NEW JERSEY MEDICAID, NJ FAMILYCARE PROGRAMS AND NJ MEDICAID LONG TERM SUPPORT SERVICES CONTRACT REQUIREMENTS APPENDIX

DOWNSTREAM PROVIDER/SUBCONTRACTOR

THIS NEW JERSEY MEDICAID, NJ FAMILYCARE and NJ MEDICAID LONG TERM SUPPORT SERVICES PROGRAMS CONTRACT REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between UnitedHealthcare Insurance Company or one of its Affiliates and the Provider/Subcontractor named in the Agreement.

SECTION 1
APPLICABILITY

The requirements of this Appendix apply to benefit plans sponsored, issued or administered by UnitedHealthcare Community Plan of New Jersey (referred to in this Appendix as "United") under the State of New Jersey Medicaid, NJ FamilyCare, NJ Medicaid Long Term Support Services and Dual Eligible Special Needs Plan (D-SNP) programs (each a "State Program" and collectively, the "State Programs") as governed by the State's designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event United is required to amend or supplement this Appendix as required or requested by the State, Provider/Subcontractor agrees that United shall be permitted to unilaterally initiate such additions, deletions or modifications.

SECTION 2
PROVIDER AND SUBCONTRACTORS WARRANTIES

The provider/subcontractor agrees to serve enrollees in New Jersey's managed care program and, in doing so, to comply with all of the following provisions:

A. SUBJECTION OF PROVIDER CONTRACT/SUBCONTRACT

This provider contract/subcontract shall be subject to the applicable material terms and conditions of the contract between the Contractor and the State and shall also be governed by and construed in accordance with all laws, regulations and contractual obligations incumbent upon the Contractor.

MLTSS Any Willing Provider and Any Willing Plan. Any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services (CRS) provider that serves residents with traumatic brain injury, or long term care pharmacy that applies to become a network provider and complies with the Contractor's provider network requirements shall be included in the Contractor's provider network to serve MLTSS Members. In addition, if the Contractor wishes to have any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services provider (CRS) join its network, those providers will be instructed to complete the application form. This is known as Any Willing Plan. The Contractor must accept all NFs, SCNFs, ALs and CRSs that serve residents with traumatic brain injury, and long term care

pharmacies which are Medicaid Providers, and network participation of these provider types cannot be denied based on the application of a subjective standard.

1. MLTSS Any Willing Provider status for NF, SCNF, AL and CRS will be from the date that the service comes into MLTSS, and continue through the end of State Fiscal Year 2026, dependent upon available appropriations and except as defined by the Commissioner and upon appropriate notice of the Contractor. For NF, SCNF, AL and CRS that would mean that Any Willing Provider status expires on June 30, 2026 except as defined by the Commissioner and upon appropriate notice of the Contractor. Thereafter the Contractor may determine the continuing provider network status of these provider types based on Member utilization and access needs. The rates for NF, SCNF, AL and CRS during the Any Willing Provider period will be the higher of: (a) the rate set by the State with the possibility of an increase each fiscal year for inflation, dependent upon available appropriation and (b) the negotiated rate between the Contractor and the facility. This does not preclude volume-based rate negotiations and agreement between the Contractor and these providers.

2. The Any Willing Plan status also expires June 30, 2026.

3. Long term care pharmacy status as an Any Willing Provider shall not expire. The Contractor shall pay long term care pharmacies the rate negotiated between the Contractor and the pharmacy.

4. Claims payment for services to MLTSS Members. The Contractor shall process (pay or deny) claims for assisted living providers, nursing facilities, special care nursing facility, CRS providers, adult/pediatric medical day care providers, PCA and self-directed Vendor Fiscal/Employer Agent Financial Management Services (VF/EA FMS) claims within the following timeframes:

    1. HIPAA compliant electronically submitted clean claims shall be processed within fifteen (15) calendar days of receipt;

    2. Manually submitted clean claims shall be processed within thirty (30) calendar days of receipt.

5. Nursing Facility Quality Incentive Payment Program (NF QIPP)

    The NF QIPP leverages quality outcome performance rate add-ons to state set Medicaid NF rate payments and is dependent on budget appropriations.

    The NF QIPP uses selected quality measures that includes Minimum Data Set (MDS) measures that are collected by CMS as part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. DHS utilizes standard quarters that are both finalized (no further revisions by CMS) and publicly available. One annual resident and family satisfaction survey measure collected by NJ is also utilized. The CoreQ Long Stay Satisfaction Survey is the tool utilized to determine an overall composite satisfaction score.

B. COMPLIANCE WITH FEDERAL AND STATE LAWS AND REGULATIONS

The provider/subcontractor agrees that it shall carry out its obligations as herein provided in a manner prescribed under applicable federal and State laws, regulations, codes, and guidelines including New Jersey licensing board regulations, the Medicaid, NJ KidCare, and NJ FamilyCare State Plans, and in accordance with procedures and requirements as may from time to time be promulgated by the United States Department of Health and Human Services.

1. The Provider/Subcontractor shall submit claims within 180 calendar days from the date of service.

2. The Provider/Subcontractor shall submit corrected claims within 365 days from the date of service.

3. The Provider and Subcontractor shall submit Coordination of Benefits (COB) claims within 60 days from the date of primary insurer's Explanation of Benefits (EOB) or 180 days from the dates of service, whichever is later.

4. Electronic Visit Verification (EVV)

    a. The Contractor shall develop or purchase and implement an electronic visit verification system to monitor member receipt and utilization of personal care services including at a minimum, personal care assistance, home based supportive care and in-home respite. This includes all applicable self-directed personal care services.

    b. The Contractor shall oversee its selected EVV vendor to ensure the EVV system operates in compliance with this Contract, with policies and protocols established by DMAHS, and with the requirements of the 21st Century Cures Act.

    The 21st Century Cures Act requires electronic (not manual) verification of the type of service performed, the individual receiving the service, the date of the service, location of service delivery, the individual providing the service, and time the service begins and ends. The Contractor shall notify DMAHS within five (5) business days of the identification of any issue affecting EVV system operation which impacts the Contractor's performance of this Contract, including actions that will be taken by the Contractor to resolve the issue and the specific timeframes within which such actions shall be completed.

    c. At a minimum, recredentialing of providers shall include verification of continued licensure and/or certification (as applicable); compliance with policies and procedures identified during credentialing, including background checks and training requirements, use of the EVV; and compliance with the HCBS Settings Rule detailed in 42 C.F.R. § 441.301(c)(4)-(5).

    d. The Contractor shall monitor all manual confirmations and take action to eliminate manual confirmations to ensure compliance with 21st Century Cures Act EVV system requirements and DMAHS EVV Compliance requirements.

i. The Contractor shall utilize an exceptions process as specified by DMAHS for visits recorded manually and outside the EVV system.
ii. Contractor shall pay claims for visits recorded in an EVV system which comply with guidelines for manual exceptions.
iii. Contractor must submit a quarterly compliance report for all services that require EVV. The report will identify all contracted Provider delivering services that require EVV and must follow DMAHS EVV Manual Compliance Guidelines.
iv. Contractor must submit a quarterly report for all Providers identifying the percentage of EVV Records matching services that were approved/authorized. DMAHS will provide the report template.

e. Contractor shall generate reports and conduct audits according to DMAHS specification to ensure members are receiving necessary services. The Contractor shall take appropriate remedial action against providers and workers who do not meet the minimum compliance requirements for manual edits. United must develop a corrective action process for Providers that repeatedly fail to use the EVV system as required.

