N.J.A.C. 10:49

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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Title 10, Chapter 49 -- Chapter Notes

Statutory Authority

CHAPTER AUTHORITY:

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

History

CHAPTER SOURCE AND EFFECTIVE DATE:

Effective: December 5, 2022.

See: *55 N.J.R. 65(a)*.

CHAPTER HISTORICAL NOTE:

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

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

Chapter 49, Administration, was repealed and a new Chapter 49, Administration, was adopted as R.1992 d.317, effective August 17, 1992. See: 24 N.J.R. 1728(b), 24 N.J.R. 2837(a). Subchapter 19, Prepaid Health Care Services: Medicaid Eligibles, was repealed by R.1995 d.337, effective June 19, 1995. See: 27 N.J.R. 853(a); 27 N.J.R. 2446(b).

Pursuant to Executive Order No. 66(1978), Chapter 49, Administration, was readopted as R.1997 d.354, effective August 8, 1997. As a part of R.1997 d.354, effective September 2, 1997, Chapter 49, Administration, was renamed Chapter 49, Administration Manual; Subchapter 2, New Jersey Medicaid Recipients, was renamed Subchapter 2, New Jersey Medicaid Beneficiaries; Subchapter 9, Provider and Recipient's Rights and Responsibilities; Administrative Process, was renamed Subchapter 9, Provider and Beneficiary's Rights and Responsibilities; Administrative Process; Subchapter 17, Home and Community-Based Services Waivers, was recodified as N.J.A.C. 10:49-22, Home and Community Based Services Waiver Programs; Subchapter 18, Home Care Expansion Program, was recodified as N.J.A.C. 8:81-2, and Subchapter 18, Early and Periodic Screening, Diagnosis and Treatment (EPSDT), was adopted as new rules; Subchapter 19, HealthStart, was adopted as new rules; Subchapter 21, Pharmaceutical Assistance to the Aged and Disabled (PAAD), was recodified as N.J.A.C. 8:81-3, and Subchapter 21, The Medicaid Managed Care Program--NJ Care, was adopted as new rules; Subchapter 22, Lifeline Programs, was recodified as N.J.A.C. 8:81-4, and Subchapter 22, Home and Community-Based Services

Waiver Programs, was adopted as new rules; and Subchapter 23, Hearing Aid Assistance to the Aged and Disabled, was recodified as N.J.A.C. 8:81-5, and a new Subchapter 23, Lifeline Programs, was adopted as new rules. See: *29 N.J.R. 2512(a)*, *29 N.J.R. 3856(a)*.

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

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

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

Chapter 49, Administration Manual, was readopted as R.2008 d.230, effective July 11, 2008. As a part of R.2008 d.230, Subchapter 21, The Medicaid Managed Care Program--NJ Care 2000, was renamed The Medicaid/NJ FamilyCare Managed Care Program, effective August 4, 2008. See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

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

Chapter 49, Administration Manual, was readopted as R.2016 d.010, effective January 7, 2016. See: *47 N.J.R. 2039(a)*, *48 N.J.R. 207(a)*.

Chapter 49, Administration Manual, was readopted, effective December 5, 2022. See: Source and Effective Date.

Annotations

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Research References & Practice Aids

CHAPTER EXPIRATION DATE:

Chapter 49, Administration Manual, expires on December 5, 2029.

N.J.A.C. 10:49-1.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 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.

History

HISTORY:

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).

Annotations

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Case Notes

County social service board erred when it denied Medicaid eligibility to an immigrant who had entered the U.S. in 2002 and whose deportation was withheld on October 3, 2002 on the ground that he was entitled to political asylum. Though the applicant's "permanent resident" card was dated April 7, 2015, that was not the relevant date for the purpose of determining eligibility, which included the requirement that the applicant be in the U.S. for more than five years. *A.S. v. Hudson Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 09735-16, 2016 N.J. AGEN LEXIS 748*, Initial Decision (August 26, 2016).

N.J.A.C. 10:49-1.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 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 (the State Children's Health Insurance Program (SCHIP)) of the Social Security Act. In New Jersey, the SCHIP program is known as NJ FamilyCare. The Division of Medical Assistance and Health Services, Department of Human Services, administers the New Jersey Medicaid and the NJ FamilyCare programs 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.

History

HISTORY:

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)*.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In the introductory paragraph of (a), substituted "agency for "Agency", substituted "programs" for "program" preceding "through its Central Office", inserted "(the State Children's Health Insurance Program (SCHIP))", inserted the second sentence and inserted a comma following "agencies".

Annotations

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N.J.A.C. 10:49-1.3

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§ 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 welfare agency (CWA)" 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 (TANF), the Food Stamp program and Medicaid. Depending on the county, the CWA 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 CFR 412.30* for the administration of the New Jersey Medicaid/NJ FamilyCare program.

"Department of Children and Families" or "DCF" means the New Jersey Department of Children and Families, created by P.L. 2006, c. 47.

"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.

"Dual eligibles" means those Medicaid/NJ FamilyCare beneficiaries who are also eligible for Medicare benefits under Title XVIII of the Social Security Act.

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

"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 below the age of 19 with family incomes up to and including 133 percent of the Federal poverty level, children under the age of one year, pregnant women eligible under the New Jersey Care . . . Special Medicaid Programs, pregnant women up to 200 percent of the Federal poverty level, AFDC-related children under age 21 and TANF/AFDC-RELATED Medicaid parents. In addition to covered managed care services, eligibles may access certain other services, which are paid fee-for-service.

"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 with gross family incomes above 200 percent and not in excess of 350 percent of the Federal poverty level, parents/caretakers with income up to 200 percent of the Federal poverty level who applied on or before June 14, 2002, and as a result, were subsequently and continuously enrolled in the program, parents/caretakers with incomes less than or equal to 133 percent of the Federal poverty level who were enrolled in the program pursuant to P.L. 2005, c. 156, adults with incomes up to and including 250 percent of the Federal poverty level formerly covered by the Health Access Program and restricted alien parents formerly covered under NJ FamilyCare Plan H. 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-l 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*.

History

HISTORY:

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".

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Substituted definition "County welfare agency (CWA)" for definition "County board of social services (CBOSS)"; in definition "County welfare agency (CWA)", inserted a comma following "government", inserted "(TANF)" and substituted "CWA" for "CBOSS"; in definition "Department", substituted "State" for "state" and "CFR" for "C.F.R." and inserted "for the administration of the New Jersey Medicaid/NJ FamilyCare program"; in definition "DYFS", substituted "Children and Families" for "Human Services"; added definitions "Department of Children and Families" and "Dual eligibles"; and rewrote definitions "NJ FamilyCare-Plan A" and "NJ FamilyCare-Plan D".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:49-1.4

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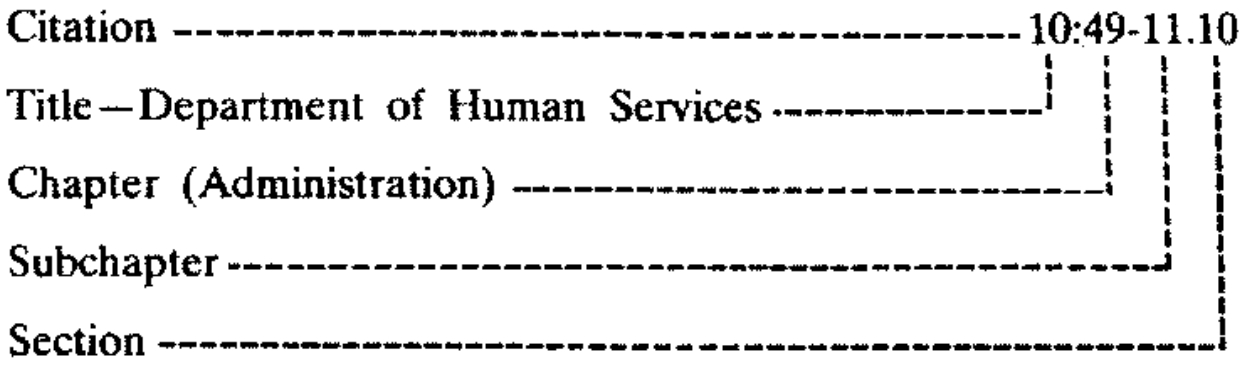
§ 10:49-1.4 Overview of provider manuals

(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:



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 and NJ FamilyCare Beneficiaries
28. 10:75--Psychiatric Residential Treatment Facility Services for Individuals Under Age 21
29. 10:76--Programs for Assertive Community Treatment (PACT) Services
30. 10:77 Rehabilitation Services Manual
31. 10:78 NJ FamilyCare Manual
32. 10:79--NJ FamilyCare Children's Program

(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.

History

HISTORY:

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.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In the introductory paragraph of (d), deleted "10:75, and 10:77 through" preceding "10:79"; in (d)27, substituted "and NJ FamilyCare Beneficiaries" for "Eligibles"; in (d)28, substituted "Psychiatric Residential Treatment Facility Services for Individuals Under Age 21" for "Programs of Assertive Community Treatment"; in (d)29, substituted "10:76--Programs for Assertive Community Treatment (PACT) Services" for "(Reserved)"; and in (d)32, substituted "--NJ FamilyCare Children's Program" for "NJ KidCare Manual".

Annotations

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Regulations establishing covered and non-covered medical supplies and equipment are valid under Title XIX of the Social Security Act, *42 U.S.C.S. § 1396* et seq., as Title XIX confers broad discretion on the states to adopt standards and requires only that such standards be reasonable and consistent with the objectives of the act. Even within the five mandatory categories of services, a state may adopt reasonable standards to determine the extent of medical ervices that it will provide, and a state may impose limitations based upon the degree of medical necessity. *Dougherty v. Department of Human Services, Div. of Medical Assistance & Health Services, 179 N.J. Super. 541, 432 A.2d 943, 1981 N.J. Super. LEXIS 614 (1981)*.

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.

End of Document

N.J.A.C. 10:49-1.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 1. GENERAL PROVISIONS

§ 10:49-1.5 Compliance with the Patient Protection and Affordable Care Act, Health Care and Education Reconciliation Act of 2010, and Federal regulations

(a) Notwithstanding any other provision of *N.J.A.C. 10:49* through 10:79A, and except as provided in (c) and (d) below, the New Jersey Medicaid/NJ FamilyCare program (including, but not limited to, the program's administration, reimbursement, payment, provider screening, provider enrollment, provider termination, provider exclusion, program integrity, use of managed care, beneficiary enrollment, beneficiary services, appeal procedures, and fraud and abuse control), will be operated in accordance with all of the mandatory Federal requirements described in (a)1 through 6 below that were created under the Patient Protection and Affordable Care Act, 111 P.L. 148 (PPACA), as amended and supplemented, the Health Care and Education Reconciliation Act of 2010, 111 P.L. 152 (HCERA), as amended and supplemented, and the implementing Federal regulations adopted at *76 FR 5862 through 5971*, as amended and supplemented, in order to ensure compliance with the mandatory provisions of those Federal Acts and regulations.

1. The program will, as required by section 6501 of PPACA at *42 U.S.C. § 1396a(a)*, as amended and supplemented, or by Federal regulations adopted in the Federal Register on February 2, 2011, at *76 FR 5862 through 5971*, as amended and supplemented, deny enrollment or terminate the participation of any individual or entity in the New Jersey Medicaid/NJ FamilyCare program, if (subject to such exceptions as are permitted with respect to exclusion under sections 1128(c)(3)(B) and 1128(d)(3)(B) of the Social Security Act (*42 U.S.C. §§ 1320a-7(c)(3)(B)* and (d)(3)(B)) participation of such individual or entity is terminated under title XVIII, XIX, or XXI of the Social Security Act (*42 U.S.C. §§ 1395* et seq., *42 U.S.C. 1396* et seq., or *42 U.S.C. 1397aa* et seq.) or under the Medicaid program or Children's Health Insurance program of any other state, and no payment shall be made by the program with respect to any item or service furnished by such individual or entity during such period.

2. No payment for items or services provided under the Medicaid/NJ FamilyCare program shall be made to any financial institution or entity located outside of the United States, as required by section 6505 of PPACA, at *42 U.S.C. § 1396a(a)*80, as amended and supplemented.

3. A voluntary election to have payment made for hospice care for a child shall not constitute a waiver of any rights of the child to be provided with, or to have payment made under the Medicaid/NJ FamilyCare program for, services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made, as required by section 2302 of PPACA, at *42 U.S.C. §§ 1396d*(*o*)(1) and 1397jj(a)(23), as amended and supplemented.

4. Separate payments will be made to providers administering prenatal labor and delivery or postpartum care in a freestanding birth center, as required by section 2301 of PPACA, at *42 U.S.C. §§ 1396d* and *1396a(a)(10)(A)*, as amended and supplemented.

5. Medicaid coverage will be provided for counseling and pharmacotherapy to pregnant women for cessation of tobacco use, and cost-sharing for these services is prohibited, as required by section 4107 of PPACA, at *42 U.S.C. §§ 1396d*, *1396r-8*, and *1396o*, as amended and supplemented.

6. Payments for primary care services furnished in 2013 and 2014 will be made as required by section 1202(a) of HCERA, at *42 U.S.C. §§ 1396a* and *1396u-2(f)*, as amended and supplemented or by any Federal regulations implementing that section, as amended and supplemented.

(b) Notwithstanding any other provision of *N.J.A.C. 10:49* through 10:79A, and except as provided in (c) and (d) below, all beneficiaries, providers, suppliers, applicants to become beneficiaries, applicants to become providers, applicants to become suppliers, managed care entities, providers of services or goods to managed care entities, fiscal agents, and parties that submit claims on behalf of health care providers, as well as the owners, officers, directors, contractors, subcontractors, agents, and employees of all such entities, are subject to, and shall comply with, all of the Federal requirements regarding any such individuals or entities under PPACA, as amended and supplemented, HCERA, as amended and supplemented, and the Federal regulations at *76 FR 5862 through 5971*, as amended and supplemented, and the Federal regulations adopted at *76 FR 32816 through 32838*, as amended and supplemented, that are described in (b)1 through 7 below, which requirements regarding such individuals or entities are collectively incorporated herein by reference. Such requirements are in addition to, and not in derogation of, any other legal requirements that apply to any such individual or entity under any other State or Federal law, rule, or regulation. The definitions of terms applicable to this subsection are identical to those definitions used by PPACA, HCERA, and the Federal regulations cited in this subsection. The requirements are:

1. All program integrity, screening, oversight, reporting, disclosure, moratorium, compliance, enrollment, payment adjustment, suspension of payment, inclusion of information, and National Provider Identifier provisions described under section 6401 and 6402 of PPACA, as amended and supplemented, or under the Federal regulations adopted at *76 FR 5862 through 5971*, as amended and supplemented;

2. All face-to-face, medical review and certification requirements described under sections 3132 and 6407 of PPACA, as amended and supplemented, or under the Federal regulations adopted at *76 FR 5862 through 5971*, as amended and supplemented;

3. All requirements to register with the State or with the Federal government as described at section 6503 of PPACA, as amended and supplemented, or under the Federal regulations adopted at *76 FR 5862 through 5971*, as amended and supplemented;

4. All requirements to submit data elements as determined necessary by the Secretary for program integrity, program oversight, and administration, effective with respect to contract years beginning on or after January 1, 2010 as described at section 6504 of PPACA, at *42 U.S.C. §§ 1396b(r)(1)(F)* and *1396b(m)(2)(A)(xi)*, as amended and supplemented, or under the Federal regulations adopted at *76 FR 5862 through 5971*, as amended and supplemented;

5. The prohibition on payment for items or services provided under the Medicaid/NJ FamilyCare program to any financial institution or entity located outside of the United States, as described at section 6505 of PPACA, as amended and supplemented, or under the Federal regulations adopted at *76 FR 5862 through 5971*, as amended and supplemented;

6. All requirements regarding reporting and returning of overpayments, as described at section 6402 of PPACA, as amended and supplemented, or under the Federal regulations adopted at *76 FR 5862 through 5971*, as amended and supplemented, unless a more expedited timeframe for reporting and returning overpayments exists within this chapter; and

7. The prohibition on payments for any health care acquired conditions in accordance with section 2702 of PPACA, as amended and supplemented, or under the Federal regulations adopted at *76 FR 32816 through 32838*, as amended and supplemented.

(c) The provisions of (a) or (b) above shall not apply in specific instances in which:

1. The Federal government has granted a waiver from compliance with a Federal requirement and the Division chooses to exercise its authority under that waiver; or

2. The Division determines that exercise of such provision would cause program expenditures to exceed amounts appropriated by law for any portion of the program.

(d) The provisions of (a) and (b) above specifically do not address State compliance with any provision of any Federal law or regulation that would expand eligibility under any program to any new groups, categories, or individuals.

History

HISTORY:

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".

New Rule, R.2013 d.052, effective April 1, 2013.

See: *44 N.J.R. 2941(a)*, *45 N.J.R. 737(a)*.

Section was "Reserved".

Annotations

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Case Notes

Provider who had been suspended from the Medicaid program on a credible allegation of fraud for which an investigation was pending was not entitled to relief on its claim that the agency was not permitted to issue any temporary suspension of participation unless and until it had independently concluded that the evidence is sufficient for a determination of wrongdoing because what was required was a "credible allegation of fraud," and such a "credible allegation of fraud" existed in this case. *Salerno v. DMAHS, OAL DKT. NO. HMA 00043-15, 2015 N.J. AGEN LEXIS 656*, Initial Decision (September 28, 2015).

N.J.A.C. 10:49-1.6

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:49-1.6 (Reserved)

History

HISTORY:

Recodified to *N.J.A.C. 10:49-22.3* and amended by R.1997 d.354, effective September 2, 1997.

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 3856(a)*.

Annotations

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N.J.A.C. 10:49-1.7

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§ 10:49-1.7 (Reserved)

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 3856(a)*.

Section was "State funded programs".

Annotations

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End of Document

N.J.A.C. 10:49-1.8

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§ 10:49-1.8 (Reserved)

History

HISTORY:

Recodified to *N.J.A.C. 10:49-1.4* and amended by R.1997 d.354, effective September 2, 1997.

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 3856(a)*.

Annotations

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N.J.A.C. 10:49-2.1

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > 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.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 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 New Jersey Register 2650(a)*, *35 New Jersey Register 1118(a)*.

Annotations

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N.J.A.C. 10:49-2.2

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§ 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 CWA. 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 of 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.

History

HISTORY:

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 82, effective February 18, 2003.

See: *34 N.J.R. 2647(a)*, 2650(d), *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.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In (b)1, substituted "CWA" for "CBOSS"; and in (b)11, inserted "of" preceding "one" and substituted "§1396a" for "§ 1396a".

Annotations

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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.

N.J.A.C. 10:49-2.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 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 CWA 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/l78) (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.

2. The CWA 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.

History

HISTORY:

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)*.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In the introductory paragraph of (e) and in (f)2, substituted "CWA" for "CBOSS"; in (f)1, deleted "that appears on the Medicaid Eligibility Identification Card" from the end; and in (f)2, inserted a comma following the first occurrence of "claims".

Annotations

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N.J.A.C. 10:49-2.4

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§ 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.

History

HISTORY:

New Rule, R.1997 d.354, effective September 2, 1997.

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 3856(a)*.

Former section recodified to *N.J.A.C. 10:49-2.5*.

Annotations

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End of Document

N.J.A.C. 10:49-2.5

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§ 10:49-2.5 Persons eligible under the NJ FamilyCare program

(a) 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.

(b) Children under the age of 19 with family incomes above 133 percent and not in excess of 150 percent of the Federal poverty level may be eligible for NJ FamilyCare-Plan B services pursuant to the eligibility rules at *N.J.A.C. 10:78* and 10:79.

(c) Children under the age of 19 with family incomes above 150 percent and not in excess of 200 percent of the Federal poverty level may be eligible for NJ FamilyCare-Plan C services pursuant to the eligibility rules at *N.J.A.C. 10:78* and 10:79.

(d) Children under the age of 19 with gross family incomes above 200 percent and not in excess of 350 percent of the Federal poverty level may be eligible for NJ FamilyCare-Plan D services pursuant to the eligibility rules at *N.J.A.C. 10:78* and 10:79.

(e) Former Health Access adults with incomes up to and including 250 percent of the Federal poverty level may be eligible for NJ FamilyCare-Plan D services pursuant to the eligibility rules at *N.J.A.C. 10:78* and 10:79.

(f) 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, may be eligible to receive NJ FamilyCare Plan-D for Adults services.

(g) Specified parents/caretakers of children enrolled in NJ FamilyCare, in accordance with *N.J.A.C. 10:78-7.1* and this chapter, may be eligible to receive NJ FamilyCare-Plan I services on a fee-for-service basis.

History

HISTORY:

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.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Inserted designation (a); and added (b) through (g).

