child Behavioral Health Services. All services shall first be authorized by the Contracted Systems Administrator or other agent authorized by the Department of Human Services and shall be included in an approved plan of care.

1. Care coordination by a care management organization (CMO) (see N.J.A.C. 10:73);

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

3. Behavioral assistance services for children, youth or young adults (see N.J.A.C. 10:77–4);

4. Mobil response and stabilization management services for children, youth or young adults under EPSDT (see N.J.A.C. 10:77–6); and

5. Intensive in-community mental health rehabilitation services for children, youth or young adults under EPSDT (see N.J.A.C. 10:77–5).

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.
Special amendment, R.2003 d.98, effective January 31, 2003.
See: 35 N.J.R. 1303(a).
Rewrote (c)2.
Amended by R.2003 d.89, effective March 3, 2003.
See: 34 N.J.R. 1593(a), 35 N.J.R. 1281(a).
In (c)2, added xxxvi and xxxvii.
Amended by R.2003 d.479, effective December 15, 2003.
See: 35 N.J.R. 2146(a), 35 N.J.R. 5584(a).
In (c)2xxxiv, inserted "or behavioral assistance services for children/youth or young adults (see N.J.A.C. 10:77–4)" at the end of the paragraph.
Amended by R.2004 d.8, effective January 5, 2004.
See: 35 N.J.R. 2620(a), 35 N.J.R. 4204(a), 36 N.J.R. 189(a).
In (c)2, added xxxviii.
Amended by R.2004 d.334, effective September 7, 2004.
See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).
In (a), rewrote 1.
Amended by R.2005 d.68, effective February 22, 2005.
See: 36 N.J.R. 379(a), 37 N.J.R. 659(a).
In (b), added 1i(1) and 1ii(3); rewrote (c); added (d).
Amended by R.2005 d.98, effective April 4, 2005.
See: 36 N.J.R. 1158(a), 37 N.J.R. 1022(a).
Rewrote (d).

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 were enrolled in NJ FamilyCare on July 1, 2002 shall be eligible to receive the NJ FamilyCare Plan H service package.

(b) Restricted alien parents who are enrolled in NJ FamilyCare on November 1, 2003, shall receive the Plan H service package.

(c) 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.

1. Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:77A) shall not be eligible for payment under NJ FamilyCare–Plan H.

2. NJ FamilyCare–Plan H beneficiaries under age 21 who are receiving services under the Division of Child Behavioral Health Services may secure additional mental health services if the services are authorized by the Contracted Systems Administrator or other agent authorized by the Department of Human Services and included in a plan of care.

(d) No behavioral health out-of-plan service of any kind, where the place of service is a hospital, shall be a covered service, unless provided in an approved psychiatric hospital to a beneficiary who is receiving services under the Division of Child Behavioral Health Services.

(e) 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. Advanced practice nurse services;

2. Ambulance—medical emergency only;

3. Ambulatory surgery in an outpatient hospital setting only;

4. Clinic services (free standing)—ambulatory;

5. Diabetic supplies/equipment;

6. Durable Medical equipment-limited benefit, only covered when a medically necessary part of the beneficiary's inpatient hospital discharge plan;

7. Emergency room services;

8. Federally qualified health centers (FQHC) primary care services;

9. Home health care services (limited benefits);

10. Inpatient hospital (non-behavioral health related);

11. Laboratory services;

12. Outpatient hospital (non-mental health related);

13. Physician services;

14. Prescription drugs (excludes over the counter medications); and

15. Radiological services.

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

1. Abortion (elective/induced); and

2. Mental health services in the community, including psychological services, up to a maximum of 60 days per calendar year;

i. Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:77A) are not eligible for payment under NJ FamilyCare–Plan H.

ii. NJ FamilyCare–Plan H beneficiaries under age 21 who are receiving services under the Division of Child Behavioral Health Services may be eligible for additional mental health and mental health rehabilitation services as authorized by the Contracted Systems Administrator. (See N.J.A.C. 10:49–5.8(d)).

(g) Additional mental health and mental health rehabilitation services as listed below may be available to beneficiaries under age 21 who are eligible for NJ FamilyCare–Plan H under fee-for-service receiving services from the Division of Child Behavioral Health Services. All services shall first be authorized by the Contracted Systems Administrator, the Division of Medical Assistance and Health Services or other agent authorized by the Department of Human Services and shall be included in an approved plan of care.

1. Care coordination by a care management organization (CMO) (see N.J.A.C. 10:73);

2. Psychiatric services provided in an inpatient psychiatric hospital setting (see N.J.A.C. 10:52);

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

4. Behavioral assistance services for children, youth or young adults (see N.J.A.C. 10:77–4);

5. Mobil response and stabilization management services for children, youth or young adults under EPSDT (see N.J.A.C. 10:77–6); and

6. Intensive in-community mental health rehabilitation services for children, youth or young adults under EPSDT (see N.J.A.C. 10:77–5).

Special New Rule, R.2002 d.214, effective June 10, 2002.
See: 34 N.J.R. 2338(a).
Special amendment, R.2003 d.417, effective September 26, 2003 (operative November 1, 2003).
See: 35 N.J.R. 4913(a).
Rewrote the section.
Amended by R.2004 d.8, effective January 5, 2004.
See: 35 N.J.R. 2620(a), 35 N.J.R. 4204(a), 36 N.J.R. 189(a).
In (c), added 1; in (f), added 2i.
Amended by R.2004 d.334, effective September 7, 2004.
See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).
In (e), added new 1, recodified existing 1, 2 as 2, 3, deleted existing 3.
Amended by R.2005 d.68, effective February 22, 2005.
See: 36 N.J.R. 379(a), 37 N.J.R. 659(a).
Rewrote the section.
Amended by R.2005 d.98, effective April 4, 2005.
See: 36 N.J.R. 1158(a), 37 N.J.R. 1022(a).
Rewrote (g).

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

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

(b) The mental health and mental health rehabilitation services listed below may be available to beneficiaries under 21 years of age who are eligible for NJ FamilyCare–Plan G if they are also receiving services from the Division of Child Behavioral Health Services. All services shall first be authorized by the Contracted Systems Administrator, the Division of Medical Assistance and Health Services or other agent authorized by the Department of Human Services and shall be included in an approved plan of care.

1. Care coordination by a care management organization (CMO) (see N.J.A.C. 10:73);

2. Psychiatric services provided in an inpatient psychiatric hospital setting (see N.J.A.C. 10:52);

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

4. Behavioral assistance services for children, youth or young adults (see N.J.A.C. 10:77–4);

5. Mobil response and stabilization management services for children, youth or young adults under EPSDT (see N.J.A.C. 10:77–6); and

6. Intensive in-community mental health rehabilitation services for children, youth or young adults under EPSDT (see N.J.A.C. 10:77–5).

Special New Rule, R.2002 d.214, effective June 10, 2002.
See: 34 N.J.R. 2338(a).
Amended by R.2005 d.68, effective February 22, 2005.
See: 36 N.J.R. 379(a), 37 N.J.R. 659(a).
Rewrote the section.
Amended by R.2005 d.98, effective April 4, 2005.
See: 36 N.J.R. 1158(a), 37 N.J.R. 1022(a).
Rewrote (b).

10:49–5.10 Services available to beneficiaries eligible for NJ FamilyCare–Plan I

(a) The services listed below are available to beneficiaries eligible for NJ FamilyCare–Plan I, on a fee-for-service basis, when medically necessary:

1. Certified nurse practitioner and clinical nurse specialist services;

2. Clinic services (services in an independent outpatient health care facility, other than a hospital, that provides covered ambulatory care services);

3. Emergency room services;

4. 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 shall not be covered by the NJ FamilyCare program;

5. Federally qualified health center primary care services;

6. 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 aid services 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)21 below;

i. Personal care assistant services are not covered;

7. Hospice services;

8. Hospital services—inpatient;

9. Hospital services—outpatient;

10. Laboratory (clinical);

11. Nurse-midwifery services;

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

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

14. Organ transplant services which are non-experimental or non-investigational;

15. Prescription drug services, except that over-the-counter drugs are not covered;

16. Physician services;

17. Podiatric services, except that routine foot care is not covered;

18. 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;

19. Outpatient surgery;

20. Radiological services;

21. Outpatient 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 period of 60 consecutive business days per incident of illness or injury beginning with the first day of treatment, except that:

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

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

23. Maternity and related newborn care;

24. Diabetic supplies and equipment;

25. 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. When authorized by the Division of Medical Assistance and Health Services, inpatient benefit exchanges are allowed, as follows:

(1) One mental health inpatient day may be exchanged for up to four home health visits or 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 outpatient visits.

(2) 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;

iv. Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:77A) are not eligible for payment under NJ FamilyCare–Plan I; and

v. NJ FamilyCare–Plan I beneficiaries under age 21 who are receiving services under the Division of Child Behavior Health Services, may be eligible for additional mental health and mental health rehabilitation services as authorized by the Contracted Systems Administrator. (See N.J.A.C. 10:49–5.10(c); and

26. Elective/induced abortion services.

(b) Unless listed in (a) above, no other services shall be covered by NJ FamilyCare–Plan I. Services which shall not be covered include, but shall not be limited to:

1. Services that are not medically necessary;

2. Private duty nursing, unless prior authorized by the Division;

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

4. Personal care assistant services;

5. Medical day care services;

6. Chiropractic services;

7. Dental services;

8. Orthotic devices;

9. Targeted case management for the chronically ill;

10. Christian Science sanitaria care and services;

11. Durable medical equipment;

12. Routine transportation, including non-emergency ambulance, invalid coach and lower mode (car, taxi, bus) transportation;

13. Hearing aid services;

14. Blood and blood plasma, except that administration, processing of blood, processing fees and fees related to autologous blood donations shall be covered;

15. Cosmetic services;

16. Nursing facility (long term care) services;

17. Special and remedial educational services;

18. Experimental and investigational services;

19. Infertility services;

20. Medical supplies, except that diabetic supplies shall be a covered service;

21. Rehabilitative services for substance abuse (methadone maintenance is not covered);

22. Weight reduction programs or dietary supplements;

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

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

25. Recreational therapy;

26. Sleep therapy;

27. Court ordered services;

28. Thermograms and thermography;

29. Biofeedback;

30. Radial keratomy;

31. Respite care;

32. Custodial care;

33. EPSDT services; and

34. Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:77A).

(c) Additional mental health and mental health rehabilitation services as listed below shall be available to beneficiaries under age 21 who are eligible for NJ FamilyCare–Plan I under fee-for-service receiving services from the Division of Child Behavioral Health Services. All services shall first be authorized by the Contracted Systems Administrator or other agent authorized by the Department of Human Services and shall be included in an approved plan of care.

1. Care coordination by a care management organization (CMO) (see N.J.A.C. 10:73);

2. Psychiatric services provided in an inpatient psychiatric hospital setting (see N.J.A.C. 10:52);

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

4. Behavioral assistance services for children, youth or young adults (see N.J.A.C. 10:77–4);

5. Mobil response and stabilization management services for children, youth or young adults under EPSDT (see N.J.A.C. 10:77–6); and

6. Intensive in-community mental health rehabilitation services for children, youth or young adults under EPSDT (see N.J.A.C. 10:77–5).

Special New Rule, R.2003 d.98, effective January 31, 2003.
See: 35 N.J.R. 1303(a).
Amended by R.2004 d.8, effective January 5, 2004.
See: 35 N.J.R. 2620(a), 35 N.J.R. 4204(a), 36 N.J.R. 189(a).
In (a)25, added iv; in (b), added 34.
Amended by R.2005 d.68, effective February 22, 2005.
See: 36 N.J.R. 379(a), 37 N.J.R. 659(a).
In (a), added 25v; added (c).
Amended by R.2005 d.98, effective April 4, 2005.
See: 36 N.J.R. 1158(a), 37 N.J.R. 1022(a).
Amended (c) and added 6.

SUBCHAPTER 6. AUTHORIZATIONS REQUIRED BY MEDICAID AND THE NJ FAMILYCARE PROGRAMS

10:49–6.1 Prior and retroactive authorization (general)

(a) Under the Programs, payment for certain services shall require prior authorization except in an emergency. It is the responsibility of the provider to obtain prior authorization before furnishing or rendering a service. Specific instructions are detailed in the appropriate Provider Services chapter.

1. Prior authorization should not be construed as a guarantee that a person is eligible for the New Jersey Medicaid or NJ FamilyCare program. At the time the service is to be provided, it is the provider's responsibility to verify eligibility.

2. "Medical emergency" means a critical illness or injury status for which prompt medical care may be crucial to saving life and limb or sparing the beneficiary significant or intractable pain. Services provided for a medical emergency are exempt from prior authorization. Any service classified as a medical emergency that would have been subject to prior authorization had it not been so classified, must be supported by a practitioner's statement which describes the nature of the emergency, including relevant clinical information, and must state why the emergency services rendered were considered to be immediately necessary. To simply state that an emergency did exist is not sufficient.

3. In addition to services that must be prior authorized under the previous subsections, a provider may be required to submit some or all services for prior authorization if in the judgment of the Medicaid Agent or DMAHS the provider has engaged in conduct which would constitute good cause for suspension, debarment or disqualification under N.J.A.C. 10:49–11.1(d). Prior authorization under this subsection may be imposed prior to a hearing under the same conditions applicable to suspensions under N.J.A.C. 10:49–11.1(j), except that the approval of the Attorney General shall not be necessary.

(b) Retroactive authorization may be granted under certain circumstances provided that the service is a part of continuing beneficiary care and, on the basis of medical judgment, would have been authorized at the time the service was rendered. Each case is considered on its own merit. Retroactive authorization is an exceptional measure granted only under the following unusual circumstances:

1. "Other coverage" (Medicare, Third-Party liability, other insurance, etc.) has denied or made only partial payment of a claim for services or items requiring prior authorization and it would have been unreasonable to expect the provider to have requested authorization prior to rendering the service;

2. Retroactive determination of eligibility;

3. An "administrative emergency" existed because communication between the provider and the staff of the New Jersey Medicaid program could not be established (for example, during a weekend, holiday or evening) and provision of the service should not have been delayed. This differs from a medical emergency in that the beneficiary's condition would not be impaired if the service was not provided (see example below). In such instances, the request for retroactive authorization, including an explanation of the circumstances as well as the medical documentation supporting the services, shall be submitted to the Medicaid District Office or Central Office, as appropriate, within five calendar days after the service was provided or initiated. If verbal authorization was obtained, confirming written documentation shall follow.

Example: A physician orders a Medicaid beneficiary home from the hospital on a Friday evening. The beneficiary requires an electrical hospital bed, but the Medical Supplier is unable to contact the Medicaid District Office to obtain prior authorization. It is advantageous to the Medicaid program, the hospital and the patient to dis-

charge the beneficiary and not wait until authorization for the bed is requested on Monday; or

4. In situations not covered by (b)1, 2, and 3 above, the New Jersey Medicaid program follows the doctrine of reasonableness which asks, "Is it reasonable to conclude that the situation presented warrants waiver of procedural rules?"

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Substituted "beneficiaries" and "beneficiary's" for "recipients" or "recipient's" throughout; in (a), substituted "Provider Services Chapter" for "Provider Services Manuals"; and in (a)3, substituted "Medicaid Agent" for "Director".
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 program in 1, and inserted a reference to DMAHS in 3.
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).

Case Notes

Unusual circumstances required retroactive authorization for payment of Medicaid services notwithstanding failure to obtain prior authorization. Pendleton Bradley Hospital v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 23.

Adapted tricycle was medically required for treating chronic encephalopathy. K.H. v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 3.

10:49–6.2 Out-of-State medical care and services

(a) Any covered service that requires prior authorization as a prerequisite for reimbursement to New Jersey Medicaid providers shall also require prior authorization if it is to be provided in any other state.

1. Services which require prior authorization are described in the specific Medicaid 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).
Deleted (a) and (c); and recodified former (b) as (a).

SUBCHAPTER 7. SUBMITTING CLAIMS FOR PAYMENT (POLICIES AND REGULATIONS)

10:49–7.1 General provisions

(a) The following information outlines the policies and regulations of the New Jersey Medicaid program that the provider shall adhere to when submitting a claim and requesting payment for services provided to a New Jersey Medicaid recipient. (To identify a Medicaid recipient, see N.J.A.C. 10:49–2.)

1. Each Provider Services Manual has information relevant to the basis of payment for services and items of payment provided that is usually found in the second chapter of each manual.

2. For requirements of the Division of Medical Assistance and Health Services and the New Jersey State Department of Health and Senior Services when submitting a claim to be considered for the charity care component of the disproportionate share subsidies for hospital services and other rules regarding eligibility for these services, see N.J.A.C. 10:52–11, 12 and 13.

(b) In addition to information in this subchapter about submitting claims for payment, a Fiscal Agent Billing Supplement is included following each Provider Services Manual. Included in the Supplement are prior authorization forms and instructions; information for the proper completion and submission of claim forms; the procedure to follow when claims are rejected and returned to the provider by the Fiscal Agent during the adjudication process; third party liability verification, procedure for submitting crossover claims, and examples of timely submission of claims; electronic media claims (EMC) submission; Remittance Advice Statements; procedures for Electronic Funds Transfer (EFT); adjustments for overpayment of claims, and adjustments by Medicare; procedure to follow when a claim is paid in error (voids); procedure for inquiries about claims; procedure for ordering forms; information about provider services; and item-by-item instructions for completing the claim form and other forms.

1. The Fiscal Agent Billing Supplement is not published in the New Jersey Administrative Code (N.J.A.C.) but is referenced as an appendix and is thus, not a legal description of the New Jersey Medicaid program's rules. Should there be any conflict between the Fiscal Agent Billing Supplement and the pertinent laws or rules governing the Medicaid program or the charity care program, the laws and rules of the Medicaid program and the charity care program, as appropriate, take precedence.

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"; in (b), deleted "form" or "forms" following "claim" and "claims".
Amended by R.1997 d.520, effective January 5, 1998.
See: 29 N.J.R. 1006(a), 30 N.J.R. 232(a).
Inserted (a)2; in (b), clarified precedence of Medicaid rules over Fiscal Agent Billing Supplement, and added references to "charity care program."
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)2, amended the N.J.A.C. references.
Amended by R.2003 d.485, effective December 15, 2003.
See: 35 N.J.R. 509(a), 35 N.J.R. 5568(a).
In (a)2, amended N.J.A.C. references.

10:49–7.2 Timeliness of Medicaid claim submission

(a) A Medicaid claim is defined as a request for payment from the New Jersey Medicaid program for a Medicaid reimbursable service provided to a Medicaid recipient.

1. For a Medicaid claim, the claim for payment from the Medicaid program may be submitted hard copy or by means of an approved method of automated data exchange.

2. It is the responsibility of each provider to ensure that each Medicaid/NJ FamilyCare–Plan A claim submitted by that provider is received by the New Jersey Medicaid/NJ FamilyCare program's Fiscal Agent within the time periods indicated in this section. Providers shall reconcile their claims submission records with the Remittance Advice they receive from the Division's Fiscal Agent in order to verify that the Division's Fiscal Agent has received their claims. Providers shall resubmit any claims for reimbursement which the provider determines have been submitted previously, but which do not appear on the Remittance Advice.

i. The New Jersey Medicaid program shall not reimburse for a claim received outside the prescribed time periods. This policy also applies to inquiries concerning a claim or claim related information received outside the prescribed time periods.

ii. For retroactive eligibility cases, a claim associated with a retroactive eligibility application, that was submitted to the Medicaid Assistance and Health Services' Retroactive Eligibility Unit will be considered as received on the date of receipt of the application on behalf of the applicant. For information about retroactive eligibility, see N.J.A.C. 10:49–2.9.

(b) "Prospective" medical bill(s) are bills submitted to the Retroactive Eligibility Unit with an Application for Retroactive Medicaid Eligibility (FD-74) on the assumption that they were incurred during the retroactive eligibility period but were actually incurred during the month of application for Medicaid or later. These bills were incurred during a time period when Medicaid eligibility already existed or should have existed (except that the individual experienced a delayed determination of Medicaid eligibility).

(c) Under the circumstances in (c)1 through 3 below, the Division of Medical Assistance and Health Services' Retroactive Medicaid Eligibility Unit will generate letters to providers whose bills were included with an Application for Retroactive Medicaid Eligibility, allowing the one-year timely submission requirements to be bypassed.

1. These "prospective" claims must not have already been submitted to the Fiscal Agent within one-year of the date that services were rendered;

2. The Application for Retroactive Medicaid Eligibility that these "prospective" bills are associated with must have been received at the Retroactive Eligibility Unit within 60 days of the date of the above mentioned letter (with the original letter attached); and

3. In order for payment to be made, these claims must remain outstanding and any collection action against the Medicaid beneficiary must be withdrawn.

