

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.

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.

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.

4. Private duty nursing services (except for beneficiaries under EPSDT, Model Waiver III, ACCAP and ABC programs);

5. Services or items furnished for any sickness or injury occurring while the covered person is on active duty in the military;

6. Services provided outside the United States and territories;

7. Services or items furnished for any condition or accidental injury arising out of and in the course of employment for which any benefits are available under the provisions of any workers' compensation law, temporary disability benefits law, occupational disease law, or similar legislation, whether or not the Medicaid beneficiary claims or receives benefits thereunder, and whether or not any recovery is obtained from a third-party for resulting damages;

8. That part of any benefit which is covered or payable under any health, accident, or other insurance policy (including any benefits payable under the New Jersey no-fault automobile insurance laws), any other private or governmental health benefit system, or through any similar third-party liability, which also includes the provision of the Unsatisfied Claim and Judgment Fund;

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

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

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

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

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

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

i. Final payment shall be made in accordance with a review of those services actually documented in the provider's health care record. Further, the medical necessity for the services must be apparent and the

quality of care must be acceptable as determined upon review by an appropriate and qualified health professional consultant.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.

See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 with changes, effective September 21, 1998.

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

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

In (a), added 17 and 18.

Cross References

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

Case Notes

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

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

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

10:49-5.6 Services available 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;

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

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

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

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

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

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

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

Substituted "beneficiary" and "beneficiaries" for "recipient" and "recipients" throughout.

Recodified from N.J.A.C. 10:49-9.4 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998). See: 30 N.J.R. 1060(a).

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

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.

See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 without change.

Case Notes

Disclosure of grand jury materials to government departments for use in civil proceedings requires strong showing of particularized need that

outweighs public interest in grand jury secrecy. *State v. Doliner*, 96 N.J. 236, 475 A.2d 552 (1984).

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

10:49-9.8 Provider certification and recordkeeping

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

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

i. The following signature types are unacceptable:

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

(b) Providers shall agree to the following:

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

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

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

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

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

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

(c) When a Medicaid or NJ FamilyCare provider employs, contracts or subcontracts with an individual or entity

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

1. The Division may recover from the enrolled Medicaid or NJ FamilyCare provider the Medicaid or NJ FamilyCare reimbursement paid by the Program to the provider for any service rendered by an employee, contractor, subcontractor or a contractor's or subcontractor's employee not meeting such requirements; and/or

2. The provider, contractor, subcontractor or other responsible party may be subject to any applicable civil or criminal sanctions and/or penalties.

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

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

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

Recodified from N.J.A.C. 10:49-9.5 and amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

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

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

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

Added (c) and (d).

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 without change.

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

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

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

10:49-9.9 Patient's (beneficiary) certification

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

1. Certifying that the service(s) covered by a claim has been received;
2. Requesting payment for those services made on his or her behalf; and
3. Authorizing any holder of medical or other information to release to the New Jersey Medicaid or NJ FamilyCare program or its authorized agents any information needed for this or a related claim.

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

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

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

(d) A provider shall complete a Medicaid or NJ FamilyCare hard-copy claim, Patient Certification Form, or certification log before it is presented to the beneficiary for signature. A Medicaid or NJ FamilyCare beneficiary shall not sign a blank Medicaid or NJ FamilyCare hard-copy claim, Patient Certification Form, or certification log, nor shall he or she sign the form prior to receiving services or as a condition for receiving services.

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

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

2. If 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.

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:

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

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

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

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

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

(j) Conditions for suspension shall be as follows:

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

2. The existence of any cause for suspension shall not require that a suspension be imposed, and a decision to suspend shall be made at the discretion of the Director of the Division and of the Attorney General, and shall be rendered in the best interests of the New Jersey Medicaid and NJ FamilyCare programs.

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

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

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

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

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

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

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

1. A suspension may include all known affiliates of a person, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The offense, failure or inadequacy of performance of an individual may be

imputed to a person with whom he or she is affiliated, where such conduct was accomplished within the course of his official duty or was effectuated by him or her with the knowledge or approval of such person.