Annotations

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Chapter Notes

End of Document

N.J.A.C. 10:49-2.6

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§ 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*).

History

HISTORY:

Recodified from *N.J.A.C. 10:49-2.4* and amended by R.1997 d.354, effective September 2, 1997.

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 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 New Jersey Register 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 New Jersey Register 713(a)*, *30 New Jersey Register 3034(a)*.

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

Annotations

Notes

Chapter Notes

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N.J.A.C. 10:49-2.7

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

§ 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 shall 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 CWA 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 CWA 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 CWA 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*).

History

HISTORY:

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)*.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

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

In the introductory paragraph of (b)1, substituted "shall" for "may"; in (b)1i, (b)1i(2) and (b)3, substituted "CWA" for "CBOSS"; and in (b)3, inserted a comma following "eligibility" and substituted "three-month" for "three month".

Annotations

Notes

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N.J.A.C. 10:49-2.8

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 2. NEW JERSEY MEDICAID BENEFICIARIES

§ 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 CWA.

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.

2. A NJ FamilyCare one-page application can be used to apply for presumptive eligibility (PE) for Medicaid/NJ FamilyCare services. This is the only application that the pregnant woman will need to complete. The HealthStart PE provider shall send a copy of the completed one-page application to the CWA to determine full Medicaid/NJ FamilyCare eligibility using the NJ FamilyCare application instructions and documentation requirements.

(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 participating Medicaid provider.

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

1. If the woman has not provided verification documents to the CWA, on or before the last day of the month subsequent to the date of the presumptive eligibility determination; or

2. If the woman has provided verification documents to the CWA, 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 CWA.

(d) A presumptively eligible pregnant woman will be issued a plastic Medicaid/NJ FamilyCare Health Benefits Identification (HBID) Card. This card is the only document acceptable for the identification of a presumptively eligible pregnant woman. The HBID Card is for identification purposes only and is not a proof of current eligibility.

1. As part of the presumptive eligibility process, a presumptively eligible pregnant woman will be given an HBID Emergency Services Letter to use as identification when seeking emergency services prior to receiving the HBID card in the mail (see Appendix, *N.J.A.C. 10:49*). This HBID Emergency Services Letter contains pertinent information, which the provider will need in order to submit claims for services provided to the beneficiary. This is not valid proof of eligibility for Medicaid/NJ FamilyCare and should not be used by the provider for presumptive eligibility purposes. A request for reimbursement based solely upon the presentation of the HBID Emergency Services Letter does not guarantee payment.

2. Even with the identification through the HBID 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. Eligibility can be verified by calling the toll free telephone number listed on the HBID Card which is available seven days a week, 24 hours a day, inquiring online at www.njmmis.com or swiping the HBID card through the reader provided by an eligibility vendor.

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.

History

HISTORY:

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).

Amended by R.2008 d.230, effective August 4, 2008.

See: 40 N.J.R. 984(a), 40 N.J.R. 4531(a).

In the introductory paragraph of (a) and in (c)2, substituted "CWA" for "CBOSS"; added (a)2; in (b), substituted "participating" for "appropriate"; in the introductory paragraph of (c), inserted a comma following "time"; in (c)1 and (c)2, substituted "provided verification documents to the CWA" for "filed an application with the CBOSS"; and rewrote the introductory paragraph of (d) and (d)1 and (d)2.

Annotations

Notes

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End of Document

N.J.A.C. 10:49-2.9

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§ 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 welfare agency (CWA) 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 CWA shall have their retroactive eligibility evaluated and processed at that CWA when they apply for Medicaid or NJ FamilyCare-Plan A. If the applicant does not indicate to the CWA that unpaid medical bills exist at the time of application, the applicant shall provide that information to the CWA within six months of the date of application. If retroactive eligibility is not requested from the CWA 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 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 CWA, 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 Supplemental Security Income (SSI)/Medicaid 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 may be reimbursable in accordance with standard Medicaid 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 CWA (see *N.J.A.C. 10:49-2.3*, Persons eligible under the Medically Needy program).

History

HISTORY:

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.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In the introductory paragraph of (a), substituted "three-month" for "three month"; in (a)1, substituted "welfare agency (CWA)" for "board of social services (CBOSS)"; in (a)3, substituted the first occurrence of "CWA" for "CBOSS other than Essex, Hunterdon or Warren Counties," and substituted "CWA" for "CBOSS" four times; in (a)4, deleted "who applied for benefits at the CBOSS in Essex, Hunterdon or Warren counties or" following "Applicants" and substituted "CWA" for "CBOSS"; in the introductory paragraph of (b), substituted "Supplemental Security Income (SSI)/Medicaid for "Medicaid or NJ FamilyCare-Plan A", deleted "or NJ FamilyCare-Plan A" preceding "may be reimbursable" and "and NJ FamilyCare" preceding "reimbursement"; and in (b)3, substituted "CWA" for "CBOSS" and inserted a comma preceding "Persons".

Annotations

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Medicaid applicant who won eligibility as of September 1, 2016 was denied retroactive benefits because such benefits were only available where the applicant would have been financially eligible in the three months prior to the date of the application. Here, because the applicant's funds clearly exceeded the resource limits for the month preceding her Medicaid application, she did not meet the criteria for retroactive benefits. *A.S. v. DMAHS et al., OAL DKT. NO. HMA 13504-16, 2017 N.J. AGEN LEXIS 525*, Final Administrative Determination (February 3, 2017).

Nursing home resident's claim for "retroactive Medicaid benefits" was not filed within six months of the date of the application for Medicaid and thus was properly denied as untimely. *E.B. v. Essex Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 19196-15, 2016 N.J. AGEN LEXIS 559*, Initial Decision (June 30, 2016).

Third application for Medicaid eligibility filed by a representative of an elderly nursing home resident who was suffering from dementia was properly granted retroactive to a date that was three months prior to the date of filing in accord with governing law over claims that it should have been retroactive to the date on which the resident had been admitted to the nursing home because there was no causal relationship between the resident being admitted to the nursing home and his access to countable resources for establishing eligibility. *E.M. v. Passaic Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 13935-15, 2016 N.J. AGEN LEXIS 49*, Initial Decision (February 10, 2016).

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.

N.J.A.C. 10:49-2.10

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§ 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, will be issued a Health Benefits Identification (HBID) Card for identification purposes. Each beneficiary will be issued an HBID Emergency Services Letter to use as identification when seeking emergency services prior to receiving the HBID card in the mail. (See Appendix, *N.J.A.C. 10:49*). This letter contains pertinent information, which the provider will need in order to submit claims for emergency services provided to the beneficiary. This letter is not valid proof of eligibility for Medicaid/NJ FamilyCare and should not be used by the provider for such purposes, except that the letter serves as proof of eligibility only in the event that the client is newly eligible and there is no record of the client when using the eligibility verification system. A request for reimbursement based solely upon the presentation of the Health Benefits Identification Card Emergency Services Letter does not guarantee payment. The beneficiary shall present either the HBID Emergency Services Letter or the HBID Card to the provider, as a proof of identification, 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) shall be used to validate eligibility each time the beneficiary presents the HBID card and requests services (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.

History

HISTORY:

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.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Rewrote the introductory paragraph of (a).

Annotations

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N.J.A.C. 10:49-2.11

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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

(a) In the event a beneficiary is unable to produce an HBID card or an HBID Emergency Services Letter 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 or the Card Control Number (CCN) found on the HBID Card 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. Eligibility can also be confirmed by inquiring online at *www.njmmis.com*.

(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/CCN 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.

3. Providers with access to the internet may use another option, e-MEVS, to obtain beneficiary eligibility information. This system is accessible via a secured connection to the NJMMIS website, *www.njmmis.com*, and is available to providers free of charge using a password and ID assigned by the Medicaid/NJ FamilyCare fiscal agent. Eligibility can also be verified by swiping the HBID card through a reader provided by an eligibility vendor.

(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 CMS; 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*.

History

HISTORY:

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. 10:49-2.9* 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).

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In (a), substituted "an HBID card or an HBID Emergency Services Letter" for "a form that validates Medicaid or NJ FamilyCare eligibility", inserted "or the Card Control Number (CCN) found on the HBID Card" and inserted the last

sentence; in the introductory paragraph of (b)1, inserted "/CCN"; in (b)2, deleted the second sentence; added (b)3; in (c)2v, substituted "CMS" for "the HCFA"; and deleted (d).

Annotations

Notes

Chapter Notes

N.J.A.C. 10:49-2.12

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

§ 10:49-2.12 Medicaid or NJ FamilyCare Eligibility Identification Number and Health Benefits Identification (HBID) Card

(a) Each Medicaid or NJ FamilyCare beneficiary will be issued a permanent, plastic identification card, the Health Benefits Identification (HBID) Card. The front of the card will include the beneficiary's name and a 16-digit Card Control Number (CCN). The back of the card will include a magnetic strip, which electronically stores the beneficiary's name and CCN.

(b) A Medicaid or NJ FamilyCare Eligibility Identification Number consists of 12 digits, which includes a two digit Person Number. The Medicaid or NJ FamilyCare Eligibility Identification Number is automatically linked in the Medicaid/NJ FamilyCare computer system to the beneficiary's CCN number on the HBID Card. The provider will only need to know the CCN number to verify beneficiary eligibility. The beneficiary's Medicaid/NJ FamilyCare Eligibility Identification Number will be provided when eligibility is verified and this number must be entered on the claim when seeking reimbursement. The components of a Medicaid or NJ FamilyCare Eligibility Identification Number as it is initially assigned to a beneficiary are described in (c) through (g) below.

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

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	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.

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 Institutional Services Section (ISS) office responsible for inspection of care, periodic medical reviews in the facility and 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 10th digits 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 (Central ISS office)

32 Trenton Psychiatric Hospital (Southern ISS office)

*32 (300,000 series) Forensic Psychiatric Hospital (Southern ISS office)

*32 (600,000 series) Senator Garrett W. Hagedorn Center for Geriatrics-Psychiatric Section (Central ISS office)

34 Ancora Psychiatric Hospital (Southern ISS office) (excluding 800,000 series)

37 Bergen Regional Medical Center (Central ISS office)

38 Essex County Hospital Center--Cedar Grove (Central ISS office)

39 Camden County Psychiatric Hospital (Southern ISS office)

ii. Identification of Intermediate Care Facilities/Mental Retardation

41 Vineland Developmental Center (Southern ISS office)

42 North Jersey Developmental Center (Totowa) (Central ISS office)

43 Greenbrook Regional Center (Central ISS office)

44 Woodbine Developmental Center (Southern ISS office)

45 New Lisbon Developmental Center (Southern ISS office)

47 Woodbridge Developmental Center (Central ISS office)

48 Hunterdon Developmental Center (Central ISS office)

iii. 51 New Jersey Veteran's Home (Unit Dose Drugs) (ISS office, 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. (ISS office, which serves the county in which the beneficiary resides.)

(d) 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

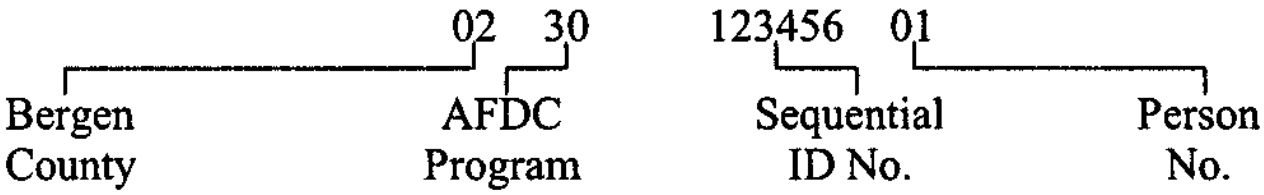
80 State Juvenile Residential Facilities

(e) 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.

(f) 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)

(g) 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:



History

HISTORY:

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)*.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Section was "Medicaid or NJ FamilyCare Eligibility Identification Number". Rewrote the section.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:49-2.13

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:49-2.13 Forms that validate Medicaid eligibility

(a) A New Jersey Medicaid provider may verify a person's Medicaid eligibility by using the identification information on either:

1. Health Benefits Identification (HBID) Card (see *N.J.A.C. 10:49-2.15*);
2. HBID Emergency Services Letter (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*).

History

HISTORY:

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.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In the introductory paragraph of (a), substituted "using the identification information on either" for "means of one of the following three forms"; deleted former (a)1; added new (a)1; and in (a)2, substituted "HBID Emergency Services Letter" for " 'Medicaid Eligibility Identification Card' (FD-73/178)".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:49-2.14

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:49-2.14 (Reserved)

History

HISTORY:

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 "HSP (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)*.

Repealed by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Section was "Validation form (FD-152) Department of Human Services Medicaid ID".

Annotations

Notes

§ 10:49-2.14 (Reserved)

Chapter Notes

End of Document

N.J.A.C. 10:49-2.15

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§ 10:49-2.15 Health Benefits Identification (HBID) Card and Emergency Services Letter

(a) The HBID Card (see Appendix, *N.J.A.C. 10:49*) is issued 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 CWA 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 HBID Card identifies only one beneficiary. Each family member will receive his or her own plastic HBID Card. The HBID Card is a permanent, plastic card with a magnetic strip on the back. The card is for identification purposes only; providers must verify eligibility before they provide services.

(c) The information on the HBID Card includes the beneficiary name and the beneficiary's unique, 16-digit card control number (CCN), which is linked to the beneficiary's Medicaid or NJ FamilyCare Identification Number as described at *N.J.A.C. 10:49-2.12(b)*.

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

(e) A message on the eligibility verification systems (REVS/MEVS/eMEVS) will indicate the cardholder's enrollment in any waivered or special programs, such as Home and Community-Based Services Waiver Programs (see N.J.A.C. 10:49-22); or in another managed care program (see N.J.A.C. 10:49-21).

1. The "Special Status program" either restricts the Medicaid beneficiary listed on the HBID 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 letter is issued, a message will be included in the eligibility information provided by the REVS/MEVS/eMEVS system 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 HBID Card issued for the Medically Needy program will have the following message included in the eligibility information provided by the REVS/MEVS/eMEVS system: "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 *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.

(f) In instances in which a beneficiary requires emergency medical services prior to receiving a permanent HBID Card in the mail, the eligibility office issuing the card (CWA, MACC office or State agency, including DYFS, DFD and DDD) will issue an HBID Emergency Services Letter. This letter shall contain pertinent information, which the provider will need to confirm eligibility and submit claims for services rendered to that client. The letter will also include an expiration date indicating when the letter will no longer be acceptable as a substitute for the HBID Card.

History

HISTORY:

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)*.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Section was "Validation form (FD-73/178) Medicaid Eligibility Identification Card (MEI Card)". In the introductory paragraph of (a), substituted "HBID Card" for "MEI Card, Validation Form FD-73/178" and deleted "monthly" following "issued"; in (a)2, substituted "CWA" for "CBOSS"; rewrote (b) and (c); in (d), substituted "HBID" for "MEI" and "his or her" for "his/her"; in the introductory paragraph of (e), substituted "on the eligibility verification systems (REVS/MEVS/eMEVS)" for "printed on the MEI card", inserted a comma following "programs" and updated the second N.J.A.C. reference, in (e)1, deleted "MEI Card for the Medicaid" preceding " 'Special Status program' ", substituted "beneficiary" for "beneficiary(ies)" preceding "listed", "HBID" for "MEI", "letter" for "card" and "included in the eligibility information provided by the REVS/MEVS/eMEVS system" for "printed on the card"; in (e)2, substituted "HBID" for "MEI" and "included in the eligibility information provided by the REVS/MEVS/eMEVS system" for "printed on the top of the card"; and added (f).

Annotations

Notes

Chapter Notes

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N.J.A.C. 10:49-2.16

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 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.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 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 New Jersey Register 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 New Jersey Register 713(a)*, *30 New Jersey Register 3034(a)*.

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

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

See: *34 New Jersey Register 2650(a)*, *35 New Jersey Register 1118(a)*.

Annotations

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N.J.A.C. 10:49-2.17

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 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 or NJ FamilyCare program, the provider shall encourage the person, or his or her representative, to apply for benefits:

1. To the CWA 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 Children and Families.

(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 or NJ FamilyCare 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.

(d) Medicaid applications are accepted by the State Health Benefits Coordinator.

(e) Applications for NJ FamilyCare can be downloaded free of charge and mailed to the Division or can be completed and submitted on the NJ FamilyCare website: *http://www.njfamilycare.org*.

History

HISTORY:

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)*.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In the introductory paragraph of (a) and in (c), inserted "or NJ FamilyCare"; in (a)1, substituted "CWA" for "CBOSS" and inserted a comma following the first occurrence of "programs"; in (a)3, substituted "Children and Families" for 'Human Services"; and added (d) and (e).

Annotations

Notes

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N.J.A.C. 10:49-2.18

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:49-2.18 (Reserved)

Annotations

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N.J.A.C. 10:49-2.19

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 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.

History

HISTORY:

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

See: *30 New Jersey Register 713(a)*.

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

See: *30 New Jersey Register 713(a)*, *30 New Jersey Register 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 New Jersey Register 2650(a)*, *35 New Jersey Register 1118(a)*.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:49-2.810:49-2.9

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 2. NEW JERSEY MEDICAID BENEFICIARIES

§ 10:49-2.810:49-2.9 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 welfare agency (CWA) 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 CWA shall have their retroactive eligibility evaluated and processed at that CWA when they apply for Medicaid or NJ FamilyCare-Plan A. If the applicant does not indicate to the CWA that unpaid medical bills exist at the time of application, the applicant shall provide that information to the CWA within six months of the date of application. If retroactive eligibility is not requested from the CWA 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 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 CWA, 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 Supplemental Security Income (SSI)/Medicaid 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 may be reimbursable in accordance with standard Medicaid 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 CWA (see *N.J.A.C. 10:49-2.3*, Persons eligible under the Medically Needy program).

History

HISTORY:

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.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In the introductory paragraph of (a), substituted "three-month" for "three month"; in (a)1, substituted "welfare agency (CWA)" for "board of social services (CBOSS)"; in (a)3, substituted the first occurrence of "CWA" for "CBOSS other than Essex, Hunterdon or Warren Counties," and substituted "CWA" for "CBOSS" four times; in (a)4, deleted "who applied for benefits at the CBOSS in Essex, Hunterdon or Warren counties or" following "Applicants" and substituted "CWA" for "CBOSS"; in the introductory paragraph of (b), substituted "Supplemental Security Income (SSI)/Medicaid for "Medicaid or NJ FamilyCare-Plan A", deleted "or NJ FamilyCare-Plan A" preceding "may be reimbursable" and "and NJ FamilyCare" preceding "reimbursement"; and in (b)3, substituted "CWA" for "CBOSS" and inserted a comma preceding "Persons".

Annotations

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While an ALJ properly found that a Medical applicant was not eligible for benefits in March 2017 because the applicant's guardian could have accessed his assets, which included $ 7000 in a bank account, it was not clear that the ALJ had also considered whether the applicant would have been eligible during any one of the three months prior to the date of the application. That being so, the matter was properly remanded with directions to undertake that analysis. *H.R. v. DMAHS, OAL DKT. NO. HMA 7011-2017, 2018 N.J. AGEN LEXIS 153*, Order of Remand (January 24, 2018).

Medicaid applicant who won eligibility as of September 1, 2016 was denied retroactive benefits because such benefits were only available where the applicant would have been financially eligible in the three months prior to the date of the application. Here, because the applicant's funds clearly exceeded the resource limits for the month preceding her Medicaid application, she did not meet the criteria for retroactive benefits. *A.S. v. DMAHS et al., OAL DKT. NO. HMA 13504-16, 2017 N.J. AGEN LEXIS 525*, Final Administrative Determination (February 3, 2017).

Nursing home resident's claim for "retroactive Medicaid benefits" was not filed within six months of the date of the application for Medicaid and thus was properly denied as untimely. *E.B. v. Essex Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 19196-15, 2016 N.J. AGEN LEXIS 559*, Initial Decision (June 30, 2016).

Third application for Medicaid eligibility filed by a representative of an elderly nursing home resident who was suffering from dementia was properly granted retroactive to a date that was three months prior to the date of filing in accord with governing law over claims that it should have been retroactive to the date on which the resident had been admitted to the nursing home because there was no causal relationship between the resident being admitted to the nursing home and his access to countable resources for establishing eligibility. *E.M. v. Passaic Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 13935-15, 2016 N.J. AGEN LEXIS 49*, Initial Decision (February 10, 2016).

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.

N.J.A.C. 10:49-3.1

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 3. PROVIDER PARTICIPATION

§ 10:49-3.1 Provider types eligible to participate

(a) Effective July 1, 2006, P.L. 2006, c. 45 and P.L. 2007, c. 111, as amended by P.L. 2007, c. 336, require the Division to institute a moratorium on new Medicaid/NJ FamilyCare providers of chiropractic services, medical supplies except those sold in a pharmacy, partial care 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 except those sold in a pharmacy, partial care 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 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. Advanced practice nurses;

2. Case managers;

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.