f. Contractor shall select its own electronic visit verification vendor, as applicable, and shall ensure, the vendor in the development of its EVV system, has the following minimal functionality:

i. The ability to effectively connect with the state procured contracted EVV aggregator;

ii. The ability to receive and store service authorizations for individual members;

iii. The ability to log the arrival and departure of an individual provider staff person or worker, through the use of a mobile device, member landline telephone or a static GPS device, when mobile and landline service is not available;

iv. Contractor shall maintain records of unique staff identifier to allow for auditing and reporting for program integrity;

v. The ability to verify in accordance with business rules that services are being delivered in the correct location (e.g., the member's home);

vi. The ability to match services provided to a member with services authorized in the plan of care;

vii. The ability to ensure that the provider/worker delivering the service is authorized to deliver such services;

viii. Schedule for service delivery is created from service authorization for each member and identifies frequency, scope and duration of each

service, and includes member preference and consideration for other needed services for the member;

ix. Ensure that workers are scheduled by providers in accordance with such authorization, including any schedule of services specified; and to ensure providers' adherence to the established schedule;

x. The ability to distinguish between electronic confirmation versus manual confirmation and monitor Provider compliance per state guidelines.

g. Comparing authorization and service delivery: The EVV system shall have the ability to receive and store service authorizations and service schedules as required. Schedule data must be used to compare to visit verified and billed.

i. The ability to identify gaps in care and provide system-generated reporting regarding each provider's compliance with member's plan of care scheduling requirements, late and missed visits, and other data specified by DMAHS;

ii. The ability to allow flexible scheduling options, including the option for scheduling daily, weekly, or monthly if the plan of care allows for the individual member while still performing all remaining system functions;

iii. The ability to receive and store updated authorizations and provide timely notification to the provider of the updates;

iv. Outline the process for provider to update schedules based on changes in authorization information.

v. The ability to capture data regarding six required elements to be compliant with the 21st Century Cures-EVV. Contractor shall provide reports to the individual contracted providers and the DMAHS Aggregation Vendor,

vi. Contractor will provide DMAHS ad hoc report regarding EVV data as appropriate, upon request;

h. The Contractor shall establish business processes regarding EVV and ensure efficient operation of EVV. The Contractor must ensure the following:

i. Timely as defined by 4.6.4B of this Contract.

ii. Consistency between MCO authorizations, and the authorizations reflected in the EVV system.

iii. Consistency between reported aggregated EVV data and MCO reported encounters.

iv. Timely remediation of issues associated with claims rejections or denials in order to provide appropriate claims adjudication for services delivered.

v. Ongoing monitoring of the total volume of rejected or denied claims due to issues with the EVV system.

a. In instances where systems outages, breakdowns, etc. are identified, the Contractor shall notify DMAHS and providers immediately. MCOs must incorporate system outage details in reports regarding EVV Compliance.

vi. Contractor shall collaborate with the Fiscal Intermediary for Self-Direction to determine root cause for rejections or denials.

vii. Contractor shall perform monthly program integrity audits of rendering provider credentials (certified home health aide, registered nurse, licensed practical nurse, physical therapist, cognitive therapist, occupational therapist, speech therapist) to verify services were provided by the authorized provider for such service. If it is determined that the credentials are incorrect, expired, or missing the Contractor shall adhere to A.7.2.1A and 7.36.5 et al (RECOVERIES AND OVERPAYMENTS) of the MCO contract.

viii. DMAHS shall have access to the MCO EVV solution which shall include dashboard of DMAHS required reports. DMAHS may conduct monitoring of the Contractor's performance with the requirements detailed in B.7.2 Provider Contract/Subcontract Provisions.

C. APPROVAL OF PROVIDER CONTRACTS/SUBCONTRACTS AND AMENDMENTS

The provider/subcontractor understands that the State reserves the right in its sole discretion to review and approve or disapprove this provider contract/subcontract and any amendments thereto.

1. The contractor and AWP provider shall only amend this provider contract unilaterally for statutory and regulatory changes, and upon mutual consent of the parties with State approval.

D. EFFECTIVE DATE

This provider contract/subcontract shall become effective only when the Contractor's agreement with the State takes effect.

E. NON-RENEWAL/TERMINATION OF PROVIDER CONTRACT/ SUBCONTRACT

The provider/subcontractor understands that the Contractor shall notify DMAHS at least 30 days prior to the effective date of the suspension, termination, or voluntary withdrawal of the provider/subcontractor from participation in the Contractor's network. If the termination was "for cause," as related to fraud, waste, and abuse, the Contractor's notice to DMAHS shall include the reasons for the termination. Provider resource consumption patterns shall not constitute "cause"

unless the Contractor can demonstrate it has in place a risk adjustment system that takes into account enrollee health-related differences when comparing across providers.

F. ENROLLEE-PROVIDER COMMUNICATIONS

1. The Contractor shall not prohibit or restrict the provider/subcontractor from engaging in medical communications with the provider's/subcontractor's patient, either explicit or implied, nor shall any provider manual, newsletters, directives, letters, verbal instructions, or any other form of communication prohibit medical communication between the provider/subcontractor and the provider's/subcontractor's patient. Providers/subcontractors shall be free to communicate freely with their patients about the health status of their patients, medical care or treatment options regardless of whether benefits for that care or treatment are provided under the provider contract/subcontract, if the professional is acting within the lawful scope of practice. Providers/subcontractors shall be free to practice their respective professions in providing the most appropriate treatment required by their patients and shall provide informed consent within the guidelines of the law including possible positive and negative outcomes of the various treatment modalities.

2. Nothing in section F.1 shall be construed:

    a. To prohibit the enforcement, including termination, as part of a provider contract/subcontract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by the Contractor to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider), but only if the guidelines or protocols under such utilization do not prohibit or restrict medical communications between providers/subcontractors and their patients; or

    b. To permit a health care provider to misrepresent the scope of benefits covered under this provider contract/subcontractor or to otherwise require the contractor to reimburse providers/subcontractors for benefits not covered.

G. RESTRICTION ON TERMINATION OF PROVIDER CONTRACT/ SUBCONTRACT BY CONTRACTOR

Termination of AWP providers is limited to State ordered termination as indicated in Section H below. The Contractor shall not terminate this provider contract/subcontract for either of the following reasons:

1. Because the provider/subcontractor expresses disagreement with the Contractor's decision to deny or limit benefits to a covered person or because the provider/subcontractor assists the covered person to seek reconsideration of the Contractor's decision; or because the provider/subcontractor discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the Contractor or not, policy

provisions of the Contractor, or the provider/subcontractor's personal recommendation regarding selection of a health plan based on the provider/subcontractor's personal knowledge of the health needs of such patients.

2. Because the provider/subcontractor engaged in medical communications, either explicit or implied, with a patient about medically necessary treatment options, or because the provider/subcontractor practiced its profession in providing the most appropriate treatment required by its patients and provided informed consent within the guidelines of the law, including possible positive and negative outcomes of the various treatment modalities.

H. TERMINATION OF PROVIDER CONTRACT/SUBCONTRACT – STATE

The provider/subcontractor understands and agrees that the State may order the termination of this provider contract/subcontract if it is determined that the provider/subcontractor:

1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any enrollee, including significant marketing abuses;

2. Takes any action that threatens the fiscal integrity of the Medicaid program;

3. Has its certification suspended or revoked by DOBI, DOH, and/or any federal agency or is federally debarred or excluded from federal procurement and non-procurement contracts;

4. Becomes insolvent or falls below minimum net worth requirements;

5. Brings a proceeding voluntarily or has a proceeding brought against it involuntarily, under the Bankruptcy Act;

6. Materially breaches the provider contract/subcontract; or

7. Violates state or federal law, including laws involving fraud, waste, and abuse.

I. NON-DISCRIMINATION

The provider/subcontractor shall comply with the following requirements regarding nondiscrimination:

1. The provider/subcontractor shall accept assignment of an enrollee and not discriminate against eligible enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, gender identity, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 USC Section 794, the Americans with Disabilities Act of 1990 (ADA), 42 USC Section 12132, and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

2. ADA Compliance. The provider/subcontractor shall comply with the requirements of the Americans with Disabilities Act (ADA). In providing health care benefits, the provider/subcontractor shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid/NJ FamilyCare beneficiaries who are

"qualified individuals with a disability" covered by the provisions of the ADA. The Contractor shall supply a copy of its ADA compliance plan to the provider/subcontractor.