(d) An institutional claim is a claim submitted by a hospital; home health agency; nursing facility; intermediate care facility/mental retardation (ICF/MR); residential treatment center; or governmental psychiatric hospital. The time requirements for submitting an institutional claim is as follows:

1. For claims submitted by home health agencies and hospitals (excluding governmental psychiatric hospitals), a claim for payment of a service provided to any Medicaid beneficiary shall be received by the New Jersey Medicaid Fiscal Agent within:

i. One year of the date of discharge on an inpatient hospital claim;

ii. One year of the date of service entered on an outpatient hospital claim or home health claim;

iii. One year of the earliest date of service entered on an outpatient hospital claim or home health claim, if the claim carries more than one date of service; or

iv. For early and Periodic Screening, Diagnosis and Treatment (EPSDT) including pediatric HealthStart services, claims must be submitted to the Fiscal Agent within 30 days of the provision of services.

2. For claims submitted by a nursing facility; an intermediate care facility for the mentally retarded; a residential treatment center; or a governmental psychiatric hospital, a claim for payment for services shall be received by the fiscal agent no later than one year after the "from date of service" as indicated on the claim.

(e) A non-institutional claim is a claim submitted by all providers except a hospital, home health agency, nursing facility, intermediate care facility/mental retardation (ICF/MR), residential treatment center, or governmental psychiatric hospital. The time requirements for submitting a non-institutional claim are as follows:

1. A claim for payment of a non-institutional service provided to any Medicaid beneficiary shall be received by the New Jersey Medicaid Fiscal Agent within:

i. One year of the date of service;

ii. One year of the earliest date of service entered on the claim if the claim carries more than one date of service;

iii. One year (365 days) of the dispensing date on a pharmacy claim; or

iv. For early and Periodic Screening, Diagnosis and Treatment (EPSDT) including pediatric HealthStart services, claims must be submitted to the Fiscal Agent within 30 days of the provision of services.

(f) The time requirements for submitting a combination Medicare/Medicaid or Medicare/NJ FamilyCare claim are as follows (Under Federal regulations this applies only to Medicare/Medicaid or Medicare/NJ FamilyCare claims and does not extend to claims involving any other third party insurance.):

1. A combination Medicare/Medicaid claim is defined as a request for payment from the New Jersey Medicaid program for a medical service provided to any Medicare/Medicaid beneficiary.

i. The claim shall contain the Medicaid Eligibility Identification Number, the Medicare three digit carrier/payor code, and the Medicare HIC Number.

2. A combination Medicare/Medicaid claim shall be received by the Medicare Intermediary/Carrier within the applicable Medicaid timely submission period (see (d) and (e) above) to be considered for further payment by the New Jersey Medicaid program.

i. The provider shall continue to have one year from the date of service for a claim to be received by the Medicaid Fiscal Agent. A claim received by the Medicaid Fiscal Agent after Medicare adjudication and within one year from the date of service shall be considered timely submitted.

ii. For combination Medicare/Medicaid claims received by the Medicare Intermediary/Carrier within the applicable Medicaid timely submission period and where Medicare adjudication occurs beyond the one year of the date of service, the provider shall submit a claim to be

received by the Medicaid Fiscal Agent within 90 days of the date of the Medicare adjudication.

iii. For Medicare/Medicaid claims where the Medicare adjudication occurs within one year from the date of service, but less than 90 days remain within the timely filing period, the provider shall submit the claim to be received by Medicaid within the one year timely filing period or 90 days, whichever is later.

iv. A combination Medicare/Medicaid claim received outside the applicable Medicaid timely submission period shall not be reimbursed by the New Jersey Medicaid program.

3. In most cases, when a beneficiary is eligible for both Medicare and Medicaid, or Medicare and NJ FamilyCare, a Medicare/Medicaid approved claim will crossover from the Medicare Carrier/Intermediary to the program's Fiscal Agent. The provider is requested to allow 45 days from Medicare adjudication for the Medicaid or NJ FamilyCare program to receive and process crossover claims. Failure to allow the 45 days for the transition from Medicare to Medicaid or NJ FamilyCare will result in claim denials due to duplicate claim errors. There are instances, however, where claims will not cross over from Medicare. In those instances, or when a Medicare/Medicaid or Medicare/NJ FamilyCare crossover is not reflected on the provider's Medicaid Remittance Advice within 45 days of the Medicare Explanation of Benefits (EOB), the provider shall follow the billing instructions in the Fiscal Agent Billing Supplement following the second chapter of the provider services manual.

(g) If additional information is required in order to process a Medicaid claim, the provider shall supply the information as soon as possible but not more than 30 days after the end of the timely submission period.

(h) Regarding a Medicaid claim submitted timely that has been adjudicated and denied, a provider may resubmit the claim within one year of the date of service or 30 days of the date of adjudication as indicated in the Remittance Advice Statement, whichever is later.

(i) If it appears that an individual is eligible for Supplemental Security Income (SSI), the Medicaid provider or a designee should, but is not required to, assist the patient in completing and submitting an application for SSI. The application for SSI shall be submitted to the Social Security Administration (SSA) so that it is received by the SSA within the time requirements for claim submission contained in (a) through (h) above. For institutional and non-institutional claims for services provided to an individual who was not found to be eligible for Medicaid as of the date of service and who thereafter is determined to be eligible for SSI (for that date of service) by the SSA, and, therefore, also eligible for Medicaid (for that date of service), the following requirements shall apply:

1. If the individual's application for SSI is received by the SSA within the time requirements for claim submission contained in (a) through (h) above, the Medicaid provider or a designee shall file a claim for services rendered to the individual so that it is received by the State's fiscal agent within the later of the following:

i. The applicable time requirements for claim submission contained in (a) through (h) above;

ii. Six months from the date of the SSI eligibility determination; or

iii. Six months from the date that the SSI/Medicaid eligibility data appears on the New Jersey Medicaid Management Information System.

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" and deleted "form" following "claim" throughout; and in (b)2, substituted "Medicaid Eligibility Identification Number" for "HSP (Medicaid) Case Number" and inserted reference to three digit carrier/payer.
Amended by R.1997 d.520, effective January 5, 1998.
See: 29 N.J.R. 1006(a), 30 N.J.R. 232(a).
Rewrote (a), inserted new (a)1 and recodified existing (a)1 as (a)2.
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 (d), inserted references to Medicare/NJ KidCare and to NJ KidCare, and made corresponding language changes, throughout, and inserted a reference to Medicare and NJ KidCare in the first sentence of 3.
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 (d)3, inserted a reference to Medicare/NJ KidCare approved claims in the first sentence and deleted "Medicaid" following "provider's" in the last sentence; and in (h)2, inserted references to Medicare/NJ KidCare claims throughout, and deleted "Medicaid" following "filed,".
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.2001 d.329, effective September 17, 2001.
See: 33 N.J.R. 1889(a), 33 N.J.R. 3334(a).
Rewrote (a)2; in (a)2ii, revised N.J.A.C. reference; in (d)3, substituted "KidCare may result in payment delays" with "FamilyCare will result in claim denials", and substituted "Advise" with "Advice"; in (e), substituted "30" for "90"; rewrote (f); deleted (g) and (h).
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)2ii, inserted ", that was submitted to the Medicaid Assistance and Health Services' Retroactive Eligibility Unit" following "retroactive eligibility application"; added a new (b) and (c) and recodified existing (b) through (f) as (d) through (h).
Amended by R.2003 d.485, effective December 15, 2003.
See: 35 N.J.R. 509(a), 35 N.J.R. 5568(a).
In (a), deleted the last two sentences in the introductory paragraph; rewrote (e) and (f).
Administrative correction.
See: 36 N.J.R. 5352(b).
Amended by R.2006 d.337, effective September 18, 2006.
See: 38 N.J.R. 2002(a), 38 N.J.R. 3899(b).
Added (i).

Case Notes

Evidence of provider's custom or practice of mailing reimbursement claims against New Jersey Medicaid Program fund, together with other evidence, was sufficient, under preponderance of evidence standard, to create presumption that disputed claims were mailed and received. SSI Medical Services, Inc. v. State Dept. of Human Services, Div. of Medical Assistance and Health Services, 146 N.J. 614, 685 A.2d 1 (1996).

Evidence supported finding that medical service provider timely submitted its Medicaid claims to fiscal agent for Division of Medical Assistance and Health Services: fiscal agent probably lost them. SSI Medical Services, Inc. v. State, Dept. of Human Services, Div. of Medical Assistance and Health Services, 284 N.J.Super. 184, 664 A.2d 505 (A.D.1995).

Denial of reimbursement for untimely claims affirmed. Capital Nursing Center v. Department of Health and Senior Services, 97 N.J.A.R.2d (HLT) 44.

Nursing facility not entitled to Medicaid reimbursement for untimely claims. Clara Maass Continuing Care Center v. Department of Health and Senior Services, 97 N.J.A.R.2d (HLT) 26.

Denial of reimbursement for untimely claim affirmed. In the Matter of Bridgeton Nursing Center, Patients: W.G. and M.R., 97 N.J.A.R.2d (HLT) 7.

Medicaid claims submitted more than two years after services rendered rejected as untimely filed. In the Matter of Bayview Convalescent Center, 97 N.J.A.R.2d (HLT) 1.

Failure to make timely inquiry regarding denial of Medicaid reimbursement claim rendered nursing home ineligible for reimbursement. In the Matter of Meadowview Nursing Home Patients, 96 N.J.A.R.2d (DMA) 65.

Medicaid reimbursement claims were denied where insufficient proof was submitted to invoke presumption of timely receipt of claims. SSI Medical Services, Inc. v. Medical Assistance and Health Services, 96 N.J.A.R.2d (DMA) 47.

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.

Twelve-month rule not applicable; government failed to give hospital provider number. Bergen Pines County Hospital v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 54.

Billing agent's error did not provide exception from one-year period. Pan American Pharmacy, Inc. v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 32.

Mismanagement by primary insurer no reason for relaxing time frames. Newark Beth Israel Medical Center v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 27.

Failure to receive determination from primary carrier did not excuse untimely application for Medicaid. Carrier Foundation v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 17.

Medicaid claim untimely; computer-indicated error not corrected for over one year. Lincoln Park Intermediate Care Center v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 63.

Claims for Medicaid reimbursement not timely filed. Jewish Hospital and Rehabilitation Center v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 53.

Corrected copy was sufficient notice of filing of discharge in error. Courthouse Convalescent Center v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 43.

Claim for reimbursement not filed within one year of date of discharge. Holy Name Hospital v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 36.

Hospital's claims for Medicaid reimbursement were untimely. Holy Name Hospital v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 33.

Long term care facility's claim for payment was untimely. Leisure Chateau Care Center v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 31.

Medicaid reimbursement; properly completed claims timely filed after rejection of improperly submitted claims. Leader Nursing and Rehabilitation Center v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 21.

Home care visits could not be added to cost report in absence of timely claim. Long Branch Public Health Nursing Association, Inc. v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 10.

10:49-7.3 Third party liability (TPL) benefits

(a) "Third party liability" (TPL) exists when any person, institution, corporation, insurance company, absent parent, Medicare program, public, private, or governmental entity is or may be liable in contract, tort, or otherwise by law or equity to pay all or part of the cost of medical assistance payable by the Medicaid or NJ FamilyCare program.

1. It is a violation of section 1902(a)(25)(D) of the Federal Social Security Act to refuse to furnish covered services to any Medicaid beneficiary because of a third party's potential liability to pay for services.

(b) Medicaid and NJ FamilyCare benefits are last-payment benefits. All TPL, for example, health insurance, Medicare, CHAMPUS, prepaid health plans, workers' compensation and auto insurance, shall, if available, be used first and to the fullest extent in meeting the cost of the medical needs of the Medicaid or NJ FamilyCare beneficiary, subject to the exceptions listed in (h) below.

(c) The New Jersey Medicaid program and the NJ FamilyCare program will supplement the amount paid by a third party, but the combined total paid to the provider shall not exceed the total amount payable under the program in the absence of any TPL. The following exceptions should be noted:

1. Medicare: The program will make payment in the full amount of the Medicare Part A deductible and coinsurance for inpatient hospital services, and for Part B outpatient hospital services. For services rendered on or after July 20, 1998, payment for Part B coinsurance and deductible for other non-hospital services shall be paid only up to the Medicaid or NJ FamilyCare maximum allowable.

2. Contracting practitioners: No program payments shall be made when the third party calls for a contracting or participating practitioner to accept the TPL as payment in full.

(d) Medicaid and NJ FamilyCare participating providers are prohibited from billing Medicaid or NJ FamilyCare beneficiaries for any amount, except:

1. For services, goods, or supplies not covered or authorized by the New Jersey Medical Assistance and Health Services Act (N.J.S.A. 30:4D-1 et seq.), as amended and supplemented, or not covered or authorized by the Division of Medical Assistance and Health Services under this chapter or N.J.A.C. 10:74, if the beneficiary elected to receive the services, goods, or supplies with the knowledge that they were not covered or authorized;

2. For payments made to the beneficiary by a third party on claims submitted to the third party by the provider;

3. For NJ FamilyCare-Plan C enrollee's contribution to care responsibility; or

4. For NJ FamilyCare-Plan D enrollee's required co-payment.

(e) When a Medicaid or NJ FamilyCare-Plan A beneficiary has other health insurance, the program requires that such benefits be used first and to the fullest extent, subject to the exceptions in (h) below. Supplementation may be made by the program, but the combined total paid shall not exceed the amount payable under the program in the absence of other coverage. The program shall not supplement covered services rendered by a participating or contracting practitioner with any private health coverage program where the private plan calls for the practitioner to accept that plan's payment as payment in full. When other health insurance is involved, supplementation claims shall not be filed with the program unless accompanied by a statement of payment, Explanation of Benefits (EOB), or denial from the other carrier. Attachment of such information will expedite Medicaid and NJ FamilyCare claim processing.

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

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.

10:49–7.6 Timeliness of charity care claim submission

(a) A charity care claim is defined as a request for the New Jersey charity care program to price the hospital services rendered and consider those services when determining the amount of the charity care component of the disproportionate share subsidies of the Health Care Trust Fund to be allocated to each New Jersey disproportionate share hospital.

(b) In order to be priced by the Fiscal Agent, the charity care claim must be a clean charity care claim, as defined in N.J.A.C. 10:52–12.1.

New Rule, R.2003 d.485, effective December 15, 2003.
See: 35 N.J.R. 509(a), 35 N.J.R. 5568(a).

SUBCHAPTER 8. PAYMENT FOR SERVICES PROVIDED

10:49–8.1 Fiscal Agent

The State of New Jersey uses a fiscal agent for the processing of Medicaid claims, the pricing of charity care claims, and payment to providers.

Amended by R.1997 d.520, effective January 5, 1998.
See: 29 N.J.R. 1006(a). 30 N.J.R. 232(a).
Inserted language referencing Medicaid claims, charity care claims, and provider payments.

10:49–8.2 Medicaid claims payment and charity care claims pricing

(a) The Fiscal Agency will process Medicaid claims daily and produce provider payments and associated Remittance Advice (RA) statements once each week. The RA is the provider's account statement and reflects the status of all Medicaid claims currently entered into the Medicaid Management Information System. Provider payments in the form of checks and electronic funds transfers will be released following approval by the New Jersey Medicaid program. For charity care claims pricing information, see N.J.A.C. 10:52–11, 12 and 13.

1. The Remittance Advice (RA) is the major vehicle for communicating to the provider the status of all Medicaid claims received by the fiscal agent. All of the provider's claims are processed and supporting records are updated during each payment cycle. RA statements are generated as a result of a payment cycle. All claims processed (entered into the Medicaid Management Information System) fall into one of three classifications: paid; in process; or denied.

i. A claim that is correctly completed for a covered service provided to a Medicaid beneficiary by an approved provider will be paid. The claim will appear on the RA Claims Status page, or pages, along with all other claims for which a provider is being paid in that payment cycle. If the amount differs from the billed charges, an explanation will appear on the RA.

ii. In process claims or processed but unpaid claims are those claims held for prepayment review by the Division or by the Fiscal Agent. The review will result in a claim or group of claims being paid, denied, or additional information being requested. If additional information is required, a letter and/or a Claim Correction Form (CCF) will be forwarded to the provider. (Additional billing information is provided in the Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

iii. Reasons for denial of a claim will be provided on the RA in the form of an error/edit code.

(1) Messages explaining all codes reflected on the Remittance Advice will be printed on a separate page.

(b) A unique 13 digit Internal Control Number (ICN) is assigned to each Medicaid claim received by the Fiscal Agent. The ICN is reflected on the RA and can be used to track the status of a claim. For more information about the ICN, see Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual.

(c) For each claim processed in a payment cycle, the ICN, beneficiary name, dates of service and other claim information is printed on the RA. On the line immediately below this information, a code is printed representing a denial reason, and other information that might be useful to the provider and payment reduction reasons, if any. Messages explaining all codes found on the RA will be found on a separate page following the status listing of all claims. For more information about Remittance Advice see the Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual.

(d) Claims may be paid beyond 12 months of the date of receipt with Federal financial participation (FFP) in the following situations:

1. When the claim invoice or retroactive adjustment is paid to a provider reimbursed under a retrospective payment system;

2. For a Medicare/Medicaid claim or Medicare/NJ KidCare claim, timely filed, payment may be made for services within six months after the program or provider receives notice of the Medicare claim disposition for a

timely filed Medicare/Medicaid or Medicare/NJ KidCare claim;

3. For claims from providers under investigation for fraud or abuse; or

4. For claims associated with administrative or legal actions pursuant to a hearing action or agency corrective action mandate, whether for an eligible individual or for all those eligibles affected in a similar manner.

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)1 and (a)1ii, substituted "in process" for "suspended"; in (a)1i and (c), substituted "beneficiary" for "recipient"; in (a)1iii, substituted "an error/edit code" for "a code"; and in (c), deleted "suspense reasons." following "a denial reason.", inserted "other information that might be useful to the provider and", and deleted reference that only a claim status paid as a bill will not have a code.
Amended by R.1997 d.520, effective January 5, 1998.
See: 29 N.J.R. 1006(a), 30 N.J.R. 232(a).
In (a), inserted reference to charity care claims pricing.
Amended by R.2001 d.329, effective September 17, 2001.
See: 33 N.J.R. 1889(a), 33 N.J.R. 3334(a).
Added (d).
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), amended the N.J.A.C. references in the introductory paragraph and rewrote 1ii.
Amended by R.2003 d.485, effective December 15, 2003.
See: 35 N.J.R. 509(a), 35 N.J.R. 5568(a).
In (a), amended N.J.A.C. references.

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, if copayment is indicated on the beneficiary's HMO card:

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; or

vii. Inpatient substance abuse detoxification 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).
Special amendment, R.2003 d.98, effective January 31, 2003.
See: 35 N.J.R. 1303(a).
In (c), rewrote the introductory paragraph and deleted viii.

10:49-9.2 NJ FamilyCare-Plans 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) Effective July 1, 2004, for 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, as follows:

1. For children, there shall be a premium of $17.00 per family per month that applies to all families, regardless of the number of children in the family;

2. For parents/caretakers, there shall be a premium of $28.50 for the first parent and $11.50 for the second parent/caretaker.

(c) Under NJ FamilyCare—Plan D, effective July 1, 2004, 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 $34.00 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 $68.00 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 $113.50 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) The premiums required in accordance with (b) through (d) above shall be adjusted each July 1, in accordance with the change in the Consumer Price Index published by the U.S. Department of Labor. The amounts in (b) through (d) above will be revised annually by a notice of administrative change published in the New Jersey Register.

(f) 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).
Special amendment, R.2003 d.98, operative February 1, 2003.
See: 35 N.J.R. 1303(a).
Rewrote (b) and (c); added new (e) and recodified former (e) as (f).
Administrative change.
See: 36 N.J.R. 3428(a).
Administrative correction.
See: 37 N.J.R. 1191(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.

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

i. A parent;

ii. A legal guardian;

iii. A relation;

iv. A friend;

v. An individual provider;

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

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

viii. An administrator or executor.

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

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Amended section name; substituted "beneficiary" and "beneficiary's" for "recipient" and "recipient's" throughout and deleted "form" following "claim" throughout.
Recodified from N.J.A.C. 10:49–9.6 and amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
Inserted references to NJ KidCare throughout; deleted "Medicaid" following "standard" in (c) and (d), and deleted "Medicaid" preceding "hard-copy" in (f)3. Former N.J.A.C. 10:49–9.9, Informing individuals of their rights, recodified to N.J.A.C. 10:49–9.12.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.
Amended by R.2000 d.449, effective November 6, 2000.
See: 32 N.J.R. 2394(a), 32 N.J.R. 3991(a).
Rewrote the section.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

Case Notes

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

10:49–9.10 Withholding of provider payments

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

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

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

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

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

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

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

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

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

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

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

5. Set forth the provider's, practitioner's or entity's right to submit to the Division, within 20 days of the provider's receipt of the withholding notice, a request for an administrative hearing, consistent with N.J.A.C. 10:49–10.3. Immediately upon receipt of such a request, the Division shall request the Office of Administrative Law to schedule a hearing on an expedited basis.