History

HISTORY:

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".

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Added new (b)1; recodified former (b)1 as new (b)2; and deleted former (b)2.

Amended by R.2008 d.277, effective September 15, 2008.

See: *40 N.J.R. 2186(a)*, *40 N.J.R. 5238(a)*.

In the introductory paragraph of (a), substituted "and P.L. 2007, c. 111, as amended by P.L. 2007, c. 336, require" for "requires"; in the introductory paragraph of (a) and in (a)1, inserted "except those sold in a pharmacy" and deleted ", pharmaceutical services" following "partial care services"; and in the introductory paragraph of (a)2, deleted "pharmacy services or" preceding "medical".

Annotations

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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).

Research References & Practice Aids

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*.

End of Document

N.J.A.C. 10:49-3.2

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§ 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).

3. If the application is denied, the applicant cannot resubmit a provider enrollment application for a period of one year from the date of the denial.

(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.

(i) All entities (as defined in (k) below) that receive or make annual Medicaid/NJ FamilyCare payments, under Title XIX of the Social Security Act, of at least $ 5,000,000 must, as a condition of receiving those payments, fully conform to the provisions of Section 6032 of the Deficit Reduction Act of 2005, *42 U.S.C. §1396a(a)(68)*, incorporated herein by reference. If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of *42 U.S.C. §1396a(a)(68)* and of this subsection and (j) and (k) below shall apply to the entity and to each of its components and locations if the aggregate payments to or from that entity meet the $ 5,000,000 annual threshold, regardless of whether the entity submits claims for payments using one or more provider identification or tax identification numbers. Such an entity shall:

1. Establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the Federal False Claims Act established under sections 3729 through 3733 of Title 31, United States Code (*31 U.S.C. §§3729* through *3733*), administrative remedies for false claims and statements established under chapter 38 of Title 31, United States Code (*31 U.S.C. §§3801* et seq.), any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs as defined in *42 U.S.C. §1320a-7b(f)*;

2. Include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste and abuse; and

3. Include in any employee handbook for the entity a specific discussion of the laws described in (i)1 above, the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste and abuse.

(j) The following provisions apply to entities regulated under (i) above:

1. The written policies established by the entity that are required under (i) above, including the entity's policies and procedures for detecting and preventing fraud, waste and abuse, may be on paper or in electronic form. There is no requirement that an employee handbook be created by the entity, if none already exists.

2. The entity's policies shall be disseminated and shall be readily available to all employees and managers of the entity and to the entity's contractors and agents. The entity also shall:

i. Require the entity's contractors and agents to comply with these policies; and

ii. Request that the entity's contractors and agents disseminate and make these policies readily available to the employees and managers of the contractors and agents.

3. The requirements of Section 6032 of the Deficit Reduction Act of 2005 are deemed to be incorporated into all current and future provider participation agreements by virtue of existing language in all such agreements that providers shall comply with all applicable Federal laws.

(k) In (i) and (j) above, the following definitions apply:

1. "Annual" or "annually," for purposes of determining whether an entity meets the $ 5,000,000 threshold, means during the previous full Federal fiscal year (FFY). As an example, an entity will have met the $ 5,000,000 threshold as of January 1, 2008, if it received or made Title XIX payments in that amount in FFY 2007, which runs from October 1, 2006 through September 30, 2007.

2. "Contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity.

3. "Employee" includes any officer or employee of the entity.

4. "Entity" includes, but shall not be limited to, a governmental agency or facility, or an organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under Title XIX or under any waiver of such plan, totaling at least $ 5,000,000 annually. A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an entity (for example, a state, county or municipal health care facility, or a school district providing school-based health services). A government agency which merely administers all or part of the Medicaid program (for example, managing the claims processing system or determining beneficiary eligibility), shall not be considered an entity.

History

HISTORY:

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."

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Added (d)3.

Amended by R.2009 d.92, effective March 16, 2009.

See: *40 N.J.R. 5930(a)*, *41 N.J.R. 1244(a)*.

Added (i) through (k).

Annotations

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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).

Research References & Practice Aids

CROSS REFERENCES

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

End of Document

N.J.A.C. 10:49-3.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 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.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 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 New Jersey Register 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 New Jersey Register 713(a)*, *30 New Jersey Register 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 New Jersey Register 2650(a)*, *35 New Jersey Register 1118(a)*.

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N.J.A.C. 10:49-3.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 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).

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 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 New Jersey Register 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 New Jersey Register 713(a)*, *30 New Jersey Register 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 New Jersey Register 2650(a)*, *35 New Jersey Register 1118(a)*.

Rewrote (c).

Amended by R.2004 d.334, effective September 7, 2004.

See: *36 New Jersey Register 312(a)*, *36 New Jersey Register 4136(a)*.

In (c), substituted "advanced practice nurse" for "certified nurse practitioner/clinical nurse specialist" in 1.

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N.J.A.C. 10:49-3.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:49-3.5 One-time provider enrollment

(a) Any potential provider that is licensed or certified by the State of New Jersey as one of the provider types listed at N.J.A.C. 10:49-3.1(a), or that is licensed or certified as such by a comparable state agency in the state in which the potential provider is located, and that is not enrolled as a New Jersey Medicaid or NJ FamilyCare provider, may submit an application to enroll as a New Jersey Medicaid or NJ FamilyCare one-time provider for the purpose of providing services to a specified beneficiary for a specified, limited period of time. The Department may approve such applications from providers if:

1. The applicant will provide, or has provided, covered services to a beneficiary; or

2. The applicant will provide a covered special or unique service to a beneficiary that is not accessible to the beneficiary from any other providers that are enrolled with the Division, as determined by the Division.

(b) One-time provider applicants shall complete and submit a one-time provider enrollment application (see Appendix, N.J.A.C. 10:49, Form 8, FD-20A) along with copies of the provider's current licenses and certifications, to:

Division of Medical Assistance and Health Services

Provider Enrollment Unit

PO Box 712

Mail Code #09

Trenton, New Jersey 08625-0712

(c) A one-time provider shall comply with all Federal and State laws, rules and regulations applicable to the provision of services to Medicaid and NJ FamilyCare beneficiaries including, but not limited to, N.J.A.C. 10:49 and all other rules applicable to the specific provider type. A one-time provider shall be reimbursed only for services provided in accordance with those laws, rules and regulations. Failure to comply with the requirements of those laws, rules or regulations shall result in denial of reimbursement.

(d) A one-time provider shall indemnify and reimburse the State of New Jersey and the New Jersey Medicaid and NJ FamilyCare programs for the Federal share of State expenditures, as described at 42 CFR 433.10, of any payment on any claim paid in accordance with this rule in the event that the Federal share of the payment on the claim is disallowed by the Federal government.

(e) Payment of a one-time provider claim by the New Jersey Medicaid or NJ FamilyCare program shall be considered payment in full for all services covered by the claim. A one-time provider shall not institute or cause the initiation of collection activities, including, but not limited to, billing, balance billing or litigation, against beneficiaries, their family members, their representatives, or others on their behalf for the payment of claims, except as permitted by N.J.S.A. 30:4D-6.c, or as otherwise specifically permitted or required by State or Federal statutes, rules and regulations.

(f) An applicant that is excluded from the New Jersey Medicaid or NJ FamilyCare program, from the Medicare program, from any other state Medicaid program, or from any State or Federal health care program, shall not be eligible for enrollment under this section.

History

HISTORY:

New Rule, R.2006 d.186, effective May 15, 2006.

See: *37 N.J.R. 4503(a)*, *38 N.J.R. 2158(b)*.

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N.J.A.C. 10:49-4.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 4. PROVIDERS' ROLE IN A SHARED HEALTH CARE FACILITY

§ 10:49-4.1 Definitions

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

"Discipline" means a branch of instruction or learning, such as medicine, dentistry, chiropractic, and so forth.

"Patient" means anyone eligible to receive benefits from the program.

"Purveyor" means any person, firm, corporation or other entity other than a provider who, whether or not located in a building which houses a shared health care facility, directly or indirectly, engages in the business of supplying to ultimate users or providers within the shared health care facility any medical supplies, equipment and/or services for which reimbursement under the program is received, including, but not limited to, clinical laboratory services or supplies; diagnostic radiology services; sick room supplies; physical therapy services or equipment; orthopedic or surgical appliances or supplies; drugs, medication or medical supplies; eyeglasses, lenses or other optical supplies or equipment; hearing aids or devices; and any other goods, services, supplies, equipment or procedures prescribed, ordered, recommended or suggested for medical diagnosis, care or treatment, and which amount to $ 10,000 per year.

"Shared health care facility" (SHCF) means four or more providers, two or more of whom are practicing within different specialties and/or disciplines, either independently or in association with each other, within a single structure; and

1. Two or more of whom share any of the following:

i. Common waiting areas;

ii. Examining rooms;

iii. Treatment rooms;

iv. Equipment;

v. Supporting staff;

vi. Common records; and

2. One or more of whom receives payment on a fee-for-service basis, and where the gross Medicaid income for the facility meets or exceeds $ 80,000 per year.

"Specialty" means a health care practice within a discipline such as pediatrics, obstetrics/gynecology, orthodontics, periodontics, and so forth.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 3856(a)*.

Amended "Discipline", "Patient", and "Purveyor"; and deleted 'Department', 'Division', and 'Provider'.

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N.J.A.C. 10:49-4.2

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§ 10:49-4.2 Scope

(a) This subchapter shall apply to shared health care facilities as defined herein and to providers located in a specific health care facility.

(b) This subchapter shall apply to purveyors, whether or not located in a building which houses a shared health care facility.

(c) Nothing in this subchapter shall apply to an association of health care providers delivering health services on other than a fee-for-service basis.

(d) This subchapter shall not apply to hospitals participating in the Medicaid program.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 3856(a)*.

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N.J.A.C. 10:49-4.3

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§ 10:49-4.3 Registration of shared health care facilities

(a) No shared health care facility shall be operated under the program unless it has been registered with the Division. The Office of Quality Management and Program Integrity, PO Box 712, Mail Code #7, Trenton, New Jersey 08625-0712 is responsible for registration.

1. Providers within the shared health care facility shall designate one provider member who shall be responsible for registration:

i. Said responsibility and liability by the designated provider, shall be limited to timely filing of accurate reports required under this section.

(b) Registration shall be made on forms furnished by the Division and shall contain the information required therein, including, but not limited to:

1. The name of the owner or owners of the facility;

2. The name, residence address and professional license number of every provider and purveyor working in the shared health care facility;

3. The name, residence address and curriculum vitae of the individual designated to assume responsibility for the central coordination and management of the shared health care facility's activities, if so designated;

4. The owner, lessor or lessee shall furnish to the Division a copy of the lease agreement upon request;

5. The name of any person, firm or corporation providing administrative, clerical or billing services to providers in shared health care facilities, other than employees of providers; and

6. The name and address of lessor of any space or equipment in the shared health care facility.

(c) The registrant shall re-register on the June 1 next following initial registration, and annually thereafter on June 1.

(d) The Division shall be notified, in writing, within 30 calendar days of any change in:

1. The owner or owners of the facility;

2. The termination of the services of the individual designated to assume responsibility for coordination and management of the shared health care facility's activities. The Division shall also be notified within 30 calendar days of the name, residence address and professional qualifications of any new individual appointed to assume such central administrative responsibility; and

3. Any addition or termination of any provider or purveyor in the shared health care facility. Such notification shall include the name, residence address and license number of each person appointed in place of such individual.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 3856(a)*.

In (a), amended office name and address; and in (d) and (d)2, inserted "calendar" preceding "days".

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N.J.A.C. 10:49-4.4

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§ 10:49-4.4 Prohibited practices; administrative requirements

(a) The Division shall not enter into any agreement of Medicaid or NJ FamilyCare participation, nor shall any payment be made to any provider in a shared health care facility where the rental fee for the letting of space or supportive professional or clerical services to a provider in a shared health care facility is calculated in whole or in part, directly or indirectly, as a percentage of earnings or billings of the provider for services rendered on the premises in which the shared health care facility is located.

(b) No purveyor or provider, whether or not located in a building which houses a shared health care facility, shall directly or indirectly offer, pay or give, or permit or cause to be offered, paid or given to any provider or purveyor, and no provider or purveyor shall directly or indirectly solicit, request, receive or accept from any purveyor or provider any sum of money, credit or other valuable consideration for:

1. Recommending or procuring goods, services or equipment of such purveyor or provider to any other person;

2. Directing patronage or clientele to such purveyor or provider; or

3. Influencing any person to refrain from using or utilizing goods, services or equipment of any purveyor or provider.

(c) Patient referral requirements follow:

1. No provider in a shared health care facility or person employed in such facility shall refer a patient to another provider located in such a facility, unless the records of the referring provider pertaining to such patient clearly sets forth the justification for such referral;

2. Every provider practicing in a shared health care facility who treats a patient referred to him or her by another provider practicing in the same facility shall communicate in writing to the referring provider, the diagnostic evaluation and the therapy rendered. The referring provider shall incorporate such information into the patient's permanent record; and

3. The claim submitted to the program by the provider to whom such patient has been referred shall contain the full name and individual Provider Servicing Number of the referring provider, and shall identify the medical problem that necessitated the referral.

(d) Any pharmacy maintaining a business in the same building in which a shared health care facility is located shall prominently post a notice informing patients that all pharmaceuticals prescribed in the program may be obtained at any pharmacy of the beneficiary's choice.

(e) No purveyor or provider other than a physician, dentist, podiatrist, optometrist or chiropractor, who maintains a business in the building in which a shared health care facility is located, shall maintain a door or window opening into the offices or waiting room of the shared health care facility.

(f) All provider claims submitted for services rendered at a shared health care facility shall contain the registration code (SHCF Number) of the facility at which the service was performed. The individual Provider Servicing Number of the practitioner rendering the service must also be entered on the claim form. The

practitioner who rendered the service or his or her authorized representative must sign and date the claim form.

(g) The requirements set forth in the Program Provider Services Manuals for each respective discipline shall apply to services rendered at a shared health care facility.

(h) It shall be unlawful for any provider to pay a bonus, commission or fee to any other provider based on business supplied or referred.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 3856(a)*.

In (d), substituted "beneficiary's" for "recipient's".

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

See: *30 New Jersey Register 1060(a)*.

In (a), inserted a reference to NJ KidCare; and in (c)3, (f) and (g), deleted references to Medicaid.

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

See: *30 New Jersey Register 1060(a)*, *30 New Jersey Register 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 New Jersey Register 2650(a)*, *35 New Jersey Register 1118(a)*.

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N.J.A.C. 10:49-4.5

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§ 10:49-4.5 Quality of care requirements

(a) To ensure quality, continuity and proper coordination of medical care, each shared health care facility shall:

1. Where feasible, designate an individual who, on a full-time basis, shall coordinate and manage the facility's activities;

2. Devise an appropriate means of insuring that patients shall be scheduled to return for appropriate follow-up care and shall be treated by a provider familiar with patient's medical history;

3. Post conspicuously the names and scheduled office hours of all providers practicing in the facility;

4. Maintain proper records. Such records shall contain at least the following information:

i. The full name, address and Program Number of the patient;

ii. The dates of all visits to all providers in the shared health care facility;

iii. The chief complaint for each visit to each provider in the shared health care facility;

iv. Pertinent history and all physical examinations rendered by each provider in the shared health care facility;

v. Diagnostic impressions for each visit to any provider in the shared health care facility;

vi. All medications prescribed at each visit by any provider in the shared health care facility who is qualified to issue prescriptions;

vii. The precise dosage and prescription regimens for each medication prescribed by a provider in the shared health care facility;

viii. All x-ray, laboratory work and electrocardiograms ordered at each visit by any provider in the shared health care facility;

ix. The results of all x-ray, laboratory work and electrocardiograms ordered as in (a)4viii above;

x. All referrals by providers in the shared health care facility to other medical providers and the reason for such referrals, and date of referral; and

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.

History

HISTORY:

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

See: *30 New Jersey Register 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 New Jersey Register 1060(a)*, *30 New Jersey Register 3519(a)*.

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

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N.J.A.C. 10:49-5.1

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§ 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).

History

HISTORY:

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)*.

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Determination by a health insurer reducing the Personal Care Assistant (PCA) hours provided to a Medicaid recipient from 40 hours weekly to 25 hours weekly was unsupported by the record, and an administrative law judge recommended that the original 40 hour eligibility be restored. The recipient had suffered a stroke and had both rheumatoid arthritis and congestive heart failure. A nurse who was an expert witness for the recipient testified that the recipient could not walk without assistance nor transfer to bed; suffered from tremors and shaking; needed constant assistance with ambulation and movement; did not cook or serve her own meals; and needed assistance dressing and assistance with toileting functions. She also needed assistance with bathing and use of a bath tub. Though the insurer presented evidence that its evaluation had resulted in an assessment that the recipient needed only 16 hours of PCA a week and that that amount had been increased to 25 hours by medical director discretion, the insurer's witness had no personal knowledge of the basis for the scoring that occurred, had not assessed the recipient and was not personally familiar with her needs. Neither could the witness provide critical testimony regarding the basis for use of the Medical Director's discretion in granting additional scoring points beyond the sixteen-hours assessed on the scoring card. Therefore, there was no evidence to evaluate why the insurer had scored the recipient at 25 hours versus 40 hours. Finally, the assessment model used by the insurer was fundamentally flawed in that it was capped at a score of 25, with the remaining scoring to be determined on the discretion of the Medical Director. However, no testimony was offered as to what the Medical Director's guidelines were or how intimately involved in the initial assessment the Medical Director became. In fact, the insurer's witness was clear that the involvement of the Medical Director to even exercise any discretion in this instance was discretionary. Fundamental fairness in the insurer's obligation to meet the requirements for the Medicaid program demand that the insurer create a more equitable scoring assessment that neither unfairly holds down, nor inflates a recipient's ability to fairly reflect the number of PCA hours required given their limitations in life activities. *C.S. v. United Healthcare, OAL DKT. NO. HMA 16677-14, 2015 N.J. AGEN LEXIS 320*, Initial Decision (June 4, 2015).

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.

N.J.A.C. 10:49-5.2

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§ 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 provided under the managed care program:

1. Advanced practice nurse services;

2. Chiropractic services;

3. Clinic services in an independent outpatient health care facility, other than hospital, that provides Family Planning, Dental, Optometric, Ambulatory Surgery services, or FQHCs;

4. Dental services;

5. 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;

6. 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.

7. Hearing aid services;

8. Home care services (home health care except for the Aged, Blind and Disabled population (ABD));

9. 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);

10. Hospital services--inpatient:

i. General acute care hospitals;

ii. Special hospitals; and

iii. Rehabilitation hospitals;

11. Hospital services--outpatient;

12. Laboratory (clinical);

13. Medical supplies and durable medical equipment;

14. Mental health and substance abuse services for clients of the Division of Developmental Disabilities (DDD), excluding partial care and partial hospitalization services;

15. Nurse-midwifery services;

16. Optometric services;

17. Optical appliances;

18. Prescription drugs (except for ABD and all other dual eligible beneficiaries);

19. Physician services;

20. Podiatric services;

21. Prosthetic and orthotic devices;

22. Radiological services;

23. Non-lower mode transportation services, which include ambulance, mobility assistance vehicle, and mobile intensive care units;

24. Audiology services;

25. Organ transplants, recipient and donor costs;

26. Emergency medical care; and

27. Treatment for conditions categorized as altering the mental status of an individual and that are organic in nature.

(b) The following services are available on a fee-for-service basis:

1. Case management services (Mental Health Program);

2. Religious non-medical health care services, (see Hospital Services Manual);

3. Environmental lead inspection services-rehabilitative services;

4. Medical day care services;

5. Mental health services, including partial care and partial hospitalization services;

6. 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);

7. 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;

8. 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. School based rehabilitation services under EPSDT;

9. Personal care assistance services;

10. Elective, induced abortions and related services;

11. Lower mode transportation services;

12. Sex abuse examinations;

13. Family planning services and supplies when furnished by a non-HMO, that is a Medicaid/NJ FamilyCare participating provider;

14. Home health care services for the ABD population;

15. Prescription drugs (legend and non-legend) covered by the Medicaid program) for the ABD population and all other dual eligible individuals;

16. Mental health services for enrollees who are not clients of the Division of Developmental Disabilities (DDD), including atypical antipsychotic medications;

17. Substance abuse services, including diagnosis, treatment, detoxification;

18. Methadone, Suboxonee and Subutex maintenance and administration for the treatment of substance abuse;

19. Inpatient psychiatric services, except for residential treatment centers, for beneficiaries under age 21 or age 65 and older if such services are:

i. Provided under the direction of a physician;

ii. In a facility or program that is accredited by the Joint Commission on Accreditation of Health Care Organizations; and

iii. Meets all Federal and State requirements.

