Volume 7 No. 7 **January 1997**

TO: All Providers

SUBJECT: Medicaid Responsibility for the Processing of Medical Services Claims and Payment For Services Rendered to Beneficiaries of the General Assistance Program

EFFECTIVE: February 1, 1997

BACKGROUND: The Division of Family Development (DFD) and the Division of Medical Assistance and Health Services (DMAHS) have jointly developed a project which will effect the processing and payment of medical service claims for the General Assistance (GA) program through the Medicaid fiscal agent, UNISYS.

The automated GA medical claims process will be established in accordance with the process already in place for the Medicaid program through the fiscal agent. For a GA covered service, the provider will forward the bill directly to the fiscal agent. The fiscal agent will process the GA medical claim and initiate payment directly to the provider at the Medicaid rate for the service rendered.

All providers of services must meet Medicaid requirements and be enrolled as a Medicaid provider. Requirements regarding enrollment and provision of Medicaid service policies are codified in the New Jersey Administrative Code (N.J.A.C.) 10:49 - Administration, i.e. chapter 49 of your provider manual.

Most administrative requirements of the Medicaid program are equally applicable to General Assistance claims. These include the requirements contained in N.J.A.C. 10:49, including but 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 (Provider's Role in a Shared Health Care Facility); N.J.A.C. 10:49-5.4 (Services not covered by Medicaid Program); N.J.A.C. 10:49-6 (Authorizations Required by the Medicaid Program); 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 program, Suspension, Debarment, and Disqualification); N.J.A.C. 10:49-12 (Provider Reinstatement); N.J.A.C. 10:49-13 (Program Controls); and N.J.A.C. 10:49-14.5(a)1 (Administrative charges/service fees).

IMPORTANT: 1- There are no provisions made for fair hearings for GA claims through Medicaid. Any such request must be initiated by the applicant through the Local Municipal Welfare Department (MWD) as per N.J.A.C. 10:85-7.

2- There is no good faith process for GA claims.

ACTION: For claims with service dates on or after February 1, 1997, the State's fiscal agent shall initiate the processing of all GA claims for medical services covered by the General Assistance program. In addition, direct reimbursement to providers of these services shall be based on Medicaid reimbursement methodologies effective on the claim service date. Medical services covered by the GA program are limited to the following:

1. Case management services for the chronically mentally ill;

2. Certified nurse practitioner/clinical nurse specialist services;

3. Chiropractic services;

4. Clinic services (services in an independent outpatient health care facility, other than a hospital, that provides services such as Mental Health, Family Planning, Dental, Optometric, Ambulatory Surgery, etc.);

i. Exception: Professional services provided by a residential alcohol or drug abuse treatment facility, to an individual who is residing in the facility. This exception does not apply if outpatient professional services are provided to an individual who is not residing in the facility.

5. Dental services, including dentures;

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. Exception: 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.

7. Hearing aid services;

8. Home care services, including home health care and personal care assistance services;

9. Hospice services, except those provided in a nursing home facility;

10. Laboratory (clinical) services;

11. Medical supplies and equipment;

12. Mental health services;

13. Non-maternity nurse-midwifery services, such as family planning;

14. Optometric services;

15. Optical appliances;

16. Pharmaceutical services;

i. These services are currently being processed by the DMAHS fiscal agent. However, for services rendered effective on or after February 1, 1997, all policies and coverage limitations related to Medicaid pharmaceutical services shall apply equally to services provided to General Assistance beneficiaries;

ii. For certain high-cost drugs and related products, GA requires special prior authorization for residents of the cities of Newark and East Orange (see. DMAHS Newsletters Vol. 6 No. 9 from March 1996 and Vol. 6 No. 62 from December 1996). For prior authorization, please contact GA at 1-800-609-0102;

iii. For all other pharmacy services requiring prior authorization by Medicaid, contact the local Medicaid District Office;

iv. Pharmacy services for newly eligible GA beneficiaries should not be billed through the pharmacy Point of Sale (POS) system until the pharmacy verifies eligibility through the MEVS or REVS system.

17. Physician services;

18. Podiatric services;

19. Prosthetic and orthotic devices;

20. Psychological services;

21. Radiological services;

22. Rehabilitative services (Payments are made to eligible Medicaid providers only. No payment is made to independently practicing therapists);

i. Physical therapy;

ii. Occupational therapy;

iii. Speech-language pathology services; and

iv. Audiology services.

23. Transportation services which include ambulance, invalid coach, and other transportation provided by an independent clinic;

24. Medicare coinsurance and/or deductible for the above- mentioned services, if otherwise reimbursed by the New Jersey Medicaid program; and

25. Inpatient services only if provided by Mt. Carmel Guild Hospital located in Newark, New Jersey.

It is also important to note that, as a minimum, GA-covered medical services shall be subject to all the Prior Authorization (PA) requirements of the New Jersey Medicaid program, when appropriate. Information regarding these requirements, as well as Medicaid reimbursement methodologies, are described in the appropriate section of the Administrative Code.

For services provided on and after February 1, 1997 and prior approved by the municipality, please send a copy of the appropriate Medicaid PA form issued by the Municipal Welfare Department to the local Medicaid District Office or central office consultant, (eg. dental, vision care, etc.). Failure to comply with this requirement may result in claim denial.

PLEASE NOTE: Each Municipal Welfare Department (MWD) provides a monthly validation card or letter for each beneficiary which is utilized to obtain medical services. The validation card or letter is supplied to each GA beneficiary at the time of opening or reopening of the case and monthly thereafter to ensure validity through all periods of assistance and eligibility. Each card or letter contains at a minimum:

1. The name, address and phone number of the MWD and the four-digit municipality code of the agency;

i. The four-digit codes range from 5001 to 5786;

(1) The digits ranging from 5100 through 5199 are not used as municipal codes;

2. First and last name(s) of the client(s) for whom the card or letter applies;

3. A six-digit case number of the beneficiary;

    i. If the case number is less than six digits, the MWD will add zeros (example: 000411);

4. A two-digit person number;

5. The effective date and expiration date;

    i. Validation cards or letters should not be valid for more than one month, whereupon they need to be renewed.

Providers may contact the local MWD that assists the GA beneficiary if there are questions regarding GA policies, coverage of services or eligibility. Only questions related to claim processing should be directed to the fiscal agent.

Providers are to be aware that newly assigned GA cases will take several days to appear in the Medicaid Eligibility Verification System (MEVS) or in the Unisys Recipient Eligibility Verification System (REVS) when eligibility verification is needed.

If there are any questions concerning this Newsletter, please call the New Jersey Medicaid program's Medicaid District Office in your area.

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