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

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

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

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

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Recodified from N.J.A.C. 10:49–9.7 and amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
Inserted a reference to NJ KidCare programs. Former N.J.A.C. 10:49–9.10, Provisions for appeals; fair hearings, recodified to N.J.A.C. 10:49–9.13.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.
Recodified from N.J.A.C. 10:49–9.10 by R.1999 d.294, effective September 7, 1999.
See: 30 N.J.R. 2808(a), 31 N.J.R. 2635(a).
Former N.J.A.C. 10:49–9.11, Fraud and abuse, recodified to N.J.A.C. 10:49–9.12.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).
Rewrote the section.

10:49–9.12 Fraud and abuse

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

Recodified from N.J.A.C. 10:49–9.8 and amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
Inserted a reference to NJ KidCare programs.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.
Recodified from N.J.A.C. 10:49–9.11 by R.1999 d.294, effective September 7, 1999.
See: 30 N.J.R. 2808(a), 31 N.J.R. 2635(a).
Former N.J.A.C. 10:49–9.12, Informing individuals of their rights, recodified to N.J.A.C. 10:49–9.13.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

10:49–9.13 Informing individuals of their rights

(a) All Medicaid and NJ FamilyCare–Plan A claimants shall be informed of the following, in writing, at the time of application and at the time of any action affecting their claim:

1. Of their right to a fair hearing;

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

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

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

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

Recodified from N.J.A.C. 10:49–9.9 and amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
In (a), inserted "Medicaid and NJ KidCare-Plan A" following "All"; and added (b).
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 with changes, effective September 21, 1998.
Recodified from N.J.A.C. 10:49–9.12 by R.1999 d.294, effective September 7, 1999.
See: 30 N.J.R. 2808(a), 31 N.J.R. 2635(a).
Former N.J.A.C. 10:49–9.13, Provisions for appeals; fair hearings, recodified to N.J.A.C. 10:49–9.14.
Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).
See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).

Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

10:49–9.14 Provisions for appeals; fair hearings

(a) Pursuant to N.J.A.C. 10:49–10, Notices, Appeals, and Fair Hearings, providers, Medicaid beneficiaries and NJ FamilyCare–Plan A beneficiaries shall have the right to file for fair hearings.

(b) A provider may be granted a hearing because of the denial of a prior authorization request or issues involving the provider's status; for example, termination, debarment, suspension, and so forth, as described in N.J.A.C. 10:49–11.1, or issues arising out of the claims payment process.

(c) A Medicaid or NJ FamilyCare–Plan A beneficiary may be granted a fair hearing in accordance with N.J.A.C. 10:49–10 if his or her claim for medical assistance is denied or is not acted upon with reasonable promptness, or because the beneficiary is aggrieved by any other agency action resulting in non-eligibility, denial, termination, reduction or suspension of such assistance. A NJ FamilyCare–Plan B, C and D beneficiary shall be afforded the opportunity for grievance review in accordance with N.J.A.C. 10:78–8.

(d) In order to obtain a fair hearing, the provider or the beneficiary shall submit a request in writing to the Medicaid Agent at the address as specified in the notice.

(e) Any nursing facility whose certification or Medicaid Provider Agreement is denied, terminated, or not renewed, may request a hearing in accordance with the appeals procedure described in the Nursing Facilities Services chapter.

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Substituted "beneficiary" and "beneficiaries" for "recipient" and "recipients" throughout; in (d), changed place to send hearing requests; and in (c), substituted "chapter" for "Manual".
Recodified from N.J.A.C. 10:49–9.10 and amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
Rewrote (a) and (c).
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 with changes, effective September 21, 1998.
Recodified from N.J.A.C. 10:49–9.13 by R.1999 d.294, effective September 7, 1999.
See: 30 N.J.R. 2808(a), 31 N.J.R. 2635(a).
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).
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 "Notices, Appeals, and " preceding "Fair Hearings"; rewrote (c).

10:49–9.15 Advance directives

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

"Advance directive" means a written expression of a patient's preferences regarding the provision, withholding or withdrawal of a medical service, treatment or procedure in the event that the patient subsequently lacks decision making capacity. An advance directive may include a proxy directive or an instruction directive, or both.

"Decision making capacity" means a patient's ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of each, and alternatives to any proposed health care, and to reach an informed decision. A patient's decision making capacity is evaluated relative to the demands of a particular health care decision.

"Declarant" means a competent adult 18 years of age or older who executes an advance directive.

"Health care decision" means a decision to accept or to refuse any treatment, service or procedure used to diagnose, treat or care for a patient's physical or mental condition, including life-sustaining treatment. "Health care decision" also means a decision to accept or to refuse the services of a particular physician, nurse, other health care professional or health care institution, including a decision to accept or to refuse a transfer of care.

"Health care institution" means institutions, facilities, and agencies licensed, certified, or otherwise authorized by State law to administer health care in the ordinary course of business, including hospitals, nursing homes, residential health care facilities, home health care agencies, personal care service agencies, and hospice programs operating in this State, mental health institutions, facilities or agencies, or institutions, facilities and agencies for the developmentally disabled. For purposes of this section, "health care institution" also means a managed care organization contracted pursuant to N.J.A.C. 10:74 to provide medical services to beneficiaries of the New Jersey Medicaid/NJ KidCare/NJ FamilyCare program.

"Health care professional" means an individual, as opposed to a health care institution, licensed by this State to administer health care in the ordinary course of business or practice of a profession.

"Health care representative" means the individual designated by a declarant pursuant to the proxy directive part of an advance directive for the purpose of making health care decisions on the declarant's behalf, and includes an individual designated as an alternate health care representative who is acting as the declarant's health care representative in accordance with the terms and order of priority stated in an advance directive.

"Instruction directive" means a writing which provides instructions and direction regarding the declarant's wishes for health care in the event that the declarant subsequently lacks decision making capacity.

"Life-sustaining treatment" means the use of any medical device or procedure, artificially provided fluids and nutrition, drugs, surgery or therapy that uses mechanical or other artificial means to sustain, restore or supplant a vital bodily function, and thereby increase the expected life span of a patient.

"Nurse" means a person currently licensed to practice as a registered professional nurse who is certified by the New Jersey State Board of Nursing in accordance with N.J.A.C. 13:37–7, and with N.J.S.A. 45:11–23 et seq., or similarly licensed and certified by a comparable agency of the state in which he or she practices.

"Other health care professionals" means licensed health care professionals other than physicians and nurses.

"Patient" means an individual who is under the care of a physician, nurse or other health care professional.

"Physician" means an individual licensed to practice medicine and surgery in this State.

"Proxy directive" means a writing which designates a health care representative in the event the declarant subsequently lacks decision making capacity.

(b) Participating health care institutions shall establish written policies and procedures concerning the rights of patients to make decisions regarding their medical care and their right to execute advance directives. In addition to policies affirming patients' rights:

1. Private religiously-affiliated health care institutions may develop institutional policies and practices defining circumstances under which they will decline to participate in the withholding or withdrawing of specific measures to sustain life. Such policies and practices shall be written, and shall be properly communicated to patients and their families and health care representatives before or at the time of the patient's admission or enrollment. If the institution's policies and practices appear to conflict with the legal rights of a patient wishing to forego health care, the health care institution shall attempt to resolve the conflict. If a mutually satisfactory accommodation cannot be reached, the health care institution shall take all reasonable steps to effect the appropriate, timely and respectful transfer of the patient to the care of another health care institution appropriate to the patient's needs, and shall assure that the patient is not abandoned or treated disrespectfully; and

2. Health care institutions shall include in their policies a statement informing physicians, nurses and other health care professionals of their rights and responsibilities, to assure that such rights and responsibilities are understood, including the right to decline to participate in withholding or withdrawing life-sustaining treatment, in accordance with sincerely held personal or professional convictions, and to provide a forum for discussion and consultation on the subject of such rights.

(c) Nothing in this section shall be construed as restricting, modifying or replacing the requirements established for health care institutions by the Department of Health and Senior Services (see N.J.A.C. 8:36, 8:39, 8:42, 8:43, 8:43C and 8:43G for specific requirements).

(d) In addition to developing the written policies referred to in (b) above, health care institutions shall:

1. Furnish patients with written information about their rights to accept or refuse treatment, and to formulate advance directives. This information shall also be made available on request to patients' health care representatives, families and other interested parties;

2. Note in each patient's medical record whether that patient has executed an advance directive;

3. Provide (individually or with others) for education of staff and the community on issues concerning advance directives;

4. Provide care or other services without discrimination based on whether or not the individual has executed an advance directive; and

5. Ensure compliance with State law regarding advance directives (see N.J.S.A. 26:2H–53 et seq.).

(e) Health care institutions shall distribute written information concerning advance directives to individuals:

1. In the case of a hospital, at the time of the individual's admission as an inpatient;

2. In the case of a nursing facility, at the time of the individual's admission as a resident;

3. In the case of a provider of home health care, personal care assistant services or private duty nursing services, in advance of the individual coming under the provider's care;

4. In the case of a hospice program, at the time the individual initially receives hospice care from the program; and

5. In the case of a managed care organization, at the time the individual enrolls in the program.

(f) A physician, nurse, or other health care professional may decline to participate in the withholding or withdrawing life-sustaining treatment, in accordance with sincerely held personal or professional convictions, consistent with the provisions of N.J.S.A. 26:2H–62(b) and (c).

New Rule, R.2001 d.294, effective August 20, 2001.
See: 32 N.J.R. 2687(b), 33 N.J.R. 2808(a).

SUBCHAPTER 10. NOTICES, APPEALS AND FAIR HEARINGS

10:49–10.1 Definitions

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

"Applicant" means any person who has made application for purpose of becoming a "qualified applicant."

"Claimant," when used within these rules, means applicant, qualified applicant or beneficiary as defined in this section.

"Notice" means an announcement of a policy decision by the Title XIX or Title XXI agency that may adversely affect the Medicaid or NJ FamilyCare–Plan A beneficiary.

"Qualified applicant" means any person who is determined to be eligible to receive benefits in accordance with N.J.S.A. 30:4D–1 et seq., as amended and supplemented.

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Amended "Claimant" and "Notice"; and deleted "Department", "Provider", and "Recipient".
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 "Notice", inserted references to Title XXI agencies and to NJ KidCare–Plan A beneficiaries.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).
In "Qualified applicant", substituted "as amended and supplemented" for "and amendments thereto" following the N.J.S.A. reference.

Case Notes

Indictment and subsequent conviction of provider for Medicaid fraud provided good cause for suspension of license and eventual debarment. Division of Medical Assistance v. A & H Medical, 95 N.J.A.R.2d (DMA) 43.

10:49–10.2 Notices

(a) The New Jersey Medicaid or NJ FamilyCare program may print a notice of prospective policy changes affecting Medicaid or NJ FamilyCare beneficiaries or providers generally in one or more newspapers in New Jersey.

1. This public notice will be accompanied by a proposed rulemaking on the subject of the notice in the New Jersey Register.

2. The public notice may precede or be subsequent to the Register publication.

3. The Department of Human Services, or the Department of Health and Senior Services where authorized by Reorganization Plan No. 001–1996, may proceed to adopt the regulatory changes pursuant to N.J.S.A. 52:14B–4 without providing further notice.

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 "New Jersey Medicaid program" for "Department/Division" and "beneficiaries or providers" for "recipients"; and in (a)3, inserted reference to Department of Health and Senior Services.
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 references to NJ KidCare in the introductory paragraph.
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).

10:49–10.3 Opportunity for fair hearing

(a) An opportunity for a fair hearing may be granted to any provider requesting a hearing on any valid complaint or issue arising out of the Medicaid or NJ FamilyCare claims payment process:

1. Such issues shall include, but not be limited to, denials of prior authorization and denial of claims submitted for payment.

2. Such requests for hearing shall be made in writing within 20 days from the date of the notice of the agency action giving rise to said complaint or issue.

3. For claim denial or payment adjustment, the 20 days' notice starts from the date in the right hand corner of the Remittance Advice Claims Status returned to providers with the Remittance Advice cover page (see the Fiscal Agent Billing Supplement following the second chapter of each Providers Services Manual regarding the Remittance Advice cover page and Claims Status explanations and examples). Providers should include a photocopy of the applicable Claims Status page, highlighting the beneficiary and applicable edit code(s) when submitting a hearing request.

(b) An opportunity for a fair hearing shall be granted to all claimants requesting a hearing because their claims for medical assistance are denied or are not acted upon with reasonable promptness, or because they believe the Medicaid Agent or NJ FamilyCare–Plan A program has errone-

ously terminated, reduced or suspended their assistance. The Medicaid Agent or NJ FamilyCare program need not grant a hearing if the sole issue is one of a Federal or State law requiring an automatic termination, reduction or suspension of assistance affecting some or all claimants. Under this requirement:

1. A request for hearing shall be defined as any clear expression (submitted in writing) by claimants (or someone authorized to act on behalf of claimants) to the effect that they desire the opportunity to present their case to higher authority;

2. The freedom to make such a request shall not be limited or interfered with in any way, and the Medicaid Agent or NJ FamilyCare–Plan A program emphasis shall be on helping claimants to submit and process their case if needed;

3. Claimants shall have 20 days from the date of notice of Medicaid Agent or NJ FamilyCare program action in which to request a hearing;

4. The fair hearing shall include consideration of:

i. Any Medicaid Agent or NJ FamilyCare–Plan A program action, or failure to act with reasonable promptness, on a claim for medical assistance, which includes undue delay in reaching a decision on eligibility, suspension of assistance or denial of such assistance in whole or in part;

ii. Medicaid Agent's or NJ FamilyCare–Plan A program's decision regarding:

(1) Eligibility for medical assistance in both initial and subsequent determinations;

(2) Amount of medical assistance or change in such assistance;

5. The Medicaid Agent or DMAHS may respond to a series of individual requests for fair hearings by arranging for a single group hearing. A consolidation of cases by the Medicaid Agent or DMAHS may be allowed only in cases which the sole issue involved is one of Federal or State law or policy;

6. In all group hearings, whether initiated by the Medicaid Agent or DMAHS or by claimants, the policies governing fair hearings shall be followed. Thus, each individual claimant shall be permitted to present his or her own case and be represented in accordance with the provisions of N.J.A.C. 10:49–9.13(a)3; and

7. The Medicaid Agent or DMAHS shall not deny or dismiss a request for a hearing except where it has been withdrawn by claimant in writing or abandoned.

(c) For purposes of these rules, the right to a hearing is considered abandoned if claimants or their representative fail to appear at a scheduled hearing and, within five days after receipt of an inquiry as to whether they desire any further action on their request, no reply is received. Refusal of acceptance of a registered letter inquiring into contemplated further action by claimants shall constitute abandonment effective the date of refusal.

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
In (a), inserted "Medicaid" preceding "claims payment"; in (a)3, substituted "beneficiary" for "recipient"; in (b), substituted reference to Medicaid Agent for references to agency and department throughout.
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 NJ KidCare claims; in (b), inserted references to the NJ KidCare program, the NJ KidCare–Plan A program and DMAHS throughout; and substituted a reference to N.J.A.C. 10:49–9.12(a)3 for a reference to N.J.A.C. 10:49–9.9(a)3 in 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 with changes, effective September 21, 1998.
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. 1118(a).

Case Notes

Opportunity for prompt posttermination hearing provided physician in connection with termination of his right to participate in state medical assistance program satisfied due process. (also cited as N.J.A.C. 10:49–63). Greenspan v. Klein, 442 F.Supp. 860 (D.N.J.1977), (See Greenspan v. Klein, 550 F.2d 856 (3rd Cir.1977).

10:49–10.4 Advance notice of intent to terminate, reduce, or suspend assistance for Medicaid and NJ FamilyCare–Plan A

(a) In cases of any proposed action to terminate, reduce or suspend assistance, the Medicaid Agent or DMAHS shall give the claimant timely and adequate notice detailing the reasons for the proposed action. Under these requirements:

1. "Timely" means that the notice is dated at least 10 days before the action is to be taken; and

2. "Adequate advance notice" means a written notice that includes a statement of the action the Medicaid Agent or DMAHS intends to take, reasons for the proposed departmental action, the specific regulations that support, or the change in Federal or State law that requires the action, the claimant's right to request a fair hearing, or in cases of a departmental action based on a change in law, the circumstances under which a hearing shall be granted, and the circumstances under which assistance shall be continued if a fair hearing is requested.

(b) In cases in which there is a request for a fair hearing within the advance notice period:

1. Assistance shall be continued until a decision is rendered unless:

i. It is determined at the hearing that the sole issue is one of Federal or State law or policy; and

ii. The Medicaid Agent or DMAHS promptly informs the claimant in writing that services shall be terminated or reduced pending the hearing decision.

2. If the Medicaid Agent's or DMAHS's action is sustained by the hearing decision, the Medicaid Agent or DMAHS may institute recovery procedures against claimants to recoup the cost of any services furnished claimants to the extent the services were furnished solely by reason of this section.

(c) The Medicaid Agent or DMAHS may reinstate services if a claimant requests a hearing not more than 10 days after the effective date of the termination, suspension or reduction of eligibility or covered services.

1. If services are reinstated, they shall continue until a hearing decision is made unless it shall be determined at the hearing that the sole issue is one of Federal or State law or policy.

(d) The Medicaid Agent or DMAHS shall reinstate and continue services until a decision is rendered after a hearing if:

1. An action is taken to terminate, suspend or reduce eligibility or covered services without affording claimants adequate advance notice as defined herein;

2. Claimants request a hearing within 10 days of the date of the notice of action; and

3. The Medicaid Agent or DMAHS determines that the action to terminate, reduce or suspend assistance resulted from reasons other than the application of Federal or State law or policy.

(e) If a claimant's whereabouts are unknown, as indicated by the return of unforwardable departmental mail directed to them, any discontinued services shall be reinstated if their whereabouts become known during the time they are eligible for services.

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Substituted reference to Medicaid Agent for reference to department throughout.
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
Inserted references to DMAHS throughout.
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).

Cross References

Notification of approval or denial of nursing facility services by Medicaid District Office as under this section, see N.J.A.C. 10:63-1.8.

Case Notes

Initial Decision (2005 N.J. AGEN LEXIS 496) adopted, which concluded that no deprivation of due process had resulted from deficiencies in the notice informing petitioners of a reduction in private duty nursing service hours provided by Medicaid, because petitioners had constructive notice of the grounds of denial at the time the appeal was initiated, the hearing before the ALJ provided due process, and the services had not been terminated but had been maintained pending the outcome of the hearing. N.S. v. AmeriChoice of N.J., Inc., OAL Dkt. No. HMA 6759-04, 2005 N.J. AGEN LEXIS 1112, Final Decision (December 8, 2005).

10:49-10.5 Location of hearing

The hearing shall be conducted at a reasonable time, date and place after adequate written notice of the hearing is given.

10:49-10.6 Impartiality of official conducting the hearing

The hearing shall be conducted by an Administrative Law Judge from the Office of Administrative Law or by other persons eligible to conduct hearings pursuant to the New Jersey Administrative Procedure Act, set forth in N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq.

10:49-10.7 Beneficiary's right to different medical assessment

When the hearing involves medical issues, such as those concerning a diagnosis or an examining physician's report or the medical review team's decision, and if the hearing officer considers it necessary to have a medical assessment other than that of the person or persons involved in making the original decision, such medical assessment shall be obtained at Departmental expense from a source satisfactory to the claimant and shall be made part of the record.

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.

10:49-10.8 Hearing procedures

The hearing shall be conducted pursuant to the procedures set forth in the Administrative Procedure Act and the Uniform Administrative Procedure Rules (N.J.A.C. 1:1). The Special Hearing Rules set forth in N.J.A.C. 1:10B apply to claimant (beneficiary) hearings. (See 42 C.F.R. 431.200, Subpart E).

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".

10:49-10.9 Prompt, definitive and final action

Prompt, definitive and final administrative action shall be taken within 90 days from the date of the request for a fair hearing, except where claimant requests an adjournment.

10:49-10.10 Notification to claimants

Claimants shall receive a written final decision, in the name of the Department and shall be notified of their right to judicial review.

10:49-10.11 Action upon favorable decision to claimants

When the final hearing decision is favorable to claimants or when the Department decides in favor of claimants prior to the hearing, the Department shall make corrective payments retroactively to the date the incorrect action was taken or such earlier date as may be provided under State policy.

10:49-10.12 Hearing decision

(a) A final decision by the Medicaid Agent's or DMAHS' head shall specify the reasons for the decision and identify the supporting evidence or may incorporate by reference the findings, conclusions, and recommendations, contained in the initial decision.

(b) Final decisions shall be binding on the Medicaid Agent or DMAHS.

(c) Under this rule, no person who participated in the local decision being appealed shall participate in a final administrative decision on such a case; the Medicaid Agent or DMAHS shall be responsible for seeing that the decision is carried out promptly.

(d) The final decision shall be promptly implemented.