20. Inpatient psychiatric programs for children 21 years of age and under; and

21. All services offered under approved waiver and demonstration programs.

(c) All Medicaid and NJ FamilyCare Plan A beneficiaries shall be eligible to receive all of the services specified in (a) above on a fee-for-service basis 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.

History

HISTORY:

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.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Rewrote (a); added new (b); recodified former (b) as (c); and in (c), inserted "on a" and "basis".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:49-5.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 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: 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 visits (medical or clinic), drugs, laboratory services, radiological and diagnostic services and surgical procedures are not available to the Medically Needy group.

History

HISTORY:

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.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In the introductory paragraph of (a), inserted a comma following "services", deleted "(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," following "groups:" and deleted a closing parenthesis from the end; and in (a)10, inserted "visits".

Annotations

Notes

Chapter Notes

Case Notes

Final agency decision properly affirmed the imposition of a transfer penalty upon a claimant's application for Medicaid benefits to pay for the cost of her nursing home care because a life care contract between herself and her daughter made as a lump sum advance payment to the daughter was not a transfer for fair market value. *E.S. v. Division of Med. Assistance & Health Servs., 412 N.J. Super. 340, 990 A.2d 701, 2010 N.J. Super. LEXIS 47 (2010)*.

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).

N.J.A.C. 10:49-5.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 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.

History

HISTORY:

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.

Annotations

Notes

Chapter Notes

Case Notes

Applicant's request for emergency medical services was not properly evaluated under the criteria for NJ Care because the applicant was neither blind, aged nor disabled. Rather, on these facts, the request should have been evaluated under the standards used for NJ FamilyCare. Since the application was not evaluated under the correct criteria, the order denying relief was properly reversed and the agency was to reassess the application under the correct criteria. *M.O. v. Somerset Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 12440-16, 2017 N.J. AGEN LEXIS 29*, Initial Decision (January 17, 2017).

N.J.A.C. 10:49-5.5

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§ 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 Medical Assistance Customer Center (MACC) for consideration;

4. Private duty nursing services (except for beneficiaries under EPSDT, CRPD waiver and ACCAP 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 who is restricted to receiving the service from another provider only. (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.

History

HISTORY:

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.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In (a)3i, substituted "Medical Assistance Customer Center (MACC)" for "Medicaid District Office"; in (a)4, substituted "CRPD waiver and" for "Model Waiver III," and deleted "and ABC" following "ACCAP"; and in (a)14, substituted "who is restricted to receiving the service from another provider only" for "whose Medicaid or NJ FamilyCare Eligibility Identification Card has a printed message restricting the beneficiary to another provider of the same service(s)".

Annotations

Notes

Chapter Notes

Case Notes

Transportation services provider's procedural due process claims under *U.S. Const. amend. XIV* and *N.J. Const. art. I, para. 1*, failed as a matter of law, as did its *U.S. Const. amend. XIV* substantive due process and takings claims, because the provider did not have any constitutionally protected property interest in its continued participation, as a certified Medicaid transportation provider, in the State of New Jersey's Medicaid program: (1) the provider sought to prevent the New Jersey Division of Medical Assistance and Health Services (DMAHS) from implementing a non-emergency medical transportation (NEMT) brokerage program, as authorized by *42 U.S.C.S. § 1396a(a)(70)(B)(i)*-(iii), claiming that the implementation of that program would violate its constitutional right to notice and a hearing before being shut out as a provider of NEMT services to New Jersey Medicaid recipients; (2) to prevail on its constitutional claims, the provider had to show that it had a property interest in its continued participation as a NEMT provider; (3) the provider's contract with the DMAHS did not create any property rights because it specifically provided that either party could terminate the contract without cause upon providing 60 days written notice; (3) *N.J.A.C. 10:49-9.14(b)* did not create any property interest because it used the discretionary term "may" rather than "shall" in stating that hearings may be granted to Medicaid providers because of the denial of a prior authorization request, for issues arising out of the claims payment process, or issues involving the provider's status, including termination, debarment, or suspension; and (4) *N.J.S.A. 30:4D-7(f)* did not create any property interest with regard to continued participation in the state Medicaid program because it required that providers be provided a hearing only with regard to complaints arising out of the claim payment process, not with regard to the termination or suspension of their contracts. *River Nile Invalid Coach & Ambulance, Inc. v. Velez, 601 F. Supp. 2d 609, 2009 U.S. Dist. LEXIS 17934 (2009)*.

Neither *N.J.A.C. 10:49-9.14(b)* nor *N.J.S.A. 30:4D-7(f)* confers on Medicaid transportation providers any constitutionally protected property interest in their continued participation in the state's Medicaid program, for purposes of *U.S. Const. amend. XIV* and *N.J. Const. art. I, para. 1*: (1) *N.J.A.C. 10:49-9.14(b)* states that a provider discretionarily "may" (rather than shall) be granted a hearing because of the denial of a prior authorization request, for issues arising out of the claims payment process, or issues involving the provider's status, including termination, debarment, or suspension; and (2) *N.J.S.A. 30:4D-7(f)* only requires that providers be provided a hearing with regard to complaints arising out of the claim payment process, not with regard to the termination or suspension of their contracts with the *State of New Jersey. River Nile Invalid Coach & Ambulance, Inc. v. Velez, 601 F. Supp. 2d 609, 2009 U.S. Dist. LEXIS 17934 (2009)*.

Given the medical conditions of a six year old boy who had spastic quadriplegic cerebral palsy and a seizure disorder, a safety bed was medically necessary, but there was insufficient evidence to support the request for an electric safety bed, and the insurer had agreed to provide a manual safety bed. *D.N. v. United Healthcare, OAL DKT. NO. HMA 08903-16, 2016 N.J. AGEN LEXIS 1007*, Initial Decision (November 28, 2016).

Request by a Medicaid recipient for approval to acquire a power wheelchair was properly denied because she failed to establish that the requested wheelchair was medically necessary to treat, evaluate or diagnose her medical condition as required by governing regulations. Inasmuch as the recipient was a nursing home resident, it was reasonable to believe that her transport needs were being met by nursing home personnel, who were already being compensated through Medicaid payments to the facility. *M.S. v. Div. of Medical Assistance & Health Services, OAL DKT. NO. HMA 04830-13, 2014 N.J. AGEN LEXIS 1153*, Final Administrative Determination (April 11, 2014).

DMAHS concluded, contrary to an ALJ's determination, that a Medicaid recipient who resided in a nursing home was not entitled to a power wheelchair. The wheelchair was not medically necessary to treat, evaluate or diagnose the recipient's medical condition nor was the item cost-effective within the meaning of governing regulations. Though the recipient claimed that she needed a power wheelchair in order to alleviate shoulder pain that she experienced when using a manual wheelchair, the fact that she was residing in a nursing home where she had access to care 24 hours a day meant that it was the nursing home's responsibility to provide qualified attendants to transport the recipient. *M.S. v. DMAHS, OAL DKT. NO. HMA 04830-13, 2014 N.J. AGEN LEXIS 1019*, Final Administrative Determination (April 11, 2014).

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).

Research References & Practice Aids

CROSS REFERENCES:

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

N.J.A.C. 10:49-5.6

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 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 medical examinations, dental, vision and hearing services, and lead screening 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. Hearing aid services;

13. Home health care services;

i. Exception: personal care assistant services;

14. Hospice services;

15. Hospital services--inpatient:

i. General hospitals;

ii. Special hospitals; and

iii. Rehabilitation hospitals;

16. Hospital services--outpatient;

17. Laboratory (clinical);

18. Medical supplies and equipment;

19. Nurse-midwifery services;

20. Optometric services;

21. Optical appliances;

22. Organ transplant services, donor and recipient costs;

23. Prescription drug services;

24. Physician services;

25. Podiatric services;

26. Prosthetic and orthotic devices;

27. Private duty nursing;

28. Radiological services; and

29. 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, for:

i. Psychiatric hospitals;

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

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

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

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

10. Sex abuse examinations;

11. Substance abuse services provided by practitioners, including physicians, psychologists, advanced practice nurses; and

12. 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.

History

HISTORY:

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).

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In (a)8, inserted "medical" and ", and lead screening services"; deleted former (a)12; recodified former (a)13 through 29 as (a)12 through 28; rewrote (a)22, in (a)28 and (b)6ii, inserted "and" at the end; deleted former (a)30; recodified former (a)31 as (a)29; in the introductory paragraph of (b)6, substituted ", for:" for a semicolon at the end; deleted (b)6iv and (b)6iv(1); deleted former (b)8; recodified former (b)9 as new (b)8; added new (b)9 and (b)10; and recodified former (b)10 and (b)11 as (b)11 and (b)12.

Annotations

Notes

Chapter Notes

N.J.A.C. 10:49-5.7

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§ 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. Dental services for individuals under the age of 19 years that are necessary to prevent disease, promote oral health, and restore oral structures to health and function, including the treatment of emergency conditions;

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 NJ 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;

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. Private duty nursing care, only when authorized by the HMO;

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 those available under (a)3 above;

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. Transportation, including non-emergency 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;

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

xxxviii. Skilled nursing facility services.

(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).

History

HISTORY:

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).

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In (a)3, inserted "and sealants"; in the introductory paragraph of (a)5, inserted a comma following "services"; in (a)5i, substituted "NJ" for "New Jersey"; in (a)7, inserted a comma following "beneficiary" and "services", and deleted "and short-term physical, speech or occupation therapy with the same limitations described in (a)22 below" from the end; rewrote (a)20; in (c)2xiv, substituted "Transportation" for "Routine transportation" and "non-emergency" for "non emergency"; in (c)2xxxvi, deleted "and" from the end; in (c)2xxxvii, substituted "; and" for a period at the end; and added (c)2xxxviii.

Amended by R.2014 d.011, effective January 6, 2014.

See: *45 N.J.R. 715(a)*, *46 N.J.R. 77(a)*.

Rewrote (a)3; and in (c)2vii, substituted "those available under (a)3 above" for "preventive dentistry for children under age 12".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:49-5.8

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

(a) Effective for dates of service on or after July 1, 2007, all beneficiaries previously covered under Plan H are covered under NJ FamilyCare Plan D. The information in (b) through (g) below applies only to claims for former NJ FamilyCare Plan H beneficiaries with dates of service prior to July 1, 2007.

(b) 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.

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

(d) 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.

(e) 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.

(f) 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.

(g) 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)*).

(h) 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).

History

HISTORY:

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).

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Added new (a); and recodified former (a) through (g) as (b) through (h).

Annotations

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N.J.A.C. 10:49-5.9

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 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).

History

HISTORY:

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

See: *34 New Jersey Register 2338(a)*.

Amended by R.2005 d.68, effective February 22, 2005.

See: *36 New Jersey Register 379(a)*, *37 New Jersey Register 659(a)*.

Rewrote the section.

Amended by R.2005 d.98, effective April 4, 2005.

See: *36 New Jersey Register 1158(a)*, *37 New Jersey Register 1022(a)*.

Rewrote (b).

Annotations

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N.J.A.C. 10:49-5.10

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§ 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. Advanced practice nurse 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. Private duty nursing only when authorized by DMAHS;

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. Inpatient rehabilitation 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. Maternity and related newborn care;

25. Diabetic supplies and equipment;

26. 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

27. 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).

History

HISTORY:

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.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Rewrote (a)1 and (a)19; added new (a)22, and recodified former (a)22 through (a)26 as (a)23 through (a)27.

Annotations

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N.J.A.C. 10:49-6.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > 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 Medical Assistance Customer Center (MACC) 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 Medical Assistance Customer Center (MACC) to obtain prior authorization. It is advantageous to the Medicaid program, the hospital and the patient to discharge 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?"

History

HISTORY:

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)*.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In (b)3, inserted a comma following "circumstances"; and in (b)3 and twice in (b)4, substituted "Medical Assistance Customer Center (MACC)" for "Medicaid District Office".

Annotations

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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.

N.J.A.C. 10:49-6.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 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.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 3856(a)*.

Deleted (a) and (c); and recodified former (b) as (a).

Annotations

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N.J.A.C. 10:49-7.1

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > 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/NJ FamilyCare program that the provider shall adhere to when submitting a claim and requesting payment for services provided to a New Jersey Medicaid/NJ FamilyCare beneficiary. (To identify a Medicaid/NJ FamilyCare beneficiary, 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.

3. The rules of this subchapter shall also apply when submitting a claim for services provided to Medicaid/NJ FamilyCare beneficiaries who are enrolled in managed care programs but who are provided certain services through the regular Medicaid program. See N.J.A.C. 10:49-5 for a list of services that are eligible to be reimbursed on a fee-for-service basis when provided to Medicaid/NJ FamilyCare beneficiaries enrolled in managed care programs.

(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.

History

HISTORY:

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.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In the introductory paragraph of (a), inserted "/NJ FamilyCare" three times and substituted "beneficiary" for "recipient" twice; and added (a)3.

Annotations

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Where a health care transportation provider and the DMAHS agreed in writing that certain denied claims could be resubmitted once errors affecting their proper processing had been corrected by the provider, which resubmission had to occur within 30 days of the date of the agreement, the determination by an ALJ that the provider in fact could resubmit those claims more than a year after that deadline passed was contrary to law and was properly reversed. *MONOC v. DMAHS, OAL DKT. NO. HMA 12658-2014, 2020 N.J. AGEN LEXIS 49*, Order of Remand (January 28, 2020).

N.J.A.C. 10:49-7.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 7. SUBMITTING CLAIMS FOR PAYMENT (POLICIES AND REGULATIONS)

§ 10:49-7.2 Timeliness and method of Medicaid claim or other 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. A Medicaid claim or any other provider claim submitted for payment from or through the Division of Medical Assistance and Health Services shall be submitted by means of an approved method of automated data exchange unless an attachment to the claim is required, in which case the claim for payment instead shall be submitted using an approved hard copy claim form.

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 will be considered as received on the date of receipt of the application at the appropriate eligibility determination agency 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.

History

HISTORY:

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).

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In the introductory paragraph of (a)2, inserted a comma following "reimbursement"; in (a)2ii, deleted ", that was submitted to the Medicaid Assistance and Health Services' Retroactive Eligibility Unit" following the first occurrence of "application" and inserted "at the appropriate eligibility determination agency"; and in (d)1iv and (e)1iv, substituted "Early" for "early".

Amended by R.2011 d.290, effective December 5, 2011 (operative January 1, 2012).

See: *43 N.J.R. 1129(a)*, *43 N.J.R. 3182(b)*.

Section was "Timeliness of Medicaid claim submission". Rewrote (a)1.

Annotations

Notes

Chapter Notes

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)*.

Where a health care transportation provider and the DMAHS agreed in writing that certain denied claims could be resubmitted once errors affecting their proper processing had been corrected by the provider, which resubmission had to occur within 30 days of the date of the agreement, the determination by an ALJ that the provider in fact could resubmit those claims more than a year after that deadline passed was contrary to law and was properly reversed. *MONOC v. DMAHS, OAL DKT. NO. HMA 12658-2014, 2020 N.J. AGEN LEXIS 49*, Order of Remand (January 28, 2020).

Where (1) a convalescent center provided services to a patient during January and February 1999, claims for which were initially denied while the local board of social services conducted its semi-annual review of the patient's eligibility for Medicaid benefits, (2) the patient was determined in April 1999 to be eligible for continued Medicaid benefits, and (3) the convalescent center mistakenly believed it would be automatically paid without the need to resubmit the claims, the center's resubmission of its claims for reimbursement for the January and February 1999

services in May 2001 was properly denied as being filed out of time. *Medicenter Neptune v. N.J. Dep't of Health & Senior Services, OAL Dkt. No. HLT 4363-01, 2005 N.J. AGEN LEXIS 567*, Initial Decision (October 3, 2005).

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.

§ 10:49-7.2 Timeliness and method of Medicaid claim or other claim submission

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.

N.J.A.C. 10:49-7.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 7. SUBMITTING CLAIMS FOR PAYMENT (POLICIES AND REGULATIONS)

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

(a) Third-party liability (TPL) exists when any person, institution, corporation, insurance company, health insurer, self-insured plan, group health plan as defined in section 607(1) of the Federal Employee Retirement and Income Security Act of 1974, *29 U.S.C. § 1167(1)*, service benefit plan, managed care organization or other prepaid health plan, pharmacy benefits manager, third-party administrator as defined in *N.J.S.A. 17B:27B-1*, absent parent, Medicare program, or any other public, private, or governmental entity or party is or may be liable in contract, agreement, 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. If, at the time the provider's claim is filed, either the existence of third-party liability cannot be established or third-party benefits are not available to pay the beneficiary's medical expenses at the time the provider's claim is filed, then the Division will pay the full amount allowed under its payment schedule and seek post-payment recovery in accordance with *42 CFR 433.139(c)*, (d)(2), and (d)(3).

(c) The New Jersey Medicaid/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, except as provided below:

1. Medicare: The program will make payment in the full amount of the deductible and co-insurance 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. No program payments shall be made when the third-party payer requires a contracting or participating provider to accept that third-party payer's payment as payment in full.

3. When Medicaid/NJ FamilyCare is not the primary payer on a claim, payment by Medicaid/NJ FamilyCare will be made at the lesser of:

i. The Medicaid/NJ FamilyCare allowed amount minus any other payment(s); or

ii. The patient liability, including denied charges, deductible, co-insurance, copayment, and non-covered charges.

4. The State will perform reviews of claims regarding beneficiaries for whom any third-party liability exists. Based on the reviews, the Division will determine whether paying the patient's liability for the service will result in a lower cost to the Division. If paying the patient's liability results in a lower cost to

the Division, the provider will be notified and the excess provider payments will be recouped by the Division.

(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 copayment.

(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.

1. Medicare is a health insurance program which covers certain aged and disabled persons. When rendering Medicare-covered services to any Medicaid or NJ FamilyCare beneficiary, providers shall inquire about Medicare eligibility especially if the third digit of the Eligibility Identification Number is a 1, 2, 5, or 7. Medicaid or FamilyCare supplementation of available Medicare benefits shall be as follows:

i. Medicare (Title XVIII): For any Medicaid or NJ FamilyCare beneficiary who is covered under Medicare, responsibility for payment by the New Jersey Medicaid Agent or the NJ FamilyCare program for non-hospital Part B services shall be limited to the unsatisfied deductible and/or coinsurance to the extent that the combined total of payments does not exceed the maximum allowable under the Medicaid or NJ FamilyCare program in the absence of other coverage for services rendered on or after July 20, 1998.

(f) When a Medicaid or NJ FamilyCare beneficiary has benefits available, such as those described above or from any other liable third party, an approved Medicaid or NJ FamilyCare provider shall be authorized to sign an insurance claim for the Commissioner, based on the third party assignment of rights, in order to receive direct payment from the insurer. This is done pursuant to *N.J.S.A. 30:4D-7.1(c)*. The following language shall be used by the provider when completing insurance claims: "(signature of authorized provider), Assignee for the Commissioner, New Jersey Department of Human Services."

(g) When recovery of benefits is sought by the Medicaid or NJ FamilyCare program from a liable third-party, the Commissioner shall authorize the Director or his designee(s) to sign the recovery demand.

(h) Payment will be made by the Division in accordance with the requirements of *42 CFR 433.139(b)(3)(i)* and (ii) in either of the following circumstances:

1. The TPL benefits are derived from a parent whose obligation to pay support is being enforced by the State Title IV-D agency; or

2. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (include Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services) that are covered by the program.

(i) TPL may be exhausted, but is not required to be, before a claim is submitted for Medicaid or NJ FamilyCare payment in any of the following circumstances:

1. The claim is for labor, delivery, and post-partum care; however, costs associated with the inpatient hospital stay for labor, delivery, and post-partum care must be cost-avoided in accordance with *42 CFR 433.139(b)(2)*;

2. The claim involves a service for which CMS has granted a waiver of the TPL cost avoidance requirements in accordance with *42 CFR 433.139(e)*. Waivers have been granted for services covered by Medicare Part B which are rendered at State and county governmental psychiatric hospitals, State and private ICFs/MR, and Vineland Special Hospital; or

3. Rehabilitation services provided by a local school district under a child's Individualized Education Program (IEP).

(j) In those situations in which a Medicare or health insurance payment is received after Medicaid or NJ FamilyCare has been billed and has made payment, the provider shall reimburse the Medicaid or NJ FamilyCare payment to the Division and not to the Medicaid or NJ FamilyCare beneficiary. Reimbursement shall be made immediately to comply with Federal regulations. In the event a provider is apprised or otherwise is on notice that a duplicate or excessive payment has been made by the Division as a result of the provider's receipt of a Medicare or health insurance payment, the provider shall have 60 days to refund such overpayments to the Division. To initiate the process, providers shall submit an MMIS Claim Adjustment Request Form. (See Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

1. In situations involving tort matters where liability has not been established at the time of billing, providers may elect to bill the Medicaid program. However, if they choose to do so, they are precluded from returning Medicaid payments for their services, and may not seek reimbursement from any proceeds resulting from the tort matter. Conversely, providers may elect not to bill the Medicaid program, and await the outcome of the tort matter. However, should the tort matter not result in an award to the beneficiary, and the deadline for timely filing of a Medicaid claim by the provider passes, the provider shall not bill either the Medicaid program or the beneficiary.