A "qualified individual with a disability" as defined pursuant to 42 U.S.C.§12131 is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

The provider/subcontractor shall submit to United a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the law, and certifies that the provider/subcontractor meets ADA requirements to the best of the provider/subcontractor's knowledge. The provider/subcontractor warrants that it will hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of the provider/subcontractor to be in compliance with the ADA. Where applicable, the provider/subcontractor must abide by the provisions of section 504 of the federal Rehabilitation Act of 1973, as amended, regarding access to programs and facilities by people with disabilities.

3. The provider/subcontractor shall not discriminate against eligible persons or enrollees on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the provider/subcontractor on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

4. The provider/subcontractor shall comply with the Civil Rights Act of 1964 (42 USC 2000d), the regulations (45 CFR Parts 80 & 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, the New Jersey anti-discrimination laws including those contained within N.J.S.A. 10: 2-1 through N.J.S.A. 10: 2-4, N.J.S.A. 10: 5-1 et seq. and N.J.S.A. 10: 5-38, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry. The provider/subcontractor shall not discriminate against any employee engaged in the work required to produce the services covered by this provider/subcontractor contract, or against any applicant for such employment because of race, creed, color, national origin, age, ancestry, sex, marital status, religion, disability or sexual or affectional orientation or preference.

5. Scope. This non-discrimination provision shall apply to but not be limited to the following: recruitment, hiring, employment upgrading, demotion, transfer, lay-off or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship included in PL 1975, Chapter 127.

6. Grievances. The provider/subcontractor agrees to forward to United copies of all grievances alleging discrimination against enrollees because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental handicap for review and appropriate action within three (3) business days of receipt by the provider/subcontractor.

J. OBLIGATION TO PROVIDE SERVICES AFTER THE PERIOD OF THE CONTRACTOR'S INSOLVENCY AND TO HOLD ENROLLEES AND FORMER ENROLLEES HARMLESS

1. The provider/subcontractor shall remain obligated to provide all services for the duration of the period after the Contractor's insolvency, should insolvency occur, for which capitation payments have been made and, for any hospitalized enrollee, until the enrollee has been discharged from the inpatient facility.

2. The provider/subcontractor agrees that under no circumstances, (including, but not limited to, nonpayment by the Contractor or the state, insolvency of the Contractor, or breach of agreement) will the provider/subcontractor bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against, enrollees, or persons acting on their behalf, for covered services other than provided in section 2.P.

3. The provider/subcontractor agrees that this provision shall survive the termination of this provider contract/subcontract regardless of the reason for termination, including insolvency of the Contractor, and shall be construed to be for the benefit of the Contractor or enrollees.

4. The provider/subcontractor agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the provider/subcontractor and enrollees, or persons acting on their behalf, insofar as such contrary agreement relates to liability for payment for or continuation of covered services provided under the terms and conditions of this continuation of benefits provisions.

5. The provider/subcontractor agrees that any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the approval by the State.

6. The provider/subcontractor shall comply with the prohibition against billing Members contained in 42 CFR 438.106, N.J.S.A. 30:4D-6.c, and N.J.A.C. 10:74-8.7.

K. INSPECTION

The State, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any record or document of the MCO or its subcontractors, and may, at any time inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. The DMAHS, the MFD, or its designee, and the MFCU, shall have the right to inspect, evaluate, and audit all of the following documents in whatever form they are kept, including but not limited to, all physical and computer or other electronic records and systems, originated or prepared pursuant to, or related to this contract:

1. Financial records, including but not limited to tax returns, invoices, inventories, delivery receipts, Medicaid claims;

2. Medical records, including but not limited to medical charts, prescriptions, x-rays, treatment plans, medical administration records, records of the provision of activities of daily living, ambulance call reports;

3. Administrative documents, including but not limited to credentialing files, appointment books, prescription logbooks, correspondence of any kind with Contractor, DMAHS, CMS, any other managed care Contractor, Medicaid recipient, contracts with subcontractors, and contracts with billing service providers; and

4. All records required to be kept to fully disclose the extent of services provided to Medicaid recipients, pursuant to NJAC 10:49-9.8(b) (1).

L. RECORD MAINTENANCE

The provider/subcontractor shall agree to maintain all of its books and records in accordance with the general standards applicable to such book or record keeping.

M. RECORD RETENTION AND PROVIDER/SUBCONTRACTOR DOCUMENTATION REQUIREMENTS

Provider/Subcontractor Documentation Requirements - The provider/subcontractor shall, at a minimum, maintain such records as are necessary to fully disclose the nature and extent of services provided, in accordance with N.J.S.A. 30:4D-12(d) and N.J.A.C. 10:49-9.8. The provider/subcontractor shall also comply with the documentation requirements set forth in this Section M, as applicable. To the extent that the Contractor has imposed more stringent requirements than those imposed by law, regulation or this Section M, the more stringent requirements shall prevail. The provisions of N.J.S.A 30:4D-12(e) and N.J.A.C. 10:49-5.5(a)13.i. through iv. may apply to these documentation requirements.

Record Retention Requirements - Records must be retained for the later of ten (10) years from the date of service or after the final payment is made under the provider contract/subcontract and all pending matters are closed.

If an audit, investigation, litigation, or other action involving the records is started before the end of the retention period, the records shall be retained until all issues arising out of the action are resolved or until the end of the retention period, whichever is later. Records shall be made accessible at a New Jersey site and on request to agencies of the State of New Jersey and the federal government. For enrollees who are eligible through the Division of Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with need to protect the enrollee's confidentiality.

If an enrollee disenrolls from the Contractor, the Provider/subcontractor shall release medical records of the enrollee as may be directed by the enrollee, authorized representatives of the Department and appropriate agencies of the State of New Jersey and of the federal government. Release of records shall be consistent with the provision of confidentiality expressed in Section 2.R., Confidentiality, and at no cost to the enrollee.

Compliance with Specific Requirements – Providers/subcontractors must comply with the following requirements:

1. Medical supplies and DME:

    a. Medical supplies and equipment require a legible, dated prescription or a dated Certificate of Medical Necessity (CMN) personally or electronically signed by the prescribing practitioner. Either document shall contain the following information:

        i. The beneficiary's name, address, gender and Medicaid/NJ FamilyCare eligibility identification number;

        ii. A detailed description of the specific supplies and/or equipment prescribed;

            1) For example, the phrase "wheelchair" or "patient needs wheelchair" is insufficient. The order shall describe the type and style of the wheelchair;

        iii. The length of time the medical equipment items or supplies are required;

        iv. A diagnosis and summary of the patient's physical condition to support the need for the item(s) prescribed; and

        v. The prescriber’s printed name, address and signature.

2. Orders for laboratory tests:

    a. All orders for clinical laboratory services shall be in the form of an explicit order personally signed by the physician or other practitioner whose license permits them to request the services, or be in an alternative form of order specifically authorized in (b) (i) through (iii) below. All orders shall be patient specific, contain the specific clinical laboratory test(s) requested, seek only medically necessary tests, shall be on file with the billing laboratory, and shall be available for review by Medicaid/NJ FamilyCare representatives upon request.

    b. If a signed order is not utilized, then clinical laboratory services shall be ordered in one of the following ways:

        i. In the absence of a written order, the patient's chart or medical record may be used as the test requisition or authorization, but must be physically present at the laboratory at the time of testing and available to Federal or State representatives upon request;

        ii. A test request also may be submitted to the laboratory electronically if the system used to generate and transmit the electronic order has adequate security and system safeguards to prevent and detect fraud and abuse and to protect patient confidentiality. The system shall be designed to prevent and detect unauthorized access and modification or

manipulation of records, and shall include, at a minimum, electronic encryption; or

iii. Telephoned or other oral laboratory orders are also permissible, but shall be followed up with a written or electronic request within 30 days of the telephone or other oral request, which shall be maintained on file with the clinical laboratory. If the laboratory is unable to obtain the written or electronic request, it must maintain documentation of its efforts to obtain them.