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

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

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

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

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

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

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

In (a), inserted ". and Reorganization Plan No. 001-1996"; in (b), substituted "New Jersey Medicaid program" and "Medicaid Agent" for "Division" throughout; in (b)3, deleted "reimbursed on a fee-for-service basis"; in (c), rewrote introductory paragraph and deleted "Division", "Fiscal Agent" and "Provider"; and in (d), substituted "beneficiary" and "beneficiaries" for "recipient" and "recipients", reference to Medicaid Agent for references to Division, Division of Medical Assistance and Health Services, and Director, and "Program" for references to the Division of Medical Assistance and Health Services, throughout; in (d)5, deleted Public Law references; in (d)17, deleted "form" following "Medicaid claim"; in (d)20, inserted reference to Commissioner of Health and Human Services; and in (j)2, substituted "New Jersey Medicaid program" for "Division".

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

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

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

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 without change.

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

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

Rewrote the section.

Law Review and Journal Commentaries

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

Case Notes

Medicaid provider's failure to file income tax returns justifies suspension from program. *Salita v. Division of Medical Assistance and Health Services*, 97 N.J.A.R.2d (DMA) 3.

Suspension and proposed debarment of doctor as provider of Medicaid services in New Jersey justified by his exclusion and debarment in New York Medicaid program. In re Roggemann, 96 N.J.A.R.2d (DMA) 83.

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.

Suspension pending resolution of criminal proceedings of Medicaid program livery transporter was proper. *Division of Medical Assistance and Health Services v. Ahmed*, 94 N.J.A.R.2d (DMA) 31.

It was proper to suspend physician from participation in Medicaid program pending outcome of criminal proceeding. *Joachim v. DMAHS*, 93 N.J.A.R.2d (DMA) 110.

Physician permanently disqualified due to engagement in illegal kickback scheme. *Scollo v. Division of Medical Assistance and Health Services*, 93 N.J.A.R.2d (DMA) 23.

Division alone could suspend provider's participation in Medicaid for crime of possession of controlled dangerous substance and possession with intent to distribute. (Director's Final Decision). *Div. of Medical Assistance and Health Services v. Kares*, 8 N.J.A.R. 517 (1983).

Suspension of provider privileges upon indictment involving moral turpitude affirmed pending conclusion of proceedings. (Director's Final Decision). *Div. of Medical Assistance and Health Services v. Rednor*, 5 N.J.A.R. 430 (1981).

Suspension of Medicaid provider reserved as indicated crime (unauthorized wiretap) does not constitute a crime of moral turpitude. (Division's Final Decision). *Div. of Medical Assistance and Health Services v. Dalglish*, 3 N.J.A.R. 23 (1981), affirmed Dfk. No. A-4941-79 (App.Div.1982).

SUBCHAPTER 12. PROVIDER REINSTATEMENT

10:49-12.1 Definitions

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

"Committee" means the Provider Reinstatement Committee.

"Person" means any natural person, company, firm, corporation, professional association, partnership, or other entity, who has been excluded from participation in the New Jersey Medicaid or 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).

Amended "Committee" and "Person"; and deleted "Director" and "Division".

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

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

In "Person", inserted a reference to the NJ KidCare program.

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.

See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 without change.

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

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

Rewrote the introductory paragraph.

10:49-12.2 Requests for reinstatement

Persons who have been debarred, disqualified or suspended from participating in the New Jersey Medicaid or the NJ FamilyCare program shall petition the Director for reinstatement in writing.

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 programs administered by the Division.

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

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

Inserted a reference to the NJ KidCare program.

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).

10:49-12.3 Petition by debarred, disqualified or suspended person

(a) Persons debarred or disqualified for a definitely stated period of time may petition the Director for reinstatement 90 days prior to the expiration of the period of debarment or disqualification.

(b) Persons disqualified for an indefinitely stated period of time may petition the Director for reinstatement after a disqualification period of eight years.

(c) Persons who have been suspended, debarred or disqualified as the result of an indictment, conviction or license revocation may immediately petition the Director for reinstatement upon acquittal, reversal of the conviction upon appeal or restoration of the license, whichever is applicable.

10:49-12.4 Director's powers

The Director may on his or her own motion order the reinstatement of debarred, disqualified or suspended per-

sons or may refer the matter to the Provider Reinstatement Committee.

10:49-12.5 Provider Reinstatement Committee

(a) The Provider Reinstatement Committee shall be a non-standing committee that is convened for the purpose of evaluating requests for reinstatement.