2. This subsection in no way precludes the Division from seeking reimbursement for Medicaid payments made on behalf of the beneficiary or from any third party liability source, including a tort liability recovery, which may be awarded the beneficiary.

(k) Regardless of the status of a provider's claim with other third parties, all claims for Medicaid or NJ FamilyCare reimbursement must be received by the Fiscal Agent within the time frames specified in *N.J.A.C. 10:49-7.2*, Timeliness of claim submission.

(l) Any individual who undertakes to legally represent any Medicaid or NJ FamilyCare beneficiary in an action for damages against any third party when medical expenses have been paid by the Division shall be required to give written notice to the Division within 20 days of filing or commencing the action.

1. The term "legal representative" shall include, but not be limited to, an attorney, administrator/administratrix, executor/executrix, conservator, guardian or guardian ad litem.

History

HISTORY:

Petition for Rulemaking.

See: 27 N.J.R. 770(b), 27 N.J.R. 1320(a).

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 (a), substituted "by the Medicaid program" for "under this act"; in (b), inserted "the exceptions listed in"; in (e)1, substituted "Medicaid Eligibility Identification Number" for "HSP (Medicaid) Case Number"; deleted (e)1i and (e)1i(1); added (h)5; and in (i), substituted "a health insurance payment is received" for "an insurance payment is received from another payer" and "MMIS Claim Adjustment Request Form" for "Adjustment/Void Request Form".

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; in (d)1, inserted ", as amended and supplemented," following "et seq.)" and added 3; and in (e), inserted a reference to NJ KidCare-Plan A beneficiaries in the first sentence.

Amended by R.1998 d.382, effective July 20, 1998.

See: *30 N.J.R. 1255(b)*, *30 N.J.R. 2646(b)*.

In (c), inserted a reference to the NJ KidCare Program in the introductory paragraph and rewrote 1; and in (e), added a new 1i, and inserted references to NJ KidCare, Medicare and Medicaid 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 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)*.

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

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

In (h)4, deleted i; rewrote (i).

Amended by R.2014 d.030, effective February 3, 2014.

See: *45 N.J.R. 103(a)*, *46 N.J.R. 295(a)*.

Section was "Third party liability (TPL) benefits". Rewrote the section.

Annotations

Notes

Chapter Notes

Case Notes

A facility providing inpatient psychiatric treatment was not entitled to review, by an administrative law judge, of a denial of Medicaid coverage and benefits on account of the facility's care of two separate patients because the facility had not exhausted its administrative remedies. Because Medicaid and NJ FamilyCare benefits are "last-payment benefits," the facility was properly required to utilize all administrative avenues to review claim decisions made by private health insurers. On these facts, that rule meant that the facility was required to appeal the benefit

denials in compliance with the Independent Health Care Appeals Program, which here would require review by an independent utilization review organization (IURO). Since the facility had not obtained IURO review, it had failed to exhaust its administrative remedies and could not obtain review in this forum. Carrier Clinic - Patient A.M. v. DMAHS; Carrier Clinic - Patient C.I. v. DMAHS, OAL DKT. NO. HMA 15487-12; *OAL DKT. NO. HMA 00480-13 (Consolidated), 2015 N.J. AGEN LEXIS 125*, Initial Decision (January 30, 2015).

End of Document

N.J.A.C. 10:49-7.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:49-7.4 Prohibition of payment to factors

(a) A "factor" means an individual or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the individual organization for an added fee or deduction of a portion of the accounts receivable.

(b) Payment for any covered services furnished to any Medicaid or NJ FamilyCare beneficiary by an approved provider may not be made to or through a factor, either directly or by power-of-attorney.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 3856(a)*.

In (b), substituted "beneficiary" for "recipient".

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

See: *30 New Jersey Register 1060(a)*.

In (b), inserted a reference to NJ KidCare beneficiaries.

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

See: *30 New Jersey Register 1060(a)*, *30 New Jersey Register 3519(a)*.

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

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

See: *34 New Jersey Register 2650(a)*, *35 New Jersey Register 1118(a)*.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:49-7.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 7. SUBMITTING CLAIMS FOR PAYMENT (POLICIES AND REGULATIONS)

§ 10:49-7.5 Use of service bureau and/or management agency

(a) Payment may be made to a business agent, such as a billing service or an accounting firm, that furnishes statements and receives payment in the name of the provider if the agent's compensation for this service is:

1. Related to the cost of processing the billing;

2. Not related on a percentage or other basis to the amount that is billed or collected; and

3. Not dependent upon the collection of the payment.

(b) If a NJ Medicaid or FamilyCare participating provider wishes to designate a business agent to perform management, clerical and/or other services related to the claims payment process, approval is required from the New Jersey Medicaid or NJ FamilyCare program.

(c) In order to obtain approval the provider/agent shall submit a copy of the signed agreement and power-of-attorney, if any, between the provider and the agent which shall contain a detailed statement of the powers and duties of the agent (including the power to sign Medicaid or NJ FamilyCare claims on behalf of the provider and the compensation arrangement) to Provider Enrollment, New Jersey Medicaid or NJ FamilyCare program.

(d) Approval shall be obtained for each provider/agent agreement. Approval of an agent agreement with one provider does not confer an automatic approval of any additional provider/agent agreement.

(e) Provider claims submitted for payment from or through the Division of Medical Assistance and Health Services shall be submitted by means of an approved method of automated data exchange unless an attachment to the claim is required, in which case the claim for payment instead shall be submitted using an approved hard-copy claim form. Procedures are detailed in the appropriate Provider Services Manual.

1. If hard copy claim forms are required and standard Medicaid or NJ FamilyCare claim forms are not utilized, the provider/agent shall first obtain approval from the New Jersey Medicaid or NJ FamilyCare program.

2. In order to obtain approval, the provider/agent shall submit a printer's prototype of an exact replica of the Medicaid or NJ FamilyCare claim form and the programming instructions for completion of the form to the Fiscal Agent.

3. The provider/agent shall assume the entire cost of printing duplicate forms at all times.

(f) The New Jersey Medicaid or NJ FamilyCare program in approving any provider/agent agreement, assumes no responsibility for the performance of the provider or agent. In the event that any error of the provider/agent requires special programming to be made by the Fiscal Agent in order to have claims paid correctly, the provider/agent shall assume the entire cost of the special program.

History

HISTORY:

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 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)*.

Amended by R.2011 d.290, effective December 5, 2011 (operative January 1, 2012).

See: *43 N.J.R. 1129(a)*, *43 N.J.R. 3182(b)*.

Rewrote the introductory paragraph of (e); and in (e)1, inserted "hard copy claim forms are required and" and "first".

Annotations

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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.

N.J.A.C. 10:49-7.6

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 7. SUBMITTING CLAIMS FOR PAYMENT (POLICIES AND REGULATIONS)

§ 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*.

History

HISTORY:

New Rule, R.2003 d.485, effective December 15, 2003.

See: *35 New Jersey Register 509(a)*, *35 New Jersey Register 5568(a)*.

Annotations

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N.J.A.C. 10:49-8.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > 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.

History

HISTORY:

Amended by R.1997 d.520, effective January 5, 1998.

See: *29 New Jersey Register 1006(a)*, *30 New Jersey Register 232(a)*.

Inserted language referencing Medicaid claims, charity care claims, and provider payments.

Annotations

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N.J.A.C. 10:49-8.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 8. PAYMENT FOR SERVICES PROVIDED

§ 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 FamilyCare 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 FamilyCare 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.

History

HISTORY:

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.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In (d)2, substituted "FamilyCare" for "KidCare" twice.

Annotations

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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.

N.J.A.C. 10:49-8.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:49-8.3 Adjustments following payment of claims

(a) If a claim is incorrectly paid, so that the provider receives an overpayment or underpayment, within 60 days of such receipt, the provider shall correctly adjust the claim by utilizing the web-based claims resolution process or another approved method of automated data exchange, unless an attachment to the claim is required, in which case the provider shall instead use an MMIS Claim Adjustment Request Form, (FD-999). (For the procedure to follow, see Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual). However, a provider shall immediately adjust all incorrectly overpaid claims that are discovered subsequent to the expiration of the 60-day deadline, also utilizing the web-based claims resolution process or another approved method of automated data exchange, unless an attachment to the claim is required, in which case the provider shall instead use an MMIS Claim Adjustment Request Form (FD-999).

(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 utilize the web-based claims resolution process or another approved method of automated data exchange to void the claim. (For the procedure to follow, see the Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual.) However, a provider shall immediately void all claims paid in error that are discovered subsequent to the expiration of the 60-day deadline, also utilizing the web-based claims resolution process or another approved method of automated data exchange.

(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).

History

HISTORY:

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.

Amended by R.2011 d.290, effective December 5, 2011 (operative January 1, 2012).

See: *43 N.J.R. 1129(a)*, *43 N.J.R. 3182(b)*.

Rewrote (a) and (b).

Annotations

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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.

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N.J.A.C. 10:49-8.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:49-8.4 Claims payment by direct deposit (electronic funds transfer or EFT)

(a) Each provider or other entity receiving reimbursement from or through the Division, except those enrolled for a specified limited period of time pursuant to *N.J.A.C. 10:49-3.5*, will receive claims payment automatically as a direct deposit to the provider's or entity's checking account through electronic funds transfer (EFT). (However, the Division and its agent may temporarily use paper checks to provide reimbursement to new providers prior to confirmation of direct deposit information.) All providers and entities shall apply for EFT in order to receive payment.

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.)

History

HISTORY:

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.2011 d.290, effective December 5, 2011 (operative January 1, 2012).

See: *43 N.J.R. 1129(a)*, *43 N.J.R. 3182(b)*.

Rewrote the introductory paragraph of (a).

Annotations

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N.J.A.C. 10:49-8.5

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§ 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.

Annotations

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N.J.A.C. 10:49-9.1

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§ 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. Advanced practice nurse: $ 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. Special 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 during normal office hours;

(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. Physician, specialist, podiatrist, optometrist, certified nurse midwife, advanced practice nurse and psychologist office visit;

(1) Optometrist office visit for newborns covered under fee-for-service are not subject to the $ 5.00 copayment.

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

iv. Hospital outpatient department visits, laboratory and X-rays services;

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;

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. A $ 10.00 copayment per visit shall be required for primary care providers, certified nurse midwives, physician specialists, and advance practice nurses for non-office hour visits and home visits; and

5. No copayment is required for well-child visits in accordance with the recommended schedule of the American Academy of Pediatrics, including lead screening and treatment, age appropriate immunizations, prenatal care and preventive dental 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.

History

HISTORY:

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.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In (a)11, substituted "Advanced practice nurse" for "Clinical nurse practitioner"; in (c)1i, inserted "during normal office hours"; rewrote (c)1ii; in (c)1iv, substituted ", laboratory and x-rays services" for "and diagnostic testing"; in (c)2, deleted "and" from the end; in (c)3i, substituted a semicolon for a period at the end; rewrote (c)4, and added (c)5.

Annotations

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N.J.A.C. 10:49-9.2

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§ 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) 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, of $ 33.50 for the first parent/caretaker and $ 14.00 for the second parent/caretaker.

(c) Under NJ FamilyCare-Plan D, effective July 1, 2009, 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 $ 40.00 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 $ 79.00 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 $ 133.00 per family per month that applies to all families, regardless of the number of children in the family.

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

(e) 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.

History

HISTORY:

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)*.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In the introductory paragraphs of (b) and (c), substituted "2007" for "2004"; in (b)1, substituted "$ 18.50" for "$ 17.00"; in (b)2, substituted "$ 31.50" for "$ 28.50" and "$ 13.00" for "$ 11.50"; in (c)1, substituted "$ 37.50" for "$ 34.00"; in (c)2, substituted "$ 74.50" for "$ 68.00"; and in (c)3, substituted "$ 125.00" for "$ 113.50".

Administrative change.

See: *40 N.J.R. 4817(b)*.

Administrative change.

See: *41 N.J.R. 2484(b)*.

Amended by R.2009 d.357, effective December 7, 2009.

See: *41 N.J.R. 2761(a)*, *41 N.J.R. 4438(a)*.

Rewrote (b).

Annotations

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N.J.A.C. 10:49-9.3

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§ 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.

History

HISTORY:

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

See: *30 New Jersey Register 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 New Jersey Register 1060(a)*, *30 New Jersey Register 3519(a)*.

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

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

See: *34 New Jersey Register 2244(a)*, *34 New Jersey Register 2549(b)*, *34 New Jersey Register 3978(c)*.

Added (d).

Annotations

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

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N.J.A.C. 10:49-9.4

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§ 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.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 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 New Jersey Register 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 New Jersey Register 1060(a)*, *30 New Jersey Register 3519(a)*.

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

Annotations

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N.J.A.C. 10:49-9.5

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§ 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.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 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 New Jersey Register 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 New Jersey Register 1060(a)*, *30 New Jersey Register 3519(a)*.

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

Annotations

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N.J.A.C. 10:49-9.6

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§ 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.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 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 New Jersey Register 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 New Jersey Register 1060(a)*, *30 New Jersey Register 3519(a)*.

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

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

See: *34 New Jersey Register 2650(a)*, *35 New Jersey Register 1118(a)*.

Annotations

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N.J.A.C. 10:49-9.7

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§ 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.

(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*).

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 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 New Jersey Register 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 New Jersey Register 1060(a)*, *30 New Jersey Register 3519(a)*.

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

Annotations

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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)*.

N.J.A.C. 10:49-9.8

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§ 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.

History

HISTORY:

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".

Annotations

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In an action to recoup overpayment to a Medicaid prescription provider based on its failure to supply supporting original prescriptions, absent any allegations of fraud, DMAHS was ordered to accept hard copies of the provider's electronic records (together with the patient signature logs) as proof that the prescription service was in fact provided; Medicaid overpayment was to be reduced to the extent that the provider could provide electronic records disclosing the prescription services provided. *Alina Drug Store v. DMAHS, OAL Dkt. No. HMA 11656-07, 2008 N.J. AGEN LEXIS 1321*, Final Decision (September 11, 2008).

Initial Decision (2005 N.J. AGEN LEXIS 1319) adopted, which concluded that a mental health service provider improperly billed full-day rates for children who did not receive the required full five hours of care and that the facility's executive officer was personally liable, within the meaning of *N.J.S.A. 30:4D-7(h)*, for any incorrect or illegal Medicaid payments. *Hentz v. DMAHS, OAL Dkt. No. HMA 5140-04, 2005 N.J. AGEN LEXIS 1320*, Final Decision (November 18, 2005).

Executive officer of a mental health service provider was required to produce sufficient back-up for claims for partial care under Medicaid; since the officer was put on notice in June 2000 that the 1997-1999 dates of service were being questioned, the documents should have been safeguarded. *Hentz v. DMAHS, OAL Dkt. No. HMA 5140-04, 2005 N.J. AGEN LEXIS 1320*, Final Decision (November 18, 2005).

N.J.A.C. 10:49-9.9

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§ 10:49-9.9 (Reserved)

History

HISTORY:

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)*.

Repealed by R.2012 d.027, effective February 6, 2012.

See: *43 N.J.R. 2641(a)*, *44 N.J.R. 229(a)*.

Section was "Patient's (beneficiary) certification".

§ 10:49-9.9 (Reserved)

In (b)1, substituted a reference to Medicaid and NJ KidCare fee-for-service eligible beneficiaries for a reference to Medicaid recipients.

Amended by R.2005 d.214, effective July 5, 2005.

See: *37 N.J.R. 436(a)*, *37 N.J.R. 2506(a)*.

Rewrote the section.

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N.J.A.C. 10:49-9.10

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§ 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.

History

HISTORY:

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.

Annotations

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Medicaid payments to an Advanced Practice Nurse (APN) were properly suspended on a temporary basis on findings that a credible allegation of fraud had been made. The APN had billed Medicaid for services exceeding 21 hours in a 24-hour day on ten different days. Moreover, on seven of those ten days, the APN in fact billed Medicaid for more than 24 hours of services in a 24-hour day. These findings supported a credible allegation of fraud for which payments properly were suspended. *Ejiofor, APN v. DMAHS, OAL DKT. NO. HMA 10634-17, 2018 N.J. AGEN LEXIS 1298*, Final Agency Determination (July 20, 2018).

N.J.A.C. 10:49-9.11

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§ 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.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 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 New Jersey Register 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 New Jersey Register 1060(a)*, *30 New Jersey Register 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 New Jersey Register 2808(a)*, *31 New Jersey Register 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 New Jersey Register 2650(a)*, *35 New Jersey Register 1118(a)*.

Rewrote the section.

Annotations

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N.J.A.C. 10:49-9.12

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§ 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.

History

HISTORY:

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 New Jersey Register 1060(a)*.

Inserted a reference to NJ KidCare programs.

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

See: *30 New Jersey Register 1060(a)*, *30 New Jersey Register 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 New Jersey Register 2808(a)*, *31 New Jersey Register 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 New Jersey Register 2650(a)*, *35 New Jersey Register 1118(a)*.

Annotations

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N.J.A.C. 10:49-9.13

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 9. PROVIDER AND BENEFICIARY'S RIGHTS AND RESPONSIBILITIES; ADMINISTRATIVE PROCESS

§ 10:49-9.13 Informing individuals of their rights

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

1. Of their right to a fair hearing;

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

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

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

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

History

HISTORY:

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)*.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In the introductory paragraph of (a), inserted "and NJ FamilyCare Plan D parents with incomes up to 133 percent of the Federal poverty level"; and in (b), inserted "all other Plan".

Annotations

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N.J.A.C. 10:49-9.14

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§ 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 and NJ FamilyCare Plan D parents with incomes up to 133 percent of the Federal poverty level 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 and NJ FamilyCare Plan D parents with incomes up to 133 percent of the Federal poverty level 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. NJ FamilyCare-Plan B, C and all other Plan D beneficiaries 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.

History

HISTORY:

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).

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In (a) and (c), inserted "and NJ FamilyCare Plan D parents with incomes up to 133 percent of the Federal poverty level"; and in (c), deleted "A" preceding "NJ FamilyCare-Plan B,", inserted "all other Plan" and substituted "beneficiaries" for the final occurrence of "beneficiary".

Annotations

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Case Notes

Adult who suffered from numerous medical problems failed to convince an Administrative Law Judge (ALJ) that her health insurer had acted improperly in reducing her Personal Care Assistance (PCA) hours from 15 hours a week to 10 hours a week. The reduction occurred following a periodic assessment, which concluded that she required assistance with bathing, dressing, housekeeping, shopping and laundry but managed other tasks, including toileting, without assistance. Based on the assessment tools, the adult's needs could be met with 10 hours of PCA. Because the adult offered no testimony that contradicted the results of the assessment, which was performed by a registered nurse as required, she was not entitled to relief from the decision reducing the number of PCA hours for which she was eligible. *D.G. v. United Healthcare, OAL DKT. NO. HMA 11621-14, 2015 N.J. AGEN LEXIS 112*, Initial Decision (February 3, 2015).

N.J.A.C. 10:49-9.15

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§ 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 (M.D. or D.O.) 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).

History

HISTORY:

New Rule, R.2001 d.294, effective August 20, 2001.

See: *32 N.J.R. 2687(b)*, *33 N.J.R. 2808(a)*.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In definition "Physician" in (a), inserted "(M.D. or D.O.)".

Annotations

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N.J.A.C. 10:49-10.1

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§ 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 or an NJ FamilyCare Plan D beneficiary who is a parent with an income level of up to 133 percent of the Federal poverty level.

"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.

History

HISTORY:

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.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In definition "Notice", inserted "or an NJ FamilyCare Plan D beneficiary who is a parent with an income level of up to 133 percent of the Federal poverty level".

Annotations

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Chapter Notes

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.

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N.J.A.C. 10:49-10.2

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§ 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.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 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 New Jersey Register 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 New Jersey Register 1060(a)*, *30 New Jersey Register 3519(a)*.

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

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

See: *34 New Jersey Register 2650(a)*, *35 New Jersey Register 1118(a)*.

Annotations

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N.J.A.C. 10:49-10.3

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§ 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, exclusive of HMO claims processing or HMO-provider contract issues:

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 erroneously 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.

History

HISTORY:

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. 1116(a)*, *1118(a)*.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In the introductory paragraph of (a), inserted ", exclusive of HMO claims processing or HMO-provider contract issues".