c. Standing orders shall be:

i. Patient specific, and not blanket requests from the physician or licensed practitioner;

ii. Medically necessary and related to the diagnosis of the recipient; and

iii. Effective for no longer than a 12-month period from the date of the physician's/practitioner's orders.

d. The laboratory must ensure that all orders described in (a) through (c) above contain the following information:

i. The name and address or other suitable identifiers of the authorized person requesting the test and, if appropriate, the individual responsible for using the test results, or the name and address of the laboratory submitting the specimen, including, as applicable, a contact person to enable the reporting of imminently life-threatening laboratory results or panic or alert values;

ii. The patient's name or unique patient identifier;

iii. The sex (if known) and date of birth of the patient;

iv. The specific test(s) to be performed;

v. The source of the specimen, when appropriate;

vi. The date and, if appropriate, time of specimen collection;

vii. For Pap smears, the patient's last menstrual period, and indication of whether the patient had a previous abnormal report, treatment or biopsy;

viii. For drug testing, the order shall indicate whether the test is for screening (presumptive) or confirmation (definitive) purposes and the specific drug classes to be tested as defined by the American Medical Association.

ix. Any additional information relevant and necessary for a specific test to ensure accurate and timely testing and reporting of results, including interpretation, if applicable.

e. All orders and results of the tests billed shall be on file with the billing laboratory performing the tests. The results of the tests, clinical and billing records shall be available for review by Medicaid/NJ FamilyCare representatives.

f. The Medicaid/NJ FamilyCare program shall have the right to inspect all records, files and documents of in-State and out-of-State service and reference clinical laboratories which provide laboratory tests and services for Medicaid/NJ FamilyCare beneficiaries.

g. All laboratory test orders shall be supported by documentation in the referring physician's/practitioner's medical records.

h. If the laboratory uploads, transcribes or enters test requisition or authorization information into a record system or a laboratory information system, the laboratory must ensure that the information is transcribed or entered accurately.

3. Services Provided by a Psychologist

a. Psychologists shall keep such individual records as may be necessary to disclose fully the kind and extent of services provided and shall make such information available when requested by the New Jersey Medicaid/NJ FamilyCare program or its agents. The recordkeeping shall document the services provided as they relate to the procedure code(s) used for reimbursement purposes (see N.J.A.C. 10:67-3, Healthcare Common Procedure Coding System).

b. For the initial examination, the record shall include, as a minimum, the following:

i. Date(s) of service rendered;

ii. Signature of the psychologist;

iii. Chief complaint(s);

iv. Pertinent historical, social, emotional, and additional data;

v. Reports of evaluation procedures undertaken or ordered;

vi. Diagnosis; and

vii. The intended course of treatment and tentative prognosis.

c. For subsequent progress notes made for each Medicaid/NJ FamilyCare patient contact, the following shall be included on the psychotherapeutic progress note:

i. Date(s) and duration of service (for example, hour, half-hour);

ii. Signature of the psychologist;

iii. Name(s) of modality used, such as individual, group, or family therapy;

iv. Notations of progress, impediments, or treatment complications; and

v. Other components, such as dates or information not included in (c)1 through 4 above, which may be important to the clinical description and prognosis.

vi. One or more of the following components shall be recorded to delineate the visit and establish its uniqueness. (Not all of the components need be included):

1) Symptoms and complaints;
2) Affect;
3) Behavior;
4) Focus topics; and
5) Significant incidents or historical events.

4. Mental Health Services Provided by an Independent Clinic

a. An intake evaluation shall be performed within 14 days of the first encounter or by the third clinic visit whichever is later, for each beneficiary being considered for continued treatment. This evaluation shall consist of a written assessment that:

i. Evaluates the beneficiary's mental condition;

ii. Determines whether treatment in the program is appropriate, based on the beneficiary's diagnosis;

iii. Includes certification, in the form of a signed statement, by the evaluation team, that the program is appropriate to meet the beneficiary's treatment needs; and

iv. Is made a part of the beneficiary's records.

v. The evaluation for the intake process shall include a physician or advance practice nurse (APN) and an individual experienced in the diagnosis and treatment of mental illness. Both criteria may be satisfied by the same individual, if appropriately qualified.

b. A written, individualized plan of care shall be developed for each beneficiary who receives continued treatment. The plan of care shall be designed to improve the beneficiary's condition to the point where continued participation in the program, beyond occasional maintenance visits, is no longer necessary. The plan of care shall be included in the beneficiary's records and shall consist of:

i) A written description of the treatment objectives including the treatment regimen and the specific medical/remedial services, therapies, and activities that shall be used to meet the objectives.

(1) Due to the nature of mental illness and the provision of program services, there may be instances in which a temporary deviation from the services written in the treatment plan occurs. In this event, the client may participate in alternate programming. The reason for the deviation should be clearly explained in the daily or weekly documentation. Deviations that do not resolve shall require a written change in the treatment plan;

ii.) A projected schedule for service delivery which includes the frequency and duration of each type of planned therapeutic session or encounter;

iii.) The type of personnel that will be furnishing the services; and

iv.) A projected schedule for completing the reevaluations of the beneficiary's condition and updating the plan of care.

c) The mental health clinic shall develop and maintain legibly written documentation to support each medical/remedial therapy service, activity, or session for which billing is made.

i. This documentation, at a minimum, shall consist of:

1) The specific services rendered, such as individual psychotherapy, group psychotherapy, family therapy, etc., and a description of the encounter itself. The description shall include, but is not limited to, a statement of patient progress noted, significant observations noted, etc.;
2) The date and time that services were rendered;
3) The duration of services provided;
4) The signature of the practitioner or provider who rendered the services;
5) The setting in which services were rendered; and
6) A notation of unusual occurrences or significant deviations from the treatment described in the plan of care.

d) Clinical progress, complications and treatment which affect prognosis and/or progress shall be documented in the beneficiary's medical record at least once a week, as well as any other information important to the clinical picture, therapy and prognosis.

e) The individual services under partial care shall be documented on a daily basis. More substantive documentation, including progress notes and any other information important to the clinical picture, are required at least once a week.

f) Periodic review of the beneficiary's plan of care shall take place at least every 90 days during the first year and every six months thereafter.

(l) The periodic review shall determine:

1) The beneficiary's progress toward the treatment objectives;
2) The appropriateness of the services being furnished; and
3) The need for the beneficiary's continued participation in the program.

(2) Periodic reviews shall be documented in detail in the beneficiary's records and made available upon request to the New Jersey Medicaid or NJ FamilyCare program or its agents.

5)APN Services:

a) The APN, in any and all settings, shall keep such legible individual written records and /or electronic medical records (EMR) as are necessary to fully disclose the kind and extent of service(s) provided, the procedure code being billed and the medical necessity for those services.

b) Documentation of services performed by the APN shall include, as a minimum:

i) The date of service;

ii) The name of the beneficiary;

iii) The beneficiary's chief complaint(s), reason for visit;

iv) Review of systems;

v) Physical examination;

vi) Diagnosis;

vii) A plan of care, including diagnostic testing and treatment(s);

viii) The signature of the APN rendering the service; and

ix) Other documentation appropriate to the procedure code being billed. (See N.J.A.C. 10:58A-4, HCPCS Codes.)

c) In order to receive reimbursement for an initial visit, the following documentation, at a minimum, shall be placed on the medical record by the APN, regardless of the setting where the examination was performed:

i) Chief complaint(s);

ii) A complete history of the present illness, with current medications and review of systems, including recordings of pertinent negative findings;

iii) Pertinent medical history;

iv) Pertinent family and social history;

v) A complete physical examination;

vi) Diagnosis; and

vii) Plan of care, including diagnostic testing and treatment.

d) In order to document the record for reimbursement purposes, the progress note for routine office visits or follow up care visits shall include the following:

i. In an office or residential health care facility:

1) The beneficiary's chief complaint(s), reason for visit;
2) Pertinent medical, family and social history obtained;
3) Pertinent physical findings;
4) All diagnostic tests and/or procedures ordered and/or performed, if any, with results; and
5) A diagnosis.

ii. In a hospital or nursing facility setting:

1) An update of symptoms;
2) An update of physical symptoms;
3) A resume of findings of procedures, if any done;
4) Pertinent positive and negative findings of lab, X-ray or any other test;
5) Additional planned studies, if any, and the reason for the studies; and
6) Treatment changes, if any.

e) To qualify as documentation that the service was rendered by the APN during an inpatient stay, the medical record shall contain the APN's notes indicating that the APN personally:

i) Reviewed the beneficiary's medical history with the beneficiary and/or his or her family, depending upon the medical situation;

ii) Performed a physical examination, as appropriate;

iii) Confirmed or revised the diagnosis; and

iv) Visited and examined the beneficiary on the days for which a claim for reimbursement is made.

f) The APN's involvement shall be clearly demonstrated in notes reflecting the APN's personal involvement with, or participation in, the service rendered.

g) For all EPSDT examinations for individuals under 21 years of age, the following shall be documented in the beneficiary's medical record and shall include:

i. A history (complete initial for new beneficiary, interval for established beneficiary) including past medical history, family history, social history, and systemic review.

ii. A developmental and nutritional assessment.

iii. A complete, unclothed, physical examination to also include the following:

1) Measurements: height and weight; head circumference to 25 months; blood pressure for children age three or older; and
2) Vision, dental and hearing screening;

iv. The assessment and administration of immunizations appropriate for age and need;

v. Provisions for further diagnosis, treatment and follow-up, by referral if necessary, of all correctable abnormalities uncovered or suspected;

vi. Mandatory referral to a dentist for children age twelve months or older;

vii. The laboratory procedures performed or referred if medically necessary per Bright Futures guidelines,

viii. Health education and anticipatory guidance; and

ix. An offer of social service assistance; and, if requested, referral to a county social services agency.

h) The record and documentation of a home visit or house call shall become part of the office progress notes and shall include, as appropriate, the following information:

i. The beneficiary's chief complaint(s), reason for visit;

ii. Pertinent medical, family and social history obtained;

iii. Pertinent physical findings;

iv. The procedures, if any performed, with the results;

v. Lab, X-ray, ECG, etc., ordered with results; and

vi. Diagnosis(es) plus treatment plan status relative to present or pre-existing illness(es) plus pertinent recommendations and actions.

i) Physician Services

a. Physician Recordkeeping; general

i. All physicians shall keep such legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services.

ii. The minimum recordkeeping requirements for services performed in the office, home, residential health care facility, nursing facility (NF), and the hospital setting shall include a progress note in the clinical record for each visit, which supports the procedure code(s) claimed.

iii. The progress note shall be placed in the clinical record and retained in the appropriate setting for the service performed.

iv. Records of Residential Health Care Facility patients shall be maintained in the physician's office.

v. The required medical records including progress notes, shall be made available, upon their request, to the New Jersey Medicaid/NJ FamilyCare program or its agents.

b. Minimum documentation; initial visit; new patient

i. The following minimum documentation shall be entered on the medical record, regardless of the setting where the examination is performed, for the service claimed by use of the procedure codes for Initial visit – New patient:

1) Chief complaint(s);
2) Complete history of the present illness and related systemic review, including recordings of pertinent negative findings;
3) Pertinent past medical history;
4) Pertinent family and social history;
5) A record of a full physical examination pertaining to, but not limited to, the history of the present illness and including recordings of pertinent negative findings;
6) Diagnosis(es) and the treatment plan, including ancillary services and medications ordered;
7) Laboratory, X-Rays, electrocardiograms (ECGs), and any other diagnostic tests ordered, with the results; and
8) The specific services rendered and/or modality used (for example, biopsies, injections, individual and/or group psychotherapy, and family therapy).

c. Minimum documentation; established patient

i. The following minimum documentation shall be entered in the progress notes of the medical record for the service designated by the procedure codes for ESTABLISHED PATIENT;

1) In an office or Residential Health Care Facility:

a. The purpose of the visit;
b. The pertinent physical, family and social history obtained;
c. A record of pertinent physical findings, including pertinent negative findings based upon (a) and (b) above;
d. Procedures performed, if any, with results
e. Laboratory, X-Ray, electrocardiogram (ECG), or any other diagnostic tests ordered, with the results of the tests; and
f. Prognosis and diagnosis.

d. Minimum documentation; in home visits and house calls

i. For HOME VISIT and HOUSE CALL codes, in addition to the components listed in N.J.A.C. 10:54-2.8, the office progress notes shall include treatment plan status relative to present or pre-existing illness(es), plus pertinent recommendations and actions.

e. Minimum documentation; hospital or nursing facility

i. In a hospital or nursing facility, documentation shall include:

1) An update of symptoms;
2) An update of physical findings;
3) A resume of findings of procedures, if any are applicable;
4) The pertinent positive and negative findings of laboratory, X-Ray, electrocardiograms (ECGs), or other tests or consultations;
5) Any additional planned studies, if any, including the reasons for any studies; and
6) Treatment changes, if any.

f. Minimum documentation; hospital discharge medical summary

i. When an inpatient is discharged from the hospital to the care of another medical facility (such as a nursing facility or a community home care agency), a legible discharge and medical summary shall be prepared and signed by the attending physician.

ii. The summary should cover the pertinent findings of the history, physical examination, diagnostic and therapeutic modalities, consultations, plan of care or therapy, medications, recommendations for follow-up care and final diagnosis related to the patient's hospitalization. Recommendations should also be made for further medical care and should be forwarded to the institution or agency to which the patient has been referred or discharged.

g. Minimum documentation; mental health services

i. For each patient contact made by a physician for psychiatric therapy, written documentation shall be developed and maintained to support

each medical or remedial therapy, service, activity, or session for which billing is made. The documentation, at a minimum, shall consist of the following:

1) The specific services rendered and modality used, for example, individual, group, and/or family therapy;
2) The date and the time services were rendered;
3) The duration of services provided, for example, one hour, or one-half hour;
4) The signature of the physician who rendered the service;
5) The setting in which services were rendered;
6) A notation of impediments, unusual occurrences or significant deviations from the treatment described in the Plan of Care;
7) Notations of progress, impediments, treatment, or complications; and
8) Other relevant information, which may include dates or information not included in above, yet important to the clinical picture and prognosis.

ii. Clinical progress, complications and treatment which affect prognosis and/or progress shall be documented in the patient's medical record, as well as any other information important to the clinical picture, therapy, and prognosis. For mental health services that are not specifically included in the patient's treatment regime, a detailed explanation shall be submitted with the claim form, addressed to the Office of Managed Behavioral Services, Mail Code #25, PO Box 712, Trenton, New Jersey 08625-0712, indicating how these services relate to the treatment regime and objectives in the patient's plan of care. Similarly, a detailed explanation should accompany bills for medical and remedial therapy, session or encounter that departs from the Plan of Care in terms of need, scheduling, frequency or duration of services furnished (for example, unscheduled emergency services furnished during an acute psychotic episode) explaining why this departure from the established treatment regime is necessary in order to achieve the treatment objectives.

j) Pharmaceutical services

a. Pharmacies shall keep and maintain wholesaler, manufacturer, and distributor invoices and other purchase invoices and documents for prescription drugs and medical supplies for a minimum of ten (10) years. Purchase records must indicate price, drug name, dosage form, strength, NDC, lot number and quantity. Pharmacies shall also maintain adequate records to validate purchases from wholesalers including but not limited to canceled check information. Pharmacies must promptly comply with any requests to produce such documentation to DMAHS and/or MFD.

b. Invoices and documentation required by subsection (a) must substantiate that the prescription drugs or medical supplies dispensed were purchased from an authorized source regulated by the federal/state entities and National Association of Boards of Pharmacy – Verified Accredited Wholesaler Distributors (NABP-