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Substituted references to Medicaid Agent for references to agency and department throughout.
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
Inserted references to DMAHS throughout.
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.

10:49-10.13 Accessibility of hearing decisions to local agencies and the public

The Medicaid Agent or DMAHS shall establish and maintain a method for informing, at least in summary form, all local agencies of all fair hearing decisions by the hearing authority and the decisions shall be accessible to the public (subject to the provisions of safeguarding public assistance information).

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Substituted "Medicaid Agent" for "Department".
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
Inserted a reference to DMAHS.
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 11. EXCLUSION FROM PARTICIPATION IN THE NEW JERSEY MEDICAID AND NJ FAMILYCARE PROGRAMS (SUSPENSION, DEBARMENT, AND DISQUALIFICATION)

Cross References

Termination of nursing facility provider agreement, good cause as under this section, see N.J.A.C. 10:63-1.6.

10:49-11.1 Program participation

(a) The provisions of this section were adopted and issued pursuant to Executive Order No. 34, dated March 29, 1976, and the authority vested in the Division of Medical Assistance and Health Services to implement the New Jersey Medicaid and NJ FamilyCare programs by rules and regulations set forth in N.J.S.A. 30:4D-5, N.J.S.A. 30:4D-17.1 a and c, Reorganization Plan No. 001-1996 and P.L. 1997, c.272.

(b) Suspension, debarment, and disqualification are measures which shall be invoked by the Division of Medical Assistance and Health Services to exclude or render ineligible certain persons from participation in contracts and subcontracts with the New Jersey Medicaid or NJ FamilyCare program, or in projects or contracts performed with the assistance of and subject to the approval of the Medicaid Agent or DMAHS, on the basis of a lack of responsibility. These measures shall be used for the purpose of protecting the interests of the New Jersey Medicaid and/or NJ FamilyCare programs and not for punishment. To assure the New Jersey Medicaid and/or NJ FamilyCare programs, the benefits to be derived from the full and free competition between and among such persons and to maximize the opportunity for honest competition and performance, these measures shall not be invoked for any time longer than deemed necessary to protect the interests of the New Jersey Medicaid and/or NJ FamilyCare programs.

1. Any individuals, including but not limited to, owners, officers, administrators, assistant administrators, employees, accountants, attorneys, and management services, who have been suspended, debarred or disqualified from participation in the Medicaid and/or NJ FamilyCare programs for any reason shall not be involved in any activity relating to the New Jersey Medicaid and/or NJ FamilyCare programs.

2. Providers reimbursed on a cost-related basis may not claim as allowable costs any amounts paid or credited to such individuals, and such amounts shall not be reimbursed by the New Jersey Medicaid and/or NJ FamilyCare programs.

3. Providers may not submit claims and shall not be reimbursed for any goods supplied or services rendered by such individuals.

4. The requirement in (b)3 above shall apply only for the period during which such individuals are suspended, debarred or disqualified from Medicaid and/or NJ FamilyCare participation.

5. Claims shall not be submitted and claims shall not be reimbursable for 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, an individual or entity, during the period when such individual, entity or physician is excluded from participation in the Medicaid and NJ FamilyCare programs, and when the individual or entity furnishing such item or service has received written notice from the Division that the entity, individual or physician has been excluded from participation in the Medicaid and NJ FamilyCare programs.

(c) The following words and terms, as used in this section, shall have the following meanings:

(n) For purposes of this section, for future estates or estates pending on or after October 4, 1999, the term "estate" shall not include:

1. A life estate in which the beneficiary held an interest during his or her lifetime, but which expired upon the Medicaid beneficiary's death;

2. An inter vivos trust established by a third party for the benefit of the now-deceased Medicaid beneficiary, provided that:

i. The trust is a discretionary trust, constructed in such a way that the Medicaid beneficiary could not compel distributions from the trust; and

ii. The trust contains no assets in which the Medicaid beneficiary held any interest within either five years prior to applying for Medicaid benefits, or five years prior to the Medicaid beneficiary's death; or

3. A testamentary trust established by a third party (including the spouse of the now-deceased Medicaid beneficiary) for the benefit of the now-deceased Medicaid beneficiary, provided that:

i. The trust is a discretionary trust, constructed in such a way that the Medicaid beneficiary could not compel distributions from the trust; and

ii. The trust contains no assets in which the Medicaid beneficiary held any interest within either five years prior to applying for Medicaid benefits, or five years prior to the beneficiary's death. Assets of the community spouse which formed a part of the community spouse resource allowance shall not be considered assets of the Medicaid beneficiary. Any assets of the community spouse other than those that formed part of the community spouse resource allowance shall be considered assets of the Medicaid beneficiary if acquired from the Medicaid beneficiary within five years prior to the date of application for Medicaid benefits or five years prior to the date of death of the Medicaid beneficiary.

Amended by R.1994 d.524, effective October 17, 1994.
See: 26 N.J.R. 2757(a), 26 N.J.R. 4184(b).
Amended by R.1999 d.332, effective October 4, 1999.
See: 31 N.J.R. 242(a), 31 N.J.R. 2883(a).
In (a), in the introductory text, substituted "the individual" for "he or she", in (a)2, substituted "of individuals who died" for "coming into being", inserted "1," following "February", and substituted "left" for "leaving", in (a)3, substituted "of individuals who died" for "coming into being", in (b), substituted "but prior to December 22, 1995" for "the effective date of P.L. 1981, c.217 (N.J.S.A. 30:4D–7.2a)", and added (c) to (n).

Case Notes

Retroactive application of statute for recovery of Medicaid overpayments did not violate due process. In re: Kaplan, 178 N.J.Super. 487, 429 A.2d 590 (App.Div.1981).

10:49–14.2 Sanctions—Special Status Program

(a) The "Special Status Program" either restricts the Medicaid or NJ FamilyCare beneficiary(s) listed on the Eligibility Identification (EI) Card to a single provider, except in a medical emergency, or warns providers that the beneficiary's card has been used by an unauthorized person or persons, or for an unauthorized purpose. If a warning card is issued, a message will be printed on the card alerting the provider to ask the Medicaid or NJ FamilyCare beneficiary for additional identification or to take other appropriate action.

1. The restrictive card is issued to Medicaid or NJ FamilyCare beneficiaries determined to have misused, abused or overutilized their Medicaid or NJ FamilyCare benefits. Overutilization occurs when a beneficiary has utilized Medicaid or NJ FamilyCare services or items at a frequency or amount that is not medically necessary. Examples of misuse or abuse include, but are not limited to, medically harmful or inappropriate use of different drugs or provider services, obtaining or attempting to obtain early refills of prescriptions in violation of N.J.A.C. 10:51–1.19(a)5, at more than one pharmacy, and forgery or alteration of prescriptions. A determination that there has been misuse, abuse or overutilization of benefits obtained by use of an (EI) Card shall create a presumption that the beneficiaries listed on the (EI) Card were responsible for such actions. If this presumption is successfully rebutted by the Medicaid or NJ FamilyCare beneficiary, he or she shall not be enrolled in the Special Status Program.

i. A beneficiary shall be permitted to change the designated provider upon demonstration of good cause and the Division may grant the request.

ii. The Division may change the provider to which the beneficiary is restricted if a pattern of continued misuse, abuse or overutilization by the beneficiary is evident, or if it is determined that the provider has engaged in fraud or abuse, or if the Division determines that such a change is in the best interest of the beneficiary and/or the programs it administers in whole or part.

iii. The beneficiary may request a contested case hearing in the following situations:

(1) If the beneficiary objects to being included in the special status program;

(2) If the beneficiary requests a change and the request is denied;

(3) If the agency causes undue delay in responding to the beneficiary's request for change.

2. The warning card is issued to Medicaid or NJ FamilyCare beneficiaries determined to have had their EI Card used by an unauthorized person or persons, or for an unauthorized purpose. The purpose of the warning card is to notify providers that the beneficiary's (EI) Card

has been used by an unauthorized person or persons, or for an unauthorized purpose. A message will be printed on the card alerting the provider to ask the Medicaid or NJ FamilyCare beneficiary for additional identification or to take other appropriate action. A determination that an (EI) Card has been used by an unauthorized person or for an unauthorized purpose shall create a presumption that the beneficiaries listed on the (EI) Card were responsible for such actions. If this presumption is successfully rebutted by the beneficiary, the beneficiary shall not be issued a warning card.

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Substituted reference to beneficiaries for references to recipients throughout.
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 references to NJ KidCare and substituted references to Eligibility Identification Cards for references to Medicaid Eligibility Identification Cards throughout.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).
Rewrote (a)1.

10:49–14.3 Authority to adjust, compromise, settle or waive claims, liens, and certificates of debt

(a) The Commissioner, Department of Human Services; Director, Division of Medical Assistance and Health Services; Assistant Director, Office of Program Integrity Administration; and the Commissioner or Deputy Commissioner, Department of Health and Senior Services, or anyone serving in an acting capacity in any of those positions shall have the authority to adjust, compromise, settle or waive any claim, lien or certificate of debt arising under this Act (N.J.S.A. 30:4D–1 et seq.), and to execute an appropriate release or document of discharge with respect to that claim, lien or certificate of debt.

(b) Such authority may be exercised by other officials only in the following limited circumstances:

1. The Administrator, Bureau of Administrative Control may compromise, settle or waive any claim or lien not arising under N.J.S.A. 30:4D–7(h) within the dollar limits specified by the Director, Division of Medical Assistance and Health Services; and

2. The Fiscal Agent may compromise, settle or waive claims arising under N.J.S.A. 30:4D–7(h) within the dollar limits specified by the Director, Division of Medical Assistance and Health Services.

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), amended Office reference and added reference to Commissioner and Deputy Commissioner of Department of Health and Senior Services.
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).
Substituted a reference to the Office of Program Integrity Administration for a reference to the Office of Quality Management and Program Integrity.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

Case Notes

Recapture of the reimbursement for pharmaceutical services; agent erroneously processed claim. South End Pharmacy, Inc. v. Division of Medical Assistance and Health Services, 94 N.J.A.R.2d (DMA) 48.

10:49–14.4 Recoveries involving county board of social services (CBOSS)

(a) The purpose of this section is to define areas of responsibility and establish basic principles and procedures in those collection activities in which the Division of Medical Assistance and Health Services (DMAHS), the Division of Family Development (DFD) and/or a county board of social services (CBOSS) may be involved. It is intended that maximum conservation of public funds be effected without duplication of effort. It is recognized that certain situations may fall into more than one of the following categories. Any such matter will be processed in accordance with the provisions of the first occurring applicable category.

(b) The following pertain to incorrectly granted assistance (cash and/or medical assistance):

1. In instances involving incorrect eligibility for medical assistance, whether or not in combination with cash assistance, the county board of social services (CBOSS) shall determine the period(s) of ineligibility and ascertain from DMAHS the amount of medical assistance incorrectly granted. The county board of social services (CBOSS) shall then attempt recovery of medical assistance incorrectly granted either by administrative collection, or by way of restitution in a criminal or disorderly persons proceeding.

i. Recoveries or attempts at recoveries can be made from those persons specified in N.J.S.A. 30:4D–7i.

2. When recovery cannot be obtained by these methods in a case generated by the Internal Revenue Service (IRS) unearned income component of the Income and Eligibility Verification System (IEVS), the case shall be referred by the county board of social services (CBOSS) to DMAHS for possible initiation of recovery proceedings.

3. When in any other case not generated by IEVS, recovery cannot be obtained by these methods, the county board of social services (CBOSS) is authorized after securing DMAHS approval to initiate recovery proceedings as DMAHS' agent. If the county board of social services (CBOSS) does not initiate such recovery proceedings, it shall refer the case to DMAHS for possible initiation of recovery proceedings.

4. When collection occurs in a case involving both cash assistance and medical assistance, the county board of social services (CBOSS) shall, in the absence of court instruction to the contrary, apply the proceeds to the repayment of cash assistance and the reimbursement of DMAHS for medical assistance. The reimbursement shall be made payable to the Treasurer, State of New Jersey, which shall then reimburse the county board of social services (CBOSS) in the amount of 25 percent of the gross recovery on a periodic basis to be determined by DMAHS.

5. When a county board of social services (CBOSS) recovers only for medical assistance improperly granted, the county board of social services (CBOSS) shall remit the proceeds to DMAHS. The reimbursement shall be made payable to the Treasurer, State of New Jersey, who will then reimburse the county board of social services (CBOSS) in the amount of 25 percent of the gross recovery on a periodic basis to be determined by DMAHS.

6. When any county board of social services (CBOSS) action, whether alone or in combination with DMAHS, results in a recovery of improperly granted medical assistance from a case generated by the Internal Revenue Service (IRS) unearned income component of the IEVS match, all funds recovered shall be remitted to DMAHS payable to the Treasurer, State of New Jersey, which shall then reimburse the county board of social services (CBOSS) in the amount of 25 percent of the gross recovery on a periodic basis to be determined by DMAHS.

(c) The following pertain to third party liability claims in tort actions:

1. Whenever either a county board of social services (CBOSS) or DMAHS learns of a situation in any case in which the other may have a claim, it will notify the other.

2. Unless the individual case circumstances intervene, the first claim after settlement or judgment is for any payments by New Jersey Medicaid or NJ FamilyCare program arising from the occurrence notwithstanding any (CBOSS) claim for recovery of cash assistance. The next claim is that which the county board of social services (CBOSS) may assert in accordance with an agreement to repay or similar document. The DMAHS and the county board of social services (CBOSS) will, insofar as their controls allow, maintain priority of payment in the above order.

(d) The following pertain to liquidation of potential resources:

1. The county board of social services (CBOSS) will participate in the liquidation of potential resources according to the Program requirements under which eligibility has been established, regardless of whether cash assistance is being granted. Notification of the potential resource to be liquidated shall be forwarded to DHSS, enabling it to seek a voluntary contribution. Sale of real property to which title is held by a county board of social services (CBOSS) is subject to DFD approval in all instances regardless of the proposed distribution of the proceeds.

2. All funds arising from the liquidation of resources and which, by action of law, regulation, or agreement with the owner, fall under the jurisdiction of either a county board of social services (CBOSS) or DHSS for distribution will, insofar as possible, be allocated as follows:

i. Proceeds will be first applied to the cash costs of liquidation, such as advertising costs and filing fees but not including costs such as county board of social services (CBOSS) staff time, supplies, counsel fees or overhead.

ii. Proceeds will be next applied to any claims superior to that of the county board of social services (CBOSS) (for example, taxes).

iii. Proceeds will be next applied to any funds owing to and collectible by the county board of social services (CBOSS).

iv. Any residue remaining after the above payments are allocated would, in the absence of circumstances to the contrary, be the property of the client and thereby subject to (d)3 below.

3. All funds properly belonging to a beneficiary free of any agency claim are to be remitted to the beneficiary as promptly as possible or otherwise disbursed at the beneficiary's instruction. The county board of social services (CBOSS) will promptly reevaluate eligibility following such distribution, taking into consideration any voluntary repayment to the New Jersey Medicaid or NJ FamilyCare program.

(e) The following pertains to recovery from estates of deceased beneficiaries:

1. The county board of social services (CBOSS) shall normally undertake recovery activity as agent for DMAHS in any case in which the county board of social services (CBOSS) is or will be undertaking activities on its own account. However, in those cases where the recovery of medical assistance is possible and where the entire county board of social services (CBOSS) claim is for burial expenses only, DMAHS shall initiate recovery activity inclusive of county board of social services (CBOSS) burial costs. DMAHS may, in certain cases, assume direct jurisdiction in recovery of its claim concurrent with county board of social services (CBOSS) activity. DMAHS shall make the county board of social services (CBOSS) aware of its activity in such cases.

2. County board of social services (CBOSS) recoveries and distribution shall be in accord with the following procedures:

i. From the proceeds of liquidation, the county board of social services (CBOSS) shall first recover the amount necessary to satisfy its own claim, including costs of liquidation and the claims of other New Jersey county board of social services (CBOSS)s. The county board of social services (CBOSS) shall recover funds from the clearing account in the order in which the funds were received in the clearing account. If any part of any remaining surplus has been received from the proceeds of assigned life insurance for which there was a named beneficiary other than the client's estate, that surplus or the policy benefit, whichever is less, is the property of the beneficiary and should be so directed.

ii. All other surplus funds are part of (or the entire) the client's estate and are payable to the legally designated representative of the estate. If the representative of the estate is unknown or if no representative has been appointed and there are no known next of kin, the county board of social services (CBOSS) shall forward to the DMAHS an amount not to exceed the amount of the proper medical assistance claim as determined by communication with the Administrator, Bureau of Administrative Control, DMAHS. Any remaining funds will escheat to the State of New Jersey.

iii. When there are known next of kin, the county board of social services (CBOSS) shall request the next of kin to take appropriate legal action to be appointed administrator if the amount to be disbursed is greater than the claim of the New Jersey Medicaid or NJ FamilyCare program. If the claim of the New Jersey Medicaid or NJ FamilyCare program will equal or exceed the estate, the county board of social services (CBOSS) shall request the next of kin to sign a consent to transfer his or her rights to the New Jersey Medicaid or NJ FamilyCare program and, upon receipt of such signed consent, the county board of social services (CBOSS) shall forward the funds to DMAHS.

iv. When the next of kin will not sign a consent to transfer his or her right to the Medicaid Agent and DMAHS and will not file to become the administrator, the county board of social services (CBOSS) may, at its option, arrange for someone to file to become administrator or the county board of social services (CBOSS) may refer the information to DMAHS for action.

v. In any questions or dispute among two or more claimants on surplus funds, the county board of social services (CBOSS) shall withhold payment pending resolution by mutual consent of all claimants or by court order.

3. The Medicaid Agent or DMAHS recoveries and distribution shall be in accordance with the following procedures:

i. DMAHS shall undertake recovery activity in medical assistance payment cases in which no county board of social services (CBOSS) shall be submitting a claim. However, should information from the county board of social services (CBOSS) be necessary to such DMAHS activity, the county board of social services (CBOSS) shall communicate with DMAHS, supplying such material as may be required.

ii. In cases in which DMAHS is acting for a county board of social services (CBOSS) in collection of burial expenses, DMAHS shall accord payment of the burial claim priority over its own recovery.

(f) The county board of social services (CBOSS) may at any time accept an offer of voluntary repayment, either on its own behalf or on behalf of the New Jersey Medicaid or NJ FamilyCare program, up to but not in excess of the amount of assistance granted. To any inquiry as to amount granted, the county board of social services (CBOSS) shall supply the appropriate information, identifying the respective amounts granted by the county board of social services (CBOSS) and the Medicaid Agent or DMAHS. In the absence of instruction from the payer, the county board of social services (CBOSS) will reimburse cash assistance first and then remit any balance to DHSS.

1. Compromise settlements of medical assistance are subject to DHSS approval.

(g) Regarding compromise settlements:

1. Compromise settlements of cash assistance are subject to DFD approval.

2. Compromise settlements of medical assistance are subject to DMAHS approval.

(h) This section shall apply to all pending and future recovery cases, except that:

1. The 25 percent incentive payments provided for in (b)4 and 5 above shall apply to all non-IEVS incorrect payment recoveries received by the county board of social services (CBOSS) on or after July 1, 1993.

2. Paragraph (b)6 above applies to all IEVS-related recoveries received on or after July 1, 1989 by either DMAHS or the county board of social services (CBOSS), whichever agency is handling the recovery.

Amended by R.1995, d.105, effective June 19, 1995.
See: 26 N.J.R. 3348(a), 27 N.J.R. 2466(a).
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), amended and deleted Division references and substituted "New Jersey Medicaid program" and "Medicaid Agent" for "DMAHS" throughout; and added (f)1.
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 (c), (d), (e) and (f), inserted references to NJ KidCare throughout; in (e)2iv, inserted a second reference to DMAHS; and in (e)3 and (f), inserted references to DMAHS.

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).
Rewrote the section.

10:49–14.5 Administrative charges/service fees

(a) A provider shall not pay nor require payment of an administrative charge or service fee for the privilege of doing business with another provider or for services for which reimbursement is included as part of the Medicaid or NJ FamilyCare fee.

1. An example of a prohibited practice is that a nursing facility may not require a pharmacy to pay an administrative charge or service fee to the facility for handling of the nursing facility resident's medications, drugs and/or related pharmaceutical records.

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)2.
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 NJ KidCare.
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).

10:49–14.6 Contracts with county boards of social services

Payment shall be made by the Department of Human Services/Division of Medical Assistance and Health Services to the county boards of social services (CBOSS) for conducting investigations and for determining whether applicants qualify for benefits under the New Jersey Medicaid or 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).
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
Inserted a reference to NJ KidCare.
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).