Annotations

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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)*.

Failure on the part of a guardian for a Medicaid applicant who had been found to be incompetent to file a timely Fair Hearing request in the 20-day period after notice of a denial of his Medicaid application foreclosed an award of eligibility based on that filing. *H.R. v. Atlantic Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 07011-2017, 2017 N.J. AGEN LEXIS 821*, Initial Decision (October 30, 2017).

N.J.A.C. 10:49-10.4

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

(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.

History

HISTORY:

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)*.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Section was "Advance notice of intent to terminate, reduce, or suspend assistance for Medicaid and NJ FamilyCare-Plan A".

Annotations

Notes

Chapter Notes

Case Notes

Twenty-seven year old man with autism and profound mental retardation who resided full time in a residential health care facility where he received continuous supervision was not entitled to receive personal care assistance (PCA) hours for the three or four days each month that his mother brought him to the family home for an overnight visit. That was because, inter alia, the patient was already receiving such services in the facility and they were available to him whether or not he was in the facility to utilize them so an allocation of PCA to cover time when he was visiting his family home would represent an improper duplication of services. Nor were there inadequacies in the notices received by the patient relative to the PCA determination. *C.J. v. Horizon NJ Health, OAL DKT. NO. HMA 06301-2016, 2017 N.J. AGEN LEXIS 607*, Initial Decision (August 14, 2017).

Decision by an insurer that 35 of the 112 hours of private duty nursing that were authorized to be provided to a 17 year old girl who suffered from congenital cytomegalovirus infection, developmental delays and intractable epilepsy were to be allocated to the hours when she attended school was a "proposed action to terminate, reduce or

suspend assistance" within the meaning of *N.J.A.C. 10:49-10.4* and the girl's parents were entitled to adequate notice of that proposed action. That being so, the insurer was not permitted to make that allocation but was required to provide all 112 hours at the girl's home pending a hearing on the proposed action. *N.P. v. United Healthcare, OAL DKT. NO. HMA 433-17, 2017 N.J. AGEN LEXIS 495*, Initial Decision (June 28, 2017).

DMAHS acted improperly when it issued a notice denying a Medicaid recipient's request for approval for a motorized wheel chair without providing any statutory basis for the denial. The notice stated only that the recipient was "not eligible" during the period and failed to specifically state that the subject of the denial was the wheel chair request. The notice as given did not meet the standards for "adequate advance notice" under governing law. *T.B. v. DMAHS, OAL DKT. NO. HMA 1858-15, 2015 N.J. AGEN LEXIS 457*, Initial Decision (July 6, 2015).

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).

Research References & Practice Aids

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.

N.J.A.C. 10:49-10.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 10. NOTICES, APPEALS AND FAIR HEARINGS

§ 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.

Annotations

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N.J.A.C. 10:49-10.6

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 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.

Annotations

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N.J.A.C. 10:49-10.7

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

§ 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.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 3856(a)*.

Amended section name.

Annotations

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N.J.A.C. 10:49-10.8

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 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).

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 3856(a)*.

Substituted "beneficiary" for "recipient".

Annotations

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N.J.A.C. 10:49-10.9

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 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.

Annotations

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Chapter Notes

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N.J.A.C. 10:49-10.10

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 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.

Annotations

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N.J.A.C. 10:49-10.11

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 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.

Annotations

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N.J.A.C. 10:49-10.12

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§ 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.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 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 New Jersey Register 1060(a)*.

Inserted references to DMAHS throughout.

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

See: *30 New Jersey Register 1060(a)*, *30 New Jersey Register 3519(a)*.

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

Annotations

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End of Document

N.J.A.C. 10:49-10.13

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§ 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).

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 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 New Jersey Register 1060(a)*.

Inserted a reference to DMAHS.

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

See: *30 New Jersey Register 1060(a)*, *30 New Jersey Register 3519(a)*.

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

Annotations

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N.J.A.C. 10:49-11

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 11. EXCLUSION FROM PARTICIPATION IN THE NEW JERSEY MEDICAID AND NJ FAMILYCARE PROGRAMS (SUSPENSION, DEBARMENT, AND DISQUALIFICATION)

Title 10, Chapter 49, Subchapter 11 -- Subchapter Notes

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Administrative law judge's initial decision suspending payments to a physician and suspending the physician from participation in the New Jersey Medicaid program was adopted because there were sufficient grounds for the actions based on the physician's arrest and a criminal complaint filed that alleged that the physician received monetary kickbacks for referring patients to a specific MRI facility. *Agarwal v. Div. of Medical Assistance & Health Serv. and Medicaid Fraud Div., OAL Dkt. No. HMA 2043-12, 2012 N.J. AGEN LEXIS 688*, Final Agency Decision (June 26, 2012).

Research References & Practice Aids

CROSS REFERENCES:

Termination of nursing facility provider agreement, good cause as under this section, see *N.J.A.C. 8:85-1.6*.

End of Document

N.J.A.C. 10:49-11.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 11. EXCLUSION FROM PARTICIPATION IN THE NEW JERSEY MEDICAID AND NJ FAMILYCARE PROGRAMS (SUSPENSION, DEBARMENT, AND DISQUALIFICATION)

§ 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:

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

"Debarment" means an exclusion from State contracting, on the basis of a lack of responsibility evidenced by an offense, failure or inadequacy of performance, for a reasonable period of time commensurate with the seriousness of the offense, failure or inadequacy of performance.

"Disqualification" means a debarment or a suspension which denies or revokes a qualification to bid or otherwise engage in State contracting which has been granted or applied for pursuant to statute, rules or regulations.

"Exclusion" means the suspension, debarment or disqualification of any individual or entity from participation in any capacity in any program administered in whole or in part by DMAHS.

"Person" means any natural person, company, firm, association, corporation or other entity.

"State" means the State of New Jersey or any of the departments or agencies in the executive branch of government with the lawful authority to engage in contracting.

"State contracting" means any arrangement giving rise to an obligation to supply anything to or perform any service for the State, other than by virtue of State employment, or to supply anything to or perform any service for a private person where the State provides substantial financial assistance and retains the right to approve or disapprove the nature or quality of the goods or service or the persons who may supply or perform the same.

"Suspension" means an exclusion from State contracting for a temporary period of time, pending the completion of an investigation or legal proceedings.

(d) Any of the following, among other things, shall constitute a good cause for exclusion of a person by the Medicaid Agent or DMAHS:

1. Commission of a criminal offense as an incident to obtaining or attempting to obtain a public or private contract, or subcontract thereunder, or in the performance of such contract or subcontract;

2. Violation of the Federal Organized Crime Control Act of 1970, or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, perjury, false swearing, receiving stolen property, obstruction of justice or any other offense indicating a lack of business integrity or honesty;

3. Violation of the Federal or State antitrust statutes, or of the anti-kickback provisions of the Social Security Act at *42 U.S.C. § 1320* a-7b (b), subject to the exceptions set forth in *42 C.F.R. 1001.952*;

4. Violations of any of the laws governing the conduct or elections of the State of New Jersey or of its political subdivisions;

5. Violation of the "Law Against Discrimination" (*N.J.S.A. 10:5-1* et seq.), or of the "Act Banning Discrimination in Public Works Employment" (*N.J.S.A. 10:2-1* et seq.) or of the "Act Prohibiting Discrimination by Industries Engaged in Defense Work in the Employment of Persons Therein" (*N.J.S.A. 10:1-10* et seq.);

6. Violations of any laws governing hours of labor, minimum wage standards, prevailing wage standards, discrimination in wages, or child labor;

7. Violations of any laws, regulations or code of ethics governing the conduct of occupations or professions or regulated industries;

8. Willful failure to perform in accordance with contract specifications or within contractual time limits;

9. A record of failure to perform or of unsatisfactory performance in accordance with the terms of one or more contracts, provided that such failure or unsatisfactory performance has occurred within a reasonable time preceding the determination to debar and was caused by acts within the control of the person debarred;

10. Violations of contractual or statutory provisions regulating contingent fees;

11. Presentment for allowance or payment of any false or fraudulent claim for services or merchandise;

12. Submitting false information for the purpose of obtaining greater compensation than that to which the person is legally entitled;

13. Submitting false information for the purpose of obtaining authorization requirements;

14. Failure to disclose or make available to the Medicaid Agent or DMAHS or its authorized agent, records of services provided to or payments made on behalf of Medicaid or NJ FamilyCare beneficiaries;

15. Failure to provide and maintain quality services to Medicaid or NJ FamilyCare beneficiaries within accepted medical community standards as determined by a body of peers;

16. Engaging in a course of conduct or performing an act deemed improper or abusive of the New Jersey Medicaid or NJ FamilyCare program following notification that said conduct should cease;

17. Breach of the terms of the Medicaid or NJ FamilyCare provider agreement entered into with the Medicaid Agent or DMAHS for failure to comply with the terms of the provider certification on the Medicaid or NJ FamilyCare claim;

18. Overutilizing the New Jersey Medicaid or NJ FamilyCare program by inducing, furnishing or otherwise causing an individual to receive service(s) or merchandise not otherwise required or requested by the beneficiary;

19. Rebating or accepting a fee or portion of a fee or charge for a Medicaid or NJ FamilyCare beneficiary referral;

20. Violating any provision of *N.J.S.A. 30:4D-1* et seq. (New Jersey Medical Assistance and Health Services Act) as amended or supplemented, or any rule or regulation promulgated by the Commissioner of Human Services or the Commissioner of Health and Senior Services pursuant thereto;

21. Conviction of any crime involving moral turpitude;

22. Submission of a false or fraudulent application for provider status to the Program or to its Fiscal Agent;

23. Any other cause affecting responsibility as a State contractor of such serious and compelling nature as may be determined by the Medicaid Agent or DMAHS to warrant exclusion, including such conduct as may be proscribed by the laws or contracts enumerated in this subsection, even if such conduct has not been or may not be prosecuted as violations of such laws or contracts;

24. Suspension, debarment or disqualification by some other department or agency in the executive branch;

25. Exclusion from participation in any state-funded medical assistance and/or health services program of another state;

26. Exclusion from participation in the delivery of medical care or services under Title XVIII, XIX, XX or XXI of the Federal Social Security Act by the Secretary of the United States Department of Health and Human Services; or

27. Failure to comply with an administrative subpoena issued by the Division.

(e) Conditions for debarment shall be as follows:

1. Debarment shall be made only upon approval of the Director of the Division, except as otherwise provided by law.

2. The existence of any of the causes set forth in (d) above, shall not necessarily require that a person be debarred. In each instance, the decision to debar shall be made within the discretion of the Director of the Division unless otherwise required by law, and shall be rendered in the best interests of the Program.

3. All mitigating factors shall be considered in determining the seriousness of the offense, failure or inadequacy of performance and in deciding whether debarment is warranted.

4. The existence of a cause set forth in (d)1 through 7 above shall be established upon the rendering of a final judgment or conviction by a court of competent jurisdiction or by an administrative agency empowered to render such judgment. In the event an appeal taken from such judgment or conviction results in reversal thereof, the debarment shall be removed upon the request of the debarred person unless other cause for debarment exists.

5. The existence of a cause set forth in (d)8, 9, 10 and 23 above shall be established by evidence which the Medicaid Agent or DMAHS determines to be clear and convincing in nature.

6. The existence of a cause set forth in (d)1 through 7, 11 through 22, and 24 above shall be established by a preponderance of the believable evidence.

7. Debarment for the cause set forth in (d)24 above shall be proper, provided that one of the causes set forth in (d)1 through 23 above was the basis for debarment by the original debarring agency. Such debarment may be based entirely on the record of facts obtained by the original debarring agency, or upon a combination of such facts and additional facts.

(f) If the Medicaid Agent or DMAHS seeks to debar a person or his or her affiliates, the Medicaid Agent or DMAHS shall furnish such party with a written notice stating that debarment is being considered, setting forth the reasons for the proposed debarment and indicating that such party will be afforded an opportunity for a hearing if he or she so requests within a stated period of time. All such hearings shall be conducted in accordance with the provisions of the Administrative Procedure Act. However, where one department or agency has imposed debarment upon a party, a second department or agency may also impose a similar debarment without affording an opportunity for a hearing, provided that the second agency furnishes notice of the proposed similar debarment to that party and affords that party an opportunity to present information in his or her behalf to explain why the proposed similar debarment should not be imposed in whole or in part.

(g) Debarment shall be a reasonable, definitely stated period of time which as a general rule shall not exceed five years. Debarment for an additional period shall be permitted provided that notice thereof is furnished and the party is accorded an opportunity to present information in his or her behalf to explain why the additional period of debarment should not be imposed.

(h) The scope of debarment rules shall be as follows:

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 FamilyCare 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.

History

HISTORY:

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.

Annotations

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Medicaid payments to an Advanced Practice Nurse (APN) were properly suspended on a temporary basis on findings that a credible allegation of fraud had been made. The APN had billed Medicaid for services exceeding 21 hours in a 24-hour day on ten different days. Moreover, on seven of those ten days, the APN in fact billed Medicaid for more than 24 hours of services in a 24-hour day. These findings supported a credible allegation of fraud for which payments properly were suspended. *Ejiofor, APN v. DMAHS, OAL DKT. NO. HMA 10634-17, 2018 N.J. AGEN LEXIS 1298*, Final Agency Determination (July 20, 2018).

Director of DMAHS adopted the report and recommendation of an ALJ who found that a pharmacist who had signed consent orders surrendering his license and prohibiting him from certain conduct was properly debarred from participation in the Medicaid program. *Patel, R.Ph. v. DMAHS, OAL DKT. NO. HMA 12544-2016, 2017 N.J. AGEN LEXIS 1341*, Final Agency Determination (July 18, 2017).

Pharmacist who signed Consent Order 2 in April 2016 which admitted that he had violated Consent Order 1, which he signed in May 2008, was properly debarred from Medicaid participation. Contrary to the pharmacist's claims that DMAHS was seeking to further penalize him for events that had occurred in 2001, the facts were such that his current debarment related to his conduct in 2010-2011 in being present in the prescription-filling area of a pharmacy despite the fact that he was not permitted to do so under the clear terms of *Consent Order 1. S.P. v, DMAHS, OAL DKT. NO. HMA 12544-16, 2017 N.J. AGEN LEXIS 222*, Initial Decision (April 19, 2017).

Notice sent by DMAHS to a physician provider that it was suspending his participation in Medicaid due to the initiation of a fraud investigation in which he was the target was timely. Though the best explication of the charges against the doctor was included in a notice sent 16 days after the date of suspension, that notification was an amended notice, with the original notice having been sent on the day on which the suspension was ordered, thus satisfying regulatory requirements. *Sehgal, M.D. v. DMAHS, OAL DKT. NO. HMA 12555-16, 2017 N.J. AGEN LEXIS 130*, Initial Decision (March 7, 2017).

Division of Medical Assistance and Health Services acted reasonably and within its regulatory authority when it suspended a physician from participating in the state Medicaid program pending resolution of criminal proceedings because the United States District Court for the District of New Jersey had issued a criminal complaint against the physician, alleging in part that the physician had received monetary kickbacks for referring patients to a specific

MRI center. *Kania v. Div. of Medical Assistance & Health Serv. and Medicaid Fraud Div., OAL Dkt. No. HMA 01245-12, 2012 N.J. AGEN LEXIS 687*, Final Agency Decision (July 17, 2012).

Good cause existed to deny petitioner's application as a Medicaid pharmacy services provider because the application contained false statements, including failing to disclose the fact that petitioner had violated Board of Pharmacy regulations for outdated prescriptions, misbranded medication, over-filled containers of medications in the active drug stock inventory, and medication held for re-dispensing in containers not properly labeled; the mere submission of false information was grounds for denial, without regard to whether the applicant intended to deceive, manipulate, or defraud *Medicaid. Oakland Pharmacy v. DMAHS, OAL Dkt. No. HMA 5062-09, 2009 N.J. AGEN LEXIS 1019*, Final Decision (October 26, 2009).

Good cause existed for the denial of a petitioner's application to be a Medicaid provider based on the submission of an application containing false information in which petitioner failed to include his name on the application as a pharmacist associated with the pharmacy and also did not disclose a penalty assessed against him for violating a Board of Pharmacy rule; the mere submission of false information was grounds for denial, without regard to whether the applicant intended to deceive, manipulate, or defraud *Medicaid. Newark Pharmacy v. DMAHS, OAL Dkt. No. HMA 3323-09, 2009 N.J. AGEN LEXIS 760*, Final Decision (September 16, 2009).

Good cause existed to deny a petitioner's application as a Medicaid pharmacy services provider because the application contained false statements, including a failure to disclose prior regulatory violations for neglecting to request allergy and other chronic conditions for 60% of its filled prescriptions and not including the "use by" date on its prescription labels, as well as the failure to disclose criminal charges brought against the pharmacist-in-charge for attempting to obtain a controlled dangerous substance by presenting a forged prescription; the mere submission of false information was grounds for denial, without regard to whether the applicant intended to deceive, manipulate, or defraud *Medicaid. New Lucy Pharmacy v. DMAHS, OAL Dkt. No. HMA 3090-09 and HMA 1624-09 (Consolidated), 2009 N.J. AGEN LEXIS 667*, Final Decision (August 17, 2009).

Good cause justified termination of provider of mental health and drug and alcohol counseling services as a Medicaid provider where substantial evidence showed that provider violated the state's anti-kickback statute, *N.J.S.A. 30:4D-17(c)*, by giving away over $ 179,000.00 in Pathmark gift vouchers in order to induce Medicaid beneficiaries into its facility. Statements obtained from DMAHS investigators confirmed that clients returned to the facility every day in order to obtain these vouchers, and provider's owner himself advised an investigator that clients came on a daily basis for the vouchers, not for the services (adopting *Initial Decision, 2008 N.J. AGEN LEXIS 1001*). *Bloomfield Health Pavilion v. DMAHS, OAL Dkt. No. HMA 03095-08, 2009 N.J. AGEN LEXIS 55*, Final Decision (January 15, 2009).

Regulations do not require that a provider intended to deceive, manipulate, or defraud Medicaid, in order to be excluded from the program; simply offering gift vouchers to Medicaid beneficiaries is prohibited under the plain language of the anti-kickback statute and is grounds for exclusion, and it is well within the Division of Medical Assistance and Health Services' discretion to take action against a provider who has clearly violated the statutory prohibition against offering a bribe or an incentive to a Medicaid client in order to influence program participation. *Bloomfield Health Pavilion v. DMAHS, OAL Dkt. No. HMA 03095-08, 2009 N.J. AGEN LEXIS 55*, Final Decision (January 15, 2009).

Although an ALJ found that an applicant knowingly and intentionally provided false information on an application to be a Medicaid provider, *N.J.A.C. 10:49-11.1* did not require that a provider intended to deceive, manipulate, or defraud Medicaid in order for an enrollment application to be denied. Rather, the mere submission of false information was grounds for denial. *Comm-Unity, Inc. v. DMAHS, OAL Dkt. No. HMA 1721-07 and HMA 3275-07, 2008 N.J. AGEN LEXIS 1316*, Final Decision (August 7, 2008).

DMAHS properly denied a pharmacy's application for participation in the New Jersey Medicaid program because the pharmacist-in-charge, who was a 50% owner, answered "No" to the question about criminal charges despite the fact that the pharmacist had previously pled guilty to criminal trespass and completed the Pre-Trial Intervention

program. Neither alleged confusion regarding the obligation to disclose Pre-Trial Intervention charges nor the fact that the pharmacist was no longer associated with the pharmacy required a different result. *Mi Farmacia v. DMAHS, OAL Dkt. No. HMA 9969-06, 2008 N.J. AGEN LEXIS 354*, Initial Decision (April 30, 2008).

N. J.A.C. 10:49-11.1(d) does not require that a false statement be made willfully in order to deny an application. *Mi Farmacia v. DMAHS, OAL Dkt. No. HMA 9969-06, 2008 N.J. AGEN LEXIS 354*, Initial Decision (April 30, 2008).

Where a registered nurse anesthetist administered 2,000 times the recommended dose of a narcotic anesthetic to three patients, and submitted false answers on applications, good cause existed for debarment from participation in New Jersey Medicaid and Division-administered programs, and the mitigating factors presented by the anesthetist, including the provider's interest in compensation from the Medicaid program, were superseded by the Division's "overriding public interest in the proper administration of the Medicaid program in *New Jersey." Frimpong v. DMAHS, OAL Dkt. No. HMA 05200-04, 2007 N.J. AGEN LEXIS 752*, Initial Decision (November 20, 2007).