VAWD). Pharmacies shall provide product tracing information (i.e. pedigree) to DMAHS and/or MFD upon request.

c. Pharmacies are required to have a product in stock at the pharmacy prior to submitting a claim for the product. All claims submissions shall contain the National Drug Code (NDC) of the product dispensed. Only the NDC of the actual product dispensed shall be submitted on the claim. Use of a similar NDC of a product not dispensed is not permissible.

d. Pharmacies shall keep and maintain any compound recipe worksheets identifying ingredients used in a compounded prescription drug. Pharmacies must submit claims with all ingredients included in each compound and may only submit claims with the NDC associated with the actual ingredients filled/dispensed. Pharmacies must promptly comply with any requests to produce such electronic or paper documentation to the Medicaid/NJ FamilyCare program and/or its agents.

e. Pharmacies may transfer inventory to alleviate a temporary shortage, or for the sale, transfer, merger or consolidation of all or part of the business of a pharmacy from or with another pharmacy, whether accomplished as a purchase and sale of stock or business assets. The transfer or purchase of covered legend and non-legend products or medical supplies from another licensed pharmacy must be verified and documented as originating from a NABP-VAWD and licensed drug wholesaler. All records involved in the transfer must be maintained and accessible for ten (10) years. These records shall be contemporaneous with the transfer and shall include the name of the prescription drug or medical supply, dosage form, strength, NDC, lot number, quantity and date transferred. Additionally, records must indicate the supplier or manufacturer's name, address and registration number.

N. DATA REPORTING

The provider/subcontractor agrees to provide all necessary information to enable the Contractor to meet its reporting requirements, including specifically with respect to encounter reporting. The encounter data shall be in a form acceptable to the State.

1. For acute care general, private psychiatric, specialty and comprehensive rehabilitation hospitals, the provider/contractor shall submit inpatient claims to the Contractor based on the medical record and services provided. The inpatient claim shall include, but not be limited to the following:
   a. Diagnosis Code
   b. Procedure Code
   c. Sex
   d. Discharge Status Code
   e. Date of Birth
   f. Newborn Birth Weight
   g. Admission Date
   h. Discharge Date
   i. Skilled level of Care (SNF) or Administrative Days and associated dates
   j. Residential level of Care (denied days) and associated dates

2. The resulting Contractor generated encounter record shall be subject to review by the New Jersey Utilization Review (NJUR) Vendor.
   a. In the event that the NJUR review results in an adverse determination, the provider/subcontractor shall adjust the claim pursuant to the adverse determination or appeal the decision utilizing the NJUR appeal process.

O. DISCLOSURE

1. The provider/subcontractor further agrees to comply with the Prohibition On Use Of Federal Funds For Lobbying provisions of the Contractor's agreement with the State.

2. The provider/subcontractor shall comply with financial disclosure provision of 42 CFR 434, 1903 (m) of the S.S.A., and N.J.A.C. 10:49-19.

3. The provider/subcontractor shall comply with the disclosure requirements concerning ownership and control, related business transactions and persons convicted of a crime pursuant to 42 CFR 455.100-106 and complete a Disclosure Statement which will be maintained by the Contractor.

P. LIMITATIONS ON COLLECTION OF COST-SHARING

The provider/subcontractor shall not impose cost-sharing charges of any kind upon Medicaid or NJ FamilyCare A, B and ABP enrollees. Personal contributions to care for NJ FamilyCare C enrollees and copayments for NJ FamilyCare D enrollees shall be collected in accordance with the attached schedule.

Q. INDEMNIFICATION BY PROVIDER/SUBCONTRACTOR

1. The provider/subcontractor agrees to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents from any and all claims or losses accruing or resulting from its negligence in furnishing or supplying work, services, materials, or supplies in connection with the performance of this provider contract/subcontract.

2. The provider/subcontractor agrees to indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from liability deriving or resulting from its insolvency or inability or failure to pay or reimburse any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this provider contract/subcontract.

3. The provider/subcontractor agrees further that it will indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from any and all claims for services for which the provider/subcontractor receives payment.

4. The provider/subcontractor agrees further to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents, from all claims, damages, and liability, including costs and expenses, for violation of any proprietary rights, copyrights, or rights of privacy arising out of the publication,

translation, reproduction, delivery, performance, use, or disposition of any data furnished to it under this provider contract/subcontract, or for any libelous or otherwise unlawful matter contained in such data that the provider/subcontractor inserts.

5. The provider/subcontractor shall indemnify the State, its officers, agents and employees, and the enrollees and their eligible dependents from any injury, death, losses, damages, suits, liabilities judgments, costs and expenses and claim of negligence or willful acts or omissions of the provider/subcontractor, its officers, agents, and employees arising out of alleged violation of any State or federal law or regulation. The provider/subcontractor shall also indemnify and hold the State harmless from any claims of alleged violations of the Americans with Disabilities Act by the subcontractor/provider.

R. CONFIDENTIALITY

1. General. The provider/subcontractor hereby agrees and understands that all information, records, data, and data elements collected and maintained for the operation of the provider/subcontractor and the Contractor and Department and pertaining to enrolled persons, shall be protected from unauthorized disclosure in accordance with the provisions of 42 U.S.C. 1396(a)(7)(Section 1902(a)(7) of the Social Security Act), 42 CFR Part 431, subpart F, 45 CFR Parts 160 and 164, subparts A & E, N.J.S.A. 30:4D-7 (g) and N.J.A.C. 10:49-9.4. Access to such information, records, data and data elements shall be physically secured and safeguarded and shall be limited to those who perform their duties in accordance with provisions of this provider contract/subcontract including the Department of Health and Human Services and to such others as may be authorized by DMAHS in accordance with applicable law. For enrollees covered by the Contractor's plan that are eligible through the Division of Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with the need to protect the enrollee's confidentiality.

2. Enrollee-Specific Information. With respect to any identifiable information concerning an enrollee that is obtained by the provider/subcontractor, it: (a) shall not use any such information for any purpose other than carrying out the express terms of this provider contract/subcontract; (b) shall promptly transmit to the Department all requests for disclosure of such information; (c) shall not disclose except as otherwise specifically permitted by the provider contract/subcontract, any such information to any party other than the Department without the Department’s prior written authorization specifying that the information is releasable under 42 CFR, Section 431.300 et seq., and (d) shall, at the expiration or termination of the provider contract/subcontract, return all such information to the Department or maintain such information according to written procedures sent by the Department for this purpose.

3. Employees. The provider/subcontractor shall instruct its employees to keep confidential information concerning the business of the State, its financial affairs, its relations with its enrollees and its employees, as well as any other information which may be specifically classified as confidential by law.

4. Medical Records and management information data concerning enrollees shall be confidential and shall be disclosed to other persons within the provider’s/subcontractor's organization only as necessary to provide medical care and quality, peer, or grievance review of medical care under the terms of this provider contract/subcontract.

5. The provisions of this article shall survive the termination of this provider contract/subcontract and shall bind the provider/subcontractor so long as the provider/subcontractor maintains any individually identifiable information relating to Medicaid/NJ FamilyCare beneficiaries.

6. Notification in Case of Breach. Should there be a breach of confidentiality with respect to the data, information or records described in this section, the provider/subcontractor is responsible for complying, at a minimum, with the following statutes and regulations: (1) Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5), 42 U>S>C> 17932 et. seq. and the implementing regulations at 45 CFR Part 164, subpart D; and (2) the Identity Theft Prevention Act, N.J.S.A. 56:11-44 et. seq.

S. CLINICAL LABORATORY IMPROVEMENT

The provider/subcontractor shall ensure that all laboratory testing sites providing services under this provider contract/subcontract have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratory service providers with a certificate of waiver shall provide only those tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

T. FRAUD, WASTE, AND ABUSE

1. The provider/subcontractor agrees to assist the Contractor as necessary in meeting its obligations under its contract with the State to identify, investigate, and take appropriate corrective action against fraud, waste, and/or abuse (as defined in 42 CFR 455.2) in the provision of health care services.