1. The Committee shall be composed of three impartial officials of the New Jersey Medicaid or the NJ FamilyCare program appointed by the Director.

i. The Committee members shall not have been directly involved in the debarment, disqualification or suspension of persons requesting reinstatement.

ii. The Chairperson of the Committee shall be an attorney from the Office of Legal and Regulatory Liaison/Division of Medical Assistance and Health Services.

iii. Whenever possible, the associate members of the Committee shall be one member of the Medicaid Agent or the NJ FamilyCare staff from the same discipline as the debarred, disqualified or suspended persons and one member from the general administrative staff of the Division.

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 "Division"; in (a)i, deleted "Under this requirement," preceding "The committee"; and in (a)iii, substituted "Medicaid Agent" for "Division". Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

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

In (a)1, inserted references to NJ KidCare 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).

10:49-12.6 Criteria for reinstatement

(a) Reinstatement will not be granted unless it is reasonably certain that the causes which led to the debarment, disqualification or suspension shall not be repeated. In determining a person's fitness for reinstatement, the Committee and the Director may consider, among other factors:

1. Statements from debarred, disqualified or suspended persons setting forth the reasons why they should be reinstated;

2. Statements from private health insurers, indicating whether there have been any questionable claims submitted during the period of exclusion from Program participation;

3. Statements from peer review bodies, probation or parole officers or professional associates, attesting to their belief, supported by facts, that the causes which led to the debarment, disqualification or suspension shall not be repeated;

4. The absence of any pending criminal, licensing, or professional disciplinary proceedings;
5. Full restitution and the payment of any criminal fines imposed;
6. Full satisfaction of any civil penalties imposed;
7. Full satisfaction of interest payments;
8. Compliance with the terms and conditions of Consent Orders or Court Orders; and
9. Satisfaction of any conditions or requirements previously imposed by the Medicaid or 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).

In (a)9 substituted "Medicaid program" for "Division".
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).

In (a)9, inserted a reference to the NJ KidCare program.
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).

Case Notes

A disqualified Medicaid provider must apply for reinstatement and satisfy all requirements of subchapter. Div. of Medical Assistance and Health Services v. Kares, 8 N.J.A.R. 517 (1983).

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

10:49-12.7 Committee procedures

- (a) The Committee shall meet at the Division's central offices.
- (b) Persons requesting reinstatement and/or their representative shall be notified, in writing, as to the time, date and place of the meeting.
- (c) All correspondence concerning the meeting shall be directed to the Chairperson of the Committee.
- (d) Persons requesting reinstatement may appear on their own behalf or be represented by counsel.
- (e) The Committee shall be governed by the New Jersey Administrative Procedure Act concerning admissibility of evidence at the meeting.
- (f) The Chairperson of the Committee shall rule on all procedural questions and objections that may be raised at the meeting.
- (g) Persons requesting reinstatement shall have the burden of providing their fitness for reinstatement by a preponderance of the evidence.

(h) Persons may present evidence of their fitness for reinstatement by the testimony of witnesses under oath or by documentary evidence, or both.

(i) After reviewing the testimony and documentation presented, the Committee shall prepare a written report which discusses the testimony, contains findings of facts and recommended disposition.

(j) At least two members of the Committee shall concur in the recommended disposition.

(k) Copies of the Committee's report shall be sent to all parties at the meeting. Upon receipt of the Committee's report, the parties shall have the opportunity to submit written objections or exceptions to said report within the time period specified by the committee.

(l) After the expiration of the time period prescribed for the filing of the exceptions, the Committee's report, exceptions or objections thereto, evidence and any transcripts shall be forwarded to the Director.

(m) The Director in consultation with the Commissioner of Health and Senior Services, where appropriate, shall have final decisional authority and may adopt, reverse or modify the Committee's recommended determination. The Director may also, for cause, remand the matter back to the Committee for further testimony.

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

In (m), inserted reference to consultation with Commissioner.

SUBCHAPTER 13. PROGRAM CONTROLS

10:49-13.1 Medical review and evaluation

Under the provisions of Federal and State law, the Medicaid Agent or DMAHS shall provide continuing review and evaluation of the care and services provided under the Medicaid and NJ FamilyCare programs. This includes review of utilization of services of practitioners and other providers.

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 "Division of Medical Assistance and Health 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).

Inserted a reference to DMAHS and substituted a reference to the Medicaid and NJ KidCare programs for a reference to programs in the first sentence.

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).

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).

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 waived 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/Alternative 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 waived 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