SUBCHAPTER 15. AVAILABILITY AND MAINTENANCE OF PROGRAM POLICY ISSUANCES

10:49–15.1 Maintenance of public policy issuances

Program manuals and other policy issuances which affect the public, including the Medicaid Agent's rules and regulations governing eligibility, need and amount of assistance, beneficiary's rights and responsibilities, and services offered by the Medicaid Agent, shall be maintained in the State or Division Central Office and in each Medical Assistance Customer Center for examination during regular workdays and regular office hours by individuals, and upon request, for study or reproduction by such individuals. These manuals and other policy issuances are also distributed to entities which serve as custodians such as the State Library, county boards of social services (CBOSS), and regional legal services offices.

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Substituted reference to Medicaid Agent for reference to Division and agency, and inserted reference to Division Central Office.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

10:49–15.2 Availability of material

(a) In order to facilitate public access, a current copy of material described in N.J.A.C. 10:49–15.1 shall be made available without charge to custodians who request the material for this purpose.

(b) Custodians shall meet the following requirements:

1. They shall be centrally located and publicly accessible to a substantial number of the beneficiary population they serve; and

2. They shall agree to accept responsibility for filing all amendments forwarded by the Medicaid Agent.

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
In (b)1, substituted "beneficiary" for "recipient"; and in (b)2, substituted "Medicaid Agent" for "agency".

10:49–15.3 Reproduction of policy material

(a) The specific policy materials necessary for an applicant or beneficiary (or his or her representative) to determine whether a fair hearing should be requested, or to prepare for a fair hearing, shall be reproduced without charge upon request.

(b) The Medicaid Agent may impose a charge for copying or reproducing materials. If a charge is imposed, it shall be computed pursuant to N.J.S.A. 47:1A–1.

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"; and in (b), substituted "Medicaid Agent" for "Division".

SUBCHAPTER 16. DEMONSTRATION PROJECTS

10:49–16.1 Purpose

This subchapter sets forth the basic parameters for demonstration projects established pursuant to N.J.S.A. 30:4D–1

et seq., as amended, and Section 1115 of the Social Security Act. Any time a demonstration project is implemented, New Jersey Medicaid providers will receive information and instructions if the project is relevant to the services they provide.

10:49–16.2 Definitions

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

"Principal" means all Division management personnel.

"Project" means any demonstration project authorized through a waiver by the Secretary of Health and Human Services of certain requirements under Title XIX of the Social Security Act as provided under Section 1115 of the Social Security Act.

"Provider" means providers of medical and health services under a project.

"Recipient" means any beneficiary who receives services from the project.

"Services" means medical or health services rendered as an integral part of the project.

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Amended "Principal", "Project", "Provider" "Recipient" and 'Services"; and deleted "Beneficiary", "Commissioner", "Department" and "Eligible beneficiaries".

10:49–16.3 Implementation of projects

The Medicaid Agent may implement projects directly or through contractual arrangements with any legal entity, including, but not limited to, corporations organized pursuant to Title 14A, New Jersey statutes (N.J.S.A. 14A:1–1 et seq.) and Title 15 revised statutes (R.S. 15:1–1 et seq.), as well as boards, groups, agencies, persons and other public or private entities.

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Substituted "Medicaid Agent" for "Department".

10:49–16.4 Necessary criteria for a demonstration project

(a) The following shall apply to all projects implemented under this subchapter:

1. All projects shall have approval from the United States Department of Health and Human Services;

2. All projects entered into under this subchapter shall be subject to all relevant State and Federal statutes and regulations, except to the extent that appropriate waivers shall have been granted;

3. The Commissioner of Human Services or the Commissioner of Health and Senior Services shall have the authority to review and approve in writing arrangements and agreements, whether formal or otherwise, between all projects and third parties prior to the execution thereof;

4. All projects in their hiring policies shall not discriminate against any individual on the basis of race, sex, religion, ethnicity or age, and shall comply with all the requirements of Title VI of the Civil Rights Act of 1964, as amended, and other applicable Federal and State laws or regulations pertaining to the civil rights of individuals;

5. No project shall deny services to any eligible person on the basis of race, sex, religion, ethnicity or age, and all projects shall comply with all the requirements of Title VI of the Civil Rights Act of 1964, as amended, pertaining to the civil rights of individuals;

6. All projects shall institute procedures for safeguarding of information in compliance with applicable Federal and State regulations and shall strictly adhere to same;

7. All projects shall collect and report data relevant to the project on a periodic basis, in a manner and fashion prescribed by the Medicaid Agent, including but not limited to, the following:

i. Financial data, such as line item expenditure statements and audit reports;

ii. Data necessary to the project regarding the characteristics of the population involved in the project and the control population, if any; and

iii. Program data, such as number and type of service rendered;

8. All projects shall furnish to the Medicaid Agent, in a manner and fashion prescribed by the Medicaid Agent, periodic progress reports;

9. The Medicaid Agent at its option may require receipt of copies of all project reports;

10. Any project entered into under this subchapter may include components fundable from sources other than that authorized by Section 1115 of the Social Security Act. These funds cannot be matched under the provisions of Section 1115 if they are Federal funds or if these funds are not otherwise matchable;

11. Nothing herein shall abridge the Commissioner's statutory authority to implement and administer demonstration programs under Section 1115 of Title XIX of the Social Security Act and N.J.S.A. 30:4D–7, as amended;

12. Each project shall have the organizational and administrative capabilities to carry out its duties and responsibilities under the contract. This shall include as a minimum the following:

i. A full-time administrator to manage the day-to-day business activities of the project;

ii. Data reporting capabilities sufficient to provide necessary and timely reports to the Medicaid Agent;

iii. Financial reports and books of accounts maintained in accordance with generally accepted accounting principles, which are sufficient to fully disclose the disposition of all program funds received; and

iv. An annual independent audit arranged for by the project;

13. Each project director shall advise the Medicaid Agent of the project's administrative organization and changes thereto. This includes the functions and responsibilities of each principal, an organizational chart and a list of all personnel and providers used either directly by the project or through contractual arrangements. For each principal and each provider not previously reported, the following information shall be included:

i. Full name;

ii. Business address;

iii. Date and place of birth;

iv. Social Security Account Number;

v. IRS employer number;

vi. Professional license number (when applicable); and

vii. Medical specialty (when applicable);

14. Each project director shall submit to the Commissioner of Human Services or the Commissioner of Health and Senior Services for written approval a manual of administrative procedures which shall include personnel, purchasing and internal fiscal procedures. This manual shall be in conformance with approved management procedure; and

15. In those instances where a project involves the delivery of services, the following shall apply where appropriate and necessary:

i. The project shall demonstrate, to the satisfaction of the Commissioner of Human Services or the Commissioner of Health and Senior Services, the capability to provide for and/or arrange for the provision of those services which are required as components of the project;

ii. All individuals receiving services funded under Title XIX of the Social Security Act shall be informed in a simple, brief statement of their rights to a fair hearing;

iii. The project shall develop and establish grievance procedures for beneficiaries in addition to fair hearing procedures established pursuant to this paragraph;

iv. The project shall take steps to insure that it is rendering services that are consistent with and utilizes existing related Federal and State programs such as the EPSDT;

v. The project shall insure that there will be periodic peer review and quality of care audits;

vi. The project shall utilize eligibility criteria for eligibles to receive services as defined by the Department, and the Department shall insure, by a review process, that the project is in conformance with these criteria;

vii. The project shall take appropriate action to insure that the eligibility criteria provided per (a)15vi above is faithfully executed;

viii. The project shall obtain written approval from the Commissioner of Human Services and the Commissioner of Health and Senior Services prior to implementing the following:

(1) The methods of enrollment and enrollment forms to be used to enroll beneficiaries;

(2) The form and content of informational and instructional materials to be distributed to beneficiaries outlining the nature and scope of covered services provided by the project;

(3) The form and content of informational and instructional materials to be distributed to inform enrollees of changes in program scope or administration; and

(4) Provider claim forms and instructions for their use where such claim forms are unique to this contract;

ix. The project shall provide to the Medicaid Agent, for written approval prior to use, the form and content of all public information releases pertaining to the project; and

x. The project shall insure that all marketing representatives have received instruction, as appropriate, from the Medicaid Agent, on acceptable enrollment practices.

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; inserted references to Commissioner of Health and Senior Services and substituted "Medicaid Agent" for "Department" throughout; in (a)5, inserted "all projects"; and in (a)15iii, substituted "beneficiaries" for "recipients".

10:49–16.5 Sanctions related to demonstration projects

The Commissioner of Human Services and the Commissioner of Health and Senior Services, in addition to any and all other authority, shall have the authority to totally suspend or partially reduce payment in order to enforce compliance with this subchapter.

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; inserted reference to Commissioner of Health and Senior Services.

SUBCHAPTER 17. (RESERVED)

SUBCHAPTER 18. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

10:49–18.1 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

(a) EPSDT is a federally mandated comprehensive child health program for Medicaid beneficiaries from birth through 20 years of age. The Omnibus Budget Reconciliation Act of 1989 (OBRA '89) codified EPSDT. Accordingly, the term "EPSDT Services" means the following:

1. EPSDT Screening Services;
2. Vision Services;
3. Dental Services;
4. Hearing Services; and
5. Such necessary health care diagnostic services, treatment and other measures to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.

(b) A physician, independent clinic, or hospital outpatient department may provide EPSDT screening services.

SUBCHAPTER 19. HEALTHSTART

10:49–19.1 HealthStart

HealthStart is a program which provides comprehensive maternity care services for all pregnant women (including those determined to be presumptively eligible) and child health care services for children (through two years of age) who are eligible for Medicaid benefits. Detailed information about this program is included in the Physician Services Manual or N.J.A.C. 10:54, Independent Clinic Services Manual or N.J.A.C. 10:66, Nurse-Midwifery Services Manual or N.J.A.C. 10:58, and the Hospital Services Manual or N.J.A.C. 10:52.

SUBCHAPTER 20. (RESERVED)

Cross References

Optical appliance services, prior authorization for inclusion in benefits package, see N.J.A.C. 10:62–2.5.

SUBCHAPTER 21. THE MEDICAID MANAGED CARE PROGRAM—NJ CARE 2000

10:49–21.1 Purpose and scope

The Medicaid Managed Care Program—New Jersey Care 2000 is a program under which Health Maintenance Organizations (HMOs) contract with the Department of Human Services to provide health care services to Medicaid beneficiaries. Requirements governing HMO providers and services are codified at N.J.A.C. 10:49–74. For more information, providers may contact the Medicaid Managed Care Hotline at 1–800–356–1561.

10:49–21.2 Capitation payment system

Under the Medicaid Managed Care Program—New Jersey Care 2000, HMOs are reimbursed through a capitation payment system whereby DMAHS pays an HMO a set amount for the services it provides to beneficiaries, as described in N.J.A.C. 10:74.

10:49–21.3 Medicaid beneficiaries

(a) The Medicaid Managed Care Program—New Jersey Care 2000 is a mandatory enrollment program for AFDC and AFDC related New Jersey Care pregnant women and children and is offered to the SSI Medicaid beneficiary as an alternative to the existing Medicaid fee-for-service program.

(b) Medicaid beneficiaries enrolled in HMOs receive two identification cards.

1. One card is issued by the HMO and appropriate toll-free telephone numbers are indicated on the card. These telephone numbers allow the provider to inquire whether a service the provider intends to perform will be covered or if the provider needs a prior approval.

2. The second card issued is the same Medicaid Eligibility Identification card issued to all beneficiaries. However, on the card, the words "ENROLLED IN HMO XYZ, 1–800–XXX-XXXX" is imprinted (see Appendix Form #7). This card also provides the toll-free telephone number of the HMO in which the beneficiary is enrolled so that the provider can verify HMO membership. Questions about covered services should be referred to this number.

10:49–21.4 Medicaid Managed Care Program—New Jersey Care 2000 Services

(a) The following services are provided under the Medicaid Managed Care Program—New Jersey Care 2000:

1. Primary and specialist care (Preventive health care and counseling, EPSDT);
2. Inpatient and outpatient hospital services;
3. Emergency medical care;
4. Laboratory and radiology services;

5. Prescription drugs (Legend and non-legend drugs);

6. Family planning services

7. Podiatrist services;

8. Chiropractor services;

9. Optometrist services;

10. Optical and hearing appliances;

11. Home health agency services;

12. Medical supplies and durable medical equipment;

13. Dental services;

14. Ambulance, Mobile Intensive Care Unit (MICU) and invalid coach transportation services;

15. Prosthetic and orthotic services;

16. Rehabilitation services (Outpatient rehabilitation therapies—physical therapy, occupational therapy, speech/language, audiology, 60 days/therapy/year.);

17. Hospice services; and

18. Private duty nursing agency services.

(b) The following services are not covered by an HMO, but are available to beneficiaries and are payable by the Medicaid program on a traditional fee-for-service basis.

1. Medical day care;

2. Elective/induced abortion services;

3. Lower mode transportation;

4. Psychiatric inpatient hospital services;

5. Residential treatment center care services;

6. Intermediate care facility/mental retardation services;

7. Rehabilitation services in excess of 60 days per year;

8. Services to beneficiaries participating in waiver or demonstration programs;

9. Personal care assistant services;

10. Nursing facility care;

11. Substance abuse services—diagnosis, treatment and detoxification costs for methadone and its administration; and

12. Mental health services.

(c) Certain services provided to beneficiaries who are enrolled in an HMO will no longer be reimbursed on a fee-for-services basis. If the beneficiary is enrolled in an HMO, and the HMO restricts payment to providers who have agreed to contract with it, a provider who is not a contractor with the HMO, or who fails to obtain authorization from the HMO, may not be reimbursed. It is therefore incumbent upon the provider to check the identification card of the Medicaid beneficiary prior to the provision of any service, even if the provider has received prior authorization from a Medicaid District Office or Medicaid's Central Dental Services Unit. Failure to do so could result in a claim being rejected by both the Division's fiscal agent, Unisys, and the member's HMO.

(d) Persons in Home or Community-based Waiver Programs, those who are in demonstration programs, those who are in long-term care facilities or residential placement facilities and those in the Medically Needy program, or presumptive eligibility program, are excluded from enrolling in an HMO. Other persons, including pregnant women past the first trimester who have an existing relationship with an obstetrician, those persons who have chronic debilitating illnesses who are under the care of a physician who will coordinate their health care needs; and individuals who are terminally ill with an established relationship with a physician or enrolled under the Hospice program, may be exempted from mandatory managed care under certain circumstances. See N.J.A.C. 10:74-8 for further information on excluded or exempted persons.

(e) A beneficiary may elect to obtain family planning services either through the HMO or through a Medicaid-participating family planning provider on a fee-for-service basis.

(f) Reimbursement for any and all drugs prescribed for the treatment of mental health and substance abuse are the responsibility of the HMO with the exception of methadone (see N.J.A.C. 10:49-21.4(b)9). A pharmacist dispensing these drugs shall participate in the pharmacy network of the Medicaid beneficiary's HMO. In addition, any ambulance, MICU or invalid coach transportation provided for behavioral health services also remain the responsibility of the HMO. A transportation provider providing ambulance, MICU or invalid coach services shall participate in the transportation network of the Medicaid member's HMO.

SUBCHAPTER 22. HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAMS

10:49-22.1 Introduction

(a) Home and Community-Based Services Waivers are five-year, renewable Federal waiver programs, prepared by the Division of Medical Assistance and Health Services in response to the Omnibus Budget Reconciliation Act of 1981 (Section 2176, Public Law 97-35 and amendments under P.L. 99-509). These Home and Community-Based Services Waivers are submitted to the CMS of the United States Department of Health and Human Services. The purpose of these programs is to help eligible individuals remain in the community, or return to the community, rather than be cared for in a nursing facility or hospital setting.

(b) Retroactive eligibility is not available to waiver program beneficiaries; no waiver service received prior to the date of enrollment shall be considered for reimbursement.

(c) Total program costs are restricted by limits on the number of community care slots and on per-person costs. The case manager is responsible for the development of the service plan with the client/family, with input from provider agencies, and for monitoring the cost of the service package.

Amended by R.1994 d.426, effective August 15, 1994.
See: 26 N.J.R. 1566(a), 26 N.J.R. 3466(b).
Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
In (b), substituted "beneficiary" for "client"; deleted (d); and recodified (e) as N.J.A.C. 10:49-22.2.
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

Contrary to the Division's contention, the applicant's mental retardation did not disqualify him from participation in the Assisted Living Waiver Program, N.J.A.C. 10:49-22.1 et seq.; the applicant was in need of nursing facility services because the assistance required by him as described by his physician met the requirements of the term "dependent" as expressed in N.J.A.C. 8:85-2.1, and even if not, the applicant's mental retardation, when combined with any appreciable medical, emotional or psychosocial condition, or Assisted Daily Living dependency, would have made him eligible under the regulation. S.B. v. DMAHS, OAL Dkt. No. HMA 6558-06, 2007 N.J. AGEN LEXIS 264, Initial Decision (April 23, 2007).

10:49-22.2 Approved Waivers

(a) The New Jersey Medicaid program has received waivers for the following programs:

1. Community Care Program for the Elderly and Disabled (CCPED);

2. Home and Community-Based Services Waivers for Blind or Disabled Children and Adults (Medicaid's Model Waivers I, II, and III);

3. AIDS Community Care Alternatives Program (ACCAP);

4. Traumatic Brain Injury Program;

5. Home and Community-Based Services Waiver Program for Developmentally Disabled Individuals;

6. Home and Community-Based Services Waiver Program for Children (ABC); and

7. Assisted Living/Alternative Family Care (AL/AFC) Waivers.

Amended by R.1994 d.426, effective August 15, 1994.
See: 26 N.J.R. 1566(a), 26 N.J.R. 3466(b).
Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Section recodified from N.J.A.C. 10:49-17.1(e); rewrote introductory paragraph and added (a)5 through 7.

10:49-22.3 Administration of waivered programs

(a) The Division of Medical Assistance and Health Services administers the following Home and Community-Based Services Waivers: Home and Community-Based Services Waivers for Blind or Disabled Children and Adults Medicaid Model Waivers I, II, and III; AIDS Community Care Alternatives Program (ACCAP) and Traumatic Brain Injury Waiver.

(b) The Division provides oversight to the Division of Developmental Disabilities in its administration of its Home and Community-Based Services Waiver for developmentally disabled individuals.

(c) The Division provides oversight to the Division of Youth and Family Services (DYFS) in its administration of Home and Community-Based Services Waiver for Children.

(d) The Department of Health and Senior Services administers the Community Care program for the Elderly and Disabled (CCPED) waiver, and the Assisted Living/Alternate Family Care (AL/AFC) waiver.

Amended by R.1994 d.426, effective August 15, 1994.
See: 26 N.J.R. 1566(a), 26 N.J.R. 3466(b).
Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Section was recodified from N.J.A.C. 10:49-1.6; in (a), inserted "and Traumatic Brain Injury Waiver; and added (c) and (d).

10:49-22.4 Home and Community-Based Services Waivers

(a) Any questions regarding Home and Community-Based Services Waiver programs described in N.J.A.C. 10:49-22.2(a)2, 3, 4, 5, or 6, may be directed to the Bureau of Home Care Services (BHCS), located in the Division of Medical Assistance and Health Services' Central Office, telephone number (609) 588-2620.

(b) Any questions regarding Home and Community-Based Services Waiver programs described in N.J.A.C. 10:49-22.2(a)1 or 7 may be directed to DHSS, Division of Consumer Support Services, telephone (609) 588-2611.

Amended by R.1994 d.426, effective August 15, 1994.
See: 26 N.J.R. 1566(a), 26 N.J.R. 3466(b).
Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Section recodified from N.J.A.C. 10:49-17.1(d); substantially amended (a), and added (b).

10:49-22.5 Community Care Program for the Elderly and Disabled (CCPED)

(a) CCPED became effective October 1, 1983. The program allows for community care slots, allocated on a county basis in accordance with the needs of the county.

(b) The seven services listed below are available under CCPED. Other Medicaid (Title XIX) services are not available to the waivered population. There is a cost cap on each individual service package.

1. Case management;
2. Home Health;
3. Homemaker;
4. Medical day care;
5. Medical transportation (non-emergency);
6. Respite care; and

7. Social day care.

(c) Eligibility requirements for CCPED are as follows:

1. All individuals must be assessed to be in need of nursing facility care.

2. Individuals age 65 or over must be eligible for Medicare or have other health insurance coverage which includes hospital and physician coverage.

3. Individuals under 65 must be determined disabled by the Federal Social Security Administration and be eligible for Medicare or be determined disabled by the Division of Medical Assistance and Health Services' Disability Review Section and have other health insurance, including hospital and physician coverage.

4. An individual's own income must exceed the SSI community standard up to the institutional cap or be ineligible in the community because of SSI Deeming Rules. An individual's resources may not exceed those required in the institutional program. A spouse's income also is not considered. While the spouse's resources are considered in the determination of eligibility, up to one-half of the couple's total resources are protected for the use of the spouse.