2. If the State has withheld payment and/or initiated a recovery action against the provider/subcontractor, or withheld payments pursuant to 42 CFR 455.23 and NJAC 10:49-9.10(a), the Contractor shall have the right to withhold payments from the provider/subcontractor and/or forward those payments to the State.

3. The Contractor and its providers, and subcontractors, whether or not they are enrolled Medicaid providers, shall cooperate fully with state and federal oversight and prosecutorial agencies, including but not limited to, DMAHS, MFD, DOH, MFCU, HHS-OIG, FBI, DEA, FDA, and the U.S. Attorney's Office. The Contractor shall include language in its contracts with its providers and subcontractors, requiring cooperation, and stating that a failure to cooperate shall be grounds for termination of the Contractor's agreement with the provider or subcontractor. Such cooperation shall include providing access to all necessary recipient information, medical and clinical information, correspondence, documents, computer files, and appropriate staff.

4. MFD shall have the right to recover directly from providers and enrollees in the Contractor's network for the audits and investigations MFD solely conducts. Such money that MFD recovers directly shall not be shared with the Contractor, but reported to DMAHS in the format that the Contractor reports its recoveries to DMAHS. In addition, as a part of its recovery process, MFD shall have the right to request the Contractor to

withhold payment to a provider in its network as a result of an MFD audit or investigation of managed care claims. Money withheld from a provider by the Contractor shall be sent to MFD from the Contractor and reported to DMAHS in the format that the Contractor reports its recoveries to DMAHS.

5. The Contractor shall have the right to recover directly from providers and enrollees in the Contractor's network for the audits and investigations the Contractor solely conducts.

6. The Contractor shall have a nationally recognized standard criteria for inpatient hospital admissions that shall substantially conform to the Milliman Care Guidelines (MCG). The Contractor shall inform and include in all provider contracts for network provider hospitals or clinical care review team subcontractors, that for purposes of audits of inpatient hospital admissions by DMAHS or MFD or its subcontractors, MCG criteria will be applied

7. The provider/subcontractor shall comply with the provisions of Section 6032 of the federal Deficit Reduction Act of 2005. The provider/subcontractor and its employees, contractors, subcontractors and vendors, shall agree to abide by the Contractor's policies and procedures regarding Section 6032 of the federal Deficit Reduction Act of 2005. As part of these policies and procedures, the provider/subcontractor shall perform monthly exclusions, certification, and licensure checks of its employees, contractors, subcontractors and vendors, who directly or indirectly will be furnishing, ordering, directing, managing or prescribing Medicaid items or services in whole or in part, using the following databases:
   a. State of New Jersey debarment list (mandatory): https://nj.gov/comptroller/doc/nj_debarment_list.pdf
   b. Federal exclusions database (mandatory): https://exclusions.oig.hhs.gov/
   c. N.J. Treasurer's exclusions database (mandatory): http://www.state.nj.us/treasury/revenue/debarment/debarsearch.shtml
   d. N.J. Division of Consumer Affairs licensure databases, including all licensed healthcare professionals (mandatory, if applicable): http://www.njconsumeraffairs.gov/Pages/verification.aspx
   e. N.J. Department of Health licensure and certification database, including:, Nursing Home Administrators, Certified Assisted Living Administrators, Certified Nurse Aides/Personal Care Assistants, and Certified Medication Aides (mandatory, if applicable): https://njna.psiexams.com/.
   f. Federal exclusions and licensure database (optional and fee-based): https://www.npdb.hrsa.gov/hcorg/pds.jsp. Please note that only certain provider types may access this database. See www.npdb.hrsa.gov/hcorg/register.jsp for more information.

U. THIRD PARTY LIABILITY

1. The provider/subcontractor shall utilize, whenever available, and report any other public or private third party sources of payment for services rendered to enrollees.

2. Except as provided in subsection 3 below, if the provider/subcontractor is aware of third party coverage, it shall submit its claim first to the appropriate third party before submitting a claim to the Contractor.

3. In the following situations, the provider/subcontractor may bill the Contractor first and then coordinate with the liable third party, unless the Contractor has received prior approval from the State to take other action.

    a. The coverage is derived from a parent whose obligation to pay support is being enforced by the Department of Human Services.

    b. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the Medicaid program.

    c. The claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay.

    d. The claim is for a child who is in a DCP&P supported out of home placement.

    e. The claim involves coverage or services mentioned in 3.a, 3.b, 3.c, or 3.d, above in combination with another service.

4. If the provider/subcontractor knows that the third party will neither pay for nor provide the covered service, and the service is medically necessary, the provider/subcontractor may bill the Contractor without having received a written denial from the third party.

5. Sharing of TPL Information by the Provider/Subcontractor.

    a. The provider/subcontractor shall notify the Contractor within thirty (30) days after it learns that an enrollee has health insurance coverage not reflected in the health insurance provided by the Contractor, or casualty insurance coverage, or of any change in an enrollee's health insurance coverage.

    b. When the provider/subcontractor becomes aware that an enrollee has retained counsel, who either may institute or has instituted a legal cause of action for damages against a third party, the provider/subcontractor shall notify the Contractor in writing, including the enrollee's name and Medicaid identification number, date of accident/incident, nature of injury, name and address of enrollee's legal representative, copies of pleadings, and any other documents related to the action in the provider's/subcontractor's possession or control. This shall include, but not be limited to (for each service date on or subsequent to the date of the accident/incident), the enrollee's diagnosis and the nature of the service provided to the enrollee.

    c. The provider/subcontractor shall notify the Contractor on no less than a weekly basis when it becomes aware of the death of one of its Medicaid enrollees age 55 or older, utilizing the "Combined Notification of Death and Estate Referral Form" located in subsection B.5.1 of the Appendix.

d. The provider/subcontractor agrees to cooperate with the Contractor's and the State's efforts to maximize the collection of third party payments by providing to the Contractor updates to the information required by this section.

V. ENROLLEE PROTECTIONS AGAINST LIABILITY FOR PAYMENT

1. As a general rule, if a participating or non-participating provider renders a covered service to a managed care enrollee, the provider's sole recourse for payment, other than collection of any authorized cost-sharing, patient payment liability and /or third party liability, is the contractor, not the enrollee. A provider may not seek payment from, and may not institute or cause the initiation of collection proceedings or litigation against, an enrollee, an enrollee's family member, any legal representative of the enrollee, or anyone else acting on the enrollee's behalf unless subsections (a) through and including (f) or subsection (g) below apply:

   a. (1) The service is not a covered service; or (2) the service is determined to be medically unnecessary before it is rendered; or (3) the provider does not participate in the program either generally or for that service; and

   b. The enrollee is informed in writing before the service is rendered that one or more of the conditions listed in subsection (a) above exist, and voluntarily agrees in writing before the service is rendered to pay for all or part of the provider's charges; and

   c. The service is not an emergency or related service covered by the provisions of 42 USC 1396u-2(b)(2)(A)(i) , 42 CFR 438.114, N.J.S.A. 30:4D-6i or N.J.S.A. 30:4J-4.1 (as both of these provisions may be amended by State Appropriations Act language in effect at the time the service is rendered, as set forth in Section 4.2.1D.2 of the contract), or NJAC 10:74-9.1 ; and

   d. The service is not a trauma service covered by the provisions of NJAC 11:24-6.3(a)3.i; and

   e. The protections afforded to enrollees under 42 USC 1395w-4(g)(3)(A), 42 USC 1395cc(a)(1)(A), 42 USC 1396a(n)(3), 42 USC 1396u-2(b)(6), 42 CFR 438.106, NJAC 11:24-9.1(d)9, and/or NJAC 11:24-15.2(b)7.ii do not apply; and

   f. The provider has received no program payments from either DMAHS or the Contractor for the service; or

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

2. Notwithstanding any provision in this contract to the contrary, an enrollee shall not be responsible for the cost of care, except for any authorized cost-sharing, under the following circumstances:

a. The services are provided in association with an emergency department visit or inpatient stay at a participating network hospital, whether or not the servicing provider(s) or the admitting physician is a participating provider in the Contractor's network; or

b. The enrollee obtains a referral/authorization for services by, and schedules an appointment with, a participating specialist, but a non-participating specialist affiliated with the same practice as the participating specialist renders the services because the participating specialist is not available.