Suspension, debarment, and disqualification are measures invoked by the Division to exclude or render ineligible certain persons from participation in contracts and subcontracts with the New Jersey Medicaid or New Jersey FamilyCare programs, the Medicaid Agent, or DMAHS on the basis of a lack of responsibility; the purpose of sanctions is not to punish the person, but rather to protect the interests of Medicaid and New Jersey FamilyCare programs. *Frimpong v. DMAHS, OAL Dkt. No. HMA 05200-04, 2007 N.J. AGEN LEXIS 752*, Initial Decision (November 20, 2007).

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. The applicant's failure to provide requested enrollment information within 35 days could not be placed within the rubric of *N.J.A.C. 10:49-11.1*, which sanctions are stated to be for the purposes of protecting the interests of the New Jersey Medicaid program, and not for punishment. *Grace Pharmacy v. DMAHS, OAL Dkt. No. HMA 6904-06, 2007 N.J. AGEN LEXIS 528*, Final Decision (June 5, 2007).

Initial Decision (2006 N.J. AGEN LEXIS 751) adopted, which concluded that a pharmacy's application to be a Medicaid provider was correctly denied pursuant to *N.J.A.C. 10:49-11.1(d)*22 because the pharmacy owner willfully or by inexcusably irresponsible omission provided false information on the application concerning the criminal history of the pharmacist-in-charge and then lied about whether the person was still an employee. *Surgi-Med Pharmacy v. DMAHS, OAL Dkt. No. HMA 3635-06, 2006 N.J. AGEN LEXIS 934*, Final Decision (October 1, 2006).

Pharmaceutical provider submitted a false answer on the application by failing to reveal the adverse action taken against it in Colorado, and *N.J.A.C. 10:49-11.1(d)* provides that the submission of false or fraudulent information is grounds for sanction; the provider's failure to comply with the laws and regulations in Colorado also provided grounds for sanction. As corporate officers and officials, the owners of the pharmaceutical providers were all responsible for the conduct providing the basis for sanction, and there was good cause for the exclusion of all of the petitioners, corporate as well as individual, from licensure. *Y & S Pharmacy v. DMAHS, OAL Dkt. Nos. HMA 02212-01, HMA 02883-01, and HMA 04220-01 (Consolidated), 2006 N.J. AGEN LEXIS 455*, Initial Decision (July 19, 2006).

To determine the proper sanctions that might be applied under *N.J.A.C. 10:49-11.1(e)*, "All mitigating factors shall be considered"; thus, the fact that the violations in Colorado had occurred over five years ago was a mitigating factor. *Y & S Pharmacy v. DMAHS, OAL Dkt. Nos. HMA 02212-01, HMA 02883-01, and HMA 04220-01 (Consolidated), 2006 N.J. AGEN LEXIS 455*, Initial Decision (July 19, 2006).

Where petitioner, a licensed dentist, entered into a pre-trial intervention (PTI) program without a plea of guilt, which effectively suspended the criminal case against the dentist pending a satisfactory performance of all conditions ordered by the court and the passage of 18 months, the dentist's claim that there was no need for the Division to suspend the dentist's privileges pending the outcome of the PTI process was inaccurate and without merit; acceptance into the PTI program postponed, rather than terminated, further proceedings based on the

criminal charges. The dentist's grand jury indictment alone was sufficient for the Director to suspend the dentist's participation in any DMAHS medical assistance programs for the length of the dentist's time in the PTI program. *Farhat v. DMAHS, OAL Dkt. No. HMA 11600-05, 2006 N.J. AGEN LEXIS 457*, Initial Decision (July 13, 2006).

Initial Decision (2006 N.J. AGEN LEXIS 266) adopted, which concluded that petitioner's application to be a Medicaid provider was properly denied under *N.J.A.C. 10:49-11.1(d)*22 because petitioner failed to disclose the past disciplinary history of its laboratory director. *Dart Med. Lab. v. DMAHS, OAL Dkt. No. HMA 9605-05, 2006 N.J. AGEN LEXIS 679*, Final Decision (May 10, 2006).

Adopting, due to the unique circumstances, the *Initial Decision (2005 N.J. AGEN LEXIS 670*), which concluded that the Division's decision to impose a disqualification of a licensed physician for an indefinitely stated period of time, without adequately explaining the basis for that determination, was arbitrary, capricious, and without any substantiated, reasonably articulated basis. *Antoun v. DMAHS, OAL Dkt. No. HMA 5721-04, 2005 N.J. AGEN LEXIS 1061*, Final Decision (December 20, 2005).

Adopting, due to the unique circumstances, the *Initial Decision (2005 N.J. AGEN LEXIS 670*), which concluded that completion of probation, payment of restitution or fines, and the absence of any criminal, licensing, or professional disciplinary proceedings are all factors to be considered for reinstatement of a provider disqualified from participation in Medicaid and other Division programs; in this matter, there were no pending criminal, licensing, or disciplinary proceedings extant, there was no evidence that the physician failed to pay full restitution and criminal fines and assessments imposed as part of the original sentence, and the record was replete with mitigating factors. *Antoun v. DMAHS, OAL Dkt. No. HMA 5721-04, 2005 N.J. AGEN LEXIS 1061*, Final Decision (December 20, 2005).

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).

Research References & Practice Aids

LAW REVIEW AND JOURNAL COMMENTARIES:

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N.J.A.C. 10:49-12.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > 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.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 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 New Jersey Register 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 New Jersey Register 1060(a)*, *30 New Jersey Register 3519(a)*.

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

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

See: *34 New Jersey Register 2650(a)*, *35 New Jersey Register 1118(a)*.

Rewrote the introductory paragraph.

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N.J.A.C. 10:49-12.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 12. PROVIDER REINSTATEMENT

§ 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.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 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 New Jersey Register 1060(a)*.

Inserted a reference to the NJ KidCare program.

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

See: *30 New Jersey Register 1060(a)*, *30 New Jersey Register 3519(a)*.

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

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

See: *34 New Jersey Register 2650(a)*, *35 New Jersey Register 1118(a)*.

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N.J.A.C. 10:49-12.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 12. PROVIDER REINSTATEMENT

§ 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.

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N.J.A.C. 10:49-12.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:49-12.4 Director's powers

The Director may on his or her own motion order the reinstatement of debarred, disqualified or suspended persons or may refer the matter to the Provider Reinstatement Committee.

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N.J.A.C. 10:49-12.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 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.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 3856(a)*.

In (a)1 substituted "New Jersey Medicaid program" for "Division"; in (a)1i, deleted "Under this requirement," preceding "The committee"; and in (a)1iii, 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 New Jersey Register 1060(a)*.

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

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

See: *30 New Jersey Register 1060(a)*, *30 New Jersey Register 3519(a)*.

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

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

See: *34 New Jersey Register 2650(a)*, *35 New Jersey Register 1118(a)*.

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N.J.A.C. 10:49-12.6

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§ 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.

History

HISTORY:

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)*.

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Adopting, due to the unique circumstances, the *Initial Decision (2005 N.J. AGEN LEXIS 670)*, which concluded that the Division's decision to impose a disqualification of a licensed physician for an indefinitely stated period of time, without adequately explaining the basis for that determination, was arbitrary, capricious, and without any substantiated, reasonably articulated basis. *Antoun v. DMAHS, OAL Dkt. No. HMA 5721-04, 2005 N.J. AGEN LEXIS 1061*, Final Decision (December 20, 2005).

Adopting, due to the unique circumstances, the *Initial Decision (2005 N.J. AGEN LEXIS 670)*, which concluded that completion of probation, payment of restitution or fines, and the absence of any criminal, licensing, or professional disciplinary proceedings are all factors to be considered for reinstatement of a provider disqualified from participation in Medicaid and other Division programs; in this matter, there were no pending criminal, licensing, or disciplinary proceedings extant, there was no evidence that the physician failed to pay full restitution and criminal fines and assessments imposed as part of the original sentence, and the record was replete with mitigating factors. *Antoun v. DMAHS, OAL Dkt. No. HMA 5721-04, 2005 N.J. AGEN LEXIS 1061*, Final Decision (December 20, 2005).

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).

N.J.A.C. 10:49-12.7

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 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.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 3856(a)*.

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

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N.J.A.C. 10:49-13.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > 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.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 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 New Jersey Register 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 New Jersey Register 1060(a)*, *30 New Jersey Register 3519(a)*.

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

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

See: *34 New Jersey Register 2650(a)*, *35 New Jersey Register 1118(a)*.

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N.J.A.C. 10:49-14.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

§ 10:49-14.1 Recovery of payments correctly made

(a) Correctly paid benefits shall only be recoverable from the estate of an individual who was 65 years of age or older when the individual received medical assistance if:

1. The individual leaves no surviving spouse;

2. For estates of individuals who died between February 1, 1984 and October 20, 1992, the individual left no surviving child;

3. For estates of individuals who died on or after October 21, 1992, the individual leaves no surviving child who is under the age of 21 or any surviving blind or permanently and totally disabled children;

4. The amount to be recovered is in excess of $ 500.00; and

5. The gross estate is in excess of $ 3,000.

(b) Paragraphs (a)4 and 5 above shall apply to recoveries from the estates of individuals who died on or after July 20, 1981, but prior to December 22, 1995.

(c) For estates of individuals who died on or after April 1, 1995, in addition to the recoveries authorized under (a) and (b) above, any Medicaid payments correctly made on or after October 1, 1993, on behalf of individuals who received services on or after age 55 but prior to age 65, are recoverable from the estates of those individuals, subject to the conditions set forth in (a)1, 3, 4 and 5 and (b) above.

(d) Effective for estates created on or after October 4, 1999, the Division shall file any claim or lien against an estate under this section within three years after receiving actual written notice from the personal representative of the estate or any other interested party of the death of the Medicaid beneficiary.

(e) For estates of individuals who died on or after December 22, 1995, Medicaid claims under this section shall be deemed preferred claims, with a priority equivalent to that under subsection c. of *N.J.S.A. 3B:22-2*, that is, debts and taxes with preference under Federal or State law.

(f) The personal representative of the estate of a deceased Medicaid beneficiary or any other interested party, upon request to the Division, may obtain a "payoff statement" on the amount due under the claim, if that information is available to the Division at the time the request is received.

(g) Effective for estates pending on or created after October 4, 1999, if a family member of a deceased Medicaid beneficiary has, prior to the beneficiary's death, continuously resided in a home owned by the beneficiary at the time of the beneficiary's death, and that home was the beneficiary's primary residence, and was and remains the family member's primary residence, the Division may record a lien against the property, but will not enforce the lien until the property is voluntarily sold, or the resident family member either dies or vacates the property.

(h) For estates of individuals who died on or after October 1, 1993, which are subject to a recovery claim under this section which was either pending on or initiated after March 1, 1995, the estate representative may apply to the Division for a waiver or compromise of the claim based upon grounds of undue hardship, subject to the following policies and procedures:

1. Undue hardship can be demonstrated only if the estate subject to recovery is or would become the sole income-producing asset of the survivors, and pursuit of recovery is likely to result in one or more of those survivors becoming eligible for public assistance and/or Medicaid benefits.

2. There shall be a rebuttable presumption that no undue hardship exists if the hardship resulted from estate planning methods under which assets were divested in order to avoid estate recovery.

3. Upon receipt of written notice that the estate is subject to a recovery claim by the Division, the estate representative shall have 20 days from the date of receipt of the notice to file a request for a waiver or compromise of the Division's claim based upon undue hardship, together with evidence in support of the request. If that request is not received by the Division within the time limit specified, the Division shall not grant a waiver or compromise based upon undue hardship. Upon receipt of a timely request, the Division shall evaluate the request and the evidence submitted, and shall notify the applicant in writing of its decision within 45 days from the date that the request was received. If the estate representative wishes to contest the Division's decision, a written request for a hearing shall be submitted to the Division within 20 days from the date of receipt of that decision, in accordance with the provisions of N.J.A.C. 10:49-10. This request shall be forwarded by the Division to the Office of Administrative Law (OAL), which shall notify the parties of the hearing date and venue, and shall provide a description of the hearing process. Subsequent to the hearing, the formal decision of the OAL shall include a description of the process leading to the final agency decision and the appeal rights available to both parties.

(i) The Division may elect not to pursue a claim under this section against the estate of an individual who died on or after December 22, 1995, if it determines, in its sole discretion, that to do so would not be cost-effective.

(j) For all estate recoveries pending on or initiated after October 4, 1999, no lien of any kind, inchoate or otherwise, and no right of recovery can either exist or be pursued until all of the conditions set forth in *N.J.S.A. 30:4D-7.2a* are met, including the absence of any surviving spouse or of any minor, blind, or permanently and totally disabled children.

(k) For all estate recoveries pending on or initiated on or after October 4, 1999, even when the statutory conditions for lien filing and recovery are met, recovery shall not be pursued against property held by any bona fide purchaser who has paid fair market value for the property, but shall be sought from the estate.

(l) For purposes of this section, the term "estate" with respect to a deceased Medicaid beneficiary shall include:

1. All real and personal property and other assets included within the individual's estate, as defined in *N.J.S.A. 3B:1-1*; and

2. For individuals who died on or after April 1, 1995, the term "estate" shall also include any other real and personal property and other assets in which the Medicaid beneficiary had any legal title or interest at the time of death, to the extent of that interest, including assets conveyed to a survivor, heir or assign of the beneficiary through joint tenancy, tenancy in common, survivorship, life estate, living trust or other arrangement, as well as any proceeds from the sale of any such property which remain in the estate of the survivor, heir or assign of the beneficiary, to the extent of the beneficiary's interest;

i. Effective for future estates or estate recoveries pending on or after October 4, 1999, for purposes of this subsection, the term "life estate" shall mean a life estate created upon the death of a beneficiary;

ii. Effective for future estates or estate recoveries pending on or after October 4, 1999, for purposes of this subsection, the term "other arrangement" shall include, but not be limited to, any trust or annuity in which the beneficiary had an interest at the time of death, including a trust or annuity established by a third party, subject to the exclusions discussed in (n) below.

(m) Any lien filed on or after October 4, 1999 against an estate as described in (*l*)2 above shall describe the extent of the deceased Medicaid beneficiary's interest covered by the lien, if known to the Division at

the time the lien is filed. For example, if a deceased Medicaid beneficiary at the time of his death owned real property as a tenant-in-common with another individual, the lien should state that it encumbers only 50 percent of the equity in the real property. If the deceased Medicaid beneficiary held a tenancy-by-the-entirety or joint tenancy with a right of survivorship, then the lien shall state that it encumbers all of the property. If the Division is not aware of the extent of the beneficiary's interest at the time that the lien is filed, the full amount of the Division's claim shall be listed on the lien.

(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.

History

HISTORY:

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).

Amended by R.2013 d.079, effective May 20, 2013.

See: *45 N.J.R. 107(a)*, *45 N.J.R. 1249(b)*.

In (d), substituted "three years" for "90 days".

Annotations

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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)*.

Property that was purchased by a decedent and her daughter and in which the pair were residing at the time of the decedent's death was subject to a lien in favor of DMAHS due to the receipt, by the decedent, of Medicaid benefits. Under governing law, the property was not automatically transferred to the daughter upon the decedent's death and it remained subject to the Medicaid lien. *Estate of V.C. v. DMAHS, OAL DKT. NO. HMA 01175-17, 2017 N.J. AGEN LEXIS 571*, Initial Decision (July 20, 2017).

Daughter of a decedent who received Medicaid benefits failed to establish that the resulting Medicaid lien that attached to real estate owned by the decedent and the daughter presumably as tenants in common was properly waived because reimbursement of the lien would constitute undue hardship. However, inasmuch as the daughter was residing in the property at the time of decedent's death, the lien would not be enforced until the daughter either sold the property or died. *Estate of V.C. v. DMAHS, OAL DKT. NO. HMA 01175-17, 2017 N.J. AGEN LEXIS 571*, Initial Decision (July 20, 2017).

Agency director adopted an ALJ's Initial Decision finding that the daughter of a decedent who had received Medicaid benefits did not establish that enforcement of a related lien on property owned by the decedent and the daughter as tenants-in-common would constitute undue hardship. Nor was the daughter entitled to the "caretaker exemption" because the decedent did not transfer title to the daughter during the decedent's lifetime. *Estate of V.C. v. DMAHS, OAL DKT. NO. HMA 01175-17, 2017 N.J. AGEN LEXIS 571*, Initial Decision (July 20, 2017).

Daughter was not entitled to a hardship waiver of a lien claim by the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), against her mother's estate. The lien was properly imposed under *N.J.A.C. 10:49-14.1(a)* because her mother left no surviving spouse or minor children, and the daughter was not permanently disabled. The daughter was not able to demonstrate an undue hardship under *N.J.A.C. 10:49-14.1(h)* because DMAHS expressly advised the daughter that she could remain in the Property as long as she so chose and that the Estate Lien was deferred. *P.V. v. Div. of Medical Assistance and Health Serv., OAL DKT. NO. HMA 9653-14, 2014 N.J. AGEN LEXIS 826*, Initial Decision (December 31, 2014).

End of Document

N.J.A.C. 10:49-14.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 14. RECOVERY OF PAYMENTS AND SANCTIONS

§ 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 HBID 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 letter is issued to a beneficiary, a message will be included in the eligibility message on the REVS/MEVS/eMEVS system alerting the provider to ask the Medicaid or NJ FamilyCare beneficiary for additional identification or to take other appropriate action.

1. The restriction 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 HBID Card shall create a presumption that the beneficiary listed on the HBID Card, or a person responsible for a minor listed on the HBID Card, was responsible for such actions. If this presumption is successfully rebutted by or on behalf of 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 letter is issued to Medicaid or NJ FamilyCare beneficiaries determined to have had their HBID Card used by an unauthorized person or persons, or for an unauthorized purpose. The purpose of the warning is to notify providers that the beneficiary's HBID Card has been used by an unauthorized person or persons, or for an unauthorized purpose. A message will be available on the REVS/MEVS/eMEVS system alerting the provider to ask the Medicaid or NJ FamilyCare beneficiary for additional identification or to take other appropriate action. A determination that an HBID Card has been used by an unauthorized person or for an unauthorized purpose shall create a presumption that the beneficiary listed on the HBID Card, or a person responsible for a minor listed on the HBID Card,

was responsible for such actions. If this presumption is successfully rebutted by the beneficiary, the beneficiary shall not be issued a warning letter.

History

HISTORY:

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.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In the introductory paragraph of (a), substituted "HBID" for "Eligibility Identification (EI)", "letter" for "card" and "included in the eligibility message on the REVS/MEVS/eMEVS system" for "printed on the card", and inserted "to a beneficiary"; in the introductory paragraph of (a)1, substituted "restriction" for "restrictive card", "HBID" for "(EI)" twice, the second occurrence of "beneficiary" for "beneficiaries", and ", or a person responsible for a minor listed on the HBID Card, was" for "were", and inserted "or on behalf of"; and in (a)2, substituted "letter" for "card" twice, "HBID" for "(EI)" four times, "available on the REVS/MEVS/eMEVS system" for "printed on the card", the second occurrence of "beneficiary" for "beneficiaries" and ", or a person responsible for a minor listed on the HBID Card, was" for "were".

Annotations

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N.J.A.C. 10:49-14.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 14. RECOVERY OF PAYMENTS AND SANCTIONS

§ 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.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 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 New Jersey Register 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 New Jersey Register 1060(a)*, *30 New Jersey Register 3519(a)*.

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

Annotations

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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.

End of Document

N.J.A.C. 10:49-14.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 14. RECOVERY OF PAYMENTS AND SANCTIONS

§ 10:49-14.4 Recoveries involving a county welfare agency (CWA)

(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 welfare agency (CWA) 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 CWA shall determine the period(s) of ineligibility and ascertain from DMAHS the amount of medical assistance incorrectly granted. The CWA 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 CWA 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 CWA is authorized, after securing DMAHS approval, to initiate recovery proceedings as DMAHS' agent. If the CWA 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 CWA 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 CWA in the amount of 25 percent of the gross recovery on a periodic basis to be determined by DMAHS.

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

6. When any CWA 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 CWA 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 CWA 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 CWA claim for recovery of cash assistance. The next claim is that which the CWA may assert in accordance with an agreement to repay or similar document. The DMAHS and the CWA 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 CWA 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 CWA 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 CWA 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 CWA staff time, supplies, counsel fees or overhead.

ii. Proceeds will be next applied to any claims superior to that of the CWA (for example, taxes).

iii. Proceeds will be next applied to any funds owing to and collectible by the CWA.

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 CWA 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 CWA shall normally undertake recovery activity as agent for DMAHS in any case in which the CWA 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 CWA claim is for burial expenses only, DMAHS shall initiate recovery activity inclusive of CWA burial costs. DMAHS may, in certain cases, assume direct jurisdiction in recovery of its claim concurrent with CWA activity. DMAHS shall make the CWA aware of its activity in such cases.