5. In order to be enrolled in the program, a waiver slot must be available.

10:49–22.6 Medicaid's Model Waivers—I, II, and III

(a) The Model Waivers are Home and Community-Based Services Waiver programs for Blind or Disabled Children and Adults. Included are Model Waiver I (effective September 1, 1983), Model Waiver II (effective April 1, 1985) and Model Waiver III (effective April 1, 1986).

1. Model Waivers I and II serve a maximum of 50 individuals each. Model Waiver III serves 150. There are no geographic limitations nor limitations on the number of individuals who can be served within any one county.

(b) The Model Waiver programs offer, with the exception of nursing facility services, all New Jersey Medicaid (Title XIX) services, plus case management. Model Waiver III also offers private-duty nursing. "Private duty nursing" means individual and continuous care, in contrast to part-time or intermittent care, provided by licensed nurses. Private duty nursing is limited to a maximum of sixteen hours per day per person and will be provided only when there is a live-in primary caregiver (adult relative or significant other adult) who accepts 24–hour responsibility for the health and welfare of the beneficiary.

1. Each individual's service package must be no more than the cost of institutional care, determined at a projected weighted cost of hospital care or net average cost of nursing facility care.

(c) Eligibility requirements for the Model Waivers are as follows:

1. Individuals must be in need of institutional care and meet the minimum nursing facility (NF) level of care criteria in accordance with N.J.A.C. 10:63–2.1 and 2.2. Model Waiver III also requires that individuals be in need private-duty nursing service, in accordance with N.J.A.C. 10:60–1.12(b).

2. For Model Waivers I and II, individuals must meet optional categorically needy standards, in accordance with N.J.A.C. 10:71 and 10:72. Total income must exceed the SSI community standard up to the institutional CAP, or the individual must be ineligible in the community because of SSI Deeming Rules. Parental income or resources are not considered in determining eligibility. While a spouse's income is not considered towards eligibility, up to one-half of the couple's total resources are protected for the use of the spouse.

3. Model Waiver III applicants can either be optional categorically eligible or categorically eligible. In other words, MW III also serves individuals who are eligible under SSI, DYFS or AFDC programs.

4. Individuals must be blind or disabled children and adults. Individuals who have not been determined disabled under the Social Security Act must be determined disabled by the Division of Medical Assistance and Health Services' Disability Review Section, in accordance with N.J.A.C. 10:71–3.12.

5. In order for an individual to be enrolled in the program, a waiver slot must be available.

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Section recodified from N.J.A.C. 10:49–17.3; in (b), substituted "beneficiary" for "recipient"; in (c)1, 2 and 4 inserted N.J.A.C. references; and in (c)5, inserted "for an individual".

Case Notes

Quadriplegic's death mooted appeal from denial of her application for home health care. J.C. v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 42.

10:49–22.7 AIDS Community Care Alternatives Program (ACCAP)

(a) ACCAP became effective March 1, 1987. The program allows for an allocation of a specific number of slots in accordance with the needs of each county in the State.

(b) Total program costs are restricted by the number of community care slots each year and on per-person costs. Each individual's service package must be no more than the cost of institutional care, determined at a projected weighted cost of hospital care or net average cost of nursing facility care. ACCAP offers, with the exception of nursing facility services, all New Jersey Medicaid services, plus those listed in (b)1 through 7 below.

1. Case management;

2. For children:

i. Intensive supervision to children who reside in Division of Youth and Family Services' foster homes; and

ii. Specialized group foster home;

3. Hospice care services at home;

4. Medical day care (specialized);

5. (Certain) Narcotic and drug abuse treatments at home;

6. Personal care assistant services (no limitation on the number of hours); and

7. Private-duty nursing.

(c) Eligibility requirements for ACCAP are as follows

1. Individuals must be in need of institutional care and meet, at a minimum, the nursing facility level of care criteria.

2. Individuals must be diagnosed as having AIDS or ARC. Children under the age of 13 may also be diagnosed HIV positive.

3. Individuals who are categorically needy or optional categorically needy are served under the program.

4. There is no deeming of parental income or resources in the determination of eligibility. A spouse's income also is not considered. While the spouse's resources are considered in the determination of eligibility, up to one-half of the couple's total resources are protected for the use of the spouse.

5. Individuals under the age of 65 who are eligible for coverage as optional categorically needy must be determined disabled by the Social Security Administration (SSA) or by the Disability Review Section, Division of Medical Assistance and Health Services.

6. In order for an individual to be enrolled in the program, a waiver slot must be available.

Amended by R.1997 d.323, effective August 4, 1997.
See: 29 N.J.R. 403(b), 29 N.J.R. 3487(a).
In (b), amended internal cite; in (c)2, substituted "age of 13" for "age of five"; in (c)5, substituted "Individuals under the age of ... categorically needy" for "Optionally categorically eligibles under age 65".
Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Section recodified from N.J.A.C. 10:49–17.4; in (c)6, inserted "for an individual".

10:49–22.8 Traumatic Brain Injury Program

(a) The Traumatic Brain Injury (TBI) Program is a renewable Federal waiver program under Section 1915(c) of the Social Security Act, 42 U.S.C. § 1396n, which offers home and community-based services to a beneficiary with an acquired traumatic brain injury. The purpose of the TBI program is to help eligible beneficiaries to remain in the community, or to return to the community rather than be cared for in a nursing facility.

(b) The waiver, prepared by the Division of Medical Assistance and Health Services (DMAHS), encourages the development of community-based services in lieu of institutionalization.

(c) The Program is Statewide, with slots allocated as individuals, ages 18 through 65, are admitted to the program.

(d) The Division administers the overall program, and has the responsibility for assessing an applicant's need for care and, for determining which applicants will be served by the program.

(e) Program oversight shall be provided by the Division of Medical Assistance and Health Services through the Bureau of Home Care Services (BHCS) and the Surveillance Utilization Review Subsystem (SURS). The delivery of home care services to TBI Waiver beneficiaries will be subject to a post-payment utilization review by professional staff of the Medicaid District Offices in accordance with N.J.A.C. 10:63–1.15.

(f) Applicants for participation in the TBI waiver program shall meet the following medical and financial eligibility criteria:

1. Be not less than 18 nor more than 65 years of age at the time of enrollment;

2. Have a diagnosis of acquired brain injury which occurred after the age of 16;

3. Exhibit medical, emotional, behavioral and/or cognitive deficits;

4. Meet the Division's nursing facility standard care criteria for Pre-Admission Screening (PAS), at N.J.A.C. 10:60–1.2;

5. Have a rating of at least four on the Rancho Los Amigos Levels of Cognitive Functioning Scale (see N.J.A.C. 10:60, Appendix I);

6. Be blind, disabled, or a child under the supervision of the Division of Youth and Family Services (DYFS) and be eligible for Medicaid in the community or be eligible for Medicaid if institutionalized. Persons eligible for the Medically Needy segment of New Jersey Care ... Special Medicaid Programs, or private Health Maintenance Organizations serving Medicaid beneficiaries are not eligible for this program.

i. There is no deeming of spousal income in the determination of eligibility for this program. While spousal resources are considered in the determination of eligibility, up to one-half of the total resources are protected for the use of the spouse; and

7. Be determined disabled by the Social Security Administration (SSA) or by the Disability Review Unit of the Division, using the SSA disability criteria.

(g) If the individual is dually diagnosed, for example, with a head injury and psychiatric illness or developmental disability or substance abuse addiction, a determination will be made during the initial review as to the most appropriate service system to manage the beneficiary's care. This decision will be made based on clinical evidence as of onset of injury, and professional evaluation.

(h) Retroactive eligibility shall not be available to waiver beneficiaries for those Medicaid services provided only by virtue of enrollment in the waiver program. Those individuals who are not eligible for Medicaid services in the community prior to enrollment in the TBI Waiver are not eligible for retroactive Medicaid eligibility.

(i) All applicants determined eligible for the TBI Waiver shall be issued a Medicaid Eligibility identification (MEI) Card.

(j) In order for an applicant to be enrolled in the program, a waiver slot must be available.

(k) Prior to formal application for the TBI waiver, a referral shall be submitted to the Bureau of Home Care Services (BHCS) of the Division, which shall review the referral to determine if the individual meets the basic criteria for the program. If it is determined that the individual referred is a potential candidate for the TBI waiver, the following shall occur:

1. Supplemental Security Income (SSI) beneficiaries shall be referred to the appropriate Medical Assistance Customer Center (MACC) serving their county of residence;

2. Children under the supervision of the Division of Youth and Family Services (DYFS) shall be referred to DYFS for the initiation of the formal application, which includes the determination of disability, and shall then be referred to the appropriate Medical Assistance Customer Center (MACC) serving the beneficiary's county of residence; and

3. Individuals who are not currently Medicaid eligible shall be referred by (BHCS) to the county board of social services (CBOSS) located in the county where the individual resides, for a determination of financial eligibility, including the referral for determination of disability.

(*l*) After the applicant has been determined financially eligible, he or she shall be referred to the Medical Assistance Customer Center (MACC) of the applicant's residence for a determination of medical eligibility by the Regional Staff Nurse (RSN).

(m) When the applicant is judged financially and medically eligible for the TBI waiver program, the MACC shall assign the case to a case management site and notify the (BHCS) of the beneficiary's approval for participation in the program.

(n) The MACC shall review and approve the plan of care prepared by the case manager initially, and at six month intervals.

(*o*) If a waiver beneficiary is categorically eligible for Medicaid services under the State Plan and no waiver services are required as a part of the plan of care, the beneficiary shall be terminated from the TBI program.

(p) All approved services under the New Jersey Medicaid program, except for nursing facility services, are available under the TBI Waiver from approved Medicaid providers in accord with an individualized plan of care. (See N.J.A.C. 10:60–5.5 for a description of services.)

(q) An individual shall be terminated from the TBI Waiver Program for the following reasons:

1. He or she no longer meets the income and resource requirements for Medicaid;

2. He or she no longer exhibits medical, emotional, behavioral and/or cognitive deficits which would qualify the individual for nursing facility care;

3. He or she attains a Level 8 or above on the Rancho Los Amigos Levels of Cognitive Functioning Scale;

4. He or she refuses to accept case management services; or

5. He or she is categorically eligible for Medicaid State Plan services and does not require waiver services as part of the plan of care.

(r) Where termination is sought pursuant to (q) above, an individual shall be afforded the opportunity to request a hearing pursuant to N.J.A.C. 10:49–9.10.

New Rule, R.1994 d.426, effective August 15, 1994.
See: 26 N.J.R. 1566(a), 26 N.J.R. 3466(b).
Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Section recodified from N.J.A.C. 10:49–17.5; substituted references to beneficiary for references to recipient and references to BHCS for references to OHCP throughout.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

SUBCHAPTER 23. LIFELINE PROGRAMS

10:49–23.1 Purpose and scope

Lifeline Programs provide an annual benefit to eligible persons toward the cost of electricity and natural gas. The Lifeline Credit Program (LCP) and the Tenants Lifeline Assistance Program (TLAP) are administered by the Department of Health and Senior Services. The rules for these programs are promulgated by the Department of Health and Senior Services. Although the Department of Health and Senior Services also administers the Lifeline benefit, because Supplemental Security Income (SSI) beneficiaries receive the benefit as a Special Utility Supplement (SUS) in their monthly SSI checks, DMAHS is responsible for establishing the policies and procedures for eligibility for this benefit as part of their SSI income eligibility for the Medicaid program.

10:49–23.2 Applications

(a) Applications for the Lifeline Programs are sent automatically to persons benefiting from the following Medicaid programs:

1. Medical Assistance to the Aged (MAA);
2. Medical Assistance Only (MAO); and
3. New Jersey Care ... Special Medicaid Programs.

SUBCHAPTER 24. WORK FIRST NEW JERSEY/GENERAL ASSISTANCE CLAIMS PROCESSING

10:49–24.1 Introduction

(a) Effective for services rendered on or after February 1, 1997, consistent with N.J.A.C. 10:90–13, the Division's fiscal agent shall process Work First New Jersey/General Assistance (WFNJ/GA) claims. N.J.A.C. 10:49–24.3 describes the covered services that shall be processed by the fiscal agent. N.J.A.C. 10:49–24.4 describes services that shall not be processed by the fiscal agent. N.J.A.C. 10:49–24.5 indicates that payment for services shall be made using existing Medicaid reimbursement methodology.

(b) The information in this subsection is provided to assist providers in identifying a WFNJ/GA beneficiary. Consistent with N.J.A.C. 10:90–13.2, each municipal welfare department (MWD) or county board of social services (CBOSS) provides a validation card or letter for each client which is used to obtain medical services. The validation card or letter is supplied to each WFNJ/GA beneficiary at the time of opening or reopening of the case and monthly thereafter to ensure validity through all periods of assistance and eligibility. Each card or letter shall contain, at a minimum:

1. The name, address, and telephone number of the MWD and the agency's four-digit municipality code;

i. The four-digit codes range from 5001 to 5099 and from 5200 to 5786;

2. The first and last name(s) of the WFNJ/GA client(s) to whom the card or letter applies;

3. A six-digit client case number;

i. If the case number assigned to a WFNJ/GA client is less than six digits, the MWD/CBOSS shall add zeros (example: 000411);

4. A two digit person number; and

5. The effective date and expiration date of the card or letter.

i. Validation cards or letters shall not be valid for more than one month.

(c) Providers may contact the local MWD/CBOSS that assists the WFNJ/GA client if there are questions regarding eligibility. Questions regarding WFNJ/GA requirements or coverage of services should be directed to DMAHS. Only questions related to claim processing should be directed to the fiscal agent.

(d) Dispute resolution requirements related to a client's eligibility for WFNJ/GA are contained in N.J.A.C. 10:90–9. Individuals shall contact the county or municipal agency to resolve any questions, consistent with the requirements contained in N.J.A.C. 10:90–9.

10:49–24.2 Administrative provisions

(a) Any provider of services shall meet Medicaid requirements and be enrolled as a Medicaid provider. Requirements regarding enrollment and provision of service are set forth in the appropriate chapters of the New Jersey Administrative Code.

(b) The administrative requirements of the Medicaid program shall apply to these claims. The requirements contained in this chapter include, but are not limited to, N.J.A.C. 10:49–1, General Provisions; N.J.A.C. 10:49–3, Provider Participation; N.J.A.C. 10:49–4, Providers' Role in a Shared Health Care Facility; N.J.A.C. 10:49–5.5, Services not covered by the Medicaid or NJ FamilyCare–Plan A program; N.J.A.C. 10:49–6, Authorizations Required by Medicaid and NJ FamilyCare Programs; N.J.A.C. 10:49–7, Submitting Claims for Payment (Policies and Regulations); N.J.A.C. 10:49–8, Payment for Services Provided; N.J.A.C. 10:49–11, Exclusion from Participation in the New Jersey Medicaid and NJ FamilyCare Programs (Suspension, Debarment, and Disqualification); N.J.A.C. 10:49–12, Provider Reinstatement; N.J.A.C. 10:49–13, Program Controls; N.J.A.C. 10:49–14.2, Sanctions—Special Status Program; N.J.A.C. 10:49–14.3, Authority to adjust, compromise, settle or waive claims, liens and certificates of debt; and N.J.A.C. 10:49–14.5, Administrative charges/service fees.

1. WFNJ/GA claims processed by the Division's fiscal agent are not subject to the fair hearing processes described at N.J.A.C. 10:49–9.14.

Amended by R.2003 d.82, effective February 18. 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

10:49–24.3 Services available under the Work First New Jersey/General Assistance (WFNJ/GA) program which shall be processed by the fiscal agent

(a) The Medicaid/NJ FamilyCare fiscal agent shall reimburse only those WFNJ/GA program covered services listed below in this subsection when provided in an ambulatory setting, except as specified in N.J.A.C. 10:49–24.4(a)14. These services include:

1. Advanced practice nurse services (for specific information, see N.J.A.C. 10:58A);

2. Abortion (elective/induced);

3. Acupuncture;

4. ADDP covered anti-retroviral drugs;

5. Ambulance;

6. Ambulatory surgery;

7. Blood and blood plasma;

8. Case management services for the chronically mentally ill (for specific information, see N.J.A.C. 10:73);

9. Chiropractic services (for specific information, see N.J.A.C. 10:68);

10. Clinic services (services in an independent outpatient health care facility, ambulatory care facility, ambulatory surgical center, ambulatory care/family planning/surgical facility, drug treatment center, Federally qualified health center, free-standing end-stage renal dialysis facility), such as dental, family planning, laboratory, mental health, minor surgery, personal care assistance, podiatry, radiology, rehabilitation, or vision care (for specific information, see N.J.A.C. 10:66), except that:

i. Professional services provided by a residential alcohol or drug abuse treatment facility to an individual residing in the facility shall not be processed;

11. Dental services, including dentures (for specific information, see N.J.A.C. 10:56);

12. Durable medical equipment;

13. 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, except that:

i. Services provided primarily for the diagnoses and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures shall not be processed.

14. Hearing aid services (for specific information, see N.J.A.C. 10:64);

15. Home care services, including home health care (for specific information, see N.J.A.C. 10:60);

16. Hospice services, except those provided in a nursing home facility (for specific information, see N.J.A.C. 10:53A);

i. The following hospice services, with corresponding HCPCS, shall be processed under the WFNJ/GA program:

(1) Y6333 Routine home care rate;

(2) Y6334 Continuous home care rate; and

(3) Y6343 Drugs and biologicals co-payment (rendered in places other than long term care facilities).

ii. The following hospice services, with corresponding HCPCS, shall not be processed under the WFNJ/GA program:

(1) Y6335 Inpatient respite care rate;

(2) Y6336 General inpatient care;

(3) Y6337 Therapeutic leave days;

(4) Y6338 Bed hold days;

(5) Y6339 Hospice Respite Care; and

(6) Z2015 Room and board;

17. Laboratory (clinical) services (for specific information, see N.J.A.C. 10:61);

18. Medical supplies and equipment (for specific information, see N.J.A.C. 10:59);

19. Mental health services (for specific information, see N.J.A.C. 10:66);

20. Non-maternity nurse-midwifery services, such as family planning (for specific information, see N.J.A.C. 10:58);

21. Optometric services (for specific information, see N.J.A.C. 10:62);

22. Optical appliances (for specific information, see N.J.A.C. 10:62);

23. Personal care assistant;

24. Thermograms;

25. Thermography;

26. Pharmaceutical services (for specific information, see N.J.A.C. 10:51);

i. Prior authorization shall be required where patterns of medically harmful or inappropriate use of specific drugs, therapeutic drug classes, enteral nutritional supplements, needles and syringes have been identified, or for claims originating in certain municipalities where such patterns have been identified; and

ii. Effective with claims for dates of service on or after August 7, 2000, the Division's processing of claims for certain antiretroviral drugs shall be accomplished under the AIDS Drug Distribution Program (ADDP), administered by the Department of Health and Senior Services (DHSS), except for emergency supplies as authorized under WFNJ/GA to avert a lapse in treatment. These drugs shall include, but may not be limited to: thymidine nucleosides, thymidine analogs, protease inhibitors, nucleoside analog reverse transcriptase inhibitors, non-nucleoside reverse transcriptase inhibitors, carbocyclic nucleoside analogs, purine nucleoside analogs of deoxyadenosine, and primidine nucleoside analogs;

27. Physician services (for specific information, see N.J.A.C. 10:54);

28. Podiatric services (for specific information, see N.J.A.C. 10:57);

29. Prosthetic and orthotic devices (for specific information, see N.J.A.C. 10:55);

30. Psychological service (for specific information, see N.J.A.C. 10:67);

31. Radiological services (for specific information, see N.J.A.C. 10:54);

32. Rehabilitative services (for specific information, see N.J.A.C. 10:66). Payments shall be made to eligible Medicaid providers only. No payment shall be made to privately practicing therapists who are not Medicaid providers. Rehabilitative services include:

i. Physical therapy;

ii. Occupational therapy;

iii. Speech-language pathology services; and

iv. Audiology services;

33. Transportation services which include ambulance and mobility assistance vehicle (for specific information, see N.J.A.C. 10:50 and 10:66);

34. Medicare coinsurance and/or deductible for services specified in (a)1 through 23 above, if otherwise reimbursed by the New Jersey Medicaid program; and

35. Inpatient services provided by Mt. Carmel Guild Hospital located in Newark, New Jersey.

(b) Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:77A) shall not be eligible for reimbursement by DMAHS, but may be eligible for reimbursement by the Division of Mental Health Services (DMHS).

Special amendment. R.2002 d.214, effective June 10, 2002.
See: 34 N.J.R. 2338(a).
Rewrote the section.
Amended by R.2004 d.8, effective January 5, 2004.
See: 35 N.J.R. 2620(a), 35 N.J.R. 4204(a), 36 N.J.R. 189(a).
Added (b).
Amended by R.2004 d.334, effective September 7, 2004.
See: 36 N.J.R. 312(a), 36 N.J.R. 4136(a).
In (a), inserted "/NJ FamilyCare" following "Medicaid" in the introductory paragraph, added a new 1, recodified existing 1 through 7 as 2 through 8, and deleted existing 8.