W. Off-Shore

All services pursuant to any provider agreement or subcontract shall be performed within the United States.

X. Further delegation of any delegated activity is not permissible.

SECTION 3
OTHER REQUIREMENTS

3.1 Subcontract. Any subcontract where the subcontractor provides claims adjudication activities must state that the subcontractor will provide all data required for Medical Loss Ratio (MLR) reporting within 180 days of the end of the fiscal year, or within 30 days of the request by the Contractor if requested sooner. This time limit cannot be extended by any other contract provision.

3.2 Over and Under Payments. In accordance with N.J.S.A. 26:2J-8.1d. (10 and 11), with the exception of claims that were submitted fraudulently or submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits, United shall not seek reimbursement for overpayment of a claim previously paid pursuant to this section later than 18 months after the date the first payment on the claim was made. United shall not seek more than one reimbursement for overpayment of a particular claim. At the time the reimbursement request is submitted to Provider, United shall provide written documentation that identifies the error made by United in the processing or payment of the claim that justifies the reimbursement request.

In seeking reimbursement for an overpayment from Provider, United shall not attempt to collect the funds for the reimbursement on or before the 45th calendar day following the submission of the reimbursement request to Provider.

Provider shall not seek reimbursement from a United or covered person for underpayment of a claim submitted pursuant to this section later than 18 months from the date the first payment on the claim was made, except if the claim is the subject of an appeal or the claim is subject to continual claims submission. Provider shall not seek more than one reimbursement for underpayment of a particular claim.

3.3 Appeals Process and Arbitration of Disputed Claims. In accordance with N.J.S.A. 26:2J-8.1(e)(2), Provider may initiate an appeal on or before the 90th calendar day following receipt by Provider of United's claims determination, which is the basis of the appeal, on a form prescribed by the Commissioner of Banking and Insurance which shall describe the type of substantiating

documentation that must be submitted with the form. United shall conduct a review of the appeal and notify Provider of its determination on or before the 30th calendar day following the receipt of the appeal form. If Provider is not notified of United's determination of the appeal within 30 days, Provider may refer the dispute to arbitration.

If United issues a determination in favor of Provider, United shall comply with the provisions of this section and pay the amount of money in dispute, if applicable, with accrued interest at the rate of 12% per annum, on or before the 30th calendar day following the notification of United's determination on the appeal. Interest shall begin to accrue on the day the appeal was received by United.

If United issues a determination against Provider, United shall notify Provider of its findings on or before the 30th calendar day following the receipt of the appeal form and shall include in the notification written instructions for referring the dispute to arbitration.

Arbitration. If Provider has exhausted United's internal appeal process Provider may seek arbitration under the Program for Independent Claims Payment Arbitration ("PICPA"). Additional information and frequently asked questions related to the PICPA process is available at https://dispute.maximus.com/nj/indexNJ.

Threshold of Arbitration. Any party may initiate an arbitration proceeding on or before the 90th calendar day following the receipt of the determination which is the basis of the appeal if the payment amount in dispute is more than $1,000. Provider may aggregate Provider's own disputed claim amounts for the purpose of meeting the threshold requirements of this subsection.

Determination. The determination must be signed by the arbitrator, issued in writing on or before the 30th calendar day following the receipt of the required documentation. The determination is not appealable and is binding on all parties.

Determination that United has withheld payment. Payment of a claim with accrued interest must be made on or before the 10th business day following the issuance of the determination. If United withheld or denied payment based on information submitted by Provider that United requested but did not receive, United shall not be required to pay any accrued interest.

Pattern and practice of improper billing. The arbitrator may award United a refund, including interest accrued.

3.4 Denial of Claims. Denial of claims is subject to the right to appeal a utilization management (UM) denial pursuant to N.J.A.C. 11:24-8.4 to 8.7.

3.5 Provider Hearing. Pursuant to N.J.A.C. 11:24-3.6, Provider has the right to request a hearing within 10 business days following the date of receipt of notice of termination of the health care professional prior to the date of termination.

In the event that Provider is a hospital and Provider's contract is not renewed, or is terminated by either party, Provider and United shall continue to abide by the terms of the most current contract for a period of four months from a severance date mutually agreed upon by both parties as required by 26:2J-11.1. In such an event, United shall provide written notification within the first 15 business days of the four month extension to all health care providers with which it has

contracted and members who reside in the county in which the hospital is located or in an adjacent county within United's service area. The notice to members shall also advise them of available options with respect to their health care coverage.

3.6 **Notifying DMAHS of Changes to Reimbursement Rates.** The Contractor shall notify DMAHS, in writing, of plans to modify reimbursement rates or the methodology applicable to a class of hospitals, nursing facilities, or medical day care providers at least 30 days before the effective date of such changes. Additionally, the Contractor shall not reduce reimbursement rates for personal care assistant services or home based supportive care services, as those services are defined by regulation or in the contract with the Division, under the Contractor's Medicaid managed care plan, unless the Contractor notifies the Division, in writing, at least 90 days before the effective date of such changes. Such notice shall be accompanied by written assurance that the reduction will not reduce 07/2024 Accepted Article 4 – Page 153 sufficient provider access or quality of service as required by the contract with the division and shall follow the notification guidelines prescribed in Appendix B.4.11. For rate reductions noted within 4.11.1, a written response from DMAHS is not required prior to implementation by the Contractor.

For all other services except those noted above, any provider rate reductions must be reported to DMAHS at least 90 days before the effective date of such changes. Such notice shall be accompanied by written assurance that the reduction will not reduce sufficient provider access or quality of service as required by the contract with the division and shall follow the notification guidelines prescribed in Appendix B.4.11. For rate reductions noted within 4.11.1, a written response from DMAHS is not required prior to implementation by the Contractor.

3.7 **Deconfliction.** Once the MFD's Notice of Audit/Notice of Investigation (NOA/NOI) has cleared for the audit or investigation to proceed, no United or United subcontractor, shall proceed with an audit, investigation or post payment recovery or adjustment involving Provider for the term stated in the NOI or NOA until the MFD or MFCU matter is resolved and notice of the resolution is provided. To facilitate this, on a monthly basis, MFD will provide a report to United of the MFD NOIs/NOAs deconflicted in the prior month and the deconfliction outcome.

A United case investigation/audit should have been cleared to proceed in accordance with established deconfliction protocols with the MFD and in accordance with CFR §42 455.14 and 42 §455.15.

3.8 **340B Drug Pricing.** United's Pharmacy Benefit Manager (PBM) or other vendor subcontractors shall ensure that all contracted dispensing pharmacies identify utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program by reporting, as a component of the pharmacy encounter record, the National Council for Prescription Drug Program (NCPDP) field 420DK populated with the Submission Clarification Code value of "20". This requirement applies to all claims submitted directly by a FQHC and from FQHC-contracted pharmacies, as well as all of United's pharmacy providers. All dispensing pharmacies shall submit a clarification code of 20 when using 340B inventory to identify these claims in the NCPDP transaction.

3.9 **NJMMIS System Enrollment.** As of January 1, 2026, all providers must be enrolled with DMAHS in the NJMMIS System. Failure to enroll in NJMMIS, or DMAHS rejection of an application to enroll in NJMMIS, will result in termination from the United Medicaid network. United will send a notice to Provider requiring Provider to submit an enrollment application

within 30 days of the notice. If Provider does not complete enrollment within 150 days of receiving the notice, United will terminate Provider from the United Medicaid network.