2. CWA recoveries and distribution shall be in accord with the following procedures:

i. From the proceeds of liquidation, the CWA shall first recover the amount necessary to satisfy its own claim, including costs of liquidation and the claims of other New Jersey CWAs. The CWA 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 CWA 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 CWA 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 CWA 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 CWA 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 CWA may, at its option, arrange for someone to file to become administrator or the CWA may refer the information to DMAHS for action.

v. In any questions or dispute among two or more claimants on surplus funds, the CWA 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 CWA shall be submitting a claim. However, should information from the CWA be necessary to such DMAHS activity, the CWA shall communicate with DMAHS, supplying such material as may be required.

ii. In cases in which DMAHS is acting for a CWA in collection of burial expenses, DMAHS shall accord payment of the burial claim priority over its own recovery.

(f) The CWA 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 CWA shall supply the appropriate information, identifying the respective amounts granted by the CWA and the Medicaid Agent or DMAHS. In the absence of instruction from the payer, the CWA 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 CWA 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 CWA, whichever agency is handling the recovery.

History

HISTORY:

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.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Section was "Recoveries involving county board of social services (CBOSS)". Substituted "CWA" for "county board of social services (CBOSS)" throughout; in (a), substituted "welfare agency (CWA)" for "board of social services (CBOSS)"; in (b)3, inserted a comma following "When", "authorized" and "approval"; in the introductory paragraph of (c), substituted "third-party" for "third party"; in (c)2, inserted a comma following "occurrence" and substituted "CWA" for "(CBOSS)"; in (d)2i, inserted a comma following the first occurrence of "fees" and the second occurrence of "costs"; in the introductory paragraph of (e)2, substituted "CWA" for "County board of social services (CBOSS)"; and in (e)2i, substituted "CWAs" for "county board of social services (CBOSS)s".

Annotations

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Determination by a county board of social services that a Medicaid recipient's resources had exceeded the maximum permitted during a three-month period of September, October and November 2019 was approved by DMAHS but the matter was remanded to determine whether the recipient's wife was also a Medicaid recipient, which data was necessary to determine whether the recipient had been ineligible for benefits during *August 2019. A.T. v. Mercer Cnty. Bd. of Soc. Servs., OAL DKT. NO. HMA 09239-20, 2021 N.J. AGEN LEXIS 56*, Order of Remand (February 23, 2021).

Medicaid recipient who did not contest the claim of a county social services board that his income in fact exceeded the eligibility limit during the relevant period due to the fact that he was awarded and began receiving pension income that caused his household income to exceed the Medicaid ceiling was properly required to repay benefits

received during that period. *L.S. v. Mercer Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 09077-2017, 2017 N.J. AGEN LEXIS 729*, Initial Decision (September 18, 2017).

Medicaid recipient who was ruled ineligible after income that he failed to report placed him above the income ceiling was properly required to repay the improperly-received benefits at the rate of $ 285.30 monthly. The agency was not bound by the typographical error made in a letter to the recipient ordering him to repay those benefits at the rate of $ 28.53. The recipient offered no credible basis for relief from his repayment obligation. *R.G. v. Sussex Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 01952-17, 2017 N.J. AGEN LEXIS 247*, Initial Decision (May 2, 2017).

Agency acted properly in adjusting the amount of income available for the purpose of determining a recipient's Medicaid eligibility based on the agency's discovery that the recipient was the beneficiary of a trust and was receiving monthly income distributions in the approximate amount of $ 350. The agency was not foreclosed from taking such action by the fact that the trust income was reflected on tax returns and bank statements because it was not disclosed on the Medical application. *Gr.B. v. Warren Cnty. Bd. of Soc. Servs., OAL DKT. NO. HMA 09157-15, 2015 N.J. AGEN LEXIS 515*, Initial Decision (August 14, 2015).

N.J.A.C. 10:49-14.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 14. RECOVERY OF PAYMENTS AND SANCTIONS

§ 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.

History

HISTORY:

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)*.

Annotations

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Because *N.J.A.C. 10:51-2.7* does not indicate that the cost of restocking and redispensing returned medications is included in the Medicaid capitation payment, pharmacy that credited only 50% of the cost of returned and recycled drugs to the Medicaid program was not violating *N.J.A.C. 10:49-14.5* by charging an administrative charge or service fee for services for which reimbursement was included as part of the Medicaid fee. *United States ex rel. Quinn v. Omnicare Inc., 382 F.3d 432, 2004 U.S. App. LEXIS 18474 (2004)*.

End of Document

N.J.A.C. 10:49-14.6

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 14. RECOVERY OF PAYMENTS AND SANCTIONS

§ 10:49-14.6 Contracts with county welfare agencies

Payment shall be made by the Department of Human Services/Division of Medical Assistance and Health Services to the CWA for conducting investigations and for determining whether applicants qualify for benefits under the New Jersey Medicaid or NJ FamilyCare program.

History

HISTORY:

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)*.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Section was "Contracts with county boards of social services". Substituted "CWA" for "county boards of social services (CBOSS)".

Annotations

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§ 10:49-14.6 Contracts with county welfare agencies

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N.J.A.C. 10:49-15.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > 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 welfare agencies (CWA), and regional legal services offices.

History

HISTORY:

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)*.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Inserted a comma following "issuances" and substituted "welfare agencies (CWA)" for "boards of social services (CBOSS)".

Annotations

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N.J.A.C. 10:49-15.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 15. AVAILABILITY AND MAINTENANCE OF PROGRAM POLICY ISSUANCES

§ 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.

History

HISTORY:

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

See: 29 New Jersey Register 2512(a), 29 New Jersey Register 3856(a).

In (b)1, substituted "beneficiary" for "recipient"; and in (b)2, substituted "Medicaid Agent" for "agency".

Annotations

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N.J.A.C. 10:49-15.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 15. AVAILABILITY AND MAINTENANCE OF PROGRAM POLICY ISSUANCES

§ 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*.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 3856(a)*.

In (a), substituted "beneficiary" for "recipient"; and in (b), substituted "Medicaid Agent" for "Division".

Annotations

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N.J.A.C. 10:49-16.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > 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.

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N.J.A.C. 10:49-16.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 16. DEMONSTRATION PROJECTS

§ 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.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 3856(a)*.

Amended "Principal", "Project", "Provider" "Recipient" and 'Services"; and deleted "Beneficiary", "Commissioner", "Department" and "Eligible beneficiaries".

Annotations

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N.J.A.C. 10:49-16.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

§ 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.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 3856(a)*.

Substituted "Medicaid Agent" for "Department".

Annotations

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N.J.A.C. 10:49-16.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

§ 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.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 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".

Annotations

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N.J.A.C. 10:49-16.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 16. DEMONSTRATION PROJECTS

§ 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.

History

HISTORY:

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

See: *29 New Jersey Register 2512(a)*, *29 New Jersey Register 3856(a)*.

Amended section name; inserted reference to Commissioner of Health and Senior Services.

Annotations

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N.J.A.C. 10:49-17

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 17. (RESERVED)

Title 10, Chapter 49, Subchapter 17. (RESERVED)

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N.J.A.C. 10:49-18.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > 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.

Annotations

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N.J.A.C. 10:49-19.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > 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*.

Annotations

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N.J.A.C. 10:49-20

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 20. (RESERVED)

Title 10, Chapter 49, Subchapter 20 Notes

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N.J.A.C. 10:49-21.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 21. THE MEDICAID/NJ FAMILYCARE MANAGED CARE PROGRAM

§ 10:49-21.1 Purpose and scope

The Medicaid/NJ FamilyCare Managed Care Program 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.

History

HISTORY:

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Inserted "/NJ FamilyCare" and deleted "--New Jersey Care 2000" following "Program".

Annotations

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N.J.A.C. 10:49-21.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 21. THE MEDICAID/NJ FAMILYCARE MANAGED CARE PROGRAM

§ 10:49-21.2 Capitation payment system

Under the Medicaid/NJ FamilyCare Managed Care Program, 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*.

History

HISTORY:

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Inserted "/NJ FamilyCare" and deleted "--New Jersey Care 2000" following "Program".

Annotations

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N.J.A.C. 10:49-21.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 21. THE MEDICAID/NJ FAMILYCARE MANAGED CARE PROGRAM

§ 10:49-21.3 Medicaid beneficiaries

(a) The Medicaid/NJ FamilyCare Managed Care Program is a mandatory enrollment program for AFDC and AFDC-related New Jersey Care pregnant women and children, Aged, Blind and Disabled (ABD) individuals without Medicare and NJ FamilyCare beneficiaries and is offered to the Medicare-Medicaid dual eligible beneficiary as an alternative to the existing Medicaid fee-for-service program.

(b) Medicaid/NJ FamilyCare 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 Health Benefits Identification (HBID) card issued to all beneficiaries. Questions about covered services should be referred to the HMO's toll-free number. Providers can also utilize the REVS/MEVS/eMEVS program to identify managed care organization eligibility and/or inquire about the HMO enrollment status.

History

HISTORY:

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In (a) and the introductory paragraph of (b), inserted "/NJ FamilyCare"; in (a), deleted "--New Jersey Care 2000" following "Program", inserted ", Aged, Blind and Disabled (ABD) individuals without Medicare and NJ FamilyCare beneficiaries" and substituted "AFDC-related" for "AFDC related" and "Medicare-Medicaid dual eligible" for "SSI Medicaid"; and rewrote (b)2.

Annotations

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N.J.A.C. 10:49-21.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 21. THE MEDICAID/NJ FAMILYCARE MANAGED CARE PROGRAM

§ 10:49-21.4 Medicaid/NJ FamilyCare Managed Care Program services

(a) The following services are provided under the Medicaid/NJ FamilyCare Managed Care Program:

1. Primary and specialist care;

2. Preventive health care and counseling;

3. Early and Periodic Screening, Diagnostic and Treatment (EPSDT);

4. Audiology Services;

5. Organ transplants, donor and recipient costs;

6. Inpatient and outpatient hospital services;

7. Emergency medical care;

8. Laboratory and radiology services;

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

10. Family planning services

11. Podiatrist services;

12. Chiropractor services;

13. Optometrist services;

14. Optical and hearing appliances;

15. Home health agency services;

16. Medical supplies and durable medical equipment;

17. Dental services;

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

19. Prosthetic and orthotic services;

20. Hospice services; and

21. 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. Outpatient rehabilitation services; these services for NJ FamilyCare Plan B and C beneficiaries are limited to 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, suboxone and subutex maintenance and their administration;

12. Mental health services (except that these services are covered by the HMO for DDD clients);

13. Partial care and partial hospitalization services;

14. Sex abuse examinations;

15. Home health agency services for the Aged, Blind and Disabled (ABD) population; and

16. Prescription drugs for the ABD population and dual-eligible beneficiaries eligible for Medicaid and Medicare.

(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 Medical Assistance Customer Center (MACC) or the Medicaid/NJ FamilyCare 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, suboxone, subutex for treatment of substance abuse and atypical antipsychotics (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/NJ FamilyCare 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.

History

HISTORY:

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Section was "Medicaid Managed Care Program--New Jersey Care 2000 Services". In the introductory paragraph of (a), inserted "/NJ FamilyCare" and deleted "--New Jersey Care 2000" following "Program"; in (a)1, deleted "(Preventive health care and counseling, EPSDT)" from the end; added new (a)2 through (a)5; recodified former (a)2 through (a)15 as new (a)6 through (a)19; deleted former (a)16; recodified former (a)17 and (a)18 as (a)20 and (a)21; in the introductory paragraph of (b), substituted a colon for a period at the end; rewrote (b)7; (b)11 and (b)12; added (b)13 through (b)16; in (c), substituted "Medical Assistance Customer Center (MACC)" for "Medicaid District Office" and "the Medicaid/NJ FamilyCare" for "Medicaid's"; and in (f), inserted ", suboxone, subutex for treatment of substance abuse and atypical antipsychotics" and "/NJ FamilyCare".

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N.J.A.C. 10:49-22.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > 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.

History

HISTORY:

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)*.

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Though an applicant who had been receiving services under the Community Choice Waiver Program demonstrated that she needed assistance in assuring adequate access to proper supplies and maintenance of a prosthesis made necessary by vocal cord carcinoma, nothing indicated that she suffered from cognitive impairment or that she was unable to perform any ADLs. Since such findings were inconsistent with participation in the program, her claim that she was entitled to remain in the program was properly denied. *E.C. v. Somerset Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 00466-16, 2016 N.J. AGEN LEXIS 700*, Initial Decision (August 1, 2016).

An Administrative Law Judge concluded that even though an elderly woman's application for Medicaid's Global Options Assisted Living Waiver Program was not processed in accordance with the requirements in *N.J.A.C. 10:71-2.2* and *N.J.A.C. 10:71-2.3(c)*, the fact was that the applicant was not financially eligible for participation in the program. That is, the processing agencies' failure to comply with those requirements, including the 45-day processing requirement, did not provide a basis for an award of benefits to an otherwise ineligible applicant as such a retroactive award would be in contravention of *N.J.A.C. 10:49-22.1(b)*. *A.H. v. Div. of Med. Assistance & Health Servs. and Morris Cnty. Bd. of Soc. Servs., OAL Dkt. No. HMA 00531-13, 2014 N.J. AGEN LEXIS 91*, Initial Decision (January 27, 2014).

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).

N.J.A.C. 10:49-22.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

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§ 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. Community Resources for Persons with Disability (CRPD);

3. AIDS Community Care Alternatives Program (ACCAP);

4. Traumatic Brain Injury Program;

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

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

History

HISTORY:

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.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Rewrote (a)2; in (a)5, inserted "and" at the end; deleted former (a)6, and recodified (a)7 as new (a)6.

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N.J.A.C. 10:49-22.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

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§ 10:49-22.3 Administration of waivered programs

(a) The Division of Medical Assistance and Health Services provides oversight to the following Home and Community-Based Services Waivers, which are administered by the Division of Disability Services (DDS): Community Resources for Persons with Disability (CRPD); 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 Department of Health and Senior Services, which administers the Community Care program for the Elderly and Disabled (CCPED) waiver, and the Assisted Living/Alternate Family Care (AL/AFC) waiver.

History

HISTORY:

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).

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Rewrote (a); deleted former (c); recodified (d) as new (c); and in (c), inserted "Division provides oversight to the" and ", which".

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N.J.A.C. 10:49-22.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

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

(a) Any questions regarding the Community Resources for Persons with Disability (CRPD), AIDS Community Care Alternatives Program (ACCAP) or Traumatic Brain Injury (TBI) Program waivers may be directed to the Division of Disability Services, by calling 1-888-285-3036 or 1-609-292-1210 (TTY system for the deaf) or by accessing its website: *http://www.state.nj.us/humanservices/dds/*.

(b) Any questions regarding the Community Care Program for the Elderly and Disabled (CCPED) or Assisted Living/Alternative FamilyCare (AL/AFC) waivers may be directed to DHSS, Division of Consumer Support Services, by calling (609) 588-2611 or by accessing its website: *http://www.state.nj.us/health/*.

(c) Any questions regarding the Home and Community-Based Services Waiver Program for Developmentally Disabled Individuals may be directed to the Division of Developmental Disabilities by calling 1-800-832-9173 or by accessing its website: *http://www.state.nj.us/humanservices/ddd/*.

History

HISTORY:

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).

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Rewrote (a) and (b); and added (c).

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N.J.A.C. 10:49-22.5

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§ 10:49-22.5 (Reserved)

History

HISTORY:

Repealed by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Section was "Community Care Program for the Elderly and Disabled (CCPED)".

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N.J.A.C. 10:49-22.6

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§ 10:49-22.6 (Reserved)

History

HISTORY:

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".

Repealed by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Section was "Medicaid's Model Waivers--I, II, and III".

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N.J.A.C. 10:49-22.7

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§ 10:49-22.7 (Reserved)

History

HISTORY:

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".

Repealed by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Section was "AIDS Community Care Alternatives Program (ACCAP)".

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N.J.A.C. 10:49-22.8

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§ 10:49-22.8 (Reserved)

History

HISTORY:

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)*.

Repealed by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Section was "Traumatic Brain Injury Program".

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N.J.A.C. 10:49-23.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > 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.

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N.J.A.C. 10:49-23.2

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 23. LIFELINE PROGRAMS

§ 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.

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N.J.A.C. 10:49-24.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > 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. 10:90-13.3, each municipal welfare department (MWD) or county welfare agency (CWA) provides an HBID card or HBID Emergency Services letter for each client, which is used to obtain medical services.

(c) Providers may contact the local MWD/CWA 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.

History

HISTORY:

Amended by R.2008 d.230, effective August 4, 2008.

See: 40 N.J.R. 984(a), 40 N.J.R. 4531(a).

Rewrote (b); and in (c), substituted "CWA" for "CBOSS".

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N.J.A.C. 10:49-24.2

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 24. WORK FIRST NEW JERSEY/GENERAL ASSISTANCE CLAIMS PROCESSING

§ 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*.

History

HISTORY:

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

See: *34 New Jersey Register 2650(a)*, *35 New Jersey Register 1118(a)*.

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N.J.A.C. 10:49-24.3

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§ 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 shall be processed under the WFNJ/GA program:

(1) Routine home care rate;

(2) Continuous home care rate; and

(3) Drugs and biologicals co-payment (rendered in places other than long-term care facilities).

ii. The following hospice services shall not be processed under the WFNJ/GA program:

(1) Inpatient respite care rate;

(2) General inpatient care;

(3) Therapeutic leave days;

(4) Bed hold days;

(5) Hospice Respite Care; and

(6) 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 GuildHospital 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).

History

HISTORY:

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.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In the introductory paragraph of (a)16, substituted a period for a semicolon at the end; in the introductory paragraphs of (a)16i and (a)16ii, deleted ", with corresponding HCPCS,"; in (a)16i(1) through (a)16i(3) and (a)16ii(1) through (a)16ii(6), deleted the HCPCS code from the beginning; and in (a)16i(3), substituted "long-term" for "long term".

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N.J.A.C. 10:49-24.4

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§ 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 welfare agency.

History

HISTORY:

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

In (a)18, substituted "welfare agency" for "board of social services".

Annotations

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Chapter Notes

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N.J.A.C. 10:49-24.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL > SUBCHAPTER 24. WORK FIRST NEW JERSEY/GENERAL ASSISTANCE CLAIMS PROCESSING

§ 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.)

According to the Paperwork Reduction Act of 1995, no persons are required to repsond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0086. Ths 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.

Annotations

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Chapter Notes

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N.J.A.C. 10:49, Appx.

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 5, March 4, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 49. ADMINISTRATION MANUAL

APPENDIX

Health Benefits Identification (HBID) Card	Form #1
HBID Emergency Services Letter	Form #1A
Medically Needy Claim Transmittal (FD-311)	Form #2
Public Assistance Inquiry (PA-1C)	Form #3
One Page NJ FamilyCare Presumptive Eligibility Application	Form #4
One-Page NJ FamilyCare Application	Form #5
Retroactive Eligibility Application	Form #6
Validation of Eligibility (FD-34)	Form #7
Provider Application (FD-20)	Form #8
One Time Enrollment Application (FD-20A)	Form #8A
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 All Applicants and Providers	Form #12
Medical Assistance Customer Centers Directory	Form #13
New Jersey County Welfare Agencies	Form #14

APPENDIX

HEALTH BENEFITS IDENTIFICATION (HBID) CARD

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Form #1

APPENDIX

State of New Jersey

DEPARTMENT OF HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

JON S. CORZINE
Governor

P.O. Box 712
Trenton, NJ 08625-0712
Telephone 1-800-356-1561

JENNIFER VELEZ
Commissioner

JOHN R. GUHL
Director

HEALTH BENEFITS IDENTIFICATION CARD

Emergency Services Letter

Dear Provider:

The following NJ FamilyCare/Medicaid client has been approved to receive a Health Benefits Identification (HBID) card in the mail. In the meantime, please accept this letter in place of the client's HBID card. This letter is not proof of eligibility. Please use the Medicaid ID for the client, as stated below, in order to determine eligibility for this client using any one of the available eligibility verification systems. In the event the client is newly eligible and there is no record of the client when using the eligibility verification system, this letter serves as proof of eligibility.

History

HISTORY:

APPENDIX

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 158.

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

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

Amended by R.2006 d.25, effective January 17, 2006.

See: *37 N.J.R. 3176(a)*, *38 N.J.R. 802(a)*.

In Form 10, replaced (HCFA-1513) forms with (CMS-1513) forms.

Amended by R.2008 d.230, effective August 4, 2008.

See: *40 N.J.R. 984(a)*, *40 N.J.R. 4531(a)*.

Updated the list of forms at the beginning of the appendix; repealed former Forms 1, 4, 5, 6, 8, 9 and 14 and adopted each as new rules; adopted Forms 1A, 8A and 13 as new rules; amended Form #3 to relocate the designation "Form #3" to the final page; amended Form #10 to include the designation "Form #10" on the final page; and repealed Form 15.

Annotations

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Chapter Notes

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