10:49–24.4 Services that shall not be processed by the fiscal agent

(a) Consistent with N.J.A.C. 10:90–13.1(a)2, the following services shall not be processed by the fiscal agent:

1. Case management for early intervention services;

2. Early and periodic screening, diagnosis, and treatment (EPSDT) screenings, and any other EPSDT services needed to ameliorate a defect if the services are otherwise not covered by the WFNJ/GA program;

3. EPSDT school-based or early intervention rehabilitation services;

4. Federally qualified health center encounter rates;

5. For individuals dually eligible for Medicaid and WFNJ/GA, any services that should have been, but were not, covered by an HMO to which the Medicaid program has made a payment, shall be provided or covered as a medical service;

6. HealthStart maternity and pediatric care services;

7. Inpatient or outpatient services/care provided by an enrolled hospital provider, either in-State or out-of-State, including, but not limited to, psychiatric hospitals, acute care hospitals, special hospitals, rehabilitation hospitals, non-religious medical institutions and county or State hospitals, except that:

i. Inpatient services provided by Mt. Carmel Guild Hospital located in Newark, New Jersey shall be processed by the fiscal agent; and

ii. Services provided by a hospital when that facility is not providing them as hospital services and is not enrolled as a hospital, including, but not limited to, hospital-based home health agency services, dental clinic services, end-stage renal dialysis services, hospital-based transportation services, and case management services for the chronically mentally ill, shall be processed;

8. Intermediate care facility for the mentally retarded (ICF/MR) services;

9. Managed care services;

10. Maternity services, including prenatal, delivery and postpartum services (through two months), provided by any type provider, including, but not limited to, physicians, certified nurse specialists/clinical nurse practitioners, certified nurse-midwives and clinics;

11. Nursing facility per diems;

12. Medical day care services;

13. Methadone maintenance services, identified by HCPCS Z2006, as set forth at N.J.A.C. 10:66-6.3(m);

14. Physician, clinical laboratory, or other professional medical services provided while a WFNJ/GA eligible individual is a patient in a hospital, including an acute care hospital, special hospital, rehabilitation hospital, non-religious medical institution, ICF/MR, an inpatient psychiatric hospital, an inpatient psychiatric program for children under the age of 21 (residential treatment centers) or services provided to a WFNJ/GA eligible individual while in an outpatient hospital department or a hospital emergency room;

15. Professional services rendered to beneficiaries residing in a residential treatment facility for drug or alcohol abuse;

16. Services provided under a home and community based services waiver under section 1915(c) of the Social Security Act, 42 U.S.C. § 1396;

17. Services that would otherwise be covered under other health insurance coverage, including services that should have been, but were not, provided by an HMO that the WFNJ/GA eligible individual is enrolled in; and

18. Transportation services provided under contract with a vendor or through a contract with the county board of social services.

10:49-24.5 Basis for reimbursement

Except as noted under N.J.A.C. 10:49-24.3(a)16ii, payment for services shall be based upon the Medicaid reimbursement methodology for the respective service. (See specific provider chapter(s) for reimbursement methodology and requirements.)

APPENDIX

Medicaid Eligibility Identification Card (FD-73/178)	Form #1
Medically Needy Claim Transmittal (FD-311)	Form #2
Public Assistance Inquiry (PA-1C)	Form #3
Certification of Presumptive Eligibility (FD-334)	Form #4
Application for Payment of Unpaid Medical Bills (FD-74)	Form #5
Department of Human Services Medicaid ID (FD-152)	Form #6
Validation of Eligibility (FD-34)	Form #7
Provider Application (FD-20)	Form #8
Provider Agreement (FD-62)	Form #9
Disclosure of Ownership and Control Interest Statement (CMS-1513)	Form #10
Patient Certification Form (FD-197)	Form #11
Notice to Providers	Form #12
Medical Assistance Customer Centers Directory	Form #14
New Jersey County Boards of Social Services	Form #15

STATE OF NEW JERSEY
DEPARTMENT OF
HUMAN SERVICES
DIVISION OF
MEDICAL ASSISTANCE
AND
HEALTH SERVICES

MEDICAID ELIGIBILITY IDENTIFICATION CARD 1939902

ADDITIONAL HEALTH INSURANCE*

HSP (MEDICAID) CASE NO. PERSON NO.

VALID FROM TO

SOC. SEC. ACCT. NO. DATE OF BIRTH

USE THIS CARD WHEN YOU NEED MEDICAL SERVICES

RECIPIENT'S SIGNATURE

FD-73/178 (REV. 3/91)

IMPORTANT NOTICE

You must sign the front of this card on the line above the Recipient's Signature. If you are unable to sign the card, the individual representing you must sign your name, initial the card and explain his/her relationship to you.

Immediately notify the Medicaid District Office or the Division of Youth and Family Services case manager or the County Welfare Agency (as appropriate):

1. if you have Medicare coverage or other health insurance not listed or incorrectly listed; or
2. if any changes are necessary to the front of this card; or
3. if you have any questions regarding the use of this card; or
4. if this card is lost or stolen. (Unless the report of the loss or theft can be documented at the appropriate agency, you may be liable to repay Medicaid for any benefits obtained through its unauthorized use)

FEDERAL and STATE LAW make it a crime and set the punishment for persons who have been found guilty of making any false statement or representation of a material fact to receive any benefit or payment under the Medicaid Program. The Department of Human Services is required to make you aware of this law and to warn you against making any false statement in an application or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended.

THIS CARD IS NON-TRANSFERABLE UNDER PENALTY OF LAW.

NOTICE TO PROVIDERS

The printed name which appears directly above the line for Recipient's Signature on this card is the MEDICAID eligible person. This name identifies that person ONLY (except AFDC can includes spouse/child(ren) listed with PERSON NUMBERS) as being eligible for MEDICAID benefits within the time period shown. If the name of a "REPRESENTATIVE PAYEE" appears on this card, that individual is not eligible for Medicaid benefits.

* Ask the cardholder if there is Medicare coverage or other health insurance not listed. Please indicate this information in the appropriate area on the claim form. Prior to billing Medicaid you are to bill other third party payers in accordance with N.J.A.C. 10:49.

Form #1

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

MEDICALLY NEEDY CLAIM TRANSMITTAL

RECIPIENT INFORMATION

HSP (Medicaid) CASE NO

NAME

ADDRESS

PROVIDER INFORMATION

PROVIDER NO.

PROVIDER NAME

PROVIDER ADDRESS

TYPE OF SERVICE	DATE OF SERVICE	CHARGE	PAYMENT FROM OTHER SOURCE	CLIENT OBLIGATION	TOTAL FROM OTHER SOURCES
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

Provider Instructions and Information:

- The services listed above were provided to the identified individual during a covered retroactive period.
- This transmittal does not guarantee payment. Your claim will be processed in accordance with current Medicaid and Medically Needy regulations.
- Each claim form submitted for payment for services listed above must be attached to this document.
- Please enter your provider number in the appropriate space in the upper right corner.
- Any amount listed in the column entitled "Client Obligation" is the responsibility of the client and should be paid by the client directly to you.

NUMBER OF ITEMS _____

SIGNATURE _____
Authorized Representative

FD-311 (5/86)

Form #2

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

PUBLIC ASSISTANCE INQUIRY

Referral for: ☐ SSI ☐ New Jersey Care ☐ Medicaid Only ☐ AFDC ☐ Newborn (complete items 1,2,4,11a,15 only)

TO: FROM:

(SSA DO)
_____ (County Welfare Agency) _____ Hospital

_____ Date _____

1 Name _____ (Last) _____ (First) _____ (Middle) Sex ☐ M ☐ F
(For newborn referral, enter name and sex of parent.)

2 Social Security Account Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___

3 Permanent Home Address _____ Telephone _____

4 Marital Status *(Check one)* Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Unknown ☐

5 Date of Admission _____ Date of Birth _____

6 Address From Which Admitted _____ Telephone _____

7 Diagnosis _____

8 Prognosis _____
For SSI disability, blindness and AFDC recipients

9 Referring Physician _____ Telephone _____

10 Spouse. Name. _____ Age. _____ Telephone. _____

Address. _____

11 Minor Children *(First Names and Ages)* _____

(a) Newborn Data Name _____ Date of Birth _____ Sex ☐ M ☐ F

Mother's HSP (Medicaid) Case No. ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___

12 Next of Kin *(If other than Spouse or Children)* _____

Address _____ Telephone _____

13 Gross Monthly Income of Patient. _____ Source _____

14 Gross Monthly Income of Family Members. _____

15 Hospital Insurance. Blue Cross ☐ I.D. No. _____ Medicare ☐ H.I.C. No _____

(a) Applicable to Newborn? Yes ☐ No ☐

Other ☐ Carrier Name _____ Policy No _____

16 Employer's Name _____ Address _____

17 Name of Spouse's Employer _____ Address _____

PA [illegible] 49

Form #3

18 What inquiries have been made regarding financial responsibility for the hospital bill?

What were the results? _____

19 Does patient, patient's authorized agent, or relatives know that an inquiry is being made for the previously checked program?

Yes ☐ No ☐

20 Whereabouts

Is client still in hospital? Yes ☐ No ☐

If YES, anticipated address upon discharge _____

If NO, date of discharge _____

Present address if known: _____

21 Other Comments _____

22. The above patient is being cared for in the hospital since _____ (Date) on a ward service or general service basis as to professional and other personal services and I believe that such a patient may be eligible for the previously checked program.

Signature _____ Title _____ Date: _____

23 Signature of Patient or Relative: _____ Date: _____

PLEASE READ CAREFULLY BEFORE SIGNING

I understand that I must furnish certain information to the SSA DO or the County Welfare Agency to establish eligibility and extent of need for Supplemental Security Income Benefits or public assistance, and that the appropriate agency will help to secure this information and verify it. I will supply complete and accurate information, within my knowledge, to representatives of the SSA DO or the County Welfare Agency. I hereby authorize and direct my relatives, physician, hospital, employers, bankers, and any other person having information concerning the persons named above to furnish complete details to the appropriate agency investigating my application for such assistance. I understand that the information obtained will be used only in connection with the application for or receipt of assistance.

"I further authorize the Social Security Administration to release benefit information and entitlement dates to the hospital whose name appears on the reverse of this form. I understand the hospital will only use this information for purposes of establishing my eligibility to Medicaid."

Signature: _____ Relationship: _____ Date: _____

IF NOT SIGNED BY PATIENT, EXPLAIN WHY: _____

NOTICE TO THE SSA DO OR CWA INITIALLY RECEIVING THIS INQUIRY: WHEN IT IS NECESSARY TO REFER THE APPLICANT TO ANOTHER PUBLIC ASSISTANCE AGENCY, INCLUDE AT LEAST A COPY OF THIS PA-IC FORM.

DMAHS USE ONLY

PROVIDER USE ONLY

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

CERTIFICATION OF PRESUMPTIVE ELIGIBILITY

CLIENT INFORMATION:

Name: _____ County of Residence _____

Address: _____ Birth Date - - -

_____ Social Security No. - - - - - - - - -

Telephone No.: ( ) _____ Household Unit: ____ *(No. of persons in household)*

(Check appropriate boxes below.)

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race ☐ White ☐ Black ☐ American Indian ☐ Oriental ☐ Hispanic ☐ Other

Does client have a pending AFDC, SSI, Medicaid application? ☐ Yes ☐ No *(If yes, circle program.)*

Client is. ☐ U.S. Citizen ☐ Alien admitted for permanent residence
☐ Alien admitted for temporary residence ☐ Undocumented alien

Medicare Coverage: ☐ Yes ☐ No If Yes, HIC Number: _____

Other Insurance Company: _____ Other Insurance Policy No.. _____

INCOME INFORMATION:

Total Household Income:	Income	Frequency	Gross Monthly Amt.	Source
Gross Earnings				
Gross Earnings				
Gross Unearned Amount				
Gross Unearned Amount				
Gross Unearned Amount				
Gross Child Support Amount				
Gross Alimony Amount				

Total Monthly Gross Income $ _____

Child Care Expense Amount: _____ Weekly _____ BiWeekly _____ Monthly

PREGNANCY INFORMATION:

Date of L.M.P. _____ Pregnancy Due Date: _____

CERTIFICATION STATEMENT:

I, _____ attest that I have read and agree to the above statements and fully realize that the county welfare agency relies upon the truth and accuracy of my statements. I have received a copy and understand the Patient Guidelines.

_____ _____
Applicant Signature *Date*

I certify the above applicant is pregnant and presumptively eligible for limited Medicaid benefits in accordance with N.J.A.C. 10:72-6.1 et seq.

_____ _____ _____
Provider Agency Name *Address* *Telephone*

_____ _____
Provider Signature *Date*

IMPORTANT: THE ORIGINAL FORM MUST BE FORWARDED TO THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, ISS SECTION, AREA #3, PRESUMPTIVE ELIGIBILITY RECORDS, CN-712, TRENTON, NJ 08625, WITHIN TWO (2) DAYS OF COMPLETION.

Form #4 FD 334

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

APPLICATION FOR PAYMENT OF UNPAID MEDICAL BILLS
NEW JERSEY HEALTH SERVICES PROGRAM (MEDICAID)

NOTE: THIS FORM (FD-74) IS GIVEN ONLY TO APPLICANTS WHO INDICATE THEY HAVE UNPAID BILLS FOR MEDICAL SERVICES RECEIVED DURING THE THREE (3) MONTHS PRIOR TO APPLICATION FOR PUBLIC ASSISTANCE OR SUPPLEMENTAL SECURITY INCOME. THE FD-74 MUST BE SUBMITTED WITHIN SIX (6) MONTHS FROM THE DATE OF APPLICATION FOR PUBLIC ASSISTANCE OR SUPPLEMENTAL SECURITY INCOME.

The New Jersey Medicaid Program will evaluate this application to determine whether or not payment can be made by the program for covered Medicaid services received by the applicant and/or eligible person(s) living in the same household during the specified period. This refers only to those services for which bills remain unpaid. The Medicaid Program will not consider payment of bills that have already been paid.

PART I - APPLICANT INFORMATION

1 _____ 2 _____ 3 _____
Name of Applicant *Applicant's HSP (Medicaid) Case No.* *Applicant's Birthdate*

4 _____ _____ _____ _____
Street Address - Apartment Number *City* *State* *Zip*

_____ _____ _____
Telephone Number (area code) *Social Security Account Number* *County of Residence*

5 _____ 6 _____
Date of Application for Public Assistance or Supplemental Security Income *Name and address of Agency processing application for Public Assistance or Supplemental Security Income (i.e. County Welfare Agency or Social Security Office, etc.)*

7 If the applicant has applied for Aid to Families with Dependent Children (AFDC) or Assistance to Families of the Working Poor (AFWP), list the full names, ages and relationship of each dependent child or eligible person(s) living with applicant.

_____

_____

_____

PART II - MEDICAL INFORMATION

A. PLEASE COMPLETE ALL QUESTIONS LISTED ON REVERSE SIDE AS ACCURATELY AS POSSIBLE.
B. YOU MUST ATTACH COPIES OF ALL UNPAID MEDICAL BILLS TO THIS APPLICATION.

8 List all unpaid medical bills and the dates incurred during the three (3) months before application for assistance.

Type of Services (Hospital, Physician, Etc.) Name of Hospital, Physician Etc.	Patient	Date(s) of Service	Total Amount Due

SEE OTHER SIDE

FD-74 Form #5

PART III - FINANCIAL INFORMATION

9 Are any of the medical bills listed on this application the result of a job related injury, auto or other accident? Yes ( ) No ( )
If yes, explain and indicate the name of the insurance company and your legal representative.

10 What were your income and resources at the time the medical bills were incurred for the **three month period before your application for Public Assistance or Supplemental Security Income?** If you had no income or resources during the three (3) months prior, please specify in the spaces provided. If you were under 18 years old, you must indicate your parent's income and resources

Please check below the type of income you received and in which month(s) received. Also, please submit verification of your income (copies of checks, pay stubs, etc.) with your application.

	WHEN RECEIVED:	TOTAL MONTHLY AMOUNT RECEIVED
_____ EMPLOYMENT	_____ 1st MONTH BEFORE APPLICATION	$_____
_____ UNEMPLOYMENT	_____ 2nd MONTH BEFORE APPLICATION	$_____
_____ DISABILITY	_____ 3rd MONTH BEFORE APPLICATION	$_____
_____ SOCIAL SECURITY		
_____ ALIMONY		
_____ CHILD SUPPORT	**HOW OFTEN RECEIVED:**	
_____ OTHER _____	_____ WEEKLY _____ BI-WEEKLY _____ MONTHLY	

_____ NO INCOME RECEIVED DURING THE THREE MONTHS BEFORE APPLYING FOR PUBLIC ASSISTANCE OR SUPPLEMENTAL SECURITY INCOME

What resources did you have during this same time period?

_____ CHECKING ACCOUNT $_____ _____ STOCKS, BONDS, ETC $_____
_____ SAVINGS ACCOUNT $_____ _____ SPECIFY _____
_____ AUTOMOBILE 1. Year 19__ make _____ _____ OTHER _____
2. Year 19__ make _____
_____ INSURANCE POLICY 1. Face Value $_____ Cash Value $_____
2. Face Value $_____ Cash Value $_____
_____ NO RESOURCE OF ANY KIND

11 Did you have any type of Medical or Health Insurance coverage, such as Blue Cross or Medicare? Yes ( ) No ( )
(If yes, explain below.)

NAME OF INSURANCE COMPANY OR PROGRAM	POLICY NUMBER OR MEDICARE NUMBER	NAME OF INSURED

12 I certify that the above information is true and correct to the best of my knowledge and that no facts have knowingly been omitted. I understand that my application may be investigated and I agree to cooperate in such an investigation. I further understand that the law provides for fine or imprisonment, or both, for a person hiding facts or not telling the truth

_____ _____ _____
Signature of Applicant *Relationship to Applicant* *Date*

NOTE: This application must be signed by the applicant, or relative, or legal guardian or friend acting on behalf of the applicant. This application must not be signed by the applicant's physician or anyone representing a hospital or collection agency.

MAIL THIS COMPLETED APPLICATION, TOGETHER WITH COPIES OF ALL UNPAID MEDICAL BILLS, TO THE RETROACTIVE ELIGIBILITY UNIT, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, CN-712-10, TRENTON, NJ 08625.

DEPARTMENT OF HUMAN SERVICES
MEDICAID-ID

7841006

VALID ONLY FOR THE MONTH OF
MEDICAID HSP #

ELIGIBLE PERSONS	PER #	ELIGIBLE PERSONS	PER #

V O I D

NOTICE TO PROVIDER

REQUEST PERSONAL IDENTIFICATION IF YOU DO NOT KNOW THE PATIENT

PLEASE REPORT THE CASE NAME, CASE NUMBER AND PERSON NUMBER ACCURATELY ON ALL CLAIM FORMS AND OTHER COMMUNICATIONS RELATING TO THE CLAIM

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES
MEDICAID ELIGIBILITY IDENTIFICATION

CARRY THIS CARD AT ALL TIMES

Present it to the pharmacy hospital physician or other providers for medical services rendered in behalf of eligible persons

RECIPIENT S SIGNATURE REQUIRED

No es valida si no está firmada Entréguela a la farmacia, hospital, médico u otros proveedores de servicios médicos prestados a personas que reunen las condiciones necesarias para poder usar Medicaid.

NOTICE

Federal law makes it a crime and sets punishment for persons who have been found guilty of making any false statement or representation of a material fact to receive any benefit or payment under the medical assistance program This Department is required to make you aware of this law and to warn you against making any false statement in an application or in a fact used in determining the right to a benefit or converting a benefit to the use of any person other than one for whom it was intended

NON-TRANSFERABLE UNDER PENALTY OF LAW

AVISO

De acuerdo con la ley federal es un delito hacer una declaración falsa a fin de recibir un beneficio o pago bajo el programa de asistencia médica, y dicha ley fija pena a las personas que la infrinjan Este Departamento le tiene que informar de dicha ley y le tiene que advertir que no haga ninguna falsa declaración en una solicitud para determinar su derecho a un beneficio, o para convertir el beneficio al uso de otra persona que no sea la destinada a recibir el mismo.

INTRANSFERIBLE BAJO PENA DE LA LEY

Form #6

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

VALIDATION OF ELIGIBILITY

Last Name	First Name	MI	Health Services Program Case No.	Person Number

NOTICE TO PROVIDERS

This form identifies the person listed above as eligible for authorized services under the New Jersey Health Services Program (Medicaid).

This form also serves as a validation of eligibility for up to 31 days from date of issue. All policies and procedures specified in the appropriate New Jersey Health Services Program Provider Manual are to be followed by providers when rendering services to this person.

The signature, title and telephone number of an authorized representative of the State Institution listed below must be included to validate this form.

THIS FORM IS THE PROPERTY OF THE STATE OF NEW JERSEY AND MUST BE RETURNED WITH THE PATIENT.

Signature and Title of State Institution Representative	Date of Issue

Name of State Institution	Telephone No.

FD-34 (rev. 5/83)

Form #7

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

PROVIDER APPLICATION

1 _____ 2 _____
Legal Name of Provider Type of Business or Facility

_____
Business Name if Different From Above

3 _____
Address - Service Location Only Street City County State Zip Code

4 _____ 5 _____ 6 _____
Employer ID Number Telephone Number Check if this is your address

7 _____ 8 _____
Billing Address if different Name of Administrator Chief Executive Officer or other responsible official

_____

9 Indicate legal status of your organization Profit _____, Non-Profit _____, Private _____, Public _____, Municipal _____ State _____ Charity _____ School Nurse _____, County _____ Other _____ If other, please specify _____

10 List the specific service(s) for which you are requesting approval for reimbursement under the Medicaid Program

_____

11 Do you operate from more than one location? _____ Yes _____ No If yes, list all other subsidiary or affiliated organizations below (Name and service address)

1 _____ _____
2 _____ _____
3 _____ _____
Please attach additional sheet if necessary

12 Please indicate if you are a member of a chain organization _____ Yes _____ No If yes, indicate name _____

13 Please indicate your preference to receive central or local reimbursement

_____ to each satellite location;
_____ to central location at _____

Billing through a central location is allowable and left to the provider's discretion. However, if the provider chooses to bill centrally pre-addressed claims MUST be utilized since they reflect the proper address and provider number for that location

14 Do you require a Certificate of Need under the Health Facilities Planning Act from the New Jersey Department of Health? _____ Yes _____ No If yes, attach a copy of the Certificate of Need. If no, explain why you do not require a certificate

15 If your business or facility requires a license permit, indicate type _____ and number _____
Please attach a copy of the license permit, i.e., Independent Laboratory Certification.

16 CERTIFICATION, ACCREDITATION OR APPROVAL Specify type and attach copy For example JCAHO (hospitals) New Jersey Department of Health (clinics), Division of Mental Health and Hospitals (mental health clinics), State Board of Dentistry (dental clinics), State Board of Pharmacy (providers offering pharmaceutical services), American Board for Certification in Prosthetics and Orthotics (Prosthetist and or Orthotist) See Item 16

17 Approved by Medicare? _____ Yes _____ No If yes, please indicate Medicare provider number _____ and attach copy of your Medicare approval

18 Are you currently or have you ever been an approved provider of services under the New Jersey Medicaid Program or the Medicaid Program of any other state or jurisdiction? _____ Yes _____ No If Yes, list types of services provided and current status If you were approved at one time and you no longer participate, explain the reason(s)

FD-20-12 (9-

Form #8

19 Have any of the entities named in response to questions I or II or their officers or partners, or any of the individuals named in response to questions 8 ever been the subject of any license suspension, revocation, or other adverse licensure action in this state or any other jurisdiction? _____ Yes _____ No If yes, please explain

20 Have any of the entities named in response to question I or II or their officers or partners or any of the individuals named in response to questions 8 ever been indicted, charged convicted of, or pled guilty or no contest to any federal or state crime in this state or any other jurisdiction? _____ Yes _____ No If yes, please explain

21 Have any of the entities named in response to questions I or II or their officers or partners, or any of the individuals named in response to questions 8 ever been the subject of any Medicaid (Title XIX) or Medicare (Title XVIII) suspension debarment disqualification or recovery action in this state or any other jurisdiction? _____ Yes _____ No If yes please explain _____

22 Do any of the entities named in response to question I or II or their officers or partners or any of the other individuals named in response to questions 8 own or have any financial interest in any other provider participating in the New Jersey Medicaid (Title XIX) Program or the Medicaid (Title XIX) Progam of any other state or jurisdiction? _____ Yes _____ No If yes please list provider name and nature of relationship

23 Do you charge for goods and or services? TO ALL _____ . TO NONE _____ TO CERTAIN GROUPS ONLY _____
If you charge to all or only certain groups, please explain your arrangement and attach a copy of your fee schedule

24 List days and hours of operation

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

NEW JERSEY HEALTH SERVICES PROGRAM
TITLE XIX (MEDICAID)

PROVIDER AGREEMENT
BETWEEN
NEW JERSEY DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
AND

_____
PROVIDER

PROVIDER AGREES:

1. To comply with all applicable State and Federal Medicaid laws and policy, and rules and regulations promulgated pursuant thereto:

2. To keep such records as are necessary to fully disclose the extent of services provided to individuals receiving assistance under the Medicaid Program;

3. To furnish the Division of Medical Assistance and Health Services, the Secretary of Health and Human Services and the Medicaid Fraud Section, Division of Criminal Justice with such information as may be requested from time to time, regarding any payments claimed for providing services under the Medicaid Program;

4. To comply with the requirements of Title VI of the Civil Rights Acts of 1964 and Section 504 of the Rehabilitation Act of 1973 and any amendments thereto; and Section 1909 of P.L. 92-603, Section 242 (c) which makes it a crime and sets the punishment for persons who have been found guilty of making any false statement or representation of a material fact in order to receive any benefit or payment under the Medical Assistance Program. (The Department of Human Services is required by Federal regulation to make this law known and to warn against false statements in an application/agreement or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended).

5. To comply with the disclosure requirements specified in 42 CFR 455.100 through 42 CFR 455.106.

The provider may, on thirty days written notice to the Division, terminate this Agreement.

_____ _____
DATE SIGNATURE OF PROVIDER

_____
TITLE

FD-62 (rev. 6/86) Medicaid 3031-M Ed. 6/86

Form #9

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0086

INSTRUCTIONS FOR COMPLETING DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT (CMS-1513)

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by titles V, XVIII, XIX, and XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the Secretary of appropriate State agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the Secretary or appropriate State agency to enter into an agreement or contract with any such institution or in termination of existing agreements.

SPECIAL INSTRUCTIONS FOR TITLE XX PROVIDERS

All title XX providers must complete part II (a) and (b) of this form. Only those title XX providers rendering medical, remedial, or health related home-maker services must complete parts II and III. Title V providers must complete parts II and III.

General Instructions

For definitions, procedures and requirements, refer to the appropriate Regulations:

Title V – 42CFR 51a.144
Title XVIII– 42CFR 420.200 – 206
Title XIX – 42CFR 455.100 – 106
Title XX – 45CFR 228.72 – 73

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks section on page 2, referencing the item number to be continued. If additional space is needed use an attached sheet.

Return the original and second and third copies to the State agency; retain the first copy for your files.

This form is to be completed annually. Any substantial delay in completing the form should be reported to the State survey agency.

DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

Item I (a) Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.
(b) **For Regional Office Use Only.** If the yes box is checked for item VII, the Regional Office will enter the 5-digit number assigned by CMS to chain organizations.

Item II - Self-explanatory.

Item III - List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Items IV – VII - Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For Items IV – VII, if the yes box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

Item IV - (a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

Item V - If the answer is yes, list name of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

Item VI - If the answer is yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

Item VII - A chain affiliate is any free-standing health care facility that is either owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

Item VIII - If yes, list the actual number of beds in the facility now and the previous number.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB NO. 0938-0086

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

(a) Name of Entity	D/B/A	Provider No.	Vendor No.	Telephone No.
Street Address		City, County, State		Zip Code

(b) *(To be completed by CMS Regional Office)* Chain Affiliate No. ☐☐☐☐☐ LB1

II. Answer the following questions by checking "Yes" or "No." If any of the questions are answered "Yes," list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued.

(a) Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by titles XVIII, XIX, or XX?

☐ Yes ☐ No LB2

(b) Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by titles XVIII, XIX, or XX?

☐ Yes ☐ No LB3

(c) Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only)

☐ Yes ☐ No LB4

III. (a) List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN
		LB5

(b) Type of Entity: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation LB6
☐ Unincorporated Associations ☐ Other (Specify)

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks.

Check appropriate box for each of the following questions:

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example: sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers.

☐ Yes ☐ No LB7

Name	Address	Provider Number

CMS-1513 (5/86) Page 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB NO. 0938-0086

IV. (a) Has there been a change in ownership or control within the last year? ☐ Yes ☐ No LB8
If yes, give date _____

(b) Do you anticipate any change of ownership or control within the year? ☐ Yes ☐ No LB9
If yes, when? _____

(c) Do you anticipate filing for bankruptcy within the year? ☐ Yes ☐ No LB10
If yes, when? _____

V. Is this facility operated by a management company, or leased in whole or part by another organization? ☐ Yes ☐ No LB11
If yes, give date of change in operations _____

VI. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year? ☐ Yes ☐ No LB12

VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN) ☐ Yes ☐ No LB13
Name EIN #

Address

LB14

VII. (b) If the answer to Question VII.a. is No, was the facility ever affiliated with a chain? ☐ Yes ☐ No LB18
(If yes, list Name, Address of Corporation, and EIN)
Name EIN #

Address

LB19

VIII. Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years? ☐ Yes ☐ No LB15

If yes, give year of change _____
Current beds _____ LB16 Prior beds _____ LB17

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Name of Authorized Representative (Typed)	Title

Signature	Date

Remarks

CMS-1513 (5/86) Page 2

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid 0MB control number. The valid 0MB control number for this information collection is 0938-0086. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

Amended by R.2006 d.25, effective January 17, 2006.
See: 37 N.J.R. 3176(a), 38 N.J.R. 802(a).
Replaced (HCFA-1513) forms with (CMS-1513) forms.

PATIENT CERTIFICATION FORM

PATIENT'S NAME ____________________

HIC NO. ____________________ HSP NO. ____________________

MEDICARE PATIENT'S AUTHORIZATION

I authorize any holder of medical or other information about me to release to the Social Security Administration, or the Health Care Financing Administration or its intermediaries or carriers, any information needed for this or a related claim. I certify that the service(s) covered by this claim has been received and request payment in accordance with Program Policy either to Dr. __________ or myself if the doctor does not accept assignment.

MEDICAID PAYMENTS

Authorization to Release Information and Payment Request. I certify that the service(s) covered by this claim has been received and request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the State Agency or its authorized Agents any information needed for this or a related claim.

Patient or Authorized Representative's Signature	Date of Service	Control Number	Other Comments

THIS FORM TO BE RETAINED IN PROVIDER'S OFFICE
THIS FORM HAS BEEN APPROVED BY
THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES,
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
FOR USE IN THE MEDICAID PROGRAM

7-415-M Ed. 7/82

FD-197-N.J. (rev. 7/82

Form #11

Notice to All Applicants and Providers

Please note that the ownership and direction of a professional practice must be in compliance with all applicable State statutes and regulations governing licensure.

Any individual or entity found by staff of the Division of Medical Assistance and Health Services to be in violation any State statute or regulation governing the ownership and direction of a professional practice will be subject to appropriate sanctions contained in the statutes and regulations governing the programs administered by the Division of Medical Assistance and Health Services, including exclusion from the New Jersey Medicaid and NJ KidCare programs. In addition, such violations will be referred to the appropriate professional board or other licensure authority.

To be completed by owner, managing partner or chief executive officer:

I hereby certify that _______ (name of entity applying for program participation) is in compliance with State statutes and regulations governing the ownership and direction of a professional practice.

______________ Date

______________________ Print or type name and title

______________________ Signature

Form #12

MEDICAL ASSISTANCE CUSTOMER CENTER
(MACC)

MACC OFFICE	DIRECTOR & PHONE #	ADDRESS
(03) BURLINGTON	Nancy Weber, Director	Mt. Laurel Corporate Park

MACC	OFFICE	DIRECTOR & PHONE #	ADDRESS
(11)	MERCER	(856) 787-3855 FAX#(856) 787-3877	1000 Howard Blvd, Suite 303 Mt. Laurel, NJ 08054-2355
(04) (08) (17)	CAMDEN GLOUCESTER SALEM	Eileen Calabro, Director (856) 614-2870 FAX#(856) 614-2575	1 Port Center, Suite 401 2 Riverside Dr. Camden, NJ 08103-1018
(06) (01) (05)	CUMBERLAND ATLANTIC CAPE MAY	, [Barbara Smith] Director (856) 690-5208 FAX#(856) 690-5223	Giles Building 1676 East Landis Ave PO Box 1513 Vineland, NJ 08362-1513
(07)	ESSEX	Kate Buckley-Straussl, Director (973) 648-3700 FAX#(973) 642-6468 John Russell, Northern Regional Administrator	153 Halsey St 4th Floor Newark, NJ 07101-8004
(09)	HUDSON	Robert Dueben, Director (201) 217-7100 FAX#(201) 217-7122	438 Summit Ave 6th Floor Jersey City, NJ 07306-3186
(12) (20)	MIDDLESEX UNION	, [Susan Simon] Director (732) 499-5700 FAX#(732) 499-5803	301 Blair Road 2nd Floor Avenel, NJ 07001-2936
(13)	MONMOUTH	, [Carol Coyle] Director (732) 761-3600 FAX#(732) 761-3621 or 3623 Thomas Rafferty, Southern Regional Administrator	Juniper Business Plaza 3499 Highway 9 North Suite 1H-A Freehold, NJ 07728-3287
(14) (10) (18) (19) (21)	MORRIS HUNTERDON SOMERSET SUSSEX WARREN	Stewart Klaus, Director (973) 631-6440 FAX#(973) 631-6448	10 Park Place Suite 340 Morristown, NJ 07960-7101
(15)	OCEAN	Gail Dempsey, Director (732) 255-0731 FAX#(732) 255-0743	1510 Hooper Ave Suite 130 Toms River, NJ 08753-2295
(16) (02)	PASSAIC BERGEN	Kathleen Lohrey, Director (973) 977-4077 FAX#(973) 684-8182	66 Hamilton St Paterson, NJ 07505-2021

Form #14

COUNTY BOARDS OF SOCIAL SERVICES

ATLANTIC	1	FORREST GILMORE, ACT. DEPT. HEAD KAREN B. ENOUS, DIRECTOR OF WELFARE &	ATLANTIC COUNTY DEPARTMENT OF FAMILY COMMUNITY DEVELOPMENT 1333 ATLANTIC AVE.	
8:30-4:30		FAX 609-343-2374	ATLANTIC CITY, NJ 08401-8297	609-348-3001
BERGEN 8:00-4:30 8:00-8:00 (Tuesday)	2	EDWARD TESTA, DIRECTOR FAX 201-368-8710	BERGEN COUNTY BOARD OF SOCIAL SERVICES 216 ROUTE 17 NORTH ROCHELLE PARK, NJ 07662-3300	201-368-4200
BURLINGTON 8:00-5:00 8:00-7:30 (Thursday)	3	ANN SABOE, DIRECTOR FAX 609-261-0463	BURLINGTON COUNTY BOARD OF SOCIAL SERVICES HUMAN SERVICES FACILITY 795 WOODLANE RD. MOUNT HOLLY, NJ 08060-3335	609-261-1000
CAMDEN 8:30-4:30 7:30-7:30 (Thursday)	4	ROBERT ELLIS, DIRECTOR FAX 856-225-5145 (Director Only) FAX 856-225-7797	CAMDEN COUNTY BOARD OF SOCIAL SERVICES ALETHA R. WRIGHT ADMINISTRATION BLDG. 600 MARKET ST. CAMDEN, NJ 08102-8800	856-225-8800
CAPE MAY 8:30-4:30	5	JOSEPH B. FAHY, DIRECTOR FAX 609-889-9332	CAPE MAY COUNTY BOARD OF SOCIAL SERVICES SOCIAL SERVICES BLDG. 4005 ROUTE 9 SOUTH RIO GRANDE, NJ 08242-1911	609-886-6200
CUMBERLAND 8:30-4:30	6	GREGORY CURLISS, DIRECTOR FAX 856-692-7635	CUMBERLAND COUNTY BOARD OF SOCIAL SERVICES 13 NORTHEAST BLVD. VINELAND, NJ 08360	856-691-4600
ESSEX 8:00-5:30	7	JAMES J. WILLIAMS, DIRECTOR FAX 973-643-3985	ESSEX COUNTY DEPARTMENT OF CITIZEN SERVICES DIVISION OF WELFARE 18 RECTOR ST., 9TH FL. NEWARK, NJ 07102	973-733-3000
GLOUCESTER 7:30-4:30	8	CAROL PIRROTTA, DIRECTOR FAX 856-582-6587	GLOUCESTER COUNTY BOARD OF SOCIAL SERVICES 400 HOLLYDELL DR. SEWELL, NJ 08080	856-582-9200
HUDSON 8:00-5:00	9	ANGELICA HARRISON, DIRECTOR FAX 201-420-0343	HUDSON COUNTY DIVISION OF SOCIAL SERVICES JOHN F. KENNEDY OFFICE BLDG. 100 NEWKIRK ST. JERSEY CITY, NJ 07306	201-420-3000
HUNTERDON	10	JOHN F. CAHALAN, DIRECTOR	COUNTY OF HUNTERDON DIVISION OF SOCIAL SERVICES DEPARTMENT OF HUMAN SERVICES P.O. BOX 2900	

8:30–4:30		FAX 908–806–4588	FLEMINGTON, NJ 08822–2900	908–788–1300
MERCER	11	DENNIS C. MICAI, DIRECTOR	MERCER COUNTY BOARD OF SOCIAL SERVICES	
8:30–4:30			200 WOOLVERTON ST., P.O. BOX 1450	
8:30–8:30 (Tuesday)		FAX 609–989–0405	TRENTON, NJ 08650–2099	609–989–4320
MIDDLESEX	12	ANGELA B. MACKARONIS, DIRECTOR	MIDDLESEX COUNTY BOARD OF SOCIAL SERVICES	
		FAX 732–745–4558	181 HOW LANE, P.O. BOX 509	
8:30–4:15		WFNJ FAX 732–745–4555	NEW BRUNSWICK, NJ 08903	732–745–3500
MONMOUTH	13	KATHLEEN A. BRADY, DIRECTOR	MONMOUTH COUNTY DIVISION OF SOCIAL SERVICES	
8:30–4:30		FAX 732–431–6017	KOZLOSKI RD., P.O. BOX 3000	
8:30–8:00 (Thursday)		WFNJ FAX 732–431–6267	FREEHOLD, NJ 07728	732–431–6000
MORRIS	14	CAROL A. NOVRIT, DIRECTOR	MORRIS COUNTY DIVISION OF EMPLOYMENT AND TEMPORARY ASSISTANCE PROGRAM SERVICES 1719C ROUTE 10 (PARSIPPANY), P.O. BOX 900	
8:30–4:30		FAX 973–326–7251	MORRISTOWN, NJ 07963–0900	973–326–7800
OCEAN	15	BEVERLY J. BEARMORE, DIRECTOR	OCEAN COUNTY BOARD OF SOCIAL SERVICES	
		FAX 732–244–8075	1027 HOOPER AVE., P.O. BOX 547	
8:30–4:30		WFNJ FAX 732–473–0669	TOMS RIVER, NJ 08754–0547	732–349–1500
PASSAIC	16	MARK SCHIFFER, DIRECTOR	PASSAIC COUNTY BOARD OF SOCIAL SERVICES	
			80 HAMILTON ST.	
7:30–6:00		FAX 973–881–3232	PATERSON, NJ 07505–2060	973–881–0100
SALEM	17	AMY THOMAS, DEPUTY DIRECTOR	SALEM COUNTY BOARD OF SOCIAL SERVICES	
			147 S. VIRGINIA AVE.	
8:00–4:00		FAX 856–299–3245	PENNS GROVE, NJ 08069–1797	856–299–7200
SOMERSET	18	MILDRED A. GAUPP, DIRECTOR	SOMERSET COUNTY BOARD OF SOCIAL SERVICES	
			73 E. HIGH ST., P.O. BOX 936	
8:15–6:00		FAX 908–231–9010	SOMERVILLE, NJ 08876–0936	908–526–8800
SUSSEX	19	JEFFREY M. DALY, DIRECTOR	SUSSEX COUNTY DIVISION OF SOCIAL SERVICES	
			18 CHURCH ST., P.O. BOX 218	
8:30–4:30		FAX 973–383–3627	NEWTON, NJ 07860–0218	973–383–3600
UNION	20	CHARLES J. GILLON, DIRECTOR	UNION COUNTY DIVISION OF SOCIAL SERVICES	
		FAX 908–965–3836 (Director Only)	342 WESTMINSTER AVE.	
8:15–6:00		WFNJ FAX 908–965–2758	ELIZABETH, NJ 07208–3290	908–965–2700
WARREN	21	HENRY D. DINGER, DIRECTOR	WARREN COUNTY WELFARE BOARD COURT HOUSE ANNEX SECOND & HARDWICK STS., BOX 3000	
8:30–4:30		FAX 908–475–1533	BELVIDERE, NJ 07823–3000	908–475–6301

rev. 6/1/01

Form #15

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Repealed Forms 7, 15 and 16, and recodified Forms 8 through 14, and 17, as Forms 7 through 13, and 14, respectively; and added Form 15B.

Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).